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Ecologies of Care: Towards a Posthuman Institutional Ethnography of nursing

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Submission for the consideration of the degree of
Doctor of Philosophy
The University of Edinburgh
Spring 2021

I declare that this thesis has been composed solely by myself and that it has not been submitted, in whole or in part, in any previous application for a degree. Except where states otherwise by reference or acknowledgment, the work presented is entirely my own.
Lay Summary

The lay summary is a brief summary intended to facilitate knowledge transfer and enhance accessibility, therefore the language used should be non-technical and suitable for a general audience. Guidance on the lay summary in a thesis. (See the Degree Regulations and Programmes of Study, General Postgraduate Degree Programme Regulations. These regulations are available via: www.drps.ed.ac.uk.)

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Nursing and care are familiar concepts to many, but it can be challenging to explain the work that nurses do. This study examined how nurses perform their duties and the various factors that influence their work. It also explored how nursing is valued from political, institutional, and personal perspectives. The project used a critical posthuman approach to examine how both human and nonhuman elements contribute to nursing. Data from regulatory frameworks, clinical environments, multimedia diaries, and interviews with nurses were analysed to explore the meaning and imagined realities of nursing work. The study found that nursing is a complicated process that requires managing diverse and ever-changing situations involving both humans and nonhumans. It highlights how critical posthuman theories offer a chance to better understand and appreciate nursing while recognising the complexities of life.
Acknowledgements

I want to thank all the nurses who participated in this project and all the nurse from whom I have learned throughout my years working as a nurse. I am indebted to all that you have taught me and will continue to teach me.

I would like to thank my friends and family for being eternally and patiently supportive.

I would also like to thank my supervisors and examiners who continually challenge my thinking and have undoubtedly improved this research.
1 Abstract

The value of nursing and nurse work in the UK is unclear. Changes in nursing within contemporary social, economic and political systems have renegotiated the power structures that produce the meaning and value of nurse work. An increasing amount of research addresses nursing and nursing practice, however there is a scarcity of research about fundamental care and nurse work in contemporary frameworks of nursing. This PhD project explores how the value and meaning of nurse work is created within contemporary institutions.

This project was a posthuman institutional ethnography (PIE) conducted at a large acute NHS hospital in Scotland. The mixed method design involved workforce demographic data, documentary analysis of the NMC Code of Conduct, participatory ethnography at an acute ward as well as three-week long multimedia diaries and semi-structured interviews from 10 practicing nurses. This heterogeneous data was examined using multiple analytical tools grounded in critical feminist and posthuman theoretical approaches. The project mapped each of the tools used onto the supporting principles of PIE and situated the findings from this perspective.

This thesis contributes to nursing research theoretically and methodologically. First, it suggests understanding fundamental care as an ecology created by people, place and structure. Second, it positions nursing in the theoretical framework of critical posthumanities as a (new)materialist practice. Third, it suggests that the obscure valuation of nurse work makes it difficult for institutions to value nurse work. Fourth, it develops the Posthuman Institutional Ethnography research method, developed in educational studies by (Taylor & Fairchild, 2020) as a research method in healthcare for the first time.
2 Preface

The work for this thesis began long before I started this PhD programme and will continue beyond the end of this project. Nurse work and care are integral to and entangled in the way that worlds have been, are and will be made.

I recently realised that my course towards this research was mapped out subtly in 2008 when I started my nursing education. Having already completed a Bachelor’s in psychology, I had started training as a nurse with an acute thirst for knowledge. I would read anything and everything that whet my appetite for nursing. This soon turned into a (pro-) feminist endeavour as I experienced privilege in practice as a student nurse due to what I perceived as my gender. As a male, I was offered more medically-oriented learning opportunities such as observing operations or preparing intravenous medications. My best friends (to this day) who I met on the course and are women, had different experiences. They were given fewer medically-orientated learning opportunities and were expected to perform much more bedside care than I was. This made me angry because of the social injustice and somewhat jealous because I wanted to be the best nurse I could and I viewed the mastery of bedside care as fundamental to that.

This anecdotal evidence encouraged me to read as much as I could about feminism, nursing and the characteristics of fundamental care. During this time, I was inspired by an Eva Gamarnikow paper entitled ‘Sexual Division of Labour: the case of nursing’ and until recently and the passage of 13 years, I did not realise the significance of this paper to my interests and career. Sometime after reading this article I completed my training as a nurse, I subsequently went on to achieve Master’s degrees in the Sociology of Gender as well as in Nursing, whilst having a successful, varied professional career thus far. However, the initial questions concerning privilege in nursing, the value of nurse work and the characteristics of care have endured. These questions led me to read widely until I discovered my theoretical home in the shape of critical posthumanism and new materialisms. The latter two will be discussed in detail in this thesis. However, the consequences of these experiences recently became perceptible to me while collating the reference list for this project. The Gamarnikow chapter was published in a collection of papers entitled ‘Feminism and Materialism’ (Kuhn & Wolpe, 1978). My rhizomatic research journey through psychology, nursing, gender, sociology and philosophy had been implicated and entangled in materialism (new or otherwise) for much longer than I had known.

I invite you along with me on part of my research journey and would like to thank you in advance for joining me. I ask for your patience, critique and understanding for us to
collectively 'stay with the trouble' (Haraway, 2016, p. 1) in the consideration of knowledges as infinite, and approach nurse work with critical posthumanism.
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1 Chapter 1: Introduction

1.1 Why now?

Over the past 50 years nursing in the UK has undergone a professionalisation project that created a more educated and self-regulated workforce. This professionalisation coincided with a paradigm shift and meeting of phenomena in economic, political, and cultural production that Rosi Braidotti (2013) describes as the ‘posthuman convergence’. Two of the critical phenomena in this merging are the 4th Industrial revolution (McAfee & Brynjolfsson, 2017) and the 6th mass extinction (Kolbert, 2014). The 4th industrial revolution is characterised by the de-centralisation of technology to an ‘Internet of Things’ which is rapidly changing traditional modes of production. Many of the changes in this economic shift lead to automation conversely leading to a reduction in humans required by some parts of these processes. The 6th mass extinction is characterised by the rapid reduction in biodiversity currently underway. Rapid environmental changes and the reduction in biodiversity have forced humanity to consider its mortality in a globalised way. The rapid development and timing of these phenomena create questions both concerning biopolitics and the individual’s position in society and on the planet, and also create conditions for post-anthropocentric thought (Braidotti, 2019). Post-anthropocentric thought is a concept that examines humanity’s position in the world and begins to imagine realities in which systems of thought do not centre on humans.

The opportunities created by the posthuman convergence for the introspection of the human and what it is to be human is of particular interest to nursing. Part of the Posthuman convergence is the mobilisation of the category of human towards a situated and post-anthropocentric view of the human that will be explored in more detail in Chapter 3. Nursing is humanistic because it involves the care of humans, much like veterinary nursing is the care of animals or nursing a plant is occupied with the care of plants. However, in an anthropocentric context nursing humans is occupied with how the human is produced in a context and in what relations humans exist with their environment. A critical posthuman approach to nursing is situated in broader feminist histories of care ethics, approaching nursing with the work of scholars such as Wynter, Plumwood, Gilligan, Young, Bird Rose and most recently Puig de la Bellacasa, to understand that self-determination does not mean self-sufficiency (Gilligan, 1982; McKittrick, 2015; Plumwood, 1993; Puig de la Bellacasa, 2017; Rose, 2012). These ethics of care are ecologically situated and approach the

---

1 Nursing in this thesis concerns the care of the human. Other kinds of nursing exist such as veterinary nursing or nursing plants (D. J. Haraway, 2016).
production and care of the human in the environment they are situated, while understanding the human has agency in these situations. Critical posthuman nursing implicates people and nurses in their situation; however, within dynamic constellations. Posthuman nursing works with materiality, relationships and accountabilities for the positions we as humans inhabit. Practicalities of care and nurse work can help us understand world making with posthuman philosophies and knowledge production beyond what has been understood as human in western thought since the Enlightenment.

The main challenge facing nursing and healthcare is meeting the care needs of a globally ageing population. The over-60 population is the growing faster than any other (Buchan et al., 2019) while the working-age population remains static. This presents the challenge of who will care for people and how will humans care for their elderly if there are fewer working age people. The political leadership of the UK and most high-income countries are issuing calls for more nurses to meet the growing demands on healthcare systems. In 2020, the UK reported a shortage of 40,000 nurses (Cowper, 2019). Considering frontline healthcare staff vacancies, these figures are predicted to rise to 250,000 in the UK by the year 2030 (Cowper, 2019). The ageing population increases demands on nursing and care, and subsequently produces nursing shortages and an increasing demand for care. The increasing demand for care embeds nursing deeply within the posthuman convergence as well as raising political and philosophical questions into what future configurations of care and society will look like.

1.2 Why nursing?
Nursing is a global issue that affects all societies (World Health Organisation, 2020), yet such a broad statement requires context and qualification. It requires us to understand what nursing is, as well as how nursing is entangled in societies. Here, if I loosely assume nursing is care, and everywhere is lived human experience, then I begin to understand the intention behind such a statement.² Nursing is everywhere because it is entangled with everyone and everything, because care is ubiquitous – that is to say, everyone is born and everyone dies. These life events are shared by all humans. Birth and death become concepts that create shared points in life. They create a space for shared experiences of care and what care may be, but although we may experience all these shared events they are not one and the same. It is this space of commonality through difference where this project begins and works to

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² Nursing is used in this thesis as the common noun to describe the profession or role of nursing. Nurse work is used to describe the abstract uncountable noun of the work done by nurses – which is sometimes described also as nursing, therefore, this distinction is made for clarity of meaning.
establish how nurse work and care are focal points (Taylor & Fairchild, 2020) to interpellate posthuman theory as practical philosophy (Deleuze & Guattari, 1988; Smith & Willis, 2020). The project will establish a contemporaneous geo-spatial-temporal-socio-philosophical viewpoint from which to approach an understanding of care in relation to nursing, with an intent to understand how this is used in professionalised nursing.

As nurses, physicians and healthcare scientists we must begin to look at the politics and philosophies employed to underwrite health systems to address challenges in healthcare. The tension that an ageing population and a new industrial revolution creates, provides an opportunity for health systems to consider how to do things differently as it becomes more clear that more of the same is not the way to prepare for a changing world. Health systems must face the possibility that they will never be able to train enough nurses to look after the ageing population if health systems do not adapt in philosophy and delivery. Consequently, there must be an acceptance of the biopolitical shift and work with it to educate and prepare for the future.

In response to global challenges, the World Health Organisation (World Health Organisation, 2016; 2020) has repeatedly made calls to upskill nurses to improve global health. Dr Tedros Adhanom Ghebreyesus is the General Director of WHO and he is involved in encouraging and setting agendas for global health systems. Nurses need to be research based, globally focussed, interdisciplinary and prepared for radical (and perhaps uncomfortable) change in response to these calls (Rafferty et al., 2019). If we as nurse researchers consider these calls in the context of the posthuman convergence, then this raises the question: how do we upskill nurses in a bio-socio-politically changed context? Nurse researchers can learn from where we have come from, however, the solutions to the issues of now and the future will not be found in the past.

This thesis will apply contemporary social and philosophical perspectives to people, places and structures that create nurse work in the UK. It will consider the context nurse work is produced in, as well as how the conditions of possibility for nurses will facilitate nurse work in contemporary contexts.
1.2.1 Beyond the RN4cast

The RN4cast study was a large, multinational research project that spanned several years, and which aimed to look at nursing and nursing workforces in 12 high-income countries (Sermueus et al., 2011). It involved many high-profile, international nursing researchers and was franchised and endorsed by leading international political leaders (Buchan et al., 2019; Rafferty et al., 2019; World Health Organisation, 2016, 2020). The study had a wide-reaching impact, leading to many publications and being cited thousands of times. The RN4cast project looked at the impact of organisational features of hospital care on nurse recruitment, nurse retention and patient outcomes. The study surveyed nurses in 12 countries and looked at patient outcome data in those countries. The study reported that a 10% increase in nurses with Bachelor’s degrees was associated with a 7% decrease in the likelihood of an inpatient dying within 30 days of admission to hospital (Frenk et al., 2010). Each 10% reduction in the proportion of degree educated nurses is associated with an 11% increased risk of patient death (Aiken et al., 2013; Ball et al., 2018). These studies also report that nursing workload was associated with poorer patient outcome as each additional patient that a nurse cares for during a shift will increase the 30-day inpatient mortality by 7%. These findings have played an important, key role in debates surrounding nursing since their publication and continue to do so to this day.
The findings support the professionalisation and academisation of nursing to improve inpatient mortality and were used to support efforts to this effect in the UK. These findings were generally well received because they suggest a clear way to improve patient outcomes and support the broader aim of raising the academic status of nursing as a profession whilst also creating a skilled and accountable workforce. There are also several perceived economic advantages to this model of the nursing workforce. Professional nurses with degrees can legitimately work in roles such as Consultant Nurses or Surgical Practitioners that were previously reserved for physicians, surgeons and pharmacists. When RN4cast was published there were further economic benefits in some countries for their commercialised higher education sectors. An academic degree qualification for nursing in a country such as England, makes students consumers in an increasingly monetised and commercialised higher education market. Consequently, the RN4cast study was welcomed by many stakeholders, but for different reasons.

I suggest that the positive response to such a large study and the many obvious benefits for nurses and patients created little room for a critical reception. RN4cast clearly demonstrates a relationship between academically educated nurses and improved patient outcomes. However, if the findings are used in reality to argue that nurses with degrees improve inpatient outcomes (measured in mortality), then it is logical to assume that nurses without degrees decrease positive patient outcomes. I do not suggest this as the breadth of nursing roles, healthcare providers and local contexts for this data create complexities over and above that outlined immediately above. The care being provided may or may not differ, however, the studies raise questions about how this data and this study could be used.

Many nurses with degrees will have been mentored and educated in practice by nurses without degrees. Nurse education programmes in many of the countries included in RN4cast project have hybrid frameworks between classroom and placements in clinical practice. This means that when student nurses in clinical learning environments are assigned mentors who are registered nurses. In the UK, these nurse mentors are encouraged to have post-registration certification in mentorship and this is becoming more formalised as part of the ongoing professionalisation project (NMC, 2020b), however this qualification is not mandated. In the UK – at the time the data was collected for RN4cast – there was a broad acceptance of prior academic and practical experience for nurse mentors as an equivalent to mentorship programmes (NMC, 2007). There remains no stipulation that nurse mentors must have a degree. Therefore, the nurses described in the RN4cast study who have degrees are very likely to have been mentored by nurses without degrees. This
creates a question about what work degree level nursing is doing to produce the results of the studies mentioned above.

A discourse relating to the tensions between degree and non-degree educated nurse was also produced in the early 2000s, around the same time as RN4cast. Growing tensions were noted by the media and academics about the professionalisation project in nursing known as Project 2000. Catchphrases emerged in academic papers and the media such as ‘Too posh to wash’ and ‘Too clever to care’ (Bore, 2004; Gallagher, 2005; Gillett, 2012; Hooper, 2004; Kirby, 2005; Scott, 2004). These soundbites highlight some of the tensions concerning the professionalisation of nursing and also draw attention to some of the resistance to nursing professionalisation which has been long disenfranchised due to misogyny and political practices (Davies, 1980; Solano & Rafferty, 2007). However, these discourses in the context of influential studies do raise the question of, how or if nursing care differs when provided by someone with a degree or those with other qualifications. It also raises questions regarding how quality of care is measured in these scenarios and what is it about nurse work that improves patient outcomes? The RN4cast is only a starting point for questions about nurse work and its value.

1.2.2 New power dynamics

The RN4cast study recognised the institutional changes occurring in many countries due to the professionalisation of nursing. Systemic credentialisation of any workforce (and especially one as large as the nursing workforce) reconfigures power structures as certain types of knowledge and power become valued in the production of new institutional systems. In nursing, the reconfiguration, and changes in credentialisation have not eliminated structural power differentials. Research indicating in which gender, class, race and education are just a few examples of longstanding prejudices which remain in professionalised nursing workforces (Punshon et al., 2019; Rafferty et al., 2019). I will further explore these power structures in the next chapter of this thesis. The point I would like to make here is that the authors of the RN4cast or the NMC code of conduct may not have intended to create new, negative power dynamics in a professionalised nursing workforce such as the ‘too posh to wash’ discourse. However subsequent research suggests that they did, and when they did, they created a line of inquiry about nurse work and about how these new power configurations are enacted within systems and what is valued more or less in these systems. The causality suggested by the RN4cast study between more academically educated nurses and lower mortality rates is interesting, however, which nurse work or care is creating this effect?
I am interested in nursing for several reasons, but mostly because I am deeply embedded in the sector. I have earned a living as a nurse for almost 15 years and therefore have a co-dependent relationship with it. I also love my job and being a nurse. I also saw that I was afforded opportunities in my career that were not offered to my female contemporaries and I often attribute this to being a white, European male. I find the latter deeply disturbing and I am compelled to understand more about what is valued in nursing and how power is configured. I am also now involved in nursing science, research and teaching as a result of my interest in the field. It is essential that critical reflection and peer review guide any changes in nursing because of the wide-reaching impact that nursing has and that reconfigurations of frameworks and professional structures directly impact millions of people’s lives.

This project takes a critical, gendered approach for several reasons. First of all, the majority stakeholders in the systemic credentialisation of nursing are the nurses working in the system and that group should be franchised in the professionalisation process using an approach that recognises structural violence against women. Secondly, nurse education is an essential component of the professionalisation of nursing and is viewed as a vehicle for raising the status of women globally (All Party Parliamentary Group on Global Health, 2016; Nigel Crisp, 2018). Thirdly, the group most impacted by any power reconfigurations are women because women are around 90% of the global nursing workforce.

1.2.3 Where we are and where we are going

We are currently undergoing the fourth industrial revolution (McAfee & Brynjolfsson, 2017) and the sixth mass extinction (Kolbert, 2014). These two phenomena also coincide with a pronounced change in demographics as people live longer than before. Healthcare is implicated and not outwith these changes. Entangled in this is how human bodies are involved in these systemic changes. In Foucault’s description of biopolitics as: ‘the endeavour... to rationalise the problems presented to governmental practice by the phenomena characteristic of a group of living human beings constituted as a population’ (Foucault, 2000, p. 74); biopolitics constitutes the ways that biopower defines what a population is and determines how that population is discursively situated and developed (Foucault, 2003, 2005). This concept has developed into defining practices of biopower and biopolitics as illuminating mechanisms of regulatory control by dominant modes of social and economic production (Cheney-Lippold, 2011). Authority over the human body is not fixed and is in flux (Greco, 2004). Before the enlightenment it was thought that health and illness were produced by deities and the adherence to religious morals. After the enlightenment this authority shifted to physicians and after the industrial revolution, to the
state; subsequently this became individualised due to advancing capitalism and neo-liberalism (Greco, 2004; Latimer, 2013; Latimer & López Gómez, 2019). However, biopower is again in flux during the fourth industrial revolution and it is shifting towards technology and the individual (Amoore, 2013). The increase in individualised medicine and the adherence to evidence-based practice for fear of litigation are examples of how technology, i.e. algorithms, produce power in contemporary health systems (Smith et al., 2022).

Challenges to how we understand humans as bounded entities also result from these developments. In a context in which the interconnectedness of life on earth is brought to the fore by rapid climate change and axioms of advanced capitalism; what it is to be human becomes interpellated. This has direct consequences for the epistemology of nursing knowledge which is built around person centred and humanistic care. Humanity inhabits a world with the over-60s being the fastest growing population group, while the working-age population is static. Rapid environmental changes and reduction in biodiversity force humanity to consider its mortality in a globalised way. This creates questions and crises which exceed the boundaries of existing health and social care systems as well as calls for the political and philosophical investigation of what future configurations of care, nurse work and society might look like. Humanity must learn from the past and the present to create sustainable and affirmative futures.

Nurses, physicians, and healthcare scientists must begin to look at the politics and philosophies employed to underwrite health systems as it has become abundantly clear that more of the same is not the way to prepare for a changing future. The tension that an ageing population and a new industrial revolution create, provides an opportunity for health care systems to consider how to do things differently. Humanity must face the possibility that it will never be able to train enough nurses (or healthcare staff) to look after the ageing population if it does not adapt its philosophy and delivery of care. This convergence and context produce a mandate to research the biopolitical shift and work with it to educate and prepare for the future.

Around the world, political leaders are issuing calls for more nurses to meet the growing demands on healthcare systems. However, where will these nurses come from, in which way and what will these nurses look like? Simply asking for greater numbers of nurses is not sustainable; where will it end? To create a healthcare system that is prepared for the 21st century and beyond, the meaning entangled in these demands must be studied.

It is becoming clearer that the status quo is not sustainable and requires reflection and introspection. This is characterised by the undefined nature of fundamental care (Feo et al., 2018) and the emerging yet multiple definitions of what constitutes nurse work (Jackson, 2015). These unclear definitions have implications beyond the immediate situation of the
production of nurse work because the latter is embedded in educational programmes, political discourse and societal expectations of women. If research begins to describe nurse work in different ways this will potentially impact many stakeholders.

Over the past 40 years, nursing in the UK has undergone massive changes in the way it is structured, regulated and organised. As of 2015 all nurses registering with the Nursing and Midwifery Council have to do so with a Bachelor’s degree level qualification (NMC, 2020b). As of April 2019, there were 706,252 nurses with active NMC registrations (NMC, 2020a). Nurses are represented by the largest union in the UK with 435,000 active members (2020). Some suggest that this restructuring and renegotiation have favoured parts of nursing and nurse work that align with the medical dominance of health care, to the detriment and disenfranchisement of more traditionally feminine labour (Dingwall et al., 1988; Fotaki, 2015; Maggs, 1996; Theodosius, 2008).

As nurses we can learn from where we have come from and now must research where we are and where we are going in collaboration and synergy with other disciplines. Nursing continues however, as do bodies, politics, and the world therefore we must also work with these to create futures of affirmative care.

This project aims to discuss how power has been renegotiated in the contemporary UK nursing context. It aims to explore how particular discourses surrounding nursing credentialisation, normalise some power structures and disenfranchise others. It addresses the following questions:

1) How is nursing care materially (co)produced in a hospital ward in Scotland?
   a. How do the human, non-human and more-than-human produce nurse work?
2) How is the nurse work imagined, created and produced institutionally?
3) How are these perceptions of nurse work used?
   a. politically in the wards and clinics to shape how care is produced?
   b. and politically by healthcare providers?
1.3 Thesis roadmap

1. Introduction

Chapter 1 identifies that it is unclear how nurse work is valued in the UK, despite there being 670,000 active registrants who comprise just over 2% of the working age population. The chapter positions nursing and nurse education, both globally and in the UK, as something that has changed and developed over the past 40 years. These changes in nursing involve diverse stakeholders such as politicians, academics and policymakers who are interested in shaping nursing’s direction. This chapter contextualises these changes in nursing within contemporary social, economic and political systems. It then explores how the value and meaning of nurse work is produced by contemporary institutions.

2. Background

Chapter 2 identifies the tensions in what is already known about nursing and nurse work. It explores the general history of nursing in the UK by examining the current state of nursing and how nursing gained the role it has today. The professionalisation of nursing over the last 150 years is situated alongside feminist projects, which explore how nurses’ roles developed. The chapter then reviews the academic literature on contemporary nurses’ roles. The role of the contemporary nurse is explored through four spheres of practice: physical, cognitive, organisational and emotional labour. Given the feminist project of developing nurse work, the traditionally gendered labour of emotional and organisational labour are explored in more depth. This project aims to discuss how power has been renegotiated in the contemporary UK context for nursing.

3. Theoretical standpoint

Chapter 3 is a deep exploration of contemporary critical feminist theory and links to opportunities for developing knowledge identified in existing literature. This chapter makes the case for a post-anthropocentric approach to nurse work and care by mobilising the concept of person-centred care. Approaching nurse work from a monistic epistemology, nurse work is situated in a critical posthuman ontology and explores the epistemological considerations required to create research methods from this position.

4. Research design and methodology

Chapter 4 explains the rationale and methods employed in exploring how the value of nurse work is produced by contemporary institutions. It explains why and how this project used Posthuman Institutional Ethnography (PIE) as a mode of enquiry, and gives a rationale for this approach by making connections between the research questions, methods and
theoretical approach. At the time of writing, this is the first PIE undertaken in healthcare and therefore adapts the emerging PIE method to the context of nursing. The mixed method design involved workforce demographic data from a large, acute NHS health board, documentary analysis of the NMC Code of Conduct, participatory ethnography at an acute NHS ward, three-week long multimedia diaries by and semi-structured interviews with 10 practicing nurses. This chapter then describes how each type of data was produced, the ethics of using this data and identifies the analyses used to interrogate the data. The types of analysis used to generate meaning from this heterogeneous data set are outlined and connections are made to critical feminist and posthuman theory.

5. Findings 1: Ecologies of regulation and practice

Chapter 5 discusses a documentary analysis of The Code, exploring how it is represented in the experiences of participants. I compare the Code's idealised, regulatory, version of nursing with participants' real-life experiences, identifying differences and potential gaps between the two. Through analysing participant data, I gain insight into how nurses perceive and navigate their professional lives within the regulatory framework of The Code. The analysis suggests that the Code can sometimes be prescriptive or restrictive to nurses in their work. Lastly, this chapter will explore the relationship between regulatory theory and nursing practice, highlighting the implications for nursing education, policy-making, and patient care.

6. Findings 2: Ecologies of theory and practice

Chapter 6 This chapter examines the ways in which affective intra- and interactions are produced for nurses between theory and practice. This chapter discusses the findings of the analysis of the data, organised around the theme of nursing as an ecology of theory and practice. Codes and themes were produced using field notes, the NMC Code of Conduct (2015) document, multimedia diary entries and participant interviews. The chapter also discusses how burnout or unpreparedness among nurses could suggest a gap between knowledge and practice.

7. Findings 3: Ecologies of people, place and structure

Chapter 7 explores how humans, non-humans and more-than-humans produce nurse work and the value it is given. Visual and interview data are used to help discuss the creation of nurse work from a socio-material perspective. Nurse work and nursing practice is shown to be deeply embodied and embedded within the material environments in which nurses practice. This chapter suggests that the materiality of places of care affects how the value of nurse work is configured. This chapter also explores the effects of nurse work on
human bodies. It discusses the effects of nurse work on nurses, patients, families and how the value of nurse work is demonstrated using bodies. Nurse work is shown to be a material practice that can support the development of critical posthuman and nursing theories. This chapter suggests connections between theoretical new materialist and posthuman paradigms and the human, and reimagines the human body in the ways it exists in relation to the more-than-human materiality of the world.

8. **Discussion/Claims**

This thesis contributes to nursing research theoretically and methodologically. First, of all, it positions nursing in the theoretical framework of critical posthumanities as a (new-)materialist practice. Second, it explores how nurse work is valued and subsequently positioned in institutions. Third, it aims to develop Posthuman Institutional Ethnography research methods — developed in education studies by Taylor and Fairchild (2020) — in healthcare. The value of nursing continues to be (re)negotiated within healthcare institutions. The materialities of institutions affect nurse work and how nurses value their work. These materialities are tangible and transgressive and have consequences for the realities of how worlds are made. Nurse work is often highly valued by institutions, nurses, politicians, regulators as well as by society at large. Nurse work and the fundamentals of care remain somewhat imperceptible to many, including institutions, politicians and regulators. Moreover, the space in which nurse work can be performed is often restricted by stakeholders. I suggest this may be because much nurse work is as yet imperceptible. The multi-faceted restrictions on nurse work have an effect on how the value, power and meaning of the contemporary nursing role is produced in the UK. This has implications as making nurse work more perceptible using innovative methods, supports equitable, affirmative valuations of nurse work.
Chapter 2: An entry point into this thesis: A review of nursing, new-materialist and critical posthuman literature

Chapter 2 will review existing literature to identify the recognised tensions in nursing and nurse work. This chapter will first explore the historical, political, sociological and academic context for nursing to affirm a feminist approach in nursing and to establish how nurse work is valued. The chapter will then discuss how nurse work is known in academic literature and will then explore the gaps in researching nurse work with critical feminist approaches.

This chapter will situate nursing in the UK by demonstrating how entangled the history of nursing, its professionalisation, politics, biopower and what comes to be valued in nurse work are when it comes to producing contemporary nursing. This section will begin with a brief history of nursing and nurse work, and how many view it as a vehicle for feminism. The review will then explore how nursing became professionalised into the contemporary concept of the nurse and nursing in the UK. This will involve briefly exploring the dominant paradigms in this professional discourse of patient-centred care and professional identity. This chapter will then continue by examining what is already understood as nurse work both theoretically and empirically and conclude by exploring the gendered aspects of nursing labour. I situate nursing in this manner to begin to understand the context of how nursing is known and how value of nursing is produced. 'Reality is an active verb' (Haraway, 2003, p6) so this project's entry point into the realities produced by nurses is found in the socio-cultural-economic-political-educational-historical context.

2.1 Situating nursing in the UK: how is nursing known and how is it valued

Prominent nurse scholars, politicians and activists such as Celia Davies (2004), Nigel Crisp (2018), Jane Salvage and Barbara Stillwell (2019) continue to issue calls for politicians and society to better understand what it is that nurses do, the structural conditions of possibility that shape the way nurses work as well as advocate to make nurses' voices heard which otherwise remain muffled by 'patriarchy' (Salvage and Stilwell, 2018). These discourses are well known and frequently discussed by nurses. However there has been little change to the rhetoric since the works of the early 1980's which reframed nursing in feminist scholarship and contextualised nursing within neoliberalism (Davies, 1980; Maggs, 1996; Salvage, 1985). Davies writes that when she first began her work, she felt an 'arrogance of the young' (Davies, 2004:11) in feeling that they were 'at the beginning of something new' yet now recognises that her work is part of a much broader, older story.
Stories of nurse work are easily imaginable to many as they have a high profile in the media, yet this chapter will mobilise the assumptions made about the positioning of nursing by different entities and begin to unpack the complex realities which remain poorly understood (Salvage & White, 2019).

Ann Bradshaw (Bradshaw, 2017) in her article on the history of nursing from the 1860’s to the present day, observes that there is a ‘deep uncertainty of what a ‘true’ nurse is’ (ibid p.1). This becomes especially apparent when attempting to define nursing more broadly, but additionally when operationalising it in order to make it an object for social, political, philosophical and scientific research. This chapter will firstly consider the concept of contemporary nursing to better understand the complex presentation of nursing, care and nurses.

### 2.1.1 How key nurse theorists and organisations define nursing

The International Council of Nurses (ICN) provides the following definition of nursing:

>*Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles.*

(International Council of Nurses, 2019)

This definition emphasises nurses as autonomous practitioners who take a holistic and situational approach to promoting people’s wellbeing. This statement also draws attention to the diversity of nursing which creates scope for better understanding the core principles – if any – of nurse work. Contemporary nursing knowledge has many conceptual models from which numerous nursing theories around the world detail similar, yet different approaches to nursing. These have prompted rich debate around the possibility of a universal nursing process, however, Fawcett and DeSanto-Madeya (2012), in their article on 'The Metaparadigm of Nursing', attempt to identify a thread which links these perspectives globally:

*The discipline of nursing is concerned with the principles and laws that govern human processes of living and dying.*
The discipline of nursing is concerned with the patterning of human health experiences within the context of the environment.

The discipline of nursing is concerned with the nursing actions or processes that are beneficial to human beings.

The discipline of nursing is concerned with the human processes of living and dying, recognising that human beings are in a continuous relationship with their environments.

(Fawcett & DeSanto-Madeya, 2012, p. 15)

Above, Fawcett and DeSanto-Madeya (2012) identify human bodies, the environment, health and nursing as key propositions which are themselves intimately connected to one another and interactive. This definition describes nursing and nurse work as a highly relational and situated process. By this definition, nursing is a process of associating people, patterns and their environment in ways which are beneficial to human beings.

The media portrays nurse work as feminine and caring (Hoeve et al., 2014) by creating caricatures of nurses along three themes: a) those committed to clinical work b) those who have poor interpersonal skills and are unintelligent or c) those who are highly promiscuous. The collective imagination of what a nurse and nurse work is also remains gendered. Longitudinal research into attitudes of nurses, conducted over a ten year period, demonstrates persistent stereotypes of nurses such as ‘angel, handmaiden, battle-axe or whore’ (Jinks & Bradley, 2004, p. 121). The continued reproduction of these stereotypes contributes to the theoretical and ethical tensions within the professionalisation of nursing, as described earlier, and demonstrates that those outside nursing hold a different view of nurses and nursing to those involved in nursing. Together these viewpoints demonstrate the plurality of what nursing is and can be. Nursing is referred to as a relational process which is concerned with people in their environment and promoting their being in an environment that supports well-being. It is also a dynamic concept which changes to suit each situation, as time passes and from the viewer’s standpoint (Harding, 1991; Smith & Willis, 2020).

In the global north, nursing is a highly regulated profession. Codes of conduct, codes of ethics and legal frameworks, regulate nurses. However, the collective imagination of what
a nurse and nurse work is, remains gendered. Therefore, an argument can be made that the contemporary production of the nurse is little changed from historical ideas of nurses as handmaidens or saviours (Dingwall et al., 1988). These ideas are entangled with regulatory frameworks for nurse work and amalgamated into how nurses are expected to practice. Regulatory frameworks exist across the global north\(^3\). In the UK this is known as The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates (Nursing and Midwifery Council, UK, 2015).

Nursing materialised in Britain as a discrete occupation during the mid-19\(^{th}\) century. In their 1978 publication, Gamarnikow’s contemporary viewpoint of late 1970’s nursing is that it remains almost completely subordinate to medical staff and views the relationships between patients, nurses and medical staff in familial terms where the predominantly male medical staff assume ‘the incumbent ‘rule of the father’ (Gamarnikow, 2013, p. 97).

Gamarnikow describes several ways in which the male-controlled character of the sexual division of labour, reproduces the nursing role. Firstly, the almost full subordination of nurses to medical practitioners, which she locates historically in interprofessional relations between medical doctors and nurses. The ‘consensus about the structural location of nursing within the occupational organisation of health care’ (ibid p. 102) is one of reproducing representations of naturalism i.e. nursing is related to motherhood and therefore presumptively caring, and medical doctors are related to authority and intelligence.

Florence Nightingale was a key figure in designing and instigating the professionalisation of nursing and developing nurse training, wrote: ‘To be a good nurse, one must be a good woman, here we shall all agree...’(Nightingale, 1881, p. 1). These sentiments link nursing to patriarchal ideals concerning women's roles in the private sphere while at the same time defining nursing as work which requires gendered acts of care and altruism. This is described by Maggs (1980) as the 'nightingale ethics' of nursing which Theodosius (Theodosius, 2008) reinforces as a lingering presence in nursing in the UK.

Nightingale ethics are the idea that nurses are women who are there to be mothers, servants, maids, carers and to complete all labours not undertaken by someone else. Theodosius (2008) discusses the physical and social features of an acute surgical ward in a large hospital in England. Over fourteen months, Theodosius conducted a participatory ethnography of nursing where she recorded her own experiences in a participant observation diary. Additionally, fifteen nurses recorded audio diaries over several weeks and were later interviewed. Theodosius presents data of nurses’ mourning the loss of therapeutic emotional labour, meaning the work nurses do to create emotional well-being in their

\(^3\) (US and Canadian Boards of Nursing and Codes of Ethics, German Nursing Act and many others). These exist less so in the global south, and if they do they are often based on models from the global north (Hopkins-Walsh et al., 2022).
patients, as a labour in itself. She argues that this type of nurse work has been deprioritised by medicalised and technical nursing tasks; however emotional labour is essential to be effective in the other labours of nursing, as well as an essential and instrumental role in nursing. Nightingale ethics are demonstrated in the way in which emotional labour is deprioritised, overlooked or assumed to be done anyway by women. Theodosius suggests that traditionally feminised labour is omitted from structures and frameworks that support nurse work because it is expected to be done by women anyway (the nightingale ethics) and that the nursing workforce remains largely female.

Theodosius (2008) described the theorising of nurse work as messy and as an affective practice. She argues that the theory of nursing should be messy because it is a dynamic, relational process. These dynamic processes are often discussed by affective post-structuralists who explain that ‘affect arises in the midst of in-between-ness: in the capacities to act and be acted upon’ (Gregg and Seigworth, 2010:2). This produces the argument that nurse work and nursing has been influenced by modernist medicine to separate the physical body from social and situated bodies. Benner (2001) argues that privileging a medical and positivist approach to nursing negates possibilities of care. She states ‘human beings dwell in human worlds constituted by care…The knower and the known are intertwined’ (ibid p. 354) therefore someone's history, experience of illness or disease and possibilities to act will be situated in their known world and will be both social and physical for them. These understandings by Benner (2001) and Theodosius (2008) underpin nurse work both theoretically and empirically as a process of nurses and patients navigating situated realities.

Contemporary nursing systems that maintain ideas such as Nightingale nursing are colonial (Wytenbroek & Vandenberg, 2017), patriarchal and reproduce knowledge production systems which I find troubling i.e. the white European male mutates into the white European female nurse, and is the perfect nurse. This perfected nurse becomes an unachievable metaphor, which in turn becomes a mechanism of control and leads to feelings of isolation, boredom and burnout, which again is a metaphor for the epoch advanced capitalism that we live in.

Carpenter (1980) situates nursing within wider labour struggles and interprets its position as a possible relegation or misplacement of nurse work. If care as a part of life – irrespective of societal modes of production – is juxtaposed to contemporary market forces, this creates a tension in the valuation of care by the market as Carpenter describes. Care is imperative to the continuation of human life and begins with the care people receive as babies or infants that allows them to grow, flourish and be able to procreate and continue humanity (Cook, 2004). Positioning nurse work within labour markets and struggles may
obscure the uniquely privileged position that Cook (2004) describes, as few other labour roles would immediately exist outside the market if societies as we know them collapsed; but care and nursing in some forms would continue. If human life were to continue the need for care would exist beyond any previous or imagined society. This builds on the meta-paradigm which outlines (Fawcett & DeSanto-Madeya, 2012) nursing as a philosophical evaluation, by creating a perspective of nursing outside any human or societal process.
2.2 Regulatory Infrastructure

In the UK, nursing is a profession regulated by the Nursing and Midwifery Council (NMC). As a UK regulatory body, the NMC is responsible for maintaining standards concerning those it has registered as a nurse and, to this end, publishes a code of conduct which documents these standards. The regulation and registration of nurses creates a distinct profession (Cruess et al., 2004) which is organised currently around four pillars of professional standards (NMC, 2020b) which are ‘prioritise people, practise effectively, preserve safety and promote professionalism and trust’. The professional standards describe outcomes of nurse work when providing person-centred care. The Code describes care yet does not describe how individuals become caring. In describing the standards of care The Code sets the minimum standard of behaviour for registrants to deliver high quality care (NMC, 2020b) therefore outlining nursing as a collection of person-centred behaviours which promote wellbeing.

Nursing is a complex and demanding profession, with nurses often being required to work long hours. Without regulatory frameworks in place, there would be an increased risk of errors and accidents occurring in healthcare settings. Regulatory frameworks help to ensure that nurses are able to practice safely and effectively, protect patients from harm, and receive adequate training and support. Nurses play a vital role in providing quality care to patients. In order to provide safe and effective care, it is necessary for nurses to follow specific standards. These standards help protect patients by ensuring that they receive high-quality care. Additionally, regulatory frameworks help ensure that nurses are competent and have the necessary skills to provide safe and effective care. Finally, regulatory frameworks help hold nurses accountable for their actions and ensure that they are following best practices. As a result, regulatory frameworks are necessary in nursing in order to protect patients and ensure high-quality care.

There are many examples of why regulatory frameworks are necessary in nursing. The Francis Report was an inquiry into the standards of care provided by the National Health Service (NHS) in England. The inquiry was set up in the wake of the Mid Staffordshire NHS Foundation Trust public inquiry, which had highlighted serious failings in the quality of care provided by the NHS. The Francis Report made 290 recommendations for improvements to the NHS, including: greater transparency and accountability, more focus on patient care and safety, improved communication between staff and patients, greater investment in staff training, more effective regulation of the NHS. Following The Francis Report, The Berwick report was published in 2013 that outlined a set of recommendations for improving the quality of nursing in the United Kingdom. The report’s recommendations focused on improving the quality of nursing care by increasing transparency and accountability,
improving communication between patients and staff, and increasing the involvement of nurses in quality improvement initiatives. Lessons have been learnt from these examples and used to build regulatory frameworks for nursing that promote safe care.

Countries other than the UK have also demonstrated that regulatory frameworks are essential for nursing. The Tuskegee Syphilis Study was an infamous clinical study conducted between 1932 and 1972 by the U.S. Public Health Service, in which nurses played an instrumental role. The purpose of the study was to observe the natural progression of untreated syphilis in rural African-American men in Alabama who were not aware they were participating in a study. The men were told they were being treated for "bad blood," (Fourtner et al. 1994) a local term used to describe several ailments, including syphilis, anemia, and fatigue. In reality, they were never given adequate treatment, and researchers continued to observe and document the devastating effects of the disease on the men and their families. The study was finally exposed by the press in 1972, and it resulted in a major public outcry. The Tuskegee Syphilis Study is now considered one of the most unethical medical studies in U.S. history. In Germany, nurse historians Smith and Foth (2021) depose how some nurses participated in Nazi atrocities by being complicit in the holocaust and associated euthanasia programs, and by participating in human experimentation. Other nurses were forced to participate in these activities against their will; nevertheless, demonstrating the need for regulatory frameworks to protect nurses and patients.

Regulatory frameworks provide a structure for nurses to follow in order to deliver safe and effective care. Without them, nurses could be free to practice however they see fit, which could lead to dangerous and/or ineffective care being delivered. This is because there is no standardised way for nurses to approach their work, making it difficult for patients to receive the best possible care. Regulatory frameworks help ensure that all nurses are held to the same standards of care, regardless of where they practice. By holding nurses accountable for their actions and ensuring that they receive proper training and education, regulatory frameworks protect patients from harm. In addition, by providing a clear structure for how nursing should be done, regulatory frameworks help new nurses become familiar with the profession quickly and efficiently. Ultimately, regulatory frameworks are necessary in nursing in order to protect both patients and nurses alike - without them, both groups would likely be put at risk. Nurses must adhere to regulatory frameworks in order to provide quality patient care. By having standardised frameworks in place, it ensures that all nurses are working towards the same level of care and help protect patients from receiving inferior treatment due to differences in practice. By setting minimum standards of care, regulatory
frameworks help to protect vulnerable populations such as the elderly and those with pre-existing conditions.

A necessary consequence of the history of the professionalisation of nursing was person-centred care (PCC). PCC emerged in the 1970s to move away from the model of the patient as a medical subject, to a model that highlights the importance of the patient’s wishes and input in their care (Smith & Willis, 2020). PCC aims to include the people using healthcare as active partners and decision-makers (Håkansson Eklund et al., 2019, p. 6; McCormack & McCance, 2010). PCC is described as making shared decisions based on patients’ circumstances, lifestyles, and values (Sepucha et al., 2008). Thus, PCC can be understood as the collection of principles it operates under, rather than a strict definition of an approach to care. PCC supports people to increase their understanding of their condition to make informed decisions about their health and intends to involve patients in their interdisciplinary care so they can be treated with dignity and respect (McCormack & McCance, 2010). Nowadays, PCC is established in nursing practice, higher education, healthcare policies, value statements, and regulatory frameworks; the dominant paradigm for care in the Global North and one of the most widespread modes to position patients in the delivery of healthcare (Buchan et al., 2022; International Council of Nurses, 2021; McCormack & McCance, 2010).

PCC is reported to work best when decision making is collaborative and relationship based, where meanings are made together (Vassbø et al., 2019). Rider et al. (2014) explore the definitions of humanistic healthcare and the characteristics of person-centred care. They highlight that person-centred care engages with improving the lives of patients, teaching patients and colleagues, ongoing self-reflection on one’s practice, and respectful, compassionate care that acknowledges the values, autonomy, and cultural backgrounds of patients and their families. Lambert et al. (1997) have critiqued person-centred care as reductive, leading to the model of person-centred care that describes a more holistic care. Tieu et al. (2022) emphasize how person-centred care produces reductive relationship between patients and nurse, creating “a relationship that is antipaternalistic whereby the care provider is not an active participant in the care relationship and whereby the responsibility to make decisions about care rests primarily on the care recipient” (Tieu et al., 2022, p.4).

2.2.1 Theorising contemporary nursing in the UK

The NMC has harmonised hundreds of years of interdisciplinary work to create a context for health, wellbeing, and care in a large workforce. The contemporary way this is created by means of a regulatory framework. The framework is a multi-level approach to how
nurses are educated, registered and regulated. The NMC maintains a code of conduct, which is the keystone of nurse work from which the educational and contemporary professional standards and expectations are created.

The way in which The Code is interpreted provides a guideline for how a nurse has learned to and will deliver care. However, it is like making a cup of tea in someone else’s kitchen or for a nurse, doing a bank shift in an area you don’t usually work in; the rules of the game are the same, but the way they are implemented is different. Registered nurses know the rules as they are registered professionally but they may not be the star player in a new environment. The knowledge and experience they have is situated and embodied, therefore, a novel situation requires time to understand how the framework is produced there.

Contemporary nursing in the UK is known as a highly trusted, flexible and adaptable role (Darbyshire & Thompson, 2021). Alongside this, nursing studies is a relatively new arrival to academia and is still negotiating and re-negotiating its place in higher education and hospital management. The relational and emotional skills that make up a large part of nursing knowledge (J. Jackson et al., 2021) are finding their place in the traditional academic settings. One example of this is the growing popularity of Leadership courses in post-registration nursing education (Fennimore & Warshawsky, 2019). Using the terms and frames of reference of business and the academy (such as ‘Leadership’), nurses learn the language of the patriarchal world to further negotiate their place in it, at the risk of overwriting/gender-washing the bodily language of care.

The process of navigating situated realities begins to ask questions concerning how structural power and care interact for nurses and nurse work. Theodosius’ data (2008) demonstrates that care is interactional and relational and should therefore consider how other actors are involved. She thereby suggests that the dynamic processes that produce nurse work involve people, places and structures.

2.2.2  Structural conditions of possibility for nurse work

Nurses in the UK are employed using a standardised nationwide pay and grading system which is called the Agenda for Change (AfC). This means that the pay scale and career progression arrangements are harmonised across the workforce according to job type and the skills the job is deemed to require (NHS Providers, 2019). For example, a nurse just leaving university and starting a job will enter on Band 5 (Staff Nurse) and may progress to Band 6 (Deputy Charge Nurse) or Band 7 (Senior Charge Nurse). The standardised tariff of remuneration offered by the AfC allows analyses of the workforce using different characteristics. These analyses can also support evaluations of the workforce using different
characteristics and diversity dimensions to understand which pay and progression conditions are apparent.

Punshon and colleagues (Punshon et al., 2019) analysed nursing workforce datasets for the distribution of gender across various pay grades. They demonstrated the existence of ‘glass elevator’ phenomena for men in nursing with men gaining promotion, higher status and higher wages more quickly. This is not a new concept in traditionally female professions (Maggs, 1996; Williams, 1992) and not a concept which receives a great deal of attention in research (Punshon et al, 2019). This adds further support to the feminist project of nursing and to understanding how people, place and structure produce and value nurse work.

The AfC framework is part of wider state healthcare provision in the UK. Mercer (Mercer, 2015) describes the contemporary UK state as a neo-liberal forerunner of the ideological landscape upon which the future debate about healthcare ethics, and practice, will take place. Mercer describes the NHS as an example of excellence in how a state-run health service can provide inclusive healthcare for a population, however the NHS is also implicated in wider market forces and behaviours. The ignored marketisation of the NHS alongside high-profile enquiries such as the Francis and Berwick reports (Berwick, 2013; Francis, 2013) document ongoing issues in healthcare which are addressed using business-led solutions. For example, the introduction of targets for aspects of care linked to an institutional view on the care quality, such as the CQUIN project (Commission for Quality and Innovation) (Bartlett et al., 2011). These initiatives have created or at least made perceptible, other structures and frameworks that affect nursing, of which the impact on nurse work has not been comprehensively researched yet.

Many organisations and institutions focus on ‘individual attributes’ of patients to facilitate high-quality person-centred care (Fotaki, 2015). In part, this establishes care as a service industry in which the individual becomes the customer who is imbued with choice as to how they purchase their healthcare. This is also supported by the expansion of person-centred care as the dominant paradigm for care in the UK (McCormack & McCance, 2010). This further establishes a neo-liberal context of care in which personal choice is privileged. Patients and nurses’ ability to make these personal choices orientates all responsibly for those choices towards the person making them. This form of governmentality contributes to a neurotic citizenship (Isin, 2004) of both patients and nurses. This is a form of neo-liberal governance that does not fully address the affective and relational consequences of people, places, structures and the (im)possibilities of decision making.

2.3 **Summary of how nurse work is situated**
Nurse work is situated in a complex social, historical, political and economic position because it is integral to how people make their worlds. The above section briefly set out key aspects about the current situation in the UK. These contexts invite approaching contemporary nurse work in the UK with critical feminist ethics. The literature also suggests considering the role (non-)human agents play in the process of reinforcing wider, structural patriarchal values. Nursing’s situation is gendered as well as entangled with feminist values. This chapter will now consider what nurse work is and how nurse work is valued.
2.4 What is nurse work?

This section discusses nurse work and what is known about nurse work. This project takes a meta-‘western’ approach to nurse work by working with paradigms of nursing and nurse work which assess, analyse and collate the broad spectrum of available literature. Jackson and colleagues (2021) suggests that literature that explores contemporary nurse work should be understood alongside the socio-political narratives of its production. Jackson, Anderson and Maben (2021) build on the work of James (1992) who attests that descriptions of nurse work have been compartmentalised in academic literature by creating or separating the descriptions of nurse work into discrete categories. This reflects the attitudes and understandings of the time. These two researchers create genealogies and inventories of academic and empirical work that acknowledge the cumulative characteristics of knowledge production and summarise how contemporary nurse work might be understood as physical, emotional, cognitive or organisational labour or as a combination of these four dimensions.

These understandings of nurse work are from the past 100 years and mostly from high-income, English speaking countries. Nurse work and care exist, and have existed outside of this specific and particular context for much longer. This project is situated in the United Kingdom and is embedded in the contexts described by Jackson (2021) and James (1992) however, I am under no illusion that this is an accurate or finite description of care or nurse work. Iconology such as Florence Nightingale create contemporary nursing systems that maintain colonial ideas (Wytenbroek & Vandenberg, 2017) and feminine histories are overwritten to create care as a branded commodity. Nursing was not ‘invented’ in the time that published literature is available for, however, to understand how this project is situated, the contemporary western paradigms of nurse work will be further explored.

2.4.1 Physical labour

Physical labour is the most well documented type of labour and has a longer documented history. Jackson, Anderson and Maben (2021) attribute it to being easier to measure and view. Physical labour also fits the paradigms of industry current when the idea of the contemporary nurse was imagined i.e. Florence Nightingale or mechanisation and mass production. Jackson, Anderson and Maben (ibid) further unpack this kind of labour in earlier literature as it was divided into basic labour such as washing, dressing and feeding patients or into technical labour such as caring for a catheter or chest drain. Nurse theorists in this field argue that the labour described as ‘basic’ is actually complex and nuanced physical labour. Jackson highlights the example of feeding a patient: this task can be described as physical labour, yet it is also a complex task of coordination, observation, adaptation and empathy.
Lawler (2006) describes the physical intimacies involved in nurse work. She provides a vivid description of how ‘nursing care requires access to every part of the body which is potentially touchable’ (ibid p. 61). Savage (1997) argues that this physical body work is highly gendered and is used to create different purposes, to different groups of people, in different areas of a ward. Shakespeare (2003) supports these interpretations of nurse work as body work and makes the case for the bodies of nurses (and their work) being given prominence when discussing nursing labour. The body work of nurses becomes prominent as nursing labour and is executed in a complex way but is ‘taken for granted’ (ibid p. 47). This body work does not exist or happen in isolation, but in combination and entanglement with other kinds of labour (Lawler, 2006; Savage, 1997; Shakespeare, 2003).

2.4.2 Cognitive Labour

Cognitive labour is also well described in nursing literature (Shakespeare, 2003; Jackson, Anderson and Maben, 2021). Cognitive labour can also be described as critical thinking and cognitive stacking (Shakespeare, 2003). These are processes that involve navigating and being implicated in multiple simultaneous activities and are therefore suited to discussing nurse work. These concepts are nuanced in nurse work because critical thinking could be summarised as knowing the ‘right’ thing to do for a patient in any given situation. However, due to the complexities of the various practical situations in healthcare, there may be many (or few!) available options. Understanding and supporting the pathway to the ‘right’ option may involve navigating many possible options.

Benner (2001) described critical thinking using the concept of how nurses develop skills and understanding by doing nurse work. She proposed that people learn to know how to do something without ‘knowing that’ which they are doing. She extends this to describe the development of knowledge in all applied disciplines. This work was seminal as a political and strategic driver for exploring the gaps between theory and practice (Field, 2004) in nursing education. In this approach, Benner (2001) addresses the potential complexities of situations and explores the intersection of theory and practice with regard to how they create knowledges. Jackson, Anderson and Maben (2021), however argue that the term critical thinking may be so broad in terms of trying to understand all thought processes, that it becomes meaningless. Critical thinking as a concept is useful, but the attempt to understand or reproduce the process in granular detail may be futile when navigating the complexities of healthcare.

Potter et al., (2005) argue that cognitive stacking may be a better way to perceive the cognitive labour of nursing. Cognitive stacking is how much a person can do in a situation at any time and the cognitive work that is done to manage that load. This analysis approaches
nurses’ cognitive labour like a dynamic task list that is (re)negotiated and (re)configured as their work unfolds. Jackson, Anderson and Maben (2021) suggest that cognitive labour is difficult to measure, which is why it was only described in literature as part of nurse work later on. This kind of labour assimilates well into traditional academic models because cognitive labour is well known and self-serving to academia as an established form of knowledge production.

2.4.3 Traditionally gendered types of labour: emotional and organisational labour

This section will discuss emotional and organisational labour. These are traditionally gendered forms of labour, and as discussed in section 1.1.1, are often disenfranchised from frameworks of nursing. Gender therefore remains a salient issue in much nursing literature (Carpenter, 1980; Davies, 1980; Salvage, 1985; Salvage & White, 2019; Theodosius, 2008) as a category which influences nursing. In the UK, in 2018, around 11% of nurses registered by the NMC are recorded as being male with 89% female. The category of gender creates a structural presence in nurse work as nursing has moved towards a professional model:

*How can a discourse of professionalism, with its recourse to qualities such as autonomy, accountability, decision-making and so on be re-centred around a concept of caring – as the new nursing has attempted to do – and yet escape the disruptive and disempowering equivalence between gender and caring?*

(Witz and Annadale, 2005 p. 29)

The explorations of nurse work also opened up room for the discussion of traditionally gendered forms of labour. Physical and cognitive forms of nurse labour are described as having privileged access to vulnerable bodies (Lawler, 2006) and therefore cannot be performed in isolation without emotional or organisational (and likely many other kinds of) labour. Nurse work and the multiplicities of labour that constitute it, are situated in an affective and material context.

The value placed on nurse work has been from a male or medical gaze as demonstrated by the RN4CAST study and the history of the professionalisation of nursing during which, for example, justifications were provided for perceiving the work of highly skilled housemaids as nurses (Dingwall et al., 1988). Haraway (1988) describes this process throughout the development of science and society since the enlightenment as the ‘modest witness’. This concept describes what happens when the male gaze becomes understood and documented as the objective ‘truth’ of a situation and the female perspective is that of a modest, undocumented and undervalued witness. Imagine if someone took a photograph of
a busy ward or clinic, what can be seen in the photo becomes privileged as an objective account of what is happening; However, the invisible labour which is often the work of the nurses, happens in the background and therefore becomes disenfranchised and can be imagined as the negative to the photograph, or all that is not captured in the photo. This section will explore the literature on this traditionally gendered and therefore ‘invisible’ emotional and organisational labour (Hochschild, 1983).

2.4.4 Gendered work: traditionally feminine labour is omitted

This section will focus on emotional labour in contemporary nursing by hosting an allegorical dinner party as described by Kamler (2006). This deeper exploration is justified by the ongoing omission of emotional labour from nursing research. Relevant theorists will be ‘invited’ to present their viewpoint and debate how it contributes to the historical and ongoing development of understanding emotional labour and contemporary narratives within nurse work and healthcare, such as compassion fatigue.

This review is timely and accompanies other reviews of this literature (Badolamenti et al., 2017) as nurses’ emotions are increasingly affected by the market forces which have entered the NHS and other public sectors, which ask nurses to manage their emotions in ways previously seen at for-profit organisations (Hochschild, 1983; Theodosius, 2008). Emotion management has become commodified for nurses (Theodosius, 2008). Nurses adapt themselves in many ways to perform their work including emotional support to their patients, colleagues and families. Many of the debates around nurse work have not changed since they were described by (Davies, 1980, 2004) who contended that nurse labour becomes all the work that is not ‘done’ by others.

Discussion of emotion in nursing is not a new concept and is visceral to personal and societal expectations of nurses and nurse work. Predictably — given the rise of ‘compassion fatigue’ among healthcare workers (Sinclair et al., 2017) and the rise in emotion studies in academia — nursing scholars have engaged theoretically with emotion in nursing (Badolamenti et al., 2017).

The concept of emotional labour is associated with the work of Arlie Hochschild who introduced the term in her 1983 book ‘The Managed Heart: The Commercialisation of Human Feeling’ (Hochschild, 1983). For Hochschild, emotional labour refers to the work done (or the effort required) by an individual to manage their own expression of feelings and emotion in accordance with their perception of external expectations of their behaviour. Emotional labour in industrial terms can be described as ‘the process by which workers are expected to manage their feelings in accordance with organisationally defined rules and guidelines’ (Wharton,
In emotional labour, workers have to hide their feelings just to fulfil their duties. Hochschild reasons that cultural and social processes regulate the lives of individuals which may fluctuate and vary from the deep story the individual maintains within them (Hochschild, 2016).

Hochschild pays significant attention to the difference between the emotional work done in people’s personal lives and the emotional work people are paid for. Emotional labour as a commodity is predisposed to devaluation from the gendered nature of contemporary emotional economies which further highlights the need to examine contemporary nurse work in this context.

2.4.5 Key concepts in emotional labour

As discussed in the previous sections, traditional notions of labour include: the fetid brow, the physical exchange or the tangible presence. Ideas of economies being constituted of more than what can be seen and held, but rather what can be sensed and felt are novel. More accurately perhaps, is to state that the ways in which humans conceptualise exchanges of feelings and discuss how they affect people, places and their interfaces have an expanding discourse which needs to be explored. Idioms such as ‘emotional labour’ may have entered the public consciousness in contemporary western society, but they are relatively recent conceptualisations.

C.W. Mills (1956) records the emergence of service industries alongside the continued development of capitalism in the west in which people had to change the way they behaved so they could ‘make sales’ resulting in their personality being ‘on sale’. This concept of ‘face work’ which teaches people about their best traits and how to market these to employers and clients, documents a shift to where the speaker is more important than the message.

The concept of multiplicities of identities, or ‘masks’ in Goffman’s ‘The presentation of self in everyday life’ (Goffman, 1956) provides a dramaturgical approach to human interaction. Goffman separates human interaction into front of stage encounters and backstage rehearsals. Each person has a ubiquity of masks to wear for others to see. Always concerned with how others perceive them as well as attempting to present themselves in the best light possible. Masks have a dynamic relationship with the social world and adapt depending on who the interaction is with. This can be described as impression management in which people are front of stage and are actors in their lives. The backstage is hidden from others, this is where people relax as they do not have to act as there is no one there to act for. Backstage, people behave in a manner that no one else is part of and in a way they are comfortable with.
What goes on front of stage is not always improvised. It is a carefully crafted representation of the person is, a manipulation of the audience by the actor. Backstage people can relax and practice the masks for use front of stage.

In Goffman’s view, there is no true self, only the different masks worn or the roles played, but there are assumptions in his theory. The conventions inherent in Goffman’s theory are that people are: active in the process of behaviour, in developing society, in devising their own conduct under some external social influences, but ultimately have agency, are devious and guide and manipulate situations to their own advantage and that they behave differently in social situations than when there isn’t anyone around. This theory supposes a theory of existence in which humans have a ‘job to do’ which is to provide the best possible presentation of themselves. A noteworthy question that Goffman poses is whether individuals or others, can ever truly know who they are if our social selves are but a variety of performances? This point reappears when positioning emotional labour within the nursing process, as will be discussed below.

Cultivating Goffman’s theatrical metaphors, Hochschild (1983) describes the body as ‘the tool of the trade’ in emotional labour. At ‘surface’ level, body language, behaviour and performance are essential to fulfilling perceived expectations to establish the desired emotions of customers in particular situations. The person does not feel conviction behind these actions and performs them to meet the expectations made of them by their social environment. Hochschild describes these as surface-acting emotions which constitute a part of a stratified network of emotions in personal interactions.

Deep-acting emotions as described in ‘The Managed Heart’ are emotions from a trained imagination that are employed to be situationally appropriate emotional responses, despite the individual not having a perception of an authentic version of themselves which holds fully congruent beliefs. These are feelings are ‘feeling for the parts we play’ and situational emotional memory so people feel as if it were true, to achieve what they think they should be feeling (Hochschild, 1983, p. 43).

Rules concerning feelings are formative parts of theories of emotional labour as they are the framework on the basis of which the emotional rules are defined, they are the scripts for directing actions in situations and negotiating lived experience. Rules on feeling are rarely codified and difficult to define or demarcate, and for Hochschild can best be viewed by peeking into the imagination between ‘... ‘what do I feel’ and ‘what I should feel’ ...’ The lived experience of feeling rules is the compensatory behaviours of how displays of emotion are interpreted and valued by other people, and how people ‘sanction’ (ibid p. 57) their behaviour according to the responses of others or are sanctioned by their responses. Rules concerning
feeling associated with emotional labour frequently conflict with an individual’s perception of their actual feelings, which may produce strain or increased emotional labour for them. This emphasises an authentic perception of the self, as being able to fake an emotion involves having a perception of one’s own position and emotional response from which to proceed. See Example 1 below.

2.4.6 Emotional labour in nursing

‘The Emotional Labour of Nursing’ (Smith, 1992) is the first example of exclusively understanding nurse work using concepts of emotional labour. Smith (1992) established emotional labour as an essential and integral part of the culture of good-quality care. However, she highlights that emotional labour was not a salient concept for those providing it nor by the profession. The emotional labour of nursing includes dealing with the enthusiastic requests of relating to patients, families and partners. Building medical attendants’ versatility is a significant methodology in moderating the pressure and burnout that might be brought about by continuous introduction to these demands.

This echoes the invisibility of emotional labour found by Hochschild (1983) which adds to the challenges of researching that which is not seen. In healthcare, the direct ‘customer’ is the patient. Economies of emotional labour outside nursing may be able to use other terms to discuss the individuals and situations involved as consumers or customers. However, ‘patient’ is a descriptor of a bespoke intersection of vulnerability, power, care, kindness, hope and debility which itself creates emotion work in the reader and contributes to the exploration of emotional labour in nursing. Nurses’ emotional labour should be valued the same as physical labour, as nursing work is emotionally complex. Nurses’ emotional labour is productive and hard work, and society needs to appreciate them for their amazing efforts.

Theodosius (as cited previously) is a sociologist and registered nurse in the UK who studies emotional labour within the broad, yet specific frame of nursing. Her book ‘Emotional labour in healthcare: the unmanaged heart of nursing’ (2008) is rooted in approaching the nursing role using the shared perspectives of Hochschild’s framework of emotional labour and her own sociological perspective as well as the experience of becoming and working as a nurse. Theodosius addresses four areas for understanding emotional labour in nursing:

- Emotional labour is central to contemporary views on holistic nursing care, although it is incorporated differently into a nurse’s labour than it is into that of the flight attendants in Hochschild’s work.
Emotional labour in nursing is a symbiotic process that is ‘interactive and relational’ and must therefore be considered from the perspective of all agents involved. This contrasts with Hochschild’s (1983) examples which, most likely due to the innovativeness of her work, only described emotional labour from the first-person perspective of the flight attendants.

Emotional labour is essential in nursing because ‘patients are vulnerable’. She argues that the power dynamic between nurses and patients is unique in the way that private acts such as toileting and washing consist of interfaces between strangers i.e. the public and personal intersect.

Emotional labour in nursing is an emotional exchange and is not solely a service industry transaction. The patient exchanges emotion alongside their right to healthcare with the nurses’ emotions and wages. This is where Theodosius expands on how Hochschild’s initial theory of emotional labour understands moments of intersubjectivity which constitute nurse work.

Hochschild’s work primarily focuses on gendered employment roles. Her most famous example states that flight attendants have jobs gendered as female and argues that women are much more likely than men to be in roles in which emotional management is a significant factor (Hochschild, 1983). Connections are made between this practice and gendered assumptions on the caring nature of females as well as job roles which combine both a subservient and a nurturing aspect being commonly performed by women. Examples include nursing, childcare, leisure and retail customer service.

Hochschild observes power relationships in the production of labour. The relationships between customer and employee, and employer and employee are moderated by the power imbalances between the employee and others as well as by the context of the gendered aspect of the work. She also raises the possibility of these incongruous emotions resulting in alienation. Hochschild (1983) approaches this with Marxist theories of labour by comparing this to 19th-century factory workers. People become detached from their work as it is meaningless and forces them to behave in mechanistic ways unlike their true selves (McLellan, 1971). Marxist alienation is infrequently highlighted in reviews of emotional labour in nursing (Badolamenti et al. 2017) and cannot be generalised to the extent that it becomes applicable to nursing, as nurses often report positive outcomes from their work (nursing people back to health) (Theodosius, 2008). However, the experiences of nurses who detach from their work remains poorly understood, yet high on the UK’s political agenda as illustrated by the debate concerning the ‘compassion deficit’ or as Hochschild describes ‘emotive dissonance’.
Theodosius (2008) understands that the Marxist theory of alienation may not be an exact fit with nursing because the former considers the description of deeper feeling rules as ‘deep acting’ problematic due to the assumption that, in a role such as nursing, the nurse delivering the care does not share some emotional parallels with the person being cared for and is pretending to have these emotions because it is expected of them in every scenario. Bolton (2000, p 553) - drawing attention to the possibility that the definitions of emotional labour might be incomplete — writes: ‘emotion work creates the social relations necessary for production and should be analysed and valued as such, but that does not necessarily mean it is part of every labour process in the same way, or, indeed as part of the labour process at all’.

Theodosius (2008) provides vignettes in which nurses report strong positive emotions resulting from their work when they perceive positive outcomes for their patients. This leads her to suggest that more complex emotional processes are at work and that emotional labour in nursing is interactive, relational and sometimes congruent with her participants deeper emotions describing this as ‘Emotional labour in ‘half measure’.

Hochschild’s ‘Strangers in their own land’ (2016) develops the concept of ‘deep acting’ by describing the ‘deep story’ of her interviewees. This subtle change in descriptor modifies contemporary understanding of ‘deep acting’. ‘The Managed Heart’ defines deep acting emotions as rubrics which are assimilated through socialisation into a role or situation, much like the cabin crews working for airlines which constitute many of Hochschild’s original examples. The deep story allegory illustrates that ‘deep acting’ rules may not always be situationally provisional rules which are activated by a specific social environment. ‘Deep acting’ is part of a story someone tells through their experiences and interactions. The ways in which a ‘deep story’ is told are many and influenced by many things. The telling of the deep story will not always leave the deeper ‘rules’ untouched thereby developing the perception of a person’s own narrative. An individual’s own deep story illustrates their self-awareness of a representation of the self in the world at large. This ‘authentic’ version of the self is esoteric yet locatable in time and space, and has the imagined continuous potential of concreteness. A working summary of emotional labour at this point is therefore an active process of how the lived experience of an individual’s deep story interpellates with the social world. Theodosius (2008) refers to this using empirical examples in her research on nursing.

Example 1. An example of feeling rules in nursing

The question posed at the beginning of Vignette 1 ‘What would you describe as good care that gives you satisfaction?’ suggests that good care elicits an emotional response
of satisfaction. This is indicative of a feeling rule: the giving of good care produces feelings of satisfaction in the carer.

(Theodosius, 2008, p 17)

Healthcare professionals often divide patients into good and bad categories. This is partly based on the social control elements of nursing, with ‘good’ patients viewed as more compliant than those categorised as bad (Lawler, 2006; Zapf & Holz, 2006). A ‘bad’ patient, according to one nurse, is someone who ‘brings an illness on themselves and can’t really be helped’ (Lawler, 2006, p32). Those with mental health or substance abuse issues are often all viewed as ‘bad patients’. Categorising patients in this way disrupts interpersonal contact and adds layers of complexity in the emotional demands on nurses for providing care.

The therapeutic ideal of equality in patient treatment sometimes conflicts with personal feelings about ‘bad patients’ (Gray and Thomas, 2006). However, there is room for discussion, perhaps with a mentor, modern matron, ward sister/charge nurse, nurse manager or teacher with regard to how conflicts between nurses’ public role and private feelings about ‘bad patients’ may be resolved. Reflecting on conflicting emotions about ‘bad patients’ or even patients in general, and managing difficult events in clinical practice are essential to professional development and reflexive nursing practice (Williams, 1992; Zapf & Holz, 2006)(Zapf and Holz, 2006; Williams, 1999).

Looking at emotional labour in health settings involves assessing the strategies of emotional regulation available to healthcare professionals. This includes analysing how nurses manage their own and patients’ emotions, and how the former come to terms with the difficult processes that are often an unavoidable part of patient care. Such research will have to explicitly deal with uncomfortable and sometimes conflicting emotions that nurses, healthcare professionals, patients and their families have to face.

2.4.7 How does emotional labour manifest in an emotional economy of healthcare?

Emotion work is what people do to present themselves in a way that may not identify as belonging to them. This transmutation of emotion takes effort and may or may not be cognisant. Emotional labour describes the effort and process of this transmutation and is therefore the term used to describe when emotion work is commodified.

Bolton (2000) approaches nursing from a managerial perspective, framing her initial research within the experience of gynaecological nurses. Nursing is again described as the
primary occupation when discussing organisational use of emotion work. This reiterates the points made earlier in Section 1.1.1 and 1.4.6 about the continuing gendered division of labour. However, Bolton favours the analogies of Goffman’s masks when discussing the work of ‘caring professionals’. For Bolton (2000, p 554) nurses ‘…glide from one performance of face-work to another…’. She describes nurses (using their own words) as ‘emotional jugglers’ indicating that understanding the markets of emotion in nursing is more complex than exchanging labour for a wage. Bolton suggests that ‘extra’ emotion is offered as a gift by nurses with the reward of creating a more amenable environment for both patients and themselves. This gift serves to reinforce two concepts in understanding emotional labour in nursing. Firstly, that nurses are ‘multi-skilled emotion managers’ and secondly, that the marketplace of emotional labour in nursing is not yet fully known. Bolton suggests that the process of exchange or creating an emotion in another for secondary benefits is itself transactional in nature.

Gift exchange could also be viewed as over simplistic. Gift exchange allows the possibility that the caregiver is left unchanged by the emotive encounters in which they perform their labour. The caregiver is somehow protected by their professional identity from the difficult situations they may be supporting others through. The theory of gift exchange also does not fully represent the way in which social structures and social capital within an environment permit the wearing of the desired mask i.e. the performance of an emotion. Hochschild (1983) criticises Goffman’s model by introducing a feminist perspective on how relational power structures affect the performance of emotion by creating conditions for the possibility of ‘feeling rules’. What is clear however, is that more recent theories attempt to separate emotion work from emotional labour. An active process is required to avoid conflating emotion work and emotional labour. Emotion work is phenomenological and emotional labour is when emotion work is commodified.

These arguments provide a base from which to further explore nurse work, now nurse work proves to be more than an exchange of emotional labour for financial capital. In the UK, emotional labour in nursing has been amplified since the advent of Project 2000 which requires nurses to attend university resulting in educational capital becoming more salient to the commodification of nurse work. However, this raises important questions concerning the composition of the educational frameworks and syllabi for nursing studies because it has repeatedly been established that emotional labour is a large part of nurse work. Emotional labour is difficult to measure (Jackson et al., 2021) therefore nursing’s academic and professional frameworks continue to develop in ways that value measurable outcomes - such as clinical labour and managerial skills.
These skills are essential to nursing, however, should not be valued over emotion work. Given the literature reviewed so far, it is possible that the professional and academic frameworks of nursing left emotion behind because academia does not speak the gendered language of emotion work.

In juxtaposition to the disenfranchisement of emotion from professional and academic structures, the collective imaginations of emotions and nursing are salient. Smith (1992) describes how institutions maintain images of the vocational calling of nurses (being born to nurse) because they view them as essential to nursing student recruitment, despite the composition of student cohorts and workforces differing between region, speciality and institution. Smith (2011) continues her prior work by reiterating the importance of emotional labour in nursing and healthcare. They argue in favour of interdisciplinary, inter-discursive approaches to understanding emotional labour which can be complex with regard to understanding theories of human becoming, but this is exacerbated when institutionalised within non-human, yet powerful frameworks in which patients have specific vulnerabilities.

2.4.8 Organisational labour

Organisational labour is alongside emotional labour in being associated as a traditionally feminine labour. This section will discuss how organisational labour is understood in nursing literature and how it becomes part of nurse work.

Jackson (Jackson, 2020) uses the example of documentation in nursing as a familiar process that is representative of organisational labour. Documentation is much maligned and complained about by nurses, but is, however, an essential element of working at a healthcare institution. Documentation is used as a communication tool, but also for the legal and economic aspects of contemporary health care. Jackson argues that this work is often understood as something that needs to be completed but is not valued as part of the labour of nursing.

Allen’s (2015) ethnography of hospitals focused on bed management. Bed management is often seen as an important, essential task in hospitals and largely consists of organisational labour. Allen sampled nurses from all the strata at hospitals, from flow coordinators/bed managers and ward managers to deputy charge nurses and staff nurses. She found that bed management was a distributed activity that was created by numerous, frequent, smaller decisions by the nursing workforce. Allen reports that this organisational labour is embedded in the nursing staff’s everyday practices.
Johnson et al. (2020) further explored the organisational aspects of hospitals. They suggest that outcome-specific routines can improve a hospital’s work. An example of this could be a surgical care pathway for an elective operation where a patients’ admission is expected to be on average 3 days; the patient, the hospital and healthcare team would work to achieve the episode of care in 3 days (e.g. a knee replacement). Many different kinds of work and labour would contribute to achieving this goal, and a significant part of those labours could be described as organisational labour. Thinking back to the concept of the modest witness (Haraway, 1988), it may be concluded that the work performed to produce the specific routines’ outcomes is invisible – much like the idea of the negative in a photograph that was explored in section 2.4.3. The organisational labour of nursing is represented by a surrogate marker of an outcome-specific routine which in this case would be the discharge of a patient 3 days post knee replacement. However, the labour that makes that happen is not discussed and only made perceptible in other ways.

The constituent parts of care, and nursing, have in recent times been the focus of further research. Feo, Kitson and Conroy (2018) conducted a series of analyses to understand what nurse work is and what its relationship to nursing practice is. Their goal was to understand more about fundamental care. They identify care as crucial to human existence and should therefore be described as such i.e. basic care should be referred to as fundamental care. They describe how fundamental care is a priority and responsibility for all those involved in healthcare whilst acknowledging that fundamental care constitutes a large part of nurse work. Feo and colleagues (Feo et al., 2018) work was motivated in part to better understand the nuanced differences between nursing, nursing care, nurse work, nursing process, basic care and fundamental care as these are often conflated. The practical recommendations outlined in these articles often mention trust as the initial priority in establishing a relationship to deliver good-quality nursing care (ibid). Trust is a complex concept which is abstracted from lived experience. It is deeply emotional and closely related to logically understanding a situation which (as will be discussed below) situates nursing in theories of emotional labour and organisational labour (Hochschild, 1983; Theodosius, 2008; Hayes, 2012).

Organisational labour is described as essential to care. Organisation labour is important in building trust within care teams, and an integral part of nurse work. Organisational labour, like emotional labour, is often difficult to quantify in health systems, therefore, is often measurable with surrogate markers.

The emotionally and organisationally navigated moments of inter-subjectivity between nurse and patient/doctor/institution is the area which nursing literature needs to unpack to develop a professional framework which supports the logistics of emotional labour in a way
that can be communicated to those outside of the situation i.e. there is a black market in nursing and its currency are the disenfranchised and gendered labours such as emotional and organisational. High impact studies such as RN4CAST highlight the over-medicalised gaze in recent nursing developments, and indirectly call for further research into the characteristics of nurse work and care.

Nurse work has a prerogative in healthcare because, what may be described by Feo and colleagues (Feo et al., 2017) as the fundamentals of care, do not follow parallel technological trajectories to those present in other areas of healthcare. In other words, emotional and organisational labour is yet to be automated or protocoled the way much healthcare has been, and given its dynamic, relational nature may never be. Methods should be developed to support the position of nurse work professionally, academically, and financially which conceptualise and communicate this invisible labour of fundamental care.

In summary, this chapter so far has discussed how nursing is situated in its geo-socio-politico-historical contexts. This chapter has discussed how nurse work navigates and (re)negotiates the materiality of a space, with the possibilities and restrictions of each situation. This demonstrates how nurse work is produced with affective engagement in how matter relates and assembles with other matter. Garminikow (1978) approached nursing with a materialist lens, however, since that time few others explored nursing and nurse work from a materialist perspective. More recently, materialist approaches to scientific research have gained popularity and traction and are becoming known as new materialism (Fox & Alldred, 2016). This chapter will now explore new-materialist literature in relation to nursing and health care.

### 2.5 New materialist and critical posthuman approaches to care

New materialist practices support the complexities described by nurse researchers while speaking to the geo-socio-political conditions of possibility of how worlds are made. The literature reviewed so far highlights how nurse work has and is gendered in the way it is produced and therefore reproduces societal power structures that franchise some kinds of labour and disenfranchise others. This section will review key works that approach care using new materialist approaches and then in the next chapter I will set out the new materialist and critical posthuman theoretical approach that this project works with.
2.5.1 New materialism or critical posthumanism?

New materialism and critical posthumanism have distinct genealogies that should be recognised in the process of understanding the theoretical standpoint of this project. There is also an ongoing debate as to how to describe feminist post-anthropocentric materialisms.

New materialism can be considered an umbrella term to refer to the revitalised interest in social, political and philosophical disciplines into materialistic approaches to research (Fox and Alldred 2016); materiality in this approach can be described as the space where the human subject intra-acts and engages with the material (non-human) world (Coole & Frost, 2010). Materialism in this sense has a longer histories such as in eco-feminism (Plumwood, 1993), Buddhism (Garrison, 2021) or non-western scholarship (Rosiek et al., 2020). The umbrella term of new materialism describes the more recent interests in materiality at the convergences of technology and social systems (Braidotti, 2019). Under the new materialist umbrella there are multiple approaches to understanding materiality. For example Actor Network Theory (Latour, 1993), transhumanism (Bostrom, 2005), ecofeminism (Rose, 2012) or critical posthumanism (Braidotti, 2019). These strands of new materialism are discussed further in Section 3.3.2 to highlight why the theoretical framework of critical posthumanism was used in this project. Nevertheless, the term new materialism is used in this project to describe the wider field of materialisms and the term critical posthumanism is used to describe the specific branch of new materialism used.

2.5.2 Who else is approaching care using new materialism or critical posthumanism?

Over the past twenty years, there has been a renewed interest in materialist approaches across academic disciplines. Fox and Alldred (2016) argue that there is a shift in research to include the human, nonhuman, other-than-human and the more-than-human in thinking how worlds are made. Researchers in new materialism and critical posthumanism have also approached healthcare in their research, however, this has largely been framed in the area of Science and Technology studies.

Bennett (2010) explains how the human and the more-than-human can be employed in academic thinking in order to make sense of the world. In her book ‘Vibrant Matter’, she situates ethical and political ideas within the material world, in a way that supports a view of the human (or ourselves), in new and connected ways. Bennett encourages us to practice such judgements with and beyond the binaries of subject-object and human-nonhuman. Bennett is renowned for her work on nature, ethics, and affect. In this book she shifts her focus from the human experience of things, to phenomenological experiences of things.
themselves. Bennett argues that political theory needs to do a better job of recognising the active participation of nonhuman forces in events. Bennett explores how political analyses of public events might change were we to acknowledge that agency always emerges as the effect of ad hoc configurations of human and nonhuman forces. She suggests that recognising that agency is distributed this way, and is not solely the province of humans, might spur the cultivation of a more responsible, ecologically sound politics. As discussed in section 1.4, the multiple situations that nurse work is produced within, are a complex and political assemblage. The way in which Bennett (2010) approaches the politics of materiality supports a new materialist approach to research in nursing.

Similarly to Bennett (2010), other researchers are approaching care with new materialist methods. Puig de la Bellacasa (2017) argues that care is an act that involves the convergence of materialities. She states that care is a process in which many things come together in complex processes of human and more-than-human agents to create what is then perceived as care.

"Care is everything that is done (rather than everything that ‘we’ do) to maintain, continue, and re-pair ‘the world’ so that all (rather than ‘we’) can live in it as well as possible. That world includes… all that we seek to interweave in a complex, life-sustaining web (modified from Tronto 1993:103)"

(Puig de la Bellacasa, 2017, p 161)

By approaching care this way, care is viewed as something that is not solely a human endeavour. Puig de la Bellacasa situates care in ecological and material terms so that care is not privileged to an anthropocentric viewpoint, moreover, a consideration of how things come together in assemblages of materiality. She provides examples of non-human animals, plants and the earth ‘caring’ for each other. Puig de la Bellacasa (2017) describes care as the co-production, co-existence and co-inhabiting of matter.

The concept of care as an environmental as well as a bodily production is further explored by Mol (2002). ‘The Body Multiple Ontology in Medical Practice’ approaches health care from a new materialist perspective to show how bodies are manipulated by various healthcare practices. Mol discusses the possibilities for care beyond the dichotomy between the body we have and the body we are. She argues that ontology is produced by what is done with our bodies in the everyday practices that they are engaged in. Using data collected during an ethnography at Dutch hospitals, she discusses how bodily acts are performed by people in healthcare, patients, and the environment’s materiality. These acts become acts of care, and the process of materialities becomes care. She also discusses
how the people implicated in these acts of care are not the same, they are contingent on many other aspects of a situation such as disease, privilege, race and background. This situatedness then facilitates which things and how these things are possible.

Although based in Science and Technology Studies, Mol, Moser and Pols (2015) explore ‘Care in Practice’ (Mol et al., 2015, p. 1) through a compilation of new materialist and posthuman essays focussing on different aspects of care. This collection acknowledges the eco-feminist traditions of care and the (new) materialisms and issues a call to action for feminist researchers of care and nursing. Mol, Moser and Pols (2015) discuss how nursing first started to talk about care before other academic fields became interested in it; this was because nursing and care are inextricably linked and nursing as a historically feminine job added a feminist dimension. Other disciplines such as philosophy, sociology, geography and so on, followed suit and became interested in care due to evolving ecological and political crises (ibid p 10). Mol, Moser and Pols (2015) warn of the academic territorialisation of care by other disciplines and that there is an imperative to acknowledge the contribution that nursing has and can make to understanding more about care, and acts as a set of signposts to resources and ambitions for how care can be discussed. The authors link the professional project of care to neoliberalisation of societies and subsequently that the 'specificities of care' (Mol, Moser and Pols, 2015, p 9) have got lost. They elaborate on this to describe care as often an intimate act, therefore, not always described in public; however, the missingness of a way to make care perceptible is an issue because it means it can be assumed or even devalued. To make care perceptible in this way, they approach care from a post anthropocentric perspective and acknowledge the techno scientific complex of it is today.

Latimer and López Gómez (Latimer & López Gómez, 2019) also engage with the ‘intimate entanglements’ of material things in respect of care. Though not strictly in a healthcare setting, this collected works discusses how worlds are made through entanglements of materiality in affective ways. Latimer (Latimer, 2013) builds on her previous work as a former nurse and as a professor of Science and Technology Studies to explore the liminal boundaries of the human within their environment. She argues that human and more-than-human relations are not separable, and that research should work with these more-than-human formations (Friese & Latimer, 2019). The entanglements which produce care are also discussed by Moreira, O'Donovan and Howlett (2014) who approached the care of people with dementia from a new materialist perspective. Moreira et al. (2014) critiqued dementia care as not recognising the environmental production of the body, illness and care because the disease of dementia was seen as separate from the situated production of the disease for people. They discussed how the extraction of people with dementia from their context can be detrimental to them or cause distress, therefore,
they issue a call for social science methodologies to represent the worlds of people with dementia.

Dennis (2019) approaches the medicalised body with new materialism, however, from the perspective of drug users. Dennis’s exploration of the materiality of people using drugs draws upon the Deleuze and Guattari (1988) concept of a body without organs. ‘Bodies without organs’ is a Spinozist concept that was developed by Deleuze and Guattari (ibid p 8), which describes the potentialities, affects or connections a body can have, of which one may not always perceive. To become a body, i.e. perceptible as a subjective entity, one must become a body without organs. Bodies move away from stable images of a body, to the production of a body through relationality and what and how those relations are made; however these relations are dynamic, numerous, not always equal and not always perceptible. A body without organs is a processual understanding of the being which declares that body's limits are always moving, that becomes what is known as a body. It means (re)configuration of identities and boundaries is the process of becoming a body. Deleuze and Guattari (1988) explore how one cannot ever ultimately reach a static body, rather because a body has no liminal boundary. Bodies and all materiality exist in meta-rigidities, at different degrees of perceptibility, at different times. The meta-rigidities of bodies (human, nonhuman, other-than-human and more-than-human) exist in ratios of motion:rest; and these contemporaneous ratios are in relation to the conditions of possibility for matter to affect other matter.

2.6 Summary of chapter 2

This chapter has summarised the I situation in contemporary nursing and new materialist theory that this thesis takes. The key points that this chapter has covered are:

- A brief summary of the contemporary political and theoretical standpoint of nursing, to understand nursing as a highly political and broad.
- An overview of the current research on understanding what nurse work and nursing is, to understand nursing as complex and dynamic work.
- An overview of new materialist and critical posthuman research in relation to care, to understand how contemporary feminist theorists are approaching care.

The exploration of this literature informs and situates the approach of this thesis to the research questions. In the next chapter, I will highlight the theoretical position and approach that I have adopted for this thesis. The latter was produced using the ideas of these thinkers and my own situatedness.
3 Chapter 3: Theoretical standpoint

Some of this chapter is based on a paper which I published in the *Journal of Posthumanism* in the Summer of 2020 (Smith & Willis, 2020)

This chapter presents the theoretical standpoint of this project and makes explicit the research design. The chapter will explore contemporary critical feminist theory and links back to the opportunities to develop knowledge identified in existing literature. It begins by making a case for why nursing could be approached using critical posthumanism, and explores the paradigm shift from a dualistic ontology to a monistic and new materialist ontology. The shift from humanism to critical posthumanism, and this chapter defines the position in posthumanism that this project uses. The three main claims of critical posthumanism are set out: all matter is one, matter differentiates in a non-dialectical manner (monism) and matter produces realities with other matter in speculative ways (sympoiesis).

This chapter then makes the case for a post-anthropocentric approach to nurse work and care using this posthuman theoretical approach to mobilise the concept of the human in care, and specifically in person-centred care. Approaching nurse work from a monistic epistemology, it is then situated in a critical posthuman ontology. Perceptibility will be increased using examples from healthcare, and care will be defined in a posthuman framework as more-than-human, always in relation to others and ubiquitous. Appropriate research methods using these epistemological considerations will then be considered.

In this chapter, I aim to approach nurse work in the United Kingdom from a critical posthuman perspective, and – as I will explain – this is a critical feminist perspective that traces its genealogy back to the waves of 20th-century feminism. I will explore critical posthuman theory as an entry point into exploring nurse work and I will discuss how this has shaped the design of this research. I argue that there is a scarcity of research into nurse work (including care), which shows that it is still unclear ‘what constitutes the discrete fundamentals of care’ (Feo et al., 2018, p. 2225). Researchers discussing philosophies of care seem to be somewhat committed to humanistic practices, such as person-centred care (McCormack & McCance, 2010). First of all, I will mobilise the humanistic perspective underlying nurse work, drawing attention to tensions in the latter that could be linked to humanistic thinking. I will then make a theoretical and practical case for the reconfiguration of nurse work using posthumanism. Next, I will suggest how understanding posthumanism theoretically may contribute to the understanding of nurse work. My first step will be to explore what is meant by humanism in this canon and by distinguishing posthumanism from transhumanism. In a second step, I will lay out three key principles for my approach to understanding posthumanism: all matter is one, monism and sympoiesis. I will explore practical examples of nurse work using posthumanism to expand understanding of the
theory by designing, analysing and discussing the rest of this project. I will demonstrate ways in which posthumanism can deterritorialise nurse work from humanism. Thirdly, I look at the implications of posthuman philosophy for nursing. Framing nursing and care practices in ways that do not necessarily centre on humans I will begin to create new possibilities for understanding nurse work with this theoretical approach.

3.1  A case for a posthuman approach to nursing

In my approach to understanding care I discuss the relationality of matter as an essential principle. The latter is grounded in nursing’s development as a feminist project, and will be described as an embedded, embodied and relational practice. To do so, I will use creative, practical critiques from nursing and care practice. Creativity is a practice that acknowledges histories and allows becoming in geo-social-temporal coordinates (Smith and Willis, 2020). Recognising the histories of people situated in a particular time and place, and embedded in their unique socio-economic connections I try to imagine which creative means I can offer nurses to act with affirmative ethics, to enable them to become with new opportunities in their practice (Lundy, 2012, p 28) and the materialities of their realities (Smith and Willis, 2020). Looking at the challenges in care work through a posthuman lens is akin to looking for ripples in water, not the rock hitting the pond (Barad, 2003). These ways of approaching nursing practice can begin to add levels of complexity to widely accepted concepts in nursing.

3.2  Nursing trends towards person-centred care

Person-centred care became more popular in nursing the 1990s and was encouraged by UK policy in the 2000s (Department of Health, UK, 2000; Wanless and King’s Fund, 2007). It privileges and emphasises the care service user’s perspective i.e. the humanistic perspective. This approach pushes for consideration of the patient in a more holistic light, defining a patient as a cultural and social being, exceeding symptoms or illness (Wanless and Kings Fund 2007). This shift was mirrored in how nurse education in the United Kingdom where shifts towards teaching person-centred care became a primary focus alongside it’s recognition in the Nursing and Midwifery Council (NMC, 2015; Glasper, 2015) code of practice. The shift towards person-centred care is claimed to push away from a narrow understanding of patients as just a disease or diagnosis (McCormack & McCance, 2010) to a more holistic approach to caring for someone. Using posthumanism, I argue that such an approach could also be a shift from one narrow understanding of care (the medical subject) to another (the neoliberal subject), which coincided with the further neoliberalisation of societies. As discussed in the background and introduction to this thesis, modes of
production in societies are changing (or have changed) again due to the Fourth Industrial Revolution, and previous developments and changes are still being explored.

In relation to nursing, patient-centredness implies a humanistic philosophy, and I argue that this contains three main flaws:

- an individual’s independence from their environment
- an individual’s identity pervades extracted from their situation
- the power relations between people/other people, and things are related.

The concept of person-centred care is a symbolic representation of what I find questionable in an (all too) humanistic perspective on care. It shows how underlying humanism acknowledges and attempts to privilege patient agency while failing to address the interdependence of human and more-than-human entities (Mol, 2002). I argue that posthumanism has emancipatory trajectories (Langton, 2007) that provide a different lens through which to discuss theoretical blind spots.

First of all, patient-centred care fails to acknowledge the interdependence of the patient to be recognised as an embodied and embedded entity. Patients/people exist in a multitude of relational connections and dependencies (Ferrando, 2019; Mol, 2002; Puig de la Bellacasa, 2017; Theodosius, 2008). On the resources and abilities around them in hospital, for example. Hence, the kinds of decisions patients can make depend not only on them as individuals, but also on, for instance, mood, education, access to information or knowledge as well as the consequences the decision has for others around them. In particular, they depend on the ability of staff to have time and resources to connect with the patient so that information is understandable and, in general, to give them the experience of being valued and cared for.

Second, patient-centred care implies the illusion of person’s self being a constant rather than an ever-changing dynamic entity, relying more on survival than identity (Rees et al., 2019). Hence, a decision that a patient might make one moment might differ days or weeks later, depending on how they and their circumstances have changed.

Third, patient-centred care disguises the hidden power relations between healthcare providers and patients. When attempting to provide person-centred care, power relations between nurses/doctors/patients/domestic staff do not stop existing, nor is the existence of such power relations necessarily nefarious. Simultaneously, I do not advocate neglecting the patient’s perspective. I, as a healthcare provider have access to rooms, private spaces and bodies (undressing, washing, examining someone), intimate entanglements of power relations. Delivering care involves negotiating these entanglements and intersections of power, but they do not go away. Patients will most likely still feel vulnerable, nurses will likely be perceived to be lower down the ranks than a doctor. Critiquing patient-centred care does
not ignore the fact that patients are very much involved in their care. However, it cannot be central because a ward with 30 patients could never function and benefit the individual patient if 30 centres of care were created non a ward. A ward is a dynamic environment of multiple centres existing at different ratios of motion and rest (Lloyd, 1994). The paradigm shift toward patient-centred care in healthcare has obscured power relations by giving the impression there are choices to be made by an idealised, appropriately advised and educated patient while often silencing those with less power. This raises the issue of how to deal with power while franchising patients care.

Using dualistic humanism in nursing research privileges the mind and erases bodily knowledge thereby failing to address the complexities of the human and more-than-human (Smith and Willis, 2020). I argue, using posthumanism, that structures themselves do not have a centre (Lloyd 1994; Barad 2003; Braidotti 2006), so imagining patients at the centre is futile. I suggest considering a patient’s perspective and the nurses’ perspective and power relations and the institution and the social situation. I suggest that in order to treat patients and nursing professionals more justly, they need to be acknowledged as embedded and embodied entities, interdependent with one another and more-than-human materialities (Ferrando, 2019; Puig de la Bellacasa, 2017).

3.3 (Re)configuring Care

To understand care in nurse work from a critical posthuman perspective, care is understood as more than the person providing it. Traditional western (i.e. post enlightenment European) humanistic and dialectic assumptions present in practice and theory inform this understanding of care as a body being looked after. This fails to acknowledge the timeless existence of care embodied in nurse work and that care existed before the enlightenment or before it was professionalised. With posthuman conviction, I resist the restrictive understanding of care as a looked after body. Instead, I acknowledge that care constitutes the existence of the nurse’s self, but in inter and intradependent relations with other humans and the more-than-human across space, time and history, and therefore aim to navigate restrictions affirmatively and with agency. Care is produced, (re)negotiated and presented through these many materialities. Care is produced by deciding which assemblages of matter are restricted in their existence and which are produced. Easily imagined daily hospital examples include the administration of medications such as antibiotics or the provision of hand disinfectants.

4 Antibiotics are intended to reduce the bacterial load of a pathogenic bacteria in the body. Antibiotics aim to kill the bacteria to privilege the health of the human.

5 Hand disinfectant reduces the bacterial load of potential pathogens on the hands so these are less likely to be transmitted in the environment.
Imagine a nurse engaging in the morning handover. During a formal handover with their colleagues from the previous shift they are told about the patients they will be looking after. However, they have already learned much from the preceding shift by listening to the ward’s sounds, smells, tidiness as they arrived: the ongoingness begins because it never ended.

I encourage others to rethink concepts of care using posthumanism to recognise the conditions of possibility under which care can be provided and suggest affirmative principles for nurse work beyond person-centred care. Care and nurse work assemble situations that are without a corpus, assembled with and through the self of the nurse, the patient, the uniform the nurse wears, the call bell, the telephone, the ward, the team working the shift and the multidisciplinary team. Care assemblies in nurse work include the person and are more than person centred.

Posthuman care takes patients and nurses into account, (re)negotiates dynamic workloads, relationships and materiality. Care assemblies in nurse work acknowledge the agency of the person being cared for and the richness of professional agency, experience and possibility, while also stating that care is always more-than-human, but the human is fundamentally franchised within this care ecology.

If I reconfigure nurse work this way using posthumanism, then how can I understand how nurses become nurses in their work environments? I argue that nurse work is (re)negotiation and (re)constitution in action with the aim to pursue an ongoingness of the environment. Nurses are positioned within situational, organisational and professional structures to reconfigure the productive and restrictive power assemblages. The purpose of nurse work is to establish ways of humans, nonhumans and more-than-humans (lay, machines, societal infrastructure) in ongoingness. Differences between relative locations become simultaneously restrictive and productive fields routinely navigated by nurses. Making a patient feel better, quality of care and ongoingness become entangled in material-discursive relations.

3.3.1 Humanism to Posthumanism

I will begin by outlining my approach to humanism. The aspect of humanism that I address is the perception of the self as an individual, rational subject (C. Taylor, 1989) that acts in the world (rather than with the world). It is the concept of the human as ‘sealed off from external relations’ (Ahmed, 2014:75) that is the focus of my criticism.

Opposition and distance are created when the self is assumed to be distinctly different from the other. Humanistic logic implies an assumption of ill-defined boundaries between the self and the rest of the world in order to build the human subject and
subsequently everything understood as not self, becomes other (Braidotti, 2013). A dialectical approach to oneself and the rest of the world therefore becomes egocentric. Egocentrism is entwined with the notion of humanism. Posthumanism shifts away from the concept of the human as a focal point in the universe when creating smaller worlds or ecologies of care.

To make a case for posthumanism and nursing, I will now discuss how I understand the posthuman. I will explain how this points to contemporary issues in nursing and acknowledge nurse work as an affirmative opportunity, as a radical pedagogy of posthuman theories, always thinking with, yet also beyond the patient.

3.3.2 Posthumanism or Transhumanism

I approach posthumanism from a critical feminist philosophical perspective (Braidotti, 2019) that is relevant to understanding and interrogating care practices on the basis of the histories of feminist movements in nursing and care work (Davies 1980). However, I acknowledge that other branches of philosophy understand or use posthumanism in different ways (Ranisch and Sorgner, 2014 p 14).

The approach I take to posthumanism understands culture and actors through the materiality of the human and more-than-human. Humanism perceives the self as an individual, rational subject, whereas posthumanism questions these discrete categories and asks where the self ends and the other begins (Barad, 2003, 2012). This does not negate thresholds between the human and more-than-human, but rather reconfigures an understanding of the discrete boundaries of the human. Posthumanism challenges us to think beyond dialectics of the self and others, and to think about the boundaries, which are assumed to be concrete; understanding the human alongside and with the more-than-human as intensities of matter and affective assemblages. This challenge to dialectical knowledge systems therefore requires elaboration. In this chapter, I will provide practical examples from nurse work to illuminate and reconfigure the liminal boundaries of the human, and to situate how a research project can develop from this. I will provide examples of care that demonstrate how individuals can be thought of as dividuals; not isolated entities, but rather deeply embedded in and produced by material and social relations (Deleuze and Guattarri, 1988).

Building on Foucault's (2005) analysis of the human as a concept imagined by state institutions, the concept of the death of the human (as a concept) encourages humans to rethink the human being the centre of the universe. According to Foucault, assuming humans are the centre of the universe is egocentric. Humanism becomes posthumanism at a time when the human category is interrogated (Braidotti, 2013). In other words,
posthumanism sees the bounded self as a site of reconfiguration. Hence, how I conceptualise of the self as not being a fixed point, but more an ever-moving constellation of matter.

The posthuman premise that the human is not the centre of the universe can be uncomfortable. As a challenge to contemporary assumptions about the self in the global North, all you need to do is think back to when Copernicus proposed that the earth was not the centre of the universe, instead revolving around the sun. Posthuman scholars invite us to let posthumanism be a contemporary Copernicus and (re)think the human as not being the centre of the universe (Smith and Willis, 2020).

Following this, which implications and consequences might the move away from anthropocentric thinking have for the understanding of the self and societies as a whole? Also, which entity/entities (if any) might take the sun’s place in this allegory? Posthuman logic encourages decentralisation. However, much of our thought builds upon assumptions of central points and stable states. These can now be points of mobilisation.

In this text, posthumanism means thinking with the human and the more-than-human, not excluding them or declaring their redundancy (Haraway, 2016). I use more-than-human as a descriptor for understanding all matter in the universe that is outwith the individual in humanistic approaches to the self (Barad, 2003). How the human and the more-than-human interact and come into being is described by Haraway (2016) as how we make our worlds. World making is dynamic and multi-focal and describes the ongoing relationality of the human, nonhuman and the more-than-human. I use this terminology to acknowledge the ongoing attempts to decentralise the focus of this writing. To make a case for posthumanism in care, I want to show how I distinguish the posthumanism that I speak from other posthumanisms. I will contextualise posthumanism with transhumanism, address the conceptual confusion (Ranisch and Sorgner, 2014) and detect the distinct theoretical ontologies proposed by these concepts (Ferrando, 2019).

Both transhumanism and posthumanism identify the humanist concept of the human as obsolete (Ranisch and Sorgner, 2014). Transhumanism seeks to make humans better, faster, stronger (Bostrom, 2009). The human in transhumanism is reconfigured using technology in ways that may not be currently recognisable as human. However, the focus of such endeavours remains anthropocentric and its impetus is around the optimisation of the

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6 The term nonhuman describes parts of materiality that is not human or not possible to be humanised in order to make sense of it (Kolozova in Braidotti and Hlavajova, 2018, p. 200). The term more-than-human is used more in this thesis as it situates the human in the discursive context when discussing the traditionally humanistic field of nursing and reduces the risk of the reproductions of self/other binaries in the phrasing of the nonhuman or other-than-human.
human subject. This presumes a transcendental design in which humanity remains the locus of rationality, no matter how networked it becomes.

3.4 Situating myself

Posthumanism is the concept I work with because it makes aspects of nurse work thinkable and communicable. Posthumanism thinks with the human and the more-than-human, however it has many centres, not just one. The human and more-than-human ongoing as dynamic waves of intensity in matter. Posthuman philosophy keeps me ‘staying with the trouble’ (Haraway, 2016, p.1) in the world, acknowledging the power of relations between things, and trying to find ways in which we can make worlds together. My understanding is that overcoming all tension is unrealistic and that this is the subtext of the trouble of which Haraway (2016) speaks. There will always be challenges in the world as constellations of knowledge and power relations are produced. Rather than aiming to remove all challenges, my approach is to act affirmatively within these new convergences (Braidotti, 2008).

In the next section, I will describe three critical concepts of how I understand posthumanism (Braidotti, 2013); all matter is one, monism and sympoesis. I will introduce these to situate the understanding of and approach to nurse work as well as define a standpoint (Harding, 1991). The three concepts are: all matter is one, monism and sympoesis. These build the paths on which I take an imaginary, illustrative dérive (McDonough & Debord, 2004) through nurse work.

3.4.1 All Matter Is One

There are many ways of approaching monism and consequently, many monisms (Schaffer, 2010). There is consensus among these monistic approaches concerning the characteristic that everything in the universe is made from the same matter (Deleuze and Guattari, 1988).

Haraway (2016) and Braidotti, (2013) support a monistic approach while also highlighting the attendant risks. If I assume that all matter in the universe is one, then this could imply a flat ontology of relationality between matter, perhaps more related to an Actor Network Theory approach (Latour, 1993). However, I disagree with this implication. Matter assembles with matter. The way matter assembles can be productive and world making or it can be reductive or restricted, and make different or prearranged worlds. Matter assembling with matter is what matter does. However, that is not to say that all matter will always have the opportunity to make worlds with other matter (Guattari, 2008). Ontologies will be flattened if I assume that matter exists without the potential of contextual relationality. Matter...
exists in geo-spatial-temporal coordinates where it has/does not have the opportunity to produce relationality. The possibility of production or restriction creates a topography of how things are able to relate (Braidotti, 2018). In monistic terms, these possibilities of relationality are described by Spinoza (Deleuze, 1988) as potentia and potestas. Potentia and potestas are both descriptions of power, however potentia describes the possibilities and potential of matter to become relational and potestas is the restrictive, authoritarian power that restricts this. Together they create an immanent ontology of power from which worlds are made (Large, 2017).

Life, if understood as assemblages of matter, is produced by life, and, if life is matter, then matter produces matter and matter is life. From a Spinozan perspective, individuality must not be dismissed as a construct or an illusion, but the way the self is understood could be reimagined (Lloyd, 1994, p. 10).

Spinozan treatment of bodies emphasises interconnections and the importance of grasping things as part of a whole - to be a Spinozan individual body is precisely to be part of wider wholes [...] individuality is constituted by what Spinoza describes as the union of bodies composing it [...] each individual is this enmeshed in a more comprehensive one, reaching up to the all-encompassing individual 'the whole of nature.

(Lloyd, 1994, p11-12)

This description of how individual elements can be conceptualised in this universe leads to an understanding that the moving parts of life are not independent. The individual is assembled from many parts that are, in turn, assembled from other many parts. Individuality in this context can be understood as a dynamic concept of constant reconfiguration with the world: the ongoing assemblage of matter.

3.4.2 Not either/or - monism

Humanism is often understood with the ‘binary logic of identity’ (Braidotti, 2013, p56) or transcendentalism i.e. the theory that human life exists as part of a design which is external to the universe (Lloyd, 1994). In assuming the self and the other as distinctly different, I risk creating opposition and attempts to create distance or alternative, which may be perception rather than fact. This means a dialectical approach can become egocentric and entwined with the notion of humanism in this manner. That which is not the self becomes lesser than the self. This anthropocentrism is how ‘othering’ becomes problematic for critical posthumanism because its logic poses the question: are some humans and more-
than-humans more important than others? I argue that, in monism, what is human is less clear.

Monism results in locating difference outside the dialectical scheme as a complex process of differing which is framed by both internal and external forces and is based on the centrality of the relation to multiple others.

(Braidotti 2013, p 56)

So, when I state that matter differentiates in a non-dialectical manner, this means that assumptions of liminal boundaries between things are not clear. Deleuze and Guattari (1988) use the terms ‘rhizome’ and ‘rhizomatic’ to describe the multiple, non-hierarchical and non-dialectical relationality of matter. An assumption of clear boundaries to the human can privilege the first-person perspective thereby implicitly conveying anthropocentrism. Instead, everyone is matter in the material universe. That is not to say that there is no difference in the material world – matter differentiates in many ways, but the absolutes of boundaries are open to reconfiguration. An individual’s hard edges become less discrete in posthumanism, but the power relations between individuals do not. So, in answer to the question whether some humans and more-than-humans are more important than others, the answer must be that focusing on the relationality between things makes the question redundant: it is not who or what is more important, it is how and when are they focused upon in the making of worlds. I will illustrate this with an example from nursing practice.

I show the fuzziness of the thresholds between the human and the more-than-human using a poster that promotes hand hygiene. The poster in Figure 1. is from a National Health Service Scotland (Health Protection Scotland, 2009) campaign. It was designed to promote infection control and encourage people to wash their hands in healthcare environments. The image is of a hand holding a cup with the hand emblazoned with the names of common, human illness causing microorganisms. The posters were intended to encourage staff to wash their hands more often.
Don’t let patients pay the price after you spend a penny.

Many germs can be spread by hand contact. Cleaning your hands thoroughly and on a regular basis with soap and warm water or an alcohol-based hand rub greatly reduces the risk of spreading infections such as colds, tummy bugs and healthcare-associated infections. For more information visit www.washyourhandsforthem.com

Health Protection Scotland

Healthier Scotland
Scottish Executive
The hand that holds the cup bears the names of the common microorganisms. The intended audience consists of healthcare workers, who (in this context) will know the importance the institution places on hand hygiene (Health Protection Scotland, 2009) and have been trained to implement this. Hand hygiene works on the principle that skin has resident microorganisms, known as its microbiota. The stable flora of skin microbiota creates a competitive environment for pathogenic microorganisms so that in typical situations, a healthy balance is maintained (Price, 1938). The resident microbiota is essential for skin functioning. In other words, microorganisms are essential to the ongoingness of the ‘human’. Healthy skin flora are integral to health. Flora and fauna also occur in the environment, which — in this case — is on the cup. The transmission of microorganisms happens when they are in proximity or come into contact. So where does the boundary between the self and others lie (Rees et al., 2019)?

Microorganisms on our bodies are so essential that our skin would not function without them. In everyday life, these ‘useful’ microorganisms are indistinguishable from pathogenic microorganisms. I wash my hands to reduce transmission of these pathogens — a potential act of restricting possibilities of assemblage — or this could be understood as creating future possibilities in the context of ongoingness, balance, and sympoiesis. The boundaries change, are negotiated and renegotiated with levels of ‘clean’ and ‘dirty’.

3.4.3 From autopoiesis to sympoiesis

In order to illustrate how thinking can be reconfigured from the human to the posthuman, I will introduce autopoiesis as an essential principle for conceptualising this as it begins to unpack how matter produces worlds. Humanistic interpretations of the world become posthuman when understood as dynamic productions of matter. Autopoiesis — first introduced by biologists Maturana and Varela, (1980) and quickly incorporated into sociological thought and social theory (Luhmann, 1986) to describe how systems reproduce themselves — is the concept of self-producing systems as a system.

Exploring the concept of autopoiesis and expanding our understanding of world making with the concept of sympoiesis will further illustrates the concept of posthumanism. I consider the concept of sympoiesis more suitable than autopoiesis because of the assumption that there is not necessarily one lowest common denominator.

Autopoiesis is an example of thinking about the social using materiality. It moves from the individual at the centre of being and focuses on communication and relationships between matter to produce and reproduce systems (Luhmann, 1986, p174). I argue that what I understand as an individual and how we make our worlds is in the process of becoming, reconfiguring and being ongoing (Haraway, 2016).
Autopoiesis assumes a corpus, a body, in the middle or a notion of self-organisation and self-sustainment and implies a lack of dynamism. This ignores the emerging, ever changing, (re)assembling matter of life. Haraway diffracts the concept further to describe the phenomenon of autopoiesis as sympoiesis.

Sympoiesis enlarges and displaces autopoiesis and all other self-forming and self-sustaining fantasies. Sympoiesis is a carrier bag for ongoingness, a yoke for becoming-with, for staying with the trouble of inheriting the damages.

(Haraway, 2016, p125)

Sympoiesis describes living with other matter. It contextualises that the individual is not an illusion, nor is life chaos; it is living with and world making with each other. Sympoiesis describes the assemblage of living and dying to make worlds (Haraway, 2016). Whilst autopoiesis acknowledges the self-organising processual (re)production of social systems, sympoiesis demonstrates that every social system produces, adapts and (re)produces other assemblages of humans, more-than-humans, times, places and other matter. If I accept this description of how worlds are made, I can suggest that nurse work is sympoietic.

Returning to Figure 1, handwashing produces an understanding and enactment of sympoiesis. It is beyond the scope of this thesis to debate if the process of handwashing is indeed humanist, transhumanist or posthumanist in character by potentially intending to value human life over other life. What this example does highlight is how worlds are made (or unmade) by the human and more-than-human. This also highlights the ongoing negotiations made within the paradox of requiring the nonhuman and more-than-human to maintain skin health and demanding the relative absence of the more-than-human for ongoing humanistic health care. How can I then relate the argument of monism and sympoiesis more broadly to the potential of posthuman care?

3.5 Care and Posthumanism

This section intends to speak to the sympoietic possibilities for posthumanism and nursing, by suggesting that critical posthuman theory may have applications for the development of nurse work. I seek to enable access to posthumanism in two ways; I will ‘walk with theory’ (C. A. Taylor, 2017) through some examples of contemporary nursing and will suggest that nurse work may be a language in which I can discuss the posthuman condition. I acknowledge that care of the human and more-than-human is not owned by any particular group, however, nurse work, nursing and care are often the domain of the care of
people. Nurse work is entwined with the specific ways in which I understand care. I therefore understand much of what nurse work entails as care, alongside internationally accepted definitions (ICN - International Council of Nurses, 2002). Consensus on the definition of care is a somewhat unruly endeavour (Puig de la Bellacasa 2017). Acknowledging the complexity of the matter, Feo, Kitson and Conroy (2018) describe the primary organising feature of care as trust. It is my reading that most descriptions of care agree on the trans-species and trans-national characteristics of care: it is ubiquitous, yet invisible (Feo et al., 2017; McCormack & McCance, 2010). However, care is less frequently described in terms of the more-than-human (Puig de la Bellacasa, 2017). Nurse work is a place where one can engage with how worlds are made, but it is also a space with tensions that I must take into account (Feo et al. 2017). Barad demonstrates how critical practice and engagement contribute to learning about the world we live in:

Moving away from the representationalist trap of geometrical optics, I shift the focus to physical optics, to questions of diffraction rather than reflection. [...] What often appears as separate entities [...] with sharp edges does not actually entail a relation of absolute exteriority at all. Like the diffraction patterns illuminating the indefinite nature of boundaries - displaying shadows the scientific is a relation of ‘exteriority within’ this is not a static relationality but a doing – he enactment of boundaries – that always entails constitutive exclusions.

(Barad, 2003, p 803)

From the entanglement of practical nursing, empirical research and theoretical contemplation, I will establish care with three principles: care is more-than-human, relational and ubiquitous, always with and beyond the human. The following section will therefore summarise how I understand posthumanism and why it matters in contemporary care contexts.

3.5.1 More-than-human

Care is more-than-human. I consider care a vehicle for navigating assemblages and producing or restricting ways in which we make our worlds. The ways in which these worlds are navigated include the human and the more-than-human to enable care. An example would be a nurse administering antibiotics to someone with a chest infection. Doing so, restricts some bacteria from flourishing while being productive in the sense of facilitating the human’s ongoingness and – as a result – other bacteria. Deciding how much space humans take up in the world is deeply rooted in power (Ahmed, 2014). The productive/reductive
world making unfolds in the context of sympoiesis. Power flows through the possibilities of assemblage and as Spinoza may describe power as potestas and potentia; potential is the productive power of relationality and potestas is the restrictive power of relationality. In this case, the sympoietic act of giving antibiotics demonstrates the sympoetic characteristics of potentia and potestas in the ongoingness of matter. Sympoietic world making of geo-socio-temporal locations creates conditions of possibility for (re)entanglements to make our worlds with power relations.

3.5.2 Relational

Care is relational. This is the second principle of care that I walk with on this dérive. As material beings, humans are inevitably anchored in geo-social-spatial and clustered in historical-economic-political coordinates. I live and inhabit a particular time, a certain place and I am connected with other specific humans and more-than-humans. Simultaneously, these variables are never static, but in continuous motion. Hence, human life equals inter-relationality, somewhat flowing, and entangled with glimpses of meta-rigidities (Braidotti, 2019). Care illuminates intra-dependence and vulnerabilities in the familiarly unfamiliar. As a nurse, I become entwined in ways which are often considered private. People probably cannot anticipate when they will need someone to care for them by washing them, changing their incontinence products, feeding them and changing their clothes. The nurse who can work with the knowledge of relational inter and intradependence, and can produce affirmative conditions of possibility, and for those co-present creates the effect of ‘good’ care. Affirmative care is not bound to the patient or nurse, it is related to the convergence and co-production by and with the nurses, patients, support workers, family, physicians, institution, environment, time, place, history and, and.

3.5.3 Ubiquity

Care is ubiquitous. Everyone is born and everyone will die. This means that everyone experiences care from other people and places. Feo and Kitson (2016) argue that ‘care is fundamental’ and I agree, but I stress the need to consider the posthuman convergence here. Care and nursing are hard to conceptualise because as discussed in section 2.4.4, nurse work is messy. The humanistic focus of nurse work and care while addressing ubiquity, yet uniqueness in situations creates a tautology; everyone will experience care, in uniquely situated way and in a way which they will sometimes be central to the care and at other times not. A critical posthuman perspective acknowledges care providers and adds that it is the ubiquity of care, that which exceeds the human, that has been understood, but not discussed until now. Care is situated at the periphery of our understanding and is
notoriously ‘slippery’ to conceptualise (Martin et al., 2015) as it is hidden in plain sight and is now being reconsidered during the posthuman convergence.

3.6 **Summary of the theoretical standpoint**

Care is a convergence of knowledge, performance and production, enacted through the materiality of carers caring. Care creates an affective and intimate entanglement (Latimer, 2013; Latimer & López Gómez, 2019) between and with human and more-than-human material entities. Using a phone, listening to a handover, gathering information by reading nursing notes, providing medication, physically restraining a patient when they are a danger or getting a cup of tea for a patient are all examples of this. Posthumanism emphasis of materiality and betweenness enables understanding of the ubiquity of care. In this sense, government policies are equally able to enable and restrict care as is architecture — describing this as merely structural framing is misleading. As I suggest, there are levels upon levels of complexity in material entanglements that tend towards a posthuman understanding of care.

Care is always with and through, but also always beyond human. The understanding of care as being person-centred becomes untenable when care work is approached using critical posthumanism. Care is an assemblage that is (re)enacted, (re)negotiated, (re)configured and (re)inhabited by nurses, but simultaneously exceeds them, flowing through time and space, humans, more-than-humans and all of materiality.

First, nurse work and care are processes of being together in complex assemblages. These can help us to discuss the dynamic boundaries of the human and give everyday examples with which to discuss critical posthuman theory. Second, this has implications for current, person-centred care work and therefore calls for reflection and contemplation of other ways of understanding nurse work. This thesis uses this monistic approach to the practice of nurse work, substituting dualistic ontologies for a monistic epistemological approach (Fox and Alldred, 2016).

3.7 **Why approach this with posthumanism now: the Posthuman convergence**

As discussed above, this thesis was produced in a particular social, political and historical context. This research may only be possible because of this convergence, at this point in time, that enables us to ‘spray the water on the web’ (Brownlie & Anderson, 2017, p1222) of the power relations of materiality and make them perceptible. The posthuman convergence is a term used by Braidotti (2013; 2019) to describe which conditions of possibility enable this discussion.
The posthuman convergence is triggered by the coming together of posthumanism (where what is understood as human is a site of enquiry) and post anthropocentrism. The posthuman convergence goes beyond the terms of this binary structure to qualitatively describe the constellations of power relations in the production of our worlds. Posthumanism enables the critique of the humanistic ideal of man as the universal representative of the human. Post-anthropocentrism critiques species hierarchy which places humans at the top of any taxonomic tree and is itself grounded in ecological and environmental sciences. It is with these two concepts, that humans inhabit the world at this time of changing paradigms, during which what it means to be human is questioned.

Braidotti (2013) traces the genealogy of this shift back to Foucault (Foucault, 2005) who articulates that there is a correlation between an object becoming thinkable and entering a state of crisis, and this is what is currently happening to the ‘human’. Braidotti and Bignall (2019) provide examples of how these existential threats are enacted by means of ecological crises, alongside the establishment of new departments at universities which address technology’s ‘threats’ e.g. artificial intelligence (fear of AI overtaking the human). The two authors therefore argue that the ‘human’ category is postulated against the background of the anxiety concerning the disappearance of the human.

This thinking leads to a conceptualisation of ‘we’ as humans emerges. A ‘we’ as a human that is endangered and a ‘we’ that is predicated on the European white man. These existential threats are framed by humanity’s shared existence. However, this is a European cosmopolitan existence. It presumes that humanity and to be human are unified concepts, when in reality, they are a complex network of relationality in which some people never get to be human in the first place (Wynter, 1989) because what is human is framed as the white European male.

3.8 The Vitruvian man

Braidotti (2013) narrates the academic production of the concept of ‘(hu)Man’ throughout recorded history. From Protagoras’ assertion that man is ‘the measure of all things’, to Da Vinci’s Vitruvian Man, the privileging of the human (and, specifically, the human male) instils a set of ‘mental, discursive and spiritual values’ (Ibid p 13). These values have come to constitute the basis for social, cultural and political production in post-enlightenment Europe. The human (explicitly referring to European White Men) is understood as an ‘intrinsically moral’ being, functioning as an axiom of perfect rationality and reason. In this mode of thought, man is capable of unlimited expansion towards his perfection and is entitled to claim ownership of whatever objects or others he encounters along the way.
This humanist ideology was adapted by Europe and the global north, in the 20th century into a cultural model that allowed Europeans to view themselves as an unequalled force on the planet, entitled to use its resources as they see fit. As Braidotti continues:

\[\text{...this makes Eurocentrism into more than just a contingent matter of attitude: it is a structural element of our cultural practice, which is also embedded in both theory and institutional and pedagogical practices [sic]}...\]

(Braidotti, 2013, p15).

Humanism became the ideological backdrop to Europe’s foreign policy, in that it helped develop the dynamic between ‘self’ and ‘other’. This approach to foreign policy followed and supported European colonialism (Wynter, 1989; Braidotti, 2013). Europe views itself as the birthplace of rationality, therefore elevating itself above non-European nations. Otherness, therefore, becomes synonymous with subordination. Entire populations are reduced to non-human bodies upon whom the will of Europe can be projected. For this reason, Braidotti points out that ‘Humanism’s restricted notion of what counts as the human is one of the keys to understand how we got to a post-human turn at all’ (Ibid p16).

Until the 1960s, the universality of human reason in philosophical discourse went mostly unchallenged. Only the publication of Foucault’s *The Order of Things*, made intellectuals begin to consider what exactly was meant by ‘the human’. In this way the Vitruvian ideal was ‘literally pulled down from his pedestal and deconstructed’ (Foucault, 2005, p 23). What was learned from the deprivilege of the human was, crucially, that ‘individualism is not an intrinsic part of ‘human nature’…but rather a historically and culturally discursive formation’ (ibid p 24). That is to say, the individualistic greed that characterised much of post-enlightenment Europe’s foreign and domestic policy was re-read to reveal that colonisation and rationality was not the manifestation of human nature, but rather an affective, psycho-somatic cultural production.

This is one of this thesis’ many entry points to approaching nurse work. This project will explore how these power relations and configurations of the human are (re)produced with nurse work.

**3.8.1 Vitalism in critical posthumanism**

Nursing is an affective practice and this section will discuss the place of vitalism in posthuman theory. Based on the ideas of Bergson (1911), Deleuze (1983) and Grosz (2004), vitalism is the tendency of life to move towards greater complexity, that is, to move towards maximising pure difference. Differing occurs not only between things that already
are, but also includes things that can be. As Grosz (2004) urges in her treatise The Nick of Time: Evolution and the Untimely, humanity should learn to think about what will have been possible. This type of thinking is especially important to those interested in radical politics. Vital materialism reaches for the future and encompasses potentiality i.e. vitality encompasses more than what is actually, currently living. Both actualised and virtual life are vital.

New materialist vitalism is closely connected to sympoesis. The properties of life cannot be fully described in terms of the properties of the associated material constituents. Life cannot be reduced to a mechanistic process. Materialist vitalism does not construct a special kind of substance which is added to matter to produce life. Rather, vitality emerges from within and between matter. Grosz develops Darwin’s ‘account of the real that is an open and generative force of self-organisation and growing complexity. A dynamic real that has features of its own which, rather than simply exhibit stasis, [...] are more readily understood as active vectors of change’ (ibid p 19). In The Posthuman, Braidotti also describes matter as intelligent and self-organising. There is nothing outside the world that makes the world. The world worlds itself. By stressing the self-organising vitality of all living systems it is possible to decentralise the anthropos, replacing species hierarchy with decentralised immanence. Braidotti (2013) encodes the vital force of life as Zoe, that which imbues all living matter impersonally. Braidotti insists:

Zoe-centred egalitarianism is, for me, the core of the post-anthropocentric critical turn: it is a materialist, secular, grounded and unsentimental response to the opportunistic trans-species commodification of Life that is the logic of advanced capitalism. The key notion is embodiment on the basis of neo-materialist understandings of the body, drawn from the neo-Spinozist philosophy of Gilles Deleuze and Felix Guattari, but re-worked with feminist and postcolonial theories. Embracing their version of vital bodily materialism, while rejecting the dialectical idea of negative difference, this theoretical approach changes the frame of reference’ (Ibid, 2013, p 22).

Vitalism is more than a flavour of new materialism, it is an essential concept with important implications for developing new epistemologies, ontologies and ethics. Vitality is what is hidden when life is reduced to ‘biodiversity’; a pool of resources to be managed and exploited. I will introduce vitalism to acknowledge the affective component of this theory. That life, the universe and humanness are produced with affective potentials for making relations. In discussing the bodily matters of care, I do not want to erase the existence of
people to an unbounded entity of component; moreover, understand what it means to be people and to care for each other in the first place.

Vitalism in posthumanism demonstrates that matter is not passive and that it assembles with matter. Matter does not exist by external design, however. The way matter assembles can be productive and world-making or it can be reductive or restrictive and make different worlds. Matter assembling with matter is what matter does, but in a way that is not predefined and is speculative. The way in which matter relates to matter is how meaning is made.

I argue this point to explain the posthuman approach to meaning in life, because this is a key point that distinguishes critical posthumanism from other new materialisms. There is a risk of nihilistic flat ontologies being produced which negate subjectivity and situatedness in this new materialist divergence from centrality and corpus. An example of this would be Actor Network Theory, which proposes a decentralised nodal mode of existence, however, flattens the ontology and relationality between the nodes of the network (Latour, 1992). Critical posthumanism approaches the reconfiguration of transcendental design into speculative mattering in a way that creates a topographical, dynamic and cartographical way of relating.

The potential reductiveness or nihilisms of a monistic materialist ontology can be (re)addressed with such concepts as the eternal return/recurrence. This thought experiment suggested by Nietzsche (1871) asks us to consider that our existence must repeat itself in a never-ending universe of space-time. If our lives are repeated over and over, then what is the point of the choices made because these will be repeated during the next cycle of our life. This then begs the question: what is the point of living? However, if matter has no choice but to exist there is no choice in the ontology of existence. The meaning in life becomes how we become to know it—the dynamic and ongoing epistemologies of life. The suffering or pain of existence that we learn to live by, is what becomes the ongoingness of life. Spinoza describes this ongoingness as conatus (Lloyd, 1994).

The productive or restrictive conditions of possibility for that matter to assemble is a description of power. Power lies in the relationality of matter in assemblage; to make worlds in a way which moves away from anthropocentrism and away from reductive conditions of possibility for all matter whilst living with sympoesis. These are the ethics of affirmation. Vitalism describes the characteristics of this process. Vitalism becomes affirmative when the principles of the potential of matter to assemble are not reduced. Lloyd (1994) argues that understanding the conditions of one’s own bondage is practicing affirmative or joyful ethics. Shared understanding of the conditions of possibility from a situatedness are a path to the
‘joy’ of existence or – in other words – the subjective and embedded experiences of becoming in the context of the ongoingness of matter. Lloyd highlights this concept in Spinoza who attests that through pain, we gain knowledge, which leads to liberation.

Vital new materialism is constrained by two concepts which are unavoidable and inevitable for us at present – language and the self (Taylor, 2017). However, care is more than language and the self, and therefore creates possibilities for shared understandings. First, language is used to communicate world making in many complicated and beautiful ways, but is a blunt tool for describing the complexities of how those worlds are produced. With nursing at the centre of this, I argue that so much more goes into nursing than language. I can communicate through smell (van Brakel et al., 2018), the way I choose lighting, how I position objects on a desk, through objects when we are absent (such as a call bell) or even a mood. Similarly, I argue that the self is bound by this complexity as it is an organising feature of meanings using language, objects, capitalism, society, etc. I understand the self as ever-changing depending on the histories actualised in materiality and reciprocal relationship with others. It is then that I ask, how nursing can acknowledge these complexities of patients, other disciplines and themselves. This critical reflection on the central role of language and the self leads to the claim that ‘becoming human involved our intimate interaction with more-than-human elements’ (Smart, 2017 p2). As a result, I believe that more goes into nursing than nursing and to understand the complex demands on nurses, I must engage with these other things. If I accept that language and the self are tools (Swidler 1986) for understanding how we make worlds, then how do I think about nursing in a way that others can understand? Critical posthumanism and new materialism is exemplified by nursing, which leads to a (re)negotiation of care using a posthuman lens in order to suggest ecologies of care explored utilising posthumanism.

We (as nurses, humans, academics) exist within these conditions and multiplicities of contradictions. This means we contribute to these problems as much as we have the capacity to address them. We are embedded, situated and implicated in the latter’s production – past, future, actual and virtual.

3.9 Using posthuman theory in research

Care is a human trouble, but this does not make of care a human-only matter. Affirming the absurdity of disentangling human and nonhuman relations of care and
the ethicalities involved requires decentring human agencies, as well as remaining close to the predicaments and inheritances of situated human doings

(Puig de la Bellacasa 2017 p2).

Empirical and theoretical research into key features of fundamental care work are intensely focused on nursing as a profession (Kitson et al. 2010). I argue that we have to broaden our understanding of fundamental care and define it beyond the individual carer, role or patient. Approaching nursing as a broad concept, using research from a posthuman philosophy is an attempt at understanding the conditions of our own bondage as nurses and to enable nurses worldwide to provide ‘care consistently and to a high-standard across any care setting’ (Feo et al. 2016 p2225).

In this section I begin to engage with a posthuman theoretical approach which guides this research and its methodology. The underlying analyses of social processes traditionally assume the individual is the centre (St Pierre 2014) and so does the concept of person-centred care, which is central to the development of the professionalisation of contemporary nursing (NMC 2015; McCormack et al. 2010). Contrary to this, I suggest that the person or the body as the centre of care, may be an assumption. Of course, the body exists, but what is up for discussion is how I think about the body and the self. As a practising nurse, I do not want to disenfranchise those I care for nor exclude others from care. However, a system which does not discuss its discreet boundaries and power dynamics will innately disenfranchise those in it. In this section, I will provide alternatives to such a perception using well-known examples from familiar settings. In these examples I engage in human issues using a posthuman perspective, thereby arguing that the human is open to reconfigurations (St. Pierre 2013).

3.9.1 Example 1. Ward Nursing

Imagine a nurse on a ward dealing with a verbally abusive patient; is the care she enacts her knowledge or is it that of an institution, a culture, a gender? A multitude of perspectives could be adopted. Are other nurses sharing their experiences with that particular patient, ‘wanting her to be prepared’ and giving her strategies for dealing with the patient, an act of care? Is it the materiality of how this world making unfolds that transmits? Will she perform acts of care by sharing her present experience with many more nurses in the future who will then deal with such situations competently? Was it the experiences with her mother with dementia who she looked after for years or did verbally abusive patients in the past cared unknowingly for her by preparing her to calm the situation down now? When it
comes to posthuman-more-than-human-knowledge, was it her experience with aggressive
dogs that she trains in her spare time that enabled her to provide good care? With regard to
materiality, is it care that she creates an intimate entanglement (Latimer and López Gómez
2019) by getting a cup of tea for the patient? Is it an act of care (towards the patient and
others) to phone security, drug the patient to make them compliant, fixate them when they
become physically abusive? Is it care to gain insight into the dynamics of the past few days
from written nursing notes? Are not governmental policies, that enable and restrict structure,
and the building which she works at, just as much a part of the care in the situation outlined?
Care is always with and through, but also always beyond human.

Care is an assemblage that is (re)enacted, (re)negotiated, (re)configured and
(re)inhabited by nurses, but simultaneously exceeds them, flowing through time and space,
humans, more-than-humans and all materiality. The processes of being together in everyday
nursing are complex assemblages. How can this then be studied? If care is posthuman, and
care illustrates posthuman thought, how can practical examples of nurse work further clarify
this?

3.9.2 Example 2. Nursing handover

Nurse work is rhizomatic, that is to say, unplanned yet planned at the same time.
Care becomes moments of meta-rigidities in time, space and affect.

Imagine nurses working at a hospital taking handover in the morning. They hear from
colleagues on the previous shift about the patients they will be looking after. They already
learned much about the preceding shift from the sounds and smells on the ward that may or
may not be present and how tidy things are when they arrived. The handover outlines the
situation, background, assessment and plan for each patient. Nurse work becomes
rhizomatic because the handover is intended to spread, twist, change, slow down, speed up
and undergoes constant reconfiguration.

If I reconfigure nurse work in this way then how can I understand how nurses become
nurses in their working environments? I argue that nurse work is (re)negotiation and
(re)constitution in action. Nurses are positioned using situational, organisational and
professional structures to reconfigure the productive powers of potencia and the restrictive
powers of potestas. The symposia of nurse work is to establish human and more-than-
human (bacteria, machines, societal infrastructure) ways of ongoingness. Differences in
location become simultaneously restrictive and productive fields which are navigated by
nurses with affirmative ethics.
3.9.3 Example. 3 Uniforms

Considering and (re)defining what fundamental care is, means observing how materialities become relational and communicate care. Savage (1997) argues that nurses navigate boundaries in their practice with their bodies. One example which I want to discuss and which constitutes a posthuman approach to nursing and care, are uniforms.

Is a uniform simply a piece of fabric or does it also transmit history and meaning about gender, labour, intention, institutions and power? Does it do so with colour and how it is cut, how it is assembled? A uniform is a symbol for creating homogeneity and professional identity (Mitchell & Boyle, 2015). Could I reconfigure a uniform as an intrahumanising technique because it signals institutional power over the wearer to be there for you, that the wearer has agreed to this by putting the uniform on? Does it emphasise concern for the infection control measures in the environment, with no haircut being long enough to touch the uniform’s collar? Does the juxtaposition of a supposed boundary between the self and others when a uniform is worn actually create potentia in nursing uniforms? Does a uniform in nurse work signal the intentions and possibility of an immanence of impending affirmative (re)configurations and negotiations of the environment which then becomes what we understand as care? And what happens if someone does not conform and has a different, dirty or unkempt appearance? I want to at least consider the conditions of possibility of what care is and how the more-than-human uniform produces very human realities of care.

3.10 Critical posthuman and new materialist research paradigm

Critical posthuman approaches to research emphasise the interconnectivity with materialities of being beyond the boundaries of what constitutes human subjectivity. This approach also allows non-human actors such as the materialities of healthcare delivery (call bells, beds, medications) and the structural frameworks (regulatory bodies, other healthcare providers) to be included in the analysis. This project will consider nurse work from a critical posthuman perspective as the literature reviewed creates the nurse as a subject who must navigate their work in the space between many subjectivities or situated matterings.

The approach to the research methods and methodology is based on the posthuman theoretical standpoint established earlier in section 3. The genealogy of this theoretical field demonstrates the heterogeneity of feminist critical theory that this approach could describe, therefore, further clarification is required to situate this thesis. In light of the divergent views about new materialisms, it is not surprising that descriptions of appropriate practices for ‘new materialist research’ differ significantly (Fox and Alldred, 2021), therefore, I will situate my methodological approach in this chapter.
Fox and Alldred (2016) explore research methods using the terminology of new materialism as this is a return to materialisms described in the early enlightenment by philosophers such as Spinoza (see Lloyd 1994). Traditional qualitative research privileges the human perspective and so does new materialism, however, it just expands the range of what is human. Fox and Alldred (2016) describe a diverse range of disciplines under the umbrella of new materialisms that share a common theme which is a ‘turn to matter’. They outline three commonalities for new materialist theories, which are:

1) The material world is a relational entity that is in a constant state of production.
2) Nature and culture are not understood separately, moreover, they are on a continuum.
3) The capacity to produce relationality in the universe is not limited to the human. The more-than-human can affect and be affected. This capacity to affect and be affected is agency, therefore the more-than-human has the capacity for agency.

Fox and Alldred, 2016, p 151-176

The theoretical underpinnings of these statements have been explored in previous chapters. This chapter will continue to situate and explore them in order to outline a posthuman approach to research.

3.10.1 Situating a critical posthuman approach to research

This project takes a critical posthuman approach to research, nevertheless, there are other posthumanism and new materialisms from which this project must delineate itself in order to be clear about the methodology used. Fox and Alldred (2021) stress the diversity of opinion in new materialist and critical posthuman research and highlight that a unified approach to new materialist methods is not feasible because of the heterogeneity of approaches and diversity in the field. Nevertheless, this should not detract from building a ‘robust scientific methodology of enquiry’ (Fox and Alldred, 2021, p. 626). Using various methods can capture the multiple ways in which labour exists in nursing work, competing conceptions of disease or definitions of care (Mol et al. 2015). Based on Deleuze’s (1988) articulation of ethology (the study of human behaviour and social organisation from a biological perspective) researchers can employ a set of guiding principles in the form of a conceptual toolkit in their research design, data collection and subsequent analyses. The research process needs itself to be understood as an assemblage of human and non-human
relations and builds upon the commonalities of new materialist research discussed in section 4.2.

3.10.2 How is the human situated in critical posthuman research?

Nursing is and has been focused on preserving the ongoingness of the human life where the focal point of knowledge production centres on people. Nursing is organised around the health and well-being of people to live healthy lives and have ‘good deaths’ (Ternestedt et al., 2002). Often this involves understanding how the human interacts with other life or materiality in the universe such as investigating a new antibiotic or technology. Yet, the human, non-human (e.g. bacteria and viruses) produce more-than-human realities in which people live; therefore, I assert how people are situated in their environments and contexts in this research. Embedding posthumanism in a field that is characterised by humanism, offers a way to move beyond the traditional human-centered perspective. In other words, it allows for a more comprehensive understanding of the world that includes non-human actors. Additionally, situating the human in critical posthuman research also allows for a better understanding of how humans interact with other non-human entities.

In a socio-material sense, the human is an assemblage that is configured in ways which create potentials of difference with other matter in the universe (Lloyd, 1994). These potentials of differences are complex and depend on where people are located and situated in their contexts. People are produced with affect and subjectivity through interactions with non-human entities such as our environments, animals, plants, and technology. The possibilities for people to intra-act can be restrictive, productive or both – depending on the situation. People perceive intra-actions as possible, and not possible, or dependent and contingent on other things. As an assemblage, people are affective in that they have the power to affect and be affected (Deleuze and Guattari, 1988). In this research, participant data produces material-discursive focal points which describe their perceptions of realities and how the materiality of the human(s), non-human and more-than-human produce worlds.

Fox and Alldred (2021) propose that the criteria human participant data, such as interviews, are vehicles to engage with data relevant to a new materialist approach to the research questions:

“…interviews can still serve as sources of data in a more-than-human study, if interviewees are considered not as privileged actors within a socially constructed setting, but rather in the way that ‘key informants’ are used in ethnographic studies: as insider sources of knowledge about a setting…”

Fox and Alldred (2021) p. 631
This approach to situating the human in posthuman research describes a subjective and affective materiality. People’s realities are created by the affective potential with which they can relate to materiality.

3.10.3 The tools of posthuman research

Posthuman research toolkits are embedded in a humanist tradition because of the conditions of their emergence – namely, post-enlightenment academia (Braidotti, 2013). Yet critical posthuman toolkits question human-centred thinking, binaries and open research to more than one logic of knowledge production. There is no singular toolkit that one can assimilate into designing a methodology in this way. Instead, it is necessary to assimilate and justify the methods available to us to understand how worlds are being made (Fox and Alldred, 2016). The broad umbrella statements made by Fox and Alldred (2016) concerning new materialist theoretical methods were reaffirmed and focussed by Taylor and Fairchild (2020) into a critical posthuman context. They elaborated on the following four points for critical posthuman research:

4. The category of human is unsettled from its politically privileged position, both epistemologically and ontologically.
5. More than one logic system can produce understanding and knowledge, simultaneously. This aims to decentralise Western reasoning as the sole account of knowledge.
6. The universe is produced in a nature/culture continuum. Binaries are ‘humanly-instituted and… well-policed’ (ibid:511) by existing knowledge production structures.
7. Humans should be understood as connected and relational to their situatedness.

Summarised from Taylor and Fairchild, 2020, p 513

Critical posthuman research is not conceptualised in a free-floating space nor does it create dichotomies of ‘humanist’ and ‘posthumanist research’, but works by acknowledging pre-existing embeddedness, contingent and implicated realities. A point to highlight here is the nuanced acceptance of other forms of logic in the production of knowledge. The language of Deleuze and Guattari enables humans to think about matters using ontologies that include the more-than-human. St Pierre (2018) writes of how Deleuze and Guattari’s language can be used in empirical inquiry. This language becomes a tool for describing ontologies which include the more-than-human.

When choosing a data sample for critical posthuman research, it is important to consider the type of data that will be most useful in answering the research questions – and
that the data includes the human, non-human and their intra-actions. For example, if one is interested in understanding how a particular material interacts with its environment, one may choose a data sample that includes both the material and the surrounding environment. It is also important to consider the size of the data sample when choosing a data sample; the larger the data sample, the more information one has to work with when analysing results. However, it is also important to keep in mind that too large of a data sample can be difficult to manage and may result in inaccurate or non-specific results (Fox and Alldred, 2021). Fox and Alldred (2021) offer suggestions for data types to choose when conducting critical posthuman research:

Qualitative data from focused individual or group interviews can be highly productive sources of data on the relations and affects in a setting, and the capacities that these produce in human bodies.

Respondent-led methods such as ‘walking tours’, in which a respondent conducts a tour of a setting to point out its salient affective features.

Arts-based methods involving individual or group creative activities may be a means to elicit and/or explore affects and emergent capacities related to a research question.

Ethnographic observation may be valuable to identify relations and physical affects, but needs to be combined with some sort of ‘insider’ perspective, to supply data on other affects and the capacities these produce.

Survey and other sources of data on participants in a setting can be used to assess the prevalence of relations, affects or capacities, or alternatively, to provide a means to stratify the sample to compare/contrast some contextual aspect.

Documentary evidence may also be trawled for data on relations, affects and capacities. This includes qualitative or quantitative meta-analysis of published or unpublished materials on a topic.

(Fox and Alldred, 2021, p. 631)

The qualities of the data needed to address the research questions for this research were socio-material, institutional, experiential, and contextual. First, sociomaterial data situates nursing work to understand the intra-actions of the human and non-human. Second, institutional data supports analysis of the position(s) and value of nursing by the institution. Third, experiential data explores how the realities of nurse work are perceived for nurses,
and also franchises nurses in the data collection process. Fourth, contextual data guides the entry point and socio-historical-political contexts in which data are produced.

3.10.4 Transgressive data

Transgressive data is the term that St Pierre (2018) uses to describe out-of-category data that is sometimes omitted from research data. Examples include emotions, hopes and dreams. St Pierre draws upon Deleuze and Guattari (1988) and calls for an understanding of reality which begins to unpack the binary between the imagined and the real. The imaginary-real becomes a continuum. This concept relies on deconstructing the boundaries of humans and the other as well as understanding the situatedness of materiality and its potential to act. Imagination can transgress traditional ideas about what is possible, the boundaries of acceptable behaviour and the realms of what could happen. In this sense, realities can always be understood as a product of the imagination at some point. In support of this, below is an example from nursing.

3.10.5 Transgressive data: the call bell

Pictured below is a call bell (Image 2). The bell is intended to be left within reach of patients so that they can call for assistance at any time even if they are unable to communicate this in any other way. The call bell represents the assumed, or imaginary, presence of a nurse, at any time the patient may want. The technology becomes loaded with emotions, hopes and promises. A nurse placing a call bell within a patient’s reach constitutes more than merely proffering communication technology: it is a promise of care. Of course, a call bell is only useful if someone responds to it. The patient may see the bell as opening up a productive, unrestricted way of becoming, despite perhaps never using it. The possibilities of assemblage are imaginary while also being real.

If a patient can’t reach their call bell then they might not get the attention or care they are seeking in good time. The call bell gives the impression that care is on call. The consequences could be what is known as poor care, which also has significance for the production of nurse work. Again, the patient may never have needed to use the call bell, however the imaginary-reality created restrictive or unconnected possibilities leading to someone perhaps not feeling cared for, connected or safe. The call bell opens up connections to how nursing work is mediated by these devices (the non-human).

Image 2

Nurse call bell
This means transgressive data is intrinsic to how worlds are made. For instance, the call bell is also a political symbol in the UK. The Francis Report (Francis, 2013) gave examples of how care can become mediated by or measured using these objects. How the bell is arranged with a patient and in the environment can become a focal point in the production of care and becomes essential to the ways nurse work can be produced.

This transgressive data is imbued with affective relations which are multiple, situated possibilities of assemblage. The Francis Report (2013) used the call bell as an example with which to highlight care, however the call bell became a surrogate marker for measuring the promises that go along with its use, and it is this potential or imagination, which St Pierre (2018) describes as transgressive data. Transgressive data therefore has a place in this critical posthuman inquiry because it enables an understanding of the connection of human and more-than-human in the production of nurse work (see research question 1).

3.10.6 Posthuman Institutional Ethnography

Nurse work is relational and interactive (Theodosius, 2008), and influenced by the environment it is performed in (Fawcett & DeSanto-Madeya, 2012). Theodosius (2008) defines relational as "the process of relating two or more entities that are either simultaneously present or have a past, present, and future relationship" (p. 12); therefore, Posthuman Institutional Ethnography is an appropriate research approach to investigate nurse work.

Nurse work is intrinsically relational because it involves caring for patients in personal, intimate and vulnerable ways. Nursing also involves interacting with patients, families and doctors on a regular basis to build relationships and provide care (Hall & Naylor, 1998). In addition, nurse work is interactive because it engages the patient in the care process by providing opportunities for shared dialogue and communication (Theodosius, 2008). These two aspects of nurse work—relationality and interactivity—help create an environment in which patients feel comfortable discussing their needs and desires.
Nurse work has repeatedly been documented as accessing vulnerabilities of the human experience (Feo et al., 2017; Mercer, 2015). The structural positioning of nurse work is documented, but less well inspected with regard to the context of how this translates into society, healthcare systems and nurse work. Orme and Magg’s (1993) clinical study into the use of intuition as an orienting device in nursing explores the inbetween-ness of nursing practice. They define nurse work as:

*A state of heightened perceptual awareness which emanates from sub conscious thought. It influences behaviour and therefore influences the decision making process*  
(Orme & Maggs, 1993, p275)

Gobbi (2005, p. 121) outlines the ephemeral elements that influence the way in which a nurse practices: “organisational cultures, behavioural obstacles, professional autonomy relationships and the weight given to different forms of evidence, whether scientific, clinical or experiential.” In her work Gobbi (Gobbi, 2005; 1998) advocates the tacit skills of the nurse, centred around intuition and the reading of the body as being about more than visual perception. The skill of the nurse to care in messy, transdisciplinary situations relates to the way these contexts diffract through the particular body-place assemblages the nurse is acting within.

The inbetween-ness of nursing experiences in relation to this research relates to moments that currently lack discourse, largely due to the oral tradition of nursing and lack of existing methodology for the convergence of embodied practices in research methods for care. Gobbi discusses Marcus’ (1994) notion of a messy text in relation to her own experience of trying to understand how a nurse came to ‘know’ how to insert a catheter on a patient with gross scrotal oedema due to malignancy and the information she receives from them both bursting out laughing mid-way through the discussion. This too is a way of caring that is in-between, it is medical, caring, even artistic.

In these ‘messy’ situations, the interactions led to the generation and production of what Marcus (1994) described as a ‘messy’ text. These texts occur when different voices endeavour to be heard and where the presence or absence of discourse is an indicator of something that deserves attention. As Marcus (1994, p 568) argued, ‘messy’ texts are interesting because they are symptomatic of a struggle to produce ‘unexpected connections’ and ‘new descriptions of old realities’. In the situation above, the nurses were struggling to account for that which had no definition (an element of nursing practice), no acceptable discourse (describing the practise of catheterising in this context) and whose existence and nature is contested (intuition/reflection/knowing in action).
In being with nursing as a diffractive practice the nurse senses what is inbetween the cartesianian body, medical model, equipment, professional role, and “reads different ideas together, such as the social and the natural, to account for how both matter” (Fullagar and Bozalek, in *Murris, 2021*, p. 104). In relating these concepts to nursing that is ‘in-between’ the nurse is placed in relationality with others, both human and more-than-human. The work of critical feminist auto-ethnographer Mackinlay (Mackinlay, 2022, p. 19) picks up on the idea of being with and definition of this word ‘with’ as an operational drive for thinking. “The word ‘with’ gestures to the entanglements of two - so often positioned in opposition rather than in between.” In diffracting this reading of withness through Orme and Mass’ positioning of intuition I understand nursing and care as an onto-ethico-epistemological praxis that can be researched with PIE.

Many of the scholars cited in this chapter work in education and not in healthcare. For – presumably obvious – anthropocentric reasons, critical posthuman methodologies are an emergent field in health and not yet well established (Puig de la Bellacasa, 2017). PIE offers a framework that can be applied to posthuman health research.

PIE employs the tools of traditional ethnography with a diffracted approach to the analysis. Drawing on concepts of sensory ethnography (Pink, 2009) the data collected for this thesis aim to understand the intra-subjectivities of nurses doing nurse work. The data aims to provide access to the socio-material experiences of nurse work and follow the journey of working nurses. These experiences will be positioned within environmental and structural conditions to look for focusing events which highlight the material-discursive possibilities for nurse work. At the time of developing and writing this thesis, I could not and still cannot find any published literature on PIE for healthcare or nursing. I therefore had to create the methodology based on the theoretical literature discussed in chapter 3 and the published literature on post-qualitative, posthuman and new materialist research. In the later stages of development, this methodology was supported by the publication of Taylor and Fairchild’s (2020) paper on PIE.

### 3.10.7 What is posthuman institutional ethnography

PIE explores how materially discursive practices create realities (Taylor and Fairchild, 2020). It allows new ways of thinking about how people, places and structures produce inequalities and can draw attention to ‘how micro instances are entangled with macro forces’ (ibid, p 520). Posthuman Institutional Ethnography (PIE) is an approach to organisational research that takes into account the ways in which humans and non-humans interact in the production of realities. PIE emphasizes the importance of understanding how these interactions are shaped by power, knowledge, and technology. The aim of PIE is to provide
a more comprehensive understanding of how organisations work by taking into account the perspectives of both human and non-human actors to create more-than-human worlds..

Taylor and Fairchild (2020) define a posthuman institutional ethnography (PIE) as the practice of institutional ethnography with posthuman modes of inquiry. The genealogy of institutional ethnography, as known in academia today, is feminist and started with Dorothy Smith (Smith & Turner, 2014). More recently, institutional ethnography has been adapted by St Pierre (2019) as well as Taylor and Fairchild (2020, p 510) to investigate how worlds are made and how ‘...other-than-human objects, bodies and forces influence the (re-)production of gendered institutional inequalities...’. PIE can spotlight matters of materiality that may not otherwise be included in analysis (Taylor and Fairchild, 2020). This approach is also documented sociologically by Brownlie and Anderson (2017) when discussing kindness in contemporary cities. They describe what may seem to be ordinary or mundane acts to some, but which are essential to the production of social realities to others. They use the metaphor of ‘...spraying water on the web...’ (Ibid, p. 1223) to highlight the aims of research into how realities come to be produced. This metaphor is synergistic with the process used by Taylor and Fairchild (2020) in their explanation of PIE of how the human and more-than-human create worlds and how this can be used as a research methodology. PIE builds on this socio-material foundation by incorporating insights from feminist, postcolonial, and critical race theory. PIE is therefore concerned with understanding how power, knowledge, and technology shape the interactions between humans and non-humans in organisations.

Taylor and Fairchild’s six features of PIE are:

- A focus on the material-discursive
- Viewing institutions as assemblages
- Looks at how specific events generate resonances and intensities
- Attends to the affective lives in an institution
- Knowledge is seen as a material practice
- Promotes ethics of shared understandings (affirmative ethics)

Summarised from Taylor and Fairchild, 2020, p 518-524

3.11 The insider/outsider role in ethnography

I will be considering the ways in which my presence as a researcher becomes perceptible within the research setting. Traditional ethnographic methods would focus on the strict boundaries between the researcher and participants, I approach power relations that exist beyond the binary in the research process and will be examining the ways in which
these relations are performed both on the "front stage" and "backstage" of the research setting.

Ethnographic methods are increasingly being used in nursing research where nurses use their insider status as the basis of the research (Allen, 2004). In understanding the human as unbounded and in relation with the non-human, there is a risk that human subjectivities are overwritten. As a researcher, I am also situated in the research field and producing relations and power differentials. Research from a critical posthuman perspective must consider these power dynamics so that human subjectivities are franchised in the research process, and the processes of inter and intra-action between participants and the researcher become part of the analytical process.

The position of the researcher must consider the insider/outsider roles of participants and researchers in the production of research data. Insiders typically share characteristics, roles or experiences with participants (Dwyer & Buckle, 2009) whereas outsiders potentially share less commonality with participants (Dwyer and Buckle 2009). Researchers will inhabit spaces in different ways during ethnographic research depending on their histories, approach, characteristics and how they are perceived in research. Both insider and outsider roles acknowledge the complex relations that are always present when doing research. This is augmented when the researcher is or has been a participant in the field because researchers inhabit both insider and outsider groups (Allen 2004).

My relationship to the participants is important to consider ethically because of the existing constellations of power between us that are then introduced to a research project. Participants may feel that they have to tell me what they think I want to hear during data collection because they want to sustain an amicable relationship with me. This is an ethical consideration because it concerns the agency of participants; on one hand the agency of the participant is potentially shaped or restricted by our existing relationship, on the other, the existing relationship could create data that was not possible as a true outsider. Both these possibilities create additional ethical considerations.

First, if the agency of a participant is restricted by my relationship to them then I ensure that this is entered into consensually and that the participant is continuously made aware of this possibility. Participants may behave in this way whether the researcher is an insider or outsider, however, being an insider adds further complexities (Rose 1985). In practice, this process involved affirmation of consent prior to each interaction to reduce the risks of coercion or persuasion and remind them of their right and agency to discontinue in the research at any time. Open discussions with participants were held to discuss how the data being produced was there to reflect their own perspectives. Participants were also frequently reminded that their data was freely given and could be withdrawn at any time.
Access to participants is a fundamental requirement for qualitative research, however, this access is moderated by many personal and institutional factors such as ethical or data protection concerns (Dahlke and Stahlke 2020). Dahlke and Stahlke (2020) found that healthcare staff felt compelled to take part in their study by their line manager, therefore, they emphasise the importance of highlighting anonymity and the right to withdraw before recruiting any potential participants. Borbasi, Jackson and Wilkes (2005) support this account of considering the power relations that an ethnographic nurse researcher inhabits during their research, and to plan for the ethical and methodological challenges that this may produce. Borbasi et al. (2005) acknowledge the potential messiness of this approach and that the subsequent research must negotiate between 'methodological purity and practical application' (p 493). Rose (1985) discussed the power relations in the production of data by saying

There is no neutrality. There is only greater or less awareness of one’s biases. And if you do not appreciate the force of what you’re leaving out, you are not fully in command of what you’re doing

(Rose, 1985, p77).

Second, as an insider researcher, the participants may share information with me that they may not with an outsider. For example, the participants and I shared registration with the NMC which means that as registered nurses we often talk openly and freely about sensitive and confidential information that we are privy to. We do this amongst colleagues because The Code of practice allows us to discuss patients and their situations, however, we do not discuss these situations outside of work as this would be unethical and not following professional guidance. Therefore, the participants and I started the interviews and production of research data at a point where it was common to talk about confidential and intimate details about things happening (on the ward) with each other. This has been reported often in nursing research (Borbasi et al., 2005; Dahlke & Stahlke, 2020) and is an established phenomenon. This was mediated by reminding participants (and myself) of our professional responsibilities and by anonymising all transcripts and research data to protect and obscure the identities of participants and incidental patient data.

3.11.1 The insider/outsider role in posthuman institutional ethnography

Critical posthumanism moves away from strict binaries, therefore, could be considered at odds with a strict understanding of the insider/outsider role in ethnography. However, as explored in the previous, the insider/outsider role is fundamentally an exploration of power relationships between actors in the field of study (Rose, 1985). This is a
shared entry point for discussing the positionality of the researcher within the field. According to Taylor and Fairchild (2020), PIE moves away from privileging the human perspective in these situations; it is about recognising power differentials between actors. Inter/intra action between assemblages – and what affective, productive or destructive things may come from how the assemblages are produced. Following this logic, the insider/outsider role in PIE moves towards expanded definitions of insider and outsider, and also to a less clear and more dynamic boundary between the researcher and their environment. Nevertheless, there is commonality between the approaches by thinking about the co-production of data in the research field.

3.11.2 Considering the front stage and back stage

The insider/outsider role can be further understood by considering the concepts of front and back stage. The classic concept of front- and backstage that Erving Goffman (1978) layed out in *Presentation of Self in Everyday Life* can help us to entangle these structures and apply them to nursing. Embedded in the frame of a backstage, nurses can rehearse and adapt their presentation, equip each other with situated knowledge, and correct one another. However, the juxtaposed binary of front- and backstages is problematic when considered from a critical posthuman perspective. Everyday interactions are closely interwoven and cannot be separated distinctly, as an action can entail multiple stages. The front- and backstage implies an image of dualistic thinking that might imply social interaction as static without including the dynamic and situated materiality of situations.

The empirical research presented in this project suggests that Goffman's concept of front- and backstage is still valuable but to show the nuances of social interaction from a new materialist critical posthuman perspective. Front- and backstages are a tool to negotiate and express different practices of people and teams. On these backstages trust is established and expressed. Nurses might be integrated in the backstages or excluded from them, and the team members address inappropriate behaviour of other nurses. However, the collaborative action of the nursing team creates a coherent and professional performance on the front stages. Hence, backstages are the social space in which a shared reality is steadily (re)negotiated and through which a performance of professional unity is asserted on the front stages. Critically reflecting on this nuance of front- and backstages, I situate these with philosophies of critical posthumanism in order to show that more goes into nursing than the human. Goffman's concept of front- and backstage is still vastly applicable, however, it can grow in relevance through engaging in a discussion around humanism and posthumanism (cf. Braidotti, 2020, p. 465, Plummer, 2001; Braidotti, 2018).
There are three assumptions that go into approaching the concepts of front and backstage with critical posthumanism. First, front-and backstage are not necessarily bound to a space or place. Instead, it is wherever nurses gather to assemble and circulate situated knowledge about nurse work. Second, front and backstage do not stand in a dichotomous or adversarial relation. We have to acknowledge that the self is not either performing on a stage or letting a guard down to be "itself" or to always rehearse. The self is always being performed and produced in different ways even when no other human is present. Third, social interaction exceeds the human. Material objects, such as uniforms, written nursing notes etc (the way they are organised, handled, left alone, smell, sound) are a vital part of a performance. The focus of performances in social interaction includes nonhuman and more-than-human objects, through and with nurses as actors.

Nurses work individually and as part of teams; becoming an assemblage of humans and non-human to create a team to achieve a goal. Nurses in a hospital can be part of different teams and other healthcare teams might exist with different purposes, cultures and formations. A team member can be part of several teams: their roles can coexist. This might depend on what performance is needed at what time and who is present during a shift.

In this thesis, the team that I focus on is the team that creates a work culture. As mentioned earlier, Goffman calls a group that creates a joint role a team. There can be more than one role and more than one team in a ward. And in addition, nurses outside the team can and mostly will orient themselves on the ethos of the team while not necessarily being part of it. From a critical posthuman perspective, front and back stage can be seen as a complex interplay between human and non-human actors – who are all part of the team. The human actors may be the primary protagonists in any given performance, but the non-human elements are also essential to the success of the team performance. The ward area, hospital beds, call bells, medications, and NMC Code all contribute to the production, and all are enabled by non-human forces. As such, both the front and back stage elements must be considered in relation to the human and non-human actors in order to create a meaningful and successful team performance. It is the creation and maintenance of a joint performance for all nurses that some nurses in a team create which make the team valuable to all nurses. In other words, ‘we are all in this together but we are not one and the same’ (Braidotti 2020 p 465).


4  Chapter 4: Research Design, Methodology and Methods

4.1  Introduction

Chapter 4 presents the research methods employed in this thesis to address the research questions below. It explains why and how Posthuman Institutional Ethnography (PIE) was used as a mode of enquiry and provides a rationale for this approach by connecting the research questions, methods and the theoretical approach. The research questions are:

To research nursing in this manner I developed a critical posthuman research design that incorporates the pillars of PIE by exploring participant-driven data, ethnographic observations and documentary evidence of human and non-human inter and intra-action. This design is congruent with the discussions in Sections 3.9-3.11, advocating against binaries and for a perspective that thinks with the affective relations of the human and non-human to create more-than-human worlds. This section describes the methods of data collection and analysis designed to investigate the research questions from a critical posthuman perspective. The research questions are:

- How is nursing care materially (co)produced on a hospital ward in Scotland?
  - How do the human, non-human and more-than-human produce nurse work?
- How is nurse work imagined, created and produced institutionally?
- How are these perceptions of nurse work used?
  - politically on the wards and in clinics to shape how care is produced?
  - and politically by healthcare providers?

4.1.1  Setting

The research was conducted on an acute care ward at a large teaching hospital in an urban area of Scotland. The ward is a regional specialist centre for renal medicine, liver, kidney and pancreas transplants. The site was accessible to me thanks to networks created by working in clinical practice as well as my association with the University of Edinburgh. The ease of access to the site, the nursing workforce and an established position as a nurse working for the organisation, supported the pragmatic choice of setting (Alaszewski, 2006). Research data priorities included gaining and establishing trust, understanding the research setting and being able to access the research site.
I met with the ward’s managers to discuss my plans for the project, the expected numbers of participants, the type of data produced and the ways in which the security and privacy of the data and participants would be safeguarded.

4.2 Overview of data sample

The methodology sampled people, places and structures related to nurse work in a manner that could access the multiple ways in which labour exists in nurse work by including data from:

- The NMC Code of Conduct
- Field notes
- Visual data from the clinical area
- Multimedia diaries from nurses working in the clinical area
- Interviews with nurses working in the clinical area
4.2.1 Sample sizes: power calculations: how much of each kind of data do I need?

The amount of data required to address the proposed research questions was calculated using a framework conceptualised for qualitative research (Malterud et al., 2016). The ‘information power’ of each type of data was developed alongside the principles suggested by Malterud and colleagues (2016) by considering the data’s relationship to the study’s aims, the sample specificity, the use of established theoretical concepts, the quality of dialogue or data, and the analysis strategy for the data. However, the principles were developed to address data that is not primarily quantitative yet are transferable to post-qualitative design because it is a processual design to understand ways in which worlds are made.

4.2.2 Human participant sample and recruitment

4.2.2.1 Sample

Human participants in this study will be referred to as participants. Participants were registered nurses working on the ward. Inclusion criteria were:

- Registered nurses currently practicing in the UK
- Registered nurses working consistently at the research site (i.e. permanent staff or Staff Bank nurses who work at least 0.5 FTE and work at least 50% of their shifts on this ward)

Exclusion criteria were:

- Staff working at the research site who are not registered nurses
- Registered nurses working less than 0.5 FTE at the research site

Sampling was opportunistic, whilst aiming to address multiple diversity dimensions of race, gender and disability. The opportunistic convenience sampling accessed the participants’ situated perspectives. The sample in this study was not stratified as the sample was delimited by the people employed in the ward area. Each participant contributed to the partial perspectives of nurse work that I used to create knowledge about nurse work. It was estimated that a sample size of ten participants would provide a data set that would enable analysis to address the research questions.
4.2.3 Recruitment

Potential participants were notified of the research project by the Ward Manager who circulated the Initial Information Sheet, asking those interested to contact me directly at my secure institutional email address. No participation incentives were offered.

Nurses who expressed interest in participating were approached up to 3 times to further discuss the project. This was done to give potential participants the opportunity to participate while also being mindful that they may have felt obliged to participate because of my existing relationships with them. If anyone indicated they were no longer interested in taking part, they were not approached again.

As a researcher who worked on the ward as a nurse, I paid close attention to the way in which I approached participants. I considered all the nurses on the ward good colleagues, and some I even consider friends. As a researcher, I was aware that this intersection between friendship, employment and research might make potential participants feel compelled to take part. To try to mitigate the possibility of exploiting participants through my relationships with them, I sent out an email containing initial information about the project. Only if they replied to the initial email did I approach them in person while on shift, to further discuss the project. If they attempted to contact me about the project from their personal phone/email, I had a standard reply, which was short and intended to minimise the burden on participants:

‘Hey, that's great. When are you working next, let’s catch up about it then? Jamie’

Informed consent was achieved as outlined in Section 4.5 of this chapter. No participants withdrew from the study.

4.3 Data and data collection methods

4.3.1 Contextual data

This data addresses the institution as an assemblage of material-discursive practices and how the socio-materiality of the location produces nursing and nurse work. The contextual data collection included an analysis of the 'NMC Code: Professional standards of practice and behaviour for nurses and midwives' (2015). The code regulates all nurses, midwives and nursing associates in the UK and is a highly embedded text which produces many other frameworks for nursing in the country. Smith and Turner (2014) explored how these 'boss texts' can be incorporated into institutional ethnographies. They describe how these texts ‘coordinate and concert people's activities across time and place’. (Smith and Turner, 2014, p 3) by explicating the relations within an organisation. Boss texts can
constitute the basis on which other texts and meanings are created to be subsequently employed in wider contexts. Boss texts carry meaning and reappear continuously, perhaps not as exact copies, but through their interpreted meanings.

4.3.2 Environmental data

The environmental data from the field site seeks to address the relations, affects or capacities of how nurse work is produced with the material environment. Although all ethnographies are inherently a study of human activity, material-sensory data in PIE necessitates a less anthropocentric perspective recognising the potential for the human, non-human intra-action to produce sensory and affective motivations that are of concern to the questions being addressed (Bennett, 2010). Environmental data was recorded following the principles of sensory ethnography outlined by Pink (2009). She describes that the way physical spaces are experienced can shape social interactions by how they are assembled or because of their imagined use. These spaces and their uses become interconnected with the humans and non-humans present. The other actors in the space also become opportunities for sensory engagement. For example, in the excerpt below:

Amelia:

‘…hmmm (to herself)... Jamie... are you wearing a new aftershave? (and looks at me as I am sat at the nurse's station)...’

Jamie:

‘...(I look up)... no, but I will just get a pinafore and some gloves...’

In this scenario, Amelia smelled that a patient had soiled themselves. She had noticed the smell and required assistance to help clean and change the patient. Amelia used humour and subversive communication because she knew that the sensory data in the environment was laden with affective connotations – the patient could be embarrassed, or a family member could be nearby. The sensory data adds depth and complexity to the understanding of the environment and acknowledges the institution’s ‘affective life’ (Taylor & Fairchild, 2020, p. 2). This also speaks to the insider-outsider role that I have as a researcher in the production of this data.

The hospital ward’s environment was documented by creating sensory cartographies using field notes. I would make notes throughout the day on the handover sheet. I noted temperature, humidity, smell, sound and light intensity as these became perceptible to me. I
also tried to listen to and write down other nurses, staff and patients’ comments concerning
the environment.

For example, I would take notes if someone opened or closed a window. If possible I
would take a few seconds to become aware of my surroundings and the situation, and
record what I perceived. If the person, for instance, opening the window was enrolled in the
study, I would then consider asking about this scenario during their interview.

4.3.3 Environmental data - visual data

You could never envisage all the camera has seen, countless images scattered at
random in time and space like the fragments of a vast and ancient mosaic, the
remnants of a visual holocaust, the ruins of representation... colossal... a unique
map, a phantom topography, coiling the entire globe, an endless collage which in the
end forms... another world, the true surrealist universe...

you will never know a limit to all the stories, plots, parables, histories,
myths and actions spawned in this oneiric archive - assuming it can exist -
the truths it could tell if only we knew how to read its languages, interpret its
codes, translate its evidence...

(McQuire, 1997, Preface)

Data collection included a series of photographs I took while the participants were
creating their multimedia diaries. The photos constitute a polysemic representation of nurse
work. The photographs were taken from my perspective as the researcher. However, the
photos also became a representation of the space in this institutional ethnographic research.
The photos became a reading of the spatial and other aspects of the built environment in
which nurse work takes place and where nurses make their worlds (Harper, 1988). The way
the structures are used and movement into, inside or out of such spaces also has meaning.
This may be the implied or observed or imagined use of the space. A space may also have
multiple meanings to multiple people or groups of people. Again, my role as an
insider/outsider affects my perception of these spaces and how I situate myself in the
knowledge production process.

4.3.3.1 Photographs from the hospital

The photographs taken in the field are part of this thesis’ field notes and visual
documents. They were analysed in their original form, however, line drawings were made of
the visual data for submission and publication to ensure the anonymity of the participants
and the hospital. The drawings have been included to help readers understand the data analysis and discussion.

The photographs were taken at all hours of the day and night. Like any photograph, the images do not tell the full story of the situations they depict. They were taken on a hospital ward and so certain restrictions applied. All photographs taken were carefully vetted so no personally identifiable information was in the shot. All patients, relatives, staff, etc. were only photographed with their express written consent whilst adhering to the ethical considerations outlined in the chapter on methodology.

4.3.3.2 Framing and choice of photographs

58 photographs were taken during this thesis' fieldwork phase. Four have been included for further analysis and discussion. The photographs selected for inclusion demonstrate themes which emerged from photographs as a whole and are also congruent and speak to the themes produced by the other data sets. The photos included do not provide an exhaustive visual account of the data collection period. Visual data was not included in this thesis to document the entirety of the ward, moreover, the photographs included represent focal points during the data production process which demonstrate synergies with other data.

4.3.4 Field notes

Field notes are a central component of research because they are a companion to the process of data and knowledge production (Emerson, 2011). The tradition of keeping field notes originated in nursing research and is an integral part of health research because they provide information essential to the subsequent analysis of data (Phillippi & Lauderdale, 2018). The contemporary standpoint on field notes is that they are an essential component of robust research (Roberts, 2009). The field notes collected during this project primarily consisted of notes, doodles and annotations on handover sheets. At other times I sent brief messages to the research phone so as to time stamp the notes or for the convenience of making the note. This was practical as when on shift I would have this phone in my pocket. Alongside the sensory data, the kind of data collected was guided by Phillippi and Lauderdale (2018) who recommend recording at least the following: the geographic setting, the demographics, the societal pressures and the cost of living. Although these suggestions may have been intended for qualitative healthcare research concerning the general public, the principles were adapted to this research. The geographic data became the locations on the ward, the time of day or temperature. The demographics became who and what were/was perceptible to me at that time. The societal pressures became the broader picture
of what was happening on the ward and at the hospital. The cost of living became the opportunities and restrictions perceptible on the ward at the time.

Field notes were only taken concerning participants who had given consent to be included in the study and any identifiable data was anonymised. Data which could not be anonymised was not included. Written field notes were handwritten then transcribed to a secure file. Photographic notes were made using a secure device and sent to a secure email address using a secure email server (NHS.net).

4.3.5 Multimedia diaries

Participants were initially asked to keep a diary for three weeks using a secure method that involved recording videos, sending photos, emojis, voice recordings or other multimedia to a dedicated research phone. Participants were asked to create an entry after each shift. The participants were anticipated to work nine shifts during this time with an estimated response rate of six of those shifts. Every weekday, the smartphone used was checked and any new diary entries were transcribed as soon as possible. The data was downloaded and then deleted from the dedicated phone with the former stored on an encrypted drive at the hospital.

This data addressed how nurse work is produced and was a component of the participant-led methods. The multimedia diaries constitute collected data and were also used as an entry point for the participant interviews. Technology has developed the way in which life is contextualised and documented. Mobile phones access intimate personal spaces where subjective moments are experienced (Seifert et al., 2018).

Multimedia diaries were chosen as a method for accessing the intimate spaces (Alaszewski, 2006) of nursing work. Wards can be intensely complex which can present access challenges to researchers (Theodosius, 2008). A participatory ethnographic approach would enable access to these spaces, particularly if the person working in situ works there as a nurse. However, my perspective on the field provides only a partial picture (Haraway, 1988) and taking this approach may have provided a less textured account of the ward. Asking participants to keep diaries creates multiple perspectives and is synergistic with the suggestions made by Taylor and Fairchild (2020) for PIE.

Multimedia diaries used in a hospital context may produce sensitive data, which could destroy patient confidentiality. Nurse work by its nature provides privileged access to information and spaces (Smith & Willis, 2020). Nurses become custodians of this information and in the UK context, must deal with it according to the NMC Code of Conduct and that of their employers. No data protection breaches occurred during this project and the processes
followed were congruent with how participants address and manage confidential data in their daily work.

Participants were informed that the multimedia diary was a component of the research and were encouraged to engage with this from the start. However, if they did not wish to keep a diary they were not excluded. All participants kept some form of multimedia diary. If participants chose not complete the multimedia diary, this was included in the analysis of their responses.

The multimedia diaries were used as memory prompts during the participant interviews and also to acknowledge and access the embeddedness and entanglements of the nurses in their practice. Multimedia diaries used as memory prompts have been shown to provide richer interview data (Kwasnicka et al., 2019; Pappalardo & Simini, 2018). This methodological choice embedded nurses in their realities of nursing and highlighted focal points (Taylor and Fairchild, 2020) from their practice which they chose to record.

4.3.5.1 Multimedia diary design

In some ways, a diary can be viewed as a questionnaire that is completed every day (Corti, 1993). It is a journal which people can fill as they choose. The diary should preferably not be overwhelming in size and that participants should be instructed of the possibilities as to how to fill it in. Gibbs (2018) recommends including an example of how the diary should be completed. He also suggests using guiding questions which encourage people to respond to and complete their diary. These approaches encourage participants to complete diaries in ways that produce better quality data.

Data quality issues considered in diary design often relate to the diary’s accessibility to the participant (Alaszewski, 2006). Issues arise from reminding participants to complete diaries, missing diary entries or completing diaries very late, all of which can change the quality of the data produced. In general, participants are more likely to respond if they perceive the desired entries to be short and are provided with some outline as keeping a diary then does not seen as onerous to them.

The first day of a diary is often completed much better than later on in the data collection period (Gibbs, 2018) and recommendations exist for ways of reminding people to complete their diary entries such as prompting. This led to an ethical question concerning participant burden and bias. Reminders may be a good way of getting participants to complete diary entries, however in this situation, there are other considerations at play as, as a researcher actively participating on the ward, any potential participants are my colleagues. Professional and other relationships are unavoidable with participants. This created a risk that any reminder sent could be viewed by participants as coercion or a favour to me. Also,
the nurses who consented to participate would be doing so on top of their work, which includes shifts at any time of the day. This meant that any reminder I sent should be timed to fit the ward’s shift patterns and not be onerous or disruptive to participants’ lives. An example would be timing reminders, so they don’t interrupt people’s sleep. This burden on participants was a key consideration when choosing this design because participants were also colleagues and friends. To minimise the disruption caused by the video diaries and any subsequent reminders, I maintained an up-to-date version of the ward rota. This meant that I could time the reminders to minimise intrusion into participants’ schedules. I would send reminders when I knew participants were on shift. I would not send reminders after their shift or on a day off because I was mindful to pay special attention to days off and sleep days post night shift.

These considerations were included alongside the recommendations from the hospital’s research and development department for designing video diaries suitable for registered nurses. Four main points emerged in the design of the multimedia diaries.

First, consenting participants were reminded that all data would be treated with the strictest confidentiality. Any personally identifiable data (PID) concerning colleagues, patients or family members was subject to the same principles identified in their employment contracts and in the NMC Code of Conduct. PID should not be discussed inappropriately outside the clinical context and if PID were recorded as part of this project, then the modes of digital communication should be secured according to NHS standards. This was therefore addressed in the methodological design.

Second, participants were given the number of a dedicated research smartphone with the most commonly used messaging apps (SMS, WhatsApp and Telegram) with access to a secure NHS.net email address. This allowed participants to securely send any diary entries as this email system is endorsed by the NHS for the transmission of PID. If the participants felt that there was no PID in their diary, they could send it their method of choice. The R&D department asked all participants to be reminded that it was their responsibility to ensure data security until it was sent to me. Therefore, if participants wanted to send data they viewed as confidential this had to be done using a service deemed secure by the local R&D department.

Third, as identified by other researchers who have used this methodology (Alaszewski, 2006; Gibbs, 2018), data quality is improved if a simple framework is provided to participants so they know how to start their diaries and which general direction the research is focused in. This study’s participants were sent a text message as a prompt, which read:
‘Thank you so much for participating in this research. How was your day? What was the highlight of your day? What was the low point of your day? If you could do your day again, is there anything you would do differently?’

Fourth, with participant consent, a reminder was sent to them on the days they were working during the data collection period. The message was standardised and sent two hours before the scheduled end time of their shift. It read:

‘Hello NAME,
Thank you again for participating in the research project. This is a reminder that the data collection period is ongoing, and a diary entry can be made about today’s shift.
Thanks again!
Jamie’

The typical shift pattern is 07:30 - 20:00 for a day shift and 19:30 - 08:00 for a night shift. The reminders were therefore sent around 17:30 (day shift) or 05:30 (night shift) on the day of the shift. This minimised the risk of disturbing sleep should the participant not be working that day and respected the participants’ rest periods.

Maintaining data confidentiality whilst using multimedia diaries and participant ethnography creates tensions. These arise from the researcher having access to much of the potentially confidential information that the participants mention. Participants wish to reference this information in their diaries as well as adhere to their perception of the confidentiality rules. An example from the diaries is:

*Excerpt from Jack’s diary*

‘...you know, Room 4’s family. He’d come back from dialysis and they’d took too much (fluid) off again. And the family were being the family…’

This is an example of a technique used in communication between Jack (a participant) and myself as the researcher. Jack perhaps included this in his diary to highlight that part of his day had been spent with the patient in Room 4 and their family. However,
much more is communicated as there is the assumption of shared meaning and shared experience. In saying ‘...you know, Room 4’s family...’ he assumes that I have met these family members or heard about them from other colleagues. This implies that the family are well known to the ward team and because during the project I was a member of the team that I would know them as well. He uses ‘Room 4’ as code to communicate information that he feels is confidential to the ward area.

From a methodological perspective, any data extraction or subsequent analysis must take the possibility of subjective interpretations into account. This means that my understanding of what a participant, like Jack, expresses could be influenced by my personal experiences. For instance, when Jack refers to a ‘family’, my perception of that family could be vastly different from someone else’s due to my unique encounters with them. Jack intentionally uses certain methods to protect patient identifying information (PID) from those outside the clinical setting. This highlights how nurses often develop unique communication techniques, utilising local codes and symbols, to relay confidential information discreetly. This method of information obfuscation is typically aimed at those outside the context to ensure patient privacy. These codes and symbols were also employed during face-to-face interviews when discussing potentially sensitive or confidential patient cases or situations. However, it’s important to note that the primary subject of these conversations was the nursing work itself, rather than specific patient information.

4.3.6 Participant interviews

Participants were invited to an interview within two weeks of completing their multimedia diary. This window was chosen so that the participants’ memories would be fresh, the patients still potentially present on the ward or recently on the ward and the situations they discussed perhaps still ongoing. The interviews took place during their working day, away from the ward environment to avoid immediate ward-related distractions. If the participants preferred to be interviewed on a different work day or a day off then the interview was conducted at the hospital or at a university building. Travel expenses were reimbursed and this cost was met by the researcher. In keeping with the PIE approach to data production, the time, place and environment of the interviews is implicated in the production of the data. This is why the interviews were approached as a ‘specific event that generates resonance and intensity’ (Taylor and Fairchild, 2020). A consistent interview environment could not always be found, however steps were taken to reduce any possible interruptions or restrictions during the interview. The entry point for the interviews was the multi-media diary. This is in line with the PIE principles as the diaries become memories and focal points for specific events (Taylor and Fairchild, 2020). The semi-structured interviews
raised the data-prompts and themes from the multimedia diaries and then encouraged participants to respond with narratives around them, for example: ‘You mentioned teamwork in your diary, can you tell me a bit more about that?’.

The interviews were produced and guided by these memories and focal points to explore the material-discursive realities for participants. The interviews attended to the affective lives of the institution and how nurse work and nursing knowledge were produced as a material practice. This approach also acknowledged my own relationship to the participant, the institution and to nursing. I had established relationships with participants as a researcher, colleague and often also as a friend. This contributed to the production of data because the participants trusted me within the boundaries of the multiple relationships we had. This was conflated with the access to their experiences that they provided to me in their diaries. I felt incredibly privileged as a researcher because I had intimate access to their worlds. I worked with them closely as a nurse which is tactile and physical, and also had access to their perspectives on nurse work when I was not present as well as their perspectives on other people and patients. This created a rich data set and a robust framework within which to explore nurse work during the participant interviews. It also produced a feeling of great responsibility for me as a friend and researcher to represent their data well and earnestly.

4.4 Summary of data collected and available for analysis

- The NMC Code, as a regulatory framework for nursing.
- 10 participant interviews were completed, analysed and included in the analysis of this project. The interviews ranged from 34 to 62 minutes long.
- Field notes were made throughout the project. In total, 24 sets of field notes from at least 24 shifts were included.
- All participants (n=10) completed at least three multimedia diary entries, in a variety of formats and across different digital modes and media i.e. photo, text, video, voice notes and emojis. Seven participants used WhatsApp, one participant used Telegram, one used NHS.net email and one used SMS. The participant completion rate was expected to be around 50% for the sample. On average each participant worked three shifts per week over a three-week period i.e. at least nine shifts during the data collection period. A total of 51 diary entries were received across all media. Three participants sent at least one video diary entry. The most common way of responding was by recording voice messages in WhatsApp.
Table 1

*Multimedia diaries received by medium*

<table>
<thead>
<tr>
<th>Type</th>
<th>Video</th>
<th>Voice</th>
<th>Text</th>
<th>Photographs</th>
<th>Emojis</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=</td>
<td>3</td>
<td>35</td>
<td>8</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>
4.5 Research Ethics

Ethics and ethical practices underpin the design and implementation of my research. An application was submitted through the Integrated Research Ethics Service for permissions and approvals for health care-related research in the UK. This involved a comprehensive description of the research process, data to be collected and the potential impacts the research may have on participants. Ethical and managerial approval was obtained from the appropriate NHS Research and Development office (Project ID: 248918), the NHS Caldicott Guardian (see Appendix 3) and the University of Edinburgh School of Health in Social Science Research Ethics Committee (Ref: NURS038). The NHS Research and Development office and the sponsor of this research project (the University of Edinburgh) reviewed the project and stated ethical approval was required from the University of Edinburgh School of Health in Social Science Research Ethics Committee, and not the local NHS ethics committee. At the time of conducting the research, I confirmed that ethical approval was required by only the university. The NHS research office clarified ‘you only appear to be involving NHS staff (no patients or patient data) therefore you study is exempt from NHS REC review….’ (email from the NHS research office, 11th September 2018); therefore, ethical approval was obtained from the University of Edinburgh and data governance and managerial approval was obtained with the NHS Trust. See Appendix 7 for the approvals and letters of agreement obtained.

4.5.1 Researcher Characteristics

During the data collection period I worked as a registered nurse at the research site. I held an existing, permanent position as a staff nurse. This position implicated me in the production of knowledge in many ways because I had existing relationships with the hospital’s people, place and structures (see section 3.11 on the insider/outsider role). I also had, and still have, a relationship with nursing and nurse work because I remain a registered nurse and continue working as a nurse (Fine, 1993). My understandings of people and places were already formed to an extent and it is from this perspective that I developed this research project and assembled the data. Considering this from a theoretical and methodological perspective, Leo (1996) states that pretending to have an affiliation with a particular field is coercive. If I conducted my research on a different ward I would assume a potentially wrongful distance as people in the hospital could still know me, they could know the university I am affiliated to and of course nurses on a different ward would know nurses from the ward that I worked on. I did not want to artificially create distance from the field, hence I conducted the research on the ward I customarily worked on.
This standpoint is acknowledged and incorporated throughout my analysis because it affected the way the knowledge was produced. The latter is a constant process of situating oneself and attempting to make perceptible the entry point into how worlds are being made and to diffract existing knowledge. This reflexivity makes the diffraction of existing knowledge that is assembled through the affectual co-production with the materialities of care more perceptible.

4.5.2 Ethical moments throughout the research project

This research was designed using the five principles of ethical research which are minimising the risk of harm, obtaining voluntary informed consent, protecting anonymity and confidentiality of data, avoiding deceptive practices and providing the right to withdraw (Dunn et al., 2019). These principles will be expanded on below and some examples of how these worked in practice will be given.

4.5.3 Minimising the risk of harm

The care of patients and each other, has priority over research activities (Morse, 2007) and this section relates to minimising the risk of harm to the researcher, participants and patients. The research design took this into account and was aimed at reducing risk as much as possible by prioritising patient care, the autonomy and self-determination of participants and the confidentiality of their data. The utmost effort was put into reducing the risk of harm to participants and patients by continually affirming consent. In congruence with the project’s theoretical approach, it is also worth noting that – because matter and people have agency – not all risk may be prevented because of the possibilities of how meaning and matter might arise in practice. Bronfenbrenner (1952, p. 453) argues that ‘the only safe way to avoid violating principles of professional ethics is to refrain from doing social research altogether’. However, situated ethics and affirmations of consent can reduce the risk of harm and promote participant agency.

4.5.4 Obtaining voluntary informed consent

Participants should understand they are taking part in research and what this entails. Informed consent involves telling participants about the risks, benefits and alternatives to taking part the project (such as not participating but being made aware of any findings). However, Wertheimer (2012) argues that voluntary consent in advance cannot always anticipate the ethical considerations at later stages of research. They argue that in order for it be open to the intradependence between practice and realities, ethnographic research
cannot always foresee issues of consent and the latter should therefore be an iterative and ongoing process. The participant information sheet and answering questions provided potential participants with as much information as was possible before data collection began. Consent was re-affirmed throughout the research before starting the multimedia diaries, after completing the diaries and prior to the longer interviews. See Appendix 5 for examples of the participant information sheet and the consent form.

Implicit in providing informed consent is an assessment of the participants’ understanding of the study and the implications of participation, having the opportunity to ask questions and documentation of the process. The following elements were discussed during the consent process: (1) the nature of the project, (2) the risks and benefits of participation, (3) reasonable alternatives or different ways of participating and (4) assessment of the participant’s understanding of these elements. At every stage, participants were made aware that they could withdraw consent no questions asked and with no consequences for their working conditions. Given my existing relationship with the potential participants, this was consistently highlighted and affirmed during each interaction; this would also happened if I did not have an existing relationship with the person. One person, who initially showed interest in participating, decided they did not want to participate after an initial conversation.

Participation was voluntary, and not contingent on engaging in any single part of the project. For example, Sophie approached me on shift one day to say that she did not want to record videos for her diary. I told her that was not a problem and that her consent, safety and comfort were of paramount importance to the project. She asked if she could record voice notes or write short paragraphs instead. I re-iterated that she did not have to keep a diary at all if she did not want to or felt uncomfortable. I also explained that the diary was multimedia and open to how she chose to keep it if she chose to. I acknowledged this and re-iterated that her consent was an ongoing and iterative process that she may withdraw at any time. I then reiterated to other participants that they could keep their diary in any way they chose to, that their consent is ongoing and that they are under no obligation to complete the diary.

Participants took part in the research elements they wished to participate in and at their own convenience. The research took place during and after their working hours and concerned their work and labour, therefore, participants had competing priorities for their time other than this project. The potential participation burden was addressed by impressing on participants that the multimedia diaries and interviews were to be made or arranged at their own convenience. Below is a list of examples of how the participants asked to schedule their participation:
• Rebecca asked that her interview was conducted outside of the ward area. Rebecca told me when it suited her to be interviewed. I offered a range of venues on the university and hospital campuses, and she was able to choose the one most convenient to her. I arranged a private room on the university campus and we conducted the interview there.

• Jack asked to be interviewed after his shift. He told me which day he would like to do the interview and I went to the hospital to meet him. I could see that Jack was visibly tired when I arrived. I asked if he would like to proceed with the interview and he said that he wanted to. However, I chatted with him about his day and how busy it was and asked if he would like to reschedule. He then said that rescheduling would work better for him, but he was still very keen to take part. I rescheduled with him and completed the interview on a different day. I was not on shift with Jack during these times and scheduled the interviews at his convenience.

Since I had an established relationship with the potential participants, the process of informed consent included extra steps to minimise the risk of coercion. This was mitigated in several ways: first, the participants were made aware of the study through a third party so that I did not ask potential participants to take part in the study directly. Participants were given Participant Information Sheets by the ward manager and then contacted me if they wanted more information or wished to participate. The ward manager distributed the Participant Information Sheets and the participants approached me directly and expressed that they wanted to participate. The potential participants then had the opportunity to ask further questions, after which I obtained their written consent. Involving a third party to notify potential participants reduced feelings of coercion, however, could also be perceived as an element of coercion because the ward manager also has authority over the potential participants. The hospital’s institutional power and the participation of a major university could also have implications for voluntary participation. I addressed the inevitability of coercive elements, the credibility of the research and achieving recruitment to the study in an iterative process. The participants were given enough information and time to make a decision at every stage. Only subsequently were they asked whether they wished to participate or not.

4.5.5 Participants reviewed the transcripts of their diaries and interviews

The content of the multimedia diaries was provided to participants before their interview, to affirm their consent to use this data during the interview process. This strategy was taken to affirm their consent in the data being shared with me and to acknowledge that
there may be things in the diaries which they did not want to discuss further. One participant asked that part of the multimedia diary not be used in this project and this diary was removed from further analysis. I fully supported this request and did not ask why they wished to remove it, moreover, I fully affirmed their decision. The participant wanted to discuss the scenario with me outside of the interview setting because they wished to contextualise why they wanted to remove it. I listened to their story and discussed the situation as a colleague, but this entry into the diary was not discussed further in the research context. With all participants, I acknowledged that the diaries and interviews were a process of co-production because once they had told me something I cannot completely forget it, rather, I can actively affirm their decisions about how they represent their perspectives and not include things in the research. However, things that they have included or discussed may diffract or change my understanding of the situations.

4.5.6 Protecting anonymity, confidentiality and data

Participant data confidentiality is paramount and also essential to the integrity of any trust developed during the research process. A detailed data management plan was produced based on guidance issued by the Information Commissioners Office (ICO), the UK Data Archives and the Caldicott Guardian. All participant data was anonymised and pseudonyms were used throughout the project.

If one of my colleagues agreed to participate in the project, this information was kept confidential. Other participants were not aware who else was participating. In practice, this meant that any conversations were conducted in private away from other colleagues (Fine, 1993).

Any communication pertaining to scheduling further discussion or interviews was made using private methods of communication chosen by the participants. In reality, this was sometimes difficult to achieve as a nurse's absence from the ward is often conspicuous. If the participants decided that they would like to be interviewed during working hours, I asked them whether they would like me to ask the ward manager to cover for them. This however did mean disclosing their participation in the project to the ward manager. If they declined, I asked them if they still wanted to be interviewed and if so when and how they would like to do so.

The hospital’s R&D department was initially hesitant due to concerns about the security of participant data. Originally, the plan was to ask participants to record the multimedia diary using a mobile phone messaging app that satisfied NHS data protection criteria and was registered with the ICO. Unfortunately, this app did not record video or voice
messages and did not function across all mobile devices. This was acknowledged as an accessibility issue during the later stages of project design and a workaround was found. The workaround found was facilitated by a framework agreed with the local NHS R&D. The salient points are listed below:

- All participants must be registered nurses and employees of the NHS organisation. As such, they are ethically and legally bound to the principles of Information Governance which satisfy the NHS and the General Data Protection Regulation 2016 (GDPR).
- According to the first principle of GDPR, the data subjects i.e. the participants creating diaries, must consent to the processing of their data.
- If the data contains information which the participants deem confidential, then it is the participants’ responsibility to keep this secure until it reaches the researcher.
- As an active participant at the research site, the researcher will have access to the confidential data throughout the study.

The confidentiality of participants and their data was acknowledged during the process. This supported a favourable ethical opinion from the hospital’s R&D department and the university’s ethics board. Other considerations around anonymity and confidentiality of data included:

*Participants reviewed the transcripts of their diaries and their interviews:* The content of the multimedia diaries was provided to participants before their interview, to affirm their consent to use this data during the interview process and its being shared with me as well as to acknowledge that there may be things in the diaries which they did not want to discuss further. One participant asked that part of the multimedia diary not be used in this project and was removed from further analysis. I fully supported this request and did not ask why they wished to remove it, moreover, fully affirmed their decision. The participant wanted to discuss the scenario with me outside of the interview setting because they wished to contextualise why they wanted to remove it. I listened to their story and discussed the situation as a colleague, but this entry into the diary was not discussed further in the research context. With all participants, I acknowledged that the diaries and interviews were a process of co-production because once they had told me something I cannot completely forget this point, rather, I can actively affirm their decisions about how they represent their perspectives and not include things in the research. However, things that they have included or discussed with me may diffract or change my understanding of the situations. The
situation that was requested to not be included was not discussed further and not used directly in the analysis of the data.

*Photographs of people:* participants engaged well with representing themselves and their work through photographs. The ward culture was very close knit and photographs of colleagues were often shared. Participants were keen to have their work shown in this way. However, concerns were raised about the ongoing consent of participants to have photographs used for research purposes. Despite efforts to anonymise photographs, the anonymity and confidentiality of participants in photographs could not be guaranteed. Therefore – as outlined above – drawn representations were created to preserve the data which the photographs convey whilst maintaining the confidentiality and anonymity of participants.

4.5.7 *Avoiding deceptive practices*

The discussion of deceptive practices is a fundamental principle of ethical research (Lincoln & Guba, 1989). This concerns seminal ethical questions such as how to promote the self-determination and consent of participants whilst maintaining the robustness and integrity of the research's value to a wider public. This project approaches ethics using the concept of ‘no harm’ (ibid p 224) and the lessons learned by past researchers. This approach was developed alongside the ethical advice offered by Fine (1993) that the possibility of ‘no harm’ cannot necessarily be anticipated and that therefore an iterative and continuously affirmative approach to consent should be taken. The research maintained open, honest pathways to discuss the contribution and use of participant data as well as an explicit process of verbal and written consent.

4.5.8 *Participants chose the time and place of the interview*

The participants chose the arrangements for their interviews after being reminded that the time and location thereof should be private to maintain confidentiality. I provided options on the university and hospital campuses and I told them I could book these rooms. Participants were informed that the interviews would be held after they finished their diaries. I had planned to remind participants that their interview was due after the diary period was over, but this proved unnecessary as all of them pro-actively arranged their interviews with me. This raised ethical concerns, because their eagerness might imply some coercion to participate in the project. I addressed this at the beginning of the interviews by asking whether the participants still wanted to participate. The overwhelming feeling I got from
participants was that they were incredibly grateful to be asked about their work life and that a wider audience might be taking an interest in nurses’ working lives.

4.5.9  Note taking in the field as ethical praxis

As a researcher actively engaged in the field, I made field notes during my shifts. At the beginning of each, it was commonplace to receive a paper copy of the handover concerning all the patients on the ward. I recorded discreet notes on the former and at the end of the shift I would transfer these notes to a secure document on the university server, disposing of my handover in the confidential waste bin. Several times, when I wanted to take more comprehensive notes closer to the occurrence I would go to the bathroom and quickly elaborate on my observations. The elapsed time between observation and note taking influences the quality and the reliability of your notes for obvious reasons. Making notes after an event or after the shift was sometimes necessary due the clinical demands of the situation. I noticed that when more time had passed this changed the representation of situations in two ways. Firstly, the things I had observed and wished to write down were diffracted by more information. Notes that I wanted to make became contextualised by extra data that I observed during the day and I found myself doing more on the spot analysis, rather than representing the situation as I observed it at the time. Therefore, I made notes as soon as possible as it happened so that more thorough analysis could be done later. Secondly, I found that my memory for events was not as good as I thought. This is understandable because as an active participant in the field I was tired at the end of my shifts.

4.5.10  Providing the right to withdraw

Participants had the right to withdraw their consent and data at any time. During the consent process, participants were made aware that if they wished to withdraw consent, the utmost would be done to remove their data from the project. The opportunity to withdraw participation was part of the research process and the latter will reach its limits with regard to consent once it is published. Anonymising participant data also aims to address the limitations of withdrawing consent after the time of publication. If participants wish to withdraw after publication, the anonymised data at least provides the more certainty that their participation cannot be traced back to them other than by the researcher or colleagues who realised what was going on or have found out since.
4.5.11 Techniques for enhancing trustworthiness and being reflective

The trustworthiness of the data produced is a marker for the reliability and validity of the mode of knowledge production and communication. Given the decentralised shift in critical posthuman knowledge production, I acknowledge that its decentralised nature could be at risk of pointlessness or nihilism because saying that ‘all matter is one’ risks disenfranchising certain people, in favour of other parts of matter. This would imply that knowledge produced is really important to other matter or that knowledge produced matters in an ontologically flattened landscape. As discussed in Chapter 3, Barad (2003) demonstrates the importance of which matter is important, and where and when it is important. I have also discussed that the making of meaning with matter is dynamic, nomadic and topographic (Braidotti, 2006a) which moves away from the flattened networks of actor network theory (Latour, 1993). With this in mind, I argue that data and researcher trustworthiness is supported by taking a position and ‘spraying water on the web’ (Brownlie & Anderson, 2017) of the conditions of possibility from that position. Or, as Haraway describes, ‘It Matters What Stories Tell Stories; It Matters Whose Stories Tell Stories’ (Haraway, 2019, p. 565).

A systematic approach was used to increase the trustworthiness of how data was produced for this project. An approach to enhancing the trustworthiness of qualitative research was developed by Guba and Lincoln (1985, p.321 -327) who identified four areas of focus; credibility, transferability, dependability and confirmability. The techniques I used in this project to address these areas are:

Credibility: To ensure the credibility of my study, I used iterative processes of data collection and participant checking. I cross-verified my interpreted findings with the nurses taking part in the study to reduce any potential misinterpretation of their practices and experiences. This approach was aimed to ensure that my representation of the posthuman institutional ethnography represented their realities of the ward.

Transferability: Recognising the intra- and interaction between human and non-human elements in specific environments, my findings in this posthuman institutional ethnography may not be directly transferable to other settings. However, I have provided detailed descriptions of the NHS ward and the nursing practices, enabling readers to gauge the potential applicability of my findings to their individual contexts.

Dependability: To ascertain dependability, I kept a clear and detailed trail, outlining decisions made during the research process. This includes comprehensive documentation of
field notes, interview transcripts, data analysis iterations, and reflexive journals, providing a full account of the progression of my research, and allowing for examination of my findings.

**Confirmability:** I approached confirmability by undertaking a reflexive analysis of my own biases, assumptions, and theoretical predispositions throughout the research process. I maintained the transparency of the research process through a reflexive journal, which also served as a means of managing potential biases and encouraging a self-awareness and critical self-reflexive approach.

A posthuman and post-qualitative methodology must therefore acknowledge that it is ‘the slow drip which carves the stone’ (German proverb) i.e. it is incremental knowledge acquisition that considers how the human and the more-than-human make their worlds which will enable future post-qualitative research. This may be compared to Barad’s (2003) concept of diffraction which he defines as small, incremental reconfigurations producing trajectories of knowledge. I decided to employ a mixed method of data collection that utilises all the qualitative, quantitative and post-qualitative methods available to investigate how nurses make their worlds.

4.5.12 Reflexivity and context

Data was collected, in various formats, over a four-month period during the Autumn of 2018 as illustrated below. The aim was to explore the production of nurse work in the contemporary local context. Brownlie (2014, p. 74) stresses that the research encounter is a co-creation of knowledge in which different knowledges are positioned, explored and understood by those involved. The presence of a researcher introduces new phenomenological positions within the field and a member of ward staff becoming a researcher requires reflection and reflexivity as the tensions that this creates within established relationships should be considered in the research encounter. Reflexivity is a practice of situating the context of where and how knowledge is produced. The process of reflexivity is the epistemological acknowledgement of the dynamic characteristics of knowledge production and the fact that research encounters produce partial perspectives that meaning can be made from (Alaszewski, 2006).

Reflexivity in the context of this research took on a particularly nuanced dimension due to my roles as both a researcher and a nurse on the ward. This intersectionality necessitated an increased level of critical self-awareness to understand how my personal experiences, biases, and the inherent power dynamics of being an insider might influence the research. For instance, throughout the interviews, I had to be continuously cogniscent of the power dynamics in play. My pre-existing relationships with the participants could
potentially influence their responses and openness. My reflexive journal became an integral tool in this process, capturing not just the responses and events during the research, but also my personal reflections, emotions, and the evolving understanding of the intricate interplay between my roles as a researcher and a ward nurse.

The data collection process was deeply entwined with the context of an NHS ward, a setting that I was both a part of and investigating. This environment, with its juxtaposition of human and non-human actors, was both my workplace and my field of study. Consequently, I was not just a detached observer but an active participant in the interactions that I was studying. For example, I experienced directly some of the things that participants would talk about and I had to reflect how my experience of the same thing may affect the data produced.

Additionally, I observed and felt first hand how the physical layout of the ward, including the placement of nurses’ stations, patient rooms, and the allocation of equipment, influenced my movement, my interactions with patients, and my workflow. These context-specific observations and experiences were instrumental in illuminating the posthuman elements within the ward and their intersections with human practices and roles. These strategies, along with reflexive and contextual considerations, were crucial to portray a comprehensive and deeply embedded representation of the complexities of the ward.
4.6 **Data analysis**

Critical posthuman research is challenged by conventional forms of data analysis. The act of categorising and creating hierarchies of knowledge through the reduction of data to numbers and labels runs opposite to post-qualitative views expressed by St Pierre and Jackson (2014). The risk is that the coding process will ‘...simplify complex and contradicting voices and data to theme 'chunks' that may be read independent of context and circumstance...’ (Mazzei & Jackson, 2012, p. 745). Additionally, MacLure makes the claim that ‘Researchers code; others are coded’, which argues that coding might give the researcher control over the subject being studied (2013, p. 168). More recently, Fox and Alldred (2022) have elaborated on how to approach data analysis in new materialist research by suggesting that data analysis should:

- be open to a post-anthropocentric, posthuman and more-than-human sensibility
- focus on assemblages, affects and emergent capacities rather than individual bodies and their supposedly essential attributes
- attend to the complex flows of affect in the everyday events that progressively and endlessly produce and reproduce the social world and human lives, and
- acknowledge research as itself an affective assemblage comprising both human and non-human components.

(Fox & Alldred, 2022, p. 632)

These four assertions are congruent with the pillars of PIE and were accordingly used to guide the data analysis for this project.

4.7 **Development of the data analysis method**

At the time of writing, critical posthuman and new materialist methods of data analysis were in some ways still being formalised in social research methodologies. Taylor and Fairchild (2020) published their article on PIE towards the end of this project and Fox and Alldred’s (2022) work was visited when revising some of this thesis. The evolving resources for this type of research meant that the analysis plan was created using the resources available at the initial time of planning which then further evolved as more information became available. An entry point was Fox and Alldred’s (2016) work and existing analytical tools for social and ethnographic research. The initial analytical framework for this project was based upon Plummer’s (2001) Documents of Life framework. This was chosen as an entry point because:

- It is systematic and can be applied across a range of data and settings
It is situated in multiple places i.e. the point of production, the point of interaction with the document, the context the document was produced in and the ways in which the document is used.

- It has a very broad definition of document, to include any data source.

Plummer describes himself as a fierce humanist (Plummer, 2012) which when taken at face value appears incongruent with a critical posthuman approach to analysis. However, upon further reading, Plummer’s (2001) approach to humanism and his critique of humanism, connect between Plummer’s concepts and a critical posthuman approach (Stanley, 2018).

First, Plummer expresses concerns about the erasure of humans in posthuman theories. He notes the risk of humans, and more specifically, certain humans being systematically and prejudicially erased when considering a monistic ontology (Plummer, 2007, p. 20). These concerns are also shared by Mbembe and Posel (2005) who discuss the value of humanism and the risks of posthumanism when the category of human is fractured, prejudiced and racialized. Therefore, any posthuman theory must acknowledge the privileged position of European whiteness from which one can call oneself human to start with.

Second, Plummer understands humanism as how we are situated in our more-than-human world much like critical posthumanism; however, Plummer focuses on human intra-action with each other as a way to make meaning from our realities. Plummer’s core concern in this regard is the affective relationships that produce the material world and he worries that a monistic theory can disenfranchise or demote the affective relations that are integral to world making (Plummer, 2021). Plummer’s concerns are that posthumanism can be reductionist – and he takes a stand against reductionism which he sees as a threat of erasure for some kinds of people and emotions. In this way, Plummer shares many of the concerns of critical posthumanists because many critical posthuman scholars (Haraway, 2016; Braidotti, 2013) define themselves differently from other posthumanisms such as transhumanism. Of great importance to this project and congruent with researchers such as Mol (2002), Plummer focusses on what work is being done by data and the realities it produces, therefore, Plummers’ analytical frameworks could be used to produce critical analysis of research data.

Plummer’s (2001) Documents of Life approach to analysis was used because it provided an entry point from which to analyse heterogenous data. It is not an authoritative model from which to approach a critical posthuman analysis of data, however, the framework provided a starting point for analysis that allowed discussion of textual, visual and affective
data. In retrospect, there are other analytical tools which could also have provided an analytical framework in a critical posthuman, new materialist or post-qualitative way. Nevertheless, St Pierre (2021, p163) argues:

‘…It [post-qualitative inquiry] refuses method and methodology altogether and begins with poststructuralism, its ontology of immanence, and its description of major philosophical concepts including the nature of being and human being, language, representation, knowledge, truth, rationality, and so on. Its goal is not to find and represent something that exists in the empirical world of human lived experience but to re-orient thought to experiment and create new forms of thought and life…’

It is from this entry point that I approached the data analysis for this project. The choice of analysis method was pragmatic and based on the theoretical standpoint taken by this project to understand what work is done by data and the affective possibilities and intra-actions that it can produce.

Other forms of analysis of the data are possible. For example, Mol (2002) studies the human body and its intra-actions in healthcare through observations and ethnography. She used multiple approaches to make meaning from her data that spoke to the affective lives of healthcare systems. More recently, Coleman and Ringrose (Coleman & Ringrose, 2013) take a Deleuzian approach to data analysis. Their book explores multiple research methodologies that can be used to ‘activate different ways of thinking’ (Coleman & Ringrose, 2013, p. 4) about how realities are made. Their work aims to pragmatically and creatively acknowledge that the ways in which knowledge is produced is a dynamic process that is open to interpretation, change and multiple perspectives that should reconcile with ‘different kinds of things’ (Coleman & Ringrose, 2013, p4). They explore methodologies which attend to the affective components of research data which may produce meaning, despite their size or apparent relevance to a situation. Coleman and Ringrose (2013) signpost to Deleuze (2001) who writes

…theory is an inquiry, which is to say, a practice: a practice of the seemingly fictive world that empiricism describes; a study of the conditions of legitimacy of practices that is in fact our own.

(Deleuze 2001, p36)

Grounded theorists have also taken a similar approach to analysing data and making meaning in research that integrates a post-anthropocentric perspective. Clarke (2003, p554) explores how grounded theory can incorporate the human, nonhuman and their subsequent social production of realities, into research data. Clarke's work looks to understand the
meanings made from the relationships and interactions between data when it is approached from a poststructuralist perspective. Clarke advocates for three ‘analytical exercises’ (ibid, p 554), listed below, that support creative inquiry into the production of social realities.

1. **situational maps** that lay out the major human, nonhuman, discursive, and other elements in the research situation of concern and provoke analyses of relations among them.

2. **social worlds/arenas maps** that lay out the collective actors, key nonhuman elements, and the arena(s) of commitment within which they are engaged in ongoing negotiations, or meso level interpretations of the situation, and

3. **positional maps** that lay out the major positions taken, and not taken, in the data vis-à-vis particular discursive axes of variation and difference, concern, and controversy surrounding complicated issues in the situation.

(Clarke, 2003, p554)

These analytical exercises are posited as supplemental approaches to more traditional grounded theory approaches and are designed to situate and deepen the understanding of data. The exercises also incorporate an affective and relational way of understanding the micropolitics of a situation. Clarke describes these exercises as an effort to map or create cartographies, of the how meaning emerges from data by incorporating smaller and dynamic points of data that other methods may not appreciate.

In summary, there are other analytical tools which could have been used in this project. These approaches, such as Ringrose and Coleman (2013) or Clarke (2003) could be used to analyse the project’s data. The grounding principles of these approaches are congruous with the theoretical framework of this project and the approach taken to analysis. However, the analysis used the principles of the six pillars of PIE (Taylor and Fairchild 2020), despite these being formalised in an article published during my analysis phase. The reason the approaches taken by Ringrose and Coleman (2013) and Clarke (2003) were not used was because the documentary data, namely the NMC Code of Conduct, formed an integral part of how this research was initialised. Therefore, a robust documentary analysis framework was used with critical posthuman principles.
4.7.1 Adapted framework for analysis

A framework for analysis was developed using the Documents of Life framework (Plummer 2001), the Spinozo-Deleuzian ethological toolkit (Fox and Alldred, 2022) and the framework for PIE (Taylor and Fairchild, 2020). The structured methodology of the Documents of Life framework was an entry-point to data analysis and was then adapted to address the critical posthuman concerns. The four main stages of the Documents of Life analysis were followed and critical posthuman concerns were addressed at each stage. These analytical concerns are not exhaustive and are based on the toolkits of critical posthuman research identified in Section 4.9. Examples of the analytical questions asked at each stage of analysis are listed below:

1) **Context 1**: the broader socio-historical context in which the document was produced
   a) How does the context of this document's production effect or affect the data produced?
   b) How does the socio-historical context shape the data that produced?
   c) Are there focal events in the data that are assembled by the socio-historical context in which the data was produced?
   d) How am I, as a researcher, part of the process of producing the context of/for the data?

2) **Pre-text**: the immediate circumstance of a text's production, for example, the organisational and institutional context
   a) How does the data produce the material-discursive realities?
   b) How does the data make human and non-human assemblages perceptible?
   c) How does the data delineate institutions as assemblages?
   d) How does the data demonstrate everyday events that progressively and endlessly produce and reproduce the social world and human lives?

3) **The text**: starting with a preliminary reading and then a deeper reading of the text
   a) How is the data (or the text) a non-human participant in the production of data?
   b) How does the data make the affects and emergent capacities of the human and non-human perceptible?
   c) How does the text promote affirmative ethics or ethics of shared understanding?
4) **Context 2**: the contemporary context of the text including its audience and the social context in which it is known
   
i) How does this data make the institution perceptible as an assemblage?
   
ii) What are the emergent capacities and conditions of possibility created by this data?
   
iii) How does this data make the complex flows of affect perceptible?

4.8 **Process of analysis**

Plummer’s (Plummer, 2001, 2007, 2012) Documents of Life framework was incorporated into the principles of critical posthuman and new materialist research (Fox & Alldred, 2022; C. A. Taylor & Fairchild, 2020). The analytical tool that was developed aligns with Taylor and Fairchild’s (2020, p. 5) features of PIE. These features are characterised as:

1) Material-discursive
2) Understanding institutions as assemblages
3) Focusing on events
4) Working with the affective lives of institutions
5) Understands knowledge is produced
6) Promotes affirmative ethics.

The data produced in this project (multimedia diaries, interview transcripts, field notes, documentary analysis and photos from the field site) were treated analytically as documents of life (Plummer, 2001). Each type of data analysis followed the framework outlined by Plummer (2001), which addresses four discreet sections:

- Context 1: the broader socio-historical context in which the document was produced
- Pre-text: the immediate circumstance of a text’s production, for example, the organisational and institutional context
- The text: starting with a preliminary reading and then a deeper reading
- Context 2: the contemporary context of the text including its audience and the social context in which it is known.

The purpose of analysing a document is to produce a deeper understanding of how nurse work is (or could be) produced and valued in the socio-material context of the field site. I adapted the Documents of Life framework to include critical posthuman lines of inquiry by expanding each section with new materialist considerations. Each type of data was analysed using the adapted framework, however, each of the four sections introduced critical posthuman concerns to its analysis (see section 4.8).
4.8.1 Preparation of the data

This section describes how the data was prepared for analysis. The software used to support the analytical process was MAXQDA (Verdi Software, 2021) because it supports the coding of text and images. Each of the data was prepared and imported into MAXQDA for further analysis.

4.8.1.1 Preparation of multimedia diaries and interviews

The multimedia diaries and interview recordings were transcribed using the principles of Gee’s (2014) framework which allows for the structure of tone and non-verbal speech to be documented, and the Successful Qualitative Research (SQR) notation system of Braun and Clarke (Braun & Clarke, 2006). Interpretation is always part of the analytical process (Braun et al., 2019) and this is essential to the production of meaning with data.

The diaries and interview data were transcribed and prepared as performances of narrative, including dramatisation not just description. Silverman’s ‘transcription symbols’ (Silverman & Marvasti, 2008, p505) enabled a partial reality of the data to be recorded including gesture and performance for any video data. This was essential as some of the multimedia diaries included video, therefore, data beyond direct voice transcription. The transcripts of the multimedia diaries and interviews were divided into short stanzas, each given a title (Gee, 2014). These small stories (De Fina & Georgakopoulou, 2019) within the narrative illustrate a repertoire of possible stories from which the participant may construct meaningful themes therefore beginning to outline the edges of what can be told (Plummer, 2001).

Knowledge and information are mediated through things which become subjectively known to the knower. These things are themselves situated and analysis must acknowledge this. The structure of communication is itself part of constructing knowledge and will hold context, intertextualities and interdiscursivities (Coffey & Atkinson, 1996). The contextual and demographic data collected provide some evidence as to how these texts and discourses are interwoven with the production of nurse work.

4.8.1.2 Coding and thematic development

Based upon the advice set out by Fox and Alldred (2022), the data was approached both deductively and inductively. The data was approached deductively using the core concepts of the Spinozan-Deleuzian ethological toolkits i.e. relations, affects, capacities and micropolitics. These core concepts were used to inductively produce codes for the data. The table (Table 2) below was an entry point into producing analytical codes from the data.
recommended by Fox and Alldred (2022). These codes are not exhaustive, moreover, they are illustrative as to direction of code production in this type of analysis:

**Table 2**

*Example of analytical codes, reproduced from Fox and Alldred (2022, Box B Coding frame for analysis)*

<table>
<thead>
<tr>
<th>Relations</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Human (e.g.: friend, family, work colleague, shop owner, manager).</td>
<td></td>
</tr>
<tr>
<td>Non-human (e.g.: pet, tool, technology, vehicle, consumer goods, postbox).</td>
<td></td>
</tr>
<tr>
<td>Places and spaces (e.g.: house, room, office, countryside, hospital, road).</td>
<td></td>
</tr>
<tr>
<td>Other (e.g.: concepts such as marriage, the economy, memories, desires).</td>
<td></td>
</tr>
<tr>
<td>Affects</td>
<td></td>
</tr>
<tr>
<td>Affects by or upon human relation.</td>
<td></td>
</tr>
<tr>
<td>Affects by or upon non-human relation.</td>
<td></td>
</tr>
<tr>
<td>Affects by or upon place or space</td>
<td></td>
</tr>
<tr>
<td>Physical affect</td>
<td></td>
</tr>
<tr>
<td>Psychological affect</td>
<td></td>
</tr>
<tr>
<td>Socio-cultural affect</td>
<td></td>
</tr>
<tr>
<td>Economic affect</td>
<td></td>
</tr>
<tr>
<td>Capacities</td>
<td></td>
</tr>
<tr>
<td>Enhanced capacity</td>
<td></td>
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<tr>
<td>-------------------</td>
<td></td>
</tr>
<tr>
<td>Reduced/constrained capacity</td>
<td></td>
</tr>
<tr>
<td>Singular capacity</td>
<td></td>
</tr>
<tr>
<td>Aggregated capacity</td>
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The suggestions and signposts in Table 2, were used as an entry point to produce the initial codes in the analysis of the data in this project, which are presented below in Table 3. Codes were initially generated using the matters of concern from the Spinozan-Deleuzian toolkit and clustered according to Braun and Clark (2022). Clusters of similar codes were gathered and those that occurred most frequently and prominently were promoted to sub-themes and then into themes. The coded data was sorted into relevant sub-themes to discern patterns in the data. Braun and Clarke's (2006) framework for thematic analysis (TA) was used. TA can be a process for identifying themes, however, it also offers a way to explore more sophisticated points in data and what these may mean. It is a flexible approach that is not tied to a particular theoretical framework, but is data driven and grounded in the data included for analysis. TA is a platform for an interrogative approach to data analysis that asks the question what could be going on? (Braun et al., 2019). Braun and Clarke (2019) are adamant that themes do not emerge from data but are produced by participants and researchers. Analysis of the interview transcripts revealed a multiplicity of interactions with humans and non-human matter; these codes and themes will be discussed below.
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<tr>
<th>Micropolitics</th>
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<td>Stereotypes</td>
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<td>Fear of making mistakes</td>
<td>Human and non-human intra-action</td>
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<td>Lack of agency</td>
<td>Patient-nurse relationship</td>
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<td>Lack of clinical experience</td>
<td>Staff Communication</td>
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<td>Administrative tasks</td>
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<td>Interpersonal relationships</td>
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I began to group the codes that seemed to share a common theme or related aspects, but I also paid close attention to the connections and affective intensities that bound these codes together. These groupings began to form potential clusters, a Spinozan-Deleuzian concept that considered these not merely as conceptual categories, but as affective and relational assemblages. I then identified possible clusters from these groupings. These clusters became a way to organise my codes under broader concepts while retaining a focus on the relational and affective dimensions of my data. Upon identifying potential clusters, I began the process of refining them in relation to my coded data and the data set as a whole. I questioned whether these clusters told a coherent and meaningful story about the data. During this phase, I found myself repositioning codes and clusters, splitting or combining them until I felt the clusters represented the relational and affective dimensions within my data. Finally, after developing a set of clusters, I moved to name them. I aimed to specify what was unique about each cluster, how it fit into the overall relational 'map' of my data, and what affective intensities and relationships it signified. This approach ensured that the research analysis wasn't merely a linear process, but rather a recursive one. I continuously moved back and forth between phases, refining my understanding of the data, and the relations and affective flows within it, as the research progressed.
These sub-themes were subsequently clustered into broader themes, capturing shared concepts and ideas. To provide a coherent structure for organising and presenting the analysis, these themes were further arranged into overarching meta-themes, or ‘ecologies’, as informed by the research’s theoretical orientation. The initial codes assigned to the data were not confined to a single sub-theme, resulting in considerable overlap and multiple layers of meaning within the data. Similarly, each sub-theme was not strictly exclusive to a specific theme. This overlapping and the nuanced nature of the data is acknowledged at the beginning of each findings chapter. To clarify how these overlaps contribute to the complexity of the analysis, a diagram is presented at the beginning of each chapter that visually represents the connections between the various codes, sub-themes, themes and meta-themes. These diagrams help indicate the relationships and interplay between different aspects of the data.

As an example, the sub-theme ‘lack of confidence’ manifests in multiple ways and at varying levels of abstraction. This sub-theme may intersect with other sub-themes, such as anxiety or motivation and may contribute to the formation of multiple themes. This interconnectedness demonstrates the rich and complex nature of the data and the importance of considering these overlaps when conducting qualitative thematic analysis.

4.8.2 Analysing transgressive data

As outlined in section 3.10.4, transgressive data is an essential part of posthuman research as it produces possibilities that ‘humanist’ qualitative methodologies do not (St Pierre, 2018). This speaks to data that becomes perceptible, however it does not have a place to be known within other structures. For example, a thought becomes known through a communication medium. Even though data exists that is incommensurable to other things, it still exists. This type of data was not excluded from this project because there are obvious examples of where this type data makes meaning by acknowledges the restrictions or productive of conditions of possibility within a context or situation i.e. what is possible, what is imagined as possible or not possible.

Transgressive data is challenging to capture in traditional or contemporary data analysis systems because an idea, a dream or an intention cannot by uploaded to a computer system. Nevertheless, transgressive data is part of this project's data (see Section 3.10.5 on ‘the call bell’ and Section 2.2 on ‘The Francis Report’) and is therefore included in the analysis. Transgressive data is clearly identified and linked to the surrogate or vicarious data from which it was produced in the analysis and subsequent discussion of data from this project.
4.9 **Presentation of Findings**

The following chapters present the findings of this ethnographic study of nursing. There are three meta-themes of this study, presented across three chapters. The chapters present analysis and discussion of the codes, sub-themes and themes produced form the data. The findings are organised and presented as ecologies – a term used to describe the relationships between humans and their environments. Each ecology provides insight into the ways in which nurses interact with patients, other hospital staff and manage the demands of a complex healthcare system.

Chapter 5 – Ecologies of regulation and practice

Chapter 6 – Ecologies of theory and practice

Chapter 7 – Ecologies of human, non-human and more-than-human bodies

The sub-themes and themes will be presented at the beginning of each findings chapter to guide the reader through the analysis and how meaning was made from the data.
5 Chapter 5: Ecologies of regulation and practice

This chapter discusses the findings of the data analysis organised around the meta-theme of nursing as an ecology of regulation and practice. Codes, sub-themes and themes were produced from the analysis of the NMC Code of Professional standards of practice and behaviour for nurses, midwives and nursing associates, multimedia diary entries and participant interviews. This chapter discusses the regulatory frameworks of nursing.

Figure 3

Sub-themes and themes informing the ecology of regulation and practice.

N.B. The diagram displays the connections and synthesis of codes into sub-themes and themes by solid lines. The dashed lines represent connections, relationships and overlaps in sub-themes.

5.1 Ecologies of regulation and practice

The NMC Code of Conduct (The Code) is a central regulatory document that guides the practice of nursing. In this chapter, I will present a documentary analysis of The Code,
exploring how it is represented in the experiences of participants. I will compare its idealised, regulatory version of nursing with participants' real-life experiences, identifying differences and potential gaps between the two. Analysing participant data will provide insight into how nurses perceive and navigate their professional lives within the regulatory framework of The Code. The analysis suggests that the Code can sometimes be prescriptive or restrictive to nurses in their work. Lastly, this chapter will explore the relationship between regulatory theory and nursing practice, highlighting the implications for nursing education, policy-making and patient care.

5.2 Boss text: Documentary Analysis of the NMC Code

The Code is a set of standards and values that guide the professional conduct of nurses and midwives in the United Kingdom. The Code is a document which outlines the standards of practice for nurses in the UK, supporting nurses to make informed decisions on a daily basis and helping to ensure the quality of patient care. The Code is designed to protect the public, promote patient safety and uphold the professional reputation of nurses and midwives. Nurses, midwives and nursing associates ‘must uphold The Code in order to be registered to practice in the UK’ (NMC, 2022, np.). Nurses working in UK are legally obliged to practice according to the NMC Code of Conduct which therefore has tangible effects on their lives as well as entangling nurses and their work in this regulatory framework. This section will analyse the 2019 edition of The Code (NMC, 2019) as a boss text (Stanley, 2018) and document of life (Plummer, 2001); these terms refer to documents that are used beyond the circumstances of their production and in ways that shape the ways in which worlds are made. This section will then discuss the critical posthuman analysis of The Code and the affectivities and relationalities as identified in the participant data. This data will be presented in relation to the four realms of nurse work (Jackson et al. 2021): organisational, cognitive, physical and emotional labour.

5.2.1 Context 1: The socio-historical context in which The Code is produced

Codes of practice for nurses are viewed by some as an integral part of professionalisation and, as such, they have existed since the late 19th century (Esterhuizen, 1996; Nursing and Midwifery Council, UK, 2015). In the UK, various organisations have produced these documents. The most recent being the Nursing and Midwifery Council. The current version of the NMC Code was published in 2015 and updated in 2018. The Code is a 24-page document and provides an outline of the values and practices that support nurse work, issued by the current incarnation of the professional regulator in the UK. The Code is
viewed as an essential document for nurses, nurse educators and the public so that each of these groups have a transparent view of which behaviour and principles can be expected of nurses in the UK (Glasper, 2015). The Code is described as an iterative document that evolves to reflect contemporary research, practices and societal views of what nursing is. This is underlined by the open access publication of the document to increase accessibility to all stakeholders. Glasper (2015) describes how the current version of The NMC Code of Conduct replaced the previous version because it was no longer ‘fit for purpose and did not adequately reflect contemporary nursing’. This would suggest that in his view (as a longstanding professor of nursing at a high-ranking university in 2020) the contents of the latest code reflect contemporary nursing practices.

Nurses first started registering with a regulatory body in the UK in 1919 and later it became compulsory to do so to hold the title and work as a registered nurse (NMC, 2019). Until 1983 the organisation registered only nurses, however, from then on, the regulatory body became an umbrella organisation for midwives, health visitors and children’s nurses. According to the NMC (2019) The Code of conduct frames everything that may be considered nurses’ work in the UK, however, the NMC does not regulate healthcare assistants. The Code was last updated in 2018 to reflect the ongoing development of governance structures for registered nurses. Since 2015, all nurses have been required to submit evidence of their professional development and practice hours to the NMC every three years. Registrants must affirm their registration every year by agreeing to practise by The Code of conduct and pay a fee to remain on the register (from 2019: £120 per year). The Code outlines the professional responsibilities of registered nurses in the UK and is intended as a document that can be used as a reminder for nurses how to practice (Goldsmith, 2011). If a nurse does not practice in line with The Code they can have their fitness to practice questioned and ultimately be removed from the register.

The version of The Code included for analysis is the most recently published regulatory framework from the nursing regulator in the UK. The NMC also published an updated regulatory framework for pre-registration nurse education in January 2019 entitled ‘Standards of proficiency for registered nurses’ which is widely referred to as ‘The Standards’. These documents are closely related and support each other. ‘The Standards’ outline a framework for nurse education which would educate student nurses to practice as nurses in the UK, in accordance with the NMC Code of Conduct.

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7 From 1983 to 2002 the regulatory body was known as the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) (NMC 2019)
5.2.2 Pre-text of The Code

The Code is given prominence on the NMC website and is available on the landing page. The website is open access and is the first result when the search string: ‘NMC code’ is entered into the top three internet search engines (Google, Bing and Yahoo). The Code is published alongside an explanatory presentation which introduces it as ‘the revised universal standards expected of nurses and midwives, which they must uphold every day in order to be registered to practise in the UK’ (NMC, 2018). The text is a 24-page, colour document, available online in English and as a PDF. It is also available in print in English and Welsh.

The NMC is an independent organisation that sets standards for the nursing and midwifery professions and holds registrants accountable for adhering to those standards. The NMC is responsible for protecting the public by ensuring that nurses and midwives are properly trained and qualified to practice safely and effectively. The NMC has legal powers to regulate the nursing and midwifery professions, which are granted to the organisation under the Nursing and Midwifery Order (Department of Health, 2001). This Order allows the NMC to set standards for education and training, conduct fitness to practice proceedings and issue sanctions against nurses and midwives who do not meet the required standards. The writing down of laws and governance structures such as the NMC code can help to initiate power for nurses by providing a clear set of standards and expectations, establishing accountability and improving the perception of the profession within society.

The pre-text of The Code provides information about its prominence in the production of nurse work. This direct association creates a discursive link between The Code, the NMC and nursing practice. The website is accessible, unique, loads quickly, is user friendly, informatively branded and the documents are available in multiple languages; these are typical of a well-resourced and thought-out design. The attention given to where and how The Code is available can indicate the importance of The Code to the NMC.

The Code is a priority publication for the NMC and is indicative of it being a Boss Text and one that guides nursing practice. The Code is a living document (Plummer 2001; Stanley 2018) and has far reaching consequences within nursing in the UK and the NHS. In its contemporary context, as a living document, The Code has the capacity to materially, psychologically, economically and socioculturally affect the lives of many because:

1. The Code has implications for how patients’ lives are lived: The Code directs the behaviour of nurses who look after people and patients. Power flows from nurses in many of the situations in which they look after people. The definitions of nurse work and the descriptions of safety are determined by using this document.
2. *The Code has implications for how nurses become in a space:* the document configures behaviour and power around nurses in a way which shapes the conditions of possibility for their work. Nurses are legally obliged to work in accordance with The Code.

3. *The Code is a Boss Text:* a living document which is used as a benchmark or framework on the basis of which to create other documents, other behaviours, shape services, validate job roles, scrutinise people, dismiss people from their work, legitimise behaviour and delegitimise others.
5.2.3 The text – preliminary reading

Figure 4
Front cover of The Code

In 2020, The Code is published on the NMC website alongside five related documents entitled:

- ‘Additional information on conscientious objection’
- ‘Additional information on FGM’
- ‘Delegation and accountability supplementary information to the NMC Code’
- ‘Good nursing and midwifery care’
- ‘The new NMC Code – Professional staff, quality services’

These additional documents are published in the same place, style and format. The font used is sans serif, no smaller than 12 point. This implies that the document was produced to be accessible as it follows recommendations for clear written communication.
There are no pictures in the document which emphasises the clarity of the message the authors intend to communicate by reducing the ambiguity of how different pictures could be interpreted. Pictures may reinforce stereotypes or support multiple meanings or interpretations (Willem et al., 2012). An absence of pictures may also denote the intention to avoid prescribing a particular fixed idea of nursing and nurse work given the breadth of the audience. This is supported in the text by the repeated description of nurses as ‘autonomous’ practitioners within their ‘scope of practice’. These broad statements, alongside sparse graphical representations of nurses, work to synergistically imagine nurses and nurse work as broad and heterogeneous.

The document is presented in the form of a booklet. It begins with an introduction spanning four pages, and this is succeeded by four primary sections. Each of these sections corresponds to one of the four statements displayed on the booklet’s front cover. Moreover, each section features a distinct colour, which is in harmony with the overall colour scheme of the document. It is important to note that the document is provided in PDF format, and it is read-only; this means that the content is locked and cannot be modified by the user.

One can observe that the layout and design of the document reflect a certain corporate identity. This is because it employs a multisensory strategy, which, according to Wiedmann et al. (2018), is aimed at creating a coherent experience across various brand touchpoints. This strategy contributes to the branding by emphasizing both the self-image and the positioning of the NMC, as well as the stance communicated through The Code.

The four statements (also known as pillars) on the front cover (Prioritise people, Practise effectively, Preserve safety, Promote professionalism and trust) are used to organise the document. Each pillar is expanded and further characterised with each statement having multiple sub-points. The sections containing the statements are written in the imperative i.e.

**Figure 5**

*The Code, NMC, 2018, p.6*
Each section contains links to the NMC website which provides more specific information. Some sections contain signposts to other sources of information from UK government agencies.

The Code reinforces the importance of nurses working within their scope of practice by outlining specific expectations for professional conduct. It emphasises the need for nurses to remain up-to-date with relevant knowledge and skills, take responsibility for decision making, act with integrity at all times, seek advice when needed and maintain professional boundaries. Additionally, it outlines how nurses should work collaboratively with other health care professionals in order to ensure safe patient care. The statement below is included on every page of the document (excluding the front cover) which reinforces this point:

Figure 6
Statement from The Code

Professional standards of practice and behaviour for nurses, midwives and nursing associates
All standards apply within your professional scope of practice

5.2.4 What is made perceptible by the text?

The NMC does not explicitly state that this is a framework for regulatory compliance; however, The Code can be recognised as a regulatory apparatus by its function. The Code is used to regulate and govern access to the UK nurses’ register. The NMC describes The Code as ‘the professional standards that nurses, midwives and nursing associates must uphold in order to be registered to practise in the UK’ (NMC, 2018). However, by terming it as ‘professional standards,’ the NMC leaves ambiguity regarding the specific ways in which The Code can be, or is, applied and implemented.
The broad accessibility of The Code as a text, suggests the intentions of the authors are for a wide audience to engage with The Code. Most people could engage with this document in some way (nurses, employers, student nurses, doctors or the general public) and therefore take a position on what constitutes nurse work. The Code makes explicit which kinds and ways of caring the NMC will support and endorse, and to a lesser extent what it will not. The expectations set out in The Code also translate into the expectations that a member of the public may have of a registered nurse. The expectations set out in The Code have consequences for how nurse work may be shaped, valued and produced.

The statement in Figure 5 appears on every page of The Code (except the cover) which suggests that this statement is important. The repetition of the statement implies that this statement is fundamental across the regulatory framework for nurses and that it applies to all aspects of nursing practice that are represented in The Code. This also signifies that The Code is a document of authority which is intended to support, guide and regulate nurses with regard to the remits of their practice. In the following statement taken from The Code, the author takes an authoritative and universal tone by addressing both public and professional audiences:

*The Nursing and Midwifery Council exists to protect the public. We do this by making sure that only those who meet our requirements are allowed to practise as a nurse or midwife in the UK, or a nursing associate in England.*

The Code, NMC, 2018, p2

The intended audience for this document is broadened by this statement, from nurses, nurse employers and educators to the public. This is enacted by language and grammatical choices in the exposition of the document. By using a deterministic plural pronoun (‘those’) it positions the author (the NMC) as an authority separate from, but supervisory to, nurses. This positioning is consistent throughout the introductory section and is synergistic with the document’s role as a regulatory framework. The statement included in the introduction of The Code (‘protect the public’) confers the authority and power to be able to protect the public. To be able to protect something, someone has to be able to control, restrict or promote another’s actions. This quote also positions the author and the document in a position of power by noting its multi-national remit. The author of The Code notes that it regulates different groups in different parts of the UK, but remains the overarching authority in each.

The Code is not an isolated document, but rather represents a framework of other texts, practices and policies. The register is used by employers, patients and the public to
check that nurses and midwives are qualified and fit to practise. This register records nurses who have been educated to a pre-determined standard, are able to practice according to this standard which is underpinned by The Code and who agree to practice in that way. The register symbolises that registrants should behave according to The Code of conduct in order to be called registered nurses. As The Code outlines, a registrant should behave according to the options set out. If they do not, then the threat of consequences is conveyed through the conditional tense ‘you must’ and ‘you should’ in the imperative. The consequences of not adhering to The Code are not explicated outlined in that the sanctions of process of being removed from the register are not discussed. However, the concepts of what constitute nurse work are emphasised and should one not practice within these then this threat of removal could become reality.

The introduction to The Code sets out the absoluteness of its content and what is included in the documents. The subject matter of The Code is emphasised by describing ‘[...] the professional standards that registered nurses, midwives and nursing associates must uphold’. This creates an authoritative voice in the document as you might expect from a regulatory body. This authority also works to create provenance and ownership for the description of nurse work that follows. This power is produced by the authors (the NMC) clearly defining their position as the institution that governs nurse work in the UK.

In conclusion, this analysis identifies that The Code is a component of how nurse work is created and produced institutionally. It sets standards for the conduct, performance and ethics of nurses in all aspects of their practice, from patient care to professional relationships with colleagues and public expectations. The Code is published in an accessible way to engage with multiple audiences including nurses but also employers, colleagues and the public. The document is written in the imperative which creates obligations to the content. Furthermore, The Code is published alongside the register of nurses who are able to practise in the UK. Publishing the NMC Code alongside the UK Nursing Register contributes to the instructional discourse of the NMC Code by providing nurses with a direct link to access information about their professional responsibilities and standards. It provides a reference point for understanding how they should act in practice and ensures that they are kept up-to-date with any changes or updates to the code. The availability of this resource also serves as an important reminder that nurses must adhere to certain standards when providing care. As a text, The Code establishes the conditions of possibility to directly affect nursing practice where nurses must assimilate and translate The Code in order to practise as nurses.
5.3 *Labours of nursing: Differences between regulatory descriptions of practice vs. participants' experiences*

As discussed above, The Code is a document that influences the work of nurses in various ways, both enabling and restricting their ability to perform their duties. In this section, I will examine how each domain of nurse work (emotion, physical, cognitive and organisational labour) is affected by The Code, as seen through participants' perspectives. I will examine the participant data to gain insight into the various aspects of nurse work and its connection to The Code as a regulatory text. Furthermore, I will examine how the participants perform the tasks outlined in The Code and their experiences related to it. This analysis will provide improved understanding of the ways in which the Code shapes the nurses experiences of their daily work.

5.4 *Care and The Code*

*Rebecca*

“...Care is... *What is care? Care is what I try to give people. It’s time, it’s effort, it’s an ear to listen to, skills to help them heal, it’s what that person needs at that time to get them better. And I suppose assessing what they need is what... Is what I learnt at uni, don’t you think?...”*

(Rebecca, nurse participant, interview)

I introduce the participant data in this section with this quote from Rebecca because she attempts to describe what care means to her. Despite being an experienced nurse, Rebecca gives a protracted and uncertain definition of what care is. There are many possibilities why Rebecca might not be able to define care in her interview: she may have needed more time to prepare an answer, there could be multiple types of care that she is considering or she could think care is undefinable. However, what this excerpt demonstrates most is that care is complex. The complexities of care would be difficult to represent in any code of practice because they express the breadth of human experience in nursing. Nevertheless, in the UK, The Code represents the breadth of care and subsequently the production of nurse work. Lily expands on this point when discussing her experiences of working with students:

*Lily*
“If I’m being honest, I didn’t feel that, I didn’t actually feel that university prepared you at all for being a nurse and your placements as well. Like I can kind of see how sometimes your placements don’t prepare you, because sometimes the wards are so busy. It’s so nice to actually be able to have days where it’s not so busy and you have time to teach students and actually show them things that they’re going to need to do and let them practice things they’re going to do… Uni is all based on The Code, ya know… and The Code isn’t real life.”

(Lily, nurse participant, interview)

Lily perceives a difference between her practice and The Code. Nursing regulatory frameworks provide a simplified description of nursing work, but the reality of nursing is often much more complex. Nursing is a multifaceted profession that requires nurses to be knowledgeable, compassionate and adaptive, with an ability to think critically and solve problems in all aspects of patient care. Furthermore, nurses must be flexible, as patient care can be unpredictable and often changes rapidly.

From a critical posthuman perspective, the relationship between nursing practice and The Code would be understood as part of a broader network of interconnected and interdependent forces. The Code would be seen as a set of imposed external standards and expectations, which are used to shape and regulate nursing practice. However, nursing practice would also be seen as having the potential to influence and shape The Code by providing feedback and insight that can be used to inform the development and revision of the standards and expectations. The Code can regulate the imaginaries of nursing in several ways. By providing a clear set of standards and expectations that nurses are expected to follow, The Code can help to shape the way that nurses think about their role and responsibilities. The Code can also help to establish accountability and transparency within the nursing profession, by outlining the standards that nurses are expected to follow and the consequences for not meeting those standards. This can help to build trust and confidence in the nursing profession, both among the public and within the profession itself. The relationship between The Code and the imaginaries of nursing would be understood as part of a broader network of interconnected and interdependent forces. The Code would be seen as a set of imposed external standards and expectations, which are used to regulate and control the way that nurses think about their role and responsibilities. However, the imaginaries of nursing would also be seen as having the potential to influence and shape The Code.
The Code can create material discursive nursing practice in several ways. First, by providing a clear set of standards and expectations that nurses are expected to follow, The Code can help to shape the way that nurses think about their role and responsibilities as well as the ways in which they approach their work. The Code outlines the values and principles that should guide nursing practice and by adhering to these standards nurses can develop a shared understanding of what it means to be a ‘good’ nurse. By outlining the standards that nurses are expected to follow and the consequences for not meeting those standards, The Code can help ensure they are held accountable for their actions and behaviour.

The next section will explore the reality of nursing for participants and how it is much more nuanced than a regulatory framework is able to convey.

5.4.1 Emotional labour and The Code

Emotional labour was evidenced by all the participant data generated as part of this project in multiple ways. Jackson et al. (2021) describes emotional labour as when nurses: ‘consciously control their emotions in order to display a desired emotion’ (p. 6). This section will demonstrate the ways in which emotional labour was expressed and described by participants, and how that might interact within The Code.

In her interview, Freya summarised her approach to emotional labour in her nursing practice. This excerpt comes from a part of her interview in which she described a day shift on a Monday. Freya described that she had been assigned 6 patients to care for that day and that 3 of those patients were expecting to be discharged. She described how the patients were eager to be discharged home as soon as possible because their care team over the weekend had told them that they could go home on Monday. Freya met the patients for the first time that morning and described how she had to quickly familiarise herself with the patients’ records and all the requirements that they had in order to be discharged that day.

Freya,

“You have to take on board everybody’s gripes but try not to make them your own… a lot of it is about expectation management.”

(Freya, nurse participant, interview)

While this is also an example of the organisational labour of nursing, Freya chose to describe the emotional labours she performed. The patients, eager to go home, made their
wishes clear to Freya and she assimilated these and began to work towards getting the patients discharged. Freya found that there were many outstanding tasks and questions to be answered before her patients could go home and she explained this to the latter. She described how she experienced the largest part of nurse work as navigating the emotions of the patients and the labour of not letting those emotions affect her other relationships throughout the day.

The following field notes illustrate more of Freya's narrative and demonstrate the insider/outsider nature of ethnography, where my position as an insider researcher influenced my outsider perception of the data.

Field notes

Freya was preparing for the discharge of three patients from the ward. She reviewed their medical records, ensuring all necessary tasks were completed and questions answered before they could be sent home. I noticed her diligently checking lab results, coordinating with the pharmacy for prescriptions and communicating with the multidisciplinary team members to confirm follow-up appointments. Freya spent considerable time speaking with her patients about their concerns and anxieties regarding their discharges. One patient expressed fear about managing their medications at home, while another worried about the availability of home care services. Freya listened attentively, empathising with their emotions while simultaneously providing reassurance and practical guidance.

(Field notes, produced during data collection)

Later, during her interview, Freya told me that a significant part of her nursing work involved managing patients’ emotions and preventing those emotions from affecting her relationships with other patients and colleagues throughout the day. She highlighted the importance of maintaining a professional and compassionate demeanour, despite the emotional toll it sometimes took on her.

As an insider researcher and a nurse myself, I couldn't help but relate to Freya's experiences. I found myself empathising with her as she balanced the emotional labour of nursing with the practical aspects of patient care. My presence on the ward seemed to provide her with an opportunity to reflect on and share her experiences, which might have otherwise remained unspoken.
Freya describes her emotional relegation and alludes to this being part of her role as a nurse. Freya is describing emotional labour and navigating the emotions of the patients who are eager to be discharged from hospital while deprioritising or suppressing her own emotions and responses to the patients' ‘gripes’. The actual reality of the situation and the work that Freya did is moderated and shaped by the imagined reality of the professionalised nurse who should ‘never allow someone’s complaint to affect the care that is provided to them’ (The Code, 2019, p.25). There is direct tension between The Code and the nurse work that Freya describes because it is unclear where this kind of emotional work is described in The Code. Freya describes how she tries not to let the patients’ gripes affect her while at the same time alludes to this not being absolute as she tries ‘not to make them [her] own’ (Freya, excerpt from interview).

Ella also describes the emotional labour in her nurse work in relation to a patient who had fallen on the ward. The patient was frustrated with themselves for falling and sustaining an injury.

_Ella_

“I was feeling exhausted by the time the shift was over. It was a busy night, the patients kept us on our toes! The most challenging part of my shift was looking after a patient who had fallen during the day and sustained a fractured pelvis. They were in a lot of discomfort and felt awful. They were also feeling really annoyed with themselves and had a really low mood. I spent a lot of the shift trying to make the patient as comfortable as I could, however I found it difficult as I felt I could not get on top of the pain that the patient was feeling, which was frustrating… but I think it was mostly their frustration. The best thing about that shift was home time! Haha especially as it ended with a patient’s relative coming to the ward.”

(Ella, nurse participant, text message, multimedia diary)

In Ella’s interview, I asked her what she thought her work was in this situation. Ella very quickly described the cognitive labour of ensuring the patient was receiving medical care and the organisational labours of ensuring that the appropriate medical specialities had been made aware of the patient, however, she focused on describing the emotional labour that she performed in caring for this patient. As described in the excerpt from her diary, Ella concentrated her efforts on talking through what had happened with the patient because the patient was annoyed with themselves for falling and potentially extending their stay in
hospital. She described the labour of empathising with the patient and trying to meet their emotional needs whilst juggling the needs of the other patients she was looking after.

In the recording, the tone of Ella’s voice indicates that she felt sympathy, empathy and perhaps even guilt that the patient had fallen. She implied she had not done enough to prevent the patient from falling and that she wished that she could have prevented them from falling. In relation to The Code, this portrays an ideal, infallible version of care. The Code, as a regulatory framework, has reasons to provide a benchmark of care which nurses should strive for. However, the reality is that nurses can’t prevent all falls, ‘bad’ things happening in hospital or situations that do not go the way they are planned. Extra emotional labour is experienced by nurses when they feel bad or guilty about these things happening.

Ella

“…when I was in there and chatting with him the pain would go… I don’t know if it was distraction or a bit of company that was helping…but when I went away you could hear them moaning in pain but when I went in they would stop. They didn’t want any more painkillers, they said that it [the pain] was OK…”

(Ella, nurse participant, interview)

Ella described her assessment of the patient’s pain and the ways she was managing it. She indicated that she had given analgesics for the pain, however, the patient’s pain is not alleviated when they are alone. Ella described the pain being addressed non-pharmaceutically through distraction and support, however, when these are not present the patient is in more pain. This is an example of emotional labour being used in clinical therapeutic practice to address the patient’s pain. The Code states that nurses should: ‘Make sure that people’s physical, social and psychological needs are assessed and responded to’ (NMC, 2019, p. 7) and in this scenario Ella was attending to those needs. Nevertheless, a tension arises here because The Code does not mention the emotional labour associated with meeting the physical, social and psychological needs of patients. This does not mean that The Code and its authors are ignorant of the emotional labour involved in nurse work. However, by not explicitly naming emotions or emotional labour in The Code the imagined realities of nursing that nurses work with and towards have a more restricted space for emotional labour. Emotional labour is not institutionally and explicitly validated by The Code, despite being a significant component of nurse work.
For some nurses, the imagined reality of nurse work minimises labours such as emotional or organisational labour. In her interview, Charlotte discussed how she imagined nursing before she became a nurse and how her ideas of what nurse work is, contribute to her work life.

Jamie

“…So what’s the most challenging part of the job for you?”

Charlotte

“…Dealing with the patients and the family. I, for myself, why I signed up to be a nurse is to look after people within their health…with a broad aspect of emotional, physical, psychological, rather than only looking after people who should be home because they are physically well…I struggle with well people whining…”

(Charlotte, nurse participant, interview)

Charlotte described how her idea of nurse work is orientated towards patients who are acutely unwell. She understands that to meet the healthcare needs of a patient she must approach them holistically, yet, she also creates a boundary between health and illness – approaching her role as dealing with the medicalised illness. Charlotte acknowledges the emotional and organisational labours in her practice, but she attached these labours to caring for someone acutely unwell rather than as a wider part of nurse work. This reading of nurse work fits with the descriptions of nursing in The Code that produce a liberal and medicalised view of nursing care.

Emotional labour is also required in nursing for inter and intra-professional communication between colleagues. Hospitals are high risk places because they deal with situations of life and death alongside highly vulnerable people. Excellent communication is therefore required between staff to reduce possible risks. This is evidenced in The Code in Sections 7-11, which highlight the need to ‘Communicate Clearly’, ‘Work co-operatively’ and ‘Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues’ (NMC 2019, p. 10-12). Nevertheless, the ways in which communication and collaboration take place in a hospital may not always meet these standards.

Jack
“…Worse part of my shift? HAN [Hospital@Night] shouting down the phone at my colleague about not making them toast at 6am😋…”

(Jack, nurse participant, text message, multimedia diary)

Jamie

“…So tell me a little bit more about the time you mentioned that HAN shouted down the phone? Was everyone OK?…”

Jack

“…a couple of the HAN members of the team can be a bit snooty and complain that I’m always coming in for advice at the end of the day and sometimes when they kind of say a snidey comment it, kind of, makes you feel a bit stupid. Um, but ultimately you’re phoning them because you feel like you need some extra support and advice. And when they’re kind of talking down to you it makes you feel [inaudible]. I am just phoning you for advice…”

(Jack, nurse participant, interview)

Emotional and cognitive labour are required by Jack and his colleague in this situation to assimilate and process the communication with his colleagues. Jack recognises the different roles of people in the situation by acknowledging that it is appropriate for him to ask for advice from his more senior colleagues. However, this is not a straightforward process because he must rationalise and empathise with their behaviours in the context of their rudeness. This behaviour is in tension with a verbatim reading of The Code, which states that collegiality and effective communication are essential. The staff members that Jack speaks to on the phone are also registered nurses and should therefore practice in line with The Code. From Jack’s perspective, the communication from the HAN team was not as collegial as he would have hoped because it required extra effort to process and created uncomfortable feelings for him.

As suggested by Charlotte’s perspective and that of the HAN team, in healthcare, some people have rigid ideas about right and wrong. They may hold strong beliefs about the
The proper way to approach patient care and may approach care with little room for ambiguity or complexity. This can create very clear boundaries between what is considered ‘right’ and ‘wrong’ in healthcare and can lead to a sense of certainty about what is the best way to approach patient care. However, as all the participants in this section describe, the reality of healthcare is much more nuanced and complex. Patients may present unique and challenging situations that do not fit neatly into preconceived ideas of nursing. Additionally, the care patients need may change over time, requiring healthcare professionals to adapt and adjust their approach to provide that care. The process of emotional labour is entangled in many aspects of nursing with patients, colleagues and the other kinds of labour that constitute nurse work.

5.4.2 Physical labour

Physical labour was evidenced in the data in various ways. This section will demonstrate ways in which physical labour was expressed and described by participants in their multimedia diaries and interviews. Physical labour includes the moving and handling of patients, any physical processes of nurse work and the effects of nurse work on nurses’ bodies. Again, there is significant overlap between physical labour and the other domains of nurse labour because physical labour is usually performed simultaneously with other labour. Nevertheless, it is a distinct and discreet theme produced in the data and sits within the context of nurse work.

The physical labour of nurse work is produced in The Code by the use of the imperative tense and action verbs (verbs that convey doing) at the beginning of each section and sub-section. Each sentence begins with a verb written as an instruction to act, to consider or to do, as in the following examples:

‘4 Act in the best interests of people at all times’

(NMC, 2018, p.8)

‘6 Always practise in line with the best available evidence’

(NMC, 2018, p.10)

‘15 Always offer help if an emergency arises in your practice setting or anywhere else’

(NMC, 2018, p.16)
The activity and movement directed by The Code is reflected in the data produced by the participants in this study. While rarely directly describing the actual physical acts of care, many participants noted how busy they were and how tiring that was for them.

*Olivia*

“…*The worse part of my shift? My back…*”

(Olivia, nurse participant, voice note, multimedia diary)

*Jamie*

“…How are you doing now? How is your back?!…”

*Olivia*

“… It’s better, it just twinges sometimes when I’m moving people… I think just getting into winter months it’s more tiring and it’s just, yeah, more busy and people are more sick and, yeah, but yeah… it’s just a lot heavier than it used to be. Everyone’s sicker, everyone’s a double because they’re so sick…”

(Olivia, nurse participant, interview)

Olivia described the seasonality of nurse work and how she expected more physical labour in the winter months. She described the physical labour on the ward as being heavy, which is a commonly used term on this ward to describe increased acuity and increased physical labour. Olivia has a back complaint aggravated by the physical labour, however, she was nonchalant about it and saw this as part of her role as a nurse. The Code states that a nurse should ‘maintain the level of health you need to carry out your professional role’ (NMC, 2019, p. 22) and that nurses should ‘take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place’ (NMC, 2019, p. 20). These sections of The Code involve the regulation of physical labour and can pertain to Olivia’s physical labour. For example, Olivia recognised the regulation of physical labour through the implementation of specific moving and handling practices when she referred to ‘doubles’ which is a reference for the need for two people to move the patient. The Code does also state that all nurses should “complete the necessary training before
carrying out a new role’ (NMC, 2019, p.15) which may also address the physical labour of nursing as all nurses at this hospital must complete Patient Moving and Handling training before working clinically.

Physical labour is also produced in the data in the form of physical effects on the nurses’ bodies. Each participant indicated the physical labour of their work at least once in either their diaries or the interviews. The effects of shift pattern variation was reported by every participant and resulted in tiredness and stress. The participant data indicates that night shifts in particular physically affect participants.

*Ella*

“…Mmm. I get quite stressed, mm-hmm and I think that it’s just to do with being awake all night, um, by the morning I find that I’m not functioning as well as I would like to be and I get stressed that I’m gonna make a mistake…”

(Ella, nurse participant, interview)

The above statement demonstrates the perceived physical effects of night shifts on her body. Ella described subjective feelings of tiredness alongside symptoms of exhaustion such as perceiving that her cognitive function was reduced at the end of a night shift. Ella also described the emotional labour of feeling physically tired as she worried that she might make a mistake.

The physical labour of nurse work was also indicated for day shifts. Participants described day shifts also making them tired and they could perceive this tiredness in their colleagues.

*Amelia*

“…You can see that they’re challenged by the day, that you can see that they’re tired… and you can tell how busy it’s been by the ward…”

*Jamie*

“How so?”

*Amelia*
“…well you know… if the buzzers are going and the obs machines aren’t tidy… if there’s people still running about…”

(Amelia, nurse participant, interview)

In the excerpt above from Amelia’s interview, she described arriving on the ward for a night shift and observing that her colleagues looked tired. She described the visible signs of nurse work on their bodies. She also described how the labour of nursing can be perceived in the environment and materiality of the ward. If the ward appears untidy to her or in a less orderly state than she expected then she could perceive this as information that the ward had been busy that day. The physical actions of nurses relate to The Code, as human and non-human, in creating the physical acts of nurses that are perceived as care.

5.4.3 Cognitive labour

Through the analysis of the data collected from various sources for the project, cognitive labour was generated in multiple ways. This section will present the ways cognitive labour was expressed and described by participants in their multimedia diaries and interviews. Cognitive labour includes the processes of engaging mind and body in a purposeful way. Jackson et al. (2021) expand on four sub-themes: learning while working, thinking while working and ‘stacking’ (p.6) and prioritisation of information. Cognitive labour involves the planning of possible care whilst responding to the speculative and unknown characteristics of care that can happen as care unfolds. Again, there is significant overlap between cognitive labour and the other domains of nurse labour because cognitive labour is usually performed alongside and simultaneously with other forms of labour.

Charlotte enjoys the cognitive labour of nursing, perceiving it as an opportunity to use her knowledge and skills to provide good patient care. In her interview, Charlotte described the process of discussing a patient’s current situation with them and supporting them to understand the complexities of what was going on.

Charlotte
“...I enjoy bringing the full facts to the table for somebody, um, and if I can, try and make… Break it down and make it, not black and white 'cos stuff is black and white, but just a bit simpler…”

(Charlotte, nurse participant, interview)

In this example, Charlotte described many different kinds of labour, however, the cognitive labour appears to be primary because of the way in which Charlotte frames her answer. She is joyful and proud to understand parts of the process and make this more accessible to patients. She uses her emotional and organisational knowledge as vehicles for her cognitive labour to explain and situate the patient because Charlotte perceived this is what the patient required to feel better cared for.

**Charlotte**

“...the basic background knowledge is there. It’s just teasing out little bits and adding to it…and then making it relevant to what's going on now…”

(Charlotte, nurse participant, interview)

In her interview, Charlotte continued to elaborate on how she explained things to patients. She discussed her knowledge of health and well-being that she had learned at university and from her work experience as well as how she employed that in her current practice. She described that her practice draws upon her knowledge which she uses to interpret the patient’s situation as well as situate the patient in the current context. This kind of cognitive labour is formative in Charlotte’s view of what nurse work is. As demonstrated by a prior excerpt from Charlotte’s interview (Section 5.4.1) she appears to somewhat depreciate the emotional labour of nursing whilst savouring the cognitive aspects.

The prominence of cognitive labour in nursing is described by Jessica. In her interview, Jessica described a situation in which the patient’s analgesia had been reduced by the medical team. When Jessica approached the patient they were not fully aware of the reduction in dose nor had this information been communicated to Jessica.

**Jessica**
‘…worst part of today?...the docs. They reduced Bed 99’s Oxycodone and didn’t tell him... safe to say he wasn’t happy...’

(Jessica, nurse participant, voice note, multimedia diary)

Jamie

“...so tell me a little bit more about what happened with the oxycodone...”

Jessica

“...it’s easy to say we’re stopping your analgesia isn’t it if you’re not there... you don’t have to be there to be the one who reduces it with them... I had to go back through the notes, see what they’d [medical team] said and then go and explain it to him and his family...”

(Jessica, nurse participant, interview)

The situation Jessica described required many complex labours such as the emotional labour of empathising with the patient’s perspective, the organisational labour of looking through the medical records to find the information she required and attending to the cognitive labours of the situation. Jessica used cognitive labour to understand the clinical reasoning behind the decision made by the medical team in the context of the patient’s current condition and by interpreting this to the patient, employed emotional, cognitive and organisational knowledge and labour.

5.4.4 Organisational labour

Through the analysis of the data collected from various sources for the project, organisational labour was generated in multiple ways. This section will demonstrate ways in which organisational labour was expressed and described by participants in their multimedia diaries, interviews and alluded to by their descriptions of practice. Organisational labour involves the often ‘invisible organising work’ (Jackson et al. 2021, p. 4) of nursing. Like the
other labours discussed, it involves the planning and facilitating of possible care whilst again responding to the speculative and unknown characteristics of care that unfold.

*Jamie*

“…so how much of your time do you spend organising things?…”

*Ava*

“…I would say this is about 70% of my work…”

(Ava, nurse participant, interview)

Ava perceived organisational labour as a major part of her work as a nurse. Organisational labour is not discrete and is entangled with many other parts of nurse work and nursing. Nevertheless, Ava acknowledged that organising things feels like the majority of her work. In her multimedia diary, Rebecca contextualised how organisational labour exists alongside other labours to produce nurse work and care:

*Rebecca*

‘…I had a patient who was, had really high blood sugars when he was leaving and he couldn’t really manage his diabetes. But luckily we managed to get him home anyway and that was because his daughter was so supportive…’

(Rebecca, nurse participant, voice note, multimedia diary)

As described, organisational labour is a large part of nurse work that supports and produces other kinds of nurse work. Rebecca describes how she successfully discharged a patient with support from his daughter. The patient and family education which she described could be understood as the cognitive labour of nurse work, however, when Rebecca said ‘because his daughter was so supportive’, she made an implicit reference to the organisational parts of discharging this patient from hospital. Rebecca indicated that in the process of discharging the patient she needed to organise the transfer of the patient’s care to the place to which he was being discharged, and in order to do that, she had to consider the patient’s physical status and his ongoing medical needs. She implied that she
educated or confirmed knowledge of the patient’s diabetes and the ongoing management thereof with his daughter.

The Code is based on the principle of 'professional autonomy', which means that nurses and midwives are expected to make their own decisions about how they will meet the standards set. The Code recognises that nurses and midwives work in a variety of organisational settings, and that they may need to use different approaches in order to meet the standards. The Code also recognises that nurses and midwives may need to work with other health care professionals in order to meet the standards.

Ella described the complexities of organising and planning care in her work. She wrote about a patient who she was looking after whose medical team was based on a different ward (‘boarding patient’).

_Ella_

‘…Not long in from work! Day one of three so feeling quite fresh! Had quite a busy day today. I would say the best part of my day today was again having a nice group of patients☺’

‘The most challenging part of my day was looking after a boarding patient. There was quite a lot going on with the patient and that [sic] they weren’t the most appropriate patient to board. I spent most of my morning attempting to contact their medical team to come and review the patient…they eventually turned up at 13:30! I find that this happens quite often and it’s pretty frustrating!’

(Ella, nurse participant, written text, multimedia diary)

This diary entry describes the organisational labour of ensuring that the patient’s medical team saw the patient that day. What is unclear from the diary is why Ella felt so compelled to contact the medical team to come and see the patient. The patient could have been unwell and needed an expedited medical review or there could have been pressure on the hospital to discharge people to create bed capacity. Both of these scenarios happened frequently in my field notes. Notwithstanding the reason for Ella seeking out the medical team, she clearly communicated that part of her organisational labour is feeling responsible for making sure the patient is reviewed.
Organisational labour is further represented in Sophie’s interview. Sophie expressed her frustration at not being able to provide the care she thought a patient needed because she was unable to offer him food.

Sophie

“I couldn't feed a man when he's hungry. And it's not my bloody fault the kitchen is closed, so I had to remain as professional as I could and just say I'm sorry... It's not within my control and I can't...”

(Sophie, nurse participant, interview)

At this hospital, the kitchen of the ward was locked outside meal times. There was a smaller kitchen in the ward area that had drinks and snacks, but did not have a significant supply of food. Sophie wanted to offer the patient food but she was unable to. The Code would advise that nurses meet the needs of the patient and offer them food. However, the situation did not allow Sophie to provide the care that she wanted to and is instructed to by her professional code of practice. This tension between the care Sophie wanted to provide, is instructed to provide and was able to provide, caused frustration. Sophie's affective experience was, in this case, produced by the entanglement of the organisational labour and her interpretation what she was expected to do if she adhered to The Code.
5.5 Discussion of the ecologies of regulation and practice

This section will discuss how regulation and practice create an ecology of nurse work. The theories of what nurse work is (Jackson et al., 2021), the regulation of nursing (NMC, 2019) and participant data show that The Code produces particular kinds of experiences of nurse work. The Code is a boss text for nursing and creates an idealised version of nursing.

5.5.1 The Code is a boss text

The documentary analysis of The Code demonstrates that it is a boss text because behaviour, actions and decision-making processes are instructed, guided and governed by the text in ways beyond the context of its production. The participant data also identifies The Code as a boss text. Lily described how nurse education is built around The Code and how she perceived significant differences between nursing practice and The Code (see Section 5.4). Lily explicitly described the functions of The Code as a boss text as a central organising feature of nurse education.

The Code as a boss text is also made perceptible by the affect and context of participants diaries and interviews. When participants described labours that are franchised by The Code the descriptions were more positive and happier, for example, Charlotte was joyful when she described a situation in which she was able to use her cognitive labours and produce nurse work in the way she imagined to help and provide care for her patient in the way that she wanted to. Conversely, both Ella and Sophie expressed frustration when they were confronted with challenging organisational labours that were impeded by situations. The Code tells nurses that organisational labour is a large part of the care that they should provide and consequently nurses want to provide that care and they become frustrated when they are hampered in doing so. Participants appeared to be frustrated when they wanted to provide care for their patients, but also that they cannot adhere to the standards set out in the boss text for their profession.

5.5.2 Which labours are given space in The Code

The Code does not pay equal attention to the various labours of nurse work. The Code explicitly prioritises organisational and cognitive labour, and implicitly prioritises physical labour. Physical labour is implied throughout the document by the tone and word choice. Organisational and cognitive labours feature significantly in the text. Emotional labour is widely acknowledged as a fundamental part of nurse work (Smith, 1991: Theodosius, 2008) and as at least an equally significant part of a nurse’s workload. However, The Code does not use the word emotion or emotional in the entire document. Despite emotional labour being discussed in literature and by participants it is not well
conceptualised in The Code. Nevertheless, the participant data demonstrated the emotional labour of nursing.

Analysis of the participant data produced evidence of all the various types of labour in nursing. Each type was not discrete and was deeply entangled with the others, which, moreover, occur concurrently and support one another. For example, in Section 5.6.1, Jack described his interactions with his colleagues on the H@N team and he used emotional labour to navigate the affective and socio-material aspects of other labours required for him to do his nurse work. Emotional labour is clearly part of his labours and part of nurse work; yet it is not explicitly included in The Code.

5.5.3 The Vitruvian Nurse

This section offers a discussion of The Code in the context of the participant data. I think about the implicit and explicit metaphors that structure our worlds as we live and work as nurses, to think with and to understand what The Code does. I understand a metaphor as a tool people use to make sense of the world we live in, a poetic device that can also be useful for grasping abstract concepts. Isolating a metaphor illuminates the way language can function as a container for meaning and can create new meaning through metaphorical imaginings (Lakoff & Johnson, 2003). In considering these imagined, yet tangible realities, I take a critical posthuman perspective expanding on Braidotti’s (2013) idea of the Vitruvian Man. The Vitruvian Man, as depicted by Leonardo DaVinci, is an imagining of a specific kind of human that has been exported and homogenised around the globe – specifically, a ‘universal’ white, cisgender, heterosexual, able, human male – instilling a set of ‘mental, discursive and spiritual values’ as normative (Braidotti, 2013, p.13). Transposing this metaphor to The Code and the participant data allows us to consider the Vitruvian Nurse.

The Vitruvian Nurse is the nurse idealised in every way and is the version of nursing that is presented in The Code. The Code is a regulatory framework for nursing in the UK, it is not a theory or guidebook on how to do nursing; nevertheless, because of the context of production and how it is used in practice, The Code becomes a document of how nursing should be done. Nurses are taught and maintain an idealised version of nursing through The Code, therefore, it becomes a mechanism of control and a technique of discipline. The limits imposed by the metaphor of the Vitruvian Nurse, structure the daily realities nurses face and constrain the possibilities that are imaginable. The metaphor of the Vitruvian Nurse envisions a uniformed woman who goes out of her way to attend to everyone’s needs in an unconditional, subservient manner which correlates her self-worth to her ability to serve others, to the detriment of herself. The conception of Vitruvian Nurse is achieved when the latter ceases to exist as a subjective entity, therefore becoming an impossibility. This is
made perceptible in The Code, for example, by the imperatives of service to patients as consumers of a nursing service in which the nurses are solely there to provide for the patients, whilst minimising themselves. This is further supported by the strong branding of The Code suggesting a streamlined commercial enterprise for which care is a commodity.

Contemporary nursing systems that maintain ideas, such as that of Nightingale nursing, are colonial (Wytenbroek and Vandenberg, 2017), patriarchal and reproduce knowledge production systems that I explored above (Section 2.2.1). These contemporary systems are troubling because the white European male mutates into the white European female nurse and becomes the perfect nurse. From a critical posthuman perspective, this metaphor is built on assumptions of the liminal human as an individual not dividual: the idea of the dividual suggests that individuals are not autonomous or self-contained entities, but rather they are constantly being shaped and influenced by the various social and cultural forces that surround them. From this perspective, the concept of the individual is seen as being fluid and dynamic, rather than fixed and unchanging. However, The Code supports the individualistic (and neo-liberal) nature of patient-centred care by revering the ‘autonomous’ practitioner over the material-discursive practices of care. This means, an irrefutable future as established by The Code is predetermined despite the situated, messy and affective ways of navigating whatever situation comes next.

5.6 Chapter Summary: Ecologies of regulation and practice

The chapter discussed the gaps between regulatory frameworks and practice in nursing, as explored through The Code and discussions of nurse work based on human participant data. The chapter began by examining how idealised forms of nursing work are created from The Code, participants descriptions of their work and how the concept of the Vitruvian Nurse is produced. However, the actual work performed by nurses (i.e. the four labours described by Jackson et al. 2021) often differs from what they have been taught and that outlined in The Code. Nurses are taught an idealised version of nursing that aligns with neoliberal expectations of care. The Code and nursing education are based on this idealised version of nurses, with the Code serving as a ‘boss text’ that outlines the expectations for nursing practice. However, as Taylor and Fairchild (2020) have noted, multiple knowledge production systems can exist simultaneously, allowing for contradictions and complexities. In the case of nursing, burnout and unpreparedness may result from frameworks that do not accurately reflect the realities of nursing work as will be explored in the next chapter.
6 Chapter 6: Ecologies of theory and practice

This chapter will examine the ways in which affective intra and interactions are produced for nurses between theory and practice. It will discuss the findings of the data analysis organised around the theme of nursing as an ecology of theory and practice. Codes and themes were produced using field notes, The Code, multimedia diary entries and participant interviews.

Figure 7

Sub-themes and themes informing the ecology of theory and practice.
6.1 Ecologies of theory and practice

This chapter will focus on the entanglement between theory and practice by looking at The Code, participants’ own expectations and their experiences of nurse work. Drawing on the notion that The Code serves as a boss text for nursing in the UK and the concept of the idealised version of a nurse (Vitruvian Nurse), this chapter discusses the affective consequences of these two phenomena. In this context, this chapter will present participant data and how there are differences, tensions and synergies between theory and practice.

This chapter will explore each of the themes in turn to situate them within the ecology of theory and practice. First, person-centred care will be discussed to explore how it is produced in nurse work. This will then be linked to how nurse work involves de-prioritisation as well as prioritisation, and how these relate to theory and The Code. Third, this chapter will examine the material effects of this on student nurses and registered nurses with regard to the themes of unpreparedness, lack of confidence and burnout. The chapter will then discuss how these material effects can be understood through the lens of the ‘Vitruvian Nurse’.

6.2 Person-centred care

Capacity for care was a recurring theme throughout the data with most participants discussing patient choice, time and agency as factors affecting their capacity to care. This section will focus specifically on the nurse participant data related to the capacity to care with person-centred care (PCC). Participants related their capacity to care to PCC. The latter is prominent in The Code and will be explored through the participants’ experiences of nurse work. This section includes participants’ approaches to the concepts, their experiences with implementing them in practice and the challenges and opportunities they encountered. By analysing the nurse participants’ perspectives on PCC through a critical posthuman lens, this section will make perceptible the ways in which nurses navigate complex care contexts and negotiate the competing demands of patients, healthcare organisations and wider social and political structures.

Rebecca

“...And a lot of patients do choose to have end-of-life care with us because they feel comfortable with us, which is nice, which doesn’t always happen in other wards like a Gen Med ward or… Because they don’t know their patients the same as, as what we do...”

(Rebecca, nurse participant, interview)
There are multiple meanings to what Rebecca said. First, that patient choice was important to her and her practice. Second, that she was proud of the care she is able to provide and third, that she and our colleagues have established relationships with longer term patients. PCC was entangled in Rebecca’s practice and she took pride in providing care that engaged the patient with their preferences. Nevertheless, this was not always possible, for example:

Freya
‘…worst part of my day was Bed 16/3 having a heart attack… they were OK in the end but I barely had a chance to look at my other patients…’

(Freya, nurse participant, voice note, multimedia diary)

Freya described one of her patients becoming unwell and requiring lots of time and attention during her day. Freya was obviously mindful of her responsibilities as a nurse and also of PCC, because she described her need to prioritise the patient that was unwell but in doing so, she felt that she may have deprioritised her other patients.

The Code instructs nurses to ‘prioritise people’ and Freya described how she prioritised the unwell patient. However, when Freya introduces the idea of not providing the care she wanted to for her other patients, it mobilised the concept of who, what and how is care prioritised by nurses in their practice. Freya did not necessarily explicitly follow The Code’s guidance to the letter because she was unable to prioritise all her patients, all of the time. The four pillars of The Code all begin with the word ‘prioritise’ making prioritisation a leading concept for The Code.

The juxtaposition of prioritisation and PCC was also produced in the data generated from field notes. Below is a reproduction of a nursing handover that I used during my data collection. The diagnoses and bed numbers have been anonymised and simplified, though the core data remains to illustrate this theme. The nursing handover showed six patients who I was nursing that day, all of whom I was attempting to care for in a person-centred way. However, each patient was uniquely situated in their sociomateriality i.e. their body, their health, their disease, the bed space, the proximity to the window, the proximity to the toilet, etc. Each patient was also uniquely situated in their perception of what was happening to them and I was also differently situated to the patients with regard to their experiences.

Table 4
This handover, alongside Freya’s diary entry and my experience of working as a nurse at the time, makes the competing priorities of nurse work perceptible. For example, on the day in question, I spent a lot of time with the patient who had loose stools because they had an urgent need of care. This meant that I could not attend to the patient who was new to dialysis in the way that I would have liked to. I noted that I felt guilty that I had not spent some time with that patient to discuss their diet and fluid restrictions, and to go through the hospital menu with them to discuss their dietary options. Nevertheless, I did not have time because the single rooms (3 and 4) needed to be prioritised. In this process of prioritisation, there was implicit and explicit de-prioritisation of patients, tasks and roles that I judged less urgent.

### 6.3 De-prioritisation

The Code addresses the prioritisation of care, but not the de-prioritisation of care. However, prioritising some care, conversely means other care will be deprioritised. It is unclear how nurses navigate these parallel and sometimes conflicting needs. This becomes another mechanism that produces the Vitruvian Nurse because, as shown in the data above, the de-prioritisation of some tasks is essential so that other care can be prioritised (see Section 5.5.3). The de-prioritisation of care is not a permanent state, but a contemporaneous
and negotiated one. Participants responded affectively to situations where they perceived that they prioritised some care while deprioritising other. Multiple participants responded with sadness or negative affectivities when describing deprioritising, deferring or adjourning the care they perceived as necessary.

Amelia

“…sometimes just admit when you’re a bit, you’ve got a bit too much on and you need help, ‘cause otherwise things could get a bit out-of-hand and you could end up leaving a whole host of things that really actually need to get done. So I think yeah, you have to speak up…like… if you have a sicky [patient] and all the others [patients] want something then what can you do? You have to say no…”

(Amelia, nurse participant, interview)

Amelia described how delegation and teamwork are part of her practice and how she perceived delegation and a team effort as essential to her practice. Amelia alluded to high workloads where she felt that the work exceeds what she is able to do, yet also described the act of asking for help or delegating care as an ‘admission’. This implied that, at some point, Amelia felt an expectation that she should be able to manage this workload alone. She also described her processes of prioritisation by acknowledging that some tasks are more important than others and ‘really…need to get done’. The nurse work that she prioritised is nursing the sickest patient and she deprioritised the ‘wants’ of other patients. Although Amelia felt able to ask the wider team for help, this is not a universal perception. Aria described the challenges of negotiating the priorities of care with the wider team:

Aria

“…I just feel like the haematology doctors didn’t really back me up either. They just…they gave her a bottle…to go home with and they just said [sniffs], in the notes, was [rustling] refused analgesia without talking [breaks down weeping] to me first…it’s like they don’t take it seriously…”

(Aria, nurse participant, interview)

Aria discussed a situation that she found challenging. Aria felt that she was prioritising PCC because of the complex needs of the patient, in this case managing the patient’s pain, but she was not supported by the medical team. Aria was upset because she wanted the patient’s pain to be addressed appropriately and because she did not feel supported by her colleagues in providing PCC. She felt ignored and that her efforts to
provide care in the way she should, were not being prioritised. Aria was emotional when she
describes the tension between her theoretical understanding of what should happen and
what happens in practice.

Participants described how they often still feel unprepared for their work and that this
led to anxiety. As in the example above, participants often described affective relationships
in their work.

_Ella_

“...And you’re just getting along and there’s another one, okay cool… Um, so like I
think I think you know at the beginning of the day whether it’s gonna be a busy day or
not and I think at the beginning of that day I kind of from handover you knew it was
going to be a busy day… Um…and I think as well with that day it was kind of like my
first day on with those patients. And the two sort of more complicated discharges that
we had, kind of nothing had been done for them the day before, so it was all like well
is there transport? Making sure the package of care was starting and they knew they
were going home, all that kind of stuff…So it was kind of you felt as though you were
being pulled in like five directions at once. Like you’ve got like people whose clinical
needs like dialysis who need a lot of attention, you need to be really careful…Again
with blood transfusions like obviously you need to like…”

_Jamie_

“...Mmm...”

_Ella_

“...You need to concentrate so much on them but at the same time you’re trying to
make sure that you’re like safely discharging someone home, two people home…and
it’s a lot… sometimes I know what to do but I don’t know what to do...”

(Ella, nurse participant, interview)

In this longer excerpt, Ella described her experience of her practice. She described
institutional and organisational challenges that she perceived towards practising as a nurse
to meet the high workload and the acuity of the ward area. She also described that this
sometimes makes her feel like she is unsure about her practice because she feels
unprepared to meet the multiple demands on her as a nurse. She described how her
knowledge, skills and body are required in several places at the same time and that she
feels that she must find a way to navigate how to prioritise, yet continue to perform in line with The Code and PCC.

Ella felt unprepared and overwhelmed by her perception of the demands placed on her by the environment. This scenario could describe a situation which is more related to the organisation of the ward area and the health system, nevertheless, it suggests that Ella did not feel prepared or able to express that this workload was too much for her and this was making her feel overwhelmed. She does not say if she reported this feeling to the person in charge of the ward that day and was able to change her workload allocation, however, from field notes, experiences and other participant interviews, this experience was common. Ella did not feel able or prepared to reallocate or deprioritise her work.

The stories of navigating and managing multiple demands are also discussed in interviews with other participants. As Ella described, there were multiple people and situations happening close together that she felt that she needed to prioritise. The Code creates an idealised version of how you should prioritise each of these things. In the context of this analysis, the tension between the nurse as an autonomous practitioner and the guiding principles of The Code is problematised. While The Code encourages nurses to make decisions based on their knowledge and interpretation of the situation, this ideal is often difficult to achieve in practice. When these two ideals are juxtaposed, a tension arises that highlights the challenges faced by nurses in balancing their professional responsibilities with the demands and constraints of the healthcare context. The rigidity of the description of the ideal nurse may not provide room for deprioritisation creating the possibility of a nurse becoming self-sacrificial to try and achieve the idealised version of nursing set out in The Code.

6.4 Becoming entangled in the profession

The value of practical experiences in nursing and nursing education was a theme within the participant data. Participants discussed their experiences with student nurses working with them on the ward during their clinical placements. All participants discussed what they learned as students and how they experience current student nurses as well as how what is taught in nursing education differs from what they experience in nursing practice. For example:

Amelia
“...like once you qualify you do a lot of things and you kind of have to teach yourself a bit...it’s a bit like learning to drive... you learn the basics how to be safe and then when you start to drive... then you learn how to be on the road...”

(Amelia, nurse participant, interview)

Amelia identified that there is a difference between the theory she was taught and her practice on the ward. She implied that she expected what she was taught at university to prepare her for nursing practice, but this was not comprehensively the case. She made a comparison to driving a car, as another theoretical and practical skill that also requires a license like nursing. Her tone implied that this gap between theory and practice is to be expected. Nevertheless, she made this statement with the benefit of hindsight because she was working as a registered nurse and therefore may have felt differently before she started or during her nurse education. She goes on to discuss her perceptions of some nursing students:

Amelia

“...they [student nurses] can just be a bit...kind of you ask them to do...like something... some of them can be a wee bit like [mimics a sigh]... do you know like?”

(Amelia, nurse participant, interview)

Amelia implied here that the students sometimes appear disengaged from the realities of nursing. The longer gaps between her words suggest that she may not know how to accurately describe to me what she means or that she has not yet fully formulated what she wants to say and is still working through how to say it. Nevertheless, Amelia described a tension between the theoretical expectations of nursing and the practical applications of it. The tension and possible gap between theory and practice is also picked up by Sophie during her interview. She discussed her recent experience working with student nurses and how she perceived them to have different expectations to their experience in practice.

Sophie

“...and it’s kind of like why do you think you are here? Like you know, like this is the way of the world! This is what the job is...”

(Sophie, nurse participant, interview)
Sophie was discussing a final year student nurse who she had recently mentored in practice. She found the student to be very engaged and smart but less willing to get involved in the more practical sides of nursing which Sophie perceived as nurse work. Sophie had been surprised by this because the student was at an advanced stage in their education and would soon be a registered nurse. This could suggest several things: first, Sophie may have a particular view of nursing that differs from what is taught in nursing education; second, the student may have had placement experiences that differed greatly from the nursing on the ward or third, that the student’s expectations of nursing were different from that of nurse work. It is likely that a mixture of this reasoning produced Sophie’s perspective.

Jack shared his experience of feeling that a nursing student he had worked with had ideas about nursing that did not align with the experience of nurse work:

*Jack*

“…they [student nurses] have to realise that actually it’s not all about what you get taught at uni and all the theoretical stuff that you kind of like have to do…”

(Jack, nurse participant, interview)

The theoretical aspects of nursing were also addressed by Rebecca when she considers nurse education and the realities of her practice. She perceives that there is often a gap between theory and practice in nursing. While nursing theories provided a framework for understanding the principles and concepts of nursing, they did not always directly translate into real-world practice.

*Rebecca*

“…I don’t think you’ll actually learn care, I don’t think you can get taught care care…it’s more like you get taught an idea of what care could be and then you make it up as you go…”

*Jamie*

“…do you think you can teach care?…”

*Rebecca*

“…I don’t know… I don’t think so… you can teach people what might happen and some expectations… but I don’t know how you can teach people to be ready for anything...”
Rebecca described how she perceived a gap between theory and practice by saying that she appreciated the challenges in teaching care. She described how she approaches care as an ongoing and situated practice that is responsive to the environment, much like when Amelia compared becoming a registered nurse to passing your driving test. She describes care in a relational way in that it is responsive to the environment, that it is in some sense planned yet, simultaneously inherently impossible to plan.

6.5 Lack of confidence

Eight of the participants spoke about how they sometimes lacked confidence in their practice. Jack had worked as a nurse for 6 years at the time of being interviewed. In his interview, he talked about a situation in which he recognised an issue on the ward and had tried to make the patient and the medical team aware of the problem.

Jack

“…Um, and I find myself to be too soft sometimes and I don’t really feel like I should be like that anymore… it’s like no one is listening to me [patients]… So, like, as a nurse we should push harder I think sometimes…”

(Jack, nurse participant, interview)

In this excerpt, Jack didn’t feel like he is being listened to by the patient. Jack went on to contextualise this and explained how he had completed several dialysis treatments for a patient and that the dialysis line had been problematic. He had told the patient that he would need to inform the doctors so that the line could be sorted out for discharge. The patient was frustrated at being in hospital and wanted to go home. Jack had explained to the patient at length and over several days that the quickest way to get home would be with a properly functioning line. Jack had informed the medical team several times and also asked the nurse in charge to highlight this issue. On ward rounds, the patient had told the doctors that the dialysis treatment had been completed without any problems and that the machine had not alarmed. The doctors had recognised the patients desire to go home and expedited this process without sorting the problematic line. Three days after the patient was discharged, they called an emergency ambulance and had to be re-admitted to hospital with complications of inadequate dialysis. Jack was frustrated by this and, as quoted above, he
did not feel as though anyone had listened to him. In conversation with Jack, he acknowledged that he supported the patient’s agency and that patient-centred care meant that he supported the patient’s choice to go home as quickly as possible. Jack’s frustration came from not feeling like he was listened to or involved in supporting the patient’s choice to go home as quickly as possible. From Jack’s perspective the most effective way to do this would have been to address the problems with the line and only then discharge the patient.

Many factors may have led to the problematic dialysis line not being addressed before discharge: there may have been a plan to replace the line soon that Jack was unaware of, there may have been a conversation between the patient and the doctors about the associated risks and the patient chose to go home anyway or the doctors may not have understood the concerns about the line. Jack’s underlying frustration came from feeling like no one involved in the care listened to him. This meant that Jack felt his voice was not heard and that his agency and knowledge of the situation were less valuable than others. On reflection, Jack acknowledged that he wants to try and be more assertive, yet at the same time felt restricted or diminished in his own agency and feels less confident in his abilities as a nurse. This could be another example of self-sacrifice as discussed at the end of Chapter 5. Jack noted that, as he learns more on the job, he should be more assertive and make his voice heard.

Rebecca shared a similar observation in her interview when she described the process of transition from newly qualified nurse to a more experienced nurse and what that meant to her.

Rebecca

“…like as a newly qualified, you’re just trying to, kind of, stay afloat and a lot of that kind of goes out the window and you’re just trying to get your jobs done and you, kind of, maybe avoid relatives a bit more. And then as you get your confidence and stuff up, you have more confidence to go and speak to relatives before they come to you with their concerns…but I still don’t know if I should, I kind of made it up myself…”

(Rebecca, nurse participant, interview)

Rebecca appeared to build confidence in her practice as she becomes more experienced. She talks about how confidence in her decisions and practice are important to her because it makes her feel more effective in doing her job by implying that she now ‘avoids relatives’ less than she used to. This also speaks to the larger theme of this section concerning the potential gap between theory and practice, but in a more pragmatic way.
because Rebecca insinuates that she expected her confidence to grow as she became more experienced. Nevertheless, Rebecca still felt that her confidence is built upon her experiences rather than a framework of nursing that she was taught or learned.

Freya also discussed her lack of confidence in some situations. She considered herself a newly qualified nurse and had been working as a nurse for two years. Freya discussed one of the experiences from her diary where she had described a particularly frustrating day. She had looked after a patient who was dying and whose symptoms were not well controlled. She had been speaking to the palliative care specialist nurses and the medical team to address these issues.

*Freya*

“...I was finding it difficult to kind of be assertive, in a way, because when you, you’re not confident, it’s difficult to be assertive...”

(Freya, nurse participant, interview)

Freya had spent a large part of her shift with the patient and their family caring for them. She felt that she had effectively and affectively communicated the patient’s physical condition to the medical team and that the patient required a change in strategy in addressing their symptoms of pain, sickness and agitation. The medical team had reviewed the patient at her request and made minor changes to the treatment plan but in Freya’s opinion these had not changed the patients’ symptoms. Despite being at the bedside for prolonged periods, she did not feel that her voice was being heard or that her perspective as the bedside nurse was being listened to. When Freya was discussing this, she focused on how she felt she could approach a situation like this in the future and reflected on how to be more assertive. She felt that she had the knowledge of what needed to happen in the situation because she had cared for many patients at the end of their lives when she had a three-month placement in a hospice. From Freya’s perspective there was a barrier between theory and practice, and her knowledge, opinion and experience of the patient’s condition at the bedside were devalued. This imposed barrier made her feel less confident about herself and her practice. This barrier was one of perception because no one told Freya not to have these experiences or do this work, people just didn't listen to her.

Participants also related their confidence with assertiveness. Confidence and assertiveness were both discussed in the context of having the confidence to practice how

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8 The process of nurses developing from novice to expert is discussed extensively in nurse literature, beginning with Benner (1983).
participants had imagined and be able to assert themselves in situations to make their intended ways of practicing possible. Ava discussed assertiveness during her interview whilst relating a similar clinical situation. She was caring for a patient with complex ongoing social care needs who was due to be discharged. She has spent a significant amount of time during her shift arranging the discharge and had been in contact with the home care providers, the transport company, the community pharmacy and the patient’s family. Like Freya, Rebecca and Jack she felt that at times her voice was not being heard.

Ava

“...I think that it’s actually, that’s definitely not my strong point, being assertive. Um, even though I do my best, I think sometimes me being assertive can seem a little bit snippy...”

(Ava, nurse participant, interview)

Ava conflates being ‘snippy’ with being assertive. Ava has negative connotations about being assertive and this reduces the space for her to be assertive because she is not confident that it is part of nurse work. In the context of this chapter, this is again suggestive of the self-sacrifice of the nurses because the perception of The Code is of an idealised subservient nurse who should be “…putting the needs of those receiving their care or service first…” (NMC, 2018, p22). This suggests that nurses cannot exercise their own agency or occupy a position that is contradictory while still promoting person centred care because they feel negative or like there is not a place for their perspective over that of the patients or doctors. On the other hand, participants spoke about how their agency and proficiency develops over time.

Jessica

‘...er...So this is memo number four and it is the sixth of November. I am feeling fine... I have no complaints. This is my last night shift and it has been my first official shift when I have been fully in charge.... I've been - not going to lie - pretty terrified for... probably up until about 2:00 AM. But then my nerves kind of calm down and I thought you know I can do this, stop being such a fanny...erm... So yeah my night shift went absolutely fine. The best part of it was realising that I can and I am capable of being in charge and I just need to get over that and just stop being such a stress head... So it was quite nice to actually finish a shift and actually said Oh I can do this. And the most challenging part was...erm... I don't think there was anything
particularly challenging on my night shift… I think with it being night three I was in a bit of a routine now…so yeah, good shift and all…”

(Jessica, nurse participant, voice note, multimedia diary)

Jessica’s diary entry adds further texture and understanding to the concept of agency for nurses. Jessica was working a night shift and was in charge i.e. in a role assigned to a nurse on each shift which makes them the coordinator of the ward area and shift leader of the nursing team. The nurse in charge is responsible for staff allocation on that shift, ensuring the running of the ward and being the point of contact for the site management. The nurse in charge is traditionally a nurse with some experience and, in this clinical area, being in charge was viewed as a post-registration competency. Jessica describes her feelings of stress of being in charge on this shift and that the role added pressure to her work. She proposes a lack of confidence in being able to carry out the role causing her stress, however, she reflects on this as a process and that she is capable of being in charge of the ward on a night shift. Jessica suggests that the more confidence she has in her own capabilities, the less stressed and the more capable she feels. In this diary entry, Jessica implies that, the greater her confidence in her autonomy to be the nurse in charge and in her own abilities, the better she feels. Nevertheless, it is unclear why Jessica did not feel confident to start with.

6.5.1 ‘Autonomous practitioners’

The ecology of theory and practice is further evidenced by participants describing their capacity to be autonomous practitioners. Confidence is an important factor in a nurse’s ability to function as an autonomous practitioner and to make independent decisions based on their professional judgment and scope of practice. Confidence is important because it allows a nurse to trust their own abilities and knowledge, which is necessary when making autonomous decisions. Sophie and Lily both described how they felt uncomfortable when they tried to be autonomous practitioners:

Sophie

“…Obviously, not copy what everybody does because some people can't be nice and sugar and sweet and some people can, some people can't be hard, some people can, but take that… What you can of that [The Code] and try and put them in your
own personality, else you get lost and you drown. Um, also, I think you learn it, family, ah, like, what you’re brought up with, it’s your own ethics…”

(Sophie, nurse participant, interview)

Sophie describes how she interprets her practice of The Code using her own ethics. To contextualise: Sophie was discussing her colleagues’ efforts to deliver PCC. Sophie’s tone is sceptical of PCC. Sophie is a more experienced nurse and is describing how she uses The Code as an entry point to her practice, however, The Code is interpreted by each person differently. Sophie implies that this is essential to working as a nurse because otherwise you would ‘drown’. This sentiment is shared by Lily:

Lily
‘…I’m a bit of a pushover but I think it just comes with, like, experience…”

(Lily, nurse participant, voice note, multimedia diary)

Lily describes how she has learned to make her position more perceptible so that she does not feel minimised in work situations. Experience has made her feel more confident in doing this, but Lily could also be describing how she has implicitly learned to prioritise (in The Code) and deprioritise (not in The Code) as she has become a more experienced nurse.

The process of moving from novice to expert and becoming entangled in the regulatory frameworks of nursing was described frequently. Participants often described how concepts they perceived as fundamental to nursing, such as PCC, were learned through sociomaterial experiences of nursing. However, the gap between how nursing is represented in this of interpretation between regulatory frameworks and their experiences of practice. The tensions between The Code and practice produced uncomfortable feelings and affective charged realities, in which some participants felt dissatisfied or burned out.

6.6 Burnout

The current section presents data concerning burnout, a condition that characterises the chronic manifestations of adverse outcomes arising from stressful circumstances. The study participants reported instances of negative affect, which are indicative of burnout given their prevalence across an extended timeframe. Burnout is distinguished from occasional job dissatisfaction caused by environmental pressures that impede the completion of tasks at the expected level. Rather, it denotes a prolonged state of diminished work performance and well-being. Participants were also familiar and conversant with the notion and risks of burnout, and subsequently used the concept to describe their experiences. In this section I
will discuss the concept of burnout in nursing, how this is described by participants in the data. The theme of burnout is discussed in the context of how it supports the tensions identified between The Code and nurse work.

The concept of burnout is well documented as a narrative in contemporary Western European and North American healthcare systems (Sinclair et al., 2017). It is not unexpected for burnout to be highlighted as a theme by everyone. In healthcare literature burnout is described as a loss of enthusiasm for work, a low sense of personal accomplishment or cynicism (Maslach et al., 1996). This was further explored by Kamal et al. (2020) who described how burnout may precipitate in healthcare settings as emotional exhaustion or depersonalisation.

### 6.6.1 The guilt

In the interview data, burnout is characterised by feelings of guilt or negative self-perception, it is also often described as tiredness or physical exhaustion. An example, from Ella’s interview in which she described her first role as a registered nurse on a general surgical ward at the same hospital she works at now. She described the previous ward as a busy place where she felt her work was never complete and she could never finish the tasks she was set.

_Ella_

“...I was away doing other things which I was like, I just felt really guilty that I wasn’t able to kind of, I didn’t feel that I could give them [the patients] the time that they needed and I just felt really bad…”

(Ella, nurse participant, interview)

Ella described how she felt guilty and had a negative perception of her work because, in the scenario described, she felt unable to meet patient needs. Ella does not say which care needs she felt are not being met or who created the definitions she measures her acts of care against; Ella talked about not having the time to care, which she interprets as fundamental to her capacity to care. She also did not say how she measures care which is itself an under-researched and notoriously difficult thing to do (Feo and Kitson, 2016). Instead, she alluded to our mutual understanding of concepts of care – i.e. that it is impossible to have enough time to care for everyone. This is shared because we both worked in the same environment, did the same job, at the same time. Her ideas of what nurse work is, not only shape how she does her job, but also how she feels about it before,
during and after work. Amelia also described these feelings in her diary, later repeating them during her interview:

Amelia

“...I know I said I’m worrying about families but sometimes like, for example, a palliative patient and their family comes to you and they’re really appreciative. And they say thank you so much, you’ve made my loved one so comfortable and you’ve… Yeah, it makes you feel valued and yeah…”

Jamie

“...Mm-hmm. Do you feel valued the rest of the time?...”

Amelia

“...Um, a lot of the time… Sometimes I do but sometimes I don’t. Sometimes when it’s just, like, so busy and you go away thinking oh, I haven’t done enough today. Um, but yes, sometimes I do. [Laughs]....”

(Amelia, nurse participant, interview)

Amelia described similar feelings to Ella’s. She implied that there is not enough time to care the way she would like to and that her capacity to care is reduced as a result. A tension is created between Amelia’s intentions of care, her capacity to care and the material realities of care. She said that sometimes when she has finished her shift, she feels like she has not done enough or achieved what she feels she should have. When I listened to these audio recordings, I noticed that Amelia discussed this topic in a much lighter tone than Ella. However, both discussed this point as a feeling and experience integral to their work.

Ella and Amelia described the affective consequences of their material practice. The affective consequences are the negative perception of their work and a persisting feeling that they should have achieved more. Nevertheless, there is some assumed knowledge in these excerpts: to whom do Ella and Amelia feel responsible for care needs that are not being met, who defines the needs that they feel they need to meet and how do they measure their performance regarding meeting these needs? Given the context, the responsibilities and definitions of care are lodged with the patient, the hospital and ward culture and The Code. The feeling of not providing enough care is a persistent feeling for Ella and Amelia and other participants also mentioned it.
6.6.2 ‘the shitshow’

Feelings of burnout were described by other participants and directly impact patients and staff, as detailed by Charlotte and Jack. The latter two had both been involved in caring for the same patient during an episode of acute illness, however, Charlotte more directly. They both documented a particular event from a night shift and went on to discuss this during their interviews. Based on this event, Charlotte described how she felt about the expectations of her nursing work and the emotional connections she has with The Code, the hospital, her patients and her colleagues.

At this hospital, like many large hospitals in the UK, night time medical cover is allocated by a central hub (McQuillan et al., 2014). The system is often called ‘Hospital at Night’ (HAN) and it is designed to efficiently allocate and distribute doctors and nurse practitioners to the appropriate patient workload, and improve patient outcomes (Beckett et al., 2009). This means that on most wards, nurses with concerns about a patient or who require a medical review of a patient have to call HAN. At this hospital HAN can only be contacted by telephone and the person answering is usually an Advanced Nurse Practitioner (ANP). The ANP will ask details about the patient you are concerned about and triage them over the phone so that they can decide if they think the patient should be reviewed, and, if so, how quickly and by which doctor looking at the skill mix and grade of staff covering the hospital that particular night. If convinced of the necessity, the triaging ANP will then ask the appropriate member of staff to go and review the patient. This system works well at creating efficiencies in healthcare provision, as fewer physicians are required overnight which leads to lower overall staffing costs and fewer junior doctors overall on night shifts as well as more doctors available for day shifts. This also works well when measuring patient outcomes when it comes to how quickly a deteriorating patient can be identified, allowing their medical care to be escalated.

In his diary, Jack describes his communication with Charlotte about the incident that had happened. Jack recounts that a patient who had been on the ward for several weeks, had become unwell overnight. Jack had not been working that shift, but had looked after the patient and he had heard about the turn for the worse from several people on the ward. Charlotte, in particular, had spoken to him about it. I will first explore Charlotte’s perspective and then how Jack perceived this event. Charlotte had been on shift when the patient became unwell and she had also been in charge of the ward overnight. I discussed this with her during her interview:

Charlotte
“…It was a feckin shitshow Jamie. Naebody had made any decisions, and the woman was turnin’ blue and gasping for breath in front of me (deep breath, pause)…”

Jamie
“…bloody hell...had (over talking)…”

Charlotte
“…and I had 1590 screaming at me on the phone trying to give me patients from downstairs…the F2 that was on lates was good bless ‘em - but useless…”

(Charlotte, nurse participant, interview)

Charlotte describes the situation vividly and frantically. During the oral description of the event her voice wavered, indicating that talking about it upset her, but also that she is keen to talk about it. Her speed and cadence denote anxiety, accompanied by an erratic speech pattern which did not follow turn taking or expected social norms. In the example above, Charlotte talks over me. Charlotte recorded this event in her diary by drawing a picture, see Image 3. She described how she felt unable to write about the event so close to its occurrence. She had wanted to record a voice memo about it, but worried someone might hear it, thereby getting her into trouble if it was heard out of context. During the interview process, I affirmed Charlotte’s consent and reminded her that her participation is voluntary. Charlotte confirmed her consent and told me that she was incredibly thankful to be able to speak about the event and wanted the event to be part of the research.
In the example she refers to the site coordinator by their pager number ('1590') and the doctor attending the patient, by their grade ('F2', which denotes Foundation Year 2 or second year in practice after leaving university). The 'decisions' that had not been made refer to the more senior medical team who had seen the patient during the day. Charlotte perceived the leader of that team as having overall responsibility for the patient.

Charlotte's description of the events reveal how she was juggling and navigating that evening because this was a focusing event for her. She described some of the expectations being placed on her at the time and how she navigated and prioritised them. Charlotte characterises her work as heterogeneous and hectic when she perceived she had many responsibilities, but it was unclear which of those were expected of her. Charlotte sent the image above (Image 3) as part of her video diary. The image depicts a ringing telephone and, when contextualised during her interview, denotes the hospital site coordinator calling while she and the doctor attend to the patient.

6.6.2.1 The telephone

An expectation of nurse work perceived by Charlotte was that she needed to communicate with the rest of the hospital. The telephone is a significant component of the diary entry for this day, as are the sound waves coming from the phone. The telephone was a particular form of stress for Charlotte in this situation. In addition to data provided in Charlotte's interview, the phone was a source of stress for her as the site manager continued to try to call her while she was attending to the unwell patient. Charlotte
emphasises the frequent use of the telephone when working to communicate with the HAN team and around the hospital. For Charlotte, the phone symbolised yet more expectations on her while she still attended to other pressing issues happening on the ward.

From a socio-material perspective, a telephone in a hospital can be seen as a technology that enables communication and coordination between healthcare professionals to enable the running of the hospital. It allows for the exchange of information and the sharing of knowledge facilitating the delivery of care and support. The telephone also serves as a tool for managing the flow of patients and resources within the hospital, enabling the allocation of resources and the coordination of care. It also enables healthcare professionals to respond quickly to emergencies and to provide timely support to patients in need. Furthermore, the telephone is embedded in a broader network of technologies, policies and practices that shape the hospital’s functioning - it is part of the infrastructure that supports the hospital's operations.

Charlotte described being very busy with a wide variety of tasks, so when the telephone rings it is disruptive and distracting. Additionally, answering the phone may require her to stop what she is doing and attend to the caller, which could add to her workload. Charlotte felt overwhelmed in prioritising her work on that night shift where she was attempting to prioritise her patient in the context of competing priorities elsewhere. Charlotte says that “…Naebody had made any decisions…”, referring to the medical team working during the day, alluding to the fact that the patient’s condition had require more senior medics to make decisions which might have avoided the extreme clinical condition of the patient.

Charlotte “…I was calling and they were fobbing me off…I know they are busy too…I take someone off dialysis in Room 16 when they called back so I had to call them back again but they were engaged…there were a million CDs (controlled drugs) that needed doing…pharmacy delivered a ton of boxes that needed unpacking…there were still visitors on the ward at 9pm…someone rang in sick for the next day and I didn’t know who I was gonna get to cover…”

(Charlotte, nurse participant, interview)

Charlotte described how she navigated the multiple expectations of her on that shift although she was unclear which of those were her responsibility. She was frustrated that skills such as answering the telephone and the subsequent labours, were prioritised over other things such as direct patient care. Charlotte was stressed by this event which
interfered with the imagined expectations of nursing and the realities of being able to do her work.

6.6.3 ‘Hold your own’

Charlotte provided further accounts of the night this focusing event happened. She described how she managed the situation. She drew attention to several interactions between colleagues, with a focus on the consequences of the interactions.

Jamie
“...so what happened?...”

Charlotte
“...well she went to HDU. The place she should've gone at 1 o'clock in the afternoon... not at 4 o'clock in the morning when it's me and the bairn looking after her all night...”

Jamie
“...sounds like quite a night...”

Charlotte
“...aye...we got everything settled in the end, but ‘a wish everyone would f'k off on a night shift...(pause)... ya dinnae know yae arse from ya elbow sometimes when everyone wants a piece... (pause) ya holdin' ya own, but then ya have to hold everyone else's as well...”

Jamie
“...and how do you feel now?...”

Charlotte
“...uff...I spoke to Kenny about it ‘cos I know him from the (name of a different hospital)... I feel better... I know that you can never see what’s coming and you get on with it but... when the day teams drop you in the shit, it really fucks me off...”

(Charlotte, nurse participant, interview)

She described the team and their interactions. First that between her and the doctor. Second with Kenny (a pseudonym) who is an experienced consultant physician she refers to
by his nickname. Third, the medical team who had seen the patient earlier that day. Each of
these communications were different and she does not focus on how these happened or
came about, but more on their consequences.

In describing the attending FY2 she referred to them as the ‘bairn’, suggesting their
younger age or perhaps short time in the job. In doing this she also alluded to the fact that,
as far as she was concerned, the amount of responsibility the FY2 had did not correspond to
their level of experience or how complicated or unwell the patient was. This communicates
that Charlotte may have felt more responsible than she was comfortable with and may have
understood herself to be the most experienced person in the situation.

She described a more senior physician – with whom she has since debriefed – by his
nickname ‘Kenny’. This demonstrates that they may be more experienced and familiar with
the ward or department and would support her reading of the attending doctor at the time of
her diary. This gave the impression that she felt that if Kenny thought the situation was OK,
then it was OK for her too. The medical team that saw the patient earlier in the day are
described less favourably. Charlotte expressed frustration at what she perceived to be their
inaction or lack of planning. This had serious implications and material consequences later in
the day. The thread that runs through these examples is that there are material
consequences of these encounters which Charlotte feels accountable for and responsible to
make happen and for the material consequences. This could also be said for her earlier
description of the event or her drawing of the ward in which she depicted herself in the
middle of the situation and later elaborated, feeling she was responsible. This links with the
tension identified in Section 5.5.2 that I discussed, where nurses are caught between
ultimately being responsible and accountable whilst also ensuring they don’t overstep the
boundaries of their practice.

Charlotte defined how she understood that it is her responsibility to ‘get things
sorted’. She described how she sees nursing partly as working with the unexpected and
indeterminate. She had expectations of her colleagues, such as the more senior physicians,
to make plans or provide frameworks for when things do not go according to the initial plan
or the best-case scenario, but says you ‘can never see what is coming’.

Charlotte described the competing priorities of the patient’s condition and her
perception of an absence of decision making earlier in the day (which might have charted
the patient’s course through the hospital differently) and the expectation that the hospital has
that new patients can be transferred to the ward and her relationship with and perception of
the skill of more junior doctors.

Charlotte felt like a large part of her work as a nurse was to facilitate these
communications and subsequent actions. She described how she felt competent to navigate
and juggle these priorities, however, she perceived that there was insufficient room to manoeuvre. She also described what constituted her view of care. She described a constellation of human/more-than-human/tangible/transgressive elements. These exist in a dynamic tension of power relations with competing priorities. She felt negatively about the situation because she didn’t have the physical and metaphorical space to do what she perceived as her work as a nurse. I suggest that these feelings of restriction contributed to the emotional exhaustion of burnout that she and Jack also described.

6.6.4 Jack’s perspective

Jack mentioned the same event Charlotte described in his diary and I asked him about it during his interview. He described how when he arrived for his day shift he had seen that his night shift colleagues had had a ‘tough shift’.

Jack
“...Heard about, yes, Charlotte said it was a bit of a tough shift…”

Jamie
“...Yes, me too…”

Jack
“...So I think she comes back to work this week…”

Jamie
“...Yeah?... she’s needed a rest, didn’t she?…”

Jack
“...Yes, I went up to meet her on Monday after, just to see how she was. Yes, it’s just told her she needs [unclear] and to do things outside the work which are not work, just to have an escape…”

(Jack, nurse participant, interview)
Jack told me that Charlotte had taken time off from work because of the incident. I had also found this out while on shift, the day before the interview. I wanted to maintain confidentiality and respect therefore acted with mild surprise when Jack told me.

Jack’s perspective supported Charlotte’s negative emotions during her interview and that – alongside the factual elements of her story – she was expressing the affective dimensions for her. These had produced emotional distress that meant she took some time off work.

6.7 Discussion

This chapter investigated the phenomenon of nurses lacking confidence in their work, as well as their struggles with deprioritisation and burnout. The findings from the participant data suggest that, although autonomy is a crucial aspect of nursing practice, it is a complex and multifaceted issue. Furthermore, it seems that the theoretical concepts and principles taught to nursing students do not always align with the realities and challenges faced by nurses in daily practice. This raises important questions about the potential gap between theory and practice in nursing education and training, and warrants further exploration into the underlying causes of this discrepancy. Building on Chapter 5, which discussed The Code as a boss text for nursing in the UK and that there is an idealised version of a nurse (Vitruvian Nurse), this section discussed the findings in context.

6.7.1 Autonomy, person-centred care and deprioritisation

The concept of nurse autonomy is closely tied to the idea of patient-centred care. Participants made their autonomy perceptible by describing situations in which they felt confident, assertive or heard. However, participants often reported tension between their ability to feel autonomous and to practice the way they felt they should. Autonomy for nurses may be restricted by self-sacrificial tropes and by the attempts to produce the Vitruvian Nurse. Autonomy for nurses refers to the ability of nurses to make independent decisions and act based on their knowledge, skills and expertise, without having to rely on the direction of doctors or other healthcare professionals. However, participants felt unable to do so on multiple occasions throughout the data collection period. Nurse autonomy is critical to providing person-centred care as it allows them to make independent decisions that are in the best interests of their patients. When nurses are empowered to make decisions based on their clinical judgment and expertise, they can tailor their care to meet the unique needs of each patient or situation.
Prominent in The Code (see Section 5.2), person-centred care is a healthcare approach that recognises and values the agency and autonomy of patients. This involves collaborating with patients to understand their needs and preferences, identifying treatment goals and agreeing on a course of action that is mutually acceptable. Person-centred care is reported to work best when decision making is collaborative and relationship based, when meanings are made together (Vassbø et al., 2019). Rider et al. (2014) explore the definitions of humanistic healthcare and the characteristics of person-centred care. They highlight that person-centred care engages with improving the lives of patients, teaching patients and colleagues, ongoing self-reflection on one’s practice and respectful, compassionate care that acknowledges the values, autonomy and cultural backgrounds of patients and their families. Lambert et al. (1997) have critiqued person-centred care as reductive, leading to a model of person-centred care that describes a more holistic type of care. Tieu et al. (2022) emphasise how person-centred care produces reductive relationships between patients and nurses, creating ‘a relationship that is antipaternalistic whereby the care provider is not an active participant in the care relationship and whereby the responsibility to make decisions about care rests primarily on the care recipient’ (Tieu et al., 2022, p.4).

When The Code instructs nurses to identify care priorities, this implies that other things must be deprioritised whilst also putting the needs of others first. Prioritising others before oneself puts extreme pressures on nurses as the text in The Code implies that others always come first, giving rise to allusions of sacrifice and martyrdom, as shown in the excerpt from The Code below:

**Figure 8**

*Section 25.1 of The Code*

To achieve this, you must:

25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first

The Code, NMC, 2018, p22

Moreover, the expectations outlined in Section 25.1 of The Code reinforce a neo-liberalised and individualist approach to the provision of nursing care. The approach outlined in The Code could be seen as problematic because it reduces both nurses and care
receivers to commodities, rather than recognising them as complex, dynamic and interconnected beings. Care is not a unidirectional transaction, but rather a reciprocal and co-constitutive process which both the nurse and the care receiver participate in. This approach recognises the importance of mutuality and interdependence in care relationships, and seeks to cultivate a sense of connection and responsibility between nurses and care receivers. Furthermore, a critical posthuman perspective would challenge the individualist assumptions of The Code, which focuses on the rights and responsibilities of the individual nurse and ignores the broader social, political and ecological context in which nursing takes place. Instead, it encourages nurses to consider the ways in which their practice is shaped by and contributes to larger systems of power and inequality. With regard to nursing students, it is important for nursing education to recognise and challenge these individualist and neo-liberal assumptions in The Code.

Despite The Code promoting nurses as ‘autonomous practitioners’ (NMC 2018), participants reported that their autonomy is restricted by the trope of self-sacrifice and the lack of confidence to practice how they would like to. The self-sacrificial concept of always putting others first may restrict nurse autonomy and is in tension with The Code which emphasises the autonomy of nurses. Despite autonomous practice being a fundamental part of The Code, nurses subordinate their agency in service to those in their care to try and live up to the idea of the idealised nurse (see Chapter 5). Uncritically prioritising person centred care elevates the wishes or needs of patients above all else, and that those wishes can be attended to by nurses regardless of other things happening (organisational, institutionally, with other patients, personally), including themselves.

Providing person-centred care can sometimes be challenging due to the presence of multiple individuals with varying needs in a given situation. In these cases, it may be necessary for nurses to prioritise certain individuals or situations, which may result in the deprioritisation of others. This decision-making process is not explicitly addressed in The Code, therefore some nurses experience feelings of guilt when they have to deprioritise individuals, tasks or situations. In these findings, PCC sometimes caused tension with the instructions of autonomy in The Code.

6.7.2 Gap between theory and practice

The participants perceived student nurses as not properly prepared for the realities of nurse work. Reflecting on their own experiences and how they perceived students, participants reported a gap between nursing education and clinical practice. There are several reasons why this may be the case. One reason is that nursing practice often involves dealing with complex, real-world situations that are difficult to anticipate and plan for. As a
result, nurses may find themselves in situations in which the theories and models they have learned do not fully apply or in which they need to adapt and improvise in order to provide effective care.

The findings from participant data indicate that, despite having a strong knowledge base and technical skills, nurses often lack confidence in their practice. This lack of confidence can manifest in different ways, such as hesitancy to perform certain tasks, reluctance to make independent decisions and lack of assertiveness in communicating with patients and other healthcare providers. Furthermore, the dynamic and complex nature of healthcare systems, with their multiple stakeholders and competing demands, can pose additional challenges and barriers to nurses' ability to practice how they would like. Given the reported disconnect between nursing education and the realities of practice, as well as the high prevalence of low confidence among nurses, it is reasonable to suggest that there may be a gap between the theory and practice of nursing.

6.7.3 Burnout

It is possible that nurses may be disappointed by their work because the expectations and ideals they were taught and promised during their nursing education do not align with the realities and challenges of the profession. At university and in professional regulatory frameworks, nursing students may be introduced to an idealised image of nursing and autonomy. Nurses are depicted as competent, compassionate and empowered to make independent decisions and take charge of their own practice. However, upon entering the workforce, nurses may encounter a different reality, in which they are confronted with various constraints, challenges and limitations that prevent them from fully exercising their autonomy and expertise.

The findings from this study provide insight into the issue of burnout among the nurse participants. Several participants described feelings aligned with key dimensions of burnout, including emotional exhaustion, depersonalization, and reduced personal accomplishment (Maslach et al., 1996). For example, Ella spoke of feeling "guilty" that she was unable to give patients "the time that they needed" due to overwhelming demands. Amelia also described persistent feelings of not having "done enough" on busy shifts. The guilt and inability to meet self-expectations expressed by Ella, Amelia, and others reflects the experience of reduced personal accomplishment associated with burnout.

Furthermore, Charlotte provided a vivid account of emotional exhaustion while managing a complex patient situation overnight. She described feeling overwhelmed
navigating multiple priorities and institutional constraints. Her frustration with the lack of support from daytime staff also indicates a cynical, detached attitude tending toward depersonalization. Charlotte took time off work following this incident, underscoring the severity of her burnout experience. Her case aligns with previous findings that heavy workloads, moral distress when unable to enact care values, and lack of support are key contributors to burnout among nurses (Dalmolin et al., 2014; Rushton et al., 2015).

Jack confirmed observing signs of burnout in Charlotte, whom he described as needing rest and respite after a "tough shift." His recommendation that she engage in non-work activities "to have an escape" accords with evidence that poor work-life balance exacerbates burnout (Nowrouzi et al., 2016). However, organizational strategies beyond the individual are likely needed to address the systemic factors enabling burnout to take root (Gómez-Urquiza et al., 2017). The disconnect described by multiple participants between nursing education and clinical realities suggests the idealized standards espoused early on are unrealistic, laying the foundation for later burnout. Resolving this theory-practice gap could help prevent burnout. The data in this chapter shows how burnout among nurses is often a result of the discrepancy between the idealised version of nursing work and the realities of the profession, leading nurses to believe that they must constantly strive for an impossible standard. This incongruence can lead to feelings of inadequacy and ultimately, burnout.

6.8 Summary

The data presented in this chapter illuminate the problematic nature of the idealised version of the nurse: the data presented in this chapter suggests that notion of the 'Vitruvian Nurse', an idealised version of a nurse, is unrealistic and cannot be achieved in practice. This chapter explored several interrelated challenges faced by nurses with regards to confidence, prioritisation of care, and burnout. A major theme that emerged was the gap between nursing education and clinical realities. Participants observed that student nurses often seemed unprepared for the complex, fast-paced demands of the job despite strong technical skills. This theory-practice gap appeared to stem from the fact that classroom learning could not fully replicate the real-world contexts nurses encountered. As a result, even knowledgeable new nurses frequently lacked confidence and assertiveness when entering practice.

Another key finding was that while regulatory codes and nursing philosophies emphasised patient-centred care, the material and institutional constraints of healthcare systems often made realising this ideal difficult. Participants described the challenges of balancing competing priorities and having to deprioritise some individuals or tasks when
unable to attend to all needs. This produced feelings of guilt and distress, as nurses could not always practice in line with their values. The mandated self-sacrificial mindset of always prioritising patients may further have prevented nurses from exercising autonomy or self-care, paradoxically undermining their capacity to provide quality care. These unresolved tensions appeared to be an underlying driver of the high levels of burnout reported. Participants detailed experiences of emotional exhaustion, depersonalisation, and reduced personal accomplishment resulting from excessive demands and perceived lack of support. The weight of unrealistic expectations coupled with the lack of confidence many nurses felt created significant risk of burnout. This had severe impacts on nurses, quality of care, and healthcare organisations.
Chapter 7: Ecologies of human, non-human and more-than-human bodies

One of the central concerns in this thesis is the examination of the ever evolving and often uncertain boundaries between what we consider to be human and non-human. This includes not only the relationship between humans and other living organisms, but also the relationship between humans and technology, and the ways in which these boundaries shape our understanding of ourselves and the world around us. In this chapter I explore these unclear boundaries through a critical posthuman lens, examining the ways in which they are constructed and reinforced, and considering the implications of these constructions for our understanding of ourselves and our place in the world. I discuss how the boundaries of being human are (re)configured with nursing and how these dynamic boundaries can be made perceptible through data. This chapter discusses the reconfiguration of liminal boundaries from the perspective of a patient, a nurse and the environment. Nurse work is shown as a sociomaterial practice in relation to the human, nonhuman and more-than-human materiality of the world.
Sub-themes and themes informing the ecology of the human, non-human and more-than-human
7.1 The dialysis machine

This section focuses on an analysis of dialysis machines in order to explore the ways in which it re-negotiates the boundary between the human and the non-human. This (re)configuration forces us to question the conventional definitions of what it means to be human and where the human experience begins and ends. By disrupting the strict dichotomy between the human and the non-human, the dialysis machine offers a new perspective on the interconnectedness of matter and the ways in which the environment and the human body are constantly in relation to one another.

Image 5
A representation of a nurse performing dialysis treatment

7.2 Haemodialysis on the renal ward

This is an image of Rebecca, a nurse who participated in this project, preparing a haemodialysis machine for use. This machine is designed as a therapy that partially replaces the function of someone’s kidneys when they do not function sufficiently. The machine takes the blood from the patient’s body, passes it through a filtration system which
removes toxic molecules and excess fluid which have accumulated, then returns it to the patient. The study site was a renal ward and this therapy was commonplace. Nursing staff on this ward receive training and education on how to safely operate the dialysis machine. A standard dialysis prescription would be four hours of therapy, three times a week. Without this therapy a patient is expected to die around 10 days after their last treatment.

Rebecca is in a single occupancy side room, just off the main ward where she is preparing a haemodialysis machine for use. The machine’s screen indicates that it is attached to water and acid sources which are piped from the walls of the hospital. The machine is in the process of mixing these two, in order to rinse the machine’s lines and create an appropriate dialysate so the patient can receive dialysis. New, sterile lines and filters (also known as a dialysers or ‘kidneys’) are unpacked and attached to the machine for every patient. Rebecca is preparing the equipment which will access the patients’ bloodstream and connect them to the dialysis machine’s tubing circuit. Rebecca is preparing dialysis needles which indicate that the patient she is attending has an arteriovenous fistula (AVF). An AVF is formed during minor surgery, where an artery is tied to a vein usually in a patient’s arm. The new flow of blood through the artery into the vein causes the vein to become wider and the walls of the vein to become thicker; these thicker and wider walls can then have a large bore needle inserted into them repeatedly. An AVF is the preferred mode of accessing the bloodstream in a long-term renal patient (Daugirdas et al., 2014) because it reduces the risk of systemic infection from nosocomial bacteria and allows for higher pump speeds, so more blood can be processed and washed during each dialysis session.

Rebecca is also wearing standard PPE to protect her from things such as blood splashes and other bits of the patient which may be infectious to her. Dialysis patients are at higher risk of getting blood borne viruses (Garthwaite et al. 2019).

Rebecca is a senior nurse on the ward and is an experienced nurse. During the dialysis treatment, the blood circulating through the dialysis machine began to clot more quickly than anticipated. Rebecca had administered a dose of medication designed to coat the inside of the dialyser as well as enter the patient’s bloodstream to stop their blood clotting during the procedure. The drug’s dosage was intended to be sufficient to stop blood clotting, but not so high that it posed an increased risk of internal bleeding to the patient during or after the haemodialysis treatment. During the patient’s treatment, the machine began to sound alarms that pressure was increasing in the dialyser chamber and in the dialysis line that leads back to the patient. Rebecca and I are both experienced haemodialysis nurses and know that this is often a sign that blood is beginning to clot in the circuit. As the alarm sounded, we began a familiar routine of one nurse checking the patient
was not becoming unwell by performing a physical assessment and the second nurse administering boluses of saline to the dialysis circuit to try to flush the circuit. This routine was repeated three times. When the fourth alarm sounded, the pressure gauge went to maximum and we saw the colour of the blood in the lines turn from bright red to a deep reddish-black. This colour change signals a cascade of clotting has happened and the whole circuit has now clotted.

This is an unfortunate and uncommon event, however, it is common enough for Rebecca and me to know instinctively how to proceed. I disconnected the lines from the needles, aspirated the needles to remove any clots that may have entered the needles and flushed the needles with fresh saline. Rebecca removed the lines from the dialysis machine (full of the patient’s clotted blood) and put them in the clinical waste bin and began to put a fresh set of lines on the machine. When full of blood, the lines contain around 9% of a person’s circulating blood volume depending on their physical size (Thijissen, 2013). After a circuit of blood is lost, it is procedure to take a blood test to check the patient’s blood count hasn’t fallen too low and to monitor their blood pressure more closely.

7.3 The liminal boundaries of the human

This example provides several entry points for discussing the human as a bounded individual. Using a posthuman lens the thresholds between the human and non-human become a point of enquiry, particularly in the context of the loss of a circuit of blood, which is a common dialysis event with around 50% of treatments experiencing some form of clotting and approximately 11% being severe (Rennke, 2014).

On average, a patient receiving intermittent haemodialysis 3 times per week, would expect to lose at least one circuit of blood per year. If clots occur in a circuit, the blood cannot be returned to the patient, nor can it be used in any other way and therefore standard practice is to discard the tubing from the circuit and put it in the clinical waste bin. Staff become aware the circuit is clotting when the colour of the blood becomes dark red, turning to almost black when it is very clotted and congealed. The nurse and patient can also tell the blood is clotting in the circuit, because the dialysis machine sounds a warning that pressure within the machine is rising. The alarms consist of loud ‘bongs’ that the staff on the ward describe as a ‘language’, as the variety of sounds intermix. The dialysis machine’s language creates an affective soundscape in the area; the sounds shape how people interact with the area. Rebecca describes a successful dialysis treatment as starting with ‘friendly’ chimes as the machine recognises the blood, whereas a problematic treatment produces frequent and deeper tones that ‘resonate through the hallways’ of the ward to alert the area that all is not going to plan. She goes on to describe the characteristics of the warning tones:
Rebecca

“…sometimes you can hear them from the break room. They are not always bad, but you get to know what they mean by how often they are going off, what they sound like or if someone is cancelling the alarm halfway through… you know someone is there then…”

(Rebecca, nurse participant, interview)

The warning tones of the dialysis machine indicate that the treatment is not going as planned. The nurse's body becomes an affective assemblage of matter that includes the sounds, smells and the relationality of their bounded selves. As they listen for the warning tones, nurse work becomes a way of navigating the boundaries and materialities of their patient's treatment. Rebecca and the patient are also an affective assemblage of matter that is implicated in the materiality of the environment. The nurse and the dialysis machine are always connected and nurse work could be described as navigating these socio-materialities.

The image of Rebecca highlights the use of PPE as a means of reinforcing the boundary between the nurse and the patient, as well as the environment in which care is provided. The purpose of PPE is to reduce the risk of infection by preventing the transmission of potentially harmful microorganisms. By wearing PPE, Rebecca is able to prioritise the well-being and ongoingness of both herself and the patient, while also acknowledging the dynamic and co-constitutive relationship between human and nonhuman entities. In this particular context, the use of PPE serves as a reminder that the body is not a static entity, but rather a site of ongoing negotiation and interaction between the self and the other. This is exemplified by the potential for Rebecca to be splashed with blood from the patient and the resultant risk of infection. PPE functions as a tool for managing and navigating these materialities, ultimately privileging human life over the potential for new forms of embodiment.

Additionally, the image also suggests the complexity of the relationships between humans and nonhumans within the healthcare setting. The presence of the dialysis machine, for example, highlights the dynamic and interdependent nature of care work, with both human and nonhuman actors playing integral roles in the provision of healthcare. Understanding these relationships and the negotiation of boundaries between the self and
the other expands our understanding of what it means to be a body and the ways in which bodies exist in the world.

7.3.1 Threshold of patient and ward

During dialysis, the physical boundaries of the human body are not clearly defined. Blood leaves the body and becomes entangled with a machine, before being returned to the body. At this point, it is only through the context of the patient's situation that we can recognise the blood as belonging to that person. In other words, the point at which the blood becomes unrecognizable as belonging to the patient is contingent on the specific context of the dialysis procedure.

When the dialysis machine switches from precirculation mode to treatment mode, it automatically shines a light through one of the last parts of the circuit to detect how much blood is in the lines. If the amount is at 50%, the machine will start the treatment timer. This is a pre-programmed way of indicating that a significant amount of patient blood has left their body and will shortly be returned, and that treatment has started. The boundary of when 'enough' blood has left the body for treatment to start is somewhat arbitrary. However, the dialysis machine has been pre-programmed to make the decision of when enough 'human', or a component of human (i.e. blood), has left the patient's body i.e. a decision made about what is considered the patient's boundary. The matter that comes to matter (Barad, 2004) is perceptible through the decision of where the patient starts and ends, and supports the assertion that all matter does not matter in the same way. In other words, the boundary of the human and non-human can be subjective, and the extracorporeal circuit of blood expands the understanding of what a liminal human has the potential to be.

The dialysis machine also removes fluid from patients who are often anuric, meaning they are unable to remove excess fluid from their body themselves through urination. If this fluid is not removed, it will quickly overload their cardiovascular system and potentially lead to death. In some ways, the dialysis machine-patient-nurse assemblage defines the liminality of the patient during each treatment. The patient's size and weight are (re)negotiated by removing fluid, and the machine and nurse define the substance of the patient's ongoingness by removing some things from their blood and not others. The excess fluid is emptied from the machine into a drain located behind each bed. The boundary of what is, or belongs to, the patient is in dynamic negotiation with the materiality of the environment.

Furthermore, the noises made by the dialysis machine indicating the rising and falling pressures are performing exactly to the machine’s planned design. The planning and
programming of the machine defines some of the parameters of the human in assemblage with it. Once again, the liminal boundaries between the human (patient) and the embedded and embodied situation they are in become a site of reconfiguration. The patient continues in their ongoingness. However, the patient as a subjective entity is no less of themselves than they were before. The patient has lost a circuit of blood or several litres of fluid from their blood, nonetheless, they are perceptible as a human through their subjectivity.

The patient's subjectivity is not diminished by the loss of a circuit of blood or the presence of the dialysis machine. In fact, it is the patient's subjectivity that allows them to continue in their ongoingness despite these physical changes. The dialysis machine, with its programmed alarms and pressures, becomes an extension of the patient's body, an assemblage that allows them to maintain their human form and subjectivity. However, this assemblage also highlights the interdependence of the patient and the machine, and the ways in which they both shape and are shaped by each other. The familiar alarms and protocols that Rebecca follows in disposing of the circuit also demonstrate the ways in which the staff and the patient are part of this larger assemblage, working together to navigate the liminal boundaries between the human and the embodied situation.

During the dialysis treatment, the patient and the nurse had a conversation about the patient's treatment and what would happen if they withdrew from it. The patient asked, “if I stop, how long have I got...” Rebecca responded by saying, “it depends on you. How much your kidneys are still working in the background...and also how much you eat and drink once your off... if ya go for your Christmas dinner and a belly full of ale... then there's no place fae it tae go...”. This exchange highlights how the dialysis treatment intensifies the patient's understanding of the connections between their everyday actions and their ongoingness. For example, and as Rebecca went on to mention, a packet of crisps can be lethal to a dialysis patient due to the high potassium content (Danovitch, 2009).

In the context of critical posthumanism, the above example can be understood as grounding the concept of the human as an assemblage of matter that is configured in affective relations. The patient in this case is no less human than before, despite having a smaller mass. This reinforces the idea that the definition of what is considered human is open to analysis and reconsideration. The idea of what is human is produced during the treatment because of the changing mass of the patient and the decisions of when the treatment begins and ends. This analysis does not erase the human, but our understanding of what it means to be human is reconfigured. I have used this example to make the concept of the human as a material assemblage of matter more accessible and perceptible to analysis, situated within a specific context of ongoingness and liminal boundaries.
7.4 Messy boundaries: Ethereal Scent

One of my key areas of interest was the blurred boundaries between the human and non-human. These boundaries, which have traditionally been defined by physical and cognitive characteristics, became a site of enquiry. In order to better understand and navigate these boundaries, it was necessary to examine them through a multi-sensory lens, utilising not just traditional visual and cognitive frameworks, but also incorporating sensory inputs such as touch, sound and smell. Examining the boundaries between human and non-human with a multi-sensory approach provided a more nuanced and holistic understanding of their complexities and dynamics.

Image 6
A representation of a photograph taken during field work

This image is a representation of a photograph that was taken by a colleague at the end of my last day working on the ward as a permanent member of staff. I had finished a day shift lasting 12.5 hours and was in uniform, walking out of the ward to get changed and go home. The smartphone photo was taken on the spur of the moment and then posted to the ward staff’s WhatsApp group by a participant in the study. I later asked for and received permission and consent to use the photo in this thesis. The photo shows nine nurses in uniform gathered for a photo. I am being lifted off the floor by four of the nurses whilst grinning cheerfully. We are stood in a corridor, at the entrance to the ward and are all wearing our uniforms. The members of the group are all laughing or smiling and generally appear very content.
I am making an awkward face in the photo, which I noted in my field notes as feeling immensely uncomfortable at being picked up because I thought I smelled of sweat, (patient) urine, faeces and general effluence from the day, and – in particular – my shoes were still wet from showering a patient in the morning, and the photo was taken at the end of the shift ten hours later. We had assembled to take a goodbye photo for posterity out of camaraderie. However, my colleagues wanted to pick me up and ‘throw me in the bath’ because this is a tradition on a nurse’s last day.

The smell of my ‘rotting body’ (field notes) and other people’s bodies in close proximity are indicators of what has taken place and what will take place. The smell demonstrates how a nurse’s body becomes intimately entangled with their work and the institution in material terms. This image is included because it conveys the intra-sections between a nurse’s body, other bodies and the institution of the hospital. The smells of nurse work are part of the labour of nursing and create depth of understanding of the material discursive realities on the ward. Sensory data such as smells become an integral part of communication and navigation in the environment because the materiality of the patients (bodily fluids, skin, etc.) and the materiality of the nurses (sweat, breath, skin, etc.) remain with each other. In this image, I am leaving work with parts of the patient still with me both physically and metaphorically.

The sensory information conveyed by this image is an example of the complex sociomaterial relationships produced by acts of care and nursing. For example, my wet feet in this image remind me of the patient I had interacted with earlier that day. People are also perceived affectively, for example, by their calls for help or the ideas of planned care which the nurses engage with.

The material boundaries between nurses and patients are blurred in this image (Image 6). I noted that on the day in question that I had helped several patients shower. Two of the patients had been in hospital for over a month and had not had many opportunities to shower or use the bathroom because they had been unwell. During the showering process one of the patients lost some urine and some went into my shoe, alongside a good amount of water from the shower. After the patient was showered and comfortable, I had rinsed my shoes and then carried on with my day. Nevertheless, in the image above, I was incredibly concerned that I smelt of my own sweat from the day and the patient’s urine. I could smell both of these things on my body and clothes and this is why I grimaced when my colleagues picked me up. This is an example of the blurry material boundary between nurse and patient.

Nurses are also deeply, affectively entangled with the world insider and outside the hospital. The sensory information experienced by nurses during their shift, such as the smell of the ward and the sound of unanswered call bells, serves as a source of information about
the level of activity in the hospital and helps to prepare them for potential emergencies. This information is not solely based on sensory perception, as nurses may also use their observations of their colleagues' reactions to stimuli to gauge the effectiveness of their work.

Ella

“...I was dreading coming in on the nightshift that day... the woman in room 3 was buzzing all night the night before... she was falling asleep with the buzzer in her hand...”

(Jella, nurse participant, text, multimedia diary)

Jack

“...you know if it's been busy when you come on [the ward] because it's a mess... the obs machines are a mess, the bins are full, it's warm, it smells different...”

(Jack, nurse participant, interview)

Ella and Jack both mentioned their socio-material entanglement at work and beyond, Ella describes sensory and transgressive data where the noises and labours of nursing created a idea and ‘dread’ of work for her before she came to work. Jack also describes the socio-materiality of nursing as a representation of the work being done on the ward and the respective workload. These two excerpts further support the affective entanglement of nurses, their work and the hospital.

The smell of nurses arriving for their shift can also create a sense of relief for nurses already present. In the multimedia diaries, several nurses describe being able to smell the next shift of nurses arriving before seeing them, noting the smells of fabric softener on freshly laundered uniforms and perfume. Amelia, in an interview excerpt, says: "I love it when you are sat at the desk doing your notes and you smell the fresh uniforms..." This recognition of the materiality of nurse work suggests that the incoming shift is not yet as entangled in the hospital environment, while nurses at the end of their shift are more entwined. Nurses are part of the institutional assemblage of the hospital even when they are not physically present.
7.5 **Material (co)production of nursing**

The previous sections of this chapter discussed the concept of rigid and liminal boundaries between humans, non-humans and more-than-humans. This section will delve into the ways in which the materialities of the institution shape nurse work using both environmental and participant data.

7.6 **Nurse work extending beyond the physical presence on the ward**

The extension of the nurse beyond the physicality of the ward speaks to an understanding of nurse work that is material, affective and transgressive. Nurse work is created and mediated through materiality and its affective components. As discussed in Section 7.4, the assemblage of what nurse work is goes beyond liminal boundaries. In the same way that nurses take material pieces of patients home after a shift (soiled uniforms, etc.) and leave pieces of themselves at work (through sweat, skin, things they have done) nurses also have a transgressive entanglement that cannot be left at the door of the ward. There were multiple examples in the data collected of how the nurse work extends beyond the physical presence on the ward. The following example of the clinical room illustrates how the presence of and living with (architecture of rooms and arrangement of equipment) its resources co-produces nurse work.

7.7 **The Clinical Room**

*Image 7*

*The clinical room*
The clinical room is the area where most of the medications and consumable/single use medical equipment (such as syringes, needles, intravenous sets, etc.) are stored. Typically, these areas have worktops which are kept clear so staff can prepare medications and treatments, which are then administered elsewhere on the ward. The role of this room requires that it is kept ‘clean’ so that medications can be prepared free from contaminants such as bodily fluids. Effluent is typically not brought to this area nor are personal care items such as incontinence pads stored there. This area is sometimes referred to as the ‘drawing-up room’, ‘clean utility’ or ‘clean room’ (taken from field notes). The room is placed in the middle of the T-shaped ward. This room should be kept ‘locked at all times’ as is shown on the note attached to the door. This room is often very busy around 8am, midday, 6pm and 10pm, as this corresponds to standard timings of medication prescriptions.

In the photo, the door to the room is propped open by a small step and the room is brightly lit. The lights in the corridor are dimmed indicating that this photo was taken at night. Image 7 shows two fridges, some shelves with open boxes on them, a bin and some closed cupboards. The bottom right corner also shows a cardboard box which says danger. There are baskets on top of the fridges and several folders with documents inside. The doors of the cupboards and the entrance door have posters stuck to them. The posters are visible, but not legible in this picture. These posters provide information on the use of the room’s materials.

The photo shows a collection of different items such as medications/drugs, fluids for intravenous infusion, fluids for topical irrigation, secure cupboards such as the controlled drug cupboard attached to the wall, compartmentalised rubbish containers such as the orange bin liner, the wipe clean floor and a locked fridge. The keypad style lock on the door suggests the room is usually locked but can be accessed by many people.

7.7.1 A focal point for nurse work

The area pictured is not a public space, is generally closed (especially during the day) and is used by nursing staff. If another member of the healthcare team such as a healthcare support worker, physiotherapist or occupational therapist wanted to speak to a member of the nursing staff when they were using this room, they would stand by the door and talk to the person (as observed in Field Notes). Sometimes physicians would enter the room to gather equipment required to complete a procedure, however, they would do this tentatively with trepidation as though the space was not theirs to be in. Their demeanour was often that of someone who has ‘gathered courage to enter the room as they know they have to, but then they don’t know where anything is’ (field notes). The room pictured is often used
as a meeting place for registered nursing staff. It is a place away from patients, visitors as well as telephones and computers. The participants described meeting places at work being important and this room constitutes a point of this convergence. This room is zoned by nurses’ behaviour as well as that of others as well as the structures that surround it. This may suggest this is protective behaviour aimed at maintaining a space where camaraderie can happen.

The organisation zones this room by not having public access, telephones or computers. When asked about these characteristics, a Deputy Charge Nurse of the ward offered many reasons off the top of her head. The first three were: the security of medications and their street value if stolen for resale, telephones are distractions to nurses preparing medications, computers would take up valuable space in the room and take too long to log into be used and so would also hinder a stream of people being able to use the room. Healthcare support workers entered the room freely and had body language indicating their ease in the space which could be seen by leaning on furniture such as the fridge, however, their language in communicating with other nurses was different to outside the room (field notes). In the general ward area, support workers would be very open with their conversations and speak with the registered nurses freely and casually. Support workers would only enter the clinical room to discuss things they felt urgent to the ward:

*Several of us are drawing up antibiotics, Charlotte/Isla/Rebecca are stood with me doing the same*

*Billy (Healthcare Support Worker) enters the room and stands by the entrance*

*Billy*

“16/3’s son is on the phone again. He wants to know what time to pick him up tomorrow…”

*Charlotte*

“Oh right, erm, I’m a bit busy just now…erm….”

*Billy*

“Shall I tell him to call back in a bit?”

*Charlotte*

“…erm, no don’t do that”
Billy
“What shall I tell him?”

Charlotte
“Tell him that he will be ready for 10am tomorrow”

Billy
“But you spoke to him earlier”

Charlotte
“Yeah I know. But I’m a bit busy the now”

Billy
“OK, what time then? 10am?”

Charlotte
“Yes, we should be ready by then. Are you on again tomorrow…”

(Field notes, night shift)

Charlotte was uneasy about delegating the telephone conversation to Billy, however, the conversation appears to be a priority for her because she did not want to delay it. Billy was tentative in how he spoke to Charlotte. Billy and Charlotte’s behaviour serves to designate the room as a space for certain types of work, specifically the physical and cognitive labour of preparing medications, while multi-tasking the emotional and organisational labours of nurse work. Using the definitions of nurse work explored above, this scenario raises the question of how the space is used for nurse work and which elements thereof are given priority. While the room seems to prioritise cognitive and physical labour, it is unclear if there is sufficient space for emotional and organisational labour because of Charlotte’s hesitance to stop what she was doing or delay the conversation. Nevertheless, the act of delegation described aligns with both Jackson et al.’s (2021) characterisation of nurse work and The Code’s emphasis on the importance of delegation in nursing practice.

The Clinical Room was also a meeting place for nurses in particular. The behaviour of the doctors and support workers underpins my observations that this room was used primarily for and by nurses. The clinical room is where lots of the backstage work (Goffman,
of nursing would happen because it was an area without a telephone and away from patients and families; it was the one space on the ward that nurses could be somewhat away from patients while also placed close enough to them - at the midpoint of the ward. From field notes, it is in the clinical room that many of the quieter and more private conversations would be conducted pertaining to events on the ward. Nurses would discretely discuss their care plans with each other or how things were not going to plan, while they prepared medications or retrieved pieces of equipment they needed. These conversations would often happen simultaneously with another part of their work because the nurses were busy, however the added conversational confidentiality as well as support and reassurance from colleagues were also important. The materiality of the hospital building and the choice of where to have certain conversations, is part of nurse work.

The clinical room as a meeting place alongside the confirmatory and supportive characteristics of conversations happening there could indicate it as a place of emotional support, therefore, indirectly acknowledging the importance of emotion in nurse work. The emotional labour of nursing also extends to supporting colleagues. After the conversation above, Charlotte and Rebecca reflected on the situation:

*Charlotte*
“…urgh, we should have a phone in here…”

*Rebecca*
“…or definitely a portable one….”

(Field notes, night shift)

Despite the room being zoned in different ways as a space for nurses and certain kinds of nurse work, there is an appetite to remain connected – Charlotte and Rebecca feel like they should not disconnect from the rest of the ward. They feel entangled in the ward and feel they should remain connected as much as they can. Nevertheless, Rebecca’s response to Charlotte acknowledges that a permanent phone may not be a good idea. A portable phone would enable a nurse to have agency as to when they are able to be connected and available by telephone, whereas a permanent telephone would remove some of the choice that a nurse has in being available or to work without distractions.

7.7.2 The open door

In Image 7, the door is propped open despite a sign on the door instructing otherwise. During day shifts the door was usually closed (field notes). One of the reasons it
was left propped open on night shifts was because nights involve fewer staff on the ward
who need to be aware of the sights, sounds and any potential events on the ward. If a
patient falls or a colleague calls for help you are less likely to hear with the door shut. If an
unexpected sign such as a noise is heard, then the nurse can go to investigate.

Isla and I are doing the stock order together on night shift

*The distant clattering of the lid of a water jug*

Isla

“I bet that’s 15/1 trying to get out of bed again…”

Jamie

“I think Michael’s on his break – I’ll go…”

Isla

“Na, it’s ok. She doesn’t like men at night…”

Jamie

“Fair enough, I’ve not looked after her yet…”

(Field notes, night shift)

The clattering of a water jug lid is often a sign that someone has come into contact
with the bedside table. There are many options as to what may be happening: a patient fails
to see table and bumps into it, reaches for a drink, stumbling on their way to the toilet or
perhaps someone falling as is common in hospitals (Kings Fund, 2019). When a nurse hears
the clatter of a water jug it becomes more than the sound of a lid or jug falling – it becomes
an affective engagement with the materiality of the ward.

This sound becomes an affective entanglement for nurses and the environment
because of the possibilities and consequences of what it could mean. The person in bed
Number 15/1 may be trying to get out of bed in a potentially unfamiliar environment. For
example, a patient fall, though common is an unwanted event in hospital (Harolds & Miller,
2022) therefore the prevention of slips, trips and falls are a major element of nurse work. A
falls risk assessment is mandated by the hospital administration for every patient after
admission because a fall could potentially cause physical injury to a patient. This
assessment must be completed by one of the registered nursing staff. The assessment
documents the ways in which the nurse manages the environment to reduce the risk of
patients falling, hence the process of completing this risk assessment and managing the materiality of the ward area that the patient interacts with, is a material co-production of nurse work. Any fall in hospital in the UK should be surrounded by other actions such as completing an incident report form, making the next of kin aware of the fall and a review by the medical team in charge of the patient's care.

Nurses are aware of the material environment because there is an unlimited catalogue of possibilities of what and how things may proceed next. These imagined paths, as occasioned by the clatter of a water jug, become momentary realities that shape nurse work. In the example above, both Isla and I recognised that this sound requires action and our brief conversation establishes how to shape the nursing that follows. The focus of how a patient interacts with the environment on a night shift has implications beyond the immediate time and place. A patient who falls during the night, becomes a catalyst for events which go beyond the event. The incident report which must be completed will ask for the scenario surrounding the fall and the patient’s details, and will, after you have submitted it, display a list of all the members of the ward and hospital administration who the form has just been sent to. The nurse will assess the gravity of the fallen person’s injury and then decides when to notify patient’s relatives – a serious or permanent injury may require telephone them in the middle of the night, whereas no apparent injuries may warrant the family being updated in the morning or at visiting time. They will also consider the impact that a fall will have on the relatives’ impression of the level of care the patient receives. The nurse also has to contact the medical team who must come and assess the patient for injury. The nurse will also be aware of the other patients on the ward who may be disturbed by the fall or may lose confidence in the care provided. A nurse at work, computes and deliberates these possibilities to navigate a pathway of care.

This example shows two ways in which nurse work can be understood. First, it interpellates the liminal boundary of the nurse by becoming entangled in and imperceptible from the work they are performing. Second, nurse work navigates and negotiates the environment to produce ongoingness. The physicality of the nurse becomes with the environment in a connected and relational way. The nurse promotes and creates conditions so they can be as connected to the environment as possible. The strand which ties this together is the continuum between nurse ↔ nurse work ↔ environment or – as described by Taylor and Fairchild (2020) – as the material-discursive. The nurse, their work and the hospital are in processes of becoming without liminal boundaries, as a nurse on duty is a nurse doing nurse work.
7.8 2.8 The orange bag for clinical ‘waste’

In the previous section, the clinical waste bag was involved as the place in which the discarded dialysis lines were placed and as a place for all the waste and detritus created by the treatment. Here I discuss the orange clinical waste bag to explore how the more-than-human is implicated in nurse work and how the value of the latter is produced.

At hospitals in the UK, waste is segregated according to its ongoing, potential risk to human health and the environment. On the ward I collected data from, the most common coloured bins; black and orange. Black denotes general waste and orange denotes clinical or infectious waste. The picture below was taken as I left after a long, public holiday, weekend. The photo shows the orange bags of clinical waste that had been produced on the ward and left in the bin area for collection. However, due to the longer weekend this hadn’t happened yet, and the bins were fuller than usual.

Image 8

The waste room

After thinking about how haemodialysis (re)configures our understanding of the human, I began to think about how the orange clinical waste bag could be understood as an assemblage of matter or a focal point. The orange bag is used for infectious clinical waste therefore by design is a multispecies focal point that is filled with human and more-than-human body waste, bodily fluids and other worldly matter.
7.9 Discussion

This chapter discussed the dialysis machine, ethereal scents, clinical waste and the situation of the clinical room at the field site. The data in this chapter demonstrated nursing to be a sociomaterial practice and how the boundaries of being human are (re)configured in nursing and how nursing can be understood as the (co)production of the material world. Data makes the dynamic and (re)configured boundaries and processes of (co)production perceptible in this project.

The dialysis machine blurs the boundaries between the nurse, patient and infrastructure in a multisensorial manner with the use of blood lines, the soundscape of the ward and the highlighting of subjectivity and perception. This blurring of boundaries between human and nonhuman entities is evident in the ongoing renegotiation of thresholds, demonstrating the dynamic and co-constitutive nature of these relationships. These observations highlight the importance of considering the multisensorial and subjective aspects of nurse work and the ways in which they shape the ongoing negotiation of boundaries between humans and nonhumans. Dialysis provides a useful entry point for considering the dynamic boundaries of the human in other contexts. The patient's experiences with dialysis highlight the importance of considering the ways in which materiality is intertwined and the potential impacts on an individual's ongoingness. These observations can be useful in a variety of contexts beyond a renal ward or hospital, and further exploration of these questions could deepen our understanding of the relationships between materiality and the human.

In the context of dialysis, the liminal boundary between life and death is also blurred. The dialysis machine acts as a mediator between the patient and death, sustaining the patient's life through the removal of waste and excess fluids from the body. However, the dependence on the machine for survival can also create a sense of uncertainty and instability, as the patient's life is constantly in a state of flux, depending on the functioning of the machine. These experiences highlight the fluid nature of the boundary between life and death and the ways in which it is shaped by the material-discursive practices and technologies of healthcare.

The dynamic nature of the boundaries between nurse, patient and hospital is also evident in the ways in which nurse work is embodied and extends beyond the nurse's skin. Nurses can be deeply intertwined with their patients, the hospital environment, and their work, creating a multisensorial experience of entanglement. This highlights the ways in which the boundaries of the human body and materiality are not fixed but are constantly negotiated and shaped by the material-discursive practices and technologies of healthcare.
The nurse's body becomes a site of interaction and connection with the patient and the hospital, and the boundaries between these entities become blurred and dynamic. This dynamic relationship between the nurse, patient and hospital is further complicated by the fact that the nurse’s body is also shaped by their own personal and professional histories, as well as the broader socio-cultural context in which they work. The complex entanglements of the nurse, patient and hospital illustrate the fluid and co-constitutive nature of these boundaries and the ways in which they are shaped by the ongoing negotiation of materialities.

This entanglement in the institutional assemblage is not exclusive to nurses. Patients and other staff may also interpret sensory information and adjudging the quality of care being provided. Nurses actively engage with the institutional assemblage and the affective engagement of patients, visitors and other staff is influenced by the ways in which nurses interact with the hospital environment. As previously discussed, the call bell is a politicised example of the material-discursive production of nurse work. If a patient or family member hears multiple call bells going off without being answered, they may interpret the nurse work as poor or disengaged. This suggests that high-value nurse work is perceived as actively entwined with the institutional assemblage in order to produce patient care.

Analysis of the data also supports nursing care as materially co-produced within a hospital. This chapter will discuss the findings of the analysis of the data, organised around the theme of nursing as an ecology of material (co)production of caring practices. Codes and themes were produced using field notes, visual data, multimedia diary entries and participant interviews. The analysis of Image 7 suggests two points which support the findings of this project. First, the clinical room becomes zoned by space, time and actions. Staff, the organisation and the architectural design create a space which becomes used in a certain way. How this comes about provides a reading of nurse work from different perspectives that are not limited to the individual nurse but are ecologies of care. Second, nurse work is not liminal or bounded within the nurses body, moreover, the navigation of materiality and its many connections. Nurse work is implicitly human and more-than-human. It is sympoetic in character. The more-than-human is evident in nurse work as part of the way that nurses make their worlds.

The material co-production of nurse work matters because comprehending the socio-materiality of nurse work helps us to understand how the time, space and places should be made available to different kinds of nurse work. This links with the power dynamics discussed above (see Chapter XX) about what constitutes nurse work and how the regulatory entanglement of nurses and nurse work may not describe nurses’ experiences. In
the excerpt from Jack, a telephone is provided for the nurse's work, but not the time to use it as he feels is expected of him. This highlights the tension between the tools provided for the job and the demands placed on nurses to utilise them efficiently. It also reveals the hierarchies at play within the healthcare system, where certain forms of labour, such as cognitive and physical tasks, are prioritised over others, such as emotional and organisational labour. This aligns with the findings of Jackson, Anderson and Maben (2021), who argue that the types of labour performed by nurses are shaped by the material conditions of their environment. While cognitive and physical tasks may be more readily visible and rewarded in the healthcare system, it does not necessarily mean that they are less demanding or less important than emotional and organisational labour. Similarly, the use of a telephone in nurse work can involve cognitive, physical, organisational and emotional labours, and it is not solely reserved for tasks that are deemed less valuable or important. Overall, the scenario described illustrates the complex and multifaceted nature of nurse work, and how it is shaped by the materiality of the environment in which it is performed. It also highlights the need to consider the values and hierarchies that shape the production and recognition of nurse work, and how they can be challenged and disrupted.

According to Twigg (2002), nurse work is considered body work because it involves direct physical interaction with patients, using all the senses. Nurses are responsible for providing care and support to patients, which can include tasks such as administering medication, monitoring vital signs and providing hygiene care. These tasks require the use of nurses' hands for administering medication and performing procedures, their sight for monitoring patients' conditions, their hearing for listening to patients' complaints and their sense of smell to detect any unusual smell that could indicate a health issue. Twigg argues that this type of work is not simply a mechanical or technical process, but rather requires the use of the nurse's body and all the senses to perform the necessary tasks. Additionally, Twigg notes that nurses must also use their bodies and all the senses to communicate and connect with patients, through touch, facial expressions and other forms of nonverbal communication.

According to van Brakel, Eikelboom and Duerinck (2018), 'ethereal scent' refers to an odour characterised by its subtle and elusive nature that creates affective entanglements. This type of scent is often described as being difficult to define or pinpoint and may be perceived as being more ephemeral or transient than traditional smells. Ethereal scents may also be associated with natural or organic materials. This type of scent could be related to nursing in several ways, for example, the use of ethereal scents in healthcare environments can be used to create a sense of relaxation and well-being for patients, as well as to mask unpleasant odours. Additionally, ethereal scents can be used as a form of nonverbal
communication, to create a sense of connection and care between the nurse and the patient. Furthermore, ethereal scents could also be used in nursing practice in conjunction with other therapeutic techniques such as aromatherapy to promote healing and reduce stress.

From a socio-materialist perspective, ethereal scent can be seen as a product of the intersection of social and material factors, and this applies to nursing practice as well. Ethereal scent in nursing is not merely a physical substance, but is also shaped by social and cultural meanings. On the one hand, ethereal scents are created by the use of natural or organic materials and its subtle and elusive nature is based on the physical properties of these materials. On the other hand, ethereal scent is also shaped by social and cultural meanings in nursing, such as the meaning of care and the connection between the nurse and the patient, the meaning of cleanliness and hygiene, and the meaning of promoting healing and reducing stress. These meanings are produced by the use of language and representation, and the way these are employed within nursing practice. Therefore, from a socio-materialist perspective, ethereal scent in nursing can be seen as a product of the complex interactions between the physical properties of natural materials and the social and cultural meanings that are created by the way it is used and implemented in nursing practice.

The concept of ethereal scent, as discussed in the Posthuman Glossary (van Brakel, Eikelboom and Duerinck, 2018), provides a framework for understanding the ways in which the human body is situated, embedded and embodied in a particular situation. This concept suggests that there are aspects of the body and its experiences that go beyond what can be seen. The entanglement of matter, including the human body and nursing work, extends beyond the visual realm. The effects of this entanglement are not one way. The following image (Image 5) illustrates the ways in which the human body and nursing work become intertwined, highlighting the complex and multi-faceted nature of this relationship.

7.10 **What could infectious mean in a posthuman context?**
The contents of the orange bags that are used for the disposal of infectious waste, are typically disposable hygiene products such as incontinence pads, bed sheets and bandages. These materials are considered potentially infectious to humans and are separated as a universal precaution to prevent the spread of disease. The management of infectious materials can be understood through the lens of critical posthumanism, specifically in terms of the relationship between potestas and potentia. This relationship between potestas and potentia is crucial to understanding the ongoing production of matterings and the desire for matter to exist in assemblage. If critical posthumanism is solely understood in terms of potentia, it could be argued that all matter should be permitted to interact and assemble.
freely, even in the case of infectious materials. This could lead to the uncontrolled spread of disease, which is something to be avoided from a human perspective. Ultimately, the ongoingness of matter is navigated in a way that is affectively productive from the point of its emergence. As humans or agential agents, we can exert (some) control over the arrangement of matter with the goal of promoting our well-being and that of other living organisms. The affective assemblage of matter has both ethical and political implications. When a position is taken on the relationality of matter, whether to restrict or produce interactions, humans implicate themselves in the situation and gain situated knowledge about what is deemed to matter. This is exemplified by the use of orange bags for the disposal of potentially infectious materials, in which the practical use of the bags is determined by the position taken on human infection.

It is important to recognise that it is not necessary to completely oppose a concept or relation in order to take a stance against it. Instead, taking a position involves acknowledging the complexities and nuances of the concept or relation, and examining its implications and consequences, both productive and restrictive. This approach enables a more nuanced and critical understanding of the concept or relation, rather than simply rejecting or accepting it outright. Furthermore, this approach also involves recognising the ways in which human and non-human entities are interconnected and interdependent, and examining the ways in which these connections and interactions shape our understanding of the world. By taking a critical and nuanced stance, we are able to move beyond simplistic binary opposition and instead engage in a more complex and nuanced examination of the concept or relation. For example, in the context of infectious materials, we do not need to argue for the circulation of waste or the encouragement of infections, nor do we need to aim for complete sterility, which is neither desirable nor possible. The conditions for ongoingness in a given situation are situated and dependent on the materiality of the situation and the decisions made with the latter. The ongoingness (or lack thereof) emerges at the point of production, where humans, as agential agents, adopt a position and produce the realities of the situation. Our knowledge and history inform the decisions we make and themselves result from complex entanglements of multi-generational materiality.

The idea of being situated and acknowledging one's position is crucial for the ongoing production of matter and the desire to continue in this material universe. As Guattari (1988, p.43) notes, ‘nature cannot be separated from culture’, and it is essential to think transversally in order to comprehend the interactions between eco-systems, the materialities and the social and individual universes of reference.
7.10.1 Political implications of adopting a position

The adoption of a position on the relationality of matter carries the risk of becoming overly human-centric, prioritising the preservation of human life and existence above all else. However, in the context of nursing, we are concerned with human health therefore the health and wellbeing of people is a primary concern. This can have negative consequences, such as the environmental impact of the waste produced by healthcare systems. Recognising that humans and healthcare systems exist within intersecting circles which include the social, economic, political and environmental factors that shape our world – these intersections relate to each other in varying and dynamic ways. These circles of existence are interconnected and interdependent, and the decisions and actions taken within the healthcare system must take this into account in order to be sustainable in the face of global challenges such as the climate crisis and therefore produce political implications. This requires a systemic approach that recognises the interconnections between human and non-human entities, including the environment, and the impact on healthcare systems and the well-being of people.

Furthermore, the position taken on the relationality of matter is inherently political, as the diseases deemed to be infectious are often indexed along lines of power and prejudice in human society. High-profile examples of this include HIV/AIDS and COVID-19, which illustrate the deep political implications of how diseases, their infectiousness and their management by healthcare systems and the world as a whole are understood and addressed. These diseases have different modes of transmission and trajectories, but they both speak to the material-discursive acts involved in dealing with infection and their implications for the creation of worlds. The politics of infection, including who, what, where, and how people become infectious or infected, are deeply situated and political. The orange clinical waste bag and the dialysis machine are parts of a broader assemblage of healthcare and highlight the responsibilities in nurse work to understand the material political conditions. Whilst providing dialysis, Rebecca wears PPE to reduce the risks of transmitting microbes and blood to herself or the environment. Staff have separated waste in the orange bags to reduce the risk of contaminating the ward. These examples illustrate the political, health and social examples of how nurse work navigates socio-materiality.

7.11 Summary: Ecologies of the human, non-human and more-than-human

This chapter highlighted the dynamic nature of human identity, emphasising that it is situated within specific contexts and is constantly (re)configured. People are not static entities but rather affective assemblages of matter, constructed within particular geo-spatial-
temporal coordinates. Our understanding of ourselves and others is thus shaped by the time and place in which we live. The findings also reveal that nurses (like other humans) can relate to other matter in both restrictive and productive ways, as demonstrated by our interactions with dialysis machines or clinical waste. While human perspectives are important, they should not be privileged above all other considerations. Analysing and understanding the world requires considering the perspectives and experiences of non-human entities, such as the environment, bacteria and technology. This chapter delved into how people, place and structure contribute to nursing work and its value. Nurses are deeply embedded in and connected to the organisation, with their work being both bodily and intrinsically tied to the organisation. Nursing work is entwined with the materiality of the spaces in which it takes place and nurses navigate these spaces to create environments that support their own ongoingness as well as that of nurses, patients, healthcare staff and the organisation. These interactions give rise to ecologies of relations, illustrating how people, places and structures relate to one another, and to their physical and imagined surroundings. By examining these relationships, we gain insight into the intricate interplay between human, non-human and more-than-human elements in the context of nursing work.
8 Chapter 8: Discussion, Claims and Conclusions

8.1 Bringing the findings chapters together

This chapter will discuss how this thesis contributes to nursing research theoretically and methodologically, and which knowledge has been produced during this project.

I contributed in developing a research method further and applied this method to a healthcare context. I show how nursing is an ecology of regulation and practice and an ecology of practice and theory.

First, this thesis positioned nursing in the theoretical framework of critical posthumanities as a (new) materialist practice. This project developed the Posthuman Institutional Ethnography research method, evolved from education studies by Taylor and Fairchild (2020) as a research method in healthcare. The materialities of institutions affect nurse work and how nurses value their work. These are tangible and transgressive and have consequences for the realities of how worlds are made. In the context of nurse work, this thesis demonstrates how conditions of possibility can be restrictive or productive. These possibilities make the values of nurse work perceptible.

In the contemporary healthcare landscape, various stakeholders – institutions, healthcare professionals, politicians, regulators and society at large (WHO, 2020) – acknowledge the role of nursing as being of critical importance. However, the fundamental aspects of nursing practice and their contributions to patient care remain somewhat elusive for many of these same stakeholders. In part, this perceived invisibility of nursing work may be attributed to certain epistemological frameworks, such as the trope of the modest witness (Haraway, 1988) and the predominantly humanistic approach to knowledge production, which tend to obscure the complex, multi-dimensional nature of nursing. Furthermore, the scope of nursing practice is often restricted by external factors imposed by these stakeholders, which may further contribute to the under-appreciation or misrepresentation of nursing work. As discussed throughout this thesis, a possible reason for these limitations could be the difficulty in fully comprehending and recognising the diverse range of tasks and responsibilities that constitute nursing, particularly when viewed through the lenses of the overly humanistic epistemological frameworks.

These multifaceted restrictions on nursing practice have significant implications for the valuation, power dynamics and overall understanding of the contemporary nursing role within the UK’s healthcare system. Making nurse work more perceptible using innovative
methodologies and approaches, may facilitate more equitable and affirmative appraisals of the contributions made by nurses to patient care, and the healthcare system as a whole. This section will now discuss how nursing requires a shift in epistemological perspectives and a greater emphasis on recognising the diverse and complex socio-materiality of nurse work. By innovatively increasing the perceptibility of nursing practice, it is possible to foster a more accurate valuation of the profession, ultimately contributing to better patient care and a more effective and sustainable approach to the latter.

8.2 Nurse work is an ecology of regulation and practice

The analysis showed a tension between regulatory codes like The Code and nursing realities. As a "boss text", The Code promotes an idealised autonomous, compassionate nurse balancing competing demands. However, nurses describe struggling to provide person-centred care amidst organisational constraints, heavy workloads, and burnout. Freya felt unable to equally prioritise all patients when one required urgent care, conflicting with The Code's directive to "prioritise people." While The Code emphasises physical tasks, nurses perform extensive emotional labour which enables care but goes unrecognised. Ella spent time empathising when a patient was frustrated after a fall, despite The Code lacking language around emotional care. Charlotte described exhaustion navigating competing duties and colleagues, using words like "feckin' shitshow", revealing the ecology's visible and invisible labours.

Nurses expressed lacking confidence to make autonomous decisions, feeling constrained by hierarchies and self-sacrificial tropes. Sophie felt lost practising independently, Jack wanted to be more assertive feeling unheard, and Ella described guilt over unmet patient needs, contributing to burnout. This data illustrates mismatches between standardisation and situated realities. Despite positioning by The Code as detached technicians, nurses are deeply entangled with patients and the care environment, literally embodying patient scents after shifts. Ella felt pulled between caring for dialysis patients and coordinating discharges, highlighting human-nonhuman connections.

Nurses navigate complex intra- and interactions linking regulatory rules, organisational constraints, patient needs and emotional effects. The ecology comprises visible and invisible labour shaped by multifaceted connections. This analysis indicates needs for greater support through education, policies and workplace revisions that account for on-the-ground realities.
8.3  Nurse work is an ecology of theory and practice

The findings reveal a sizeable gap between nursing theory and clinical realities. Despite extensive classroom learning, nurses described feeling unprepared for the complex pace of practice. Students sometimes demonstrated reluctance to engage in practical care and this theory-practice gap appears foundational to the lack of confidence many nurses experience. While education focuses on textbook knowledge, the data shows nurse work transcends physical tasks. Nurses performed constant emotional labour to empathise with patients and negotiate colleague dynamics, obscured in formal teaching. In chapter 6 Charlotte became exhausted navigating emergent duties and interactions for which no textbook prepared her. This invisible work enables the smooth functioning of healthcare organisations.

Person-centred care emerged as an ideal taught extensively to nurses that does not fully transfer to practice. Competing demands and institutional constraints hampered efforts to implement situated care. Participants described guilt and distress when forced to deprioritise some individuals and tasks. The self-sacrificial mindset taught, also conflicted with assertions of nurse autonomy. Overall, the findings demonstrate nurse work is an ecology where multiple socio-materialities intersect. Rigid professional frameworks can clash with situated needs. Multiple labours, as discussed throughout the thesis (Jackson et al. 2021) enable and produce care. Standardised expectations meet complex institutional realities. This ecology contributes to lack of preparation, confidence and burnout issues that must be addressed through training and workplace improvements attuned to on-the-ground needs. Rather than a standardised set of technical tasks, nurse work comprises a dynamic constellation of relational practices. Navigating patient psyches and collegial dynamics proves just as crucial as monitoring vital signs. By acknowledging nursing's realities as messy, relational and contextual, education and policy can better support nurses' navigation of care's demanding ecology.

8.4  Nursing is a material (co)production of human, non-human and more-than-human bodies

The findings demonstrate the profound entanglements between nurses' bodies, patient bodies, and the healthcare environment. Boundaries between human and non-human entities were shown to be fluid and dynamic. For example, nurses literally embodied patient scents after shifts, carrying pieces of them home. Dialysis machines were produced as irrevocably intertwined with patients' bodies and identities, mediating between life and
death. The sounds of the machine constituted an affective soundscape shaping ward interactions. Here the human body is reconfigured through its relationship with technology.

Spaces like the clinical room were shown to be socio-material productions where priorities manifest through allocation of resources. The presence or absence of phones reflected hierarchies between different nursing tasks. Organisational routines and physical layouts shaped care possibilities. Waste management practices further illuminated the situated, context-specific nature of deciding what is considered risky or infectious matter. Disposal in orange clinical waste bags enacted a particular relationship between human and non-human bodies, privileging some over others.

The findings demonstrate nursing as a sympoetic practice, intricately embedded within material and social relations. Human and non-human bodies are mutually shaped and nurtured through reciprocal care practices. Nurse-patient-environment form an ecology greater than the sum of its parts. This conclusion highlights needs to support nurses' navigation of complex healthcare assemblages. Education, policy and environments must empower caregiving as an emergent, relational process. Greater recognition is warranted of nursing's inherent socio-material and ethical dimensions.

8.5 Summary of the ecologies of care

This research set out to critically examine the complex production of contemporary nursing practice. Building on Jackson, Anderson and Maben's (2021) framework of the four pillars of nurse work, the study found experiences of emotional, physical, cognitive and organisational labour. The findings revealed the interconnections and misalignments between regulatory ideals, material realities and affective dimensions. Analysis of The Code as a "boss text" surfaced tensions between standardisation and on-the-ground practice. While directives emphasize physical tasks and autonomy, nurses described invisible emotional work enabling care amidst constraints. These tensions produced negative affectivities including lack of confidence, guilt and burnout.

Investigating human-nonhuman boundaries made the embodied, entangled nature of nursing perceptible. Nurses literally carried pieces of patients with them, just as spaces like the clinical room materialised priorities. Waste disposal practices enacted particular notions of infection risk, privileging some relations over others. Synthesising across data sources, nursing emerges as a dynamic ecology negotiated through situated judgement. Regulatory frameworks espouse textbook ideals that clash with complex institutional realities. Emotional and organisational labour prove inextricable from physical care tasks. Material configurations
enable particular social relations and subject positions. Foregrounding nurses' navigation of these entanglements produces affirmative alternatives to persistent assumptions made of nursing. Nursing is not a standardised set of technical competencies, but an intricate constellation of emerging practices. This demands greater recognition of skilled invisible work, reform of misaligned training, and environments that empower nurses as embedded, relational care providers.

Adopting a critical lens produces a perspective on how care is enacted amidst competing priorities and material-discursive configurations. This narrative highlights needs to holistically support nursing practice within its broader soci-material production.

8.6 Conclusion

This section will draw together the research journey of this doctoral thesis by revisiting its research questions. It will re-affirm the path I have taken, from my entry point into this project, to the exposition of the situation for nurses in the UK, through the aims of this project, to how theoretical and methodological approaches produced this project’s findings. This section will then discuss the research’s limitations and make suggestions for future priorities, both in practice and in research. The meta-aims of this study as outlined in the introduction, were to explore how some discourses around the credentialisation of nursing normalise some power structures and disenfranchise others. This research project and thesis were conducted to address the following research questions:

- How is nursing care materially (co)produced on a hospital ward in Scotland?
  - How do the human, non-human and more-than-human produce nurse work?
- How is nurse work imagined, created and produced institutionally?
- How are these perceptions of nurse work used?
  - politically on the wards and in clinics to shape how care is produced?
  - and politically by healthcare providers?

8.6.1 How is nursing care materially (co)produced in a hospital ward in Scotland?

This project sought to explore how nursing care is materially (co)produced on a hospital ward in Scotland, utilising a critical posthuman theoretical approach. Most of the previous research focused on individual healthcare practitioners. Not a lot of research has explored the relationality and coproduction of care between human and non-human entities. I choose posthuman institutional ethnography to research knowledge and practices in nurse work that have not yet been systematically studied or appraised in other ways, such as
I hold the assumption that to aim for a more sustainable workforce and to overcome shortages of staff and the wellbeing of practitioners, there is value in upcoming/novel/... researching areas in nursing that might be known as lived knowledge or are implicitly displayed in everyday action but have not yet been documented in academia. The study also emphasises the significance of emotional and affective labour within nursing practice, which is often inadequately addressed by existing frameworks. A framework aims to give guidance to nurses and inform their practice, but what areas of practice might be missing from being formalised in frameworks? Hence, examining a nursing framework and contextualising this framework with the everyday work is how this research is designed. Through this I aim to inform practitioners and institutions about knowledge production that has barely been recognised. The value of this PhD is to contribute to a discourse that acknowledges the extremely difficult and ethically precarious situations nurses navigate everyday, yet guidelines have not adequately addressed this essential field of practice. Nonetheless, my research in the field has not only shown that nurses actively engage with affect to create meaningful experiences in healthcare settings but also create affect with patients, other practitioners and non-human entities. The gap between the regulatory definitions of nursing and actual nursing practice generates tensions that can contribute to boredom and burnout among nursing professionals. When (if) nurses feel that their work is not being seen or represented, they might conclude that frameworks are limited in their usefulness because they do not address a field of their work in which they face many ethical dilemmas. Examining nursing care through a critical posthuman lens, this research offers valuable insights into the material (co)production of nursing work on a hospital ward. It is essential to recognise the interconnectedness of various factors in nursing environments, as well as the importance of emotional and affective labour, to develop more affirmative models of care that better address the complexities and challenges faced by nurses in their everyday practice. As my findings indicate, many of the challenges nurses face are not solved as individual practitioners but in a web of interaction that comprise of human and non-human team members.

The findings indicate that nursing work is deeply embedded and embodied within its context, reflecting the interconnectedness of people, place and structure in the production of care. Nursing care is not solely individualised, person-centred or nurse-centred, rather it involves dividual nurses working in relation to the broader environment to foster the ongoingness of matter (conatus) and facilitate living and dying processes. This research highlights the importance of understanding the relationality within nursing environments, as this impacts the conditions of possibility for various types of nursing work. Nurses engage with the affective potentials of matter to forge connections with other matter, ultimately
shaping the care provided within their specific contexts. The Code exemplifies how humans and non-humans contribute to the creation of these conditions, either restricting (potestas) or promoting (potential) specific forms of nursing work. I aim to contribute to a discourse that informs future organising of nurse work.

8.6.2 How do the human, non-human and more-than-human produce nurse work?

This thesis explored the question of how human, non-human and more-than-human elements contribute to the production of nurse work, employing a critical posthuman theoretical approach. Nursing work emerges as practice that can be read through a critical posthuman lense that continuously renegotiates and navigates the inter and intra-connectedness of human, non-human and more-than-human elements to produce ongoingness of the life of patients and their kin. Nurses actively engage with the materiality of a situation, creating pragmatic realities in dynamic and context-dependent scenarios. The study emphasises that nursing work resides at the intersection of theory and practice, where nurses recognise affective potentials and the possibilities within their specific contexts. As a relatively recent addition to academia, nursing contributes new practical perspectives that intersect with existing theoretical conversations, creating space for revaluation and reconsideration. As explored in Chapters 1 and 2, the elusive nature of fundamental care in research may be partly attributed to the need for a monistic and feminist approach as well as the situated and affective nature of care practices.

Numerous examples were discussed throughout the project, showcasing the intersections of human and more-than-human elements in the production of nursing work and care. These illustrate how nursing work functions as a praxis with a pedagogical thrust among nurses, patients and institutions acquiring knowledge through their experiences in various situations. The process of nurses creating worlds with patients within the scope of their work serves as a method for learning, exploring, and operating within monistic theoretical frameworks. Consequently, nursing work and praxis can be considered a form of pedagogy that nurses produce to navigate their work; a pedagogy that is lacking so far in formalised guidance provided by institutions and frameworks. This research provides valuable insights into the production of nursing work by examining the intricate relationships between human, non-human and more-than-human elements, emphasising the importance of understanding these connections to create more effective, holistic models of care.
8.6.3  How is nurse work imagined, created and produced institutionally?

This project aimed to explore how nurse work is imagined, created and produced institutionally in nursing practice on a ward and in formalised form such as the Code through the approach of critical posthumanism. The findings suggest that nurse work is a multifaceted practice with certain aspects aligning with descriptions found in empirical literature. However, the data analysis also uncovered the concept of an idealised ‘perfect nurse’ or the ‘Vitruvian Nurse’, which is an unattainable standard in practice. The findings highlight that certain aspects of nursing work are emphasised more than others, contributing to the complex and varied ways in which nurse work is produced institutionally. By examining these various angles, we can better understand the factors influencing the creation and production of nurse work within institutions. This understanding will enable us to develop more effective and realistic models of nursing practice that acknowledge the complexities and challenges faced by nurses in their daily work.

8.6.4  How are these perceptions of nurse work used politically?

Nurse work becomes political in this thesis by challenging traditional notions of care in healthcare institutions by advocating for a post-anthropocentric approach to nursing. This approach recognises that care is more-than-human, always in relation to others and ubiquitous. By situating nurse work in a critical posthuman ontology, I illustrated the complex ecologies of care that exist within healthcare institutions and paved the way for more sustainable and affirmative futures for both patients and healthcare workers.

One of the ways this understanding could be used politically is by developing policies that approach the non-human, i.e. the materiality of the buildings and things that care is provided with, as a fundamental aspect of healthcare. Recognising these multifaceted aspects of nursing work, policymakers could develop policies that prioritise the diverse needs of patients, healthcare workers, including systems and the environment alike. Another potential political application of this approach is improving working conditions for nurses. In chapter 6, I discussed that when participants describe labours that are franchised by The Code the descriptions are more positive and happier. Understanding how The Code affects nurses’ perceptions of their work, policymakers could develop policies that prioritise nurses’ well-being and job satisfaction. In conclusion, my research underscores the importance of recognising the political implications of the more-than-human ecologies of care that exist within healthcare institutions.
8.7 Contribution

This thesis contributes to nursing research theoretically and methodologically. First, this thesis suggests understanding fundamental nursing care as ecologies, which are created by the assemblages of humans and nonhumans to create more-than-human worlds. Second, this research positions nursing in the theoretical framework of critical posthumanities as a (new)materialist practice. Third, it suggests that the purely humanistic valuation of nurse work makes it difficult for institutions to value nurse work and create more sustainable working environments. Fourth, it utilised the research method of Posthuman Institutional Ethnography as a research method in healthcare. Thinking about nurse work with critical posthumanism and new materialism creates ways of talking about nurse work, care and relationality.

8.7.1 Care as an ecology

This thesis explored nurse work by incorporating scholarship from disciplines beyond nursing, as discussed in Chapters 1 to 3. I propose that an ecological perspective, which considers the materiality of the person receiving care, could lead to more affirmative care practices. Recognising that individuals involved in care play a significant role in the latter, this research demonstrated that a purely person-centred approach did not capture the complexity of care provision. By conceptualising care as an ecology – comprising multiple, interrelated components – we could create more affirmative changes that benefitted nurses, patients and society as a whole by creating shared understanding at the point of emergence. This perspective valued the patient's involvement in care whilst acknowledging the contributions of the nurse, the patient and other socio-material factors that have implications for practice.

- The theory-practice gap highlighted indicates needs to enhance nursing curricula and clinical training to better prepare students for real-world complexities from a socio-material perspective. More practice-based learning could improve confidence and competency, while theoretical and regulatory frameworks could include socio-material concerns and considerations.
- With the extensive emotional, cognitive and organisational labour made perceptible in a socio-material framework, care models and staffing levels must ensure nurses have adequate time and support to perform this "invisible" work. This could improve retention of nurses, their wellbeing, improve the quality of patient care and make care as a wider concept more sustainable in the context of increasing demands.
- Person-centred, holistic care should be enabled through revised policies, material contexts and workplace cultures that recognise nursing’s relational dimensions. Rethinking rigid metrics and tasks could allow more meaningful engagement with nursing as a process that is in continuous becoming.
- Nurses entangled, embodied relations with patients and the workplace deserve greater acknowledgment through training, procedures and environments fostering interdependence and connectivity of human and nonhuman to produce more-than-human worlds.
- Dismantling lingering binary assumptions about nursing work could open up more inclusive, context-specific practice identities, improving belonging.
- Critical perspectives appreciating complex ecologies of socio-materiality should increasingly shape nursing regulation, education, research and organizing. This philosophical shift can develop understandings of nursing and care.
- Nursing must be supported as a nuanced, situated practice through tailored training, adaptable protocols, and empowering workplace relations that recognize its inherent complexity.

Key implications centre on enhancing training, policies, cultures and environments to better address on-the-ground needs. Valuing invisible work, flexibility, and critical perspectives can ultimately improve experiences for nurses and patients. This ecological approach to care recognises that power relations and dynamics are not static, and that different human, non-human and more-than-human affective assemblages have varying degrees of influence over time. By understanding care as an ecology, we could better comprehend how care environments are created for nurses and patients.

### 8.7.2 Critical posthuman nursing

This thesis defines critical posthuman approaches as a significant area of interest in nursing research. This project demonstrates that it is possible to approach nurse work using dominant epistemological frameworks (such as person-centred care) which are important in the unfolding knowledge journey, but also to diffract these with contemporary approaches from the philosophy of science. These convergences and intersections could be beneficial in nursing and healthcare because they create new opportunities to address existing restrictions and challenges. This is not to say that what we know and how we practise nursing now, is not valuable. Still, to continue the best care possible and overcome challenges, existing dominant epistemological frameworks should be appraisable and open to adaptation where the workforce and health provision could be improved. Nurse work and
care are ongoing practices that have existed since what we know as humans existed. I have suggested understanding these practices as dynamic, productive and not fixed within frameworks produced by recent socio-political paradigms.

8.7.3 Methodological contribution

To my knowledge, this project is the first time PIE has been used as a research method in healthcare. This thesis does not claim to have strictly adhered to PIE, let alone be a piece of research completed systematically using a posthuman approach; this project began before Taylor and Fairchild (2020) published their paper on PIE, however, the subsequent write up of this research was greatly supported by their work. This thesis can contribute to the ongoing discursive conversation and methodological development of critical posthuman methodologies by producing another partial perspective.

8.8 Limitations

Like any research, this thesis has limitations. Nursing is broadly approached as a humanistic practice because it involves the care of humans. This is why using a theoretical approach which seeks to challenge the currently most dominant concept of the human to present supplementary concepts is challenging because (and for good reasons as discussed in Chapter 2) the human has to be included in their care. Achievements such as the self-determination of individuals in their care cannot be called into question. Interpolating the category of the human and situating the human in this de-centralised framework is very different from much of the existing nursing literature. A posthuman entry point into nursing research is consequently an interdisciplinary project to create new knowledge, nevertheless, the approach taken may not have attended to nuances of nursing and critical posthumanism that may have been possible if the field of research was more established. An example of this is discussed in Chapters 3 and 4 by acknowledging the humanistic frameworks that were used to produce and analyse the data. The methodological choices have been justified. However, like any form of knowledge production, these processes are ongoing.

A critique that I have been thinking of throughout this project is approaching this project with theories such as Symbolic Interactionism (SI). I found many synergies with SI, however, SI remains somewhat humanistic in its approach. It would be possible to approach this project with Symbolic Interactionism however, I have explored how care and nurse work has characteristics that can be explored more using a monistic and more-than-human approach. That is not to say that the ideas of SI are redundant, because they are not. I have
thought with the ideas of Goffman, Hochschild and Brownlie, who would in some part be considered scholars of SI. Like Le Guin (Le Guin, 2010) says, these are ideas that I have encountered along the research journey and these have informed my thinking. Knowledge is infinite and will continue to take steps along many roads to create many different situated understandings of how worlds are made. Therefore, I have used SI ideas to inform my thinking in a critical posthuman approach.

A limitation of this project could be that the research was conducted in an environment that I was already very familiar with. Carrying out the research on a ward I was already established in created challenges that might not have been present if I had conducted it elsewhere. I addressed this limitation through methodological choices with regard to how I conducted the study and the reflexivity that I employed and demonstrated in my analysis. This is congruent with my theoretical approach because all knowledge is produced in a context and the context and researcher are co-producers of knowledge in some way.

8.9 Directions for future research

This research points towards several promising directions for future study at the intersection of nursing practice and critical posthumanist thinking. One area for further research is collaborative ethnographic studies looking at how nurses navigate complex healthcare systems across different cultural settings. These studies could explore how nurses' negotiations differ based on the specific context. Innovative research could also incorporate multi-species perspectives to reveal the vibrant more-than-human elements underlying and exceeding human care work and creating more-than-human worlds.

Additional studies are needed incorporating critical posthumanist ideas into nursing education curricula and clinical training, and evaluating the impacts this has on approaching care as a socio-material practice. Micro-level and situated research examining nurses' daily practices and relationships are also important, to understand how they embody, follow, resist or change standards - this could reveal how dominant narratives are reinforced or disrupted. This research could then be used to develop regulatory frameworks which govern nurses.

Action research collaborating with healthcare organisations to test and assess posthumanist-inspired changes like decentralised hierarchies, valuing invisible labour, making labours more perceptible and emphasising interdependence also holds promise. Further research on emerging technologies reshaping nursing is critical, as is inquiry into the gendered, racialized, and colonial roots of current self-sacrificial nursing models.
In summary, this research highlights many fertile areas for future studies at the
crossover of nursing and posthumanism, to elucidate nursing's complex, relational
characteristics. Research centring nurses' navigation of healthcare environments, impacts of
posthumanist thinking, micro-level practices, and power dynamics could enrich
understanding of what nurse what is and could be in the context of the posthuman
convergence.


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10.1 Appendix 1: COREQ Checklist

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

Developed from:

**YOU MUST PROVIDE A RESPONSE FOR ALL ITEMS. ENTER N/A IF NOT APPLICABLE**

<table>
<thead>
<tr>
<th>No. Item</th>
<th>Guide questions:description</th>
<th>Reported on Page #</th>
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<tbody>
<tr>
<td><strong>Domain 1: Research team and reflexivity</strong></td>
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<tr>
<td><strong>Personal Characteristics</strong></td>
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</tr>
<tr>
<td>1. Inter viewer/facilitator</td>
<td>Which author/s conducted the interview or focus group?</td>
<td>Results</td>
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<td>2. Credentials</td>
<td>What were the researcher’s credentials? E.g. PhD, MD</td>
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<tr>
<td>3. Occupation</td>
<td>What was their occupation at the time of the study?</td>
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<tr>
<td>4. Gender</td>
<td>Was the researcher male or female?</td>
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<tr>
<td>5. Experience and training</td>
<td>What experience or training did the researcher have?</td>
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<td><strong>Relationship with participants</strong></td>
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<tr>
<td>6. Relationship established</td>
<td>Was a relationship established prior to study commencement?</td>
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<tr>
<td>7. Participant knowledge of the interviewer</td>
<td>What did the participants know about the researcher? e.g. personal goals, reasons for doing the research</td>
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</tr>
<tr>
<td>8. Interviewer characteristics</td>
<td>What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic</td>
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<td><strong>Domain 2: study design</strong></td>
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<td><strong>Theoretical</strong></td>
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<tr>
<td>framework</td>
<td>9. Methodological orientation and Theory</td>
<td>What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis</td>
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<tr>
<td>Participant selection</td>
<td>10. Sampling</td>
<td>How were participants selected? e.g. purposive, convenience, consecutive, snowball</td>
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<tr>
<td>11. Method of approach</td>
<td>How were participants approached? e.g. face-to-face, telephone, mail, email</td>
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<tr>
<td>12. Sample size</td>
<td>How many participants were in the study?</td>
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<tr>
<td>13. Non-participation</td>
<td>How many people refused to participate or dropped out? Reasons?</td>
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<tr>
<td>Setting</td>
<td>14. Setting of data collection</td>
<td>Where was the data collected? e.g. home, clinic, workplace</td>
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<tr>
<td>15. Presence of non-participants</td>
<td>Was anyone else present besides the participants and researchers?</td>
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</tr>
<tr>
<td>16. Description of sample</td>
<td>What are the important characteristics of the sample? e.g. demographic data, date</td>
<td>Results</td>
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<tr>
<td>Data collection</td>
<td>17. Interview guide</td>
<td>Were questions, prompts, guides provided by the authors? Was it pilot tested?</td>
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<tr>
<td>18. Repeat interviews</td>
<td>Were repeat interviews carried out? If yes, how many?</td>
<td>Methods</td>
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<tr>
<td>19. Audio/visual recording</td>
<td>Did the research use audio or visual recording to collect the data?</td>
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<tr>
<td>20. Field notes</td>
<td>Were field notes made during and/or after the interview or focus group?</td>
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<tr>
<td>21. Duration</td>
<td>What was the duration of the interviews or focus group?</td>
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<tr>
<td>22. Data saturation</td>
<td>Was data saturation discussed?</td>
<td>Methods</td>
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<tr>
<td>23. Transcripts returned</td>
<td>Were transcripts returned to participants for comment and/or correction?</td>
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<tr>
<td>Domain 3: analysis and findings</td>
<td>24. Number of data coders</td>
<td>How many data coders coded the data?</td>
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*Data analysis*
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<td>Derivation of themes</td>
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<td>What software, if applicable, was used to manage the data?</td>
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<td>28.</td>
<td>Participant checking</td>
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<td>Reporting</td>
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<td>29.</td>
<td>Quotations presented</td>
<td>Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number</td>
<td>Methods and Results</td>
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<td>Data and findings consistent</td>
<td>Was there consistency between the data presented and the findings?</td>
<td>Relationship to existing knowledge</td>
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<td>31.</td>
<td>Clarity of major themes</td>
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<td>32.</td>
<td>Clarity of minor themes</td>
<td>Is there a description of diverse cases or discussion of minor themes?</td>
<td>Discussion</td>
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### Table XX Codes, sub-themes and themes for the ecology of regulation and practice

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### Table XX Codes, sub-themes and themes for the ecology of theory and practice

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<td>Teamwork</td>
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### Table XX: Codes, sub-themes and themes for the ecology of human, non-human and more-than-human bodies

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<td>Body language</td>
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<td>Affective relationships with patients</td>
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<td>Affective relationships with technologies</td>
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<td>Aggregated capacities to nurse</td>
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<td>Entangled with the hospital</td>
<td>The Clinical room</td>
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<td>Physical connections with the hospital</td>
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<td>Sensing beyond the visual</td>
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<td>Team work</td>
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<td>Technology and the body</td>
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<td>Interdisciplinary Cooperation</td>
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<td>Interpersonal relationships</td>
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<td>Joint Actions</td>
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<td>Limits of the body</td>
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<td>Making things perceptible</td>
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<td>Mood</td>
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<td>Multisensory experiences</td>
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<td>Multisensory Inter and intra-actions</td>
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<td>Non-human bodies</td>
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<td>Non-visual nursing practices</td>
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<td>Non-visual senses</td>
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<td>Topic</td>
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<td>Organisational labour</td>
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<td>Overlapping roles</td>
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<td>Patient-nurse relationship</td>
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<td>Physical labour</td>
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<td>Professional relationships</td>
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<td>Shared goals</td>
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<td>Staff Communication</td>
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<td>Staff Interactions</td>
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<td>Staff Relationships</td>
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<td>Team Dynamics</td>
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<td>Team Efforts</td>
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<td>Teamwork</td>
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<td>Technology</td>
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<td>Time</td>
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<tr>
<td>Touch</td>
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</tbody>
</table>
"Navigating nurse work: understanding the conditions of possibility for nurses working in Scotland”

Data management plan

Department of Nursing Studies
School of Health in Social Science
University of Edinburgh

Jamie B. Smith
PhD Candidate
Jamie.B.Smith@ed.ac.uk
10.3 Data capture

Basic demographic data of the nursing workforce will be collected according to basic social categories as is available publicly and verified by the health board. The Human Resources department of the health board will be approached to access the publicly available information.

<table>
<thead>
<tr>
<th>Band</th>
<th>Gender</th>
<th>Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td></td>
<td></td>
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<td>6</td>
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<td>8b</td>
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<td>8d</td>
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<tr>
<td>9</td>
<td></td>
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</tr>
</tbody>
</table>
10.3.1 Environmental data

A floor plan of Ward 206R will be created using Microsoft Office computer software. Photographs of the ward environment will be taken and integrated into this plan to begin to illustrate the physical context in which participants do their nurse work. This may include pictures of nurses, but not clinically or patient identifiable data.

The photographs will be taken using a digital camera which does not have any networked capability. The photos will be downloaded to the University of Edinburgh computer network on site at the hospital as soon as they are taken and then deleted from the camera. The photos will not contain any personal or patient identifiable data and are for environmental illustrative purposes only. The photographs will be taken to purposefully not include any personal/patient identifiable data (PID), however, the photos will be double checked for PID before being included in any documentation or analysis.

10.3.2 Participant data

10.3.3 Multimedia diaries

Participants are asked to keep a diary by recording video after their shifts on the ward, outside their work place. Participants will be provided with a prompt sheet to support structuring their entries which will prompt:

How are you?

How is your day going?

What has been the best part of your day so far?

What has been the most challenging part of your day?

Participants will be asked to create an entry after each of their work shifts for three weeks, and a reminder message sent to their personal mobile phone on the days they are scheduled to work. Participants will be asked to create their multimedia diaries using their smartphone. And a messaging service they are comfortable with. The video diaries will be completed using a smartphone messaging service (such as MMS or Whatsapp) and sent to
a dedicated phone held by the CI. Participants will be reminded that they must not discuss personally identifying information in this diary entry. These entries will be completed outside the NHS Trust and outside the University of Edinburgh.

10.3.4 Structured Interview

Each participant will be invited to a structured interview during their work day which will last no longer than one hour after they have completed their video diaries and received a summary of the transcriptions. The interview will begin with an affirmation of continued consent to participate. The summary of data generated from the video diaries will be reviewed with participants. This summary will be used as a starting point to discuss the meaning of the experiences for the nurses.

The interview structure will then be guided by the information contained in the video diaries which will be orientated around the following themes:

- Discussing the thoughts and feelings related to events described in their diaries.
- Discussing how the participants reacted and behaved in response to events.
- Discussing how participants came to know how to respond to situations which arise.

The structured interviews will also ask demographic data of participants which includes:

- How long have you worked as a nurse? (When did you qualify?)
- Where did you train as a nurse?
- What nursing qualifications do you have?

10.3.5 Summary of proposed data collection
<table>
<thead>
<tr>
<th>Participant</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
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<td>60</td>
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<td>60</td>
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<td>mins</td>
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<td>5</td>
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</tr>
</tbody>
</table>

### Environmental sensory data

- **Focused Video diaries**
  - 1st
  - 2nd
  - 3rd
  - 4th

### Field notes
- 5 mins
- 5 mins
- 5 mins
- 5 mins
- 5 mins
- 5 mins
- 5 mins
- 5 mins
- 5 mins

---

**Participant**

**Focused Video diaries**

- 1st
- 2nd
- 3rd
- 4th

**Field notes**

- 5 mins
- 5 mins
- 5 mins
- 5 mins
- 5 mins
- 5 mins
- 5 mins
- 5 mins
- 5 mins

---

272
10.3.6 Data Management

The raw data captured will be recorded on an encrypted device and downloaded directly to the University of Edinburgh network whilst on site at RIE. This directory will be further password protected which will be only known to the CI. A directory has been created with the following tree to organise data.

10.3.7 Integrity

The demographic data collected is anticipated to be publicly available, however, may become organisationally sensitive when collated and gathered in a way which looks for
structural inequalities within a workforce. This data will be stored within the University of Edinburgh alongside other data collected.

Participants will be randomly assigned participant numbers using an open source random number generator and then assigned a pseudonym. The numbers will be assigned randomly to reduce the risk of breaking confidentiality between participants as they be aware of other participant’s and the order in which they are recruited and be able to deduce their responses in the discussion section of the project. The gender of the name will be assigned from the context the participant uses it. Names and numbers will be randomly assigned as during qualitative analyses the flow of speech and dialogue has meaning and therefore the heuristic value of names is linked with the meaning of the text.

The diary entries will be formatted as .mp4 video and downloaded to the University of Edinburgh network within 7 days of being sent and deleted from the phone. These will be transcribed and analysed as soon as possible. Any images or photographs will be sent from the device they are taken on to an NHS.net email address and securely downloaded to the University network on a University computer. They will then be deleted from the device.

The video diary of each participant will be summarised before being invited to interview. The summary will be sent to the participant for affirmation that the information was as intended when they recorded their diary. This summary will be discussed during the interview.

The focussed interview will be audio recorded on an encrypted voice recorder and downloaded to the University of Edinburgh network as soon as the interview is concluded. The data will be saved in the corresponding folder as displayed in the directory above, using the following naming convention:

Floor Plan

Z:JamieSmith/MyDocuments/NavigatingNurseWork/Environmental/FloorPlan206R.pub
Estimated size of file is 1MB.

*Photographs*

Z:JamieSmith/MyDocuments/NavigatingNurseWork/Environmental/Photo1.jpg

Estimated size of files are around 1MB per photograph.

*Video diaries*

Z:JamieSmith/MyDocuments/NavigatingNurseWork/Diary/Participant1.mp4

Estimated size of file is 2GB per diary entry, creating 12GB of data per participant set. In total the estimated size of this data type is 60GB.

*Interviews*

Z:JamieSmith/MyDocuments/NavigatingNurseWork/Diary/Participant1.mp3

Estimated size of file is 2GB per interview. In total the estimated size of this data type is 12GB.

**10.3.8 Confidentiality**

The confidentiality of the participant data is paramount, and also essential for the integrity of any trust to develop in the research process.

All recording devices used will be encrypted to a level defined by the NHS IT services. No data will physically leave the NHS site, and will be downloaded to the University of Edinburgh network on site at the hospital.

The project will also follow these practices:
● Consent forms will be kept in a locked cupboard in a secure room, in a secure building at the University of Edinburgh.

● Interview data will be anonymised.

● Research smartphone will be kept in a locked cupboard in a secure room at the University of Edinburgh.

● Interview recording devices encrypted as per NHS local standards

● All data downloaded to the University of Edinburgh network ASAP All data stored within the University of Edinburgh network.

● All transcribing completed on a University of Edinburgh computer

● Raw data will be deleted as soon as it is transcribed

● The study will adhere to the principles of Good Clinical Practise, as GCP is also defined by statutory instrument and also addresses confidentiality issues.

10.3.9 Retention and Preservation

The University of Edinburgh undertakes to maintain the digital outputs of this project for the long-term and will utilise University infrastructure (namely the Edinburgh DataShare repository) to ensure preservation and continued access. Edinburgh DataShare is an online digital repository of multi-disciplinary research datasets produced at the University of Edinburgh, hosted by the data library in Information Services. It acts as a trusted repository, ensuring that anonymised research data will be preserved for at least three years.

10.3.10 Sharing and Publication

Even though the final dataset will be stripped of identifiers prior to release for sharing, we believe that there remains the possibility of deductive disclosure of subjects with unusual characteristics. Thus, we will make the data and associated documentation available to users only under a data-sharing agreement in negotiation with the Caldicott Guardians at NHS Lothian.
Appendix 4: Caldicott Application Form

Local Caldicott and/or Information Governance Application Form

You must address the Caldicott Principles and Information Governance and Security requirements when submitting this application for the use of patient identifiable information.

SECTION A: GENERAL INFORMATION

1. Project/Proposal Title:

<table>
<thead>
<tr>
<th>R&amp;D No:</th>
<th>IRAS No:</th>
<th>Sponsor No:</th>
<th>Caldicott No:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018/0253</td>
<td>248918</td>
<td>CRD18106</td>
<td></td>
</tr>
</tbody>
</table>

2. Name of Organisation accessing or receiving patient identifiable data:

University of Edinburgh

3. Person Responsible for the released data and Declaration:

(Principal Investigator or person responsible for local activity)

<table>
<thead>
<tr>
<th>Name: Jamie Smith</th>
<th>Address: School of Health in Social Science</th>
</tr>
</thead>
<tbody>
<tr>
<td>Position: PhD Researcher</td>
<td>Doorway 6, Teviot Place,</td>
</tr>
<tr>
<td>Organisation: University of Edinburgh</td>
<td>Edinburgh</td>
</tr>
<tr>
<td>Email: <a href="mailto:jamie.b.smith@ed.ac.uk">jamie.b.smith@ed.ac.uk</a></td>
<td>EH8 9AG</td>
</tr>
<tr>
<td>Telephone: 07596263266</td>
<td></td>
</tr>
</tbody>
</table>

Declaration: I agree to abide by the Caldicott Principles, NHS Lothian eHealth Security Policy. I confirm that the study will comply with the legal requirements and the responsibilities and obligations to respect patient confidentiality.

Signature: J. Smith

Date: 3rd October 2018

Counter-signature of Supervisor/Principal Investigator
(In the case or applications from students, junior doctors)

<table>
<thead>
<tr>
<th>Name: Rosie Stenhouse</th>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Position: Lecturer</td>
<td>School of Health in Social Science</td>
</tr>
<tr>
<td>Organisation: University of Edinburgh</td>
<td>Doorway 6, Teviot Place,</td>
</tr>
<tr>
<td>Email: <a href="mailto:rosie.stenhouse@ed.ac.uk">rosie.stenhouse@ed.ac.uk</a></td>
<td>Edinburgh</td>
</tr>
<tr>
<td>Telephone: 0131 651 3969</td>
<td>EH8 9AG</td>
</tr>
</tbody>
</table>

I DECLARE THAT (the responsible person named above) is a *bona fide* worker engaged in a reputable project and that the data he/she asks for can be entrusted to him/her in the knowledge that he/she will conscientiously discharge his/her obligations, including in regard to confidentiality of the data, as stated in the declaration above.

Signature: R. Stenhouse

Date: 3rd October 2018

4. Please provide a briefly description of aims, objectives and methods for the proposal for which identifiable data is required:

Multimedia diaries, environmental data (incl. photos and videos) Structured interviews of nurses working at the NHS Trust will be recorded on an encrypted recording device a part of a PhD research project which explores the lived experience of nurses and their work in Scotland. No patient identifiable data will be collected. Please see attached Data Management Plan.

5. Consent – what will the patient/participant consent to?

Please describe the consent sought in relation to collection, handling, storage and transfer of data i.e. what information is in the consent form? Is this consent explicit?

Potential participants will be made aware of the project by a third party. Potential participants who are interested will be provided with a comprehensive information sheet which they will have at least three days to consider; they will then be approached to decide if they wish to participate. Participants will be asked to keep a video diary for a period of three weeks, kept in their own time away from the clinical workplace using their mobile phone. The participants can choose the way in which they wish to keep the diary using services such as MMS messages, Whatsapp, email etc. The participants will be asked to send this data to a dedicated research smartphone located in a secure cupboard in a secure room at the University of Edinburgh. Participants are made aware that the digital safety of the files while on their own phone and during transfer cannot be guaranteed. These diaries will be transcribed at the University of Edinburgh and the transcriptions stored on the University network, and then deleted from the research smartphone. Participants may also be asked to be in photos of themselves at work; these photos will not contain clinically or patient identifiable data. The participant information sheet describes how their data will be analysed and used, and how they can withdraw their information from the study. If they wish to proceed they will be asked to complete a written consent form.
What patient identifiable information are you looking to use?

Unless patient identifiers are required to meet the purpose of the request only anonymised or pseudonimosed data should be requested.

As patients can be identified from a combination of variables in anonymised data, such as date of birth, data of admission, treating hospital, area of residence, please request only the minimum details required to meet the purpose of the study.

The CHI (Community Health Index) is a unique personal identifier made up of data of birth, gender, and other information. It should wherever possible remain within the NHS. If required, consideration should be given to replacing the CHI with a study identifier and retaining the CHI within the NHS.

If CHI is used for data linkage please ensure you describe, in section C of this form, by whom and where this is undertaken.

If accessing image data, please consider whether these contain identifiable information.

Please indicate all potentially identifying items that you are requesting.

Why is each data item required (Caldicott Principle 3)?

<table>
<thead>
<tr>
<th>Data Item</th>
<th>Required (Y/N)</th>
<th>Reason Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHI Number</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Forename</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Surname</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Initials</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Postcode</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Other, please specify</td>
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<td></td>
</tr>
<tr>
<td>(e.g. audio or video files)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interview recordings</td>
<td></td>
<td>Interview recordings - For inclusion in analysis of the lived experience of nurse work in Scotland</td>
</tr>
<tr>
<td>Nurse participant’s multimedia/video diaries</td>
<td>Participants will determine the device they wish to use to record and send their video diaries – this may be their smart phone, laptop or ipad. If photographs are taken, these will be done in the method chosen by the nurse participants.</td>
<td></td>
</tr>
</tbody>
</table>
Are there any other data items requested?
(Items that in combination with other information may increase the risk of disclosure)

<table>
<thead>
<tr>
<th>Data items</th>
<th>Reason Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse participants age</td>
<td>For inclusion in analysis of the lived experience of nurses in Scotland.</td>
</tr>
<tr>
<td>Nurse participants time of</td>
<td>This information is publicly available on the NMC register. It will be collected</td>
</tr>
<tr>
<td>qualification</td>
<td>for inclusion in analysis of the lived experience of nurses in Scotland.</td>
</tr>
<tr>
<td>Nurse participants ethnicity</td>
<td>For inclusion in analysis of the lived experience of nurses in Scotland.</td>
</tr>
</tbody>
</table>

SECTION B: CALDICOTT PRINCIPLES

You must address the Caldicott Principles (see Appendix 1)

7. Outline Purpose(s) for which confidential information is to be used (Principle 1) and why patient identifiable Information is required? (Principle 2):
   The need for patients to be identified should be considered at each stage of satisfying the purpose(s).
   Patient identifiable data should not be used unless there is no alternative.

   No patient identifiable data will be collected. Participant identifiable data will be collected; all participants are registered nurses who have been reminded of the confidentiality required by their NMC code of conduct and contract of employment at NHS Lothian. The Participant Information Sheet and Consent Form have been prepared to conform to the principles outlined by GDPR.

   Contacting Patients
   If you intend to make contact with patients identified through the processing of this data, indicate how this will be done and how you will ensure that it is appropriate to contact them. It is recommended that contact is through correspondence signed by the patient's GP/Clinical or Health of Clinical Services.

   No Patients will be contacted. The participants that will be contacted are registered nurses who work on 206 Renal at RIE.

Data Linkage
If you intend to undertake data linkage to other health datasets what data is to be linked and where will this linkage be undertaken?

Data will be contextualised in the NHS Lothian and UK wide workforce demographics. No direct linkage between participant data and other health datasets will be made.

8. **Outline access to information? (Principle 4):**
   Only those individuals who need access to patient-identifiable information should have access to it, and they should only have access to the information items that they need to see.
   Please describe how, where and by whom this information will be accessed.

   No patient identifiable information will be accessed. Participant information will be accessible to the CI and their supervisors at the University of Edinburgh – totalling 3 people.

9. **Outline action taken to ensure that everyone with access to the data is aware of their data protection and confidentiality responsibilities? (Principle 5):**
   Actions should be taken to ensure that those handling patient-identifiable information – both clinical and non-clinical staff – are aware of their responsibilities and obligations to respect patient confidentiality.
   Please provide detail of Information Governance and Confidentiality training undertaken.

   No patient identifiable data will be collected. Participant identifiable information will be handled by individuals who have undertaken GCP training. The CI and their supervisor have undertaken IG training at NHS Lothian. The supervisors of this project work and are bound by the NMC Code of Practice and the University of Edinburgh guidance on confidentiality.

10. **Outline how your organisation’s legal requirements for the use of the data will be met? (Principle 6):**
    Every use of patients-identifiable information must be lawful. Please specify what that legal basis is and how it will be met. Someone in each organisation should be responsible for ensuring that the organisation complies with legal requirements.

    No Patient identifiable data will be collected. Participant identifiable data will be used with informed clear consent from participants which is recorded in writing.
**SECTION C: DATA SECURITY**

You must address the Information Governance and Security requirements

11. **Data Transfer**

Give details of How, What and to Where the requested information will be transferred from the Data sources e.g. encrypted USB drive, password protected file, secure file transfer, NHS email attachment, paper sent by recorded delivery etc.

If data is to be transferred outside of the UK or outside of the European Economic Area (e.g. US), please specify?

<table>
<thead>
<tr>
<th>Physical Location (Institution, NHS Lothian, University, Room )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access controls (How will the data be stored and protected from unauthorised access?):</td>
</tr>
<tr>
<td>Anonymisation (How will the identify of individuals be protected)</td>
</tr>
</tbody>
</table>

The encrypted recordings of the interviews with nurses will be downloaded using a USB wire to the University of Edinburgh network in the Chancellors Building immediately after the interview and deleted from the recording device. The recordings will then be saved on the University of Edinburgh secure network. Any photos taken will be sent to an nhs.net email address and deleted from devices.

12. **Safe guards**

Describe the measures in place to protect and use the data securely and confidentially

For paper records:

<table>
<thead>
<tr>
<th>Physical Location (Institution, University, Room )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access controls (How will the data be stored and protected from unauthorised access?):</td>
</tr>
<tr>
<td>Anonymisation (How will the identify of individuals be protected)</td>
</tr>
</tbody>
</table>

For electronic data:

<table>
<thead>
<tr>
<th>Physical Location (Institution, University, Room )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access controls (Will a Safe Haven be used, if so, which one?):</td>
</tr>
<tr>
<td>If not using a Safe Haven:</td>
</tr>
</tbody>
</table>
How will the data be protected from unauthorised access?
University of Edinburgh IT Security Protocols.

Device to be held on (desktop, laptop, network storage, etc.):
Network Storage

Encryption (what encryption method will be used to protect the data?)
Each file will have a password alongside the secure network it is stored on. An Olympus DS7000 Voice recorder with AES256 encryption will be used for the recording of interviews.

Format of the data (spreadsheet, database, etc.):
Voice recordings – mp3.

Anonymisation (how will the identity of individuals be protected):
All files will have a randomly generated number assigned and not stored by name. The video and voice data will be permanently deleted after it is transcribed due to reduce the risk of participant data being identifiable. Any specific photos that participants wish to be included will be verified with participants and anonymised. Any data which could be identifiable will be anonymised in the transcription process. If it is not possible to anonymise data then this will be omitted from the transcription and a note made in the transcript that a section has been removed to protect the anonymity of the participant.

13. Data Retention and destruction
How long do you intend to retain the information that you will rely on for your study and how will you dispose of the information at that time?

For clinical trials, data cannot be destroyed without sponsor approval and retention will be in accordance with the protocol.

Retention and destruction
The voice records and video diaries will be deleted and destroyed from the device they are held immediately after they are transferred to the University Network. The video and voice recordings will be deleted as soon as they are transcribed. The transcription data will be held for three years on the University of Edinburgh’s long-term electronic data repository.

Once the application has been completed please email or send it to:

ACCORD@nhslothian.scot.nhs.uk
ACCORD
Queen’s Medical Research Institute
47 Little France Cresnet
Edinburgh, EH16 4TJ
CALDICOTT PRINCIPLES

Principle 1. Justify the purpose(s) for using confidential information
Every proposed use or transfer of patient-identifiable information within or from an organisation should be clearly defined and scrutinised, with continuing uses regularly reviewed, by an appropriate guardian.

Principle 2. Don’t use personal identifiable information unless it is absolutely necessary
Patient-identifiable information items should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose(s).

Principle 3 Use the minimum necessary personal identifiable information
Where use of patient-identifiable information is considered to be essential, the inclusion of each individual item of information should be considered and justified so that the minimum amount of identifiable information is transferred or accessible as is necessary for a given function to be carried out.

Principle 4. Access to personal data should be on a strict need-to-know basis
Only those individuals who need access to patient-identifiable information should have access to it, and they should only have access to the information items that they need to see. This may mean introducing access controls or splitting information flows where one information flow is used for several purposes.

Principle 5. Everyone with access to personal confidential data should be aware of their responsibilities
Action should be taken to ensure that those handling patient-identifiable information - both clinical and non-clinical staff - are made fully aware of their responsibilities and obligations to respect patient confidentiality.

Principle 6. Understand and Comply with the Law
Every use of patient-identifiable information must be lawful. Someone in each organisation handling patient information should be responsible for ensuring that the organisation complies with legal requirements.

Principle 7. The duty to share information can be as important as the duty to protect the persons confidentiality.
Health and Social Care professionals should have the confidence to share information in the best interest of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.
10.5 Appendix 5: Participant Consent Form

CONSENT FORM
Version 1.0, 13th September 2018

Navigating nurse work: understanding the conditions of possibility for nurses working in Scotland

Lead Researcher:  Mr. Jamie B Smith
PhD Researcher, Department of Nursing Studies

1. I have read and understood the information sheet (Version 1, 13th September 2018) titled 'Navigating nurse work: understanding the conditions of possibility for nurses working in Scotland'.

2. I have had adequate opportunity to ask questions and these have been answered to my satisfaction.

3. I understand that my participation is voluntary, and I am free to withdraw from the study at any time without giving any reason and without my employment and or legal rights being affected.

4. I agree to my interviews being recorded.

5. I give permission for photographs of me to be taken for purposes of research.

6. I understand that the interviews are confidential and will not be discussed outside the interview.

7. I understand that all identifying material will be removed and quotations anonymised in research products. The anonymised findings of this study will be used in academic and artistic outputs which may include publication in academic journals, presented at conferences used to create artwork and enter the public domain.

8. I understand that relevant sections of data collected during the study may be looked at by individuals from the regulatory authorities and from the Sponsor (the University of Edinburgh) or from the/other NHS Board(s) where it is relevant to my taking part in this research. I give permission for those individuals to have access to my records.

9. I consent to take part in this study.

Name (Printed)  Signature  Date

Name of person giving consent: 
Name of person taking consent: 

This form will be held in the project file at the Royal Infirmary of Edinburgh. A copy should be made and given to the participant.

Participant ID ____________
Original (x1) to be retained in site file. Copy (x1) to be retained by the participant.
PARTICIPANT INFORMATION SHEET

Version 1.0, 13th September 2018

Navigating nurse work: understanding the conditions of possibility for nurses working in Scotland.

Lead researcher: Mr Jamie Smith
PhD Researcher,
Department of Nursing Studies,
University of Edinburgh

jamie.b.smith@ed.ac.uk

Thank you for taking the time to read this information about a research project which is taking place in your work area. It is important that you read and understand this information about the study before you decide if you would like to take part or not. Please free to ask me any questions that you may have when I am in your work area or alternatively my contact details are included at the end of this sheet.

What is the purpose of the study?

This project aims to better understand nurse work from the perspective of registered adult nurses working in physical health care in Scotland. The project aims to explore how people, place and structures interact in nurse work. A better understand how and what fundamental nursing care is can contribute to the continued development of professional and educational nursing frameworks.

Who will conduct the research?

The research will be conducted by Mr Jamie Smith who is a registered nurse and a PhD student at the University of Edinburgh. You may know Jamie as a colleague and he will continue working in the ward area during the project. If you choose to take part, Jamie will complete a written consent form with you.

Why have I been invited to participate?

The site of this study is Ward 206 at the Royal Infirmary of Edinburgh. You have been invited to take part in this project as you are a registered nurse working in this area. As you maintain your registration as nurse, you are aware of and maintain the regulatory framework of your professional body and have therefore been asked to participate in this research.
Do I have to take part?

No, it is up to you to decide whether or not to take part. Participation is voluntary, and you may withdraw your consent at any time. If you withdraw all attempts will be made to remove your data from the study. However, data that is included in findings already published will not be able to be withdrawn. Deciding not to take part or withdrawing from the study will not affect your employment or legal rights.

What will happen if I do decide to take part?

If you consent to participate you will be asked to keep a multimedia diary using your smartphone after your shifts at work; this would take place over a three-week period and you would be asked to record diaries after as many shifts as possible during that time.

You will record your diary outside your workplace using your smartphone. The diary can be audio or video and can be sent as an MMS message or a Whatsapp message to the researcher. You will be given brief prompts to help you start your diary entry, for example:

How are you?
How is your day going?
What has been the best part of your day so far?
What has been the most challenging part of your day

You will be given the details of a smartphone used exclusively for this project which is kept securely at the University of Edinburgh. Only the Chief Investigator, Jamie, has access to this phone. These entries will not be on a secure network and therefore you must be mindful not to discuss patient identifiable information.

Jamie will send you a reminder message on the days on which you are working during the data collection period to remind you that data collection is ongoing. Jamie will message up to three times to remind you.

The diaries will be transcribed, and summaries sent to you by email to affirm the meaning of the content. The summary of the diaries will be used as a focus of a structured interview which you will be invited to take part in when you have completed your multimedia diary entries (after the three week period). You will be invited to this informal interview at your place of work, or a place of your choosing, which will take no longer than an hour. This interview will be recorded on an encrypted device and kept in a secure location, and only available to Jamie the Chief Investigator.

You may also be asked if your photograph could be taken by Jamie while you are at work. This is voluntary and consent would be affirmed at the time of taking the photo.

If you choose to take part, the Chief Investigator will go through this information with you once more and take written consent for your participation.

What are the possible risks or disadvantages of taking part?
This project is designed to minimise risk to participants. The video diaries will reflect on nurse work and the experiences of nurses, therefore, there is a risk that the video diaries may discuss or disclose vulnerabilities which are emotionally attached or painful – or be during/after a really tiring or challenging day at work. Your insight and input to nurse work is valuable, however, no part of this project is compulsory, and you do not have to complete a video diary if you chose not to after a shift. Often people find that it is helpful to be able to talk about their experiences, even when they are challenging.

Your employer will not be told if you take part in this project although it is hoped that the interview can take place during your work day to minimise the impact on your time. If you would prefer the interview to take place elsewhere or at a different time then please let Jamie know and this can be arranged easily to suit you.

Are there any possible benefits to taking part?

The interview session may be beneficial to you as it will offer an opportunity to reflect on your work, which aligns with the reflective practice of the professional framework of nursing. It is hoped that you will help contribute to the ongoing development of nursing in the UK. The data will not be used by any member of the project team for commercial purposes, therefore you should not expect any royalties or payments from the research project in the future.

What happens when the study ends?

The data created in the study will be included in the PhD project at the University of Edinburgh and stored for three years. If you choose to participate then you will be asked during the interview if you would like to receive a summary of the final thesis when it is available. The data that is stored or used will remain anonymous at all times.

Will my taking part in the study be kept confidential?

Your data will be processed in accordance with Data Protection Law. All information about you will be kept strictly confidential. Unless they are anonymised in our records, your data will be referred to by a unique participant number rather than by name. If you consent to being audio/video recorded, all recordings will be destroyed as soon as they have been transcribed. Video diary data and interview recordings will be stored on an encrypted device which is multi-level password protected and kept within NHS Lothian and the University of Edinburgh. All audio/video data will be deleted after it is transcribed.

What happens to the findings?

The anonymised findings of this study will be used in academic and artistic outputs which may include publication in academic journals, presented at conferences used to create artwork and enter the public domain. This may mean the results support future developments in regulatory nursing frameworks or institutional changes.

Who is funding the project?

This project is supported by the University of Edinburgh and NHS Lothian. This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.
Who has reviewed this study?

This study has been reviewed by the ethics committee in Nursing Studies, School of Health in Social Science, University of Edinburgh. NHS management approval has also been obtained.

Contact information for further information?

If you would like any more information, please get in touch with the lead researcher:

Jamie Smith
PhD Student

School of Health in Social Science,
Department of Nursing Studies,
Teviot Place,
Edinburgh,
EH8 9AG.

Email Jamie.B.Smith@ed.ac.uk

The project is supervised at the University of Edinburgh by:

Dr. Rosie Stenhouse
Lecturer
Principle Supervisor
Nursing Studies
School of Health in Social Science
Doorway 6
Old Medical School
Teviot Place
Edinburgh
EH8 9AG

Email rosie.stenhouse@ed.ac.uk

Dr Angus Bancroft
Senior Lecturer
Supervisor
Sociology
School of Social and Political Science
Chrysalis MacMillan Building
15a George Square
Edinburgh
EH8 9AG

Email angus.bancroft@ed.ac.uk

If you would like to discuss this study with someone independent of the study team please contact: Dr Mary Holmes on: 0131 65 3140 or email: mary.holmes@ed.ac.uk

If you wish to make a complaint about the study please contact the University of Edinburgh’s Research Governance team via email at: resgov@accord.scot

You can find out more about how we use your information and our legal basis for doing so in our Privacy Notice at https://www.ed.ac.uk/records-management/privacy-notice-research

If you wish to raise a complaint on how we have handled your personal data you can contact our Data Protection Officer who will investigate the matter. If you are not satisfied with our response or believe we are processing your personal data in a way that is not lawful you can complain to the Information Commissioner’s Office (ICO) at https://ico.org.uk/
Data Protection Officer contact information:
University of Edinburgh
Data Protection Officer
Governance and Strategic Planning
University of Edinburgh
Old College
Edinburgh
EH8 9YL
Tel: 0131 651 4114
dpo@ed.ac.uk
10.7 Appendix 7 Ethical Support

Ref: NUR5038

Jamie Smith
PhD Researcher
Nursing Studies
School of Health in Social Science
Medical School
Teviot Place
Edinburgh
EH8 9AG

30/10/2018

Dear Jamie,

APPLICATION FOR LEVEL 1 APPROVAL

PROJECT TITLE: NAVIGATING NURSE WORK

Thank you for submitting the above research project for review by the Section of Nursing Studies Ethics Research Panel.

I can confirm that the submission has been independently reviewed and was approved on October 17th, 2018.

Should there be any change to the research protocol, it is important that you alert us to this as this may necessitate further review.

Yours sincerely

Julie Watson
Lecturer/Research Fellow
Nursing Studies

Ruth Jepson
Director
SCPHP

The University of Edinburgh is a charitable body, registered in Scotland, with registration number SC005336
University Hospitals Division

Queen’s Medical Research Institute
47 Little France Crescent, Edinburgh, EH16 4TJ

FM/MLM/approval

02 October 2018

Mr Jamie Smith
The University of Edinburgh
Doorway 6, Old Medical School
Teviot Place
Edinburgh
EH8 9AG

Dear Mr Jamie Smith

Lothian R&D Project No: 2018/0253

REC No: 18/NRS/0013

Title of Research: Navigating nurse work: understanding the conditions of possibility for nurses working in Scotland

Participant Information Sheet: Version 1.0, dated 13 September 2018

Consent Form: Version 1.0, dated 13 September 2018

Protocol: Version 1.0, dated 13 September 2018

I am pleased to inform you this letter provides Site Specific approval for NHS Lothian for the above study and you may proceed with your research, subject to the conditions below.

We note that this study has submitted an application to obtain Caldicott approval for those aspects of the study that involve collection of audio/video recordings and transfer of the data. You are responsible for informing the NHS Lothian R&D Office if there are any changes to the study that impact the terms of this approval.

Please note that the NHS Lothian R&D Office must be informed of any changes to the study such as amendments to the protocol, funding, recruitment, personnel or resource input required of NHS Lothian.

Substantial amendments to the protocol will require approval from the ethics committee which approved your study and the MHRA where applicable.

Please keep this office informed of the following study information, which is a condition of NHS Lothian R&D Management Approval:

1. Date you are ready to begin recruitment, date of the recruitment of the first participant and the monthly recruitment figures thereafter.
2. Date the final participant is recruited and the final recruitment figures.
3. Date your study / trial is completed within NHS Lothian.

I wish you every success with your study.

Yours sincerely

Dr Heather Charles
Head of Research Governance

cc. Ms Caroline Whitworth, Associate Medical Director for Surgery and Orthopaedics, NHS Lothian
Mr Michael Pearson, General Manager, Surgical Services Directorate, RIE, NHS Lothian