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**‘What Nursing’s All About’: The Caring
Ideal and Ambivalence to ‘Profession’ in
Nursing’s Occupational Discourse**

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PhD (sociology) University of Edinburgh 2018

Declaration

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 stated otherwise by reference or acknowledgment, the work presented is entirely my own.

A handwritten signature in black ink, appearing to read 'D. Hope', with a horizontal line drawn through the middle of the signature.

Dan Hope 11/07/2019

Date

Acknowledgements

I would like to thank the Economic and Social Research Council (ESRC) who provided the funding for this PhD. I also wish to thank my supervisors, Dr Angus Bancroft and Dr Rosie Stenhouse, for their advice and support, and I am sincerely grateful to the nurses who made the research possible by giving up their time to speak with me. Finally, I would like to thank my wife and my family for their enduring belief and support.

Abstract

This thesis examines the occupational discourse(s) of a group of nurses working on a single medical unit in a Scottish NHS hospital, in light of debates concerning the contemporary function and focus of nursing. There are a number of (seemingly conflictual) impulses concerning how the work of nurses might be conceptualized and the study here aims to demonstrate how nurses' discursive practices seek to negotiate these varying demands and expectations. Principally, the research comments on the relationship between 'care' and 'profession' which, as the thesis establishes, are mutable concepts whose discursive elaboration can be variously realized. Recent efforts to establish nursing as an independent profession have identified 'care' as the theoretical basis of professional knowledge, with the recent move to degree-level study seemingly providing the academic credentials to support this. Some have argued however that a professional, academic outlook is antithetical to authentic caring, while others, still, have made the case that the centrality of relational care to the actual work that nurses undertake is questionable. These debates are inherently complicated by the fact that the terms 'care' and 'profession' have been theorized and interpreted in numerous different ways and are indeterminately related to one-another. The significance of 'person-centred care' (PCC) is examined in the thesis as one concept in which both discourses of profession, and care, might be articulated.

The research eschews any attempt to concretely define 'profession' or 'care' and focuses on the discursive construction of these concepts; that is to say, on how such terms are appealed to in making certain claims. Conducting loosely-structured, qualitative interviews with nurses from each of the occupational bands represented on the ward, I aimed to find out how they conceived of their occupational role and the ways in which they sought to legitimate these perspectives. A critical realist ontology informs how nurses' discursive constructions are understood and analysed, which means that the intelligibility of nurses' responses is comprehended in the way that they correspond to extra-discursive contexts. In this regard, empirical data is analysed in terms of how it relates to the real-world contexts in which it is produced, and discussion seeks to elucidate the plausible reasons for nurses' particular discursive practices. The findings are considered in relation to the practical service contexts of nursing, and of healthcare more generally, as well as in relation to extant discourses through which nursing work has been understood.

The results of the empirical study indicate that nurses, on the whole, are ambivalent about claiming professional status as this would appear to contradict the notion that caring is internally motivated and reflects a sincerely felt concern for patients. Many nurses expressed that a personal predilection to caring was necessary to fulfil the demanding nursing role, and several seemed

to see their job as a natural extension of their private (caring) selves. Thus the findings problematize the notion that 'care' represents the theoretical basis for nursing's professional practice, however nurses did accede to the importance of professionalism in their conduct, though this was recognized as arising from a personal regard for the welfare of patients. Because interviewees perceived the capacity to care as resulting from a natural predisposition to do so, they were largely dismissive of educative attempts to inculcate caring behaviours. In spite of pressures on services, nurses' sought to maintain the primacy of interpersonal relationships with patients and were derisory about working practices which reduced the prospects for this kind of relational engagement.

The thesis concludes that nurses' commitment to a particular caring ideal allows them to retain valued sources of prestige and offers a means of validation for work whose 'professional' rewards remain obscure. Nonetheless, it is suggested that nursing's singular relationship with the concept of care may detract from the wider realization of care as an institutional endeavour.

Regarding the study of professions, the thesis makes the case that it is more productive to concentrate on 'profession' as a rhetorical device which may be employed to achieve various ends, and not always simply in making claims to professional status, which may not, in every case, be desirable.

Lay Summary

In this research project, I interviewed individual nurses working on a single acute ward in a large Scottish hospital to try and find out the ways in which they comprehend the nature and purpose of their work. There are a range of ways in which the nursing role has been, and may be conceived, and so this research sought to understand which ideas and concepts nurses themselves use to describe what they do and why they do it. There is a strong vein of opinion which perceives nursing as being dependent upon natural caring qualities that not everyone can possess, this is often described as a vocational view, while, at the same time, many commentators see this as reductive and wish to emphasise the centrality of knowledge and skills to nursing. Within this, there is a central debate concerning the notion of care; is care simply something natural and innate, or can it be a professional skill which may be learnt and taught? Nursing's recent move to a degree-level subject and the development of academic 'nursing theory' reflects this latter thinking. The research here holds that there is no 'right' or 'wrong' solution to these debates, but that seeing how nurses position themselves in reference to them can tell us something about the perceived value and meaning of nursing work.

The findings derived from the interviews indicate that nurses do not place much value in the notion of profession and do not appear to be interested in actively pursuing formal professional status. Most nurses interviewed related to the idea that nursing work requires a degree of in-built compassion and natural caring qualities and so were sceptical of the value of educational approaches to 'care'. Despite the growing pressures on NHS services which reduce the time available for nurses to spend in direct contact with patients, most nurses identified interpersonal interactions with patients as the fundamental feature of their work and many bemoaned having to do administrative/organizing work. I conclude that in distancing themselves from the idea of nursing as a profession, and in affirming their own individually-cultivated caring abilities, nurses are protecting an occupational identity that provides a means of personal validation, and which is publicly valued, particularly in the wake of recent care scandals such as that documented by the Francis Report (2013).

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1. Introduction

This introductory chapter sets out the rationale for social research into the contemporary discourse of nurses. The empirical study of this thesis aims to understand how nurses construct an occupational identity through their discourse and the reasons behind particular constructions. Some of the most prominent issues affecting modern nursing practice are described to illustrate the contexts in which nurses conceptualize their work. I then provide a personal account of how this research interest originated and the questions which I initially sought to answer, before going on to consider how sociological approaches allow us to conceptualize nursing as a social practice. The empirical study and research approach are cursorily outlined.

1.1 Tensions within the Contemporary Landscape of Nursing

The time is arguably ripe for studying nursing and nurses. A number of interrelated developments are seemingly coalescing to problematize fundamental aspects of the occupation's role and identity. 2013, in particular, was somewhat of a seminal year for nursing in the UK, marking the formal establishment of degree-level entry to the occupation, separating nurse education from its service contexts and, for some, indicating official recognition of nursing's professional credentials. The same year also saw the publication of the Francis Report into poor standards of patient care at the Mid-Staffordshire NHS trust (Francis, 2013), prompting criticisms of nursing care more generally, and fuelling the perception that there is a lack of compassion in public health care (see e.g. Stenhouse, et al. 2016). Framing these events are the growing levels of pressure on NHS services, increasingly stretched by demand; the perennial problem of nurse recruitment and workforce maintenance; and the progressively widening remit of the nursing role (encompassing more technical and managerial tasks), which has resulted in 'basic' care activities being undertaken by less-trained ancillary workers. All of this serves to problematize the notion of nursing care. How may apparent

failings in nursing care be explained and remedied? What effect are the occupation's professional aspirations having on nurses' approaches to care? How can nurses 'care' for patients when they spend seemingly less and less time with them? These questions have all come to the fore in recent years, illustrating uncertainty over nursing's relationship with 'care', a concept which has been widely assumed to be the fundamental basis of the occupation's identity (McEvoy & Duffy, 2008; Dingwall & Allen, 2001; Leininger, 1984). In light of contemporary changes in, and challenges to, nursing work, it would appear to be an opportune time to (re)examine the concept of care as it relates to nursing's occupational (and professional) discourses.

Francis (2013) reported on substantial evidence of fundamentally poor care at mid-Staffordshire and his findings have been widely recounted in the media, along with similar findings from other inquiries (for example, the Patients' Association, 2009; Health Service Ombudsman, 2011), prompting considerable discussion as to who, and/or what, should be held accountable for such failings. It should be made clear, before going any further, that this thesis does not represent a further attempt to explain instances of inadequate care; for a start, there is nothing to suggest that the participants in my empirical research are in any way complicit with poor care standards. However, some of the discussions prompted by the Francis inquiry serve to crystalize issues of more general and abiding significance for nursing, and illustrate some of the prominent discourses through which nursing care is conceptualized. For instance, the 'blame game' that ensued following the revelations in the report reveals a variety of beliefs about what is needed for care to happen and what stands in its way. For some, degree-level education and the quest for professional recognition are held culpable; nurses, so the charge goes, are now career-motivated, cerebrally-oriented and resultantly neglectful of 'lowly' basic-care activities (Woodward, 1997; Corbin, 2008; Borland, 2013). Others have focused criticism upon a management culture in the NHS in which targets and cost-effectiveness are pursued at the expense of quality in care (Smith, 2012). Sheer workload has been cited as another impediment to adequate care, with nurses simply overburdened to the extent that they fail to notice patient suffering (Paley, 2014). Others, still, frankly maintain that some nurses

may, for whatever reason(s), now lack the values and personal characteristics demanded of their role (Darbyshire, 2014).

Whatever position nurses take in regard to these debates demonstrates an orientation to the concept of care and has consequences for the occupation's self-image. For instance, there are plausible reasons for embracing 'professionalism', supported by higher educational standards, which may raise the profile of the occupation (Bliss, et al., 2017; Anderson, 2010), however, there is the countervailing contention that a professional outlook represents an undermining of fundamental care. As Corbin (2008, p164) ponders;

"I am wondering if in the quest for professional recognition nurses have come to devalue the more mundane tasks that nurses used to do routinely, tasks such as bathing, walking ill persons, and yes that long forgotten activity doing back rubs."

Similar, though less tentatively-expressed, opinions have been promulgated in the popular press, such as an article in the *Daily Mail* (Borland, 2013) which claimed that a graduate nurse refused to clean up vomit on the basis that she was over-qualified for that task. The article also reports the views of some former nurses who contended that "nurses today were more concerned with complicated medical tasks such as taking readings rather than changing dressings, washing or feeding" (Borland, 2013).

Thus, nurses are compelled to negotiate between dualistic interpretations of the occupation's professional development in articulating their perspectives on care. While espousing a professionalized view of nursing care risks apparently disavowing the importance of so-called basic care tasks, the reverse has equally negative potential connotations. Under-emphasising technical and academic abilities can exacerbate a reductive and limiting view of nursing in which simply being 'nice' and hardworking are seen as the central requirements. Resultantly, nursing finds itself between the proverbial rock and hard-place when advancing a position on the role of education, and the presumed professional status that it denotes. On one hand, it is argued that contemporary healthcare needs require well-educated, professional nurses, able to problem-solve and exercise clinical judgement (Ali & Watson, 2011), on the other is the contention that educational demands are undermining the

importance of 'naturally' cultivated caring abilities. As Ilora Finlay (2012) has written in *the Times*:

"Some excellent clinical nurses had to take degree courses for which they had no aptitude, driving them out of nursing. Career progress demanded the letters of a degree rather than the merit of hard-earned bedside practice"

Here emphasizing the perceived disjuncture between educational formalization and practical competence.

Another source of tension in contemporary nursing discourse which has been brought into focus by Francis is that between organizational conditions and the individual caring capacities of nursing staff; the report highlighted that deprivations in working conditions, such as staff-shortages, contributed to shortcomings in care provision at mid-Staffs (Kaufman, et al., 2014, p41). The liability of such obstacles, however, is mitigated through what MacKay (1998, p66) has described as an 'I will always manage' attitude evinced by nurses, along with a related commitment to the idea of 'self-sacrifice' (Bolton, 2005). Nurses' acceptance of individual responsibility for the care that they provide (Apesoa-Varano, 2016) can be seen as demonstrating personal commitment to the role but, to some extent, excuses trying organizational conditions. Again, nurses are faced with navigating between seemingly opposed accounts of their capacity to provide care. A nurse's own personal devotion to the caring role may entail the presumed ability to compensate for organizational constraints on care-provision, yet nurses still wish to express dissatisfaction when practical conditions make caring more difficult.

Relatedly, and briefly for the time being, there is the tension between nursing's commitment to holistic emotional care for every patient, and the practical reality of the role which entails considerable organizational and technical skill, often not undertaken by the bedside. The popular and pervasive perception that nurses are marked out by their ability to offer emotional support (whether as a result of inherent caring characteristics, or as part of their professional mandate) is tested by the demands on time and resources in a modern, publicly-funded health service. Both within and outside of nursing, the image of nurses as 'caring, nurturing, kind, loving and supportive' (MacKay, 1998, p63) and as 'angels of mercy' (Rezaei-Adaryani, et al., 2012)

remain pertinent to the widely held conceptions of the occupation, supported by dissemination through television and in other popular media (see Theodosius, 2008). However, the actualities of day-to-day nursing may often preclude the development of holistic therapeutic relationships. While nurses may wish to uphold an association with emotive, relational care, this is not readily facilitated in practice. Indeed, Dingwall and Allen argue that it may be expedient, now, for nursing to accept the prevalence of the technical aspects of the job, and realize that any emotional component of the work is likely to be “based on a fleeting encounter rather than an established holistic relationship” (Dingwall & Allen, 2001, p70). In the present climate of unprecedented demand for NHS services, extensive waiting lists for surgery, and long waiting times for hospital admissions, the ability of nurses to deliver inter-personal, relational care is arguably more circumscribed than ever.

Taking a long-lensed view of nursing’s occupational development, De Meis, et al. (2007) depict nursing as an occupation whose essential meaning is in flux; negotiating movement between two separately constituted discursive frames of reference, analogous (the authors claim) to the realms of ‘house’ and ‘street’ (De Meis, et al., 2007). They explain that, previously:

“... care was seen as a natural knowledge strictly connected to the private domain (the “house”), whereas technique and rationality were connected with acquired knowledge, requiring study and discipline belonging to the institutional world, to the public space (the “street”).”

(De Meis, et al. 2007, pp325-326)

Nursing’s professionalizing tendencies, realized globally, are viewed by the authors as signifying a transition away from the ‘house’ to the level of the ‘street’, where nursing skills are formalized, and concentrated away from direct patient care. It is observed, however, that this transition is not unproblematic as the traditional and new aspects of nursing identity overlap and confront one another. The authors conclude that: “Care and knowledge continue to be seen as antagonistic because care is perceived as belonging to the universe of the “house” and knowledge remains in the “street” universe.” (2007, p328)

A similar opposition is proposed by Bliss et al. who argue that “Currently, there are two discourses in nursing theory that are seemingly at odds regarding the question of how nursing should represent itself as a discipline.” (2017, p2). These are broadly conceptualized as a ‘caring’ discourse, and a ‘knowledge’ discourse which are presented as encompassing rhetorical opposition. The authors contend that:

“Those who promote the caring discourse may not always consider whether (and how) these ideals can be accommodated within nursing knowledge’s evidence base” whilst, concomitantly, “those who emphasise the importance of disciplinary knowledge can devalue certain moral qualities as part of their broader vision for how nursing should represent itself.”

(Bliss, et al., 2017, p2)

Ultimately, Bliss, et al. put forward a means of resolution (via Aristotelian virtue ethics) to this seeming impasse, although the two overriding discourses that they identify are often perceived to be conflictual and represent a general ambivalence in the articulation of a contemporary nursing identity.

Thus, there is a considerable plurality of discursive possibilities that may be drawn on to express the essential meaning of modern-day nursing; many of the prominent discourses appear to be conflictual or dualistically conceived (nursing as either ‘profession’ or ‘vocation’, as either technically or expressively oriented) although the possibility of synthesis between various standpoints should not be discounted. The research presented here is interested in the ways in which nurses conceive of their role, in light of the tensions highlighted above, and in how they respond to the seemingly conflicting demands and expectations of the occupation at this specific socio-temporal juncture. In particular, the relationship between ‘care’ and ‘professionalism’, terms which are each imbued with great significance but whose usage is mutable and ambiguous, is extensively examined. Ultimately, I attempt to identify the discourses through which nurses understand and articulate the meaning of what they do.

1.2 Origins of the Research/Thesis

It is worth stating here, early on, that I am not, and never have been, a nurse, or a student of nursing. Nor am I a member of any associated healthcare occupation. Nor, even, have I any close family or friends who have followed a career in nursing. Thus, in the field of nursing research, this contribution is relatively unique as it is not informed by prior experience of working in the sector. The majority of empirical studies of nursing and nurses which I have encountered in carrying out this project have been produced by nursing academics whose interest in the occupation is, perhaps, self-explanatory. In my case, it may be worth briefly explaining how this thesis has come about given that I have no personal affinity with the occupational group under examination, and given also that it is something I am frequently asked in relation to my studies, considering my 'non-nurse' status: 'why nursing?'

It might be conventionally expected that one's choice of research topic is based upon a substantive area of personal interest. For example, in my undergraduate studies, I took sociology courses on the subjects of 'food' and 'music', respectively, because of an existing, 'lay-person', interest in those areas. Learning what was sociologically significant about these subjects came after the initial predilection towards them. In the case of this research, the choice to study nursing and nurses was theoretically determined and was, in fact, a relatively late decision in the planning of the project. I had previously done a (smaller) piece of research on not-for-profit organizations and their funding mechanisms, in particular, focusing on what these organizations were required to demonstrate to funders in order to receive their support. The project was concerned with the differences between an organization's *actual* activities and the way in which they were reported; between on-the-ground-ways of working and their formal rendering. One of the two organizations I studied was a psychotherapeutic counselling service and I was struck by the contrast between the fairly intimate relational work that goes on in therapy, and the systematic manner in which it had to be presented to funders. It was this fairly abstract idea concerning the relationship between actual practices and formal conceptualization that led me to the consideration of 'Person-

centred care' (PCC) which, of course, has its origins in counselling and psychotherapy, and which seemed to contain this ambiguity between formalization and intimacy; a 'person-centred approach' serving as a theoretical means of describing the quality of interpersonal relationships. I wondered about the ways in which 'person-centredness' was manifested in the therapeutic relationship between client and practitioner.

However, I soon moved away from psychotherapy as a frame of investigation when I began to search in earnest for literature pertaining to person-centred care and came to realize its current prominence in contemporary healthcare speak, noting some authors' recognition of its especial relevance to nursing (i.e. Nolan et al., 2004; McCormack, 2004). It should be observed here, though, that person-centred care is a concept promoted across, and within, several 'caring professions', from social work to medicine and these areas could doubtlessly provide compelling case-studies into how the concept is understood. Nonetheless PCC has been identified as an approach to nursing care which has the potential to support nursing's professional ambition by providing a means of theoretically conceptualizing nursing work (Dewing & McCormack, 2017) and perhaps in this way bears greater significance on occupational practice. Price has claimed that, in the literature around PCC, the concept has been treated as representing "a redefining of the expertise base for nursing-highlighting psychosocial and interpersonal skills as much as those associated with physical care" and as a means of "distancing the work of nurses from that of other healthcare practitioners" (Price, 2006, pp49-50). Again, I was predominantly concerned, at this early stage, in the potential disjuncture between PCC as a formalised, codified approach to nursing care, and the actual practices and beliefs of nurses, particularly in consideration of the strength of vocational discourse in nursing in which caring is perceived as an inherent trait. My initial, broadly-conceived question to research was simply 'How do nurses conceptualize 'person-centred care'?'

The research presented here has developed quite considerably from its formative stages, most notably in the scope of the conceptual analysis. Whilst it may be more common to pare-down the focus of one's research, from

general topics to more specific concepts, I seem to have scaled-up the overall level of analysis. I had initially concentrated my investigations on the concept of 'person-centred care' (which will be discussed in greater detail later), recognizing this as an approach to healthcare that could be conceived of in a number of different ways (see, e.g. Gillespie, et al., 2004). It seemed to encapsulate the nature of many of the debates around care discussed here earlier; for instance, can 'person-centred care' be read as evidence of a professionalized approach to 'care', wherein caring becomes the object of a theoretical body of knowledge and expertise? Or is it reflective of the idea of vocational care, wherein the realization of 'person-centredness' depends upon the natural skills of nurses, coupled with genuine regard for the welfare of patients? Is being 'person-centred' applicable to nurses whose chief responsibilities are managerial and technical in nature? Can person-centred care be provided in the highly pressurized environment of a modern NHS hospital?

When I began talking with nurses about PCC, I came to recognize that, much of the time, their responses were representing some fundamental beliefs about nursing more generally, and it became increasingly difficult to try and relate everything back to PCC without eschewing substantial amounts of rich data. It also quite soon became clear that many nurses did not readily use the term 'person-centred care' when describing their work idiomatically and, in this sense, to treat the concept as my overriding research concern, may have over-exaggerated its significance to nursing discourse. In short, I was, perhaps, more invested in the meaning of the specific term than were the nurses with whom I spoke. The focus on person-centred care transpired to provide a kind of opening gambit that, while worthy of analysis in its own right, enabled more wide-ranging discussions on the nature of care (more broadly conceived) and nurses' motivations for doing the work that they do. Addressing the original question 'how do nurses conceptualize person-centred care?' prompted more comprehensive investigation into the bases of these conceptualizations. For instance, the responses of many nurses in regard to PCC betrayed a conviction that the provision of such care was heavily dependent upon the natural

qualities of nurses and so I sought to ascertain the effects and consequences of this belief, beyond its bearing on the understanding of PCC.

1.3 Research Questions

The overriding question addressed by this research and its findings essentially concerns the ways in which nurses construct an occupational identity. Very broadly speaking, the thesis aims to provide insight into the meaning of nursing work to nurses, however this objective is certainly too nebulous to be comprehensively realized. While the analysis is conceptually wide-ranging, there are 3 principal themes of inquiry which, taken together, offer a coherent account of some of the dominant discourses within nursing. These themes are stated plainly below along with more specific sub-questions which indicate the approach to the primary themes.

How do nurses conceptualize person-centred care (PCC)?

- Is PCC something that can be taught and learnt?
- Do nurses recognize 'person-centredness' in their practice, and what does this entail?
- What are the conditions which facilitate 'person-centred' care provision?

How is the concept of professionalism understood in relation to nursing?

- Do nurses consider themselves to be professional?
- If so, what behaviours and attitudes signify this?
- How might we explain continued ambivalence over the meaning of professionalism for nursing?

How do practitioners conceptualize care in nursing?

- What are the conditions which make caring possible?
- What actions, behaviours and attitudes are associated with 'caring'?
- What are the barriers to the realization of nursing care?

Of course, these areas of inquiry are not discrete categories. For instance, a nurse's perspective on 'care' might well inform their views of professionalism in nursing. A cynical attitude towards 'professionalism' as a way to conceptualize the work of nurses may be related to a nurse's belief that nursing care is attributable to individual characteristics and is not amenable to

formal prescription. The research themes should thus be considered as a pragmatic means of presenting the research and not as separate lines of inquiry.

1.4 Sociology and Nursing

In a recent collection of essays on 'Social Theory and Nursing' (2017, Lipscomb, ed.) a distinction is realised between social theory *for* nursing, and social theory *of* nursing. The former refers to the use of sociological theory to *inform* nursing practice, such as when Porter (2017, pp76-90) suggests that critical realist approaches to causal explanation represent a more suitable strategy for evaluating nursing interventions than randomised control trials which submit to the logic of evidence-based practice. Social theories *of* nursing represent the endeavour to understand nursing as a social practice which is part of wider societal structures. Pam Smith (perhaps unwittingly) neatly illustrates this distinction as she describes nursing's efforts to identify a distinctive orientation to occupational practice, writing;

"An alternative knowledge base for nursing was sought which turned away from a biomedical one (...) biological science was no longer seen as the predominant knowledge base of nursing...there was now a requirement to balance it with psychology and sociology as part of the 'scientific basis of nursing'"

(Smith, 2012, p68)

On one hand, the discipline of sociology is identified as a constituent element of nursing's (new) knowledge base, i.e. as something which may be used to inform the work of nurses. On the other hand, the act of seeking to establish a knowledge base distinct from bio-medicine can, of itself, be analysed as an effect of social relations and we can draw upon social theory to explain the structure and organization of nursing work. The questions posed in the research here are oriented to this latter use of social theory; using sociological methods and ways of thinking to try and understand something about why nursing is the way it is, rather than assuming nursing as a self-evident practice to which sociology might be useful (see Traynor, 2017). Thus, for instance, the point above concerning the nature of nursing knowledge may be analysed and

understood with reference to professional relations and/or to the gendering of types of work; phenomena which exist outside of, and interact with nursing.

As Traynor (2017, pX) notes; “many academics have a foundational commitment and orientation to the value of nursing and what nurses do”, arguably exhibited in statements such as that caring is the essence of nursing (Leininger, 1984). A sociology *of*, rather than *for*, nursing is concerned with determining the basis and significance of such claims and much of the theoretical discussion in this thesis considers the way that the relationship between nursing and caring has been constructed and utilized.

1.4.1 Nursing and Medicine

The relations between medicine and the nursing occupation has been one of the main lenses through which nursing’s caring prerogative has been comprehended. A socio-historical perspective of the development of nursing is instructive to showing how a bio-medical model of healthcare may be said to have contributed to the occupation’s caring focus. As several commentators have noted, the work of nurses has, historically, developed in response to the priorities of bio-medicine which concentrates on disease, its physical symptoms and medical treatment. Indeed, Williams recognises that the nursing role was first formally established to carry out routine observations of patients which were perceived as being beneath the skill remit of physicians (Williams, 1978, p37), and the trend for delegation of responsibilities has continued with nurses, for instance, now administering drug treatments.

The hierarchical relationship between medicine and nursing, based on the dominance of a bio-medical approach to healthcare has been cited as a principal driver for the development of a nursing ideology based upon ‘caring’ for patients, in apparent contradistinction to a medical concern with ‘cure’. Modern efforts to professionalize nursing have been based upon assertions that nursing harbours a distinctive theoretical knowledge of care and later in the thesis, I suggest that ‘person-centred care’ has been identified (by some) as particularly salient to nursing because it represents a theoretical basis upon which to base professional claims (see, e.g. Dewing & McCormack, 2017).

Nursing's attempts at professionalization have been conceived of as a means of overcoming subjugation to medical dominance, the preservation of which has been strongly associated with the gendered division of labour in medical care in which the work of nurses is devalued as 'women's work'. Williams (1978, p27) declares that, from the off, women were recruited as nurses as this "would not threaten the subordinate role of the new occupation" and so challenging medical dominance is viewed also as a means of combating the devaluation of work that is predominantly performed by women.

As evidenced in this study, and elsewhere, the equation of caring with nursing professionalism has not, however, been unanimously endorsed as many perceive the notion of care as transcending purely professional concerns. One possibility, examined later on herein, is that caring, as a way of relating to others, is significantly prescribed by its manifestation in informal and/or familial settings and is seen as something entailing a fundamentally personal commitment. Indeed, another feature touched on in the thesis is nursing's seeming uncertainty as to whether caring attitudes can be formally cultivated, or whether they inhere in the person of the nurse, along with the consequences of endorsing either of these positions. In either case, the centrality of 'caring' to nursing is maintained and the research here examines how, and to what ends, the notion of caring is conceptualised by nurses.

1.4.2 The Place of Emotion

Another significant way in which nursing care has been theorized is as a form of emotional labour wherein nurses' obligation to engage in caring behaviours requires the manipulation of inner feeling states. In Arlie Hochschild's (1983) original theorization of the concept, which is more fully outlined later on, certain (people-facing) workers must suppress authentic emotions in order to conform to forms of relationships which are occupationally prescribed. For nurses, for example, this could mean having to care for somebody whom they dislike, or alternatively, subdue feelings of sadness in order to maintain a 'professional' face.

One of the key debates in respect to this theorization concerns nurses' use of 'authentic' emotions because Hochschild claims that the emotions which workers employ have the effect of self-alienation, i.e. feelings are not the worker's own. Hers is an essentially Marxian argument that the division of labour strips people of their autonomy as their work activities are provided in service to organizational interests and market logics. Against this, it has been maintained that, particularly in the case of NHS nurses, emotions at work are in fact induced and used autonomously and spontaneously as a naturally compassionate response to suffering (i.e. Bolton, 2005). This thesis aims to engage with this debate by considering the bases of nurse-patient relationships and the reasons given by nurses for engaging in such relationships. The distinction made between caring *for* and caring *about* patients is later discussed and appears central to the debate as to whether providing nursing care is perceived as self-alienating or self-affirming. Seemingly, from the responses of nurses in this research, the use of emotions is primarily dictated by the interests of patients and is seen by nurses as signifying genuine care, although, ultimately, it might be argued that exhibiting care in this way is frustrated by the practical organization of nursing work.

1.4.3 Institutional Care

Because nursing is not simply an abstract concept but requires concrete practices and activities as part of our understanding of it, there is a significant pragmatic component in much of the theorization of nursing work. For instance, Dingwall and Allen (2001) commented on the limitations to 'holistic emotion care' in terms of time and resources, since which time, demand for services has only increased. Nurses have accumulated expanded responsibilities in terms of both organizing for care and in administering technical aspects of patient care in dealing with an increasingly aged and sick population, yet, as Bolton (2000, p18) claims the 'symbolic anchor' of care maintains. Therefore, another key theme examined in the research has to do with how nurses respond to the practical demands of the job which often result in relatively brief interactions with patients. A prominent discussion in the nursing literature concerns the perceived discrepancy between the

idealisation of nursing care (propounded through a variety of sources) and the practical realities of practice (Dahlke & Stahlke Wall, 2016; Henderson, 2002; McCarthy, 2006). Part of the research study aims to see how nurses deal with this tension, both through their rhetorical practices, and in the practical actions that they claim to engage in.

1.5 The Study

In depth, loosely-structured interviews were conducted with a sample of nurses working in a single, acute medical unit of a large NHS hospital in Scotland. The sample was purposively selected to include nurses from a range of occupational bands and to ensure that men were not excluded, which might have resulted from a random sample given the male/female ratio in nursing. The unit chosen is a busy ward with a high turnover of patients, although the length of patient stays are variable and regularly returning patients are fairly common. The ward is mixed-sex and the patients are of varying ages, although as with many acute conditions, there is a skew towards older-aged patients who represent more of the hospital population overall. The interviews were largely organized on an opportunistic basis to fit around the unpredictable workloads and general level of busy-ness of the nurses working on the ward; resultantly, all of the interviews were conducted in situ, on the ward, at times when nurses were able to take a break from their duties. I employed a roughly-drawn interview schedule in order to retain focus on a few broad themes but did not adhere to this rigidly, in order to allow considerable scope for expansion in the nurses' answers and to accommodate follow-up questions.

The aim of the interviews was to identify nurses' discursive practices in relation to their work. Discourse has been described as "a particular form of language that constructs versions of the world that have consequences for selves, relationships and morality" (Nunkoosing & Haydon-Laurelut, 2011, p407). Thus, it was nurses' own *versions* of their occupational world that I was striving to ascertain. In this sense, interview responses are not considered to be 'objectively' accurate accounts of nursing work; rather, they give insight into

how nurses interpret the meaning of their work and the means through which they construct an occupational identity. At one level, nursing work is a set of practical activities and observable behaviours, though the significance of these actions is situated at the level of discourse. To give a brief illustration, the decision to enter a career in nursing might be explained via various discourses; for instance, in the past, nursing was viewed as respectable work for young middle-class women and therefore a discourse of propriety, based on views of class and gender, may be appealed to in contemplating nursing behaviours and their consequences. By contrast, many nurses might adhere to an individualistic discourse in explaining their career choice; expressing the belief that some semblance of natural personality traits drew them towards a 'caring' occupation and therefore explaining their actions within a narrative of personal fulfilment. These discourses, respectively, make different claims concerning the meaning of nursing work for the individual nurse; in one sense, to nurse confers a position of social respectability onto the nurse, in the other, nursing is understood as a practice that affirms the altruistic tendencies of the individual practitioner.

Moreover, the concepts in which I am invested throughout this thesis, in particular 'professionalism', and 'care', are not empirically observable phenomena but derive their meaning from the social contexts in which they are employed. As will be shown, at length, herein, there is considerable variability in the way that these terms are applied and, owing to this, it is contended here that the only viable means of understanding their significance is to treat them as discursive constructs. In recent theoretical literature on the professions, the recognition of professionalism as a discourse, shaped by differing occupational contexts and employed to meet various ends, has gained prominence (Dingwall, 2008; Watson, 2002; Evetts, 2003; Noordergraaf, 2011) and, likewise, this research posits that professionalism in nursing is articulated in correspondence with the particularistic aspects of nursing as a social practice. Arguably, there has never really been an attempt to concretely define 'care' (unlike with 'profession' which, for some time, was the object of theoretical attempts at classification) and so this acknowledged subjectivity (Morse, et al., 1990; Thomas, 1993) seems to necessitate a

context-based approach. Even a more specific focus on 'nursing care' does not significantly narrow down the number of ways in which said care may be symbolically understood.

The transcribed interviews were manually coded for themes and evaluated via what might best be described as critical discourse analysis, although, it should be noted right away that this is not a singular or prescriptive approach to data analysis (Wodak & Meyer, 2009, p16). The principal contention of critical discourse analysis is that people's discursive practices are liable to reflect the contexts in which they are constructed and that, therefore, what people say can be understood more fully if we take into account the significance of these contexts. Unlike conversation analysis which only allows for talk to be interpreted as a product of the conversation in which it takes place, critical discourse analysis contends that talk reflects wider social narratives as well as responding to the immediacy of the conversational encounter. Thomas and Hewitt (2011) argue for the value of attending to modes of social practice in the interpretation of discourse. Citing Chouliaraki and Fairclough, the authors state that "CDA takes as its starting point the idea that social life is made up of social practices: 'habitualised ways, tied to particular times and places, in which people apply resources (material or symbolic) to act together in the world'" (Thomas & Hewitt, 2011, p1378). Essentially this entails that discourse does not simply arise from out of nowhere, but that people's discursive practices are delimited by the relative stability of social life; a stability which is necessary for people to be able to engage in meaningful communicative interaction. In turn, modes of discourse are able to shape social practices in a dialectical relationship. In nursing, for instance, an 'holistic care' discourse may be said to have concretely affected nursing educational programmes, changing the way that nursing is taught which, in turn, generates new discourses, such as the claim that nurses are becoming 'too clever to care'.

This mode of discourse analysis is fully complementary with the critical realist ontology that informs the overall interpretation of this research. Critical realism essentially maintains that discourse is dependent for its sense upon extra-discursive referents. This will be elaborated upon later in the

methodology chapters, though, simply put, this means that, while a plurality of discourses certainly exists, these discourses are only viable insofar as they can be related to the social world which they describe. Correspondingly, we can only discern this relation insofar as the discourse makes some kind of sense.

In Van Leeuwen's (2008, p5) view of discourse as the 'recontextualization of social practice', "... all representations of the world and what is going on in it, however abstract, should be interpreted as representations of social practices", though Chouliaraki and Fairclough add that discourse itself is an element within social practice and is therefore constitutive, as well as representational; "representations of a practice are generated as part of the practice" (Chouliaraki & Fairclough, 1999, p37). If we conceive of nursing as a relatively bounded social practice, made up of specified actors (nurses, patients, doctors), institutional arrangements (e.g. a publicly funded health service), and including discourse itself, we can evaluate the significance of any discursive text (for instance, a nurse's interview responses) in relation to these contingent features of practice. In this sense, each of the things discussed at the beginning of this section; the pressure on the NHS caused by increased demand for services, changes to nursing education, extant discursive understandings of 'care', are all elements of social practice to be analysed in conjunction with nurses' discourse produced in this research.

1.6 Organization of thesis chapters

Following this introductory section (1), the thesis is divided into four broad segments; the literature review, the research design, the presentation of the findings and analytical commentary, and finally, a discussion and conclusions section.

In the literature review (2), I present a more detailed examination of the concept of 'person-centred care'; its origins, development and its significance to nursing. I then relate perspectives of person-centred care to the professional status of nursing, and argue that ambivalence over embracing PCC as theoretically central to nursing practice reflects uncertainty concerning the desirability of a 'professional' identity. The uneven historical development of nursing professionalism is presented and discussed (2.2)

The dominant sociological approaches to the theorization of 'professions' are considered (2.3); from the functionalist belief that professions are uniquely pro-socially motivated, upholding society's norms and values, to power-based theorizations of professionalization as a volitional strategy to consolidate privileges for an occupational group, to contemporary constructivist accounts which view professionalism as a rhetorical construct, contextually-determined and mobilised for a range of purposes. I then contemplate some empirical studies that have sought to elucidate how 'nursing professionalism' has been conceived of, and demonstrated, in practice (2.4).

In chapter 2.5, I consider how 'care' has been theorized as an element in nursing practice, drawing particularly upon the theoretical distinction between 'caring for' and 'caring about'. The emotional nature of the nurse-patient relationship is appraised. Finally, the relevance of relational, affective care in nursing is discussed and some criticisms of the 'caring ideology' within nursing are introduced.

Section 3 sets out the research design and methodological approach for the project. The first chapter (3.1) outlines a critical realist approach to discourse-based research which aims to understand the relation between discursive practices and the social reality of which they are a part. A critical realist

understanding of causality is forwarded to explain how qualitative research studies may be both reliable and amenable to generalization (3.2). The practical research strategy is outlined in 3.5, dealing with issues such as sampling and access as well as explaining and justifying the employment of loosely-structured interviews in obtaining data. The ontological status of this data is contemplated. Finally, I explain the approach taken to coding the data, illustrated with an applied example.

The 4th section of the thesis constitutes the presentation of the empirical research findings along with discussion of their significance. The first chapter (4.1) of this section is chiefly concerned with nurses' perspectives on the concept of person-centred care and its relation to the increasing academicism of nursing. Nurses' attitudes towards pedagogical approaches to nursing care, including whether person-centred care can be learnt, are considered. Chapter 4.2 concentrates on nurses' views of 'professionalism'; what it means to be professional in a nursing context and how this understanding contributes to the overall occupational identity of the nurses with whom I spoke.

Finally, in this section, chapter 4.3 attempts to delineate the way in which nurses conceive of 'care'. What motivates nurses to care? What kinds of activities do nurses consider to be representative of care provision? What kinds of factors are necessary for the realization of care? Nurses' conceptualizations of care are discussed and considered with regard to the institutional setting in which nursing work takes place.

The discussion and conclusions section (5) relates the significance of the research findings to the contemporary situation of nursing more generally. The use and value of 'professionalism' is explored and alternative ways of conceptualizing the work of nurses are evaluated, while contextual reasons are offered as to why nurses might be ambivalent over embracing 'profession' (5.1.). The varied use of professional discourse is emphasized and it is suggested that 'professional talk' can have purpose beyond simply trying to establish professional status (5.2).

Nurses' 'caring' discourse is assessed in light of some of the contemporary challenges facing healthcare, as a whole, and it is posited that 'care' is a systematic concern which all healthcare professionals contribute to (5.3). In chapter 5.4, I consider some directions for future research and appraise the methodological contribution that actor-network theory could make to similar studies before, finally, offering some concluding remarks and reflections on the present state of nursing work.

2. Literature review

The literature review deals predominantly with the way in which relations between nursing, 'professionalism', and 'care' have been theorized. It begins by considering the relevance of Person-centred care to nursing practice and a link is drawn between ambiguity over PCC and the ambivalence surrounding nursing's claim to professional status, the value of which is contemplated. A thorough review of sociological approaches to 'profession' precedes consideration of some empirical research studies that have sought to show how nurses conceive of professionalism and its correspondence to practice. Finally, different ways of theorizing 'care' are discussed and the reasons for the concept's centrality to nursing are contemplated. The distinction between caring *for* and caring *about* patients is drawn upon in considering the resistance on the part of some nurses against the formalization of care.

2.1 Person-centred Care: Historiography

'Person-centredness' was first referred to in the context of psychotherapy in the mid-20th century and is widely attributed to US psychologist Carl Rogers; though he used the term 'client-centred' more often, client and person are used interchangeably in reference to his work (e.g. Kirschenbaum, 2012; Dupuis et al. 2011). Rogers developed the idea of 'non-directive' therapy (1942); an approach recognizing that the power to affect personal change or growth lies ultimately with an individual themselves, and is not resultant from prescriptive, professional intervention. As such, Rogers argued that "clients do not need the judgement, advice or direction of experts. They need 'supportive counsellors and therapists to help them rediscover and trust their own inner experiencing, achieve their own insights, and set their own direction' (Kirschenbaum, quoted in Dupuis et al. 2011, p430). Thus, the efficacy of client/person-centred therapy is perceived in the quality of the relationship between the therapist and their client, rather than on the 'proper' application of some abstract theory. A therapist works *with*, not *on* a client towards the realization of their therapeutic goals.

The person/client-centred approach represented a significant departure from the then dominant, though increasingly divided, school of Freudian psychoanalysis which Rogers (1959, p191) criticised for its ideological dogmatism. By contrast, Rogers' therapeutic approach avoids processes of diagnosis, classification and prescription, emphasising instead client self-determination and self-understanding. Defending Rogers' philosophy, Schmid (2014, p11) contends that "the danger of alienation is to be found in any place where the human being is not aware of their personhood in all its dimensions", thus stressing the importance of cultivating self-understanding.

Psychotherapeutic models that rely on the 'expertise' of practitioners, inevitably, are seen to retard the prospects for that which Rogers termed 'self-actualization', because the therapist retains a privileged, professional understanding of the client. Conversely, Rogers (1951) proposed that "The best vantage point for understanding behaviour is from the internal frame of reference of the individual".

'Person-centredness' was not a significant fixture of healthcare terminology, outwith psychotherapy, until some time after Rogers' initial elucidation of the concept in that context, and it would therefore be erroneous to posit a straightforward transposition of these ideas into the realm of medical care. The 'person-centred care' endorsed by the national health service of today arguably has no singular origin, but derives from the combination of a number of different ideas and processes. Nevertheless, many of the fundamental premises of Rogers' beliefs concerning the therapeutic relationship remain as reference points for healthcare professionals committed to person-centred approaches. Perhaps the strongest link between Rogers' work and more contemporary models of healthcare are to be found in writing on the care of dementia patients, which is frequently identified as the area in which PCC was first explicitly outlined (Nolan et al., 2004, p46). Tom Kitwood is widely cited as pioneering a person-centred approach to dementia care, evidenced through his writings of the 1980s and 90s, (Nolan et al., 2004; Edvardsson et al. 2008; Brooker, 2004 etc.) and Kitwood's use of the term was, according to Brooker (2004, p215) "intended to be a direct reference to Rogerian psychotherapy with its emphasis on authentic contact and communication." It should be

noted however that Rogers was not the sole influence on the thinking of Kitwood who, in turn, is not the sole instigator of person-centred dementia care.

Similarly to Rogers, Kitwood's views on personhood were essentially phenomenological in that he emphasised the primacy of the lived experience of individuals and thus sought to promote the "serious attempt to take the standpoint of the person with dementia" (Kitwood, 1997, p4). Whilst "some investigators suggest that the cognitive decline of the disease process gradually erodes personhood down to nothing" (Edvardsson et al. 2008, p362), a phenomenological perspective views personhood as constituted in an individual's experience of, and relation to, the world around them. Thus, "even when cognitive impairment is very severe" (Kitwood, 1997, p12), people remain persons because they still engage with the world and with other people. These views of personhood transcend a purely 'bio-medical' treatment of people with dementia which, according to Edvardsson et al. (2008, p363) "downgrades the person to a carrier of an incurable disease and thereby ignores personal experiences of well-being, dignity, and worth." Although there is no real consensus on how a person-centred approach is best operationalized, there appears to be general acceptance that respect for personhood is essential to caring for people with dementia, a condition for which purely medical intervention has been deemed inadequate (Edvardsson et al. 2008, *ibid*).

The development, and wide-spread endorsement of person-centred dementia care can be seen as a response to a growth in diagnoses of cognitive impairment, which is linked to an increasingly aged population. Indeed, the coincidence of cognitive impairment with old-age may explain why 'person-centred' approaches have come to represent quality care for older people more generally (Nolan et al. 2004). In the context of UK health policy, Nolan et al. (2004) view the establishment of the 'National Service Framework for older people' (Department of Health, 2001) which promotes person-centred care, as resulting from the recognition "that services needed to be more responsive to future health challenges, particularly those posed by the growing numbers of

older people.” (p45). The population of elderly patients in hospitals continues to grow (NHS digital, 2016) and these patients are exceedingly likely to present with multiple co-morbidities, of which dementia may be one; therefore, the necessity of a more holistic approach to their care has been realized (Nobili et al. 2011) as the discrete treatment of different conditions becomes untenable.

Furthermore, the reality of an increasingly aged sick population has brought attention to the issue of ageism in healthcare and its potential ill-effect upon patients (Sao Jose et al. 2017). Indeed, Nolan et al. (2004, p46) argue that the National Service Framework’s aims of ‘promoting person centred care’ and the “rooting-out of age discrimination in the NHS” are ‘inextricably linked’. Of course, healthcare provision is not restricted to the elderly, though recent figures from ‘Age UK’ estimate that people over 65 account for over 40% of all hospital admissions; moreover, the average length of stay in hospital increases with age (Age UK, 2018). For this reason, demographic trends in healthcare are surely a major reason why person-centred approaches have gained wide recognition, throughout the entire field of healthcare, in recent years.

Person-centred approaches to care have also been viewed as resulting from long-standing challenges to bio-medical reductionism. Second-wave feminism certainly provides the backdrop for some of these critiques (Bower & Mead, 2000), with (male) medical expertise being perceived as a vehicle for the exercise of patriarchy through control over women’s bodies (e.g. Ehrenreich & English, 1979), but the bio-medical model has been more widely criticised for the insidious control exerted upon the population as a whole. Illich, writing in 1976 (p6), for instance claimed that;

“During the last generations, the medical monopoly over healthcare has expanded without checks and has encroached on our liberty with regard to our own bodies. Society has transferred to physicians the exclusive right to determine what constitutes sickness, who is, or might become sick, and what shall be done to such people.”

According to Bower and Mead (2000, p1089), “these critiques were translated into calls for greater medical recognition of the legitimacy of lay knowledge and experience, and greater respect for patient autonomy”. In a seminal paper of 1977, George Engel proposed the ‘biopsychosocial model’ as way to

incorporate a patient's own experience into the treatment of illness, explaining that:

"The boundaries between health and disease, between sick and well, are far from clear and never will be clear, for they are diffused by cultural, social, and psychological considerations. The traditional bio-medical view, that biological indices are the ultimate criteria defining disease, leads to the present paradox that some people with positive laboratory findings are told they are in need of treatment when, in fact, they are feeling quite well, while others feeling sick are assured that they are well."

(Engel, 1977, pp196-197)

In light of such criticisms, healthcare policy has sought to make assurances that those in receipt of services have a say in their treatment; illustrating this, Bower and Mead (2000, p1090) report that "notions like 'user involvement', 'negotiation', 'concordance' and 'patient empowerment' have been particularly evident within the sphere of health policy in the 1980s and 90s".

Such developments in policy terminology have also been seen to coincide with the marketization of NHS services wherein the emphasis on 'user-involvement' is viewed as reflective of a 'consumer-oriented' approach. In the early 1990s, the Conservative administration oversaw the establishment of an internal market in the NHS that was intended, through competition between providers, to increase the accountability of services, and provide patients with greater choice in their healthcare (Klein, 1995). Patient/customer satisfaction thus becomes one measure of service quality and an indicator of 'value for money'. While some commentators have seen a consumerist approach to healthcare as potentially more responsive to users (e.g. Limentani, 2002), others have expressed concern that, within such an approach, care becomes commodified and performed superficially to meet customer (patient) expectation (e.g. Theodosius, 2008). Commenting on a Labour government proposal to 'measure' nurse compassion, Bradshaw (2009, p467) for instance, argues that; "It asks nurses only to practice techniques such as the art of smiling, or the saying of warm words, in order that measures can be ticked and audited and data thereby gathered." In the same vein, Gillespie et al. (2004, p146) have shown that, in the case of patient-centred care, NHS managers saw the concept as "being grounded in quality assurance, and tended to focus on easily

measurable activities". It can therefore readily be seen how the endorsement of the concept of 'person-centred care' might be aligned with the consumerist rhetoric of recent government administrations.

In addition to these antecedents, the contemporary emphasis on person-centred healthcare may be said to have been bolstered by developments in nursing which have led to the concept assuming especial centrality to that occupation. While, ostensibly, PCC should be put into practice *throughout* the health services, it has been widely posited as something to which nursing (particularly in light of its continued 'professionalization') can lay particular claim. Indeed, Dewing and McCormack see "person-centredness as a "coherent, theoretically informed and practice-embedded framework for nursing" (Dewing & McCormack, 2017, p2509), while Price (2006, p49) notes, within academic nursing literature, "a tendency to define nursing using the term person-centred care as something that nurses do and which characterises how we think or work".

Recent decades have seen nursing seemingly advancing its claims to professional legitimacy by accruing the formal signifiers of that status. Following a classical (though much disputed) professional model, nursing has attempted to develop its own discrete theoretical knowledge-base, formalized through university education (Yam, 2004). Nursing's 'professionalizing' contingent has sought to define nursing knowledge in relation to primary care within the nurse/patient relationship (Melia, 1987) in order to constitute an unique professional discipline. As Smith (2012, p68) writes:

"An alternative knowledge base for nursing was sought which turned away from a biomedical one (...) biological science was no longer seen as the predominant knowledge base of nursing...there was now a requirement to balance it with psychology and sociology as part of the 'scientific basis of nursing'"

Person-centred care has been seen to present a ready conceptual basis for nursing's own discrete body of knowledge, offering a way to theorize the 'nurse/patient relationship' which had already been proposed as "the foundation of nursing practice" (Dowling, 2006, p48). The (ostensible) move away from task allocation to a 'continuity of care' approach in the 1980s

(Savage, 1995) meant that nurses, at least in theory, were better able to facilitate more meaningful relationships with patients and, as McEvoy and Duffy (2008, p413) contend; “nursing does claim to have a *unique* focus on caring, understanding and knowing the whole person”. In corroboration, Draper and Tetley (2013) have (somewhat simplistically, perhaps) averred that “Getting to know the person behind the patient is the *raison d’être* of person-centred nursing care”. Thus, even though PCC has not been comprehensively defined (Dewing & McCormack, 2017; Nolan et al., 2004), the concept has been seen as constituting an area of practice in distinction to biomedicine and one in which nurses are, supposedly, uniquely positioned to engage.

2.1.1 “Oft-Quoted but Ill-Defined”?

In line with the opinion of Nolan et al. (2004), quoted above, several commentators have observed that, in spite of its apparent centrality to healthcare, and to nursing practice in particular (Nolan et al., 2004; Dewing & McCormack, 2017), PCC remains a somewhat enigmatic concept which has not been thoroughly elaborated and of which there is “no single agreed definition” (Health Foundation, 2014, p6). It is arguable that the term inherently defies formalistic articulation because its use must be adapted to each individual service user; as the Health Foundation report; ‘Person-Centred Care Made Simple,’ (2016, p6) acknowledges; “if care is to be person-centred, then what it looks like will depend on the needs, circumstances and preferences of the individual receiving care. What is important to one person in their health care may be unnecessary, or even undesirable, to another.” Therefore, there is no singular prescriptive course that one may adhere to in order to achieve ‘person-centredness’. Indeed, Carl Rogers demurred from concretely defining his ‘person-centred’ approach to therapy in order that it remained flexible and impervious to formulaic adherence (Kirschenbaum, 2012).

Furthermore, each attempt to define, or at least to outline, that which person-centredness entails invariably relies upon appeals to sub-terms which are, themselves, subject to interpretation. For instance, calls to treat patients with ‘dignity’, ‘compassion’ and ‘respect’ (Health Foundation, 2014) ultimately rely on practitioners to determine how these values are to be recognized. Similarly,

directives such as “understanding the patient as a unique human-being” (Bower & Mead, 2002, p51), require fairly significant levels of interpretation in order to be realized and acted upon.

Another definitional problem arises from the insufficiently differentiated usage of myriad terms which appear to reflect a similar impulse. In particular, person-centred care, and patient-centred care (both abbreviated to PCC) have regularly been treated as one and the same, by both commentators and practitioners, and neither term has been consistently or systematically defined. In an effort to rectify this, Zhao et al (2016) have attempted to elaborate key differences between the two concepts, chiefly emphasizing that the use of the word ‘person’ connotes a more holistic approach which entails health promotion across different service contexts and acknowledges an interactional relationship between the different spheres of a person’s life. *Patient* centred care, on the other hand, implies a more curative emphasis whereby personal preferences and needs are taken into account, but mainly insofar as they determine approaches to the treatment of a specific episode of illness or disease. In general, however, such nuances are not readily elaborated and a more general underlying philosophy has been broadly identified. This is arguably owing to the practical consequences of making such distinctions; while a theoretical delineation of these similar concepts may be possible, the practical application of this knowledge is somewhat harder to elaborate. Both terms, even if theoretically distinguishable, may be open to interpretation in practice and, as has often been acknowledged, there is significant conceptual overlap (McCarthy, 2006; Price, 2006; Zhao et al. 2016).

Furthermore, different sectional interests within the healthcare environment have developed varying understandings of what PCC represents (Gillespie et al. 2004) and each interpretation varies in the emphases placed on underlying aspects, for example, those from the education segment construed PCC with communication skills, managers understood it as a quality assurance measure, while policy-makers understood PCC as increasing public participation in healthcare (Gillespie, et al., 2004, p146). As such, there is room for divergence concerning that which the application of person-centred approaches seeks to

achieve. There is evidence that, within nursing, uncertainty over the articulation of PCC is, at least partly, attributable to these positional concerns. Discussing the role of preceptor nurses who are tasked with instructing students in clinical practice, McCarthy (2006, p636) argues:

“With a PCC approach to health care it is arguable that preceptors experience a conflict between the demands of humanism, the demands of professionalism and the demands of the health service providers. This conflict arises because humanistic approaches to care demand respect and autonomy for the patient. Professionalism demands expert knowledge, skills and accountability which according to Dickinson (1982) places the patient in a passive role, and finally the demands of health service providers require that care is visible and reflects risk management principles.”

Another source of tension that hampers the prospects for a conceptually coherent account of PCC within nursing has been identified in the apparent disconnect between the academic conceptualization of PCC and its practical realization; what has been termed the ‘theory-practice gap’ (e.g. Henderson, 2002). In short, it is claimed that the organization of work in clinical settings, with attendant limits upon time and resources, is not conducive to actions which might help to facilitate ‘person-centredness’, such as taking time to talk with patients, or flexibly attending to routine activities. In McCarthy’s 2006 (p635) study, one respondent commented:

“When you’re in the classroom, everything is lovely and straightforward, things should be done this way and that way and then when you come on the wards things aren’t like the textbooks at all, you just have to use your initiative and common sense.”

It is, perhaps, the perceived impracticability of PCC, and a resultant reliance on ‘initiative’ and ‘common-sense’, which has meant that, while PCC is endorsed in a general way, it has continued to be only vaguely formulated and espoused. As Dewing & McCormack (2017, p2509) attest:

“...whilst practitioners have an outline appreciation of person-centredness, they tend not to draw on empirically developed theoretical models, have an incomplete personal understanding of what person-centredness is and generally experience working in contexts and cultures that are inherently unsupportive of person-centredness, meaning they cannot embody or practice in person-centred ways.”

The authors openly express frustration at the underdevelopment of a consistent application of person-centredness, arguing that a lack of meaningful engagement with the concept is detrimental to the aim of establishing “a coherent theoretically informed and practice-embedded framework for nursing” (ibid). Acknowledging the precariousness of formal definitions, Dewing and McCormack (2017) nevertheless contend that a working definition of person-centredness should be utilised if the concept is to have any practical significance. Moreover, a thoroughgoing and critical approach should underlie any attempts at definition; “Person-centredness is still in its ascendancy; therefore, we need to settle into exploring and expanding the concept with more rigour and drawing on relevant theories” (Dewing & McCormack, 2017, p2510).

This appeal to greater theoretical rigour signals exasperation not only with the reticence to *define* person-centredness, but moreover, with the insufficiently sophisticated thinking *around* it; for, one may study and debate a subject extensively without producing definitive explication of it, e.g. ‘art’, and yet still feel satisfied that they have given it its due contemplation. Arguably, it is ambivalence, as much as ambiguity, which underscores the nursing occupation’s relationship with person-centredness. As the subject of a theoretical body of knowledge, and through its enshrinement in the principles of nursing practice (RCN, 2010), PCC has been framed as a professional prerogative (Dewing & McCormack, 2017; Rodrigo, et al. 2017) yet the stability of nursing’s professional identity remains somewhat contentious. The failure to fully embrace PCC as the basis for professional practice may be reflective of the fact that the designation of ‘profession’ has not itself been wholly subscribed to by nurses.

Attempts to frame care as a theoretically informed practice, which constitute a conventionally recognized way of delineating a professional occupation (e.g. McEvoy & Duffy, 2008; Abbot, 1988), have met with some resistance from both nurses and commentators who believe that caring work cannot be professionally mandated. For instance, in a paper notably titled ‘Professional Caring: a contradiction in terms?’, Vivien Woodward (1997, p1001) argues that

professionalism is incommensurable with an authentic caring ethos; "...the affective nature of caring means that it cannot be undertaken as an intentional, professional act and neither is it amenable to command or contract". Similarly, reporting on her own study into the teaching of PCC, McCarthy notes that; "Preceptors did not detail or demonstrate a specific philosophy of care. Caring was considered innate; part of having a vocation and nursing was something learnt through experience" (McCarthy, 2006, p634). The strength of the belief that caring ability is inherent, supported by a vocational discourse, continues to undermine nursing's claims to professional status based upon possession of a theoretically informed body of knowledge. As Yam (2004, p981) attests; "Some nurses are ambivalent about the need for academic and professional development" and so indifferent attitudes towards PCC are arguably reflective of nursing's apprehension over embracing 'professionalism'.

2.2 Professionalism and Nursing

Nursing's professional status is the subject of much ambiguity and debate which has arguably endured for at least the last hundred years. While the complex history of nursing's relationship with professional status cannot be comprehensively appraised in full here, a sufficiently longitudinal perspective should help to elucidate why the issue of professionalization, and its contested significance, has been, and remains, prominent to nursing's occupational identity. In short, we need to try to understand the reasons behind (certain members of) the occupations' efforts to attain professional recognition, as well as the reasons why these efforts have seemingly failed to resoundingly establish the professional credentials of nursing.

2.2.1 Attracting and Maintaining a Workforce

Nursing's historical relationship with professionalization is significantly coloured by the practical concerns of employing a nursing workforce to appropriately meet the changing healthcare demands of the national population; the professionalizing tendency has, variously, been perceived as an allure to encourage interest in the occupation, and as an unviable strategy that

overly restricts recruitment and leads to under-resourced services.

Occupational aspirations have been both fuelled and thwarted in relation to demographic changes (within and outwith nursing), and to prevailing economic concerns, and moves towards the establishment of nursing as a profession have been accordingly inconsistent. The ambiguity of the status of the occupation can be traced back well over a century and, in many ways, the identity-conflict of Victorian-era nursing is reflected in contemporary debates. In their instructive account of nursing's social history, Dingwall, et al. (1988, p68) posit the essential problematic thus:

"Should it (nursing) be a profession with a high educational requirement which would, implicitly, also mean a narrow class basis for entry or should it be a craft with less emphasis on educational attainment and a broad appeal to women of less exalted backgrounds?"

Arguments in relation to attracting and maintaining a suitable nursing workforce have been advanced on both sides of this debate over a number of years.

The endorsement of higher educational standards and qualifications (an embryonic signifier of professional status) has been long-supported in the name of quality improvement in the standards of nursing care. In the latter half of the 19th century, concern over conditions, and some 'well-publicized scandals' in workhouse infirmaries, where nursing work was performed by paupers in exchange for food and accommodation, prompted the engagement of 'trained and paid nurses' who would be able to deliver a higher standard of care (Dingwall, et al. 1988, pp61-63). Gradually, poor law nursing by paupers was phased out and occupational reformers sought to reinvent nursing as a "respectable alternative to the work of a governess for economically marginal female members of the middle class" (Dingwall, et al. 1988, p68). Despite this aim of gentrification however, engaging 'higher class' recruits proved difficult and the occupation remained highly populated by people who, of necessity, needed to earn a living, with many having previously been engaged in domestic service (ibid, p70). Thus, the ambition of creating a professional career for respectable middle-class women was frustrated by the relative

paucity of suitable recruits in relation to the healthcare requirements of the wider population.

A similar pattern can be seen to occur during and following the First World War when hospital care was increasingly experienced by members of the upper and middle classes, partly due to advances in surgical techniques that could only be properly administered in a hospital, and partly resulting from the establishment of 'Officers' hospitals' to care for the war-wounded (Dingwall, et al. 1988). Many nursing volunteers at this time were drawn also from the socio-economically better-off, thus distorting the perception that hospital nursing was done by the poor, for the poor. As Dingwall, et al. affirm (1988, p75); "The incorporation of the handywoman class had defined nurses as controllers of poor patients. The arrival of the middle classes in hospital called this into question".

Following these developments, nursing arguably began to be seen increasingly as a respectable and aspirational career for middle class women. The proposed registration of qualified nurses which was enacted after the war was seized upon by some as an opportunity to cement this occupational reputation. Campaigners such as Mrs Bedford Fenwick were keen to see stringent registration requirements which "would have the effect of producing a closed occupation recruiting mainly from the middle classes" (Dingwall, et al. 1988, p82). Longer and more arduous training, it was supposed, would favour those who were already fairly well-educated (Chua & Clegg, 1990). Ultimately, however, though the Registration Act passed in 1919, admission to the register, administered by the General Nursing Council, was not as highly circumscribed as the Bedford-Fenwick faction would have liked and educational requirements were undemanding. As Dingwall et al. (1988, p96) point out; "registered nurses might share a common certificate but could have gained this out of a great variety of clinical and educational experiences." The introduction of state examinations for nursing in 1925 seemingly increased the recruitment of better-educated probationers by the 1930s (Chua & Clegg, 1990), although this served to create an overall shortage of hospital staff,

which necessitated the employment of greater numbers of uncertified personnel to work alongside the registered nurses (Abel-Smith, 1960).

Around the time of the Second World War, the employment of unregistered nursing staff continued in order to meet service demands and, in 1943, a distinct hierarchy of nursing care was recognized in legislation, which some commentators have seen as strengthening the credentials of registered nurses.

As Chua and Clegg (1990, p153) explain:

“... the war effort had necessitated the employment of large numbers of assistant nurses in both civilian and military hospitals. The GNC (General Nursing Council) became anxious that after the war, the ambiguous divisions between the ranks of assistant nurses, nursing auxiliaries, and registered nurses, all of whom were employed in hospitals and through private nursing agencies, might be such as to dilute the prestige and status of the registered nurse.”

The 1943 Nurses Act, which formalized the status of the assistant nurse was seen to enhance the standing of more highly qualified nurses; as Dingwall et al. (1988, p115) argue:

“The legitimization of a lower stratum of nursing labour would then free the student nurse to pursue an educationally-oriented form of training. Thus, the assistant nurse could provide the key to registered nurse professionalization.”

Thus, an emphasis on educational qualifications came to be vaunted as a way of attracting those interested in pursuing a *professional* career. The 1964 Platt report recommended the raising of entry requirements for nurse training programmes, and a structured 3-year curriculum to be funded by a grant, arguing that “nursing should be able to offer a course that could attract and retain students who might otherwise have chosen to go to university or some other form of higher education” (RCN, 1964, quoted in Ousey, 2011, p70).

Further legislative proposals sought to enhance the legitimacy of nurse training by creating a unified set of standards to replace the ‘patchwork quilt’ (Davies, 1985) of extant nurse education. The 1972 Briggs report recommended that “in the interest of the profession there should be one single central statutory organisation to supervise training and education and to safeguard and, when possible, to raise professional standards” (quoted in Darling, 1981, p13). And the separation of training from service contexts was further promulgated by

the Judge report (1985) which recommended the “transfer of nurse education to the higher education sector” (Ousey, 2011, p72). The implementation of project 2000 proposals towards the end of the century can, according to Meerabeau (1998, p87), “be seen as the high point of professional influence on nursing education. It raised the level of training to diploma level, thereby giving it academic currency, and distancing it from service priorities”.

Interestingly, Meerabeau posits that the adoption of project 2000 was partly attributable to the perennially recurring concern with recruitment (1998, p97). This time however, the prestige of professional education was perceived as a means of boosting the desirability of a career in nursing.

“One factor was the concerns about workforce supply and retention, the so-called ‘demographic timebomb’. Nursing shortages have remained a politically sensitive issue. An argument commonly used (although not well supported by evidence) was that if the educational preparation were a more enjoyable experience, more newly qualified nurses would see themselves as standing on the threshold of their career, rather than leaving after 3 year’s work as an apprentice.”

(Meerabeau, 1998, p97)

Meerabeau points out that an alternative solution to this problem may have actually been to *lower* entry requirements to ensure sufficient numbers of nurses, but argues that the constitution of national health boards was disproportionately weighted in favour of those who supported an advanced educational programme, such as the RCN (Meerabeau, *ibid*).

The recent move, in 2013, of making nursing across the UK an all-graduate discipline, arguably, represents the new ‘high point of professional influence on nursing’, ostensibly supporting the concern with having nursing recognized as a theoretically informed, professional area of practice. In light of the overall expansion in higher education participation, Ali and Watson (2011, p316) argue that nursing must be able to keep up with a proliferation of alternative career choices in order to maintain a sufficient workforce:

“To improve the quantity and quality of recruits, nursing needs to be able to compete with other career options. It should offer attractive future prospects for its graduates who should be treated with respect comparable with other healthcare professions. Making nursing a degree profession is a major step in this direction.”

Moreover, the authors contend that the increasingly complex healthcare needs of the population, coupled with more and more sophisticated medical technologies, means that nurses need to be trained to a higher level and possess critical thinking skills that extend beyond mere task-completion (Ali & Watson, 2011, pp313-316). Watson and Shields (2009, p2926) challenge the perception that 'good nurses' would be lost due to the new academic demands, arguing that the nostalgic view of the 'good nurse' is based in a time "when highly technological care was not demanded by the public, and when hospitals were comparatively simple entities with accompanying simple management needs, unlike the super-corporations they have become today."

The move to an all-graduate occupation would appear to signify that adequate maintenance of the nursing workforce consists in ensuring that, more than just being numerous, staff are also educationally equipped to contend with the complexity of the modern healthcare system. However, in England, the most recent development in nursing qualification is seemingly a revivification of an apprenticeship model of training that appears to shift control of staff preparation back towards (NHS) employers and would not entail full-time study at university (Department of Health and Social Care, 2016). Again, the long-standing issue of nurse recruitment is the purported driver of this alternative route into the occupation. In a brief paper in the Nursing Standard written by Erin Dean (2017, p12), University of Derby head of prequalifying health care Denise Baker is quoted as saying;

"In the East Midlands we are struggling with recruitment and have about 250 nursing vacancies ... We are not alone, and have to think about doing things differently. For trusts, the option to grow your own and support talented and loyal people in your workforce is highly attractive. It is a time of fantastic opportunity for our support workers."

Critics of the scheme, however, contend that it "gives the impression of devaluing the academic underpinning of the profession" and represents 'dumbing down training and education' (Dean, 2017, p13). Presently, the apprenticeship scheme applies only to NHS England and is still in its infancy with a relatively limited number of places (Donohue, 2018) although, arguably, this latest development demonstrates, once again, the recurring conflict

between professional aspiration and economic necessity which seems to have dogged the nursing occupation for the greater part of its professional(izing) history.

2.2.2 Professional nursing: better for patients?

The idea that a professional image, sustained by participation in higher education, serves as an enticement for potential recruits into nursing has not been convincingly demonstrated. Although there is some evidence of increased uptake in nursing degrees in the 2000s (Nursing Standard news, 2012), 2017 has seen a significant reduction in applications in relation to other courses, which many commentators have attributed to the replacement of bursaries with tuition fees (RCN, 2017). If financial reasons are its cause, this decrease in uptake does not likely represent the desertion of nursing for other degree programmes as these, too, entail fees. Nonetheless, it does indicate that nursing is not attracting students in line with other university courses. Thus, it is not necessarily that the educational component is off-putting, and advocates maintain that, however it is funded, degree-level education is essential in producing nurses who are adequately equipped to meet contemporary health needs. Research studies supporting the contention that the employment of better-educated nurses results in better results for patients have been cited in arguing for the necessity of maintaining a graduate workforce. For instance, Aiken, et al. (2003) showed that “In hospitals with higher proportions of nurses educated at the baccalaureate level or higher, surgical patients experienced lower mortality and failure-to-rescue rates.” Similarly, significant effects of degree-educated nurses on mortality rates were found in a later Europe-wide study reported in the Lancet (Aiken, et al. 2014).

Other, less directly observable, benefits for patients have been attributed to nursing’s professional self-conception. Sabatino, et al. (2014) claim that, when nursing’s professional attributes are recognized (by those within and without the occupation), nurses perceive their role more positively and the authors report that this can have a knock-on effect in terms of ‘patient safety’ and ‘quality of care’ (Sabatino, et al. 2014, p666). In effect, a self-fulfilling effect is observed wherein acknowledgement of nursing’s professional attributes

provides licence for their exercise. Sabatino, et al. (2014, p665) assert that:

“If nurses develop a strong professional identity, they are better aware of their skills and responsibilities, they might display autonomy in taking care of others, and they might have the authority to make decisions and the freedom to act in accordance with their professional knowledge base.”

A related claim has been made that the availability of a ‘professional discourse’ to nursing affords nurses a better position from which to represent their priorities and concerns. Johannison and Sundin’s study of nursing practice in Sweden (2007) indicates that claims to professionalism can help to legitimize a nursing point of view, especially in relation to the bio-medical discourse of physicians. While the authors recognize that bio-medical knowledge is still often deferred to, they posit that:

“The newer, nursing-oriented occupational identity dominates on the occupational group level and is characterized by challenging medical knowledge claims in favour of a developed and independent formal nursing knowledge.”

(Johannison & Sundin, 2007, p206)

Thus, in appeals to “the more holistically-oriented nursing discourse” (Johannison & Sundin, 2007) nurses are seemingly drawing on a professionally mandated area of knowledge which serves to increase their level of influence in healthcare processes. In terms of benefits to patients, it is arguable that nursing’s professional challenge to bio-medical dominance is a means of improving the overall treatment of those in receipt of care. Theresa Carvalho (2014) makes the case that nurses have used their professional training as a means of validating a specific focus on ‘care’ and the ‘nurse-patient’ relationship. Furthermore, she argues that nurses’ have incorporated ‘managerialism’ into their professional identity which allows them to institute occupational values, based around the concept of ‘care’, at an organizational level (Carvalho, 2014, pp185-188). Carvalho contends that nurses can use organizational constructs and languages to legitimize certain ethics of care. For instance, discussing the utilisation of the term ‘holistic care’, Carvalho (2014, p184) writes that:

“The use of holistic care is crucial because it allows for creating a useful linguistic tool to transpose the patient–professional relationship to the political and

organizational arena and, in this way, manifest a clear and distinct approach to care."

It may be contended therefore that, in drawing upon professional credentials, nurses may more legitimately articulate concerns in regard to the holistic care of patients.

However, the resistance by many to equate 'care' with professionalism, which has already been mentioned, means that arguments linking 'professionalism' with better patient outcomes have not been comprehensively accepted. Indeed, it is often argued that patients value the 'softer skills' of nursing which are perceived as "incompatible with academic nursing" (Darbyshire & McKenna, 2013, p306) reflecting the persistence of the idea that good nursing is predicated upon the possession of a host of 'natural' qualities which cannot be taught (e.g. Bray et al, 2014; Smith, 2012) and the concomitant 'rejection of the academic' (MacKay, 1998, p68). Many nurses, too, uphold this kind of vocational ideology and have been found to play down the significance of academic ability and training (Mackay, 1998, p63).

In response to the news that nursing was to become a graduate profession, the 'Patients Association' reacted negatively, issuing a statement which argued that:

"The academic must be secondary to the practical. Only then will patients get the nurses they want and trust – the right ones with the right attitude. It must never become more important to write about care than to give it. If our nurses do not have the basics of training, the costs of care will soar because of infection rates and overblown bureaucracy."

(Reported by Bowcott, 2009)

The recent move, referred to earlier, which reintroduces an apprenticeship route into nursing seems similarly to endorse the view that advanced educational preparation in universities is secondary to a caring disposition, with health secretary Jeremy Hunt declaring that:

"...the routes to a nursing degree currently shut out some of the most caring, compassionate staff in our country. I want those who already work with patients to be able to move into the jobs they really want and I know for many, this means becoming a nurse. Not everyone wants to take time off to study full time at university so by creating hundreds of new apprentice nurses, we can help

healthcare assistants and others reach their potential as a fully trained nurse.”
(Department of health and Social Care, 2016)

A further difficulty in defending nursing's professional aspirations on the grounds that it benefits patients lies in the accusatory notion that the professionalizing endeavour is self-serving, and the real benefit is conferred upon the occupation itself, rather than upon those it serves. There is, therefore, some sense that professionalizing strategies, which may serve to enhance pay-levels and working conditions, belie the values that nursing espouses, such as altruism and self-sacrifice. As Woodward (1997, p1002) frets; “An additional means of losing caring as a central value could arise as recruits may be motivated by the opportunity to acquire an academic qualification rather than out of the desire to care for others”. Any benefits that accrue to members of the occupation as a result of professional recognition may be seen as evidence that nurses are driven by these such incentives, rather than by the primary concern with simply helping others.

Lesley MacKay (1998, p66) has observed that:

“In evincing an ‘I-will-always-manage’ sentiment, nurses can be seen as potentially more malleable and less demanding than more vociferous NHS employees, such as some ancillary workers, who espouse a more instrumental view of work. In this way, nurses’ sense of vocation and their accompanying commitment to patients may be used against them.”

Fears concerning the professionalization of nursing are founded upon concern that the ‘career’ nurse is instrumentally, rather than altruistically, motivated, and that ‘caring’ qualities will come to be marginalized. This has arguably made it difficult to elaborate the case for nursing professionalism as a means of improving conditions for the workforce, as this is seen as contradicting a selfless service ethic.

Professional Nursing: Better for nurses?

Nevertheless, the case has been made that nursing, and nurses themselves, can and should benefit from having their work recognized as a professional undertaking that demands the application of skill and knowledge as other professions do. Supporters of nursing's professional project recognize that nursing work has been subordinated in the division of labour in healthcare,

largely by dint of the fact that the workforce is, and always has been, predominantly populated by women and thus perceive the reluctance to acknowledge nursing as professional work as inherently bound-up with a wider patriarchal social structure. The status of 'profession' is not bestowed as a result of the intrinsic value of an occupation, but rather insofar as it conforms to 'masculinist' notions of what a profession ought to consist of.

Nursing has long been associated with subjectively (though widely perceived as naturally produced) 'feminine' qualities, and it is this that has been perceived as an obstacle to attaining a 'professional' title and reaping the associated rewards; as Abbot and Meerabeau write: "caring is seen as a natural attribute of women and is, therefore, downgraded and devalued - not recognized or rewarded for its skills" (1998, p10). The subjugation of women in society in general, is reflected in working structures where caring is "marginalized as the 'little things'" (Smith, 2012, p184) and where "the emotional labour of nurses is invisible compared to the "real" work of medicine." (Gray, 2012, p13).

With the acknowledgement that nursing's subordinate status in the healthcare hierarchy results from its association with 'feminized' work, the aim of professionalizing nursing is intrinsically linked with the aim of overcoming structural, gender-based discrimination. Even as long ago as the late 19th century, the lowly status of nursing was ascribed to the injustice of gender politics, the two causes were realized most notably in the person of Mrs Bedford Fenwick whose campaigns for nursing reform corresponded to her avid support for women's suffrage (Dingwall, et al. 1988, p78). The argument for the professionalization of nursing is seen to challenge a gender-bounded value system within society. As Melia explains (1987, p167); "claims to profession in these terms have much more to do with claims to a place in the hierarchy of occupations and in the socio-economic class structure of society than with the nature of the work." In other words, the title of 'profession' represents a relative, not absolute, status claim, made necessary by the inequity of gender-based occupational hierarchy. Thus, nursing (or at least some factions within it) has sought to shed "its association in popular ideology with mundane bedside drudgery that is seen as women's work" (Abbot &

Meerabeau, 1998, p11), and aimed to establish its own professional credentials.

The formal professionalizing strategy of the occupation entails the contention that nursing work is based on a discrete, theoretically informed body of knowledge and, as such, is more than simply intuitive 'women's work'. In being recognized as such, it is intended that nursing can improve its standing and enjoy the associated benefits, such as "increased income, status and prestige" (Yam, 2004) that accrue to other professional groups.

As well as the potential to bring structural benefits for the workforce, like better pay and conditions, gaining professional recognition has been identified as having positive consequences for individual nurses. Yam (2004, p978) for instance, cites evidence that nurses whose educational socialization has included an emphasis on 'professional identity' experience greater levels of job satisfaction. Similarly, Caricati, et al. (2014) find a correlation between the conception of nursing as a profession and job satisfaction, and posit that 'professional commitment' acts to enhance nurses' sense of the 'intrinsic' value of their work (Caricati, 2014, p991). The authors also note that satisfaction levels are further increased when the workplace environment supports the articulation of professional values (ibid). Sabatino (2014) attests to a mutually reinforcing relationship between professional identity and nurses' personal sense of self-esteem, making the case that accepting a professional identity entails increased belief in one's own abilities and competencies.

"Nurses who feel dignified and worthy of esteem for their work, due to their skills, attitudes, and ethical comportments, should be even more capable and determined to show attitudes, thoughts, and professional behaviours worthy of respect."
(Sabatino, 2014, p667)

A significant factor in affirming the positive effects of professional identification for nurses is that this identity is recognized by others; namely, other medical professionals and patients. As Sabatino notes: "a lack of understanding of nursing as a science and the old traditional image of nurses as non-professional workers can compromise the relationships between nurses and other healthcare professionals in different work settings and in different

cultural and societal frameworks” (Sabatino, 2014, p666). Based upon this assertion, it can be seen how the success of the professional claim of nursing (and, indeed, any other occupational group) is significantly dependent upon reciprocal recognition within the wider social context in which that claim is made. Therefore, for the benefits of professionalism to be conferred upon nursing requires, to some extent, the assent of others. As Yam (2004, p980) points out:

“The public is ambivalent about nurses’ status. They appreciate the contribution made by nurses and support their claim for better remuneration but, at the same time, they are less inclined to pay more taxes to improve the pay and conditions of nurses. Also, some may question why nurses should be paid more for roles that anyone with mothering or parenting skills can fulfil.”

As long as such attitudes persevere, it is unlikely that nursing will be able to achieve professional status on a par with medicine in terms of achieving comparable respect or remuneration. Surely, a key element in this is the continued belief that work associated with femininity is, intrinsically, of less value than that aligned to traditionally masculine characteristics. As Yam (2004, p980) simply puts it; “the changing image of nursing corresponds to the changing image of women” and therefore, until such a time as either, ‘feminine’ traits are considered of equal value to ‘masculine’ traits, or the attributes deemed necessary for any type of work are disassociated from gender altogether, nursing is likely to remain in a subordinate occupational position.

Nursing professionalizers have sought to disassociate the occupation from its supposed femininity by demonstrating that traditional (masculine) signifiers of professionalism apply to nursing; such as practising upon a ‘scientific basis’ (Smith, 2012, p68), the learned application of knowledge, decision-making autonomy, and the implied independence from purely organizational interests that is conferred by university-based education (Chua & Clegg, 1990, p161). This has entailed an implicit rejection of the vocational ideology which stresses personal attributes as the foundation for satisfactory nursing care. It is perceived that eschewing the vocational ideology will serve to diminish the

close association between nursing and 'femininity' whose attributes are seen as synonymous: "Caring, nurturing, kind, loving and supportive, the 'good nurse' looks suspiciously like the 'good woman'" (Mackay, 1998, p63).

However, some commentators seem uncomfortable with the anti-vocationalism that seemingly underpins a professional claim. Mackay, for instance, argues that "it is possible to maintain that it takes a special kind of person to be a nurse, and yet acknowledge the need for advanced training and skills in nursing" (Mackay, 1998, p67). White (2002, p286) observes that "It is because of the historical connection between the notion of nursing as a vocation and ideals of motherhood that some nurse theorists have urged that the vocational model should be abandoned", but argues that the vocational discourse can be instrumental in sustaining the commitment of nurses. White advocates that "the concept of nursing as a vocation can and should be disentangled from its historical association with concepts of motherhood." (ibid) and suggests that vocation should be reconceptualised to describe the nature of nursing *work*, rather than the nature of those who perform it:

"Nursing work is the skilled and educated provision of service to those in need and not merely an elaboration of wifely and motherly work. It is the identification with and sensitivity to particular needy people that gives nursing its vocational status. This also means that men can nurse."

(White, 2002, p288)

It may be claimed that nurses derive benefits both from professional recognition *and* from subscription to vocational discourses; 'professionalism' allows nurses to practise with more confidence and derive enhanced feelings of self-esteem, vocationalism can provide nurses with a means of expressing their own personal dedication to caring for others (Mackay, 1998, p68; White, 2002). However, the dualistic, and indeed oppositional, status ascribed to the two concepts means that advocates of 'profession' for nursing may often be disparaging of the idea of vocation, such as Watson and Shields (2009, p2926) who associate 'vocation' with "the 'good old days of matrons' (and) military style discipline" therein illustrating the problematic associations that White (2002) highlights. The difficulty of articulating an occupational identity that combines elements of professionalism and vocation is understandably difficult

given this apparent opposition between the connotations of both terms.

2.3 Sociological Theorization of Professions

Sociological approaches to the study of 'the professions' may broadly be conceived of as either 'essentialist' or 'constructivist'. Stated simply, an essentialist theory of profession involves identifying a particular *something* (i.e. an attribute or process) that is common to every instance of 'profession', thus facilitating definition; a constructivist position, on the other hand, contends that the meaning of profession is contingent upon the context(s) in which it is used and that, therefore, attempts at an all-encompassing definition are superfluous. While it will become apparent that I favour this latter orientation, it is important to appraise in some detail these broadly-defined approaches, as various formulations of 'essentialism' have been ascendant until recently. Despite the claim by Evetts that now "most researchers have accepted definitional uncertainty and moved on" (2006, p133) it remains valuable to examine the evolution of debates which prefigure such conclusions. I hope also to demonstrate why a constructivist stance represents a more fruitful base for conceptualizing 'profession' and 'professionalism' as they occur in general usage.

2.3.1 Functionalism and Parsons

Early sociological writing on the professions was prominently grounded by a functionalist assumption that the professions represented a stable moral system serving the interests of society at large (see e.g. MacDonald, 1995). According to Evetts (2013, p409), in her summary of this tradition, the 'key concept' for functionalists was the 'occupational value' of professionalism; professions differ from other occupations in that their values are inherently social, representing the normative collective order. For instance, Marshall (1950) perceived that professionals were exceptional because of their altruistic motives (cited by Evetts, 2003, p25) while Carr-Saunders and Wilson (1933) contended that, along with the family and the church, the professions act to

preserve social stability in the face of “crude forces which threaten steady and peaceful evolution” (quoted in MacDonald, 1995, p2). In short, the *function* of professional groups was to uphold the moral order of society through its embodiment of socially-desirable values. It is perhaps not hard to comprehend why these ‘value-laden’ (Johnson, 1972, p12) appraisals of professionalism have come under criticism; they rather uncritically assume that professions are, inherently, bastions of moral stability along with an assumption that the moral values that they uphold are, *prima facie*, social goods. Rueschmeyer (1964), for instance, questions the notion of ‘central values’ that “are shared equally by all sections and interests in society” (cited by Johnson, 1972, p34). For example, the legal profession may be said to uphold values of ‘justice’, however different groups within society may hold varying conceptions of what is, and is not, just.

Talcott Parsons provides arguably the most highly-theorized account of its time concerning the place of professions in modern societies. According to Parsons, in his seminal paper ‘The Professions and Social Structure’, “the professional type is the institutional framework in which many of our most important social functions are carried on” (Parsons, 1939, p367), such as medicine, science, and law, in which a professional person has achieved technical competence. Unlike the more baldly moralistic claims made by some authors in relation to the professions, such as that they are intrinsically altruistically motivated, Parsons appears to see the essence of the professional role as constituted chiefly by its particular institutional form. According to Parsons (1939, p460), ‘professional authority’ ...

“... is not as such based on a generally superior status ... nor is it a manifestation of superior “wisdom” in general or of higher moral character. It is rather based on the superior technical competence of the professional man [sic]”.

In this way, achieved competence in, and knowledge of, a clearly demarcated field is a, if not *the*, key characteristic of the professional role; as Parsons (1939, p460) claims; “This specificity is essential to the professional pattern no matter how difficult it may be, in a given case, to draw the exact boundaries of such a field.”

By contrast, other institutional formations, namely, commerce and bureaucracy, draw on different mechanisms of authority. In the case of commercial relationships, Parsons observes that it is contractual terms and agreements that legislate the 'rights and obligations' between two parties. In bureaucratic institutions, it is a person's office within a recognized hierarchy that determines who may do what and under what circumstances; Parsons uses the example of the treasurer of a company and their authority to sign cheques that may "far exceed his [sic] private resources" (Parsons, 1939, pp460-461). As Parsons (1939, p461) helpfully points out by way of distinction from the professions, "Authority in this sense is not enjoyed by virtue of a technical competence. The treasurer does not necessarily have a skill in signing checks which is superior to that of many of his subordinates."

Although Parsons identified, then, different forms of functionally specific authority, his principal contention was that these institutions exercised their authority along the same principles; "Functional specificity, the restriction of their domain of power, and the application of impersonal standards on a universalistic basis, without regard to the personal characteristics or circumstances of their subjects" (Dingwall, 2008, p3). While Parsons is often considered, and criticized, along with functionalist perspectives that claim professional groups are unique in their altruistic motivation, Parsons himself is actually firm in his contention that, whether altruistic or otherwise, the motivations of individuals are somewhat redundant considerations in understanding professionalism as an institution.

"It is seldom, even in business, that the immediate financial advantage to be derived from a particular transaction is decisive in motivation. Orientation is rather to a total comprehensive situation extending over a considerable period of time. Seen in these terms the difference may lie rather in the "definitions of the situation" than in the typical motives of actors as such."

(Parsons, 1939, p464)

Parsons goes on to demonstrate that the rewards accruing from success in both professional and commercial fields may actually bear close resemblance, i.e. promotions, monetary rewards, enhanced reputation etc.; they are, however, attained by 'different paths' which are "determined by the differences in the respective occupational situations" (Parsons, 1939, *ibid*).

This point of consideration of Parsons' work is simply to demonstrate that criticisms which question the assumed moral superiority of professional persons, as intimated by some functionalist thinkers (i.e. Marshall, 1950; Barber, 1963), may not be as readily applied to Parsons who stressed functional specificity as a signifier of professional distinction.

Nevertheless, there is a normative element to Parsons' theorizing which may be questioned; when Parsons claims that the professions account for "many of the most important social functions", he is clearly making some form of value judgement, although the basis for this is not elaborated. Dingwall (2008, p5) observes that, in regard to 'profession', "Parsons took the category for granted", although without stipulating the criteria for 'functional importance', the range of professional activity is difficult to identify. Parsons specifies that professional authority is maintained by 'technical competence' but the scope of activities in which one may achieve this competence is not fully delineated.

Furthermore, the idea that 'technical competence' provides the basis for professional authority has been called into question; described by Brante (1988) as a 'naïve' point of view. Naïve in the sense that Parsons eschews the potential effects of non-technical factors upon the actions and decisions of professional people, instead seeming to see the professions as operating outside of political and affective relationships.

"The fact that the central focus of the professional role lies in a technical competence gives a very great importance to universalism in the institutional pattern governing it. Science is essentially universalistic, who states a proposition is as such irrelevant to the question of its scientific value. The same is true of all applied science."

(Parsons, 1939, p462-463)

A number of critics have argued that the extent to which rationality and universalism dominate professional conduct is here overstated. Johnson (1972, p36), for instance points out that:

"... affective neutrality and professional authority – the latter stemming from professional competence – are likely to operate only where they do not conflict with other and more important aspects of the relationship between professional and client."

For instance, in the case where a professional is patronised by a single powerful client, the professional's conduct may respond as much to the particular desires of that client, as to universal principles (Johnson, 1972, p36). Brante makes a similar argument, pointing out that when professionals are faced with uncertainties, disagreements or controversies, "political affiliation, ideological conviction, or occupational position" (Brante, 1988, p132) may all determine the course of action taken. Further to this, Brante argues, conversely to Parsons, that material rewards for professional activity do not simply accumulate as a result of the exercise of technical competence in a functionally specific field; rather professional proficiency is determined by the community in which one operates. Making a broader point about the 'social-constructedness' of science, Brante (1988, p133) writes that:

"Therefore individual strategies are not primarily orientated towards finding the Truth, and research areas are not primarily chosen because their solutions are beneficial for, say, the welfare of mankind. Strategies are primarily internally orientated. Scientists turn inwards to the 'marketable' paradigm and puzzles, the articulation of which is strictly ranked in the scientific community. In this sense the scientific community is not a rational institution."

Overall, functionalist accounts of professions have been rejected because they make undue assumptions concerning the underlying stability of professional institutions; whether it be a moral stability wherein collective norms are simply assumed, or stability based upon the supposedly disinterested pursuit of technical competence. Perhaps most pointedly, functionalist theories of professions take the needs of society as a given and see professions as the necessary means of fulfilling these needs, overlooking Everett Hughes' contention, paraphrased by Dingwall, that "Not only do professions presume to tell the rest of society what is good and right for it: they can also set the very terms of thinking about problems which fall in their domain." (Dingwall, 2008, p4). This kind of insight is reflected in later 'power' or 'closure' theories of professionalism which emphasise how professional fields are constructed and maintained; these will be discussed at greater length herein. Beforehand however, I will briefly review that which is commonly termed the 'trait', or 'attribute' approach to the analysis of professions which, like functionalism,

represents an attempt to identify professional groups in absolutist terms, though within a different framework.

2.3.2 Professional Traits

While functionalist and trait approaches are sometimes appraised together (subjected to simultaneous critique) (e.g. Macdonald, 1995; Abbott, 1988), they are analytically quite distinct from one-another. Functionalist theory aimed at elaborating a theoretical basis of professional work, stressing its role and place within a more general social structure, while the trait approach reflects more methodological concerns; an attempt to pin down, concretely, the observable features by which we may recognize a profession. The perceived success of such a systematic endeavour to identify the salient and abiding attributes of an area of social activity is largely dependent upon the degree of agreement that it achieves. This has been perhaps the most intractable problem for those wishing to produce a set of inviolable criteria by which a profession may be measured. Several defining characteristics have been variously proposed including; 'possession of a specialized body of knowledge', 'extensive theoretical education', 'autonomy over working practices', subscription to a code of ethics or conduct', etc. however an exhaustive and irrefutable model has not been realised. By way of illustration, Johnson (1972, p23) relays that Millerson (1964) undertook a review of the relevant literature and sought to extract from it the 'essential elements' of a profession, producing a table of 23 items. Resultantly, "no single item (was) accepted by all the authors as essential to a profession" and "no two contributors (were) agreed that the same combination of elements can be taken as defining a professional occupation" (Johnson, 1972, *ibid*).

Even if the unlikelihood of consensus were to be obtained, the matter would remain far from resolved as questions still persist concerning the relationship of each identified attribute to the others. As both Johnson (1972) and Brante (1988) point out, the lack of theoretical underpinning means that in some cases, it can be argued that a singularly sanctified characteristic may in fact be reducible to another so identified; in some instances, one attribute may be dependent upon, or even causally related to another (see Johnson, 1972, p24).

Furthermore, it is not readily apparent whether attributes should pertain to the profession as a whole, the individuals within it, or indeed both.

Finally, there is built into trait approaches of the professions a real, or imagined, ideal type that legislates the *kind* of attributes that are being sought. As Dingwall (2008, p12) observes, the sociologist "... derives his [sic] definition from his own member's knowledge of his society or from an inspection of some collection of data." In this way, the sociological investigation of the professions has already been conspicuously shaped by normative understanding of what that category entails. In many cases, it is likely to be professional groups themselves who have (tacitly) transmitted this understanding.

This appraisal of trait approaches to defining the professions has been kept intentionally succinct; it would perhaps be somewhat unproductive to dedicate too much space to knocking down what has arguably come to be seen as a straw man. Nevertheless, it should be borne in mind that this kind of trait thinking continues to inform the practical strategies of professionalizing groups who pursue status symbols such as lengthier education and state licensure in their bids for professional recognition. That these strategies do not necessarily result in the undisputed realisation of greater occupational standing bear testament to the fact that 'professional status' may not be simply reduced to finite criteria. However, some of the conventionally ascribed attributes of the professions may certainly be said to bear upon the discursive possibilities of the concept. As Yam writes, for instance, of nursing; despite 'severe criticism' of trait-based methodology, "nursing continues to measure its state of professionalization against these discredited attributes." (Yam, 2004, p979).

2.3.3 Professional Power and Closure

Responding critically to the functionalist notion that the professions fulfilled certain pre-ordained, societal needs, a number of commentators began to focus attention upon the means and motivations of professional groups; if their status is not the result of '*functional* necessity' (Noordegraaf, 2011), how, then, does their work come to be recognized, and feted, as 'professional'?

Macdonald (1995) recognizes this analytical shift as, in part, a delayed realization of the significance of the writing on the professions of Everett Hughes who, unlike Parsons, perceived that professional work was contiguous with other occupational activity and, as such, occupational groups could position themselves in ways which might advance their professional ambitions. As early as 1963, Hughes had written that:

“...in my own studies I passed from the false question ‘Is this occupation a profession?’ to the more fundamental one ‘What are the circumstances in which people in an occupation attempt to turn it into a profession and themselves into professional people?’

(Quoted in Macdonald, 1995, p6)

In the 1970s and 80s, this fundamental question formed the basis of a new paradigm to the study of the professions which emphasised the active pursuit of professional status and the means utilized by occupations to attain it. As Muzio, et al. (2013, p702) put it; the “alternative conflict or power framework was developed around the realization that professionalism is not so much an inherent characteristic of an occupation, but a means of *organizing* and *controlling* an occupation”. The central contention within this framework is that professionalization is achieved by occupational closure; i.e. achieving monopoly over a recognized service or capacity in order to maximize the rewards entailed by its provision. The analytical focus of the closure approach is upon how this monopolization is achieved and is therefore focused on social *processes* rather than on structure; the question is not ‘what is a profession?’, but ‘how has it come to be?’.

Indicative of this processual approach, Larson (1977) coined the term ‘professional project’ to refer to the way in which aspirant occupations pursue their professional goals. A successful professional project is one whereby the occupation has achieved monopolistic control over the services that it offers, thereby ensuring a dominant position in the market from whence high income and prestige may be reaped. According to Larson’s schema, all of this depends upon an occupation’s ability to control knowledge to the exclusion of others. MacDonald (1995, pp10-11) explains the general process succinctly:

“The market control aspect of the ‘project’ requires that there should be a body of relatively abstract knowledge, susceptible of practical application, and a market, or

market potential, given the social, economic and ideological climate of the time. If the possessors of this knowledge can form themselves into a group, which can then begin to standardize and control the dissemination of the knowledge base and dominate the market in knowledge-based services, they will be in a position to enter into a regulative bargain with the state. This will allow them to standardize and restrict access to their knowledge, to control their market and supervise the 'production of producers'."

One notable facet of this sort of explanation is the stress on intentionality and action. Professionalizing groups engage in deliberate strategies to close-off an area of practice, such as the pursuit of lengthier periods of education and/or obtaining licensure, which serve to exclude others from participating in a given area, with the ultimate goal being to maximally secure material reward. As such, theories of professionalization that emphasize occupational closure tend to reveal a somewhat cynical underpinning philosophy. As Brante (1988, p129) attests:

"... the closure theory's conception of history and society is based on a hedonistic philosophy of the nature of man and social groups. Individuals and groups are viewed as guided by their interests. Closure theory is built upon a notion of a collective egoism as the motive force of history."

Indeed, this is one reason why power-based approaches to the professions have been criticised. It can be simply argued that construing professionalization as a strategic ploy to secure status and financial reward is overly deterministic and denies the perfectly plausible explanation that professionals are motivated by the nature of the work they undertake. As MacDonald (1995, p35) concedes: "by far the greater part of the actions of members of professions are providing a service for their patients or clients". Professionalization may be pursued in an attempt to gain greater recognition for a particular type of work and, in so doing, ensure it is granted adequate funding, resources etc. in order that greater benefits will be derived by the users of professional services.

Some authors have sought to maintain a focus on professional closure but without the explicit concern with market monopolization. For example, with particular reference to the American legal system, Halliday (1987) argues that while professional groups may well dominate particular fields, this influence is wielded at a political level, impacting on public and social policy and, in theory

at least, professional motives might be said to be 'public-spirited' (MacDonald, 1995, p32). Abbott's (1988) take on professionals as interdependent actors within a general 'system' similarly eschews the notion that self-interest propels professionalizing strategies, in favour of the proposal that professionals continually vie for control over *jurisdictions*. Abbott's case though is, arguably somewhat tautological in that he seems to suggest that jurisdictional control is the goal, as well as the process, of professional(izing) groups. As MacDonald suggests, Abbott's 'jurisdiction' could readily be replaced with 'monopoly' and be read simply as an extension of Larson's analysis, but with the added recognition of inter-professional competition (Macdonald, 1995, p33).

Freidson (1994) somewhat sidesteps the issue of underlying motivation by reappraising occupational closure as a structural condition of professionalism. With some traces of Parsonian theorizing, Freidson essentially maintains that the intrinsic motivations of professional groups are immaterial; what is of concern is the way in which work is organized. For Freidson, the most salient feature of a profession is that it controls "access to, and organization of, the tasks that constitute its work" (Dingwall, 2008, p12). Beyond this, the actions and performances of members of a profession are determined by the nature of the work itself. Freidson's perspective thus stresses *autonomy* as the key designator of professional activity, regardless of how that autonomy is then mobilised.

While there exists a divergence of perspectives concerning to what ends occupational closure is attained, the theorists discussed above all contend, in some way, that professionalization entails cordoning-off an area of activity and maintaining exclusive control over its practice.

This ultimate concern with occupational control and exclusivity has been seen by some critics as a recapitulation to attributional thinking in that it simply replaces the enumerative approach with one which prefigures a singular definition. For instance, as Dingwall suggests, Freidson, with his emphasis on 'autonomy', believes he has identified a 'fundamental criterion' of professionalism (Dingwall, 2008, p13). However, as Dingwall goes on to reflect, some areas of work generally considered as 'professional' are in fact quite

constrained in the level of autonomy they enjoy but have not seen their professional status disputed or revoked (e.g. physicians in the NHS) (Dingwall, 2008, *ibid*).

In a similar vein, Abbott's 'fundamental criterion' appears to be 'abstraction', in terms of a professional knowledge base, which, the author claims, allows professional groups to continually redefine and reassert their jurisdictional authority; "practical skills grow out of an abstract system of knowledge, and control of the occupation lies in control of the abstractions that generate the practical techniques" (Abbott, 1988, p8). Again, however, the identification of 'abstraction' as a key defining characteristic of professional work can be challenged, especially in so far as 'abstraction' is said to provide professionals with the means of defining their scope of activity; a relationship which is arguably overstated. Evetts (2003) and Muzio, et al., (2013) respectively discern, that the limits of professional jurisdictions are, in fact, contingent upon a number of actors, notably governments who are responsible for licensure, but also the "increasingly large and complex organizations" in which the majority of professional work is now carried on (Muzio, et al., 2013, p702).

Indeed, a general criticism of occupational closure theories is that they tend to view professional status as principally resulting from the internal actions of occupational groups, whereas, as Muzio, et al. (2013, p700) declare; "Professions are (...) not only key mechanisms for, but also primary targets of institutional change. They act and are acted upon by a myriad of social, economic, technological, political, and legal forces". This recognition has engendered an 'institutionalist' approach to the sociological study of professions which has gained prominence in recent years and proceeds from the contention that 'profession' is a mutable term whose usage develops and changes in relation to its institutional contexts. As Noordegraaf (2011, p1358) writes; "Because professionalism cannot be detached from service contexts, and because these contexts are changing and contested, professionalism itself will be a contested concept".

This institutional framework primarily deals with the relations between 'professionals' and 'organizations', and has focused on the emergence of

hybridized forms of working which synthesise organizational and professional logics (Noordegraaf, 2011; Muzio et al., 2013; Evetts, 2011). Evetts comments on the discursive interpolation of 'management' and 'professionalism' arguing that:

"Management is being used to control, and sometimes limit, the work of practitioners in organizations but, in addition, management is being used by practitioners and by professional associations themselves as a strategy both in the career development of particular practitioners and in order to improve the status and respect of a professional occupation and its standing."

(Evetts, 2011, p417)

Noordegraaf arguably recognizes an even greater capacity for an holistically conceived 'organizational professionalism', seeing the confluence of 'professionalism', 'organization' and 'management' as a necessary adaptation in the face of the changing needs and demands of society, stating that; *"increasingly, organizing and managing must be seen as professional issues"* (Noordegraaf, 2011, p1358, original emphasis). These authors challenge the tendency to "treat professionalism, managerialism, and entrepreneurship not only as distinct, but also as opposing and mutually exclusive, logics whereby an increase in one would trigger a proportionate decrease in the other." (Muzio et al. 2013, pp702-703).

2.3.4 Professionalism in Context

The insights gained from an institutional approach to studying the professions need not end with reconsidering the conceptual basis of profession to include organizational and/or managerial elements. There are many more contextual considerations which legislate the usage of professional discourse; as Watson (2002, p95) simply states *"the word "professional" is used to cover a potentially bewildering variety of things"*. In each instance of professional discourse, there is arguably a complex constellation of factors shaping how and why a particular appeal to that term is made. Brante (1988) begins to capture the variable nature of professional discourse through what he terms a 'realistic approach', in contrast to the absolutist predilection of functionalism and closure-theorists. Brante, quoting Hellberg, argues that "the concept of professionalization is a concept of relations; it is impossible to attribute professional status to groups without talking about those who are granting this status to those occupational

groups.” (Brante, 1988, p136). The author thereby recognizes that ‘profession’ takes on different forms depending upon the other actors who are invested in, or affected by the scope of professional activity. Professional status is responsive to the occupational milieu in which it is sought. As Brante (1988, p137) writes: “My point is that these types [of profession] possess different *inherent* rationalities, depending upon which ‘target group’ the professional activity is oriented at and depending upon.” Professional groups each offer different services or products (“In principle the product can be anything: material goods, services, care, knowledge, administration, ideologies, symbols” (Brante, 1988, p139)) to different audiences and, as such, the grounds for claiming professional competence will vary in every case.

Arguably, Brante limits his analysis somewhat in producing a professional typology in which professional activity is categorized into 4 groups; “(1) ‘free’ vocations (contractors), (2) academic professions, (3) professions of the capital, and (4) professions of the (welfare) state.” (Brante, 1988, p137). The author claims that:

“Employing this categorization, essential similarities and dissimilarities between different professions can be analysed and explained in a new light, and it will also become relatively easy to connect the development of various professions to larger social conjunctures and trends, ultimately to type of social formation”
(Brante, 1988, p138)

However, it is perhaps ambitious to make such claims given the potentiality for new services, and new markets for those services, to evolve; the conceptualization also doesn’t make clear how professionalism is achieved in cases where multiple products and/or multiple ‘target groups’ are in contention.

Schinkel and Noordegraaf (2011) develop this relational line of thinking by expanding on Pierre Bourdieu’s (scant) writing on the professions to posit ‘professionalism’ as a form of symbolic capital determined by relations in a given field of social action. In doing so, Schinkel and Noordegraaf move towards a more permissive stance concerning what may be claimed as ‘professionalism’ as the relations within a given field are in a state of continuous flux. Following Bourdieu, ‘Professionalism’ is an essentially

arbitrary concept whose content is dictated by relationships of power within a field; ““Professionalization” is then a process of struggle over the attainment of professionalism as symbolic capital. Such struggles are always also struggles over legitimate definitions of professionalism.” (Schinkel & Noordegraaf, 2011, p89).

This Bourdieusian analysis demonstrates how professional discourse is subject to continuous (re)development as it is used to legitimate a wide variety of occupational practices. In this vein, Schinkel and Noordegraaf discuss how business managers have sought professional legitimacy by converting their economic capital into cultural capital and, thence, into symbolic (professional) capital; “by using economic capital to set up educational institutions, a way is gained to generate cultural capital (diplomas and certificates).” Thus, “For many, the professional manager is no longer a contradiction in terms.” (Schinkel & Noordegraaf, 2011, pp91-92).

While the notion of (continually changing) ‘professional’ fields helps us to realize the variability amongst discourses of professionalism, it is arguably difficult to conceptualize the relevant field(s) in *every* case where we wish to understand the usage of the term ‘profession’ or ‘professionalism’. In common parlance, we might readily switch between different meanings when using the term professional to describe someone or something; for instance, one might say a musician is professional if, in distinction to an amateur, they get paid for their playing. At other times, we might declare that a plumber provided us with a professional service as a result of their punctuality, appearance, general conduct etc. It could be said that, when making such distinctions, we continually modulate between different ‘fields’, though this is perhaps an overcomplicated way of asserting that professional discourse denotes a plethora of meanings between various contexts.

Moreover, the conceptualization of professionalism as symbolic capital implies that ‘profession’ is always a desirable state to attain, whereas, as Watson shows, ‘professional talk’ is occasionally used much more ambiguously; in one instance a ‘professional’ personnel manager claimed that “as a profession, we are too professional for our own good” (quoted in Watson, 2002, p97). In a

single utterance, the nominal status of 'profession' is accepted while the utility of 'professional conduct' is questioned. Given this ambiguity, Watson suggests that researchers "consider simply using "occupation" as our key analytical category, and then to look at "professional talk" as a topic -namely, as something that members of occupations use to further their interests" (Watson, 2002, p98). This would include the use of 'professional talk' which may be critical or derisive of the notion of 'profession' and that might serve occupational interests other than those associated with professional recognition. This focus also allows for anomalies within 'professional talk' to be accounted for; for instance, if in a singularly identifiable occupational group, members articulate different understandings of 'professionalism', or where different situations dictate the boundaries of a professional performance. For example, as Dingwall documents (2008, pp12-26), accomplishing 'profession' in the eyes of one's colleagues may be a quite distinct operation from demonstrating professionalism to a member of another occupational group.

In Watson's appeal to focus analytical attention on 'professional talk' and in Dingwall's (2008, p14) declaration that; "We cannot define what a profession is. All we can do is to elaborate what it appears to mean to use the term...", it should be apparent that we have moved firmly into 'constructionist' territory as far as the study of the professions is concerned. The endeavour to delineate the constitution of professional work is abandoned in favour of a discursive approach which seeks to discern how people make use of notions such as 'profession' and/or 'professionalism'.

As Watson (2002) and Dingwall (2008) both, respectively, contend, discursive practices have meaning insofar as they are *purposefully* utilized. As Watson (2002, p94) asserts "social actors ... use "professional talk," both to make sense of and to manipulate the social world in which they live". Discursive practices, therefore, can only be interpreted and understood in relation to this social world. Moreover, discourses of professionalism necessarily relate to other occupations as, without sources of comparison and distinction, there would be little purpose in staking a claim to professional status. As Dingwall (2008, p20) writes of health visitors (a classic case-study for sociologists of the professions),

their “claims to professional status are based upon their conceptions of the social structure of their society and of the relative placing of occupations within it.”

It is crucial, here, to note that, maintaining professionalism as a *relative* concept does not mean endorsing the view that profession is a meaningless term; rather that its meaning is developed *in relation* to the contexts in which it is used. In line with the critical-realist stance which encompasses the analytical approach of this research project, discourse is seen as something which, while it does not simply represent an objective social reality, is constrained by relatively stable social phenomena. This issue is taken up and elaborated in greater detail in the ‘Research Design’ chapter of the thesis.

2.4 Professional Nursing: Empirical Studies

Kath Melia’s work from the late 1980s serves to illustrate a lack of coherence over how the term ‘profession’ may be used in nursing. She writes of a ‘segmented’ occupation in which an ‘academic elite’ conceive of nursing professionalism as owing to the possession of a distinct body of theoretical knowledge, fostered in the universities and signifying equal status to other professional groups (particularly medicine) (Melia, 1987). By contrast, the nursing students interviewed by Melia appeared to see nursing professionalism as increasing insofar as it resembled, or took on, elements of technical-medical work, thus tacitly endorsing the subordination of nurses to doctors in the professional hierarchy. Finally, Melia (1987, p166) writes of a managerial view of professionalism which emphasises comportment and behaviour; for frontline nurses, professionalism has to do with ‘duty and compliance’, for nurse managers, their professional skill is ensuring the maintenance of such a workforce.

Arguably, no one of these iterations of professionalism has firmly taken hold in the ensuing years and there remains a number of potential sources for professional elaboration. In a relatively rare example of quantitatively driven research into nurses’ use and understanding of ‘professionalism’, Akhtar-

Danesh, et al. (2013) observed a divergence of perspectives among nursing faculty and nursing students as to what it meant to be 'professional'; appeals to both 'professional conduct', and to distinct nursing values are variously evidenced and emphasised. Using a Likert-type scale to show agreement or disagreement with a series of pre-prepared statements, formulated through focus groups and drawing upon extant literature, the authors identified four distinct professional viewpoints; 'humanists', 'portrayers', 'facilitators' and 'regulators'. These four groupings placed differing emphases upon the components of their work they deemed to signify professionalism; for example, the 'portrayers' were concerned with maintaining an appropriate professional image through attire, expression and outward appearance, while 'humanists' conveyed a value-based approach to professionalism, believing, for instance, in the central importance of 'respect for human dignity', while being less concerned about timeliness and being well-organized (Akhtar-Danesh et al., 2013, pp255-257).

While one may certainly gripe as to the methodology here employed, for instance in relation to the use of statement-rating, rather than allowing respondents to choose their own descriptors, it seems viable to accept the authors' conclusions that "The differences identified between the four factors indicate that there may be numerous contextual variables that affect individuals' perceptions of professionalism" (Akhtar-Danesh et al., 2013, p266). The type of variables indicated include "differences with respect to age, nursing experience, areas of clinical expertise, and tenure in the nursing profession" (ibid) although, in theory, there may be several more. Ultimately, this study indicates that, even within a single bounded research population, there is a distinct lack of consensus over what constitutes nursing professionalism and that this is, at least in part, due to the heterogeneity of the nursing workforce. The authors also indicate that this divergence of viewpoints reflects a deficiency in the transmission of professional values in nursing education (Akhtar-Danesh, et al. 2013, p266). While the importance of context is vaunted by the authors, they only speculate as to which contextual factors may inform nurses' perceptions of professionalism. Other empirical (qualitative) studies, to be discussed herein, have sought to understand

nursing's professional discourse as a product of the environment in which it is elaborated.

One of the key contextual factors, specific to the elaboration of nursing's professional identity, is the occupation's status vis-à-vis the medical profession; the adequacy of nursing's professional discourse rests in a large part upon its ability to define itself as a practice differentiated from medicine, but deserving of equal status. This is not to say that nurses cannot be considered as professional workers *in their own right*, but at an occupational level, inevitable comparisons with medicine serve to determine the extent to which this status is realized. Medicine has long been considered as a prototypical profession (i.e. Freidson, 1970) and its position as such is rarely called into question, in spite of the constraints on professional autonomy already here referred to. Indeed, as an area of practice, medicine has inured us into accepting many of the symbols that have conventionally indicated professionalism; extensive theoretical study, formal certification systems, the exercise of clinical judgement etc. Nursing's bid for professional recognition has, inescapably, been cultivated in the shadow of the behemoth that is professional medicine. As Davies has pointed out:

"It (nursing) has clearly not had the first bite of the cherry in defining its work and... we get closer to the ... matter in recognizing that it is trying to put a conceptual framework around just those aspects of health and healing that are 'left over' after medicine has imposed an essentially masculinist version."

(Quoted in Abbott & Meerabeau, 1998, p8)

Indeed, Etzioni's consideration of nursing as one of an emergent group of 'semi-professions' demonstrates the prevailing influence of archetypal professions, such as medicine and law, upon the way in which novel claims to professionalism are received. Etzioni (1969, p5) includes nursing among ...

"... a group of new professions whose claim to the status of doctors or lawyers is neither fully established nor fully desired. ... [Their] training is shorter, their status is less legitimate, their right to privileged communication less established, there is less of a specialized body of knowledge, and they have less autonomy from supervision or societal control than "the professions".

A long-standing relationship with the established profession of medicine, in which nursing has traditionally been cast in a subordinate role, supporting, and

carrying out the orders of, physicians (Hoeve et al. 2014; Yam, 2004; McMurray, 2010) has presented a central challenge to nursing's claim to professional status.

A number of interview-based studies of nursing attend to the elaboration of nursing's professional identity as a product of inter-professional relations. Daykin and Clarke's (2000) study of nurses and HCAs (health care assistants) working on 2 NHS hospital wards found that nurses defended their professionalism with direct reference to their experience of higher education. The authors posit that this emphasis on professional education represented a discursive response to a new skill-mix project on the wards, in which HCAs were taking on many of the primary care activities previously administered to by qualified nurses. The nurses' 'professionalism' was perceived as being under threat as it was felt that having HCAs perform nursing tasks undermined the skill-level required in their undertaking. According to the authors, the nurse-respondents "offered a coherent perspective in which qualified nurses were presented as offering holistic, patient-centred care. This was seen as qualitatively different from the care offered by health care assistants..." (Daykin & Clarke 2000, p353). However, an overall ambivalence in the occupational discourse was found as, paradoxically, nurses also appeared to recognise a hierarchy of healthcare tasks with the work performed by HCAs occupying the lowliest position, and medicalized tasks at the apex. The study findings suggest that nursing's occupational strategy is trying to pursue two contradictory strategies of closure; 'usurpation' which seeks to "renegotiate role boundaries between nurses and doctors" through demarcating a distinct and autonomous area of knowledge and practice, and 'exclusion' which "seeks to create a clear division of labour between nurses and less-skilled carers" (Daykin & Clarke, 2000, p358).

Johannison and Sundin (2007) illustrate what might be regarded as a more successful negotiation of inter-occupational relations in articulating nursing as a professional role. Again, medical dominance is recognized as impacting significantly upon the ways in which nurses frame their own sense of professionalism, but the authors claim that nurses' participation in the medical

discourse actually contributes to the professional development of their occupation. Focusing on the knowledge-seeking practices of nurses, Johannison and Sundin contend that nurses engage in medically sanctioned forms of information usage as a means of demonstrating professional capacity, which lends legitimacy to a nursing professional discourse which is enacted at the occupational level.

“... the nurse expresses a view of information-seeking practices that includes more than rational task-based information seeking. The nurse relates the ability to seek information to the power of shaping her own work, and she shows how she considers the mastering of formal information-seeking tools as an important component of her new occupational identity. The ability to seek, obtain, evaluate, and use formal professional information becomes part of the discourses that are used as tools in the negotiations between nurses and doctors.”

(Johannison & Sundin, 2007, p212)

At the practical, work-place level, nurses negotiate with doctors within the terms of ‘medical discourse’, for instance, by referring to well-respected medical journals but, the authors contend, in demonstrating their skilful use of information within this specific relationship, nurses are claiming the validity of their own ‘holistic nursing discourse’ which applies to a separately delineated sphere of knowledge. The very practice of seeking and using information is seen to represent a professional way of working; “The use of formal professional information could be interpreted as part of the new nursing identity, while informal information seeking is considered as part of a more traditional occupational identity.” (Johannison & Sundin, 2007, p10). Nurses’ proficiency in participating in the medical discourse lends credibility to the articulation of the ‘new identity’ as one which is separate, but equal. As one respondent in the study testified; “They have the medical responsibility, but there’s a lot more to the care of patients than just the medical part. And the nursing bit ... that’s not their area at all.” (2007, p2018).

2.4.1 Organized Professionalism

Many recent studies of the relationship between nursing and professionalism have drawn conclusions broadly in line with the ‘institutional’ approach to theorizing professional work, and demonstrate how the professional discourse of nursing has incorporated organizational and managerial aspects.

Recognizing the co-constitutional potential of 'professionalism' and structures of 'organization', some writers have argued that the centrality of care to nursing might actually be enhanced by the new organizational roles that professionals may inhabit. From her intensive interview-based study of Portuguese nurses, Teresa Carvalho (2014) contends that nurses can use organizational constructs and languages to legitimize caring as the professional basis for nursing. For instance, the "organizational discourse of giving the primacy to patients as clients" (Carvalho, 2014, p187) is realized in nursing's assertion of 'reflexive practice'; "the reflexive dimension reinforces the need for practice and emotional involvement with patients to be considered a 'real' professional" (Carvalho, 2014, p188). Managerial skill is further incorporated into professional discourse with the contention that direct physical care is optimized through planning and organization, with one interview respondent stating "They (nurses) need to manage the time to develop care, manage the resources and materials they are going to use in care, manage the public attendance, so, management is always implicit in nurses' practices" (Carvalho, 2014, p187). Indeed, Allen (2015) argues that activities of organizing and managing care provision do not simply facilitate the elaboration of nursing's professional discourse, but should, themselves, be recognized as the principal component of nurses' professional work.

Blomgren (2003) discusses (in a Swedish context) how nurses' increased presence in managerial positions allowed them to implement 'quality assurance programmes' which helped to formally define and demonstrate the caring work performed by nurses (often described as invisible (e.g. Gray, 2012)) and thus promote nursing as a distinctly recognisable area of practice. However, as Blomgren (2003, p68) warns, this strategy is not without risk; "Establishing formal classifications of nurses' work is walking a tightrope between increased visibility and increased surveillance; between over-specifying what a nurse should do and taking discretion away from the individual practitioner".

Yam draws attention to the fact that movement into management positions is an increasingly viable career option for nurses and claims that, from such

positions, nurses can be proactive in promoting 'a more nurse-led service' (Yam, 2004, p981) wherein nurses may be able to exercise greater control over clinical practice. In support of this contention, Henderson (2002) indicates that senior nurses, responsible for coordinating care, can play an important role in inculcating professional values at the practice level, as one of Henderson's study respondents reported; "the nurses who are co-ordinating will allow us to be professional, so you do have the opportunity to provide holistic care where you can actively solicit patient input." (Henderson, 2002, p248). In short, having nurses occupying senior management positions may help to provide the resources that enable nursing to identify and extol its own sense of professionalism.

In a critical case-study, McMurray (2010) focuses upon the activity of a small group of advanced nurse practitioners (ANPs) who were granted a commission to manage an 'unwanted practice space' in a disadvantaged area of England (the practice is referred to as 'Sharedcare') (McMurray, 2010, p811). The author contends that, through their entrepreneurship, this group of nurses were able to occupy a position from which to subvert the medically dominated occupational hierarchy in healthcare systems.

"In working in many of the same ways as GPs and drawing on the same knowledge base – but from the added position of entrepreneurial employer as partner in Sharedcare – they began to claim the right to question medical authority."

(McMurray, 2010, p815)

McMurray's principal conclusion is that 'executive authority', here wielded by the ANPs by virtue of practice ownership, represents a means of countering medicine's presumption of authority in clinical matters. In particular, this newly acquired position of authority is seen to grant ANPs greater licence in applying their extended medical skills. McMurray discusses how, under conventional circumstances, advanced nurses who had acquired a certified right to diagnosis were discouraged from utilizing these skills in practice settings as "the business of diagnosing was seen as a purvey of doctors" (McMurray, 2010, p810). In the new practice setting, doctors' resistance could be more readily challenged and nurses were provided the space to claim the legitimacy of their diagnostic abilities. Where Doctors were unwilling to cede

some diagnostic authority, the ANPs drew upon their executive positionality to exert occupational power:

“Where, however, ANP partners deemed that a doctor would not engage in such discussion, as on an occasion where an employed GP refused to discuss or explain his reasons for not conducting a home visit, the ANP partners shifted their emphasis from interaction based on licensed equivalence, to attempts to direct apparently errant doctors through combined appeal to rightful mandate and executive authority. As GP partner Rachael noted, ‘these are not nurses who are willing to play Greek chorus to doctors anymore.’”

(McMurray, 2010, p815)

Drawing on Hughes’ usage of the concepts of licence and mandate, McMurray attests that the combination of the occupational licence to diagnose, and the professional mandate to manage the practice and its staff (including GPs), acts to bolster the professional claims of this particular group of ANPs. Thus, based on this singular study, the potential for a re-ordering of the occupational hierarchy within healthcare is recognized, though the author points out that the *eclipsing* of the medical profession was not the aim of the ANPs; rather they used their executive authority to institute “a realignment of relations based on mutual recognition of different yet interdependent diagnostic roles of complementary occupational specialities.” (McMurray, 2010, p817).

Furthermore, McMurray is cautious in claiming the study as a portent for nursing/medical relations more generally, pointing out that, at the time of writing, this ANP partnership represented an unique case in point. The study does however, perhaps demonstrate the potential for nurses and other ‘subservient’ professional groups to challenge this status.

One potential obstacle to these kinds of innovative approaches to professionalization, i.e. using ‘management’ or ‘entrepreneurship’ to advance professional claims, is that they draw attention to some of the perceived tensions within nursing’s occupational discourse. For instance, McMurray (2010, p813) observes that some commentators see nursing’s move into the area of diagnosis as representing ‘the abandonment of nursing’ and yet, in his study, diagnostic qualifications were an essential part in the ANPs’ pressing of claims for professional recognition. Similarly, while several authors have argued, in the institutionalist vein, that nurses have incorporated a managerial

identity into their professional(izing) discourses (Carvalho, 2014; Blomgren, 2003), there is also evidence which illustrates a fundamental sense of unease, among nurses, over embracing management roles and capacities.

2.4.2 Resisting 'Managerialism'

Although the examples provided by Carvalho (2014) and the theoretical work of institutionalist writers on the changing (and changeable) nature of professionalism (i.e. Noordegraaf, 2011) support the assertion that there is no *inherent* opposition between nursing professionalism and its organization, there is other evidence to suggest (Brown et al. 2014; Bolton, 2005) that, rhetorically, these categories encompass contradiction. Despite the fact that "Nurses, at every level of the complex bureaucracy that characterizes the NHS hospital service, have long been involved in management functions" (Bolton, 2005, p6) and that nursing work thus simultaneously involves both the management *and* direct provision of care, nurses participate in the discursive decoupling of these roles so that 'management' is seen as external to the fundamental aspects of nursing care.

For instance, Bolton (2005) describes the reluctance of nurses, even those in fairly senior management roles, to fully embrace a 'managerial identity' and its attendant connotations; "Nurses are keen to disassociate themselves from the term manager and all that this implies. They are not prepared to see themselves, or be seen, in terms of a management role..." (Bolton, 2005, p15). Instead, "nurses are firmly attached to their image (however over-idealized) as professionals who possess unstinting compassion and self-sacrifice" (Bolton, 2005, *ibid*). Despite some evidence that managerial decisions and initiatives are underpinned by these same values, e.g. "I can honestly say, hand on heart, that we have quality care as our main priority. Some of the involvement in recent initiatives has allowed us to push through things that benefit patients a great deal" (manager respondent, Bolton, 2005, p18), management and nursing are still ideologically assigned to opposing camps. It is arguable that the separation of these aspects of healthcare derives predominantly from the discursive contexts of these concepts. In other words, there are particular ideas surrounding management and caring, respectively, that confines them to

distinct and discrete realms of social activity. Drawing on the idiom of Erving Goffman, Bolton (2005, p9) explains that; “Within a system of social action... Each role is recognized as having specific characteristics and there are certain expectations as to how the role will be enacted”. The managerial role is thus perceived as requiring an entirely different performance to that involved in ‘real’ nursing. Bolton also shows how the physical performance of “the perceived dirty work of nursing” commands greater respect (in the “situated social system of the hospital”) than managerial activities and leads to a cynical view of management who are often referenced derogatively (Bolton, 2005, p15). This perpetuates and sustains the division between ‘nursing’ and ‘management’ identities. Increasingly, it is the ‘hands on’ elements of care that are associated with the ‘pure’ identity of a nurse.

Brian Brown et al. (2014) also highlight this discursive separation of care practices from their organizational settings and arguably go further than Bolton in emphasising the extent of this separation. In their study exploring mental health nurses’ understanding of ‘compassion’, they argue that acts of compassion were conceived of as being based in practical activities involving face to face or bodily interaction with patients. The authors use the term “interpretive repertoires”, defined as an “internally consistent bounded language unit” (Brown, et al. 2014, p388), in order to explain the ways in which compassion was conceptualised in the work of mental health nurses.

“In discussing compassion in their working lives, the participants drew on two key repertoires. The first of these, the practical compassion repertoire, focused on the practice of compassion through support, practice and meaning, whereas the second, the organisational repertoire, focused on a variety of contextual factors that reduced the availability of compassionate care for patients.”

(Brown, et al. 2014, p388)

Compassionate care was construed as that which was practically actionable; “Moving patients around, pre-empting the potential for disruptive behaviour, satisfying the longing for an anticipated cigarette – these are all actions in a practical repertoire” and were cited by respondents as acts of compassionate care (Brown, et al. 2014 p389). Brown (et al.) stress the extent to which compassion is embedded in a practical repertoire in their evocation of Bourdieu’s notion of habitus; “Common to all these characterisations of

compassion was the notion of doing things for and to the people in the participants' care – a mode of compassion intimately connected with the '*sens pratique*' and with a kind of practice-based habitus of caring work" (Brown, et al. 2014, p392). Thus, compassionate practice is not simply *enacted* through the body; it becomes almost subconsciously embodied in the person of the mental health nurse; "...habits are routinized practices which immediately inform us of what is going on in practical situations before we reflect on them..." (Brown et al. 2014, p394). Because 'compassion' was so intimately bound up with physical practices, other activities which were not bodily actionable were not construed as compassionate and were often viewed as inhibiting the compassionate care of patients. Crucially, these other activities were discussed and referred to as part of a fundamentally different (and oppositional) 'organizational repertoire'.

"It is also noteworthy that in contrast to the bodily, corporeal and emotional aspects of the practical compassion repertoire, the organisational repertoire evoked something altogether more cerebral and literate and was considered to be less valuable."

(Brown, et al. 2014, p394)

Because they were not concerned with direct physical interactions with patients, organizational activities, such as paperwork and the drawing up of care plans, were seen as incommensurate with compassionate care. From Brown (et al.)'s study, we can see how certain concepts are discursively limited as they are confined to certain distinct 'interpretive repertoires' and, concomitantly, certain spheres of social activity. In this way, organizing and planning for care are seen as qualitatively distinct from 'real' (practically-based) caring activities, and thus the perception remains that management gets in the way of care, rather than supporting or enabling it.

Taking a normative stance, Brown, et al. (2014, p396) conclude that;

"Perhaps... developing a more fully compassionate mode of care is primarily about changing the culture of how mental health work itself is done".

Presumably the kind of culture change that they refer to would entail an expanded understanding of 'compassion' which transcends the limits imposed by the interpretive repertoires that they identify, creating new modes of discourse in which organizing and managing can, too, be seen as constituting

compassionate practice. However, their study illustrates the inherent difficulties in creating these new kinds of discourse when certain conceptions of 'care' and 'compassion' are so entrenched.

2.4.3 From Vocation to Profession?

Indeed, narratives surrounding 'care' may be seen, not only as resistant to managerial or organizational discourses, but as potentially incompatible with the notion of professionalism itself. Many recent studies have tended to endorse the view that nursing now is, and should be, considered a profession, and that this status is based upon nursing's jurisdictional claims over caring practices; as Dowling (2006, p48) claims, the "one to one relationship between nurse and patient has been a catalyst for professionalization". That nursing still struggles for professional recognition has been explained by a number of mitigating factors, such as the disparity between theoretical models of care and the reality of ward-based nursing (Henderson, 2002) or the lack of understanding within the general public over what 'professional' nursing entails (Hoeve, et al., 2014; Yam, 2004). Hoeve concludes that nurses, and nursing, need to be more active and vocal in promoting nursing as a professional practice in order to win recognition outside of the occupation itself (2014, p306). There is an evident narrative, within some research, that nursing has now taken the requisite steps in professionalizing, and is waiting for external parties (the public, the wider health service) to catch on to its progress, as evidenced in the following from Hadid and Khatib (2015, p70):

"On one hand, the nursing profession succeeded in developing independently and producing an evidence-based body of knowledge, which includes care protocols and directives, the significant development leading to a more professionalized field; on the other hand, many studies have shown that nursing still receives insufficient recognition for its actions from the majority of the public."

While some commentators, just prior to the turn of the century, openly questioned the desirability of professional status for nursing, (e.g. Woodward, 1997; Savage, 1995), it appears that this debate has now largely been eschewed in contemporary analysis, which tends to apply the term 'profession' fairly assertively to nursing (Dewing & McCormack, 2017; Ali & Watson, 2011).

One reason for this may simply be the proliferation of 'profession' as an occupational descriptor (Evetts, 2003) and a concomitant liberality in acceptance of this usage. It is almost certainly that, in some instances, authors' endorsement of nursing professionalism reflects the belief that the occupation is deserving of greater respect and recognition; a professional persona raises the status and image of nursing (Ali & Watson, 2011, p316). These aspirations are further supported by the denigration of the notion of 'vocation', which is seen as accountable for nursing's undervaluation and exploitation.

In 1998, Lesley MacKay pondered whether 'the idea of vocation' would survive in nursing and argued that, while "the attractions of being 'a professional' and establishing nursing on an equal footing with medicine cannot be denied ... something intrinsic to nursing practice would be lost if the vocational element were extinguished" (Mackay, 1998, p69). Ten years later, in an editorial for the journal of clinical nursing, Watson and Shields (2009, p2926) dismissed 'talk of vocation' as an undesirable relic of nursing's past. Indeed, seemingly, part of nursing's professional claim involves killing-off the vocational ideology; two separate papers from the early 2000s are each entitled 'from vocation to profession' (Hallam, 2002; Yam, 2004), both implying that nursing is following a linear progression from one state to its mutual opposite. Similarly, the writer of a letter to the editor in the 'Nursing Standard' asserts that "The idea of nursing as a vocation has long gone. We have enthusiastically embraced a profession that demands academic study, incorporates scientific and technical advances, and grows ever more demanding by the day." (Zeba, 2010).

However, it is far from apparent that 'professionalism' has simply displaced vocationalism in regard to nurses' occupational identity. Without wishing too much to pre-empt the reporting of my own findings which will be delineated here later, from my own study, it seems evident that the idea of vocation, despite its current unfashionableness, still carries significant discursive weight with frontline nurses, while the concept of 'professionalism' is treated with marked ambivalence in many cases. This may be partly explicable by the fact that the formally structured means of professionalizing, such as the move to an all-graduate profession, have not been seen to have significantly improved the

working conditions of frontline nurses and, thus, nurses have little to gain in subscribing to a professional discourse. McCann et al. (2013) show, from a case study of ambulance workers, that a senior-level bid to professionalize (including the formation of a regulatory body and the restructuring of certification and training into institutions of higher education) has had little effect upon 'street-level' ambulance workers and that, resultantly, these workers simply reproduce traditional labour patterns, referred to in the study as the maintenance of 'blue-collar professionalism'; "... a kind of professionalism predicated on stoical devotion to duty in the face of physical and psychological risks, insults, and 'dirty work'." (McCann, et al., 2013, p766-767). It may be that nurses similarly find that the perceived value of their work is better explicated through vocational discourses in which, significantly, the general public are complicit, as evidenced, for example, by Smith (2012, p52) who reports the sentiments of patients such as; "I'd always imagined it (nursing) was a calling" and asserting that caring is something "you've got to have in you." Arguably, these vocational ideas have more cultural cachet and sustain the nurse in their endeavours and interactions with patients. Many nurses evidently still subscribe to the idea that the ability to care is, to a great extent, predicated on inherent caring characteristics; in a study by Bray et al. (2014) respondents indicated that delivering 'compassionate care' was a skill which could not be 'learnt and taught'. In this respect, claiming care as a professional undertaking is perceived as undermining some of the natural qualities which nurses believe they possess and that allows them to do the work that they do. Others have attested to the blurred line between psychological and professional identities in nursing (Hoeve, et al., 2014) and the felt need for nurses to invest fundamental aspects of the self in their work to render it meaningful and rewarding (Sabatino, 1999; Bolton, 2000).

Furthermore, there is an irony inherent to nursing professionalism in that the professional distinctiveness of the occupation is purportedly based on an enhanced theoretical knowledge relating to 'care', and yet the further one advances through a professional career path, the further they are removed from face-to-face interpersonal caring (De Meis, et al., 2007), being promoted to positions with greater managerial responsibility. Nurses might therefore

come to view professional status as representing a move away from direct patient care, which is cited by many nurses as their motivation for entering the occupation (Eley, et al., 2012).

Similarly to the discussion of 'profession' and 'management', it is not being contended here that 'vocation' and 'profession' are inherently opposing concepts; Salvage (2004, p17) claims that "there are some inspiring examples of an emerging new professionalism that embraces the noble ideal of vocation but expresses it in ways more in tune with contemporary culture." although, unfortunately does not elaborate further. In many instances, it appears that, to borrow Brian Brown's (2014) terminology, nursing care may be conceived of as belonging to either the vocational, or professional 'interpretive repertoire' and instances of hybridity are uncommon. The usage of this terminology entails certain positionalities; 'profession' is used to discredit the idea of vocation and its perceived unsophistication, vocation is evoked in order to counter the depersonalizing connotations of 'professionalism'. As a nurse-respondent in a study by King (2012, p60) averred:

"Well, we're not allowed to care, we have to be professional. And the way that professional is explained to me it's like in cold; you go in, do your job and you get out. Well, it's not always that easy when you are dealing with human beings."

In an editorial for 'Nursing Management'. Tom Keighley summed up the predicament thus; "The term 'profession' now simultaneously implies an enhanced social standing and increased public distrust, while the term 'vocation' can indicate naivety and low self-esteem." (Keighley, 2002, p1). Nursing has to mediate between these conceptions in elaborating its occupational identity.

2.5 The Meaning of 'Care'

As referred to in the introduction, a generally conceived discursive split between 'knowledge' and 'caring' within nursing has been posited by Bliss, et al. (2017). According to the authors, the 'caring discourse' "has humanistic values such as empathy, compassion, trust and mutuality at its core" and

“centralises the cultivation of virtuous character traits that enable this way of caring for others” (Bliss, et al. 2017, p2). However, the delineation of such a caring discourse is arguably more elusive than may be supposed from this; indeed, the complexity of the concept of ‘caring’ is such that a singularly identifiable discourse is unlikely to be able to contain all that may be suggested by the term. To start with, the ‘humanistic values’ that supposedly underpin (nursing) care are, themselves, not meaningful in any inherent or decisive way and are liable to deconstruction and criticism. Powerful abstract nouns like ‘love’, ‘compassion’, ‘empathy’ and ‘intimacy’ have all been appraised as components of care, and variously affirmed or discounted by different authors (Griffin, 1983; Fitzgerald & van Hooft, 2000; Dowling, 2006). Griffin, for instance, appears to recognize the place of love and compassion in nursing care, though seems dismissive of ‘empathy’ and ‘affection’ as necessary emotional elements (Griffin, 1983). In other explorations, emotional investment in caring relationships is given less credence, for instance in the consideration that caring may simply be equated with ‘therapeutic intervention’ (Morse, 1990); in Parker’s recognition of physical ‘tending’ as a form of caring (cited in Thomas, 1993); or Henderson’s (1966) view of nursing care as simply assisting individuals with those tasks which their illness prevents them from being able to do (cited in McCance, et al., 1997, p245). All of these conceptualisations submit that caring may be provided as an instrumental response to (chiefly physical) need and may not necessitate an affective relationship in which to occur.

It has thus been observed that caring is subject to a dual conceptualization referring to both practical actions and/or emotions and feeling states (Wilkin, 2003; Griffin, 1983). For instance, Griffin has argued that “there are two major aspects to caring in nursing; an activities aspect, and the attitudes and feelings underlining them” (1983, p291), though this is arguably a pertinent recognition for the concept of caring outside of nursing, too. As McCance, et al. (1997) observe, dictionary definitions of ‘care’ (verb form) contain both of these impulses; “to be concerned; to have regard affection or consideration for; to provide physical needs, help, or comfort.” (Dictionary of English language, quoted in McCance, et al., 1997). These ‘two major aspects’ of care are often

referred to in the literature as 'caring for' and 'caring about' (Cronqvist, et al., 2004; Thomas; 1993; Savage, 1995) where 'caring for' refers to the demonstrable manifestation of care and 'caring about' describes internal feelings of concern (empathy, compassion etc.) It should be asserted, at this point, that *caring for* could also include comforting actions (such as handholding) which, while not always producing any definitive physical health benefit, are done to induce feelings of wellbeing in the care-recipient, though may still conceivably be performed prescriptively. What makes the distillation of the concept of care so difficult is that these two aspects of it are analytically distinct, that is to say, we can imagine them existing separately from one another. As Savage (1995, p50) explains:

"In general, to care about someone suggests an attachment or emotional relationship but implies little about carrying out practical activities or devoting time to that person. In contrast, caring for someone implies providing for that person's needs without necessarily suggesting anything about affection or affinity."

To give an example (from real life!), in composing this section, I was engaged in a text conversation with my mum on my mobile phone and I explained to her that I was trying to write about 'what it means to care'. She replied with a picture that she had taken of my year-old niece, eating at her high chair, and wrote; "It means making tuna sandwiches and changing nappies!". This seemed to represent an excellent illustration of *caring for*; in her response, my mum had referred only to attending to my niece's *material* needs. I know that the relationship, in this instance, extends far beyond simply 'caring for', and so my mum could just as soon have mentioned being concerned about her granddaughter, and wishing her health and happiness (caring about), however the actions described in her initial reply do not demand the presence of such sentiments.

Faced with this kind of dualism, there are essentially four positions that, hypothetically, may be adopted in relation to what can be considered 'care'. The first is maintaining that *caring for* is what really matters and that practical attendance to need is the fundamental basis of care; whether or not this is accompanied by caring *feelings* is of little or no concern. The second position is

the opposite of the first. It could be maintained that *caring about* someone is the truest expression of care, reflecting authentic emotion; one may not be able, or in a position, to fulfil wants and needs, but is, in some way, emotionally invested in the wellbeing of another. Thirdly, it may be averred that caring may only be deemed as such when both the practical and affective elements of the concept are aligned; caring actions must be impelled by feelings of concern, compassion, affection etc. Finally, a more permissive approach might be maintained which recognizes the validity of all of the above positions and allows that caring can be conceived of as 'caring for', 'caring about', or both of these elements together, depending upon the context in which the term is used.

Acknowledging the multi-faceted nature of the concept of care, Thomas (1993), exemplifying the fourth position outlined above, has eschewed the task of concrete definition and has instead forwarded a conceptual framework that demonstrates the variability in usage and understanding. Thomas proposes that caring can be conceived of as the relationship between 7 discrete variables; 1) The social identity of the carer, 2) The social identity of the care-recipient, 3) The inter-personal relationship between carer and recipient, 4) The nature of the care, 5) The social domain within which the caring relationship is located (i.e. public/domestic), 6) The economic character of the relationship (i.e. waged/unwaged), and 7) The institutional setting in which care is delivered (Thomas, 1993, pp651-653).

The conceptual range of Thomas' framework is perhaps most acutely demonstrated by the fact that the various permutations of these variable-relationships can permit caring as both the product of intimate familial ties within the domestic sphere, and as professional activity conducted in public institutions between relative strangers. There is, however, one variable here that cannot be accounted for in the same way as the others which is the fourth-the 'nature' of the care; this is the very thing that most commentators are concerned to describe but which cannot be readily delineated. The 'nature' of care is here concerned with whether care consists of practical interventions, alone, or if these are accompanied, or stimulated, by the emotional states

previously touched upon; love, affection, compassion etc. (Thomas, 1993, p652). By including the 'nature' of care as a variable within a nexus of 'caring', Thomas (possibly quite sensibly) avoids normative evaluation of different forms of caring; in other words, there is nothing in her schema to suggest that 'emotive' caring should be viewed as inherently superior to more instrumental forms of care, in every case.

For many however, the 'nature' of the care is not simply a variable *aspect* of caring, but defines the concept itself. To some commentators, whether or not actions and behaviours really count as care is determined by the extent to which those actions are propelled by concomitant 'caring' emotions. In her 1983 treatise 'Caring; A labour of love', Hilary Graham argues the central point that fundamental care is that which arises from affective relationships, however, for Graham (in this earlier work, at least) this occurs specifically within the family and is provided by women. Therefore, remunerated care in the public sphere does not qualify as care. Reviewing Graham's work, Thomas (1993, p658) explains:

"Although 'caring' is also performed by paid health or social service workers in the public domain ... the relationship between the carer and client is not quintessentially one of 'caring'. These substitute services are not care, since they lack the very qualities of commitment and affection which transform caring-work into a life-work. A job into a duty"

In light of Thomas' framework, it seems here that Graham recognizes several of the proposed variables as proxies for the fourth- 'the nature of care' - in that, where caring is based on a familial, domestic relationship and is carried out in the home, it is assumed to encompass feelings of love and affection and is therefore considered a true expression of care. This would appear to discount the possibility that some forms of familial care are provided reluctantly, begrudgingly, or even under duress, and also suggests that formal, institutionalized care necessarily entails a lack of love and/or affection, which Qureshi (1990), for example, has found reason to dispute. Furthermore, empirical research in nursing has shown that nurses often do reference the concept of 'love' in explaining the types of care that they (endeavour to) offer (e.g. Fitzgerald & Van Hooft, 2000) and love has continued to be considered as

an element in the theorization of nursing care (e.g. Dowling, 2004). With these reflections, it would be difficult to conclude that familial care is necessarily better than, or superior to, other more formal modes of care on the basis of emotional investment. Indeed, in Woodward's discussion of nursing care in her paper 'Professional Caring; a contradiction in terms?' (1997), the author argues that caring necessarily involves an emotional commitment, contending that without "concern, involvement, attachment and connection with the recipient", nursing actions constitute "mere techniques and knowledge" (Woodward, 1997, p1000) which alone are not considered to represent care.

Woodward essentially argues the same thing as Graham; that caring simultaneously requires the presence of both material actions (caring for) and psychological dispositions (caring about) though, unlike Graham, claims this as characteristic of authentic *nursing* care, and not only confined to care within families. Given that the aspects of the variables involved in nursing care are, by Thomas' model, distinctly different from those implicated in familial domestic care, it is interesting that the 'nature of care' is similarly constituted in both contexts. Unlike in the family where 'caring for' is assumed to be a direct effect of 'caring about' (James, 1992, p503), 'caring for' in nursing is concretely prescribed and codified by the occupational job description. There is rarely a pre-existing relationship between carer and cared-for and nurses are paid to tend to the material needs of their patients in accordance with institutional regulations. As Nicky James (1992, p491) describes:

"Formal, health service ideology involves paid professionals, trained in a form of 'scientific' knowledge, skilled in the use of specialist tools and requiring specialist buildings in which to use those tools. It is about 'doing', and treating with physical interventions."

On this view of formal care, it is perhaps remarkable that an *emotional disposition* to care is deemed by many, theorists and nurses themselves, as being an essential component of nursing work (i.e. Sabatino, 1999; McCance, et al., 1997; Dowling, 2004) when it may readily be argued that 'caring for', when properly undertaken, would be sufficient, as expressed in the idea of caring as a therapeutic intervention (Morse, et al., 1990).

2.5.1 Why 'care about' patients?

Whether or not nurses *actually* care about their patients is perhaps, theoretically at least, something of a moot point. In the absence of mind-reading capabilities, we cannot ascertain this for certain, nor can we assume it from nurses' outward behaviours as there is no way of telling whether these are manifestations of a deep-seated caring impulse, or a convincing and capable workplace performance. In this respect, it is difficult to refute an 'emotional labour' analysis of nursing care which posits that nurses' utilization of emotion, in the act of caring, is primarily dictated by the expectations of the organization in which nurses work.

In 'The Managed Heart', Hochschild defines emotional labour as work that "requires one to induce or suppress feeling in order to sustain the outward countenance that produces the proper state of mind in others" (1983, p7). Throughout the book, Hochschild uses flight attendants for an American commercial airline to exemplify the concept of emotional labour, however she notes herself that she could just as readily have studied 'nurses, lawyers or salespeople' (1983, p12). According to Hochschild, jobs requiring emotional labour can be defined by the following characteristics: they involve "face-to-face or voice-to-voice contact with the public", they "require the worker to produce an emotional state in another person-gratitude or fear for example" and they "allow the employer, through training and supervision to exercise a degree of control over the emotional activities of employees" (Hochschild, 1983, p147). These criteria can be appealed to in order to comprehend the ways in which nursing might be considered a form of emotional labour.

Firstly, it is clear that nursing, by necessity, involves a significant amount of face-to-face contact; this point needn't be laboured through example. It also should be readily apparent that a significant element of nursing entails bringing about a certain emotional state in patients; particularly so with the recent increased emphasis on the nurse/patient relationship. As Savage (1995, p9) asserts: contemporary approaches to nursing are underlain by "a belief that the relationship between nurse and patient has the potential to be

therapeutic and central to the process of recovery". This contemporary focus on relational, person-focussed care as central to nursing practice, identified as representing nursing's professional jurisdiction, may also be seen as evidencing Hochschild's third stated criterion for work that might be considered emotional labour-the employer's ability to exercise control over the emotional activities of the workforce. It is arguably an occupational expectation of nurses, reinforced through training, that they will exhibit caring behaviours.

Accordingly, Hochschild's principal contention that emotional labour involves the *suppression* of feeling in order to generate appropriate emotional states in others has been recognised as a feature of nursing work. Nurses' attempts to live up to the expectations of their role may require the subduing of their natural emotional responses. For instance, Smith identifies instances where nurses felt that they couldn't say what they really wanted to say to some patients "because that was not the way one was expected to talk to patients, *irrespective of how you felt*" (2012, p103, my emphasis). Hochschild argues that the result of this emotional suppression is that workers become estranged from the feelings which are "used to do the work", in the same way that a factory worker becomes estranged from their own body as it becomes merely an instrument of production (1983, pp5-8). Workers' feelings are not their own but are 'acted' out on behalf of a company or organisation who specify appropriate 'feeling rules'.

Hochschild maintains that this performance can be constructed in two ways; through either 'surface', or 'deep' acting. In surface acting, a worker "clearly distinguishes herself (sic) from the job" (Hochschild, 1983, p187), acknowledging their own superficial performance. While this protects against the possibility of burnout, the recognition of insincerity tends to render work unsatisfying. Conversely, in deep acting (akin to Stanislavskian 'method acting') 'real' feelings are self-induced in order to suspend disbelief as to the (un)reality of a performance (see Hochschild, 1983, chapter 3). While work may be experienced as more 'satisfying and rewarding' (Lopez, 2006, p135), the risk of burnout is greater, and the consequences more personally damaging should the illusion be disrupted or shattered. In either method, "an

actor may separate what it takes to act from the idea of a central self” (Hochschild, 1983, p36).

This ‘self-estrangement’, which is fundamental to Hochschild’s overall analysis, has been challenged by a number of authors (see particularly, Bolton & Boyd, 2003) and especially insofar as it applies to care-work (Theodosius, 2008).

Bolton and Boyd, for instance, take issue with Hochschild’s idea that emotions used in the workplace are under the sole duress of the organization and that there is thus “no room for the ‘private’ in organizational life” (2003, p293). Instead, they argue that authentic feelings (belonging to a ‘central self’) may often be in evidence in the workplace. Following Hochschild in studying air stewards, Bolton and Boyd affirm that; “For instance, they (cabin crew) may genuinely empathize with a passenger, rather than present the cynical face of a service provider” (2003, p304).

Moreover, in the case of nursing, it has been argued that the experience of *genuine* emotion is integral to the job as it represents the primary source of reward, over and above monetary remuneration (Theodosius, 2008, p37). Indeed, Bolton (2000, p584) has developed the notion of emotion work, in the form of care, as a ‘gift’ given, by nurses to patients, “with little or no expectation of a return on their investment-other than the satisfaction they derive from being able to ‘make a difference’”. Not only do ‘gifts’ have no transactional value, they are given outside of prescribed organizational practices and procedures; “... they (nurses) offer more than the detached face of the professional carer. They carry out hard emotion work and offer a gift (to grieving parents) (Bolton, *ibid*). The idea of emotion work given as a gift is not accommodated by Hochschild’s (1983, p78) original conception of emotional labour in which emotional exchange is essentially a zero-sum equation wherein “we keep a mental ledger with “owed” and “received” columns for gratitude, love, anger, guilt and other feelings”.

Against the notion that nurses perform care in line with organizational ‘feeling rules’, the claim that, within nursing, “caring actions arise from feeling with and for patients” (Forrest, 1989, p818) is widely subscribed to and significantly

informs perceptions of nurses and nursing, both within and outwith the occupation. The significance of this discourse bears especial consideration.

There are, without doubt, fundamental structural differences between familial care, and care as it occurs in a public institution, such as a hospital or hospice. On a practical level, as James (1992, p493) notes, “the analogy between family and healthcare staff is limited by the inability to take account of how health services divide the labour force to meet the demands of a large organisation processing large numbers of people.” Nonetheless, reverence for an ideal-typical domestic model of care presents one plausible explanation for the prevalence of a ‘caring about’ discourse in nursing. The linkages between familial care and nursing care have, historically, been widely vaunted, particularly the supposed accord between nursing and mothering. Gray (2012, p50) reports that “...mothering the patient until they feel better” has been a common way of thinking about the role of a nurse, even amongst students of nursing. Similarly, the historical use of the words ‘sister’ and ‘matron’ to refer to nurses evokes a familial feminine image and perpetuates the association of nursing work with women’s domestic work (Mackay, 1990, p58). Staden has shown, also, that some nurses (who, in her study, are all women) recognise the emotional skills which are used when caring for their families as transferable to the work-setting. The author reports that one nurse identified “her home as an ‘experimental ground’ where emotional management can be tried out, sometimes unconsciously, before confronting a similar situation at work” (Staden, 1998, pp151-152). However, as Staden (1998, p152) goes on to point out, her nurse-respondents were uneasy about equating these emotional skills with ‘female skills’.

It is perhaps the case that the historical connection between nursing and ‘femininity’ is weakening as nursing has sought professional recognition and the gendered basis of nursing’s vocational status has been questioned (White, 2002). Also, importantly, traditionally ‘masculine’ medicine has seen female entry rise to the point where women-doctors now, for the first time, outnumber their male counterparts in the UK, thereby problematizing the notion of a simplistic, gendered division of labour between medicine and

nursing. Although not overwhelmingly successful, there has also been some effort to recruit more men into nursing and it has been argued that the presence of men in the occupation is now more accepted than it once was (Juliff, et al., 2016; Koch, et al., 2014). In 1990 (p34) Mackay claimed that “males, unable to lay claim to all the necessary personal characteristics of the nurse with a vocation may be forced to pursue the ‘professional’ line.” However, more recent studies suggest that male nurses are emotionally engaged in patient relationships and that this provides motivation and satisfaction (e.g. Rajacich, et al., 2013), and, as will later be seen from my own analysis, both male and female nurses made appeal to their *natural* caring abilities, often referring to the care of family members, in explaining what made them suited to the role.

Perhaps then, expectations about the constitution of nursing care (as affective and relational) have their roots in the historical association between the occupation and conventional notions of ‘femininity’. Although, the increasing recognition that gendered caring traits are socially, rather than naturally produced, has facilitated the possibility that womanhood, as the mediating factor between nursing and caring, may not be necessary in explaining the ability to give care to patients. Nonetheless, the type of care that is *represented* by motherhood (kind, loving and supportive) survives as an idealized epitome of what nursing care should resemble. As White has argued, the values associated with nursing as a vocation can, and should, be:

“... conceptually disentangled from its identification with ideals of motherhood and femininity. It is nursing work and the identification with the moral and social meaning of nursing that give nursing its vocational status, not the feminized character of the nurse.”

(White, 2002, p279)

Somewhat tangentially, it could be argued that this is analogous to Weber’s (1905[1930]) famous account of the evolution of capitalism. Weber explains the emergence of the capitalist system as, essentially, a by-product of a religious impulse. Calvinist Protestants engaged in profiteering activities in order to try and discern their standing in the eyes of ‘God’; earthly success is taken as a sign from God that they are among ‘the chosen’ who will be

rewarded in heaven. Eventually, however, the religious impetus wears (or is rationalized) away and money-making is pursued as an end in itself because of the material benefits it brings. Perhaps we might propose a similar evolutionary process with regard to nursing care, wherein the 'femininity' once regarded as the stimulus for nursing care becomes less significant, but the associated behaviours and attitudes remain as integral to nursing's identity.

Another proposed reason that nurses emphasize their capacity to care *about*, as well as for, their patients is that the experiencing of caring feelings provides the motivation for the physical labour involved in nursing work. The practical activities that nurses do for, or on behalf of, patients may be physically exhausting, 'mundane' (James, 1992) and/or 'unsavoury' (Mackay, 1998); shifts are usually long and can be stressful when shortages in staffing or resources occur. Additionally, nursing work is considered by many to be poorly remunerated. Given these material deprivations associated with the job, the moral value of the corporeal work becomes pre-eminent. Caring for patients is not undertaken simply for a wage but because it serves as an expression of nurses' intrinsically altruistic tendencies. As Bolton reports of the gynaecology nurses that she studied with: "They confirm continually the view that their emotional attachment to the job reflects their commitment to quality patient care and that if they were able to be emotionally uninvolved then they 'shouldn't be in the job' (2000, p583). Thus, it is a deep-seated emotional predilection to care that is seen to sustain nurses' engagement with the 'dirty work' demanded by the occupation.

Moreover, more than simply providing justification for the undertaking of hard, physical labour, nurses' emotional investment in the job has been cited as a means of personal self-expression. This assertion entails that 'caring about' people extends beyond its perceived necessity for the performance of nursing tasks, and reflects more fundamentally the character of the individual carer. A natural inclination to care about people precedes one's work as a nurse.

"Although nurses are paid a financial reward, this is perceived as less important than their motivation to nurse because they care; thus, their care is perceived as

genuine because their patients matter to them. In this way it is arguable that the meaning of care is linked to personal identity."

(Theodosius, 2008, p37)

Thus, nursing care can be seen as a channel into which more generalized moral sensibilities of individuals are directed. Eley, et al. (2012, p1553) write of a "caring impetus" which draws people to nursing in the first place, and then contributes to them remaining in the profession.", affirming the view that engagement in nursing care serves as a means of individual self-fulfilment. Similarly, Bolton (2000, p584) has noted that there is an 'underlying social expectation' that nursing is based upon "an overwhelming drive to 'care' for people"; Eley, et al. (2012, p1552) have even gone so far as to say that nursing fulfils, not just a desire, but a 'need' to care, on the part of the individuals who take-up the occupation. Bolton (2000, pp584) reports that nurses see "the emotional stresses of the job as bringing the greatest potential for job satisfaction" and, accepting the link between personal and occupational identity, this job satisfaction translates into personal enrichment. As Griffin contends, "... as a result of this caring a nurse may have an increased sense of personal worth. We have a natural demand for fulfilling aims in life which lie outside ourselves." (Griffin, 1983, p294).

Finally, for the time-being, the expectation to engage in forms of caring which transcend merely 'caring for' is endorsed as a professional imperative, with nurses increasingly encouraged to form relationships with their patients and 'get to know them'. Savage chronicles the development of the 'new nursing' which, she claims, developed in response to "low-levels of job satisfaction among nurses, discontent with task-oriented nursing and the superficial relationships between nurses and patients" (Savage, 1995, p8) and which Dowling (2006, p48) has attributed to the "humanistic philosophy of the 1960s" which "penetrated nursing theory and promoted the concept of a relationship between the nurse and the patient as being achievable". Savage (1995, p1) goes on to claim that, in contrast to traditional nursing, in which "emotional involvement with patients was strenuously discouraged", new approaches positively stress emotionality.

“... within discussions about the ‘new nursing’, the meaning of nursing care appears to be shifting from the requirement for nurses to understand and address the patient’s needs (caring for), towards a broader interpretation which includes both ‘caring for’ and ‘caring about’.

(Savage, 1995, p51).

Concepts such as ‘intimacy’ (Dowling, 2004/2008), ‘closeness’ (Savage), ‘emotional presence’ (Swanson, 1991) and, perhaps most ubiquitous, ‘compassion’ (Bray, et al., 2014; Adam & Taylor, 2013; Christiansen, et al., 2015) now permeate nursing’s theoretical literature; the concept of compassion is vaunted as one of the ‘6 Cs’ of nursing which have emerged from the NHS England’s ‘Compassion in Practice’ initiative (2013-2016). Thus, even if nurses do not identify with a *personal* compulsion to provide affective, relational care to other people, it would appear that this kind of caring has become the object of professional inculcation.

It is, however, a matter for debate as to whether or not ‘caring about’, with its attendant emotional commitment, can be instilled through policy and educational enterprises. As Bray, et al., conclude from their study of the link between professional education and ‘compassionate practice’, “Debate surrounding the role of education in promoting compassionate care (...) is fraught with ambiguity and contradiction” (Bray, et al. 2014, p486) largely owing to the belief that, while certain relational skills may be enhanced, the fundamental ability to be compassionate cannot be taught and is either ‘there or it’s not’ (Bray, et al. 2014, p484). The notion of ‘caring about’ is inherently unquantifiable, unlike ‘caring for’ which, while perhaps variable by degrees of competence, has always a finite limit. Maybe the perception that formal approaches are an attempt to specify the boundaries of ‘caring about’ is the reason that nurses tend to maintain that things like ‘compassion’ reflect a personal disposition. Compassion is potentially limitless and resists easy definition and quantification. This is arguably something recognized by Bray, et al. (2014, p485) in the observation that “Whilst it may be possible to teach or learn how to give compassionate care this may be very different to how the more personal attribute of compassion could be taught, learnt or conveyed.” Demonstrably ‘compassionate’ care is not, then, necessarily a direct reflection

of a nurse's *internal capacity* for compassion and therefore *learning* to nurse in a compassionate manner may only be categorized as a form of 'caring for'.

Furthermore, the formal organization of nursing work appears to make concession to the notion that in-built caring characteristics are a prerequisite for nurses, even as this seems to fly in the face of nursing's bid for recognition as a theoretically informed area of professional practice. This is evident in the recent endorsement, by the NHS, of 'values-based recruitment' which has been seen by some as a direct response to reported care failings such as those highlighted by the Francis inquiry (e.g. Rankin, 2013), and "is an approach which attracts and recruits students, trainees and employees on the basis that their individual values and behaviours align with the values of the NHS Constitution" (hee.nhs.uk). This is tantamount to sanctioning the quintessentially 'vocational' declaration that "nurses are born, not made" (Mackay, 1990, p34) and is, perhaps, a tacit acknowledgement of the limits of nursing education and training in its ability to foster compassionate practice.

The ambiguity concerning the relationship between caring as a natural predisposition, and caring as a professional skill is well illustrated in a short article by Geoff Trickey who declares that:

"Fortunately, innate compassion is not the only route to considerate and professional nursing. (...) Since not everyone can be inexhaustibly compassionate, providing a consistently professional and caring service will depend on altruistic values being a part of the code to which nursing aspires."

(Trickey, 2014, p63)

This implies that appropriate values for nursing can be instilled within a professional framework. However, the author also claims that "Personality is a driver for competency in this demanding environment and those who do not have a natural disposition for nursing are likely to find the job more difficult." (Trickey, *ibid*). It may be arguable that nursing care requires both a 'natural disposition' *and* adherence to a professional code of values, though, given the contention made here earlier that care is not a finite concept, it is perhaps understandable that 'natural abilities' assume primacy because they represent the indefinable, expressive element of caring. As Dahlke and Stahlke Wall

(2016, p3) note: "Interestingly, it seems that expertise in nursing practice, which is knowledge-and skill-based, is subsumed within and, thus, eclipsed by a focus on caring." In a brief article by a nursing student describing their placement in a hospice, the author writes that "The placement helped me remember why I decided to study nursing in the first place. I want to learn clinical skills and practise them competently. But above all, I want to be a nurse because I care." (Short, 2011, p29). This sentiment, and particularly the use of the phrase 'above all', reveals the continued strength of the idea that a personally felt dedication to caring is the primary requirement for the nursing role.

2.5.2 In what way do nurses 'care about' patients?

So far, the theoretical distinction between 'caring for' and 'caring about' has been delineated and it has been posited that an emphasis on 'caring about' is significant to nursing's sense of occupational identity; as well as tending to a patient's physical condition, nurses affirm the value of emotional investment in those for whom they provide care. There remains, still, however, a question as to the nature of this emotional investment. Commentators have proposed and considered a number of ways in which a nurse may 'care about' their patients and the kinds of emotions that characterize a caring relationship (Morse, et al. 1990; Dowling, 2004 & 2008; Griffin, 1983). Morse et al. (1990) for example, recognize five distinguishable conceptualizations of caring, of which one is the aforementioned 'therapeutic intervention' in which care may simply be seen as an instrumental response to the patient's care needs (caring for), the other four, though, may all be considered different theorizations concerning a nurse's capacities for affective care, entailing an emotive response. Griffin (1983) takes a more normative approach when she reviews exactly which emotions should be present in a caring nurse-patient relationship. The following attempts to broadly outline some of the different ways in which nursing care, as affective and relational, has been theorized.

2.5.2.1 General or particularistic?

One of the questions which has been asked of the care that nurses give to their patients is how the emotions which motivate this care (assuming that nurses do 'care about' their patients) are constituted. The principal point of divergence here concerns whether emotions are stimulated through the nurse/patient relationship, or if the emotional states which compel caring precede, and exist outside of, this relationship. Among the perspectives on caring considered by Morse, et al. (1990), the authors contemplate that caring might occur as a result of the 'interpersonal interaction' between the nurse and their patient (Morse, et al. 1990, p6). A nurse's impulse to care would thus proceed on the basis of personal feelings towards a patient and therefore affection or liking for particular patients is what transforms 'caring for' into caring about. This is akin to what the ancient Greeks would have termed 'philia'; a form of 'love' referring to that which occurs between friends or members of a close community, and which is commonly characterized as friendship or affection.

Dowling (2004) discusses love in the context of nursing and proposes that the related Greek concept of 'agape' could provide a different understanding of nursing care which, unlike philia, isn't particularistic and dependent upon the nature of discrete, intimate relationships. Instead agape reflects a universal and unconditional form of love which is recognized as the kind of love that 'God' has for all humankind. In the context of nursing, Dowling (2004, p1290) refers to a 'disinterested love' "whereby a person can care for a complete stranger as if they were a family member". Morse, et al.'s (1990, p5) consideration of 'caring as an affect' is arguably the perspective most closely associated with this kind of universalistic altruism which is presumed to motivate nurses to care. According to Morse, et al., nurses empathize with the 'patient experience' (though note, not with individual patients themselves) and are thereby "moved to act selflessly without immediate gratification or expectation of material reward" (Morse, et al., 1990, p5). This is in contrast to providing care on the basis of liking wherein nurses may gain a sense of

personal fulfilment from having helped somebody towards whom they feel affection.

Griffin (1983, p293) appears to endorse this latter form of generalized caring when she refers to the desirability of compassion as a motivator for nursing actions. Griffin suggests that, beyond merely seeing the patient as a 'suitable case for treatment', the nurse also acknowledges the loss of autonomy which accompanies the status of 'patient' and it is this recognition that, the author claims, induces "something like compassion" (Griffin, 1983, p293). According to Kaufman et al. (2014, p40) compassion "refers to the humane quality of being able to understand suffering in others and to feel the need to do something about it" This element of compulsion – feeling the need to do something – has been identified as specifying the nature of compassion, distinct from e.g. pity or empathy (Ledoux, 2015). Indeed, Griffin is quite clear in maintaining that 'empathy', which she argues may be inherently unrealizable anyway, distorts and introduces biases into the nurse-patient relationship, as empathy represents 'fellow feeling', sharing the same emotional experiences as another. Griffin (1983, p294) writes:

"... surely, an appraising sympathetic perspective on a patient's feelings is necessary, rather than wholesale immersion in them (...) in seeing someone not unlike ourselves in a predicament which may always befall us too, we may become aware of a protective feeling. Since we want to preserve ourselves, we may want to preserve creatures like ourselves."

In a similar way, Griffin contends that liking, or affection, for patients is not a necessary basis for care, however the author does acknowledge that "given the irrational nature of affection it is entirely possible (likely) that this emotion may be contingently present." (Griffin, 1983, p293). This sentiment is echoed by Dowling (2004, p1292) who argues simply that "some patients just mobilize intense caring from nurses which is of an intimate and loving nature."

Therefore, the distinction made by Morse, et al. (1990) between caring based upon interpersonal interaction and 'caring as an affect' is not one of mutual exclusivity (which, in fairness, is not a claim made by Morse, et al.). Rather, it may be that nurses can be driven by a general, altruistic tendency to care for others whilst also, on occasion, entering into relationships of greater intimacy

with *some* patients. This particularism need not necessarily override a more general commitment to caring.

2.5.2.2 “*To be able to care, what must a nurse first be like?*” (Griffin, 1983, p291).

Morse, et al.’s review of various perspectives of caring presents a few possible approaches to answering the question posed above. The notion of care based upon interpersonal interaction arguably stipulates no particular qualities that a nurse must possess in order to be able to care, because the caring that occurs, on this view, is contingent on a reciprocal relationship between carer and cared-for. Therefore, a nurse’s personal attributes do not matter, in and of themselves, but only in response to the attributes of another. A cynical, misanthropic nurse may still be able to provide care to patients who share a similar disposition.

‘Caring as an affect’ perhaps most closely relates to the idea of nursing as a vocation and so this perspective would allow the contention that nursing reflects a natural, personal impulse to care for others (possibly owing to the possession of ‘feminine’ caring qualities (Morse, et al., 1990)). It is often asserted that nurses are simply more compassionate than other people (e.g. Williams, et al., 2009; Trickey, 2014) and that they have therefore elected to work in an institutional context where this can be exercised.

In subtle contrast to this viewpoint, Morse, et al. (1990, p4) introduce the notion of ‘caring as a human trait’ in which it is considered that caring (minimally, about *something*) is the natural way of being in the world. *Everyone*, it is contended, has the innate potential to care, although this is differentially realized depending upon one’s experience and subsequent understanding of care. With this conceptualization, there is a strong basis for supposing that the capacity to care can be developed, and is not simply intrinsically present in a few, or, alternatively, lacking in others. Citing Benner & Wrubel, Morse et al. convey the view that “one’s ability to care is enhanced by learning and that differences in nursing practice reflect different levels of expertise in understanding the meaning of the patient’s experiences of health and illness” (Morse, et al. 1990, p4). From this perspective, to be able to care, a

nurse must, first and foremost be human, and therefore be naturally disposed to caring but, arguably, also be willing to explore and cultivate the human trait of caring. A nurse may, feasibly, then become more compassionate, altruistic, etc. having been exposed to potentially transformative caring experiences. As Henderson (2001, p135) avers “the self which is private person and the self which is nurse are constantly interacting and changing one another.”

Finally, the perspective considered by Morse, et al. which defines caring ‘as a moral imperative’ suggests that the personal traits and behaviours of nurses are subsumed within an overriding commitment to nursing care as a ‘moral ideal’ (Morse et al., 1990). The caring actions of nurses ought not to be attributable to the individual character of the practitioner, but should be determined by an ethical standard which is universally applied to nursing. For instance, ‘preserving the dignity of patients’ has been suggested as a moral ideal guiding nursing care (Morse, et al., 1990, p4), and thus caring equates with adherence to this ideal. As Morse, et al., write:

“From this perspective, caring is not manifest as a set of identifiable behaviours, images or traits evident in the caring nurse (e.g. sympathy, tenderness or support), nor does it encompass all that nurses do. Rather, caring is the adherence to the commitment of maintaining the individual’s dignity or integrity.”

(Morse, et al., 1990, pp4-5, original emphasis)

A nurse may plausibly abide by a moral imperative regardless of their own subjective feelings; indeed realizing caring as a moral imperative may often require that these feelings are restrained in service to upholding that moral imperative. Caring actions are conceived of as the result of obedience to an explicit ethical ideal; thus, it is *nursing itself*, and not individual nurses, which determines the nature and content of nursing care. In this sense, the primary requisite attribute for nurses, in order to be able to provide care, is that they are able, and disciplined enough, to abide by a recognized moral code. In a sense, nursing assumes a quasi-religious role, guiding the conduct of its adherents, just as a religious devotee might strive to follow the ‘golden rule’ or obey the commandments, recognizing their moral goodness as absolute.

2.5.3 Criticism of the caring ideology

The expectation that nursing entails the provision of affective, interpersonal care (which is contained within both 'vocational' and 'professional' narratives) has been condemned as an unrealistic ideal in light of the contemporary pressures on healthcare services; particularly with regard to time-availability, relating to heavy workloads and staff shortages (Christiansen, et al., 2015). The caring ideology that nursing is seen to adhere to has thus been criticised on the basis that it inevitably leads to the self-attribution of failure on the part of nurses who find that they cannot live up to the caring paradigm. Dahlke and Stahlke Wall (2016, p5) contend that, in reference to nursing education, "If caring is taught to nursing students as being the fundamental core of nursing, it follows that moral distress will only be compounded when work environments limit caring as it is idealized." The authors go on to show that, beyond pedagogical expectations, the failure to realize a *personally-held* caring ideal represents further despondency; "the focus on "natural caring" in the ethics of care could reinforce nurses' beliefs that they personally have fallen short of historically situated ideas of good nursing." (Dahlke & Stahlke Wall, 2016, p5). There is therefore double the potential for dissatisfaction in adhering to a caring ideology which presages emotive care but which cannot be adequately put into practice. Moreover, a number of authors have contended that the focus on this kind of care has no empirical foundation and argue that it has never been the case that nursing has been actively concerned with holistic relational care; this is an 'occupational myth' (Dingwall & Allen, 2001; Dahlke & Stahlke Wall, 2016). Dingwall and Allen (2001, p72) forcefully maintain that "nurses are trained to do a job that did not exist in the past, does not exist in the present and may never exist in the future. Is it any wonder that so many feel alienated?"

2.5.3.1 Emotional (Over)Attachment and Burnout

Relatedly, even if nurses enjoyed adequate time to form therapeutically meaningful relationships with patients, it has been proposed that greater emphasis on the nurse-patient relationship can bring its own dilemmas. Savage

(1995, p1) describes how, within traditional approaches to nursing work, “nurses were encouraged to distance themselves from patients as a form of self-protection”. Therefore, “new organizational modes stressing continuity of care would seem to pose new, personal challenges for nurses.” (Savage, 1995, p12). For instance, encouraging the development of closeness or intimacy between nurses and patients has the potential to blur the boundaries of what is an appropriate relationship. The idea of ‘over-involvement’ has been cited by a number of authors (Dowling, 2006; Morse; 1990; Williams, 2009) as a possible outcome of increasing intimacy between nurses and patients. Morse, et al. (1990, p5) write that “the personal vulnerability of the nurse who becomes involved with a patient or patient’s family as a result of empathetic identification with the patient’s experience can be potentially damaging to the nurse”. Williams notes that ‘over-involvement’ describes instances in which “the nurse appears to move out of the professional role and becomes subjectively and emotionally involved.” And later observes that “Such involvement had negative effects on their clinical judgement.” (Williams, 2009, p665). Caring ‘too much’ about the welfare of patients may thus, potentially, detract from nurses’ ability to carry out practical care interventions. As Morse, et al. (1990, p10) write:

“There is evidence that a nurse may become over-involved with a patient so that the nurse’s commitment to the patient as a person takes precedence over the nurse’s commitment to the patient’s treatment goals. Consequently, the nurse may serve to assist the patient to bend or to break institutional rules or to avoid therapy which, from a curative perspective, is not in the patient’s best interests.”

May, similarly, argues that a certain level of detachment is needed for nurses to be able to make valid and accurate evaluations of a patient’s condition and also to meet physical care demands which may, of necessity, involve the patient “being pressured into activities which he [sic] might otherwise resist” (May, 1991, p556). Problems may also be experienced by the patient if they come to over-rely on a particular nurse as a result of a close relationship having been established, for instance, when that nurse is not on duty, or has more pressing work concerns. Furthermore, from a patient-perspective, differential levels of intimacy which may be facilitated by patient response or

the type of condition with which they are suffering, can lead to an uneven distribution of care amongst patients (May, 1991, p555).

It has also been proposed that the heightened expectations around nurses' abilities to make an affective connection with their patients increase the likelihood of burnout, where the emotional toll of caring simply becomes too overwhelming. As Mendes (2014, p1146) describes it "when you are caring for people on regular basis, you draw on emotional reserves to do this and if you don't take the time to fill those back up, you will find yourself running on empty.". When emotional reserves become depleted, the work behaviours of the nurse can become deleterious to both themselves and patients. According to Maslach (1982), the signifiers of burnout are; the depersonalization of patients, to the extent that a nurse may come to resent those for whom they provide care; reduced feelings of accomplishment - work is perceived as unsatisfying; and emotional exhaustion which impinges upon a nurse's ability to do their job (cited by Omdahl & O'Donnel, 1999, p1352). In addition to material factors such as lack of resources, shortages in staffing, and lack of administrative support (Miller, et al., 1995) that contribute to work-related stress and increase the likelihood of burnout, Omdahl and O'Donnel (1999) have identified 'emotional contagion' as being strongly related to levels of burnout in nursing. Emotional contagion, as the authors describe it, refers to "sharing or taking-on the emotion of another person" (Omdahl & O'Donnell, 1999, p1352) so that the nurse actually feels (some of) the pain, anxiety or distress experienced by their patients. This, the authors contend, represents "the lone significant predictor of emotional exhaustion and reduced occupational commitment" in nurses (Omdahl & O'Donnell, 1999, p1357).

Omdahl & O'Donnel make the important distinction between emotional contagion and other 'empathy variables' which do not involve direct sharing in patient suffering. The authors maintain that the realization of 'empathic concern', which describes the nurse's concern for the well-being of their patients but does not entail vicarious emotional experience, coupled with 'communicative responsiveness', i.e. "the ability to effectively communicate with others about sensitive and emotional topics" (Omdahl & O'Donnell, 1999,

p1353) can actually reduce the possibility of burnout, providing emotional contagion is avoided. This finding supports Dowling's (2006, p51) argument that "nurses are encouraged to find what could be termed as a safe equilibrium and are expected to care with empathy and kindness but, at the same time, maintain a degree of emotional detachment."

However, it is not readily apparent how such an equilibrium can be achieved in practice. One of the difficulties is that, as in any area of social life, one cannot easily legislate for the nature of social interactions which may occur. As Dowling testifies in her 2008 (p322) study on nurse-patient intimacy:

"Many nurses talked about 'clicking' with some patients, and not 'clicking' with others, with this 'clicking' sealing the identification process. The term 'identification', in this context, is the process revealed in the nurses' narratives, whereby the nurse identifies something in the patient that triggers the encounter to move to another level, prompting empathy on the part of the nurse"

The phenomenon of 'clicking', or mutual liking, as the foundation of caring relationships has been viewed as problematic because it almost inevitably results in an uneven distribution of care and thus arguably lacks moral integrity. As Olsen (1992, p1022) puts it: "patients who are personable ought not to receive more care than those who are low in self-esteem.". It is also arguable that the problems, here discussed, concerning over-involvement and the potential for burnout are more easily combatted if personal identification with particular patients is avoided, as this would reduce the chances of 'emotional contagion'. However, as indicated here, perhaps it is simply inevitable that nurses will develop close relationships with some 'special' patients (Dowling, 2004, p1292). Indeed, according to Dowling (2004, p1292);

"Caring in nursing is on a continuum and nurses move along all parts of this continuum from engagement to detachment, depending on the patient for whom they are caring. A type of magnet, made up of the patient's personality, needs, and vulnerability, forces the 'pull' towards the engaged and intimate end of the continuum."

2.5.3.2 Satisfaction from closeness

Although engaging in close and/or intimate relationships with patients has been recognized as potentially leading to over-involvement and burnout,

which have negative consequences for both nurses and patients, the prospect that the development of intimacy can result in considerable gratification for nurses should also be acknowledged. Henderson (2001, p137), for instance, contends that “For many [nurses], much of the satisfaction they derive from the job is predicated on the emotional contact with patients”. A nurse-respondent in a study by Dowling affirms that relationships with patients that transcend the superficial can be experienced as more rewarding, saying: “... well it makes you feel that sometimes that what you do is worthwhile if you’re able to make contact with somebody I think sometimes they don’t realise that we get something from it too”. (Dowling, 2008, p324). Bolton observes that nurses actively go out of their way to offer patients extra ‘emotion work’ and argues, from her study, that nurses “celebrate their capacity to ‘care too much’ as an essential ingredient of professional nursing.” (Bolton, 2000, p586).

Resultantly, some commentators have suggested that nursing care entails achieving an appropriate balance between involvement and over-involvement (Turner, 1999), and between intimacy and detachment (Henderson, 2001).

Bolton (2000, p585) appears to support this as a possibility, saying that:

“In offering extra emotion work as a gift the nurses involve themselves much more in particularly emotional and stressful situations. Nevertheless, though they empathise deeply with many of the women, they cannot truly share their grief whilst at work as they must always maintain the professional face.”

Others, however, suggest that the maintenance of this balance is precarious, at best. As an interview respondent of Turner’s explains: “It’s difficult to know when somebody is overinvolved or too involved, because, what for one nurse is a relationship that they can cope with may be over-involved for another nurse.” (1999, p155) Similarly, one of May’s interviewees expressed:

“... it’s this fine line — which I’ve got now but it’s taken me years to get. I used to leave the unit in floods of tears some nights and go and cry half the night and go in looking like a bald owl which, one, didn’t help my patient any, and, two, didn’t help my frame of mind towards my patient”

(May, 1991, p555)

The desirability and appropriateness of this level of emotional involvement is thus questionable if, as reported in the quotation above, it is perceived to have no benefit, or even be detrimental, to patients’ wellbeing. Yet, at the same

time, there is also a kind of symbolic capital attached to the extensiveness of a nurse's relational engagement with patients. Henderson (2001, p133) has reported how, often, nurses perceived "emotional engagement as a requirement of excellence in nursing practice" (p133). One of her respondents appeared to appeal to emotional engagement as a signifier of one's deep-seated commitment to genuine nursing care:

"I think there's two kinds of nurses. There's nurses who want to care for patients and there's nurses who want to shuffle paper work and who want to be managers, nurses who want to be in charge and boss people about. Nurses who are like that want to remain detached, cool and clinical and there's the ones who can't help themselves, who want to look after patients."

(Henderson, 2001, p133)

Emotional attachment to patients seems to validate nursing's identification with 'caring'.

2.5.3.3 Whose care needs?

It might be argued that the aforementioned 'need' to care (Eley, 2012) that nursing satisfies for its practitioners can come into conflict with the 'needs' of the patient if the type of care-relationship fails to match up to nurses' own expectations of their role. Dowling (2008) discusses how patients have sometimes been negatively perceived by nurses if and when their behaviours or attitudes discourage the nurse from engaging in intimacy or making an emotional connection. The author cites the example of one nurse who "... believed her relationship with a patient was 'ineffective and nontherapeutic because it was not the kind of helping relationship she valued'. The patient actively refused to be a 'good patient' because her attitude was: 'just do it [treatment] and don't talk to me'." (Dowling, 2008, p322). With reference to oncology nurses, Dowling goes on to say that the (...)

"... need for fulfilment and reciprocity in their caring role is deprived when they encounter 'detached' patients. The 'detached' patient may be labelled 'bad' by virtue of their lack of need for support from nurses, or assuming independence."

(Dowling, *ibid*)

Thus, even if the wishes of an individual (detached) patient are observed, the nurse may feel disappointed that their caring capacities have not been allowed to be exhibited in a personally gratifying way.

Nurses' desire to realise an idealised form of caring has been seen by some as self-serving, with nurses and nursing arguably more concerned with demonstrating virtuosity than with meeting the immediate health needs of the population whom they serve. Barker, et al. (1995, p395) maintain that:

"Only through the careful study of what people need nurses for, however, will our proper function emerge. Our interest, therefore, is in the object of our care: the subjective experience of the people for whom we care. The almost narcissistic expression of interest in the experience of the use of the self for therapeutic ends, to paraphrase Travelbee (1971) is, in our view, an unnecessary digression from the path of enlightening nurses and nursing."

The impulse to give care, and the duty, entailed by the job, to respond to patient need are not, then, one and the same thing. Barker, et al. are arguing here that it is the recipients of care who should determine the requisite nature of that care, not the nursing occupation or its individual members. Similarly, Roy Parker advocates that the way in which care is provided should be formulated in response to "the special needs of people in dependency groups" (cited in Thomas, 1993, p658) and thus, caring based on an holistic emotional relationship may not always be what is called for. Dingwall and Allen (2001) make the additional observation that the needs of those being cared for are mediated, in the majority of instances, by the healthcare system in which they are treated (the NHS in the UK). Thus, it is not just patients that determine the nature of care but the limits imposed by the institutions responsible for providing that care. As much as nurses (and perhaps, patients) may endorse the development of genuine caring relationships, the practical likelihood of this is often inherently circumscribed. Dingwall and Allen (2001, p72) claim that, within a publicly-funded healthcare system, "holistic emotion work will always have a limited place. This should not prevent patients who want more of it from using their own money to pay for it."

In any case, it seems that it is not necessarily accurate to say that patients do tend to seek out, and value, this kind of care from nurses. From a systematic review of 23 articles, Papastavrou, et al. (2011, p1199), attest that:

"Patients appear to value the instrumental, technical caring skills more than nurses do and perceive behaviours that demonstrate competency on how to perform

nursing activities ('know how') as more important. On the other hand, nurses perceive their psychological skills and expressive or affective caring behaviour as more important than patients do, leading to the conclusion that nurses may misperceive the necessity of the emotional aspect of caring in comparison with patient judgments. These results, repeatedly reported in the research literature, indicate that nursing staff may not accurately assess patients' perceptions of caring and that patient care is not congruent to the patients' preferences, expectations, or individual needs."

This is similarly evidenced by Dowling (2008) who reported that patients placed a great deal of importance on the technical competence of nursing staff which lead to increased levels of trust, with one patient saying; *"Well I suppose the ones (nurses) that found it easier to put the needle in my arm were the ones that I [laughs] identified with. I suppose the best was *** [nurse]. I would look for *** [nurse] to be here"*. (Dowling, 2008. p323) Dowling goes on further to cite other studies in which it was attested that "cancer patients perceive caring behaviours dealing with information and competent clinical expertise as more important than expressive/affective caring behaviours" (Dowling, *ibid*).

Why, then, are nurses (as Papastavrou, et al. (2011) argue) 'misperceiving the necessity of the emotional aspect of caring'?

2.5.3.4 Slave Mentality?

Some authors (Paley, 2002; Barker, et al., 1995) have criticised nursing's emphasis on emotive, relational caring on the basis that it is a political and ideological construct which has been (erroneously) used to define nursing. The idea that emotional connection with patients is important is not limited to a handful of nurses, it is a central component of almost all nursing 'narratives' and, as such, is a culturally-sanctioned way of talking about and defining nursing.

The differences between nursing as a 'vocation', wherein the 'natural' characteristics of the nurse are the foundation for the ability to care, and as a 'professional' undertaking, where caring skills can be theorised and taught, have already been articulated here. However, both of these discourses are used to assert that affective care is fundamental to nursing, and that this focus provides nursing with its unique occupational character. Thus, the expectation

that nursing involves the exercise of one's emotive capacities is widely cultivated; views may differ as to how these capacities are produced, though the contention remains that nursing is about emotive relational care, involving compassion, empathy, altruism etc.

For instance, as Dingwall & Allen (2001, p65) claim:

"... emotion work in this second sense has also become a key element of the nurse's mandate, part of a claim to a distinctive jurisdiction in the division of labour in health-care. In this context, emotion work becomes more than just an intrinsic aspect of working with people: it is one of the things which nurses say that they do which differentiates them from other health professionals and justifies their status as a separate and independent profession, worthy of respect equal to that of any other health profession."

In a similar way, though not in reference to its *professional* standing, Mackay (1990, p32) points out that:

"Nurses say they like helping and looking after people. They are aware that they are doing a job which others will not or could not do. It is the awareness that special qualities are needed in nursing which distinguishes it from other jobs."

This is subtly, but crucially, different from averring that *there are people within nursing who possess special qualities*; the attribution is that nursing *requires* specialness and that, therefore, nursing is special *because* its practitioners care. The 'special qualities' of the person are linked directly with the uniqueness of the job.

It is this equation of nursing, *as an occupation*, with 'caring' that Paley (2002) objects to. As he states:

"... there is no harm in nurses being caring, even in the emergent sense (Dunlop 1994), provided no attempt is made to identify nursing with caring – as when Leininger claims that caring is the essence of nursing (Leininger 1984), or when Watson identifies it with the core of nursing (Watson 1979)."

(Paley, 2002, p32)

Both vocational and professional discourses serve to achieve precisely this; the assertion that nursing's unique identity is founded upon an ability to care which is lacking in other occupations, particularly medicine; the 'yang' to nursing's 'yin'. As Sabatino (1999, p376) has claimed; "Nurses recognize the impersonal and dehumanizing potential of medical practice. They have long accepted the responsibility to provide the personal touch of care."

Paley (2002) sees nursing's preoccupation with a 'caring' mentality as a response to its occupational position qua medicine, namely a position of subordination. Drawing directly on the moral philosophy of Friedrich Nietzsche, Paley describes how the dominance of the medical model in healthcare fosters resentment (ressentiment) within nursing, which stimulates a desire for retribution.

"Nurses are passive, timid, powerless. They are at the beck and call of god-like, self-assertive doctors, who regard them as little better than useful parasites. If it is possible to extrapolate from Nietzsche's primordial scene of power at all, then it is possible here – the implication being that nursing's imputed inferiority will, like the slave's, foster resentment, and a latent desire for compensation in the face of impotence."

(Paley, 2002, p28)

The attempt to bring about this compensation is realized in a morally-precipitated inversion of the relationship between medicine and nursing. Paley's informed, detailed review of Nietzsche's work, from which he takes inspiration, will not be reconstituted here; hopefully a brief account will be sufficient to conveying Paley's overall argument which, in itself, demands fairly intricate elucidation. In Nietzsche's work 'On the Genealogy of Morality', the philosopher explains how a 'slave mentality' amongst the disenfranchised in society operates to produce a moral value system through which the relationship between the 'nobles' and the 'slaves' is reinterpreted.

"The powerless man attacks the ruling class, in effigy, as Nietzsche puts it (GM I.10), by describing as evil everything the nobles are, everything they stand for. What the noble regards as good, the slave now stigmatizes as wicked; and, as a sort of corollary, what the noble takes to be bad - the slave's own weakness and timidity - the slave now categorizes as good."

(Paley, 2002, p27)

In reference to nursing and medicine, Paley argues that nursing attacks the values which are seen to underpin the dominant position that medicine enjoys. In particular, 'objectivity' is (re)construed in a negative light; "Scientific method becomes 'positivist', the biological stratum is 'reductionist', and clinical dispassion is rejected as 'mechanistic', the symptom of a lack of concern for the 'person' behind the patient." (Paley, 2002, p29). Nursing is then able to step into the breach that has been opened by the perceived shortcomings of medicine. Against the rigours of positivistic inquiry, nursing espouses

qualitative research design, narrative enquiry and phenomenological investigation; “explanation, confirmation, and quantification are systematically disowned; and, in a final dismissive gesture towards objectivity, ‘multiple realities’ are permitted.” (Paley, 2002, p29). Medical biology is seen as reductionist and limiting; instead, nursing promotes its commitment to holism; seeing the patient as a whole person, not merely a medical diagnosis. Finally, clinical detachment is “reinterpreted as a form of indifference” perceived to represent “a lack of feeling, a sign of callousness and inhumanity” (Paley, 2002, p30); by contrast, nursing makes virtues of emotional connection and intimacy with patients. Paley ultimately argues that nursing’s ‘virtues’ are not *intrinsically* realised because they are an inversion of the values of the medical model; nursing therefore *creates* virtues from absence (Paley, 2002, p29).

Paley’s chief criticism seems to be that the ideology of caring has been mobilized for nursing’s own benefit; motivated by the desire for superiority (via moralism) over medicine. He says, of the ‘caring paradigm’; “Officially (as it were), it is an unqualified good, morally attractive in, and for, itself. Unofficially, it is a way of satisfying the will to power, if only in the imagination of nursing theorists.” (Paley, 2002, p30). From this, the author concludes that the ideology of caring in nursing is essentially disingenuous as it is primarily directed towards the ‘inflation of self-esteem’ (Paley, 2002, p31).

Again, it ought to be stressed that Paley’s arguments do not represent a whole-sale attack on caring, per se, within nursing, but express misgivings over its adoption as an occupational ideology. The author makes the point that “Values and attitudes cannot be ascribed to conceptual systems, only to individuals.” and therefore implies that nurses’ identification with emotive caring is misguided. Drawing comparisons with another service-based occupation, banking, Paley (2002, p32) writes;

“What the bank manager needs, essentially, is an ability to appraise my financial situation realistically, and some decent ideas for getting me out of my embarrassing predicament. Warmth and humour will be welcome bonuses, but it is competence I’m looking for. The same, I would say, is true of nursing.”

Paley concludes by arguing that the focus of nursing's professional practice should be 'recovery and rehabilitation'; an area in which the author suggests nurses can validly claim expertise and through which professional competence may be demonstrated (2002). Other alternative bases for nursing's professional remit are considered, here, later on.

2.5.4 Nursing Care: A Disputed Concept

The perceived benefits of promoting a caring ideology within nursing have also provided the primary sources for its criticism. For instance, claims concerning the therapeutic value to patients resulting from nursing's endorsement of a holistic, affectively-oriented, mode of caring have been perceived by some to be overblown. Several empirical studies seem to suggest that care-recipients are more concerned to see that clinical interventions are performed competently than they are with establishing psychological intimacy with nurses. The perception, by nurses, of the value of developing closer relationships with patients has also invited questions concerning the level of involvement that is appropriate within these relationships, as over-involvement may lead to distorted clinical decision making and may increase the likelihood of burnout.

Against this, it has been argued that nurses can gain a sense of personal satisfaction from emotional involvement with patients and realise nursing as a form of self-actualization, and as contributing to personal growth. This view of nursing as more than just a job may serve to attract and motivate the nursing workforce. On the other hand, it is maintained that the expectation of emotional involvement is an unrealistic one, promulgated by an over-idealized occupational image, and that nurses are more likely to be frustrated when this is not realized in practice. As Dingwall and Allen (2011, p66) assert; "The result is a measure of professional demoralisation because nurses are not doing the work they are trained to value.". Furthermore, it may be argued that nurses who see the potential, in nursing, of satisfying an innate desire to provide relational care are systematically exploited as they make personal sacrifices in order to overcome the institutional barriers to the provision of this kind of care (Apesoa-Varano, 2016).

Finally, suggestions that a wholesale focus on 'caring' might settle the struggle to "attain the status of professionals and to free nursing from the shadow of medicine" (Savage, 1995, p8), and thus improve the general standing of the occupation, have been criticised as both misguided and disingenuous. 'Caring', in the holistic, emotive sense, arguably does not adequately reflect the majority of what nurses actually do on a day-to-day basis and so may not be a suitable object of professional expertise. Moreover, as Paley proposes, nursing's consistent stress on the importance of the emotive aspects of nursing care has not been operationalized in the interest of patients, but chiefly as a means of demonstrating moral superiority, particularly in relation to medicine and thus represents an exercise in occupational egotism.

It seems clear, however, that most nursing commentators do not wish to abandon an occupational commitment to caring, which perhaps still suffers from inadequate theorization. As Dowling (2004, p1289) acknowledges;

"Caring is an elusive concept, but that does not mean that a pursuit of its meaning should cease (...) It is argued that caring, love and intimacy are at the heart of the therapeutic nurse/patient relationship and represent 'everyday' nursing practice, which is complex and often taken for granted"

Pragmatically, it may be contended that if nursing can elucidate the value of caring to its 'everyday practices', then its prominence in nursing discourse may be better defended. Morse, et al. (1990, p11) assert that;

"Reflections on the efficacy of caring, on the health outcomes of caring actions, and, to take this one step further, on quantifying caring and communicating caring epidemiologically with morbidity and mortality have not been attempted".

Although it is unlikely that such endeavours could be achieved irrefutably owing to the difficulty discussed earlier surrounding defining 'the nature of care' and the difference that 'caring about', over and above 'caring for', may actually make.

2.6 Looking for Meaning in Nurses' Discourse

The literature review highlights that the nature of nursing work can be, and has been, theorized in several different ways and that debates endure concerning the occupation's purpose and direction. Despite a seeming assumption on the

part of some commentators (e.g. Hadid, et al. 2015; Watson, et al. 2008) that nursing has succeeded in establishing its professional credentials (even if this is not always widely recognised), the issue of nursing professionalism is far from settled. For one thing, there appears to be some significant variance in the ways that nurses conceive of 'professionalism' as suggested, for instance, by Akhtar-Danesh et al. (2013). Although theoretical models of 'care' have been identified as the knowledge base for nursing practice (Dewing & McCormack, 2017), there is evidence of considerable scepticism over the idea that care can be articulated through formal educational methods (Bray, et al. 2014). Moreover, there remains a fundamental doubt concerning whether the centrality of care to nursing is supported, or diminished by a 'professional' approach.

The wide-ranging literature concerning how 'care' may be theorized illustrates that the concept of caring is multi-faceted and that any way in which care is conceived of has the potential to support distinctly different interpretations of the fundamental purpose of the nursing role. While a number of commentators have endorsed the view that nursing is distinctive because it entails caring *about*, as well as *for*, patients (Sabatino, 1999; Dowling, 2004), Morse, et al.'s (1990) broad overview of caring as a concept illustrates how the underlying impetus for this kind of care may be differentially attributed. Indeed, the nursing occupation, as a whole, seems uncertain of the relationship between the notion of caring as a natural disposition, and care as a professional endeavour, arguably demonstrated, for instance, in initiatives such as 'values-based recruitment'.

The renewed scrutiny of nursing, prompted by the reporting of recent shortcomings in care, and by nursing's wholesale move into higher education has reignited discussion as to the appropriate and necessary conditions for nursing care to be realised. Some writers have drawn a link between the new academic status of nursing, signifying a professionalized outlook, and the perceived diminishment of 'compassionate' care (Darbyshire & McKenna, 2013; Corbin, 2008). This has called into question the motivation behind professionalizing endeavours, even as others (i.e. Ali & Watson, 2011) claim

that professional skill and expertise are essential for contemporary nursing practice.

The practical reality of nursing work reflects the increasingly complex healthcare needs, and growing demand for hospital services, of the population and this has prompted some to argue that an emphasis on relational caring is an unrealistic ideal. Dingwall and Allen (2001) argue, for instance, that an holistic, emotionally-based approach to nursing care is frustrated in the context of a health service in which time and resources are inherently circumscribed. Additionally, it has been reported that the value placed by nurses on expressive, interpersonal forms of care is not necessarily mirrored by the views of patients (e.g. Papastavrou, et al., 2011).

Stated briefly, the definition of caring in the context of nursing is contestable and can be seen as fulfilling potentially disparate purposes and expectations, and thus analysing appeals made to the concept can contribute to our understanding of nursing's occupational mores and values. The range of possible conceptualizations of nursing care and the differential value attached to the notion of profession, means that the relationship between care and profession is indeterminate and, for this reason, it seems exceedingly worthwhile to solicit nurses' opinions on these concepts and their perceived relation to practice. This indeterminacy also justifies a discourse-based approach to research given the different types of meanings with which 'care' and 'profession' can be invested.

Tony Watson's (2002, p94) incitement to "examine the way members of certain occupational groups utilize notions of professionalism to achieve certain purposes", rather than treating 'profession' as a specific *status*, is instructive to the research here. The question is not whether or not nursing has achieved professionalism, but pertains to the ways in which the concept is employed by nurses to convey a particular occupational discourse. The same may be said of 'care' in that the study does not represent a commentary on the quality of nursing care, per se, but seeks to identify how this care is conceptualized and what this might be in service to. This view of discourse supports a critical discourse analysis approach in which the rhetorical practices

of people and groups are analysed in terms of how they relate to social practices of which they are a part. Thomas and Hewitt describe discourses as attempts to temporarily fix meaning in ways that productively make sense of situational contexts.

“Social practice is characterized by undecidability or openness, and by antagonism and struggle between social actors who make bids to fix advantageous meanings in the local conjunctures within which they act.”

(Thomas & Hewitt, 2011, p1380)

My interviews in this study essentially sought to examine how nurses interpret and use certain concepts in discursively articulating an occupational identity and to understand the utility of certain appeals. In the following chapters, I describe the design and methodological choices for this study and elaborate on the ontological status of my data and the claims that can be made in relation to it.

3. Research Design and Methods

In this chapter, I elaborate on the ontological underpinnings of the research design, namely how a 'critical realist' foundation contributes to the way in which the salient features and issues of this study are identified, framed and analysed. The following introduces the central tenets of critical realism and aims to demonstrate the value and appropriateness of such an approach for the present study. Specifically, I explain; how the central concepts at stake here are considered to be 'real', and are not purely ideational abstractions; how a realist view of discourse as both constitutive and constituted facilitates causal explanation; the ways in which a critical realist perspective informs data analysis (prefiguring the application of a form of Critical Discourse Analysis (CDA)); and how a realist position seeks to account for the validity of theoretical explanations and the ends to which they might be realised.

I also, in this chapter, detail the practical steps taken in planning and carrying out the research study, and the rationale for these decisions, commenting on, for instance, strategies of site and participant selection and recruitment, interview procedure and the approach taken to the coding of my data.

3.1 Critical Realist Assumptions

Critical Realism (CR) represents a distinctive approach to the explanation of social phenomena in that it combines 'ontological realism' with 'epistemological constructivism' (Maxwell, 2012). Simply stated, this entails a belief that there is a 'real world' which exists independently of our conceptualizations of it, whilst also maintaining that we cannot understand this world other than via our own constructions of it. In this way, critical realist approaches tread what might be considered a mediating position between positivism and strong constructivism (or relativism). While positivists, too, believe in the existence of a real world, this world is viewed as objectively knowable through the empirical observance of regularities within it. In this sense, our constructions of the world may be more or less adequate in so far as they correspond to the observable features of a real world, though, ultimately, our perception of events exists independently of the actual

functioning of the world. By contrast, strong constructionist, or relativist positions hold that there is no ‘real’ world but that there “exist multiple, socially-constructed realities” (Guba & Lincoln, 1989) and thus, in converse to positivism, ‘reality’ is conceived of as subjectively produced.

Despite not coining the term (see Cruickshank, 2003, p14), Roy Bhaskar is the theorist most associated with the development of Critical Realism as a philosophy of science. His seminal ‘A Realist Theory of Science’ (1975, [1978]) sets out a critique both of empiricism, and of transcendental idealism, against which Bhaskar argues that our knowledge of the world neither reflects its underlying (objective) reality, nor does it simply consist of human constructs. Bhaskar states:

“The third position, which is advanced here, may be characterized as transcendental realism. It regards the objects of knowledge as the structures and mechanisms that generate phenomena; and the knowledge as produced in the social activity of science. These objects are neither phenomena (empiricism) nor human constructs imposed upon the phenomena (idealism), but real structures which endure and operate independently of our knowledge, our experience and the conditions which allow us access to them.”

(Bhaskar, 1978, p25)

Bhaskar argues that there are three independent, though overlapping, domains of reality and that recognising this allows us to avoid the ‘epistemic fallacy’ of conflating ‘statements about being’ with ‘statements about knowledge’ (Bhaskar, 1978, p56). Instead, Bhaskar proposes a ‘stratified’ ontology which grants that “causal structures and generative mechanisms of nature must exist and act independently of the conditions that allow men [sic] to access them” and also that “events must occur independently of the experiences in which they are apprehended” (Bhaskar, 1978, p56). The table reproduced below illustrates Bhaskar’s ontological approach.

	Domain of Real	Domain of Actual	Domain of Empirical
Mechanisms	X		
Events	X	X	
Experiences	X	X	X

(Bhaskar, 1978, p13)

Bhaskar maintains that it is the social activity of scientific explanation through which the interrelations between these domains are apprehended.

A CR approach proposes that reality consists of both physical entities and subjective constructions but is not reducible to either. CR considers that the meanings, motives, intentions etc. of human actors are not *purely* mental phenomena but are features of the world in which we act; as Maxwell (2012, p18) puts it; “Concepts, meanings and intentions are as real as rocks” and, accordingly, are capable of producing real effects. In pronouncing on the nature of reality, primacy is granted to *neither* physical nor ideational processes; instead, CR perceives that physical and mental states co-productively interact with one-another and that this relationship is the basis of ‘social reality’.

It might be proposed that CR represents a viable solution to the problematic relationship between structure and agency which has been a fundamental focus of sociology since the discipline’s naissance. In positing that subjective beliefs and the practical features of a situation are interdependent, CR allows for explanation of the social in which neither structural constraints, nor agential capacity are over-determined. Our beliefs and understandings are influenced by practical context, while simultaneously, our perceptions can affect how we act in, and relate to our environment.

Moreover, the relationship between the material and the ideational is not unilinear, i.e. it is not simply the case that the *physical* environment influences our beliefs; meanings precede, and exist outside of the minds of individual agents, for instance, racism, religiosity, or ideas pertaining to gender norms, which can affect our actions in the world. For (a glib) example, we might dress in ways which reflect cultural norms, rather than as a direct result of personal opinions. Correspondingly, we can be, by our actions, capable of disrupting or changing such normative cultural beliefs, for instance, by dressing in ways that subvert these norms.

The central points to emphasise here are that mental and physical phenomena are influenced by, but not reducible to one-another, and that both should be

considered equally 'real' in terms of their consequences for social life. A purely constructivist ontology necessarily infers that ideational constructions are what constitutes reality and therefore mental processes are rendered omnipotent, but this eschews pragmatic questions of how constructs come into being in the first instance. A positivistic view contends that our perception of reality is entirely distinct from an actual, existing reality, a perspective which presupposes the primacy of structural forces. CR recognises, in distinction to both of these paradigms, that our ideational constructs both refer to, and are part of the real world, implying an equilibrium between structure and agency. In the following section, I discuss this contention with reference to one of the key concepts that is considered in this study – professionalism - and this will hopefully allow further elaboration of the CR approach taken here.

3.1.1 The Reality of a Concept: Profession

One of the central issues in this research has to do with the operationalization of the terms profession, professional and/or professionalism, specifically, what do nurses mean when they draw upon such terminology in relation to their occupational practices? In this section, I aim to demonstrate how research informed by CR allows us to comprehend the dynamic and contentious meaning of a concept such as profession. On one hand, as has been elaborated in the literature review, an accepted definition of profession(alism) has not been, and will likely never be, established and thus its meaning is indeterminate. It might, then, be assumed that there is no real limit to the ways in which the term may be appealed to. Indeed, a purely constructivist account would surely assert that the meaning of 'profession' is entirely attributable to the form of its discursive elaboration; given the acceptance of multiple, socially-constructed realities, there are no grounds upon which to legislate for any particular usage of the concept.

A critical realist approach, however, contends that, despite its indeterminacy, the concept of 'profession' has a 'real' social existence which actually delimits the discursive possibilities of its use. As Sayer argues; "social phenomena are concept-dependent ... what the practices, institutions, rules, roles or relations

are depends on what they mean in society to its members” (quoted in Maxwell, 2012, pp24-25). Profession, as a concept (however unspecified) precedes, and is external to, its usage in discrete discursive practices and thus discourses of profession derive their sense from their relation to previous instantiations.

For discursive practices to have any significance, they must necessarily relate to some broadly recognizable social world. To take the concept of professionalism as illustrative; if I were to claim that I was a professional person on the basis that I wear yellow socks and eat marmalade, it would be patently ludicrous as this claim does not in any way engage with any existing social knowledge pertaining to professionalism, in Sayer’s (2000) words, this discourse has no ‘practical adequacy’. Although our common social knowledge of ‘professionalism’ is a construction, it is socially instituted as an aspect of society and therein assumes its ‘real’, effectual character.

In outlining their own method of ‘critical discourse analysis’, Thomas and Hewitt (2011, p1378) describe the relative stability of discursive practices with appeal to the notion of ‘conjunctures’:

“Instead of seeing structures as determining social action, structural moments of social practice, such as institutions, are articulated together with other moments within conjunctures in ways that may demonstrate patterning, or temporary stasis, but are not forever fixed. Widely shared discursive constructions of professional autonomy and management, and institutional arrangements within conjunctures, influence local discursive practices, which in turn contribute to reshaping those constructions and arrangements.”

Thus, in regard to professionalism, discourse can vary and change over time and between contexts, though only insofar as it sensibly relates to those constitutive contexts. Discursive forms cannot simply be created from nowhere, without precedent. Thomas and Hewitt’s description above also helpfully serves to highlight how CR accounts for social change as “local discursive practices ... contribute to reshaping more widely held constructions”. This is also a theme taken up by Jorgensen and Phillips in their discussion of discursive ‘intertextuality’ (2002, chapter 3). The authors point out that “all communicative events draw on earlier events. One cannot avoid using words and phrases that others have used before” (2002, p73) before going on to

explain that discursive practices can incorporate disparate 'texts' in novel ways, and thus represent sites where change takes place.

To return to the discussion of profession, and again referring back to the literature review and particularly the 'institutionalist' view of professional discourse, it can be seen that the meaning of profession can be reconstituted as it incorporates aspects of other discourses, such as 'managerialism' (Evetts, 2003), though it cannot simply be severed from extant understandings and radically re-appropriated (to permit, for instance, the centrality of marmalade and yellow socks).

One of the benefits of a CR approach as far as the application of concepts is concerned is that it accounts for the contingent nature of concepts that allows them to be operationalized in varying ways, without losing sight of the fact that the discursive production of certain concepts necessarily corresponds to the history of said concept. Ultimately, this allows us to concur with the view that the meaning of profession (and other abstract concepts) is socially constructed, but that the efficacy of any such construction relies on its relationship to features of the external social world in which it operates.

3.1.2 Realist View of Causality

This realist view of the production of discourse has important consequences for the explanation of social phenomena. A fundamental notion for CR accounts, as indicated in the preceding section, is that discourse is both productive of, and produced by, features of the real world. As Jorgensen and Phillips (2002, p61) describe:

"For critical discourse analysts, discourse is a form of social practice which both constitutes the social world and is constituted by other social practices ... It does not just contribute to the shaping and reshaping of social structures but also reflects them."

This means that critical realist explanation is able to appeal to discourse as having mutual causal interactions with the social world; we can both explain discursive practices via reference to their external contexts, and explain the character of structures and features in the world as attributable to forms of discourse. In terms of explaining social phenomena, CR, again, mediates

between positivist and strong constructivist positions and offers solutions to their shortcomings. Against a positivist, empiricist view which entails that causal relations can only be established through the *observable* relationship between discrete events, proponents of CR argue that (unobservable) properties of the world, such as ideas and beliefs, can be considered to be causes of events. Against purely constructivist views, CR asserts that features of the social world can causally shape discursive practices. As Fairclough states; “The discursive constitution of society does not emanate from a free play of ideas in people’s heads but from a social practice which is firmly rooted in and oriented to real, material social structures.” (quoted in Jorgensen & Phillips, 2002, p62). I will briefly elaborate on how CR appeals to causal explanation in a way that emphasises the continuity between discursive practices and the social world to which they pertain.

According to a classic empiricist conception of causality:

“... causal conclusions are assumed to be based on the observation of how a certain event is followed again and again by a certain other event, not on knowledge of causal mechanisms and the generative properties of things.”

(Ekström, 1992, p108)

In this sense, the primary criterion for establishing a causal relationship is in demonstrating regularity; that under specified conditions, the same effect is observed to the extent we may formulate laws to describe the relationship of the type if *a*, then *b*. This is, arguably, severely limiting for research of the social world in which people are conscious and reflective of their actions, and in which behaviour can thus not simply be reduced to observed regularities. Instead, critical realists contend that just because much social phenomena cannot be explained in terms of regularity, this is not to say that they have no causal antecedents, but that illuminating these causal relationships demands different criteria of explanation. Rather than seeking to make law-like statements based on the observance of regularities, causal explanation from a CR perspective refers to “the actual causal mechanisms and processes that are involved in particular events and situations” (Maxwell, 2012, p35). In this framework, the thoughts, beliefs and intentions of actors involved in these situations are treated as real elements of causal processes. As Porter (2017, p86) writes in reference to the evaluation of healthcare interventions:

“Rather than responding automatically to the influence of structures, agents interpret their position and choose to act on the basis of those interpretations. Those agents include both the nurses and other healthcare professionals involved in implementing interventions and the patients or clients upon whom the professional’s actions are focused. Qualitative data is required to uncover the interpretations, understanding and motivations of these actors in their contextual responses to interventions.”

Following the fundamental tenet of a CR perspective that discursive constructions are real and productive elements that simultaneously reflect and produce social practices, discourses should be treated as potential causal mechanisms which interact with the other elements involved in social practice. This view of causality also entails a rejection of the empiricist, regularity view in that explanations are explicitly context-dependent and thus the relationship between causal mechanisms is not determinate. Because the CR focus is on the actual interactions between different mechanisms, causal explanation is necessarily localised, although, as will later be argued, this does not mean that its relevance is limited only to the immediate context of a social research study.

Some theorists have maintained that the concept of causality is simply inappropriate as a means of explaining social phenomena which are arguably too complex to distil into causes and effects; most notably, Lincoln & Guba argued that “It is certainly time to abandon the concept of causality and begin thinking about the world in other terms” (1985; p146). As has been convincingly argued however, these objections are largely attributable to a rejection of causation as defined by empirical science and do not take sufficient notice of the ‘process’ approach to causality entailed in CR (i.e. Maxwell, 2012). Moreover, there is a strong case to be made in defence of causal reasoning on the grounds that, quite simply, it is a naturalistic means of explanation to which we appeal every day. This theme will be elaborated upon in the section concerning plausibility and generalizability.

3.1.3 Realist approach to data; Critical discourse analysis

As briefly touched upon in the introduction to the thesis, Critical discourse analysis (CDA) is the approach that best describes the treatment of the data here because it shares the fundamental assumptions of Critical Realism; namely that social reality exists independently of any singular construction of it

and that these constructions necessarily reflect, and constitute aspects of a 'real' world. Therefore, a central premise of CDA is that discursive practices be analysed in relation to their socio-cultural contexts and not as self-enclosed entities. Discursive practices may, in theory, inhere in a number of actions although here, in terms of my analysis, 'discourse' is most fruitfully understood as "a way of speaking which gives meaning to experiences from a particular perspective" (Jorgensen & Phillips, 2008, p66). It should be noted that 'speaking' may refer not solely to talk but to other forms of semiotic representation, though, in my research, the focus *is* on how discourse operates through language use.

In social research studies, CDA focuses on the relationships between empirically-derived data (in this case interviews with nurses) and the social conditions of their production. This is perhaps the chief aspect of CDA which distinguishes it from other discourse-based approaches; because discourse is conceived of as productively interacting with an external social reality, analysis is explicitly focussed on these relations. As Jorgensen and Philipps (2008, p75) explain; "It is one of the main purposes of the analysis to show the links between discursive practices and broader social and cultural developments and structures." Indeed, on CDA (and CR) views of discourse, it is not possible to comprehend discourse without accounting for context as discourse is dialectically related to other elements of social practice. Another important assumption of CDA is that the relationship between discourse and social practice is marked by intentionality; not only is discourse a way of giving meaning to a situation, these meanings are constructed to align with the interests of actors.

"The research focus of critical discourse analysis is accordingly both the discursive practices which construct representations of the world, social subjects and social relations, including power relations, and the role that these discursive practices play in furthering the interests of particular social groups."

(Jorgensen & Phillips, 2008, p63)

Thomas and Hewitt (2011) draw on the notion of 'articulation' to explain how groups and actors attempt to 'fix meanings' which are advantageous, in terms of the social practice of which they are a part. The possibility of successful articulation is constrained by the other contingent elements within an area of

social practice, which reiterates the critical realist contention that discourse gains its adequacy from the way in which it corresponds to extra-discursive factors. The belief that discourse is both *produced by*, and *productive of* social reality crucially informs the CDA approach to the analysis of data. Analysis aims to identify the extra-discursive influences upon actors' discursive practices, as well as the ideological intent of these practices.

To illustrate briefly, with reference to my own study here, I was interested in what nurses understood by the term profession as applied to nursing, given the variety in opinion concerning the value of such an attribution for the occupation. In an example of articulation, nurses' views on profession can be seen as both engaging with an extant conceptualization of profession, whilst also employing such understandings in support of particular identity claims with perceived advantages for nurses. While largely eschewing the notion of profession as referring to an independent occupation with a discrete area of expertise, nurses mainly drew upon what might be considered a fairly superficial idea of *professionalism* as the adoption of a professional manner; dressing appropriately, using suitable language at work, not being overly casual in relations with patients etc. However, this discourse was employed in order to emphasise nurses' commitment to patient well-being in that it was supposed that outwardly representing oneself as professional engenders trust and confidence in a nurse, from a patient's perspective. In this way, nurses articulated some received notions concerning professionalism in combination with, and in service of, an overarching 'caring' discourse.

To more fully comprehend the significance of this, CDA exhorts further analytical extrapolation so that this 'caring' discourse is considered in terms of its relation to broader social practices. In the earlier work of Fairclough, the author identifies an overarching dimension of analysis that relates discursive practices to wider institutional and structural contexts (cited in Jorgensen & Phillips, 2008), which entails extending analyses beyond discourse to the 'totality of social practice of which the discourse is a part' (Reisigl, 2013, p80) and which may involve some theoretical reasoning. In the research study here, for example, it is posited that the significance of nurses' caring discourse could

potentially be illuminated (though by no means exhaustively) with reference to; the institution of 'the family' with its attendant ideas concerning care; to the historical relations between nursing and medicine; and to the status accorded to 'care' work more generally. Of course, specifying the range of a social practice is a matter of discretion and different researchers may identify different structures in their understanding of discourse. In this sense, what matters is the plausibility of theoretical explanations. Briefly, do the theories to which we appeal help us to comprehend the discursive features of our data? This theme is further examined later, herein.

3.1.3.1 Considering the 'critical' in CDA

Another element that is commonly cited as being central to CDA is that it is oriented to solving social problems. According to Jorgensen and Phillips (2008, p64), CDA perceives itself as "... a critical approach which is politically committed to social change. In the name of emancipation, critical discourse analytical approaches take the side of oppressed social groups", while Reisigl relays Fairclough's approach which includes as its primary steps 'focusing on a social wrong' and 'identifying obstacles to addressing the social wrong' (Reisigl, 2013, p85). This explicitly normative bent is often cited as that which marks CDA out as a novel approach to social inquiry, against conventional research strategies which see researcher bias as distortive, however, this 'politically critical' focus has also been a source of consternation for CDA's detractors. Concerns over the applicability of a predisposed commitment to normative evaluation seem particularly pertinent to my own study, here, as well as being questionable in a more general sense and therefore I feel it necessary to clarify the limits of the 'critical' aspects of analysis. Whether or not this represents a desertion of CDA is a matter for debate, however, I believe analysis can still be considered 'critical' without being explicitly politicised.

A central criticism of CDA's agenda is that it encourages a tendency towards confirmatory research. By declaring an explicit stance from the outset, the relations within any research settings are presumed to be evidence of some wider, pre-identified phenomena. Indeed, Fairclough's directive to 'focus on a

social wrong' would appear to immediately limit the scope of inquiry. As Breeze (2011, p513) notes:

"... there is an observable trend for work carried out in CDA to operate in a top-down manner, in that it presupposes a particular theory of social relations, and looks at language data from that perspective, or singles out interesting aspects of language that tie in with a particular theoretical view, rather than embarking on an all-round, in-depth study covering the multiple dimensions of a text to determine how language works in a particular setting."

Breeze also indicates a similar tendency concerning 'a priori' assumptions of how certain actors and institutions operate, such that "politicians are manipulators" or "the media are ideology-reproducing machines" (Breeze, 2011, p515). In this way research questions become oriented to answering presuppositions such as 'how does the media reproduce gender inequality?', for example.

Relatedly, the commitment to the emancipatory potential of research means that narratives necessarily assume a confrontational structure that allows for 'wrong' and 'right' to be identified. As Hammersley (1997, p245) has argued:

"One result of this excessive ambition is that work in this tradition takes much for granted and adopts relatively crude positions on a variety of issues. For example, it often involves the adoption of a macro-sociological theory in which there are only two parties - the oppressors and the oppressed - and only one relationship between them: domination."

There is a charge that, despite understanding discourse as socially-embedded, CDA exponents overstate the meta-theoretical context which provides the means of adhering to a political agenda, resultantly overlooking the nuances of local discursive production. Breeze (2011, p515) has contended that:

"... by jumping from what might be termed the "symptoms" (recognisable features of a specific phenomenon) to the macro-context, we learn little about how people appropriate or resist hegemonic discourses or indeed about how such discourses are enacted on the micro-scale."

Furthermore, the predilection for normative critique is not easily accommodated to each and every research setting, especially those where the motivations of actors are inconstant. As Thomas and Hewitt (2011) note from their own discourse-based study of the effects of management systems on GP's professional status, the interrelations between 'professional' and 'management' discourses were characterized by deep ambiguity. As the

authors conclude; “One archetype is not being swept away uniformly by a new and stronger one; new articulations are being forged on the ground in the day-to-day struggles between managers and clinicians.” (Thomas & Hewitt, 2011, p1388). In cases such as this, it is exceedingly difficult to identify either what the ‘social wrong’ is, or uncontentious ways for the situation to be improved.

In my own research here, discursive elaborations are not necessarily simply restrictive or emancipatory but can be seen as fulfilling different types of functions. For instance, the endurance of a vocational ideology in nursing *might* be seen as a means of oppression in so far as it limits nursing’s standing as an occupational grouping; i.e. if nurses are vocationally motivated, demands for higher pay, for instance, will be viewed as unbecomingly mercenary (see, e.g. MacKay, 1998). However, it can also be argued that vocational motivation is central to nurses’ sense of self-esteem and represents a source of public approval and cultural kudos which is undermined by adhering to an overly ‘professionalized’ image. In this instance, it is not easy to identify inequitable power relations which are sustained through discourse because the discourses at stake have varying consequences in terms of actors’ interests. Thus, the ‘critical’ aspect, referring to uncovering the role of discourse in systems of oppression, may result in, ironically, the somewhat uncritical imposition of theoretical categories. As Hammersley (1997, p245) opines; “the terms ‘oppression’, ‘equality’, and ‘emancipation’ are used as if what they referred to could be identified easily and uncontentiously, yet there are fundamental problems with each of them.”

This is not to refute that discourse functions ideologically and it can still be maintained that people’s discursive practices are employed in pursuit of certain advantages. The reservation here is with the notion that we can unproblematically adjudicate between pernicious and emancipatory ideologies. Relatedly, the stated aim of CDA to actually instigate social change is problematic if researchers do not have a privileged view of situations that allows them to identify precisely what ought to be changed. In any case, as Breeze (2011, p516) notes, even CDA proponents themselves “admit that this objective is rarely met”. Even if the need for social change was accepted and

the proposed means of achievement heeded, it is unclear how, practically, emancipatory strategies could be fully-realised. As entailed by a critical realist perspective, there are elements of social reality which are relatively intransigent and it is ambitious (Hammersley (1997) claims 'impossible') to recognize such transformative goals on the basis of research alone. There may be material limitations to the kinds of changes that researchers feel ought to be made. It is also surely the case that, given the impermanence of relations within an area of social practice (recall Thomas and Hewitt's notion of 'conjunctures'), any emancipatory strategies would only inhere as long as the conditions giving rise to discursive constructions maintain. Events, however, are prone to change the nature of that which may be desirable in a given field of social practice and discursive strategies will change accordingly.

This is emphasised by Thomas and Hewitt (2011) when they refer to discourse as a means of *temporarily* fixing meaning in situations. Actors make provisional, pragmatic constructions which are oriented to their immediate environment, rather than necessarily pursuing wholesale or definitive changes. It may not always be apparent to actors, let alone to researchers, what the ultimate goods are which should be pursued. Several debates within nursing illustrate this, exemplified for instance when Savage (1995, p92) asks "Should nursing want to be a profession and, if so, what do we mean by it?" Thomas & Hewitt's work (2011) similarly considers the uncertainty over the discursive uses of profession, arguing that:

"The ambiguity of situations and the ambivalence felt by actors need to be better understood if we are to properly analyse the important articulation processes at work in changes within and around the professions."

(Thomas & Hewitt, 2011, p1388)

If the prospects for change are uncertain, either because of constraining situational dynamics or inherent ambiguity concerning the benefits of adherence to any particular discourse, then the aim of discourse analysis might be better geared towards understanding why, in the contemporary context of that which is being studied, certain discursive practices are engaged in over others. Towards the end of the thesis, I suggest that nurses' espoused

perspectives are a provisional means of responding to contemporary concerns, which are liable to change.

Despite not claiming to take the side of an oppressed group or right a social wrong, I maintain that this approach to the analysis of discursive practices can be considered 'critical' in that it aims to illuminate how discourse is used constructively to attain benefits (albeit contingent ones), rather than simply understanding discourse as a way of describing or representing reality.

Because of the CR belief that discourse has real effects upon social reality, analysts seek to understand actors' intentions which only have force when we recognise that they have practical consequences.

3.2 Plausibility and Generalizability

There are two prominent, and related, criticisms that might be levelled at research that concerns itself with analysing discourse through language that have to do with the interpretation of findings and the ends to which these may be used. The first is to be found in the contention that, because discourse (as with all language) requires interpretation for its understanding, the bases of these interpretations can be questioned. Why should readers believe in the veracity of these interpretations? Do they not inevitably reflect the personal opinions, beliefs and/or motives of the researcher? Howard Becker (justifiably) decried the possibility of doing social research "uncontaminated by personal and political sympathies" (Becker, 1967, p239) so how can the credibility of any piece of social research ever be established? The second criticism concerns the prospect of generalizing from small-scale studies that rely on the analysis of discourse, for, following the first criticism, if our interpretations are unreliable *in terms of our own research problems*, why should they have any pertinence to any other context? I aim, here, to show how a critical realist account of discourse can combat these accusations, as well as trying to make a more general defence of the veracity and usefulness of qualitative research studies.

3.2.1 Plausible Interpretation

Much research that is occupied with the use of language and the discursive formulations that it produces is often automatically presumed to be 'anti-realist'; i.e. containing an assumption that there is no social reality external to our descriptions of it (Bryman, 2001, p360). On this view, it is easy to see how discourse might be dismissed as 'just talk' (Sayer, 2000, p96) and thus limited in its potential to contribute to our general understanding of social processes. A CR approach, however, recognizes discourse as a means through which we understand the world, but permits that some semblance of reality exists outside of our discursive constructions, and that this necessarily limits the scope of these constructions. Discourse is not merely self-referential but relies on some, more general, conceptual stability in order to make sense; without admitting the material limitations of the extra-discursive world, we would be free to interpret anything in any terms we wish. The unviability of this should be apparent as Sayer (2000, p39) demonstrates in stating:

"Those who claim that reality is a discursive construct don't believe what they say, for their practice—for example avoiding extra-discursive dangers such as oncoming cars, show that they cannot make the world a slave to their discourses"

Indeed, if linguistic constructions of the world were purely self-referential, then either one or the other of discourse, or the material world, would be redundant.

"Idealism makes discourse both inconsequential and all-powerful: inconsequential because it refuses to acknowledge that it can be causal and that its causal efficacy depends on how it relates to extra-discursive processes; all-powerful because it also makes it seem like we can remake the world merely by redescribing it."
(Sayer, 2000, p97)

CR therefore argues that discourse can indeed be cited as a causal mechanism that should be acknowledged in order to explain people's actions in the material world *and* that the features of the material world are what allows discourse to make sense. The way in which we think about things influences how we act towards them. Drawing on Bolton's work on nurse managers for an example, we can see how nurses' discursive formulations of their roles lead to practical action, for instance in the observation that "at other times they

(nurse managers) remain distant from the role, continuing to discard what they see as unnecessary paperwork in the 'LBWF' (let the bugger wait file)" (Bolton, 2005, p19). An operative discourse concerning the perceived value of paperwork (i.e. as being less important than patient contact) results in the practical consequence that the completion of paperwork is delayed and, in this way, discourse can be cited as causing an action. At the same time, however, we can see, from this example, how discourse, and its causal potential, is limited by its relation to practical circumstances. The very existence of paperwork represents the material basis upon which nurses' discourse is based. Nurses would not ascribe any value or meaning to paperwork at all if it was not a tangible feature of their work. Moreover, this simple account of causality makes sense because we comprehend the practical meanings of the real-world referents to which this discourse appeals; namely, 'nursing' as a particular type of work, and 'paperwork' as a particular kind of activity.

Because critical realism supposes that discourse makes reference to concepts outside of itself, an interpretive account that rests on consistent identification of these concepts is arguably more persuasive than one which treats discourse as self-enclosed. As Sayer (2000, p46) maintains; "What reduces the range of possible interpretations ... is the situation of communication and action in determinate practical contexts". He goes on to argue that; "Accounts of interpretive understanding or hermeneutics which divorce it from ... practical contexts are likely to conclude that there are no good or bad interpretations, just different ones" (Sayer, 2000, p46). Therefore our interpretations may be considered to have greater, or less, practical adequacy in so far as they sensibly relate to these contexts. This appeal to 'practical adequacy' counters the accusation that we can interpret discourse however we like; our interpretations are in fact bounded by extra-discursive structures and are more convincing according to how they relate to these structures. In finding out as much as we can about the practical contexts in which discourse is elaborated, we are in a stronger position to defend the veracity of our interpretations and, in doing so, tentatively make the case that they be considered 'good' insofar as they are plausible. In this way, we avoid the relativism that post-modern accounts of discourse must inexorably concede to.

Establishing the plausibility of our interpretations as researchers, then, depends upon showing how the discursive practices that are reported are related to features of a recognizable 'real world'. This inevitably involves some form of causal reasoning, i.e. explaining discourse as a product of contemporaneous social practices. When analysing the talk of nurses, for example, it is the contextual knowledge that informs our understanding of nursing as a social practice that provides the grounds for plausible interpretation. In short, how do the responses of nurses correspond with what we already know about nursing? Social researchers, and people more generally, draw upon a variety of contextual knowledge(s) in order to make sense of events and discriminate between competing claims. While we may not be able to account for each and every aspect that impinges on social behaviour, we do have a "great deal of tacit, unspelled-out knowledge of the predictable expectations of others as well as a large stock of explicitly-stored information" (MacIntyre, 1985, p102) that we can draw on in order to render social phenomena explicable. Furthermore, it is arguable that the more contextual information we have, the better placed we are to draw plausible interpretations. For instance, we are likely to place greater stock in a radiologist's interpretation of an X-ray than we would in the opinion of a concert pianist.

Naturally, when dealing with complex social action, the theories at our disposal may occasionally prove to be misguided but this is inevitable given that the social world is subject to several sources of 'systematic unpredictability' (MacIntyre, 1985, pp94-100) beyond our control. What qualitative researchers can aim for, and that which people routinely engage in when accounting for experiences in every-day life, is proffering the most plausible explanations that we can, given what we know about a given phenomenon.

Part of the accepted process of a research project is developing an understanding of the subject of interest; keeping abreast of recent and continuing developments, reading what has already been said about the topic, considering the various theories that have been employed to describe the phenomena under consideration. This is, of course, in addition to the

knowledge gained by empirical study and data collection. Investigators can establish that their interpretations have been subject to considered analyses by showing clearly that they have made a sufficiently thorough examination of the subject, appraising and synthesising relevant information to advance a coherent account. Practically speaking, this could mean showing that a variety of theoretical positions have been thought-about and critiqued, and in relation to the data one has collected, demonstrating efforts at 'comprehensive data treatment' (Porter, 2007, p85), for instance in explicating data management techniques such as coding, and including instances of 'deviant cases' in order to show that general conclusions have not simply been imposed upon the data. Particularly in studies to which the interpretation of language is central, researchers can bolster the plausibility of interpretive accounts by presenting excerpts from their data to concretely illustrate how respondents' language use has been treated. Also, explaining the rationale behind sampling strategies and research methods helps to show the kind of knowledge claims we can expect to make. The thrust of this kind of accounting is that being clear and explicit about one's purposes, about what one has found out, and about the concepts that one draws upon helps to establish the bases of interpretations. Even if "multiple valid descriptions and explanations of the same phenomenon are always available" (Hammersley, quoted in Porter, 2007, p84), researchers can at least offer a defence of their own. As Seale (1999, p16), using an appealing musical analogy, states:

"Clearly, in research the concept of a correct version is dubious, but there is a great deal to be said for 'playing loud' nevertheless. You are then at least 'heard' by your potential critics, rather than hiding behind the sounds made by others."

3.2.2 Prospects for Generalization

This kind of defence of a researcher's interpretations can also stand as a means of affirming the possibility of generalizing from the findings of one's study. By showing the bases of interpretative inferences, the researcher can defend their reasoning, and the subsequent readers of research reports are supplied with a greater wealth of material on which to form a judgement as to whether the conclusions drawn might have any explanatory relevance in other contexts.

Frederick Erickson (1992, p10) promulgates the idea that the usefulness of social research is in the eye of the beholder; “The locus of judgement about what generalises from one setting to the next lies with the reader of the report rather than the writer of it”. Erickson (ibid) advises those evaluating a piece of research to ask “How does the situation the author describes resemble what goes on around here?” While any single research setting is subject to idiosyncrasies, there are invariably also more general and stable processes at work. Borrowing an example from Becker, Erickson (1992, p10) explains how prisoners “developed a culture and social organisation to address problems created by the deprivations of prison life”. In each discrete case, prisoners will have different means of cultural development and social organisation, but these processes are generic and endemic in socially similar situations. Thus, causal explanations which account for context can still (with an additional interpretive step) be used to advance knowledge of more general social processes.

However, the possibility of generalization is arguably not the *sole* preserve of the audience, although the subsequent use of research findings certainly helps in the development of theory. At least some of the grounds for generalization can be established by the investigator by indicating what they believe to be the general mechanisms that might account for the form of whatever data are obtained. Research with a critical-realist foundation aims to explain empirical observances (i.e. social actions, uses of discourse) in a particular situation in terms of how they relate to more general underlying structures. As Delmar (2010) puts it, every situation is both unique and typical at the same time and, if research is to have any utility beyond the immediate conditions of its conduct, then it should aim to illuminate the operation of the typical, as it occurs in unique contexts.

While acknowledging that the study of phenomena expressed through people’s deliberations, experiences, decisions and actions are contingent on time, space, relations, power and context (including society and culture), there will be typical traits and recognizable patterns – it is the experience from a similar situation that gives meaning. It is this recognisability that contributes to the “generalizability” of qualitative studies.

(Delmar, 2010, p122)

The potential for generalizability of small-scale, context-specific research thus inheres in the interpretation of findings, rather than in the representativeness of the data. As Bryman asserts; "...attention needs to be paid to the *adequacy of the theoretical reasoning* deriving from language investigations and to the possibility of confirming inferences in different contexts." (Bryman, 1989, p224, my emphases). The example briefly referred to earlier about prisoners developing cultures to compensate for the deprivations entailed by incarceration serves as a useful illustration of this contention. The actions of the prisoners are temporally and contextually specific, but the explanation for these actions, i.e. that they are a response to life in an institution, constitutes a form of theoretical reasoning. If a plausible causal argument can be made as to how the prisoners' activities represent an attempt to mitigate the effects of institutionalization, then it may be posited that this relationship could be in evidence elsewhere, although the actual means of mitigation will vary. If we take institutionalization to be the general mechanism that affects behaviour, we might hypothesise that similar responses might apply in other 'total institutions' (Goffman, 1961) such as boarding schools, asylums, the military etc.

In the present study, it is suggested that the particular empirical material - nurses' occupational discourse – may be understood (or make sense) in relation to a number of processes and relationships occurring outside of this discourse. For instance; nursing's relationship with medicine, extant conceptions of 'care', extant conceptions of professionalism, the media portrayal of the occupation etc. to name a few. There may be no one 'thing' that comprehensively accounts for nurses' occupational discourse, but illuminating the practical conditions under which this discourse is elaborated increases the chances of identifying generic mechanisms. For example, the effect of the nursing/medicine relationship on occupational discourse might lead us to consider the discursive productions of other situations involving defined groups in a historically hierarchical relationship. Indeed, Paley's 'slave mentality' (2002) theory of nursing's 'caring' discourse could plausibly have relevance to other relations in which one party is historically dominant,

although the specific rhetoric of the dominated group would, of course, be different in each case.

Finally, two further points should be made concerning the nature of claims to generalizability that might be advanced from qualitative studies; the first being that such claims should never be regarded as absolute or *provable*. Qualitative generalization is unlike positivistic approaches in that it does not seek to control for (or eliminate) contextual variables and so research findings suggest, rather than dictate, what might be of more general relevance. As Macintyre notes; our generalizations must inevitably “be prefaced...by some such phrase as ‘characteristically’ and ‘for the most part’ (Macintyre, 1985, p104), though this fallibility simply reflects the critical realist belief that, although we cannot ‘know’ an objective social reality, there is a level of stability that facilitates plausible explanations of social action. Generalizability in qualitative social research is not a matter of replicability in which the same sequence of events is continuously observed, but a matter of ‘recognisability’ (Delmar, 2010) which depends upon human experience and tacit knowledge. It is analogical understanding; we recognize the meaning of a situation even if the concrete features of that situation are foreign to us. We are neither the ant, nor the grasshopper but we understand the significance of their actions.

Secondly, it ought to be recognised that individual pieces of research do not simply ‘stand-alone’ but are situated within a broader research framework which includes extant theories and empirical studies. Thus, the prospects for generalizable interpretation are, at least in part, dependent upon how research studies engage with, and contribute to, an existing body of knowledge. As Chenail (2010, p7) notes:

“... this embracing of a broader perspective helps to remind the researchers that their investigative enterprises take place within a larger community of scholars and consumers and a communal approach to generalization requires that interested parties need to be able to locate relevant research to consider its generalizability.”

This is not to say that studies are simply valued in so far as they confirm, or refute, previous research, but that citing investigations within a wider range of concerns can help to develop and refine any operative theories, particularly

when a singular case seems to identify discontinuities with established explanations.

Some commentators have been decidedly cagey about using the terms 'causality' or 'generalization' in relation to qualitative research. Perhaps, most notably, Lincoln and Guba suggested that, due to the inherent complexity of the social world, the term 'mutual simultaneous shaping' ought to replace 'causality' and that 'fittingness' was a safer way of framing extrapolations than 'generalizability' (Lincoln & Guba, 1985). However, it seems to me that there is no reason for qualitative researchers to abandon the established terminology, as long as the ways in which we are employing it are made clear. Lincoln and Guba's rejection of this nomenclature appears to be founded upon an overall critique of the logic of positivistic inquiry in social research; they reject causality and generalizability on the grounds that these concepts do not account for situational context, without recognizing that contextual features can themselves be considered 'causes' and that generalities can be realised in explanation, not merely in the characteristics of the research site and population.

3.3 Research Procedure

Having outlined the ontological underpinnings of the research design, namely a critical realist approach to discourse which is concerned with showing how discourse both reflects and constructs social reality, I now turn my focus to the practical steps involved in carrying out the study and how I collected the data upon which the analysis of discourse is based.

3.3.1 Overview

16 loosely-structured, in-depth interviews were conducted with nurses working on a single acute medical ward (referred to here as 12b) in a large Scottish NHS general hospital between November 2015 and September 2016. All of the interviews were conducted on the ward during nurses' working hours, providing a direct contextual reference point for much of the practical content of the interviews and also enabling the formulation of some questions to be based on in situ observations. A range of occupational levels was represented,

from charge nurses who manage the unit, to student nurses who, while technically supernumerary, engage in a significant amount of nursing work while on clinical placements. Sampling was both ad-hoc and selective in that interviews had to fit around unpredictable workloads and schedules though, at the same time, I ensured that nurses of varying age, sex and experience-level were approached. Every participant read and signed a consent form containing information about the rationale behind the study and the ends to which interview data would be used which included guarantees of confidentiality. All of the interviews were audio-recorded and transcribed verbatim by the interviewer. The research was subjected to a university ethical review (https://ethics.sps.ed.ac.uk/ethics_form) and it was decided that the research met the criteria of a level 1 review as it was not expected to have an adverse effect on participants, participants are not considered to represent any vulnerable demographic and it has not been necessary to collect data covertly or without the expressed consent of those taking part in the research. The research also submits to the BSA's (British Sociological Association) 'Statement of Ethical Practice' (2017).

3.3.2 Sampling

I wanted, as far as might be feasible, to conduct the research in a setting that could reasonably be considered a typical, or representative, case (Yin, 2009, p48) from which to draw a sample of participants. Of course, nursing is a very broad occupational field encompassing numerous roles and specialisms but I was concerned that such distinctions should not overly-determine the nature of participants' responses. For instance, citing the research in a rarefied environment such as child, or mental health nursing, which, as specialisms, are likely to entail further specific subsets of knowledge and theory as far as patient care is concerned, would arguably be less representative of the views of a wider population of nurses.

It was decided, then, that participants would be drawn from a sample of *NHS adult nurses* working in a Scottish hospital. NHS adult nursing, at least numerically, represents the basis of a *typical* case in that the NHS is by far the largest employer of nurses in the UK, and around three quarters of those

nurses are qualified in adult nursing (RCN, 2017); the majority of nurses qualifying in the adult branch of nursing go on to work in medical wards in hospitals ('the Number of Nurses and Midwives in the UK', 2018). The preference for a Scottish location is, admittedly, entirely for reasons of practicality and easy access. While the research presented here is relatively small-scale and qualitatively inclined and therefore makes no claims to statistical generalizability, it is intended that in identifying a typical case, at least as far as job-roles and standard work-tasks (e.g. washing, feeding, toileting patients) are concerned, extrapolations of a more general nature might be recognised and applied to similar cases elsewhere. As Maxwell (2012, p94) advises, the rationale behind selecting a research site should be:

"... to identify groups, settings or individuals that best exhibit the characteristics or phenomena of interest (...) and to select those that are most accessible and conducive to gaining the understandings you seek"

The research could just as readily have been conducted among a sample of *community* nurses working primarily outside of hospitals wherein person-centred practice is equally foregrounded (although this type of work represents a considerably smaller sector than general medical wards). However, the institutional context of a hospital setting has been preferred due to the heightened interaction between different occupational groups and ways of working; as has variously been proposed, the professional discourse of nurses has historically been constructed in relation to that of medical doctors (e.g. Johannison & Sundin, 2007; Melia, 1987). Additionally, the presence of care-support workers (who, formally less skilled than nurses, undertake much of the perceived 'dirty work' of care) in the hospital setting might be seen to have an effect on nurses' conception of the practical aspects of their work which Bolton (2005) has shown to be an important form of symbolic capital for nursing's identity. Finally, in a physical sense, the hospital is a unified site at which the activities of 'managing' (e.g. paperwork, negotiation with other healthcare professionals) and the provision of direct patient care are simultaneously performed.

A unit (or ward) where patients' stays are more than transitory was deemed preferable in terms of representing the potential for PCC and for nurses to be

able to comment on patient interaction more generally. If, as Draper and Tetley (2013) claim; “Getting to know the person behind the patient is the *raison d’être* of person-centred nursing care”, it is arguable that an accident and emergency department, for instance, provides limited opportunities for the development of interactive relationships between nurses and patients and so would be less helpful in the theoretical development of the research. Conversely, a care setting wherein nurses’ work is specifically focused on patients with terminal conditions and their long-term palliative care, a hospice, for example, may not have allowed as great an insight into the effects of certain demands that might be perceived as competing with individualized care, such as discharge and admission targets, which represent a prevalent and contentious issue on medical wards.

A meeting with a nursing studies contact working as a lecturer at my university led to the suggestion that a ward on which they had previously worked (hereon referred to as ward 12b) as a practitioner might provide a suitable sampling frame. As a medical, rather than surgical, ward, there is a lower level of patient turnover which means that nurses often do have lengthy periods of contact with patients (patients might occasionally stay on the ward for a month at a time) and many patients frequently return for regular treatments. As such, the unit, ostensibly, facilitates opportunities for person-centred practice or at least increases the likelihood that nurses’ experiences can provide sources of reflection on issues of care as they occur in relationships with patients. The ward is mixed-gender and patients represent a diverse group with a variety of conditions (although all fall under the specialism of the ward). Ward 12b admits patients of any age although generally patients are more likely to be middle-aged or elderly, however, this is reflective of hospital admissions on the whole where the 65-69 age cohort represent the largest single group of admissions (digital.nhs, 2016). As such, there is no significant reason to suppose an homogeneity in terms of personal beliefs, values, or religious affiliation other than those which align with wider population demographics. Resultantly, it was not expected that approaches taken regarding patient care would be characterised by atypical idiosyncrasies that might inhere on, for example, a single-sex or gerontological ward.

Along with arguably enhancing the validity of any generalizable explanations, the decision to try and illustrate a typical case was partly impelled by my own position as a neophyte researcher and the potentially vast scope of my research interest. With little prior knowledge of healthcare and nursing, I felt that researching within a general ward would provide the optimum means of a broad introduction to nursing work and the issues therein. While it would be difficult to argue that any one single unit in any hospital could be considered entirely typical of the 'average', given the differences in the use, for example, of specialist equipment and procedures, it may perhaps be said that some wards are *less atypical* than others. I was minded to avoid selecting a research site with overtly atypical features that might have come to dominate subsequent analysis and that were not germane to the research problems as formulated.

It should certainly be stressed, however, that further research into nursing care, and nurses' perceptions of their role(s), where specific or unique ward dynamics are *explicitly considered* in relation to how patient care is conceptualized would be invaluable. Indeed, a comparative study that recognized the potential for different care environments to differentially affect attitudes to caring practices would represent a laudable endeavour and would doubtless be able to build on the research presented here.

3.3.3 Access and Recruitment

Before I could begin data collection in earnest, I sought to obtain "research and development management" (R&D) approval from the participating NHS organization which can be applied for in conjunction with ethical approval which is determined by the NHS research ethics committee. However, "ethical approval is not required for some proposals that only use NHS resources" (scot.nhs.uk) and having evaluated my research using the HRA (Health Research Authority) decision tool, it appears the project proposed here does not qualify as 'research' as defined by the National Research Ethics Service. Therefore, it was necessary to obtain clearance at a local level which I did by directly contacting the NHS health authority with jurisdiction over the hospital where I hoped to conduct my study. I was, again, assured that my study was

not considered 'research' and therefore did not require R&D approval and was given permission to approach the service manager for the unit (12b) from whence I planned to collect my data.

My nursing studies contact at the university provided me with an introduction, via email, to the clinical nurse manager of ward 12b to whom I provided a condensed proposal of my research so that they could consider whether it would be practicable. I imagine it was also a matter for consideration as to whether the proposed research represented an unnecessary burden upon nurses' time. The clinical nurse manager forwarded the contact details (email) of ward 12b's two senior charge nurses and said that I was free to get in touch with either or both of them to negotiate the viability of the research and potential access to nursing staff.

For some time after contacting the charge nurses, there was no response; I later came to appreciate the volume of email correspondence that the charge nurses have to contend with and so, in retrospect, I am not surprised at the ineffectuality of this means of making acquaintance. If I were attempting to contact charge nurses on a busy ward again, I would probably contact the ward on the telephone as first recourse. Nevertheless, after sending another email a couple of weeks after the first, I got a reply from Steve (pseudonym), a senior charge nurse, who invited me to attend the ward in person. I met with him to discuss my proposed research and it was agreed, in principle, that I could recruit nurses from the ward for interview provided they could spare the time.

Ultimately, being granted access to a research population is the paramount objective if one is going to practically carry out any research at all, however, it is worth reflecting upon how this process is managed, as a researcher's initial means of contact can potentially affect subsequent participation. For instance, as Brewerton and Millward (2001, p47) point out, obtaining consent and generating interest within a hierarchical structure can be hazardous. If 'the go-ahead' is given by those in more senior positions before junior staff are consulted, this staff could potentially feel devalued and less willing to engage in research which has, essentially, been approved on their behalf. On the other hand, junior staff may feel unduly inclined to participate in research if they

perceive that not to do so would contravene the wishes of their superiors. Further to this, participants may view managerial consent to research as a form of endorsement of, or complicity with that research and so may be minded to tailor their responses in a way favourable to management. Clearly, this would serve to distort the direction and content of conversations and require that a significant caveat be added to any subsequent analytical claims.

However, precisely because of hierarchical structure, it is rarely possible to obtain consent simultaneously throughout each echelon of an organization that one wishes to study. As Bryman notes (1989, p162), for the purposes of practicality, access is usually most easily negotiated by making connections at the 'top' (senior level) of an organization. After all, there is little purpose in going to the effort of recruiting members of an organization if management declines to grant permission for the study to proceed. Moreover, a senior contact can often act as a reliable gatekeeper with the means to broker access with other potential participants. With these considerations in mind, I endeavoured to implement a participant recruitment strategy that emphasized the voluntary nature of participation *and* which was agreeable to ward management, i.e. the senior charge nurses.

Once I had been granted permission to recruit nursing staff from ward 12b, I designed a simple poster (appendix iii) detailing briefly the aims of my study and explaining that I was actively seeking willing participants; this was posted in the staff room of ward 12b where nurses might take breaks, eat lunch etc. For most of the nurses on the ward, the poster would have been their first acknowledgement of the research, which was considered preferable to my being introduced to participants directly through one of the charge nurses. The poster provided potential participants with my contact details should they wish to volunteer or ask any questions. In actuality, nobody got in touch with me as a direct result of the poster although several of my respondents affirmed that they had read the poster and recognized me from it when I took to recruiting in person. In this way, I maintain that the poster was a valuable tool in disseminating my intentions and providing nurses with the assurance that I was conducting the research legitimately. To this end, I made sure that

the poster included the university crest and contained an explanation of my status as a PhD candidate at that institution. I was physically present on the ward when negotiating access and explaining my research to the charge nurses and informally introduced myself to potential interviewees at this time, sometimes engaging in short, off-the-record conversations with nurses about the broad aims of my study. In this way, I was able to broadcast my intentions to much of the staff and reassure them as to who I was, and what I was doing on the ward. I feel that subsequent recruitment of interviewees benefited from these informal preliminary exchanges.

Having already made contact with the senior charge nurses, and after having met Steve in person, interviews with senior staff were agreed, in principle, at an early stage. Thus the first 3 interviews I managed to complete were with the two charge nurses and a deputy charge nurse who was copied into an email thread after I had accepted the invitation to come on to the ward for the first time.

Initially I had tried to recruit further participants by speaking with nurses at any one of the three nursing stations on the ward, introducing myself, and attempting to agree on a predetermined time slot when I could come back in and conduct an interview. However, it soon became apparent that unpredictable workloads made it difficult for nurses to foresee if they would be able to commit sufficient time for an interview on any given day. After a couple of scheduled interviews had to be cancelled due simply to nurses being too busy, one nurse suggested it might be more productive to ring the ward on a day when I intended to come in, in order to gauge how busy the ward was and, thus, the likelihood of being granted an interview.

The result of this was that my sample of interviewees was assembled in a largely ad-hoc way which, actually, provided certain advantages. Firstly, this, admittedly informal, means of recruitment served to alleviate any possible pressure to participate; because nurses had not made prior arrangements and, therefore, were not necessarily expecting to be interviewed it was entirely reasonable (and, indeed, expected) for them to simply say 'no' to my inquiries without feeling that they had reneged on an agreement. Consequently, I am

confident that the nurses I interviewed gave up their time freely when they were able to do so. Secondly, it might be argued that nurses' responses were as spontaneous as possible in that they had no time preceding the interview encounter to prepare answers in a way that they might have done had they been cognisant of an impending interview appointment for some time. As Brinkmann and Kvale (2015, p157) note, "The more spontaneous the interview procedure, the more likely one is to obtain unprompted, lively and unexpected answers from the interviewees". Finally, by obtaining participation in this way, I was able to exert some control over the demographic features of my sample by being selective about whom I next approached. In actual fact, for the most part, the sample of respondents exhibited heterogeneous features without too much manipulation, encompassing nurses of different age-ranges, levels of experience and educational backgrounds. However, on occasion, I was able to express a preference to the charge nurse on duty if I felt the sample could be balanced by, for instance, the inclusion of a recently qualified nurse. In these instances, the charge nurse could usually recommend somebody on duty that I could then approach independently. Overall, I was satisfied in managing to assemble a sample of interviewees that encompassed a wide variance in age range, occupational banding, nursing experience and gender. As expected, women outnumbered men in the sample; only around 1 in 10 UK nurses are male (rcn.org.uk) although, in fact, men are actually marginally overrepresented in my sample (3 of 16).

All nurses who agreed, or indicated that they would be amenable to participating in the research were provided with an information sheet and consent form (appendices I & ii) which summarised the purpose of the research, gave assurances of confidentiality and confirmed agreement to being audio-recorded. The consent form was signed before any interviews began in earnest and nurses were invited to voice concerns or ask any other questions before recording commenced. Making assurances of confidentiality and anonymity was particularly important as participants could be confident that their responses wouldn't be openly attributed to them and/or shared with colleagues. While overall, throughout the course of interviewing, no issues arose that could have any legal or serious professional ramifications, some

nurses occasionally intimated that their responses weren't of a kind that they would necessarily share with co-workers or those in upper management. Any rifts or disagreements would be considered an undesirable consequence of the research process; especially when the preservation of anonymity makes such occurrences readily avoidable. If further use is made of the findings here, for instance, if they are subsequently reported elsewhere for a different audience, it may be necessary to consult participants again to ensure they are comfortable with any further use of their data.

3.3.4 Banding

Before going onto the ward, occupational banding represented the only formal means through which I could categorise nurses for interview selection. It will perhaps here be useful to those unfamiliar with the occupational structure of the NHS to provide a brief explanation of the 'bands' that are represented on hospital wards and, more pertinently, in my sample of interviewees. Under 2004's 'Agenda for Change' (see RCN, 2018), the roles associated with NHS nursing were re-specified to align with different bands entailing different skills, responsibilities and pay-scales. Broadly speaking, banding refers to a nurses' seniority within the formal occupational structure of the NHS. A nurse's band may have little, or nothing, to do with their age or experience; it is more a reflection of the type of responsibilities that nurses assume. To characterize very generally, the higher a nurse's band designation, the more likely it is that their job will entail some management of the ward and its staff, although band 6 also includes specialist nurses with a specific clinical focus. In the initial proposal for this research, I provided generic job descriptions for bands as outlined on the RCN's website (rcn.org.uk). Having since conducted the interviews, I can now more usefully expand upon these descriptions to represent the nurses with whom I actually spoke as bands do not necessarily refer to just one singularly specified role. Below, briefly, details the roles and responsibilities of the nurses I interviewed.

Band 7-Senior Charge Nurses: Ward 12b has two senior charge nurses, both of whom I interviewed. They are responsible for the overall operation of the ward including managing discharges, dealing with staff sickness, pay and training,

and recruiting new nursing staff. The charge nurses also have primary responsibility for introducing and delivering any new healthcare programmes and initiatives and any reporting involved with these.

Band 6-Deputy Charge Nurse, Nurse Specialists: I interviewed three nurses at band 6, one a deputy charge nurse who takes on many of the managerial responsibilities of the senior charge nurses but continues to work some of the time with a patient caseload of their own. The other nurses from this category were nurse-specialists, which entails having advanced medical knowledge of certain specific conditions. The nurse specialists I interviewed from 12b fulfilled two separate roles; one assessing patients for potential admission to the ward (or referral elsewhere) and the other involved in the planning of more complex discharges, i.e. providing services and packages of care for patients leaving the ward.

Band 5-staff Nurses: Staff nurses are the most numerous on the ward (and in my sample, N=9) and are responsible for providing day-to-day care of patients. Typically, staff nurses have six, or occasionally eight, patients for whose care they are directly responsible. Day-to day activities include the administration of drug treatments, washing, toileting and wound care of patients. Staff nurses are also responsible for completing documentation relating to their patients, including vital signs and recording that the nutrition and hygiene requirements of patients have been met. Of the band 5 staff nurses I spoke with, there was a wide spread of age and experience; from 2 days qualified to 13 years' ward experience. Band 5 staff nurses on 12b work 12-hour shifts, including nights.

Student Nurses: Student nurses are supernumerary and therefore do not fall under NHS banding; they qualify at band 5. I spoke to two student nurses who were on clinical placement on ward 12b at the time of the research. There seemed no real reason to exclude student nurses from my sample as they do (albeit temporarily) contribute to the nursing care that takes place on the ward and thereby should be considered as having valuable things to say about care practices on the ward. Students of nursing are also uniquely well placed to comment upon the formal modes of teaching interpersonal care, and their utility (or otherwise).

A more detailed breakdown of the characteristics of the nurses interviewed for this study is included at appendix iv, and, as well as occupational band, includes information on years of experience, degree qualification and gender.

It ought here to be stressed that representing the spread of banding was not intended as an analytical frame; I was not explicitly looking to ascertain the differences in responses between nurses within different bands. Rather, reflecting the banding mix on the ward was intended as a 'pre-hoc' means of assembling a sample in a way that would not discount the *possibility* of occupational level as having some influence on the kinds of answers given by respondents

In the same vein, I sought, too, to recruit participants of varying ages and levels of experience and was mindful to include some male nurses in the sample. Again, this was not impelled by the desire to test particular hypotheses, but simply as a way to ensure that my data and analyses would not be overly reflective of any one specifiable category. Of course, there are several less visible features of the sample unaccounted for; for instance, would it have made a difference if all of my respondents were married? Had children? Were left-handed? Instead of trying to contain all possible factors, my informal means of categorizing interview participants was based upon themes in extant research.

For instance, I was cognisant, before I began interviewing, that differential levels of involvement in both management and direct patient care, respectively, might impinge upon nurses' perceptions of care practices and patient relations and so sought to ensure that I spoke with nursing staff from a range of bands. As Gillespie (2004) has illustrated, staff members' perception of 'person-centred care' may be significantly influenced by the immediate context of their specific role and its discrete demands. Similarly, it has been suggested that men may experience nursing work differently from women (Mackay, 1998) and that, particularly owing to changes in nurse training and education, differences in age and routes into the occupation might impact upon nurses' perceptions of certain issues (Woodward, 1997),(Smith, 2012).

In these ways, my sampling strategy was theoretically informed (although practically constrained by nurses' availability at any given time), however this way of classifying participants was not designed to determine the direction of talk in interviews nor provide thematic structure to subsequent analysis. As with the reading one does prior to conducting primary research, sampling strategies should enable, rather than limit, the range of interpretations that can be made. Moreover, of course, that which a researcher regards as significant alters throughout the course of a study and may reflect a different set of concerns following the completion of data collection.

3.4 The Use of Methods

The use of any particular method in social research is prefigured by a combination of pragmatic and theoretical considerations, which may not be readily disentangled. Bryman writes that the methods a researcher chooses should represent the optimal means of collecting 'problem-relevant data' and goes on to claim that "... methods do not bring a trail of epistemological assumptions in their wake" (Bryman, 1989, p253). This implies that researchers may exercise flexibility in their choice of methods as they attempt to address various different social problems; as Clark and Causer (1991, p169) claim, "the ultimate test should be the utility of the methods in helping them (researchers) to achieve their overall research objectives".

We might concur that certain research objectives are best served by certain methodologies; for instance, if one wished to obtain information on average household income, a large-scale survey would provide a better fit than conducting a small number of in-depth interviews. However, this 'horses for courses' approach does not adequately account for the *genesis* of research 'problems'. As Silverman (2001, p83) argues "...research topics never arise 'out of the blue'. Whether or not we are aware of it, any research topic will derive from particular models of looking at the world...". Therefore, while it might be legitimate to claim that methods need not be *directly* beholden to theoretical or ontological standpoints, it would be misleading to assert that a researcher's orientation to knowledge about the social world has no ultimate bearing on methodological preferences. As Atkinson et al. (2003, p99) explain:

“...in the world of real research, social scientists do not dream up ‘problems’ to investigate out of thin air, divorced from concerns of theory and methodology, and only then search for precisely the right method. Clearly, problems and methods come as part of packages of ideas-whether or not one chooses to call them ‘paradigms’.”

The arguments of Silverman and Atkinson (et al.), respectively, suggest the unlikelihood of research activity being divorced from the fundamental assumptions that researchers hold about the social world that they inhabit. Nevertheless, simply because holders of certain ontological views are *more likely* to engage certain methodological strategies in order to research the certain kinds of questions that they are inclined to investigate, it would be inaccurate to posit the relationship between ontology and method as completely deterministic. No one theoretical position can claim a *monopoly* over the usage of any given method, even where there is tacit affinity. For instance, as Michael Westerman has contended, even those methods we might typically think of as positivist (such as quantitative surveys) can, and, Westerman argues, should be analysed in an ‘explicitly interpretive’ way, i.e. by attending to the practical social contexts in which quantitative data is produced (Westerman, 2014). Furthermore, as will presently be discussed, the method of ‘qualitative interviewing’ may be undertaken by researchers from a range of theoretical standpoints with widely diverging analytical approaches. This illustrates that, rather than simply determining *which* methods will be used, a researcher’s ontological assumptions, more importantly, dictate *how* those methods, and the material or ‘data’ that they generate, are to be treated.

The following considers the rationale behind using qualitative interviewing, assesses the status accorded to data derived from interviews and how this shapes the kind of analytical claims we can ultimately make. In short, what kind of knowledge, if any, results from the conduct of research interviews?

3.4.1 Interviewing

Why?

“If you want to know how people understand their world and their lives, why not talk with them?” (Brinkmann & Kvale, 2015, p3). This advice may perhaps

seem to be a little glib although it illustrates, quite simply, the value of conversation as a means of acquiring certain kinds of knowledge and, by extension, provides justificatory grounds for the use of interviews in social research. When we are concerned to understand how people experience, and attach significance to things, actions and events, it seems intuitive that we should ask them questions about those things. This research sought to understand how nurses conceptualised 'care' and their role in providing it, and the significance of 'professionalism' for nurses. This kind of knowledge can only sensibly be communicated through the medium of language as we cannot readily surmise, from observation alone, the motives and justification behind social action. While maintaining that 'what people do', and 'what people say' may both be considered instances of performative social action we can recognise that they represent "different kinds of enactments" (Atkinson (et al.), 2003, p108). Language allows us to reflect on, and construct, our actions in ways that invest them with meaning.

Focus groups are another method that might plausibly have been used to elicit nurses' opinions and accounts however I chose to conduct one-to-one interviews for two principal reasons. The first is entirely logistical; the ward would simply have been depleted if several staff members had participated in a focus group at the same time. Indeed, it was often difficult getting just one nurse away from their duties for long enough to conduct a sufficiently lengthy interview. Theoretically, it may have been possible to arrange for focus groups to take place outside of working hours although this would likely have had a detrimental effect on participants' willingness to participate and there would have been less control over the constituency of the group.

The second reason has to do with the type of data that focus group research produces. As Mitropolitski (2014, p1) notes, "forming focus groups...gives excellent results in tracing group discursive dynamics" however, these group dynamics may have a paralyzing effect upon the contributions of certain members given that comments cannot be given in confidence. This is not to say that the confidentiality of an interview automatically results in greater levels of honesty, but it does discount the potential of participants mediating

responses to account for the presence of (possibly more senior) colleagues, with whom they must maintain a working relationship. Using focus groups in an occupational environment thus requires an especial focus on how specific, and established, relationships between participants influence the construction of discourse. While it should not be claimed that interviews give access to a 'truer' or more authentic account than focus groups, it is arguably easier for an interviewer, in a one-to-one encounter to 'stimulate the production' of discourse that transcends the immediate situation (O'Rourke & Pitt, 2007).

In total, I conducted 16 interviews with nursing staff on ward 12b. The average duration of interviews was just over one hour (range= 26mins-2.04hrs). All of the interviews took place on the ward itself, usually in one of the 'family rooms' that are reserved for confidential discussions between medical staff and relatives of patients. In early visits to the ward, I had attempted to conduct some interviews with nurses as they worked but this proved impracticable as nurses tried to continue attending to their duties whilst carrying on a conversation. For instance, discussion with a nurse at one of the bases was continually disrupted by the ringing of the phone, and by the nurse's obligation to respond to colleagues. Interviewing in a more closed-off space meant that respondents could give questions adequate attention while at the same time not being removed entirely from their work environment.

Before the first interview, a rough topic guide was drawn-up which contained headings indicating the substantive areas that I wished to discuss along with key word prompts. The topic guide reflected themes prompted by reading done prior to the research and was simply suggestive of ways in which to 'get the ball rolling'. The *specific* types of questions asked were very much directed by the talk that ensued between the interviewees and me, and the topic guide was continually modified and updated to reflect newly emerging considerations that presented themselves through the course of interviewing.

There was some variance in the extent to which the topic guide *did actually* guide the conversation. An interviewer needs to be responsive to the direction of discussion, knowing when to follow up and when to move on to a new topic; as Rapley contends, the point is to work with interviewees and "not strictly

delimit the talk to your predetermined agenda” (2004, p18). Over reliance on the interview guide means that respondents have less freedom to talk about the things that they, themselves, perceive to be pertinent, interesting or, even, profound. As May notes, flexible interviewing, with a loosely defined structure, permits participants greater scope to “talk about the subject in terms of their own frames of reference” (May, 1997, p112) which, ultimately allows for more articulate expression of subjective meanings.

Beyond the roughly articulated topics contained in the interview guide, interview interactions were not coloured by any specific strategy or premeditated questioning ‘style’; again I was more minded to respond to the situational dynamics of the conversation without losing sight of the overall aim of the discussion. For instance, if somebody doesn’t understand a question posed, it is usually of little utility to repeat it verbatim, nor is it always profitable, although it may be expedient, to simply move on to the next item. Instead, an interviewer regularly needs to clarify, rephrase and draw on examples in order to keep the conversation moving in a productive way. Brinkmann and Kvale (2015, p165) explain that the ‘expert interviewer’ (a descriptor I would not readily apply to myself) is:

“...sensitive to the situational cues that will allow them to go on with the interview in a fruitful way that will help answer the research question, instead of focusing all attention on the interview guide, on methodological rules of interviewing, or on what question to pose next.”

3.4.1.1 Interview Knowledge

For some researchers, interviewing is employed as a means of gaining access to, or information about, some kind of inalienable truth. This conceptualisation of interviews treats respondents’ talk (the data produced in interviews) as “more or less reflecting the interviewees’ reality outside of the interview” (Rapley, 2004, p16). Brinkmann and Kvale’s (2015, p57) analogy of ‘the miner’ is instructive here:

“In a miner metaphor, knowledge is understood as buried metal, and the interviewer is a miner who unearths the valuable metal. The knowledge is waiting in the subject’s interior to be uncovered, uncontaminated by the miner.”

The mining metaphor applies to researchers who wish to (and believe that they can) dig up nuggets of 'truth' about their respondents' worlds, using interviews as their means of excavation. However, within this, the type of truth that researchers aim to uncover is a matter of contestation; truth may refer either to objectively discernible facts, or to 'subjective authentic meanings' (Brinkmann & Kvale, *ibid*). This difference in emphasis will be discussed presently but, in either case, it is assumed that analysis of what people say in interviews can provide a researcher with access to the fundamental truth of a situation.

The belief that interview data can reflect *objective* fact is founded on a positivist supposition that there is an objective social reality independent of social actors. On this foundation, interview data are treated as "accounts whose sense derives from their correspondence to a factual reality" (Silverman, 2001, p87). Typically, therefore, positivist researchers construct research methods so that their results may be verified empirically, often with reference to social statistics or classifiable demographic characteristics (such as age, ethnicity, sex etc.). For this reason, positivist researchers tend to use standardized interview instruments, such as surveys, with replicable questions and comparable response categories; firm positivists are unlikely to use open-ended interviews although Kathryn Roulston, (2010) has outlined a 'neo-positivist' conceptualization of research interviewing which advocates interviewer neutrality and strategies of corroborating interview responses against multiple other sources of data. This exemplifies the notion of the miner-interviewer looking to uncover objectively true knowledge.

Unsurprisingly given the 'narrative turn' in contemporary social research (see Goodson and Gill, 2011), this kind of approach to interview data, embodying positivist assumptions about the nature of knowledge, has been subject to considerable critique. Much of this criticism applies more broadly to the 'mining' mentality concerning data and will be discussed at greater length shortly, though two specific objections are here considered. Firstly, it is debatable whether an interviewer can ever achieve neutrality in practice. As

Rapley (2004, p20) argues, "Interviewers are always active. Interviewers have overarching control, they guide the talk, they promote it through questions, silence and response tokens". Even as an interviewer assiduously attempts to minimize their personal influence, their impact is inherently inscribed upon the interview encounter itself. Furthermore, as Seale points out, some sources of potential interviewer distortion simply cannot be controlled for; "prejudices or subconscious desires...are by definition not available for explanation by the person who has been influenced by them" (Seale, 1999, p163).

Secondly, the neo-positivist conceptualization of interview data assumes that respondents' talk is truthful insofar as it refers to an externally observable reality, yet this severely limits the kinds of conclusions a researcher may draw. Interview data is only deemed credible by comparison to some predesignated source external to the speaker however, as Silverman (2001, p90), quoting Maeside, attests, "interview responses are delivered at different descriptive levels" and often will represent introspective concerns. Positivistic analysis of interviews struggles to account for subjectively derived opinions, motivations or emotional responses in any meaningful way nor can it explain why there may often be multiple accounts of a single event.

In a contrasting approach to interviewing, termed 'emotionalism' (Silverman, 2001) or 'romanticism' (Roulston, 2010), subjective representations become the focus of attention. Rather than aiming to ascertain *facts* about a generalized social world, romantically inclined interviewers seek to gain knowledge of the *subjective experience* of social actors by encouraging respondents to 'open-up' to them. This approach is based on the notion that, through sustained rapport building and self-disclosure, researchers can gain the trust of their respondents who are then willing to proffer intimate personal reflections and reveal their 'true' emotional states. In this conception of interviewing, data are seen to be 'true' insofar as the trust and rapport between interviewer and interviewee can be convincingly demonstrated. The overarching concern of the romantic approach is with obtaining *authentic* accounts, as opposed to establishing objective *facts*.

While ostensibly engaged in very different endeavours, neo-positivist and romantic interviewers share some fundamental assumptions about the nature of interview knowledge. Neo-positivists treat interview data as revealing facts about an external social reality while romanticists perceive that interviewees' statements reflect authentic inner states; though in both cases, researchers believe that they "are able to access the authentic selves of interview subjects via interview talk" (Roulston, 2010, p218). Neo-positivists defend the veracity of interview statements through appeals to methodological rigour and the crosschecking of data whereas for romanticists, the credibility of interview accounts rests upon the stated ability of the researcher to engender "an atmosphere conducive to open and undistorted communication" (Silverman, 2001, p90). In both cases, researchers attempt to claim that the research strategies taken are capable of facilitating the production of uncontaminated (truthful) data.

From a CR perspective, neither of the 'mining' strategies discussed here are able to uncover that which they seek. As Maxwell (2012, p133) argues:

"As observers and interpreters of the world, we are inextricably part of it; there is no way for us to step outside our own experience to obtain some observer-independent account of what it is that we experience."

Thus, we cannot treat features of an externally real world as the reference point upon which to ground interview responses as we simply do not have non-subjective knowledge of this world. At the same time, the CR contention that discourse gains its sense from its relation to extra-discursive features means that neither can we suppose that the truth or reality of an interview account can be established with reference solely to its internal features. If data is considered truthful insofar as it corresponds to an agent's own subjectivity then, logically, researchers must concede that all perspectives (however nonsensical or objectionable) are equally valid. Maxwell (2012, p133) maintains that:

"... there exist ways of assessing accounts that do not depend entirely on features of the account itself, or the methods used to produce it, but in some way relate to those things that the account claims to be about."

Regarding the treatment of interview data, the CR position advocates that responses be assessed in terms of how they *interact* with their wider contexts, rather than treating what people say in interviews as “reports corresponding to matters outside the interview” (Roulston, 2010, p218). Again, rejecting the extremes of both positivism and relativism, CR sees language as neither simply descriptive, nor completely constitutive of reality, but as both simultaneously. Thus, researchers should take account not simply of *what* is being said but also (and arguably more so) of *how* respondents construct accounts and the ends to which these constructions are employed. As Atkinson et al. (2003, p117) state:

“People...use biographical accounts to perform social actions. Through them they construct their own lives and those of others; they justify and legitimate past, present and future actions; they formulate explanations; they locate their own actions within socially shared frames of reference.”

This latter point concerning ‘shared frames of reference’ is important; in order for people to ‘get their point across’, they must necessarily appeal to culturally realized forms of expression. As Atkinson et al. (2003, p136) recognize, even deeply personal revelations (such as ‘coming out’ stories) are “constructed in accordance with culturally shared narrative formats”. In order to be intelligible, personal narratives must draw upon shared discursive resources; the task of interview analysis should be directed towards understanding how and why these resources are utilized.

3.4.1.2 *‘Thinking’ with Interview Data*

Bryman’s (1989) concern with obtaining ‘problem-relevant data’ indicates that the way in which researchers treat interview responses should be determined by how the responses appear to address one’s research problems. Similarly, Rapley (2004, p27) has stated that:

*“How you analyse interviews is **always** inextricably linked to your specific theoretical interests. And your theoretical interests will, in part, define what sort of questions you ask in interviews, what sort of questions you ask of the data...”*

Aspects of data are interpreted as pertinent by researchers based upon their reading, their disciplinary background and their ongoing formulation of what the research problem(s) may be, and various analytical approaches emphasise

different aspects of discourse production. For some researchers, intense focus on the minutiae of spoken communication (i.e. conversation analysis) is employed to address concerns with how local-level social interaction is achieved. From a critical discourse analytical perspective, however, an intrinsic aspect of any research problem is the relationship between discourse and wider socio-cultural contexts. Therefore, analysis which restricts its focus upon concrete features of texts alone are deemed impoverished by their inability to “shed light on the links between texts and societal and cultural processes and structures” (Jorgensen & Phillips, 2008, p66). Indeed, it may be argued that conversation analysis inherently relies on meanings derived from more general social structures in order to make sense of a discrete conversational encounter.

My own analytical approach is broadly in line with O’Rourke and Pitt’s (2007) description of the interview as an encounter used “to stimulate the production of discourse of interest to a particular researcher” (O’Rourke & Pitt, 2007) wherein I treat the discursive content of accounts garnered through interviewing as reflecting a wider social reality than that confined to the interview encounter itself. This is not to say that the interaction in any given interview is unimportant but simply that restricting analytical attention to the interview encounter is not germane to addressing broader questions of how nurses construct themselves in relation to wider occupational contexts, such as the significance of ‘professionalism’ and the changing nature of nursing work. Understanding nurses’ accounts in relation to such considerations ultimately produces explanations that have greater plausibility *given the conceptual framework of the research* as presented here and arguably provides what Maxwell (2012, pp139-141) terms ‘theoretical validity’. In short, the concepts drawn upon in analysis correspond to the theoretical concerns that underpin the research.

How far a researcher goes beyond the text in the analysis of data is not easily specified although the CDA view of social practices as consisting of interdependent elements, of which discourse is one (Thomas & Hewitt, 2011), suggests that there is no specific ‘level’ at which explanation should be aimed, but that discursive practices may be understood in conjunction with any of a

number of interactional features. Inevitably, a researcher cannot realistically include every single constituent feature as part of their analysis, although the formulation of research questions, in conjunction with the actual content of the data, i.e. the concepts to which respondents appeal, should help to clarify the pertinent relations between discourse and other elements of social practice. The importance of what people actually say in interviews is important to note here; while researchers may have a good understanding of the social context of the phenomena being investigated, we must be open to reappraisal. For instance, before I began interviewing, I had not explicitly theorized the role that familial models of caring might have on nursing practice, however, a number of nurses made reference to the parallels between nursing care and care in the family and, subsequently, I incorporated this as a feature of my analysis.

Pragmatically, Silverman (2001, p113) maintains that “Everything depends on our purposes at hand” when it comes to the ways in which we think with the data we have attained and thus data can never simply ‘speak for itself’. As eminent anthropologist Clifford Geertz affirmed “what we call our data are really our own constructions of other people’s constructions...” (quoted in Seale, 1999, p159). Nonetheless, as argued earlier, a CR approach enables us to maintain that these constructions can be evaluated for their plausibility.

3.5 Coding: Purpose and Strategy

According to social research methods guru, Alan Bryman, “Coding is the starting point for most forms of qualitative data analysis” (2001, p398) and is considered a systematic way of identifying themes from across a data set. Bazeley (2013) identifies three principal purposes of coding; to ‘manage data’, to ‘build ideas’ and to ‘ask questions of the data’. Typically, coding involves close reading of texts, in this case interview transcripts, and organizing the material into categories based upon some underlying similarity which, ultimately, allows a researcher to comment on the data, as a whole, in order to build explanatory theories of the phenomena in question. While systematic

coding strategies have been variously criticised, I maintain here that coding represents a useful means of staying attentive to the details of interview responses, as well as providing a critical check on researchers' interpretations. In the interests of clarifying the bases of interpretation, I provide a brief example of my own coding strategy at the end of this section.

3.5.1 Where do codes come from?

Faced with a wealth of interview data, it can be difficult to know how to begin the process of categorization. Arguably the most widely-cited coding strategy is 'Grounded Theory' coding, most commonly associated with Glaser and Strauss (1967), which maintains that the codes under which data are categorized should only 'emerge' from the data itself. Theoretical categories should not be imposed upon the data, rather the data should inform theoretical explanation and so transcripts should be approached from a position of neutrality. A number of writers have subsequently questioned the feasibility of this approach (Charmaz, 2008; Harding, 2013), arguing that researchers simply cannot approach "their subject without preconceived ideas" (Harding, 2013, p14), considering that they have already selected and framed an area of investigation. Additionally, without drawing upon some prior understanding, the process of deciding what to code is potentially inexhaustible and thus unfeasible for a researcher to embark upon.

It is therefore, surely, legitimate to approach a text with an idea of the kind of things one might be looking for, rather than trying to discount the interests which have prompted the study in the first place. Bazeley (2013, p142) advises, contrary to conventional grounded theory:

"Before you start (coding), remind yourself of the aims and objectives for your project and the questions your research is designed to answer, as these will critically influence what you will look for in coding your data".

Against this strategy, it might be argued that researchers are simply imposing coding categories upon their data which may reflect the biases and preconceptions of the investigator. However, the practice of diligent coding may, of itself, provide a defence against any such accusations. At the very least, systematic coding processes force researchers to focus closely on their data

and think about it in different ways and from different perspectives. As Atkinson and Hammersley advise; “It is not good enough to skim a transcript or set of field notes and to have a broad sense of “what it’s all about, cherry-picking bits of data for quotation” (quoted in Bazeley, 2013, p126). Coding allows us to question and interrogate this ‘broad sense’ of what our data are telling us; as Charmaz (2000, p515) claims it “helps us to gain a new perspective on our material... and may lead us in unforeseen directions”. While accepting (and even emphasising) that “even when using empirical codes, it is likely that the researcher’s prior knowledge of the subject will inform decision making to some extent” (Harding, 2013, p83), attentive coding should work to ensure that this prior knowledge does not suffocate the data. As Bazeley (2013, p126) contends; “The task of coding assists the researcher to break out of an ‘imprisonment in the story’ to see new connections and alternative ways of framing and interpreting a text or situation”. Coding can help researchers to find a balance between their “prior knowledge and theories about their topics” (Charmaz, 2008, p402) and new considerations raised via data-collection.

3.5.2 Preserving Context

A prominent criticism of coding practices is that, in breaking texts into fragments for categorization, data are decontextualized and thus their original, intended meanings are threatened. Martin Packer (2011, p102) argues that “terms take on specific and contextually grounded meanings within and through the discourse as it develops and is shaped by the speakers” and, thus, fractions do not necessarily reflect the whole. Relatedly, Maxwell argues that the effect of ‘decontextualization’ can be compounded if coded categories become the sole unit of subsequent analysis:

*“...using connecting techniques only on the categories, rather than the data, results in an **aggregate** account of contiguity relationships and can never reconstitute the actual, diverse connections that were lost during the categorizing analysis.”*

(Maxwell, 2012, p114, original emphasis)

In light of such criticisms, it seems crucial that categorizing data through coding is not pursued at the expense of representing contextual relations within the data. To this end, Maxwell (2012, pp111-123) advocates combining categorizing strategies (i.e. coding) with what he terms ‘connecting’ strategies

which seek to understand categories in relation to each other, and to the original data. In the same way that coding may provide a check on our intuitive understanding of the data, more holistic reflection on our data can allow us to make sense of these categories.

There are some practical ways in which this balance is achieved that, arguably, inhere naturalistically in one's research process. It would seem counterintuitive (and difficult to achieve in practice), for instance, to disregard any understanding that one has gained from an interview encounter when it comes to coding what was said in that encounter. As Charmaz (2000, p515) claims: "...the researcher's *interpretations* of data shape his or her emergent codes" and these interpretations are inevitably informed, in part, by the experience of conducting the interview itself. In this way, the context of the interview is inexorably inscribed upon the development of codes.

Pragmatically, in relatively small-scale studies, in which a sole researcher has conducted, transcribed and coded all of the interviews themselves, it is arguably even less likely that contextual understandings will be lost in the coding process because the overall process of interpretation is not fragmented. As Miller, commenting on her own coding strategy, describes, a somewhat instinctive feel for the quality of data one has attained can make us sensitive to the adequacy of coding categorizations; "These matrices seemed too simplistic for the complex, inter-connected data I felt I had." (Miller, in Maxwell, 2012, p121).

There is no prescription for how to integrate coding with more holistic analyses, though I found that regularly re-reading transcripts was a simple but effective means of evaluating the significance of similarities between codes. Often, a useful prompt for re-reading was when codes appeared to overlap, thus suggesting a conceptual relationship between different aspects of interview narratives. Reappraising transcripts was done with the aim of establishing whether such instances of overlap were contiguously associated; were interviewees making the same kinds of claims in different segments of data? The worked example at the end of this section will hopefully clarify this analytical process

3.5.3 Occupational Context

It seems worthwhile to briefly comment on the supposition that coding serves to establish links between the responses of different interviewees, which could be criticised on the basis that it reduces the saliency of individual narratives.

We might be able to argue that the codes we develop are sensitive to the context of an individual interview, however, it is arguably more difficult to defend the practice of applying the same codes across an entire data-set. Can we compare and contrast two or more separate incidents of data-collection and reasonably propose that they are similar in kind to the extent that we might draw wider inferences? My research assumes some level of shared discursive understanding between participants who are linked by a specific occupational context. Therefore, it is imperative for my analysis that my research population have some shared understanding of common concepts.

In part, the 'critical realist' ontology that informs my research provides some justification for assuming that this is the case. From a critical-realist perspective, Sayer (2000) argues that for discourse to be viable, it must maintain some 'practical adequacy'; in other words, we cannot simply interpret the world in any way we wish; recall, for instance, the earlier cited example concerning the very real dangers posed by oncoming traffic which cannot be mitigated by discursive constructions.

While words may not always refer to any one single thing, it would be obtuse to argue that the words people use can refer to absolutely *anything*. Without at least some common referents, we simply could not communicate or operate adequately together in the world.

Furthermore, at a more practical level, it may be legitimately presumed that, when research is conducted in a rarefied and specific institutional environment, the probability of a set of commonly-held referents that inform shared discourse is increased. As Smith testifies:

"Institutions, as objectifying forms of concerting people's activities are distinctive in that they construct forms of consciousness – knowledge, information, facts, administrative and legal rules, and so on and so on – that override individuals' perspectives".

(Smith, quoted in Mason, 2006, p15)

For a group of nurses working in the same physical environment and faced with the same set of tasks, relationships and obligations, it is reasonable to assume similarities in terms of experiences, perceptions and the language used to relate these.

While each individual research encounter does entail its own unique context, by privileging the particularistic construction of a single individual text, we might miss out on the connections and shared meanings that indicate a collective narrative within a wider context. Thus, coding using general categories provides an effective way to bring the researcher's attention to where there is common understanding and also to where there is contradiction.

3.5.4 Coding: an Example

By the time I began coding in earnest, I had closely read my initial set of transcripts (7 or 8) without explicitly looking for connections but simply to become immersed in the data. Acceding to the contention that coding is unlikely to begin from a position of objective neutrality, I began coding by seeking out parts of the data which corresponded to aspects of my initial research questions. Given the debates surrounding nursing's recent move into higher education, and the notion that degree-level study is a means of advancing claims to professional status, I had asked nurses about their experience of formal education and decided to code for this by simply looking for instances where nurses referenced their training, whether at university or elsewhere. I already had a sense from conducting the interviews that respondents were somewhat resistant to the idea of 'care' being formally prescribed through educative approaches so sought to examine this assumption more systematically. Initially, I simply coded for 'learning experience', applied wherever nurses referenced their education or training, before going back over these instances to see whether nurses were conveying generally positive, or negative views. Within the 'negative' experiences, it seemed that attempts to formally codify what might be considered the more 'expressive' aspects of caring were a source of consternation. It should perhaps be noted at this point that in applying codes to excerpts of texts, I have

preferred what seems an intuitively naturalistic approach of identifying 'meaning units' (Bazeley, 2013, p144) which may be a three-word phrase, or a couple of paragraphs but is dictated more directly by the structure of respondents' speech. For instance, both of the following relatively lengthy excerpts were coded under 'negative learning experience: care formalization'

D: OK, what about the kind of 'classroom' side of it, do you think that prepared you...

V: as in Uni?

D: yeah university lecture time rather than being on the ward.

V: No, not at all. Erm, they focus on holistic care and things like that which is what you bring into nursing, I mean you treat your patient holistically, you consider them as a whole. But, nah, uni definitely, the classes I wouldn't say in any way have helped me to where I am now.

(Interview with Valerie)

I didn't actually like uni that much. I thought it was too, erm, like although I agree with holistic nursing, they made a lot of err ... a lot of their content related around holistic, err... which is fine, I totally agree with it but I would have preferred to have gained more knowledge on like, medical...

D: More kind of technical...?

J: Yeah, technical, medical stuff instead of, you know, how to care for people cos I already knew that...

D: Right, I was gonna say, if I can push you a bit more, what was it about the holistic focus that you kind of...

J: erm, like, once you know what it is, you know what it is. Erm, I think if you're a nurse, it should already be embedded, it should already be holistic, you know, you don't do the job because you like being a nurse, you do it because you like the people, the patients. I don't agree with trying to make people like that. I think if you want to be a nurse and you wanna be a good one, you already have to have those...embedded in you, you know....

(Interview with Jonathon)

When coding for nurses' view on PCC, I found several instances in which nurses used similar language to one another to convey the sense that, although being relatively new terminology, the precepts of PCC are an abiding feature of nurses' practices, the formal nomenclature simply describing that which nurses already do. I coded such excerpts as 'PCC: formal terminology'. There seemed to be, then, significant conceptual overlap between these coding categories, specifically in the resistance, or scepticism to *formally* pronouncing on the content of care. Due to this perceived overlap, I returned to the transcripts

with this theme in mind to see if the same kind of sensibilities could be cited as underlying these types of claims and also looking for other instances of this 'formal'/'natural' distinction. In re-reading transcripts, it indeed appeared that this was a central theme in nurses' discourses and helped to explain various aspects of nurses' talk. For instance, the espoused attitude of many nurses to paperwork might be similarly elucidated, i.e. that much paperwork is viewed as an unnecessary formalization of work which nurses feel is intuitive.

3.6 Preface to Data and Findings

The findings to be reported here presently make a number of causal inferences in trying to account for nurses' occupational discourse, reflecting the beliefs that actors engage in discourse to 'achieve certain purposes' (Watson, 2002) and that discourse has real-world antecedents. However, in line with that which has just been discussed in relation to 'plausibility' and 'recognisability', I make no claims to provide a singular or definitive account of the observed phenomena, although I believe my interpretations to be credible. The interpretation of the data is multi-faceted; I do not attempt to subsume all of the findings under one centralizing theory but invoke various contextual features which frame nursing as a social practice in order to explain the significance of nurses' responses. Because contextual factors are inextricable from each other, it would be erroneous to claim the precedence of any discretely identified factor; discourse can easily serve more than one purpose. Equally though, just because causal factors may be interrelated, it should not mean that the prospects for generalizations are severely diminished. No other situation will be framed within the *exact same* contexts as the study reported here and therefore certain inferences will have little utility, while others might be entirely pertinent. Furthermore, the generalizations from research findings can be made at multiple levels depending on how similarities are perceived; as Delmar (2010, p121) states, "The individual is like no others, like some others and like all others". Later in the thesis, following the discussion of my findings, I suggest some ways in which the insights from this research might inform further investigations, ranging from the study of similar situations, such as

other healthcare occupations, to the wider applications of concepts like 'profession', though these proposals are not exhaustive.

The final coding scheme has been reorganized across three broad but distinct categories so that the findings can be presented and discussed thematically. The three substantive data sections consist of; nurses' views on nursing education, the perceived significance of the concept of 'profession', and nurses' conceptions of what it means to 'care'. In each section, the empirical data is described, supported with direct, verbatim quotations from my respondents, and then an interpretive explanation of the significance of the data is offered. The organization of the coded data also reflects an attempt to respond directly to the research questions outlined in the introduction and to help situate the findings in relation to theoretical constructs and debates, for example the 'caring for/caring about' distinction. The way in which the findings are presented here also arguably makes it easier to present a broad selection of data given that the general headings (education, profession, care) are descriptive rather than analytical and so do not presuppose normative or overtly theoretical claims. In other words, the categories permit the inclusion of a lot of different responses which can be readily analysed in relation to each other.

4. Findings

This chapter reports extensively on nurses' interview responses in attempting to convey a sense of 'what nursing's all about' for the participants. Nurses' feelings towards formal nursing education and, specifically, the academic theorization of care, are presented and the reasons for nurses' generally sceptical views are considered. The construction and usage of 'professional' discourse is considered and it is suggested that nurses' conceptualization of 'professionalism' is employed in service to an overriding commitment to patient welfare. Finally, nurses' perspectives on the type of care that characterizes the role, and the actions that demonstrate this care, are contemplated, especially as they relate to the institutional context in which they take place. Overall, the findings appear to show that nurses' discourse is principally utilized in the maintenance of a specific ideal of nursing care which fundamentally reflects the inherent, personal dispositions of nurses themselves.

4.1 'Learning' to Care

Over the last 30 years, nurse training has migrated from hospital-based schools, and an apprenticeship model of learning, to colleges and universities with their attendant academic qualifications; following the recommendations of the Willis Commission (2012), as of 2013, registering as a nurse in the UK has been dependent upon possession of a nursing degree. It should be noted here that a degree route had already been established in Wales in 2004, though nursing students could still leave with a diploma before degree-only registration was instituted throughout the UK. The effect of this increased academicism has been the subject of some considerable debate. While several commentators have seen the shift as supporting the articulation of a professional mandate for nursing (Daykin & Clarke, 2000; Francis & Humphreys, 1999) by demarcating a distinct area of knowledge, a concomitant claim has been made that an academic focus is serving to erode the occupation's core values. For instance, Vivien Woodward (1997, p1002) writes that a "means of losing caring as a central value could arise as recruits may be motivated by the opportunity to

acquire an academic qualification, rather than out of the desire to care for others.”

Similar opinions have come to the fore more recently following the Francis Report into standards of care at the Mid-Staffs NHS trust (2013). Following the report’s publication, Darbyshire and McKenna (2013) were minded to question whether aspects of university nursing curricula were serving to ‘devalue and marginalise’ so-called ‘basic care’ along with the values of ‘kindness, compassion and thoughtfulness’ (Darbyshire & McKenna, 2013, pp305-306). In explanation, Pam Smith (2012, p182) has suggested that “technically oriented learning objectives” may be coming to overshadow a more holistic understanding of caring or, as Adam and Taylor (2013, p1) succinctly put it: “cure may be valued above care”.

These debates prompt us to consider the place of ‘person-centred care’ in nurse training and education as, presumably, a ‘person-centred’ curriculum would emphasise the importance of the very things which some observers fear are being eroded. Indeed, universities have been identified as playing a key role in promoting person centred approaches; “For educators, it is crucial that the educational process enables students to develop the skills, knowledge and attitudes required to deliver care with compassion” (Adam & Taylor, 2013, p1). Thus, whilst on one hand, the move into higher education has been cited as a (possible) catalyst for the diminishing of compassionate care, on the other, it is recognized that nursing degree programmes might foster caring attitudes among their students through encouraging person-centred care which, as McCarthy (2006, p630) notes, “has been recommended as the philosophy to be demonstrated by educationalists and preceptors alike”.

In my interviews with nurses, I was minded to find out what role education played in informing their understanding of person-centred care and of nursing more generally. I wanted to understand how nurses’ formal education, whether degree-based or not, directed their approach to patient care and, particularly, their interpersonal relationships with those under their care. The responses problematized both the idea that an academically oriented education fosters an instrumental outlook at the expense of compassionate

care *and* the contention that university curricula (and formal education more generally) is a key means through which the precepts of person centred care are instilled.

4.1.1 Data

4.1.1.1 Person-Centred Care- “You either can do it or you can’t”

I asked nurses about whether they had encountered PCC (and/or other theoretical approaches to patient care) as part of their education and training, and, if so, what their experience of this was. When discussing the university treatment of person-centred care, many of the nurses I interviewed were dismissive of the idea that formal education could enhance their understanding of the concept, as it was generally held that provision of person-centred care should be intrinsically motivated; one shouldn’t need to be told how or why they should care for people.

“I think if you’re a nurse, it should already be embedded, it should already be holistic, you know. You don’t do the job because you like being a nurse, you do it because you like the people, the patients. I don’t agree with trying to make people like that.”

(Jonathon, Band 5 staff nurse)

Similarly:

“They (university) focus on holistic care and things like that which is what you bring into nursing, I mean, you treat your patients holistically, you consider them as a whole. But, nah, uni definitely, the classes I wouldn’t say in any way have helped me to where I am now.”

(Valerie, Band 5 staff nurse)

Respondents were generally eager to emphasise that person centred care is “just something that’s within you, you either can do it or you can’t” (Beryl, band 6 nurse specialist).

In a similar vein, another respondent with considerable nursing experience, and now working in a band 6 role managing admissions, Mildred, emphasised, numerous times, the idea of ‘nursing instinct’ which, again, one either has or has not and which was seen to significantly determine one’s aptitude; “I think

you're either instinctive or you're not. You're either meant to be a nurse or..."

According to Mildred, the aspects of nursing that rely on instinct are what might be referred to as 'people skills'; "Some people... they've got a natural ability and a natural instinct with people"; "They're very good with people, very chatty". A 'good nurse' possesses these natural abilities.

"You know, you can get two completely contrasting, you know, who can't grasp...this person who's instinctive, they'll pick it up no problem, they'll go on, they'll be good nurses. The ones who you have to spend a lot of time with, teaching how, even saying to them "go and talk to a patient for half an hour, go and find out what Betty's like at home, ask her, you know, who comes in to visit her, you know."

There was a strong sense, throughout all of the interviews, that formal education only contributes to a relatively small proportion of being able to nurse well; As one of the charge nurses, Lillian, said of herself:

"I mean, you have to have an academic level of knowledge, of course you do, but a lot of nursing ... is instinct with lots of things and it's common sense; the caring part just kind of comes naturally to me..."

Here, once more, the reference to 'naturalness' (made in direct distinction to possessing 'an academic level of knowledge') supports the claim (common amongst the sample) that the ability to be caring, as a nurse, is attributable to something intrinsic and unteachable. Recently qualified staff nurse Poppy suggested that having inherent 'compassion' explained a natural affinity for caring and claimed that 'person-centred' care was dependent for its realization upon this attribute. Poppy declared that "I don't think you can teach someone to be a compassionate person because it would just be fake otherwise" before going on to explain:

"You're going to give person centred care because you've got that compassion behind you to actually care to give person centred care ... If somebody didn't have compassion, do you really care about giving person centred care, then?"

The idea that person-centred care proceeds from innate compassion supports a division between inherent, authentic care and a superficial academic version.

4.1.1.2 More Than Just Words

When directly discussing 'person-centred care', several respondents elaborated upon the disjuncture between the formal, academic treatment of

the idea and a more tacit, emotive comprehension illustrated here by Jonathon;

“Somebody telling you in a lecture hall about what holistic care is...unless you feel it... you realise it’s your job not only to give them medication but also see if you can improve their mood and if you actually feel like you want to do that, then the job’s suited to you.”

(and later)

“I think it’s all good to say that you can write a book about holistic care, you know what it is...and, matter of fact, I think probably the authors have done it and you know...they probably have been nurses and they know how to give it. But then I think the only way of learning how to do it is not reading a book, till you do it, you do not know what it is. But that’s just my thoughts, you know, I’ve got strong opinions so...”

The ‘books’ and ‘lecture halls’ which Jonathon cited as the academic manifestation of PCC were perceived as unable to get at the fundamental tenets of nursing in a person-centred way; as Lillian explained: “nursing’s all about compassion, it’s not just words, it is reality, you’ve got to empathise with people, you’ve got to be compassionate, you’ve got to have insight into what people are feeling.”

Indeed, the notion that PCC, as encountered at the academic level, was largely ‘just words’ was widespread amongst the sample. Significantly, almost everybody described knowing about person centred care, through university and from changes in healthcare policy, as learning to apply the correct terminology to something that had “*always been done anyway.*” ‘Person-centred care’ was seen as little more than nomenclature. As Lucinda put it:

“You know, we had ‘releasing time to care’ and there was ‘compassionate care’...these things are all the same, they all tie-in, it just depends on what the buzz phrase is that particular year or whatever.”

Many nurses were unconcerned with distinguishing between myriad terms; ‘person-centred care’, ‘patient-centred care’, ‘holistic care’, ‘individualized care’ were taken by over half of the respondents to mean ‘more or less the same thing’ (e.g. “for me, I think it’s all the same, just different terminology” – Maria). In this way, it was generally asserted that nurses’ approaches to caring for their patients have remained relatively unchanged but the terminology has been modified over the years and, particularly, more recently as nursing has moved further into higher education.

“It [PCC] may be slightly different terminology from what we used then but I think we’ve always done patient centred care here because we’ve always, like I said to you before, we’ve always had the staff who’ve gone above and beyond for the patients here...”

(Mildred)

The following extract from an interview with Poppy, who had only very recently graduated, similarly illustrates the view that recognizing PCC is predominantly perceived as an exercise in semantics:

D: And do you think it’s something you need to learn about? I mean, if you say it comes naturally, do you feel like you already came to nursing with the ability to provide person centred care?

P: I think they just give you a term to describe it. Cos like, you are giving person centred care but you know what it is because uni has taught you ‘this is what it is’ ... (Laughs).

As here evidenced, nurses’ provision of person-centred care is seen to precede its theoretical articulation and is dependent upon the volition of the staff. In this way, the formal theorization of person-centred care is considered to *describe* that which nurses do, rather than as something to be learnt and applied in practice. This sentiment was summed up by Lillian who said:

“I think it’s something, maybe I’m wrong, but I think it’s something that you’ve always done. It’s like everything, people put fancy names on stuff these days, it’s something we’ve always done but we’ve just probably never formalized it I’d like to think.”

A small minority of respondents seemed to be more accommodating of an educative approach to person-centred care, although none went as far as to claim that ‘compassion’ and ‘caring’ could be instilled in nurses through study. Only one interviewee, Greta, explicitly maintained that PCC could be achieved without the nurse necessarily having a compassionate and caring disposition, saying;

“Like, I think some people can perform person-centred care fantastically but they might not necessarily be the most compassionate or caring nurse. They might be really firm or sharp but they do the person centred care, you know, adequately or properly.”

4.1.1.3 Value in Education?

Unlike many respondents, e.g. Poppy and Jonathon, quoted earlier, student-nurse Greta did not view the provision of PCC as being impelled by the personal feelings and attitudes of nurses and instead perceived it as amenable to instruction, thus separating the 'doing' of PCC from 'being' person-centred. She stated; "Yes, you can be taught how to be person centred, you can be taught to do anything, you know, and you can execute it well". In this sense, the formal, academic version of PCC was not viewed as inherently impoverished, provided it was correctly observed. Nonetheless, the value of possessing individual caring qualities was not discounted; these qualities were seen as an additional and separate aspect of nursing and signified greater overall capacity for the job; as Greta proffered "I just think some people are more naturally...I don't know, maybe they're just more naturally sensitive to other people.". Speaking of her own suitability for the nursing role, Greta contended that: "People always say I've got the right sort of nature for that, so that always helps I suppose. I don't think things like that can be taught, like caring and compassion, I don't think that can be taught."

In these responses is the suggestion that there is a base-line level of care which can be learnt and (to paraphrase Greta) 'adequately executed', but that an inherently caring nature (which cannot be taught) means that "some people are just, you know, better at it than others." (Greta). Regrettably, the interview exchange does not serve to clarify exactly how 'naturally being better' at nursing is manifested.

Another student, Danni, conveyed a contrasting view concerning the potential for learning opportunities in relation to PCC. While Greta held that performing PCC was independent of a caring disposition and could thus be prescriptively taught and learnt, Danni averred that the realization of PCC depended upon knowledge of the concept *and* the volition to independently apply it. "I think if you're a good nurse and you genuinely still have the genuine desire to help people and give good care then I think anyone can do what they can to put it [PCC] into practice." In this sense, PCC is viewed more as a way of thinking

about nursing practice than as specifying procedure. Conceptual awareness is perceived as supporting nurses in their practice.

"I think you can be taught about the concept of it [PCC], you can talk about, maybe, like some ways for example in which you can put person centred care into practice but... it's not black and white, I don't think. Cos it depends on every person otherwise it wouldn't be person-centred care if it was just tick box, like 'have you done this, have you done this?' cos different things matter to different people. But I think having the knowledge about the whole concept of it and maybe even learning about it, even so it might just trigger something when you're on practice if you learn about person centred care, it might be like 'oh I should do this for them or I should do this for them', and it would just be good for the patient."

(Danni)

Danni claimed that several aspects of PCC were already present in her approach to nursing; "Like I would automatically, d'ya know, you just take it like into consideration without thinking about it." However, much of what she said indicated that personal qualities could be enhanced through undertaking, and reflecting on, care provision. For instance; "... being at uni and studying nursing and meeting patients and talking to patients and doing person centred care and stuff has definitely made me...not a nicer person but a more considerate person."

For most of the nurses with whom I spoke, however, PCC was seen as simply a means of formally stating that which nurses already, instinctively do; even Danni conceded that some nurses "might be person-centred in their care without realising that that's what person-centred care is. It's just something that comes naturally as part of nursing". Thus, an academic approach was seen by many as somewhat redundant. As Beryl summed-up when asked whether PCC is the kind of thing that one can learn: "I just think it's something that's within you to do that. You either can do it or you can't." A static state on which formal educational approaches to care can have little bearing.

4.1.1.4 Not 'Too Posh to Wash'

Most nurses claimed to enjoy, and derive more satisfaction from, 'basic' nursing tasks such as washing, shaving and/or simply chatting to patients. Many even directly contrasted this satisfaction with more onerous technical procedures. For instance, Brenda, a staff nurse only 7 months qualified, preferred tasks which facilitated spending time with her patients:

*"I Like doing dressings and stuff like that because you get to spend a bit of time with them and get to know them" ...
... "or just helping someone with a shave or cleaning someone's nails..."*

Whereas, when asked what parts of the job she was less keen on, responded:

"Erm, dunno. Doing drug rounds, doing tablets...it just takes so long and it's quite a drawn-out process..."

This was similarly echoed by a more experienced band 6 nurse, Hannah, who bemoaned the more technical, extended nursing roles as getting in the way of the things she enjoyed such as "getting a patient up, washed and dressed" and "chatting away to them, putting their make-up on..." Whereas; "There's some of the nursing roles you could maybe do without-the extended roles...your ABGs (Arterial Blood Gas), ECGs (Electrocardiogram)..."

A sentiment shared, too, by staff nurse Lucinda:

"I suppose that's what's wrong with the job as it is now is that you're doing a lot more that's maybe, was medical staff's job. So it takes you away from the actual thing that a lot of people want to do, that is the personal care."

The preference for routine, practical activities based on physical interaction with patients was, to a significant degree, owing to nurses' perception that the time spent doing these things presented an opportunity for nurses to get to know their patients and so enhance the caring relationship. In contrast to what she termed "high-tech" things, charge nurse Lillian explained the importance of attending to personal care:

"You know, sometimes, if you're bathing a patient or showering a patient that's when you can have a great conversation and you realise that a patient's wife's died recently, he's struggling at home, he's not been eating, he's a bit depressed, he's got stairs he can't get up to his bed so he'll sleep on the sofa, you know, those conversations take place." ...

... "It's basic things that we should be doing as nurses but external pressures take you away from what nursing's all about".

The contention that interpersonal engagement with patients is 'what nursing's all about' also serves to reinforce the notion that it is the natural, or instinctive caring abilities of a nurse that matter the most, given the previous comments reported here which broadly state that a nurse's capacity for relational caring is internally derived. While attending to 'basic care' may not entail substantial application of theoretical knowledge, its performance creates the conditions

for engaging a nurse's (valued) emotional faculties, displaying adeptness in the aspects of nursing which are seen as unamenable to formal instruction.

Many nurses similarly saw these kind of interpersonal interactions as central in articulating 'what nursing's all about' for them. As one recently qualified staff nurse, Poppy, explained when asked about what parts of the job provided satisfaction; "I think that's...like, my favourite part of it is getting to know all these people, knowing that they trust me to look after them". And shortly after when asked, simply, 'what makes a good nurse?':

"...somebody who focuses on the smaller aspects of caring, like, knowing what they like in their cup of tea, knowing they like 2 sugars in their cup of tea. Knowing what name they like to be called, like, those little things about what makes a person a person".

In addition to enabling nurses to exercise their 'natural proclivity' for expressive care, there was another discernible reason that so-called basic tasks were overwhelmingly cited as the activities that nurses enjoyed the most. There was a sense in which engagement in physical (rather than intellectual) tasks indicated a willingness to (quite literally in many cases) get one's hands dirty and get stuck into the visceral reality of nursing work. As the following from Danni, a 3rd year nursing student on placement, demonstrates, attending to 'basic' tasks indicates a 'down-to-earthness' conceivably lacking in others:

"I mean, like, personal care and bathing people I think is something that some nurses don't enjoy; it's called 'too posh to wash', is what they use. But again, doesn't bother me at all."

Dani's reference to the phrase 'too posh to wash' indicates a response to the charge that the 'academic-ization' of nursing produces practitioners who assume their status precludes certain 'lowly' tasks. In a similar vein, when asked about her experience of the 'classroom' side of nursing education one student, Greta, responded:

"I hate it! I would rather be out on placement. I find it really difficult to motivate myself to go into university, to actually just look at lectures, you know, slides and 'PowerPoints'...give me a placement any day, I don't mind getting up at 5 in the morning to work 13 hours a day".

Although not explicitly referencing personal, bodily care, the idea of getting up before dawn and working for 13 hours conveys a sense of physical hardship

and 'slogging it out' in the real world of nursing. The physical demands of a clinical placement are preferred to the intellectual (and, implied, boring) work entailed by university attendance.

Indeed, *none* of the interviewees claimed any great enthusiasm for theoretical, classroom-based activities, regardless of their qualification-route into nursing, emphasising a strong preference for practically-based learning on the wards. Current students and more newly-qualified nurses were uniquely well-placed to comment on this distinction owing to the fact that degree-level nursing courses are split evenly between university and placements. Every one preferred being out on placement.

4.1.1.5 "Not that kind of job"

Finally, some nurses appeared to reject an academic focus for nursing on the basis that it simply is not a discipline which, fundamentally, requires a high degree of intellectualism and in some cases an academic approach was identified as being detrimental to the essential requirements of the role. Mildred was explicit in linking degree-based nursing education with a decline in nurses' ability to both provide basic care and connect with patients:

"The best nurses are not the ones with degrees... (it) made me quite sad when they've now decided to make everything degree-based because those nurses, some of them are completely bloody useless. They can't...they don't know how to talk to a patient."

(And later);

"The academically-based people who are academically minded; they're good at the university stuff but not good at the nursing practical stuff."

In this excerpt, academic skills are completely disassociated from the practical requirements of nursing and it is insinuated that these are two mutually exclusive logics. The ability to provide relational care was considered to be something that transcended the limits of academic learning; aspects of care such as talking to, listening to and generally just being with patients were overwhelmingly cited as those which could not be taught or learned in a classroom. Instead, these 'people skills' were perceived as an innate quality of the individual nurse:

"I suppose it depends on the person. I mean, there's some girls that work here that are very young and they're absolutely bang on, you know, they know. They may

not have been through it themselves but they understand. Whereas, there's other ones and you can tell they're very erm...they're looking at it from an intellectual point of view and you're like 'but it's not that kind of job'..."

(Lucinda, Band 5 staff nurse)

As well as the idea that academic learning cannot overcome a lack of inherent natural ability, some nurses made the related claim that the core attributes required of nurses can only be realised in actual practice, on the ward. Also dismissive of a pronouncedly academic approach to nurse training was recently qualified Brenda, who said:

"I find academics not me...it's not the best way I found learning, I can't really sit and get from a book what I could learn on a ward".

Specifically, nurse/patient interaction was considered to be something which could not be articulated via theoretical abstraction:

"... so just interacting with patients; you couldn't, you know, you don't learn how to do that in the classroom (...) they definitely talked, like, touched on it and we had a lot of simulated patients that would have come in so it was...they did try but it's a hard thing to get, you know, to teach somebody isn't it?"

(Brenda)

Valerie, too made a similar point but appeared to allow that, as well as simply having an in-built, personal aptitude for relational care, there was scope for these abilities to be developed, though only through practical experience.

"Everybody's different, some people probably would learn it, like if you done skill (unclear) classes at Uni, like how to be patient centred and things like that but, I dunno. I think it's a skill you pick up rather than, you know, going to lessons and them being like 'right this is how you deliver patient centred care', I dunno; you have to have that, I dunno what the word is,.... I dunno, a certain skill I suppose...."

4.1.2 Commentary

Generally speaking, the nurses with whom I interviewed did not embrace the relationship between nursing and academia and the value of theoretical models of nursing practice was largely marginalized. The downplaying of formal academic approaches would appear to represent the mobilization of a discourse which serves to affirm particular aspects of nursing identity, allowing nurses to; emphasise the value of intrinsic, personal qualities as necessary to the role; distance themselves from the perception that involvement in higher

education has led to an emphasis on intellect at the expense of expressive 'care', and preserve the sense that nursing, as an occupation, is essentially committed to this kind of care above all else.

For almost all respondents, PCC is simply seen to describe something that has been central to, and inalienable from, nursing's core occupational identity based on the inherent compassion and empathy of its practitioners. In this way, most participants, tacitly at least, endorsed the view that nursing is a vocation based on an innate desire to care (see Woodward, 1997; MacKay, 1998). Nurses therefore, for the most part, felt that they already did, and could do, PCC without having it formally delineated, i.e. through education, and were therefore sceptical of the potential of increased intellectualism.

Given that none of the participants referenced their formal academic experiences as the basis for their own 'person-centredness' (even though a small minority granted that educative approaches could be of value for some nurses) disparaging comments about intellectual approaches may be understood, at least partly, as rhetorical strategies designed to enhance the legitimacy of the declaration that caring for people derives from an internal and personal motivation to do so. As MacKay notes, from her own research; "In descriptions of the good nurse, great stress was laid on the importance of the personal qualities of the nurse, with a curious lack of emphasis on their academic abilities and training" (MacKay, 1998, p63). Thus, just as nurses' disdain for 'management' as evidenced in Bolton's work (2005) served to uphold a nursing identity based on the possession of 'unstinting compassion' (Bolton, 2005, p15), a similar distancing from the idea of intellectuality in nursing might be perceived as serving the same purpose.

Nurses affirmed a strong preference for engaging patients in prosaic activities of daily living, washing, dressing, etc. Perhaps the reason for nurses placing so much emphasis on the value (to both themselves and their patients) of so-called basic tasks is that these are seen, simultaneously, as the least intellectual, and as the primary means of demonstrating compassionate, individualized care which is attributed to the innate personal characteristics of nurses.

The predilection for basic caring tasks, and concomitant lack of enthusiasm for more technically complex undertakings, may also be held up as a means of dismissing the charge that nurses are becoming too clever to care as a result of an increase in technical responsibilities.

The view that the supposed intellectuality of degree-level education produces graduate nurses who are 'too posh to wash' (Morrall & Goodman, 2012, p936), in other words, who value the prestige of more cerebral tasks, is not borne out in the vast majority of interview responses. The phrase 'too posh to wash' is used frequently in discussion concerning the effect of degree-level education; a clear link is established between higher levels of education and 'poshness' which, purportedly, renders people uncaring (see Ford, 'Nursing Times', 2012). Of course, the word 'posh' has no real objective meaning but has been used to associate university education with aloofness and detachment. It is perhaps because of this vaunted association between degree-level education and superciliousness that the value of academia to nursing is downplayed by nurses.

In this light, engaging in basic nursing tasks while disparaging more technically complex activities is very much in line with Sharon Bolton's (2005, p15) contention that the "perceived dirty work of nursing" is, in fact, an important source of symbolic capital for nurses in the hospital setting, and such tasks (or, at least, the esteem in which they are held) are essential in maintaining a 'true' nursing identity. While Bolton makes the case that the valorisation of, and attachment to, these activities constitute a disavowal of increasing *managerialism* in modern healthcare, it might also be readily argued that the stated preference for performing, and enjoying, hands-on, fundamental caring tasks over more technical activities which, arguably, demand more cerebral effort (calculations, etc.) serves to distance nurses from an overly-academic occupational identity.

The notion of instinctive, genuine caring was often juxtaposed with intellectualism, evincing "The frequently expressed rejection of the 'academic' and the scorn aimed at the 'clever' nurse" (MacKay, 1998, p68). Interestingly, the 'clever' nurse was conspicuously absent from my sample of interviewees.

By this I absolutely do not mean that the participants exhibited low levels of intelligence! Rather that *none* of the interviewees claimed any great enthusiasm for theoretical, classroom-based activities, regardless of their qualification-route into nursing, emphasising a strong preference for practically-based learning on the wards.

This finding is in sharp contrast to the conclusions of Daykin & Clarke's study (2000) from which they reported that "Nurses' ability to offer holistic care was attributed to their enhanced theoretical knowledge, acquired through the higher education process" (Daykin & Clarke, 2000, p354). Conversely, when discussing the university treatment of person-centred care, many of the nurses I interviewed were dismissive of the idea that formal education could enhance their understanding of the concept as it was generally held that provision of person-centred care should be intrinsically motivated; one shouldn't need to be told how or why they should care for people.

The very few nurses who did seem to see more of value in academic theorizations of care did not abandon the idea that natural abilities were beneficial to one's nursing ability. While Danni claimed that theoretical models of person-centred care might help nurses to more acutely consider their actions, she nonetheless upheld the importance of having a 'genuine' desire to help people. The role of education, relating to PCC, might then be to facilitate a critical awareness of nurses' practices. Danni's perspective on PCC might be said to most closely align with the notion, discussed by Morse, et al. (1991) of 'caring as a human trait' wherein a humane approach to caring can be heightened by one's experiences of care in the world but must necessarily be present in the first place.

Ostensibly, Greta's views of PCC might be accounted for by another of the types of caring described by Morse, et al. (1991), namely that of 'caring as a therapeutic intervention' in that she claimed that, regardless of a nurse's own character, they might still be capable of learning and carrying out PCC prescriptively. However, along with the nearly all of the respondents, Greta also intimated that 'having the right nature' meant that some nurses were

implicitly more suited to nursing and would better inhabit the role. Thus, while PCC itself might be conceived of as a therapeutic intervention, caring, over all, demanded something extra.

Therefore, even when respondents were less disparaging of educative approaches to care, there remained the caveat that the better nurses had something inherent in their nature that allowed them to be so; both Danni and Greta testified that they, personally, felt they had naturally caring natures which made them suited to their jobs.

The majority of nurses in the study were unconvinced that an academic approach to care would serve to greatly enhance nursing practice, primarily based upon the view that the caring element of the role is already accounted for by nurses' inherent dispositions. In this sense, the idea of nursing as a calling, or vocation, heeded by certain individuals was, at least implicitly, if not expressly, upheld by the majority of interviewees. Most attributed their own caring abilities to a tacit and in-built predilection to care and perceived that theorizations of care, such as PCC, were simply formal ways of articulating these natural abilities, rather than resources for informing practice. These findings are potentially problematic, in the first instance, for those charged with designing university programmes that seek to instil the values of person-centred care but moreover, for the professional project of nursing. Marina Dowling (2006, p48) has suggested that the "one-to-one relationship between nurse and patient...has been a catalyst for the professionalization of nursing". Yet if these relationships are largely predicated on a nurse's own inherent personality and innate caring characteristics, it is unlikely that this can provide the basis for claims to professional practice. Despite 'professionalism' being a fairly open concept which may be elaborated in various ways, in different contexts (see Dingwall, 2008), for an occupation to claim professional status requires a definitive *something* around which that occupational group can cohere.

Although most nurses saw basic care and patient interaction as the central tenets of nursing practice, it seems that this focus reflects the impetus of individual nurses to act upon their personally-felt desire to provide expressive

care. Thus, the cohesiveness of nursing as an occupational grouping appears to be predicated, somewhat illogically, on the personalities of its individual members. If nurses privilege individual attributes over a collective identity, then claims to professionalism are arguably less likely to be legitimized.

It is the uncertainty concerning nursing's professional aspirations that the following section seeks to explore. If, as has been conveyed here, nurses are indifferent to the academic theorization of their work, then it might be hypothesised that they are implicitly rejecting the predominant means of articulating nursing as a discretely recognizable professional practice. In the next section, nurses' views in relation to the concept of professionalism are reported and analysed with a view to understanding how nurses' discourses of professionalism contribute to occupational identity. The section starts with a brief introduction to explain my understanding of 'profession' as an analytical category.

4.2 'Professional' Nursing

As Abbott and Meerabeau (1998, p1) state:

"The concept of profession was largely taken for granted in sociology until the 1960s. Sociologists were concerned with defining what a profession was (and) what occupational groups could lay claim to professional status"

This concern engendered definitional approaches which attempted to establish an immutable set of criteria that could be used to determine whether an occupation was professional or not (e.g. Goode, 1960; Carr-Saunders, 1955); these have typically been termed 'trait' or 'attribute' theories. Much of the contemporary sociological writing on 'professions' has, however, sought to dispel the notion that we can categorize professions based upon some set of inviolable criteria. The inadequacy of trait theories has been recognized on several levels including the fact that any social theorist is free to draw up their own list of attributes, in which case *"a profession is nothing more or less than what some sociologist says it is"* (Dingwall, 2008, p12), not to mention that each of these lists may not be in accordance with one another. Abbott and

Meerabeau have pointed out that the kinds of traits that are usually appealed to are narrowly conceived through reference to “the ‘archetypal’ professions- medicine and law” (Abbott & Meerabeau, 1998, p4) and thereby give credence to a rarefied version of ‘profession’ that reflects certain social class interests.

In an attempt to move away from defining professions by the external imposition of a list of conditions that must be met, Eliot Freidson has argued that, regardless of possession of certain traits, the meaning of profession lies in the control of its every day practices:

“...structural considerations, Freidson argues, only set the broad limits of professional performances. Their details, the routine conduct of professionals, depend upon the concrete features of their everyday work settings”
(Dingwall, 2008, p12)

For Freidson, professional work is defined by *how* it is conducted, rather than by extrinsic attributes; *“I use the word profession to refer to an occupation that controls its own work, organised by a special set of institutions sustained, in part, by a particular ideology of expertise and service”* (Freidson, 1994, p10).

However, as Dingwall (2008, p13) attests, Freidson is effectively reinstating the thinking of trait theorists by claiming to have identified an inviolable criterion- i.e. professional autonomy-by which to define a profession. Dingwall, quite simply, demonstrates the unviability of this proposition with the example of UK doctors whose autonomy is curtailed by the organizational contexts in which they work but who, nevertheless, maintain a strong claim to ‘professional’ status (Dingwall, 2008, p13). Furthermore, one might argue that some occupational groups may have significantly more control over their working practices than, for instance, doctors but for whom the title ‘profession’ has not been applied. As Howard Becker famously claimed, professions are “simply those occupations which have been fortunate enough in the politics of today’s work world to gain and maintain possession of that honorific title” (1970, p92- quoted in Watson, 2002, p98).

All of this suggests that the differences between ‘occupation’ and ‘profession’ may be more rhetorical than empirical and, indeed, many commentators are attempting to redirect focus of the subject onto the discursive elaboration of

professionalism as it occurs in different contexts (Evetts, 2003; Watson, 2002; Dingwall, 2008). Watson (2002, p100) endorses a ...

“... focus on notions like that of “profession” as resources that social actors themselves use to further their purposes, rather than as resources that the social analyst uses to analyse the occupational activities of those actors.”

There is a general recognition amongst many of these authors that ‘profession’ and ‘professionalism’ are concepts that are employed in different ways by diverse groups in differing environments. As Dingwall (2008, P14) suggests, rather than seeking to define a profession, “All we can do is elaborate what it appears to mean to use the term and to list the occasions on which various elaborations are used”.

This should not, however, be taken for some kind of postmodernist argument that profession (as discourse) can encompass any old meaning. Importantly, professional discourse is operationalised ‘to achieve certain purposes’ (Watson, 2002) and so must be contextually meaningful in order to be advantageous. In many cases, claims to professional status depend upon distinguishing one occupational group from others, as Dingwall (2008, p20) puts it, “It is ... the assertion of a claim to a particular kind of social location in relation to other social groups”. The context of nursing is instructional in this respect; as an occupational group that has traditionally been seen as “subordinated to medical control” (Abbott and Meerabeau, 1998, p11) it seems imperative that, for a successful claim to the status of *profession*, the discursive resources that nurses draw upon in elaborating this must be able to identify a discrete social location, distinct from that of doctors. It also appears increasingly apparent that, if professional distinction is a goal, nursing’s professional discourse should, similarly, be able to differentiate the work of nurses from that of CSWs (care support workers) who are progressively taking on more of the ‘basic’ work of nurses.

The following section presents nurses’ perspectives on professionalism; principally, what it means to be ‘professional’ as a nurse and the perceived advantages and disadvantages to recognizing nursing as a professional activity.

Following the presentation of the data, I comment upon the ways in which nurses' use of 'professional talk' acts to shape a nursing identity.

4.2.1 Data

4.2.1.1 Vocation

There is an indication, in the responses of some of the participants in my research, that the discursive separation between 'profession' and 'vocation' remains a salient feature in nurses' conceptualization of their work. As this extract of an interview with Steve, a senior charge nurse, illustrates, the idea of 'profession' was not able to adequately account for nurses' personal commitment to their role.

DH: *Do you think there's anything that you would say, specific to nursing, that makes nursing a professional occupation?*

S: *(pause) Well, they say it's more a...what's the word? A calling is another word for it.*

DH: *A vocation?*

S: *That's it. Erm, and I think, you know, I was in at half 6 this morning when I'm meant to be in at half 7, I'll probably be here 'til 6 when I'm meant to finish at 5 today, you know? I think the type of people that nursing attracts and the people that stay in nursing, it's not for the money. Yeah, OK, if you look at various professions, nurses maybe moan about their pay in relation to what they do but if you look in the wider scheme of things, it probably isn't that bad. But I think nurses are not the type that'll (say) 'right my shift's finished at 8 o'clock'. If they've got somebody that, you know, if you're needing a (unclear) put out or there's an emergency, or some of the staff will say 'oh, it's 8 o'clock but I've not finished my notes yet, I need to finish my notes. I don't know the type of person it attracts but I just know most nurses I know, I'd say 90% of them go above and beyond.*

Here, Steve's reluctance to describe nursing as a 'professional occupation' seems to stem from a connotation of professionalism with a formal standard of work, for instance observing the structure of a working day and being remunerated accordingly. By contrast, nursing is 'not for the money' and nurses go 'above and beyond'; the implication being 'above and beyond' what might be expected of normative 'professionalism'.

As with Steve, the idea of vocation was sometimes invoked explicitly; "It is a vocation, it isn't just a job" (Lucinda) and often in contrast to the idea of a profession:

“years ago, you came into nursing for the love of nursing whereas (now) I think nursing’s seen as a profession with reasonably good job security, it’s reasonably paid, a lot of people will say otherwise but...”

(Lillian)

Again, ‘a profession’ is here associated with the formal structure of work -job security and payment- whereas nurses’ claims concerning the unique nature of their work are based upon transcending such material concerns. Going ‘above and beyond’ or ‘over and above’ for patients was frequently alluded to by several nurses and this impulse was attributed to the character of individual nurses: “Every nurse is different and some people go above and beyond, and some people do what they have to do” (Beryl, RNS). Acts of kindness that go ‘above and beyond the call of duty’ (Lillian) are thus internally motivated and reflect a nurse’s natural compassion and empathy for their patients.

4.2.1.2 Jack of all Trades

Few nurses attempted to make the case that nursing had a distinct professional prerogative and when intimations to this effect *were* made, interviewees struggled to elaborate upon what this entailed. A significant proportion of my respondents commented upon the wide array of responsibilities encompassed by modern nursing and it is perhaps this multifariousness that makes it hard for nurses to identify a distinct area of activity that might, potentially, be considered grounds for applying the title ‘profession’. One long-serving staff nurse, Bill, affirmed that he thought nursing should be considered a professional occupation and explained his take on what it meant to be professional:

“I think a thing that’s professional is usually involving...someone who’s professional is usually somebody who has a large body of evidence, and knowledge even, about a certain job that they do. Err, so I think a professional is someone that has lots and lots of knowledge about lots of different things. Certainly, in nursing, you have to have a lot of knowledge about numerous medical conditions, the treatments, erm, about dealing with the public in general”.

As can be seen here, there is an acknowledgement that to be considered professional, a *certain type* of knowledge is necessary, however, the wide-

ranging work of nurses makes pinning down something that is exceptional to nursing problematic. For instance, 'knowledge of medical conditions and treatments' is widely accepted as the terrain of doctors and so cannot be accepted as demarcating nursing professionalism. As Beryl ruminated:

"I think, like, the nurses have a wealth of knowledge regarding all those things which I suppose are relatively basic compared to what the medical staff know". Beryl summated; "I do think that the (nursing) role is unique but I don't think the professionalism...I think in every role it should be the same".

A number of respondents echoed the idea that the distinctiveness of nursing work lies, somewhat paradoxically, in its diversity. As Mildred put it;

"So, I think, as a nurse, like you said, you have to be jack of all trades, master of none sometimes"

and added;

"...the other thing that's very frustrating about nurses these days is, if nobody else can do the job, say for instance, wouldn't surprise me if now cleaning the floor was a nurse job. Because everything seems to be the nurses' job..."

Recently qualified staff nurse Brenda similarly declared:

"I find that, as a nurse, you're, kind of, like the middle man between everybody; between the OT (occupational therapist) and the family, you're, sort of, like a switchboard almost-putting everyone in contact with everybody else".

This kind of liminal position within the healthcare milieu, straddling various levels of responsibility ("If the CSWs off, we can do all that role, we can do our own role and we can also do some of the FR1s role..."-Beryl) arguably acts to suppress any strong claim to a distinctive professional location. The kind of professional discourse that relies on the assertion of a unique body of knowledge is thus hard to maintain.

On the other hand, Beryl's claim (quoted above) that the nursing *role* is unique was upheld by several other of the nurses, though this uniqueness was not articulated as *professional* distinctiveness. Danni, for instance, while seemingly recognizing a nominal professionalism, articulated quite a clear distinction between 'being professional' and 'being a nurse' with the latter being recognized in the exercise of compassion.

DH: *OK, so you said also part of it was being a 'human being' as well. Do you consider that...and you also said compassion, like, staying compassionate...do you think that's all part of being professional?*

D: I don't know if it's part of being professional but it's part of being a nurse. And if, depends if you're trying to come across as professional, like 'professional, professional' like a doctor or if you're trying to come across as your profession, like a nurse. If you're trying to come across as a nurse then it definitely is. Cos if you are showing no compassion or no interest in, like, the patient if you're talking to their family then they won't care what you have to say cos they'll just think 'you don't even know what you're talking about cos you don't even know my relative, you obviously don't care about them'.

Here, showing compassion and interest in patients exemplifies 'being a nurse' although this role is considered as something distinct from being professional. While many of my respondents were reluctant to equate holistic care with a 'professional' identity, they certainly did consider direct relational work as fundamental to their occupational identity and drew upon this to distinguish themselves from other healthcare workers:

"Erm, it's more the smaller things, it's just like, you know, we're hands on with the patients, we know them well. You're (doctors) making these decisions and you don't really know the patients, as well as what we do..."

(Hannah)

4.2.1.3 Professionalism

While, on the whole, participants struggled to identify anything unique and/or specific to nursing that might provide the basis for its consideration as 'a profession' (i.e. shared professional knowledge, values or particularistic guiding theories) the majority were more consistent in elaborating on certain behaviours considered to represent 'professionalism' and it was these aspects that were more readily described when discussing what it meant to be professional as a nurse:

- "I suppose it's the front that you have, it's the uniform isn't it?" (Lillian)

- "Like your manner and things, if you act in a certain way it's not going to look good in front of the patients" (Rachel)

- "Professionalism (is) in your communication, professionalism in your appearance and the way you look. Professionalism is how you present yourself to people" (Danni).

It is crucial, then, to distinguish between the notion of nursing as 'a profession' and the 'professionalism' displayed by nurses themselves. 'Professionalism' was used to describe nurses' outward comportment:

“...make sure that you always maintain in a professional way with everything that you do, with how you conduct yourself, with how you interact with people. And your communication skills I suppose. And the way that you look, you’ve got to smell nice, you’ve got to look nice, your hair’s got to be tidy, your uniform’s got to be ironed, you know, your shoes have got to be polished, you know.”

(Lillian)

This type of presentational professionalism is represented by a very general set of behaviours that could arguably stand for ‘professionalism’ in any situation or occupation, whereas to make a claim to the status of *a profession* involves making a claim to a particular kind of social location as Dingwall (2008) discusses.

As several of my respondents averred, the type of professionalism they observed was not exclusive to nursing, as illustrated, for instance, in this exchange with Brenda:

DH: *No, ok. Still taking about professionalism, is there anything very specific do you think to nursing as a profession as opposed to, say, being a professional doctor or a professional CSW, is there something unique to nursing that makes it...?*

B: *What do you mean, like, the way that we act professionally?*

DH: *Yeah, is there something about nursing that...?*

B: *I wouldn’t say it’s any different...*

DH: *Just, I suppose what you’ve said about drawing a professional line could be attributed to a few professions, is there something...*

B: *No, I would’ve said the doctors and CSWs would have to go by the same guidelines, there’s not, you know, it’d be different, obviously, than a professional person that works in a bank cos, you know, you’re getting to know your patient in a more intimate manner than what somebody that works in a shop would. But I would say for doctors and us and CSWs it’ll be all the same, or anybody that works in healthcare.*

In this way, nurses did not tend to attempt to claim nursing as an uniquely constituted professional grouping with its own specific body of theoretical knowledge. The precepts of nursing professionalism were identified, not in what nurses do, but in the way in which they do it.

In one singular instance, a deputy charge-nurse, Hannah, suggested that, alongside this kind of presentational professionalism, another element of

professionalism in nursing was related to greater involvement in management activities.

D: *So you kind of associate the professional side with...*

H: *The push to get into management, the drive to get into management and have a full a career over it, erm, where some of the nurses are quite happy, staying the grade they are-with the patient care and that sort of thing so they might call it 'non-professional' well, not 'non-professional' but you know what I mean.*

This usage of 'professional', however, does not indicate something endemic to nursing as an occupation, considering that the majority of nurses do not occupy formal management positions (i.e. bands 6, 7 and 8). Rather, Hannah seems to be referring to *herself* (and others who pursue promotions) as having a professional mind-set that stimulates career progression. In this way, professionalism is considered as having more to do with career ambition and, again, could conceivably be extended to other occupational settings. Moreover, a divide between professionalism in this instance (represented by managerial aspiration) and authentic relational nursing care is still supported in Hannah's narrative when she describes the essential nature of nursing, in contrast to administrative activities.

"... you know I'm a nurse true and true [sic?], I'll never sit in an office constantly, even today, I'm in charge, I'll still go and get hands-on with a patient so, I can sort of try and still do that. I mean, that is the better side of nursing, better than paper pushing but erm, I feel I've got a happy balance."

4.2.1.4 Professional Boundary

It was frequently asserted that, in adopting an outwardly professional persona, nurses were erecting a boundary between themselves and patients. Most nurses perceived this to be necessary in order to maintain a trusting relationship with those under their care as the following from Maria (first quotation) and Poppy (second quotation) explained:

"I don't like to share everything about me. Of course, I share some things, er, but I don't want to share everything about me because, er, even, I try to develop a relation for trust and confidence and I like to, thinking how can I say this, erm, you need to develop also a professional relation and they need to understand that we are professionals here and we're not just friends."

-“...Like knowing the difference between a professional trusting relationship and having them on facebook as a friend - those sort of boundaries. So, it is a profession; so you’re a nurse, if you’re in your uniform, you should be, sort of, representing NHS. That sort of profession. Mmm, but yeah, just not being silly really. Because people need to know that you’re a nurse, trust that you’re a nurse. Like, you can’t...they always taught us at uni, you can’t really have pictures on facebook of you, out last weekend, lying on the pavement. That wouldn’t be professional at all. So, yeah.”

Like Brenda, Poppy later made it clear that to demonstrate professionalism in this way was not something particular to nurses:

DH: *Yeah. Just thinking about professionalism, do you think there is anything particular and specific to nursing as opposed to, say, other jobs in the NHS-being a CSW, being a doctor? Do you think there’s something specifically about nursing that makes it different as a professional group?*

P: *I wouldn’t say so ‘cos we’re all sort of working for the NHS so it should, sort of, be the same professionalism that we’re giving off.*

Most respondents concurred with this assessment that in order for patients to trust in one’s abilities as a nurse, one should avoid becoming over-familiar with patients, as Bill remarked:

“Well, they don’t need to know about me as much; they know my name, they might know I’m married with a kid, you know, but I’m here to try and help them rather than, obviously the other way ‘round.”

Although, even while acknowledging the importance of a professional boundary, some nurses implied that these boundaries were flexible under some circumstances:

R: *Sometimes the professional side goes out of the window ‘cos you just want them to be alright*

DH: *But do you think that’s OK in some circumstances? To maybe drop the...?*

R: *If it’s gonnae make them feel OK and, like, you’ve gave the care that they’re looking for, then why not?*

(Interview with Rachel, band 5 staff nurse)

In this instance, the immediate needs of the patient eclipse the concern with maintaining a professional persona, revealing the fundamental priority of the nurse. Presumably the ‘care that patients are looking for’ referred to above does not entail some clinical intervention but a more emotive response.

Charge-nurse Lillian expressed the same kind of sentiment, intimating that the emotional needs of patients could override the need to maintain 'professional' comportment.

"I was taught that you don't cuddle patients, you don't cry in front of patients. I've never listened to that! You know, there are times when you have a tear in your eyes because you're human and there are times when you do cuddle your patients 'cos they need a wee cuddle."

A few respondents indicated that the relaxation of certain aspects of professionalism was more acceptable for nurses as compared to medical staff, as Jonathon explained:

"...although I think it's crucial for doctors to be professional in the way that I am professional, I think they also need to show a bit more decorum, or a bit more level-headedness, you know. Can't always be cracking jokes and stuff if they're telling bad news to a patient, you know ... and I think doctors, it's more important for them to be sincere and then nurses are there to cover your 24-hour care and maybe bring a bit of light to the day, you know. But that's just my opinion."

A similar sentiment was expressed by Valerie:

"Patients enjoy you having a laugh with them and you know, developing a professional relationship but if you, you know, if you can't have a laugh with them and a joke but be professional at the same time, they're not really...you're not gonna get that relationship with them, they're not gonna, you know, you're not gonna open up to them type thing and they're not gonna open up to you. And that's what you really need in nursing because you're providing care for them."

In both of these excerpts is endorsed the idea that nurses may occasionally behave less formally than doctors in order to establish rapport with patients. In comparison to doctors, nurses have more of a licence to 'have a laugh' and bring some levity to their dealings with patients although, as Valerie points out, this is achieved alongside, but in contrast to professionalism, i.e. 'have a laugh and a joke **but** be professional at the same time'.

4.2.2 Commentary

4.2.2.1 The Use of Professional Discourse

While the majority of my respondents, sometimes reluctantly, accepted that nursing should, nominally at least, be considered a profession, there was a significant degree of ambivalence about how and whether to use the term. Indeed, this reflects debates within nursing more generally as the question of

its status has become increasingly significant; as Savage has suggested, “the question we should ask is not ‘Is nursing a profession?’ but ‘Should nursing want to be a profession and, if so, what do we mean by it?’ (Savage, 1995, p92). It seems that, despite the accruing of what might be considered some of the formal trappings of professionalism (i.e. degree-based education, codification of professional conduct, etc.), these questions are still pertinent to many nurses. The range of responses from my interview sample suggests that nurses do not collectively endorse any singular notion that would support the articulation of nursing as a profession in its own right.

From her study of nursing students in the mid-1980s, Kath Melia identified the difficulties of coherently elaborating a nursing professionalism as owing to segmented interests within the occupational group (Melia, 1987). On one hand she described “a small but ever-growing, academic faction ... promoting nursing as a profession independent of medicine”, whilst on the other was the nursing workforce itself who, according to Melia (1987, p158), perform nursing work “on the basis of medical prescription”. It is not difficult to comprehend how this split, thus identified, is problematic for nursing’s claims to professionalism. While the academic ‘professionalizers’ “seek to achieve autonomy for nursing by elevating the status of ‘basic’ or ‘primary care’ and placing less emphasis upon medically prescribed work” (Melia, 1987, p163), the students interviewed by Melia classified basic care activities as ‘not really nursing’ (perceived as requiring little skill) and instead appeared more invested in technical tasks. Melia suggests that students’ accounts of professional behaviour reflect the dominance of a medical model of professionalism in that students viewed ‘doctor-devolved’ work as prestigious and “appeared to be content with the reflected professionalism which is gained from the close working relationship with the medical profession” (Melia, 1987, p180).

Thus, in Melia’s assessment, there are two distinct professional logics existing in opposition to one another. If we acknowledge, as Watson (2002, p95) declares, that “the word “professional” is used to cover a potentially bewildering variety of things”, then we need not assert that either usage of professionalism is more correct or better than the other; the difficulty for

nursing lies in the fact that these discourses represent 'analytically different claims' (Melia, 1987, p158). If the ambition for nursing is to free itself from the dominance of medicine and establish its own independent basis for its professional identity, then the professional discourses subscribed to by the students in Melia's study are unlikely to meet with any success. The academic approach, which emphasizes the uniqueness of nursing knowledge based on 'care' and the nurse/patient relationship, would appear to represent a more fruitful base from which to make claims to a distinct and discrete professional status although, as a number of authors have argued (Wigens, 1997; Smith, 2012) the organization of modern healthcare services often serves to curtail nurses' ability to develop meaningful therapeutic relationships with patients. Nevertheless, nurses may still, discursively, appeal to a commitment to this type of care as forming the basis of their professional identity in spite of pressures on time and resources, as evinced by the nurse respondents in Daykin and Clarke's study (2000).

It is perhaps indicative of the time at which it was carried out that the participants in Melia's research did not make such appeals and instead deferred to medicine as the aspirational model of professionalism. Since that time, nursing has, in some ways, evolved to reflect the interests of the 'academic professionalizers'; primarily, of course, via the advent of degree-based nursing education but also in the organization of a nurse's workload, wherein an individual nurse is allocated their own set of patients for/to whom they are responsible, in apparent opposition to former 'task'-based approaches. Perhaps, by virtue of possession of these newly acquired resources, which may serve to bestow a degree of professional legitimacy, nursing maybe now feels less inclined to align itself with medicine in order to affirm its status and identity (though it should be stressed that this is somewhat speculative hypothesizing).

Certainly, from my own research, there is little evidence that nurses take their professional cues from medicine, or that technical or more 'medicalized' tasks are seen to carry any great prestige. In fact, for the most part, nurses placed greater value on (basic) personal care which was perceived as 'what nursing's

all about'. This is in marked contrast with Melia's respondents who didn't deign to consider this type of care as 'real nursing'.

Crucially, however, the importance that the participants in my study placed on 'basic' care activities was *not* linked with being professional. Instead, as has been previously discussed, nurses' ability to provide basic care was predicated upon a host of 'natural' personal attributes. Thus, despite nurses being of the opinion that these fundamental caring activities are central to their *occupational* identity, it cannot be convincingly argued that these are also the basis of a *professional* identity as envisaged by the academic professionalizers.

The comparison here to Melia's depiction of the tensions within nursing professionalism in the '80s is to illustrate that, at least in reference to my interview sample, neither the academic, nor the medicalized versions of professionalism have been widely realised. Instead, nurses tended to refrain from describing professionalism in terms of the content of their work (i.e. either basic care or technical tasks). While responses varied, most interviewees conceived of professionalism in terms relating to the outward behaviour of individual practitioners rather than appealing to any internally cohesive features of nursing as an occupational group. This is not to imply that nurses' conception of 'profession' is somehow impoverished or misled, concurring, as I do, with Evetts when she says that "The meaning of professionalism is not fixed and the discourse of professionalism does not always operate in a deterministic fashion" (Evetts, 2003, p32). What we should ask, though, is how the discourse of professionalism is operating in this particular case; how are nurses 'making use of this notion to account for what they do?' (Watson, 2002, p94). To what ends is nurses' usage of 'professionalism' being mobilised?

4.2.2.2 Endurance of Vocation

As evidenced here, it appears nurses' discourses of professionalism are not being utilised to advance the cause of nursing's claim to a distinct and autonomous professional status like the 'academic professionalizers' identified by Melia. Indeed, some nurses demurred from endorsing a claim to professional status ("Well, I know I am (a professional) but I wouldn't, sort of, class myself like that"-Lucinda) while others struggled to explain how nursing

professionalism was different to that of other occupational groups. If the aim of nursing's 'professional project' is to extricate nursing from a professional hierarchy dominated by medicine, it would seem that, by and large, this aim is not supported by the discourse of professionalism that I encountered in my conversations with nurses on the ward.

Arguably, in circumventing any strong claim to nursing as 'a profession', participants were, in fact, strengthening the case that nursing's specialness as an occupation lies in the fact that it consists of individual practitioners who are naturally compassionate and empathetic and who, owing to this, go above and beyond for their patients. Attempts to claim that caring abilities are professionally inculcated represents a threat to nurses' sense of their individual capacities that make them always capable of 'going over and above' the call of duty. As Steve seemed to suggest, professionalism implies a form of standardization for practice that undermines the personal volition to care.

As nursing began to take on the accoutrements of professionalism, some commentators feared that the pursuance of nursing as a vocation (i.e. a personal dedication to the cause) would inevitably begin to decline; this is based on a popular view that 'professionalism' is incompatible with the idea of 'vocation'. As Vivien Woodward (1997, p1001) claims; "...the affective nature of caring means that it cannot be undertaken as an intentional, professional act and neither is it amenable to command or contract". Similarly, Mackay (1998, p54) has hypothesized that "...changes within nursing, nurse training and the NHS may be acting to reduce the salience of the idea of vocation among nurses."

The discourse of professionalism that Melia (1987) identifies as being promulgated by the 'academic professionalizers' within the occupation entails that nurses espouse the value of *nursing theory* in accounting for their unique ability to care, and thereby enhance claims to professional status based upon a distinct nursing knowledge base. The majority of the nurses that I spoke with, however, were reticent in affirming nursing's formal status as 'a profession' because this notion appears to belie the personal attributes of individuals that attract them to the occupation, and make them good nurses. The idea of

vocation, then, has seemingly not been discounted in order to accommodate overt strategies to 'professionalize'. In fact, the notion of professionalism was often used in contrast to nurses' caring behaviours and as something that could be suspended to facilitate the expression of 'genuine' care. With caring behaviours perceived, for the most part, as being impelled by a *personal* sense of compassion, there seemed to be little else unique to nursing that distinguished it as an independent profession.

In maintaining that caring for people transcends the perceived limits imposed by the concept of 'professionalism' (associated with a formally prescribed standard of work), nurses did not seek to articulate any strong alternative basis for professional practice. Rather, the miscellany of tasks and activities that occupied the rest of nurses' time were seen to negate the identification of any one singular function that might be said to represent professionalism.

Instead, nurses subscribed to the idea of *professionalism* as a very general set of behavioural guidelines that may conceivably be applied to any occupational group. In doing so, nurses allowed themselves a degree of flexibility in explaining how this fits-in alongside their natural proclivity to care. On one hand, an outward sense of professionalism, entailing the necessary construction of some 'barriers', demonstrates to patients that nurses take their role seriously and can be trusted. On the other hand, the establishing of some formal barriers allows nurses' inherent caring nature to come through when these barriers are deliberately tested or even broken. In both cases, a commitment to the welfare of the patient provides the justification.

This is in contrast to some previous assessments of nurse-patient relations in which detachment on the part of the nurse was assumed to be employed "as a form of self-protection" (Savage, 1995, p1) from the effects of emotional involvement. Instead, the nurse respondents in my sample steadfastly affirmed that any benefits derived from the construction of a professional barrier between themselves and patients accrued to the patients, who were supposedly assured of a nurse's clinical competence.

From the standpoint of those who would see nursing establish itself as a professional practice, comparable to, but distinct from medicine, it would

seem that the views on professionalism proffered by the nurses here are impoverished. However, following Dingwall, I have attempted to focus on 'how and when' the notion of profession is used by nurses, rather than attempting to define what nursing professionalism *is* (or ought to be) or, indeed, addressing whether nursing should be considered a profession or not. It would appear that nurses' professional discourse is used predominantly in support of an occupational identity that, ironically, eschews a strong claim to professional status. Instead, the notion of professionalism is invoked as a foil against which the more spontaneous, expressive aspects of care are accentuated.

4.3 The Meaning of Care

Introduction

So far, it has been posited that nurses' scepticism concerning the value of theoretical nursing education, and reticence over describing nursing as a professional undertaking, is, in a significant part, attributable to nurses' conviction that caring for people is necessarily internally motivated and so is averse to formal prescription. The present section considers, in far greater depth, the significance of the concept of 'caring' for nurses. 'Care' encompasses a vast amount of conceptual terrain and might refer to both actions and feelings, to collective or individual responses and may be constituted within a wide variety of relationships. While it is all but impossible to discern a single, definitive meaning of nursing care, the responses of the nurses whom I interviewed elucidate which activities are considered representative of caring, and which aren't; the relationship between nurses' capacity to care and the institutional environment in which they work; and the reasons nurses give in explaining their compulsion to care.

4.3.1 Data

4.3.1.1 'Actually Looking After Patients'

"D: So is that an important aspect of the job to you? The patient contact?"

S: Well, it's nursing!"

(Excerpt of conversation with Steve)

As has been discussed, nurses placed great emphasis on the interpersonal aspects of nursing care as central to their occupational identity. Washing, dressing, talking with and, generally, just spending time with patients and getting to know them were cited by the vast majority of nurses I spoke with as the elements of their work that they valued the most, and which they perceived as the very fundamentals of nursing; as Rachel (staff nurse) simply stated, so-called 'basic care' *"is the basis of nursing"*. Work duties not involving *direct patient interaction*, such as paperwork, were, in most cases, regarded as diverting nurses' attention from spending time in the company of patients, where they engaged in 'real' nursing work. One recently qualified nurse, Valerie, explained how the paperwork component defied her initial expectations of nursing work:

"I thought it would be more about being with your patient, I didn't think it would be the amount of paperwork that we have to do, I thought it was totally different so, I probably came in a bit blind, erm, I got a shock on my first ever placement but yeah..."

Valerie demonstrates here a belief, prefiguring entry into a nursing career, that direct personal contact with patients is the essential foundation of the occupation; consequently, the volume of paperwork provided a 'shock'.

In a similar vein, a nurse-specialist with many more years' experience, Mildred, contrasted her motivating expectations of nursing with the job's less desirable administrative aspects:

"I didn't get into nursing to sit in an office, I hate office work, I don't like it at all and in nursing these days, I've found quite disappointing and, actually being one of the old-fashioned nurses, as we're called (laughs). We're the ones who keep the standards up though, we're the old-fashioned nurses who keep the standards up. Erm...I prefer to be actually looking after patients but nowadays, there's so much paperwork involved in looking after a patient now that it's, from my perspective, personally, it's gotten out of hand."

In this excerpt, (hated) 'office work' and paperwork are seen as getting in the way of 'actually looking after patients'. In this way, Mildred is re-affirming that real nursing work is about directly interacting with the patient to make sure their care needs are met and concomitantly casting administrative and managerial duties as somewhat removed from nursing's core purpose. As she goes on to say:

"...for me, from a nursing perspective, patients need to be comfortable, cared for, pain free and looked after, fed and watered. That's the basic stuff you need to do... We've got so much paperwork, so many bundles, infection control bundles...And I know that all that stuff is important but, see, years ago, you never did that stuff years ago, and the patient very rarely came to any harm."

Crucially, here, Mildred prefaces her list of patient care priorities with the phrase 'from a nursing perspective', again associating direct personal interaction (providing nutrition and pain-relief) with 'nursing', while protocols contained in bundles, and paperwork -technologies that serve to formally prescribe core aspects of nursing practice- are perceived as extraneous to the 'nursing perspective'. The notion that nursing work centres primarily on the direct provision of basic care is defended with reference to a former time when these activities alone were sufficient to keep the patient from harm. Invoking the past in this manner, along with casting herself as an 'old-fashioned nurse', compounds the notion that there is a stable and enduring essence to nursing that excludes things like paperwork and other managerial activities.

From my time spent in and around the ward, the management of discharges and admissions stood out as a particularly contentious issue. This subject encapsulates the discursive division between 'nursing care' and the 'organization' of care; nursing's concern with directly providing relational care to individual patients was seen to conflict with an organizational concern to treat as many people as possible, and many nurses were generally critical of the managerial impetus to expedite patient discharges in order to free up bed space in an attempt to meet the constant demand for hospital care.

Certainly, the demand for beds is a very real, and possibly irresolvable, issue and, in a practical sense, there may be very little that nurses, at any level, can

do to alleviate bed-pressure whilst also maintaining the highest standards of care for patients being treated on a ward. As Greta, a student nurse, conceded: “I suppose it’s very much what you can do at the time, really, at the end of the day. We’re not miracle workers, as much as we try.” However, many nurses’ attitudes to rapid discharges emphasise a specific orientation to care based upon the primacy of personal interaction with those under their charge, as opposed to a more utilitarian (à la Bentham) conception in which care provision may be perceived as a need of the wider population. In fact, ‘bed pressure’ was regularly held up as an impediment to ‘person-centred care’. It seems that this perception chiefly stems from nurses’ categorization of ‘bed-pushing’ as a managerially driven activity (akin to ‘office’ and paper work) rather than as an action directed, ultimately, towards the care of patients. As Bolton (2005) attests, ‘management’ and ‘care’ are seen as belonging, respectively, to discrete realms of social activity, and following different logics.

4.3.1.2 Beds vs Care

“...the management role has very much become (sic) a job of turning beds round and it’s very much bed pressures, very much not really much patient care because you’re more involved in the managing of staff and managing budgets and infection control and lots of other jobs, rather than actually looking after patients as such. It’s a different role and I would rather, you know, I trained to be a nurse, I’d rather just be with the patients.”

(Bill, staff nurse)

This quotation from Bill illustrates how ‘bed-pressure’ is almost completely disassociated from ‘patient care’; the ‘job of turning beds ‘round’, along with other management duties concerning staffing and budgets, is seen as wholly distinct from (note the recurrent phrase) ‘actually looking after patients’, here associated with ‘being with the patients’ which, in turn, is linked with simply ‘being a nurse’. Even within this short excerpt, managing is clearly rendered as distinct from nursing, as if the management of beds was pursued as an end in itself, rather than as part of a process of healthcare. Frequently, the managerial focus on making discharges to provide bed-places was directly contrasted with a nurse’s own ability to provide patient-centred care as here described by Henrietta, a long-serving staff nurse:

“The emphasis is getting patients out, new patients in so, you know, patients are out their beds, to sit out so they can get patients in for patient flow. So, no, it’s not patient centred care.”

Here, maintaining patient flow throughout the hospital is made to stand in direct contradistinction to ‘patient-centred care’. This is explicable via the fact that most nurses took ‘patient (or person)-centred care’ to refer to the care of individual patients already on the ward and therefore perceived that hastening the discharge of these patients impeded upon the overall quality of the care that they received. Of course, the converse argument is that patients who may be waiting on trolleys in A&E are, themselves, not being adequately cared for in a person-centred way and that fast discharges aim to rectify this by providing space on a ward where their care needs can most appropriately be met. I began to ask nurses directly about the problems concerning patients waiting to come up on to the ward and whether these people featured in nurses’ thinking about their role as providers of care.

Most of the staff nurses that I spoke with steadfastly affirmed that their primary concern was with patients already on the ward:

“I think when you’re on the ward and you have patients that you’re treating, they’re your priority, cos you, it’s almost like the other people, you haven’t met them yet, they’ve not come under your care yet, directly under your care, so I think you do kind of forget about them.”

(Danni)

This respondent’s claim that it is difficult to think about the needs of patients awaiting admission as owing to the fact that ‘you haven’t met them yet’ underscores the stress on interpersonal relationships as the medium through which patient care happens. Staff nurses generally didn’t consider the admission of new patients as something to prioritize and instead highlighted their commitment to maintaining relationships with patients on the ward. As Poppy admitted:

“I don’t know if this sounds bad but I don’t think I have thought about the people waiting. I don’t know if that is a bad thing ‘cos they’re down in A&E where they should be providing person-centred care as well, so I think I always tend to focus on who I’m actually looking after that day. Does that sound really bad?”

For most of the staff nurses with whom I spoke, concerns with patient flow - discharging patients so that others might be admitted- was considered the remit of managers:

J: But I don't like it, I definitely don't like rushing people through the door and that's not what I think nursing should be about...

D: Do you think there's any way around that, if it was up to you.

J: Erm, it's a tricky one, but it's not for me it's for a manager to deal with.

(Conversation with Jonathon)

Again, management and nursing priorities are seen as incompatible. Here it is implied that management are responsible for 'rushing people through the door' which is decried as not what nursing should be about. A similar sentiment is exemplified in the following from Lucinda:

"If the bosses want to come in and get rid of people that are [unclear], fine, but my priority is those that are still requiring medical attention, that's my job, you know. But they want it the other way 'round, they want you in the morning to prioritise people that are going home, that are well. You think 'well that's kind of wrong'. I understand it's for flow and stuff but it does'nae help sometimes."

Long-serving staff nurse Bill asserted that, unlike "most staff on the ward", he could see 'both sides', i.e. both the rationale behind the push for beds, and nurses desire to attend to the needs of their own patients on the ward.

"I mean, their (management) point is they've got somebody lying in a stretcher downstairs, lying in a corridor with nowhere to go. And what they're saying is 'well, yeah, you want to wash that patient but there's somebody downstairs lying in a bed, lying in a corridor and it's not dignified' so their idea is that that shouldn't happen and they should be brought to a ward where they can have an element of dignity, put in a bed if there's a bed available."

Although, while claiming to 'see both sides', Bill stops short of endorsing the 'management side' of the argument, subtly distancing himself from this point of view by continual references to 'them' and 'they'; 'their point is', 'what they're saying', 'their idea'. The elaboration of a distinct managerial agenda is thereby still being supported and, like other staff nurses, Bill perceives that the focus on discharge is diminishing the care of patients on the ward:

"Management are focused on, very much, the pressures downstairs where we sometimes feel they should be more focused on the ward."

What is notable from all this is, perhaps, not so much that staff nurses do not take on direct responsibility of the management of discharges; it is, after all, the case that staff nurses *are not* ward, or hospital, managers and have limited control over the overall pattern of discharge and admission; as student nurse Greta declared: "I can't look at the 12 hour trolleys, you know. It's awful but what do you do? I can't split myself into 4 people!" What is worthy of comment however is the way in which many nurses took a decidedly antagonistic stance to how discharges were managed, asserting that quick patient turnover directly inhibited their ability to properly fulfil the nursing role as they perceived it. Rather than seeing bed-management as a necessary component of nursing as a whole process, staff nurses generally maintained a ready distinction between 'bed-pushing' and patient care by framing quick discharges as serving singly managerial interests. While nurses at bands 6 and 7 argued that swift discharges ultimately satisfied the needs of patients (more of which shortly), ward-based staff nurses viewed them as reflecting impersonal, instrumental concerns. Expressed, for instance, in the idea that discharges were pursued to meet targets or avoid sanctions:

"I think the emphasis is on breaching times and they're not really thinking about the patient anyway, it's more 'we have to get them out because they're breaching and we'll get fined'."

(Henrietta)

Management activity was often cast in this way; as being a somewhat self-serving enterprise, removed from the more tangible concerns of real patients. In particular, in regards to discharge, respondents frequently talked about the managerial concern with 'beds' as antithetical to a concern with people. As Jonathon said; "You know, so, I don't enjoy where, as a, even as a health board, our motivations are not with the patients on the beds; it's actually getting the beds." Danni similarly pointed up the perceived disconnect between finding beds and thinking about patients. Discussing a previous placement as part of her studies, she commented:

"... basically in meetings it was just like "you need to get them out 'cos I need that bed and we need to move there and they need to move there". It wasn't anything to do with patients at all. It was just 'beds, beds, beds' which is always the huge issue. It's a barrier to most things in nursing is needing beds."

Again, finding beds (for patients awaiting admission) is depicted as an activity responding to a purely managerial agenda rather than having 'anything to do with patients'. The majority of staff nurses seemingly readily subscribed to the notion that the management role was quite distinct from the caring role and that the work of managers was not pursued in the interests of patients. This division was, at least in part, sustained by the language that staff nurses used when describing what management was about; chiefly, in their appeal to terminology that stressed the depersonalized nature of management. For instance, in referring to a management concern with 'beds', 'numbers' and 'targets' rather than with 'people'. In the following from Lucinda, the accoutrements of management are portrayed in direct contrast to her 'idea of nursing':

"So, my idea of nursing is not to go to a meeting about a meeting, then go with your clipboard and talk about beds or whatever, or get involved in rotas and staffing issues and whatever. I want to go and deal with the patients, get familiar with the patients, feel I've done a good job, get a bit of satisfaction out of it and, hopefully, send them off feeling better than they did when they came in and they have a nice experience. I don't think I could achieve that by sitting in an office and going to meetings about bed numbers and things."

Here, the stuff of management is meetings, offices, abstract discussion of beds (and, of course, clipboards), whereas, once more, 'nursing' is primarily concerned with actually being with and interacting with patients directly. Moreover, the ability to enhance a patient's hospital experience is the terrain, solely, of the ward-based nurse and Lucinda clearly makes the case here that participation in management produces no recognizable benefit to patient wellbeing.

Importantly, it should be noted that a minority of staff nurses were more sympathetic to the position and concerns of managers. For instance, Valerie maintained that the emphasis placed upon beds by charge nurses did not represent an inherent challenge to the care of patients on the ward:

"Management always help you the best they can so, you know, if they're pushing a bed and you've still got a patient, they'll help you. I've not known them on this ward not to help you so..."

She was also one of the few who seemed to, as Bill put it, 'see both sides' and attributed managers' focus on beds as a response to the needs of patients yet to be admitted:

"Erm, I suppose they do keep the patient at the centre of care-the one you're looking after-but they've also got a patient who's probably more sicker than the one you're discharging so they're probably thinking about both, both patients and who's requiring the more care and things."

Despite admitting that she, herself, had not really considered the status of patients awaiting admission to the ward, Poppy indicated that it would be beneficial for nurses to appreciate the rationale behind the work of colleagues from other occupational bands in order to alleviate the potential for antagonism that might arise from 'bed pressure'.

"It is what it is but it's definitely just trying to understand each other's roles. Like, the charge nurse took me to the morning meeting this morning just to make sure, like, I understood the bed pressure, like how many people are waiting in A&E currently etc. So, I think it's just understanding each other's roles, like you say."

These responses illustrate that it is *possible* to conceive of managerial actions as being, in some way, underpinned by a concern with the needs of patients, however, more commonly, staff nurses considered that the push for beds owed more to external pressures and the prospect of sanctions for senior staff. Lucinda, describing a hypothetical discharge scenario, suggested that the primary driver for making swift discharges was a desire to meet imposed numerical targets: *"...what you did (delaying a discharge) was for the patient's well-being, not to make their numbers look better or to help their side of things."*

Thinking about discharges in this way, i.e. as a 'numbers game', arguably acts to justify staff nurses' resistance to endorsing fast discharges as this could be perceived as subscribing to the managerial agenda which, as has been argued, is seen to inhibit the ability of nurses to provide direct personal care to their patients.

4.3.1.3 Managers Responses

As might perhaps be expected, nurses at bands 6 and 7, with greater levels of responsibility for the running of the whole ward, offered different interpretations to those of some staff nurses concerning the rationale behind meeting discharge targets, defending them as ultimately reflecting a concern with patient welfare, especially with regards to patients awaiting admission:

“There’s certain things we have to do to make 12 o’clock discharges because the government says that’s what you’ve got to do. Now, I’m all in favour of that! You’ve got a patient in A&E; that patient shouldn’t wait 12 hours on a bed. If you were that patient in A&E, you would welcome those targets.”

(Lillian, Charge nurse)

A fellow charge nurse, along with a deputy charge nurse, voiced similar arguments in favour of meeting discharge targets and appealed to a sense of empathy in explaining why such targets ought to be welcomed. Steve, for instance, observed that it *“could be your mum waiting 12 hours in A&E”* while Hannah similarly sought to humanize the person waiting for a bed-space, also adding that the patient being discharged is, too, benefited by an expedient approach:

“...we need to get patients moving and not have, you know, a poor 92-year-old lying on a trolley in A&E because there’s no beds up the stairs. Because I’m now in management, I can see that side of things, you know, I wouldn’t want anybody lying in a trolley in combined assessment so I want discharges out as early as we possibly could to help them but then, at the same time, the quicker we get a discharge home and get them settled before night, and that sort of thing-it benefits the patient, so...it’s just a big circle of admissions and discharges, you just don’t want anybody hanging about.”

Overall, nurses with ward-management responsibilities emphasized the necessity of moving patients in and out of the ward as fast as safely possible in order to meet patient demand and recognized this as a central facet of their managerial role. Hannah even claimed to derive some satisfaction from strategically managing patient flow:

“I like problem solving so, yeah, sometimes, there’s nothing you can do; you have to, you know, leave patients downstairs in combined assessment but I do quite like the problem solving and making sure you can get everybody up and move rooms about and that sort of thing.”

Managers were not reticent in admitting that their chief focus is on making beds available (*“beds; beds are the only thing that really is the main focus.”* -

Lillian) and defended this prioritization as a necessary component in the operation of the hospital and, even, the health service as a whole. Beyond consideration of the needs of those hospital patients awaiting admission to the ward, Steve made the case that the speedy admission and discharge of patients should simply be an accepted facet of hospital care:

"It (the hospital) is an acute site; you're meant to come in, get your operation and go home, come in, get your illness treated and then go somewhere else. It's not a rehab hospital, it's not a long-term care facility. It's when you have an acute disease or an acute illness-primarily, I mean, obviously we do palliative care, we do end of life care as needed but it is an acute hospital, it's meant to be a short stay."

Steve summed up this theme by situating the *overall* care of patients in a broader context in which the nursing care provided in hospitals represented a relatively limited component:

"You know, we've got an ageing population, which is wonderful, but I don't think...it's not so much the hospitals, you know, everyone says 'we've not got enough beds' but I don't think that's the case, I think it's the social care we need to look at and I think that's when the whole 'person-centred care' comes in to it because you need to look at the journey, you need to look at what's brought them into hospital, what you're doing, you need to look outside the hospital-where are they gonna go?"

Here, Steve contends that the notion of 'person-centred care' transcends the personal relationships between nurses and those they are looking after and relates to the entire system of health and social care. By contrast, staff nurses often emphasised the minutiae of the patient experience as being a central concern; according to Poppy, a good nurse is "somebody who focuses on the smaller aspects of caring, like, knowing what they like in their cup of tea, knowing they like 2 sugars in their cup of tea."

Nonetheless, despite appearing to endorse a wider conceptualization of care in which managerial activity serves a vital function, every nurse at bands 6 and 7 to whom I spoke indicated that they felt a qualitative difference between the fulfilment associated with *managing* for care, and that with actually *providing hands-on care*. These nurses *all* claimed to derive greater levels of satisfaction from direct interaction with individual patients, despite this accounting for relatively little of their time at work. In this way, the conceptualization of nursing work as being fundamentally enacted at the level of interpersonal

relationships with patients is affirmed. Responding to a question about the appeal of patient contact, Steve attested:

"I suppose it just makes you feel like you've cared for someone or looked after someone or you've made a difference. I mean, I know finding a bed for someone makes a difference to that person but that doesn't feel as direct, d'ya know?"

Similarly, Lillian reflected on the satisfaction derived from the rare occasions when she was not overwhelmed by charge nurse duties:

"...and the odd day when you get peace to be a nurse you go home and think 'I've done good today' you know, you see your work in patients, you see patients thank you going out the door at the end of the day, you know, you feel, you feel like you've been a nurse and that you've done a good job because you've took time and you spoke to that patient and you made a difference and you made them feel better and you don't often get to do that, you know?"

This excerpt is particularly enlightening in illustrating the sustained divide between nursing and managing, in that Lillian appears not to consider her regular management duties as congruent with 'being a nurse'; reinforcing the idea of real nursing as only fully realizable via interpersonal relations with patients that have an immediate and direct effect. Ward managers did identify a relationship between the actions associated with their role and the welfare of patients, as demonstrated, for example, in Lillian's recognition of the importance of leadership in maintaining staff morale:

"And make sure that if you've got a good team of people working with you and you're a good team leader, you've got happy patients; if you've got a happy team, you've got happy patients, and if you've got happy patients you've got a happy ward and you can't ask for anything more than that."

Nevertheless, making patients happy through such indirect means was not considered to provide the same level, or kind, of satisfaction as instantaneous interaction with patients. Significantly, both Lillian and Steve described *feeling* as if you've made a difference having engaged relationally with patients. While it may be difficult to elaborate on the nature of a *feeling*, the satisfaction derived from direct patient contact may, in part, be explained by the ready means of recognition for this type of work.

Many nurses with whom I talked identified being thanked by patients as significantly contributing to a sense of reward, and several associated feelings of achievement with the observable effects on, and reactions of, patients. For

instance, Jonathon said that "...if you feel like you've made a difference one day it's great, you know. It can be a simple, kind of cliché, but like putting a smile on someone's face that wasn't there before. That for me does it." while Mildred claimed that "we develop relationships...or for me, I develop a relationship, you've got a bit of banter going, I personally like nothing better than when I get it back." Great stock was placed in eliciting a concretely perceptible reaction in patients. A majority of nurses indicated that the receipt of thanks from patients represented validation of their role; "You see patients thank you going out the door at the end of the day, you know, you feel, you feel like you've been a nurse and that you've done a good job" (Lillian).

"D: OK, just quickly, I know I asked before about what you like about the job but a slightly different question; what, kind of, gives you the most satisfaction from being a staff nurse?"

B: erm...just whenever somebody says thank you. Just whenever people are a bit grate...you know show a bit of gratitude and, yeah."

(Conversation with Brenda)

In direct response to a question about 'person-centred care' specifically, Poppy maintained that the key indication of person-centred nursing was the way in which individual patients responded to the care that they had received, saying; "How do you know if it's person centred care? ... I guess if you're making them happy, they'd tell you 'you're a good nurse', thank you, or they smile at you."

Sharon Bolton makes the case that the care provided by nurses is given "with little or no expectation of a return on their investment-other than the satisfaction they derive from being able to 'make a difference'" (Bolton, 2000, p584). It might be added, however, that nurses gauge this ability to 'make a difference', to a significant extent, upon patient reaction, and that positive patient reactions sustain their dedication to the role, as demonstrated, for instance, in Brenda's claim that satisfaction is derived from gratitude. While not doubting that nurses are motivated by a generalized desire to help people, it appears that a necessary element to continued commitment to the caring role is that this motivation be duly recognized in perceptible ways. The rewards of nursing are not merely intrinsically produced, they rely, to a degree,

on tangible manifestation. One staff nurse, Lucinda, described a sense of personal satisfaction arising from making a lasting impression on a patient:

"I went to another hospital the other day to do a shift and one of the ladies who was in there straight away was like 'oh Lucinda' and she was asking all these questions about things I'd obviously told her in passing and I thought that's really nice. You know, cos she must have met hundreds of people, but then I thought, well maybe that's a bad thing if she remembers me (laughs). But she was going on about 'how's your dogs?' 'Cos she used to show pictures, 'cos she had dogs, and you know, some people have pictures in their locker and stuff and I thought that was really nice cos I thought that's made an impact on that person's day, or life, you know, that they remember you."

As well as illustrating that 'making a difference' requires some external ratification, this extract also shows that there is some importance attached to the recognition of having *personally* made a difference, making an impact as an individual nurse. Lillian, too, drew attention to the sense of reward associated with making personal connections:

"So, I often think you're privileged sometimes to be looking after patients, doing the job that you do. You know, you touch people, I'd like to think, it's corny but you touch people's hearts and there's an abundance of patients that are in my head that you have in your heart and there are certain patients that you remember that you never forget because they leave something with you."

The foregoing arguably helps to explain why nurses in management positions attest to differential levels of satisfaction attributable to the management, and (hands-on) nursing roles respectively. It is perfectly conceivable that nurses at higher bands *could* derive a sense of fulfilment from the knowledge that their activities contribute to the overall healthcare of countless people, for instance in ensuring the ward is properly staffed, or in negotiating for the installation of new equipment, or in finding a bed for a new admission. However, there is little *tangible* reward associated with this kind of work because such interventions are not recognized on a personal level by the patients who may benefit from them. Moreover, charge nurses indicated that their role was a somewhat thankless one in which 'you make decisions that people don't necessarily like' (Lillian) and where staff nurses could occasionally be hostile. Even as managers defended their activities as being in the interests of patients, there was no real means for this motivation to be reciprocally acknowledged.

One of the material consequences of charge nurse work being thus devalued is that very few staff nurses aspired to a position of ward management, preferring to remain in a role that presented greater opportunities for patient interaction and where their actions might more readily result in a tangible sense of achievement. Staff nurse Jonathon expressed interest in moving up a band, but intimated that that such a move would not be in a 'management' direction:

D: "Do you have any ambitions yourself to move beyond the staff nurse to band 6 or 7?"

J: Definitely, definitely yeah. But I don't know whether I'd want to do it on a ward basis, like deputy or charge nurse. I'd maybe like to go sideways and do palliative care, I'd be a specialist or something like that. I think palliative care suits me and I enjoy it so...

Bill conveyed a similar disinclination for management in explaining (in a converse direction to Jonathon) why he relinquished a higher band, managerial position:

"I done a deputy charge nurse role for a while at the [another hospital]. Erm, but I decided, for lots of reasons, not to continue, that was completely my choice. But, I think at the time, it was a good choice because management...it's a changing role. Very much it's becoming a lot about moving beds, turning beds over very quickly so that patients downstairs don't breach." (...) "It's a different role and I would rather, you know, I trained to be a nurse, I'd rather just be with the patients."

Every nurse that I spoke with maintained that direct patient contact constituted the very essence of nursing work and implied that the further one removed from this, the less fulfilling the nature of the work. I have illustrated how this contention results in the derogation, particularly among staff nurses, of any activity or process that detracts from nurses' ability to engage in interpersonal relations with their patients, including paperwork and, significantly, working towards swift discharges. Even though nurses at bands 6 and 7 with managerial responsibility for the ward were more forward in recognizing the value of administrative work in keeping care processes moving in order to meet the health needs of the population as a whole, these nurses still maintained a ready distinction between these activities and the 'real' elements of patient care, entailing interpersonal interaction, which provide a tangible sense of gratification.

4.3.1.4 'A Certain Kind of Person'?

It has so far been posited that nurses strongly associate the fundamentals of nursing with direct patient interaction and suggested that this is because relationships with patients represent the primary means for nurses to act upon their in-built capacity for expressive caring. Through my interviews, I tried to gain a greater understanding of how the supposedly natural proclivity to care is accounted for by nurses and the difference, if any, that a personally-felt impulse to care on the part of nurses makes to nurses' relations with patients, and to how they conceive of their work.

It was remarkable, in many nurses' accounts, how strongly they connected their occupational identity to an overall sense of their personhood. Jonathon, for instance, firmly indicated this unity of 'nurse' and 'person' in stating that: "I think it's from your background, where you're from, what culture you have, beliefs, values and that's how you are as a nurse. That's what I would say anyway", while Danni responded to the question 'what makes a good nurse?' with: "I think just generally being a good person. I think if you're a good person you can make a difference to people's lives."

It seemed that the maintenance of a strong sense of personhood in one's nursing practice was perceived as important in that it gave nurses the ability to meet and overcome the challenges of the occupation. There was a sense in which having the appropriate personality type was the *only* real way of realising the demands of the role. In reference to a variety of workplace situations, it was professed that genuinely caring about the welfare of patients provided an ultimate guide to nursing actions and behaviours.

As Mildred expresses here, an emotional commitment to the job is necessary in order to validate the labour that it entails; "You couldn't do this job unless you, you really loved it. You couldn't do the things that you have to do to patients and to people that...I don't think you could, I couldn't anyway." A similar sentiment was present in the following statement from Beryl:

"I do think that you have to care about your job and you have to care about people to do the job. It's not a job you come into just for money or anything like that. You have to want to do it. It's a hard job and it's seeing people at their worst and helping them, you know"

These responses assert that nursing is difficult and demanding work with the potential for distress and it therefore requires a level of investment from practitioners that transcends (modest) material reward. As Beryl later said: "It's quite a thankless job at times and I think if you didn't love to do it you wouldn't; you'd find another job to do that's probably better paid and less hassle". In claiming that doing the work of nursing is not motivated by extrinsic factors ("money or anything like that"), many respondents defined their occupational activities in relation to an internal sense of self. As Danni said: "It takes a certain kind of person to be a nurse, I don't think anyone could do it, I think it definitely depends on what kind of person you are".

In asserting that nursing actions are done under the auspices of, and in fact reflect, a caring central self, many of my respondents maintained that the care they delivered was genuine, that is to say, not merely performative. Thus, actually 'caring about' patients serves to mitigate against the potentially damaging consequences (dissatisfaction, emotional burnout) of having to sustain an insincere performance at work. As Beryl argued:

"I would say, if any, there is very few people (nurses) that don't care about people and don't want the best to happen. Erm, I just think it would be a hard job to do if you were constantly trying to be aware of the fact you needed to make sure you looked after someone properly, I think it is something that just is a natural thing."

This excerpt indicates that, without an underlying personally-derived regard for people's wellbeing, the effort required in ensuring someone receives the appropriate care could simply be overwhelming. In this sense, a natural affinity for caring is a much more reliable basis for guiding nursing actions.

Even in challenging workplace situations, it is the personal commitment to the welfare of patients that is seen as stimulating nurses' behaviour, and even when behaviours involve the suppression of emotions (and thus, on one level are not natural), the underlying motivation can be traced back to a fundamental concern for patients.

Some nurses recalled instances where they exercised tactful emotional restraint; for instance, not being visibly angry with patients, or taking five minutes away from the ward in order to grieve (perhaps in response to the death of a patient) beyond the sight of other patients, and it could be contended that such cases are illustrative of 'emotional labour'. I would argue however, that these instances do not constitute alienation from a central sense of self but rather, are consistent with nurses' widely-stated claims to genuinely care about the welfare of patients. The difference is in the underlying motivation; according to Hochschild's (1983) original formulation, workers perform emotional labour to aid the commercial pursuits of their employers and for their own financial reward, whereas on the occasions when nurses, for example, choose not to retaliate with angry or aggressive patients, it is reflective of the altruistic commitment to provide care for that patient, even in trying circumstances. As Hannah said on this subject:

"...when it's a young guy shouting at you for no reason it can be hard to go 'well I'm just going to be nicey-nicey' but you have to, you have to just be professional, give them the care that they need, give them the care that they want. At the end of the day, I'll walk out at 8pm, you know, but I know fine well I've given them the care they deserve, whether they want to shout at me or what, it's up to them."

Sensibilities reiterated by Jonathon:

"I think even if I'm annoyed or frustrated or feeling pressure, er...you have to think it's not about me it's about them [patients]. I'd probably say that, yeah. You just have to keep in mind that there is people a lot worse off than you."

In a similar vein, adapting one's interactional style in line with different types of patients was seen, not as being inauthentic, but as representing a more fundamental concern to provide the most appropriate care:

"It's easy to act in anyone's interest because you want the best for that patient; sometimes the patients who are, you know a bit more 'hold back', it's difficult to get the information that you need but you always do what's best for your patient and I think even if they are holding back, you have to ask the right questions to get the information that you need."

(Valerie)

Quite simply, wanting what is best for a patient is seen to derive from naturally caring about people and is the precursor to acting, and doing things, in the patient's interest. It might be possible to posit that desiring positive outcomes for patients results from the practical nature of the job itself, though given the

responses here which claim that it takes a certain kind of person to be a nurse, it would be fair to contend that in claiming to care about patients, nurses are affirming a caring identity that transcends the principles of the occupation.

This is further borne out by several responses in which nurses appeared to view their nursing careers as a means of fulfilling particular aspects of their personalities.

D: "Yeah, do you think things like being compassionate is something you had before you became a nurse? I mean, is that part of why you became a nurse? Because you think you are a compassionate person or a kind person or a caring person?"

R: "I think you have to, you do have to have, yeah, definitely. I think you have to have part of that to go into nursing."

A consequence of the idea (evident in the above exchange with Rachel) that entry into nursing presupposes an innate caring disposition is that nurses assume individual responsibility for the quality of the care that they provide. As entailed by the vocational perspective, nursing actions are impelled by the inherent personal trait of 'caring'. Thus, many respondents perceived it as important that this causal relationship was overtly declared, making it clear that to care was a personal compulsion, not merely an occupational mandate. Many nurses expressed consternation over the idea that care consisted of knowledge and skills which could simply be 'performed'. As Jonathon said when discussing the concept of 'holistic care': "I don't agree with trying to make people like that. I think if you want to be a nurse and you wanna be a good one, you already have to have those...embedded in you, you know..."

Several other respondents indicated that the inbuilt proclivity of individuals to care impelled some nurses to offer more to patients than other (hypothetical) nurses might:

- "Some people treat it just as a job, they turn up and they just do what they have to do and they leave at the end of the day. I mean, I like to think I can come in and have a good rapport with all the patients and see if I can improve their morale."

(Bill)

- "Erm...like you might have your focus, like you might want, some nurses might prefer that once they're physically fit, that's their job done, we've got them better, you know, medically they can go home now where other nurses might care about where they're going home to and who they're going home to, if they're not going

home to anyone so... it all depends on the nurse I think."

(Jonathon)

"I think that a lot of people provide more cos they're happy to, you know, some people just do their job and, you know, your job's to give out medication and...you know, you'll have a task list or whatever for the day; give their meds, get them washed, get them dressed, do their beds...some people just do that cos that's what their job is to do and they'll not do the chatting to people and seeing..."

(Beryl)

Thus, meaningful interpersonal engagement with patients is perceived as something which is not circumscribed by the job itself, but as a means of demonstrating the caring characteristics of individual nurses. Correspondingly, the more technical aspects involved in 'caring for' patients (e.g. giving out medication) are not seen to denote an inherent caring nature as these tasks are mandatory and do not permit a great deal of variation in their performance. By contrast, nurses indicated that their relational (i.e. not strictly medical) interactions with patients were self-prescribed and thus constituted a means of exhibiting their own individual caring persona. As staff nurse Maria affirmed; "Yeah, 'cos it kind of depends on your personality a bit so, any person is different, the way they talk with patients and they evolve with them so yeah, I think everyone's different". Additionally, the majority of respondents maintained that interpersonal skills or techniques were not discussed amongst nurses; "I don't think we would speak about it, I think each individual nurse will interact with patients differently" (Beryl) therein compounding the perception that interpersonal relations with patients are privately dictated.

4.3.1.5 Natural Carers

Given that nurses with whom I conversed generally credited the possession of natural personal qualities as the basis of caring behaviours at work, I was minded to try and find out where nurses felt this predisposition to care came from.

Many of the nurses with whom I spoke directly referenced the influence that their family life had made on their decision to join the nursing workforce and on the subsequent understanding of their work. Several drew parallels between their experiences of care in a familial setting and the care that they

strove to provide in the hospital environment. For some respondents, familial caring relations were seen to presage caring attitudes at work:

- "I think I already cared about people. I'm from a big family, I've got 4 sisters and a brother and I'm the oldest. So, I dunno if that's made a difference. I mean, I looked after them quite a lot when I was younger and I do like to look after people in general and I like to make sure that everything's ok. As a person, whether that's with my grandparents or my mum and dad or whatever. I would make sure I'm always quick to offer help if I can, or find out things if I can, I think that's just part of who I am as a person."

(Beryl)

- "Cos I mean, I suppose I was always somebody who looked out for friends and family and was always there for people, you know. I suppose it maybe was...erm...could have been, yeah, I suppose it probably was cos I always did look out for everybody and that was something that was always something that was in my nature, to look out for other people and make sure friends were OK, family were OK. Paying visits to grandad or making sure mum's OK."

(Bill)

As well as these early, formative experiences of caring roles, some nurses cited the continuing development of their family life as enhancing their ability to care for others, e.g. "now I'm a lot older, you know, I'm a mother, you've got empathy in ways maybe you didn't before." (Lillian). Others drew upon notions of familial care in a more conjectural way to describe the nature of the care that they wished to give their patients: "I was heavily involved with grandparents and things like that, so, the care I wanted them to get, I wanted to be able to deliver to other people." (Hannah)

Aside from Lillian's claim concerning the potential for empathetic development through progressive life-stages, which articulates the idea that one's caring capacities may be enhanced, it is not clear from most of these responses whether family life has been the *cultivator* of a caring personality, or whether it served as a primary means of demonstrating something already inherently possessed. Without exception, the nurses with whom I spoke claimed some kind of natural proclivity for nursing care though few (reasonably enough) could pinpoint why or how this might have come about. Danni reported an interest in nursing from an early age as a 'natural leaning':

"Like when we were at school and were looking through prospectus and it was like 'just look through the prospectus and see if there's anything that interests you', it was always the nursing page and the midwifery page that were folded down. Just was. Just lean naturally towards it."

Only one respondent (Rachel) explicitly stated a belief that the compassion that motivated her to care for others as a nurse was something that had been present from birth:

D: But, do you think, in providing compassionate care, you draw on your own, kind of, resources? You haven't picked up how to be compassionate from somewhere else?

R: No, that's something you're born with, you know. Something you're born with, I think.

D: And do you think most nurses would agree with you that those things have to be in place before you even think about qualifying? Or do you think it's possible to learn those kind of things?

R: I think so [to the former] because there's folk come in that haven't been in nursing before and you can see they've still got compassion and still got nice ways about them but...erm, they could have been in a completely different career before that but it still needs to be there. I think you have to have something there.

Regardless of whether or not nurses believe a compassionate, caring personality is something with which they were *born*, all of the interviewees indicated that their involvement with nursing was dependent upon the realization of pre-existing personal characteristics. Even Steve, who, by his own admission, 'fell into nursing', described it as a vocation to which only a particular kind of person would be attracted, and/or (more pertinently for him) want to remain in. Rachel's comments (above) show how the compassion seemingly required in nursing is seen to precede practical experience of the work itself. On the whole, the responses here portray the idea that people are nurses because they care, rather than that people care because they are nurses.

The final selection of data presented here moves from nurses' beliefs about *why* they care to *how* this personal caring compulsion is practically manifested on the ward.

4.3.1.6 'You've never got Enough Time'

As noted here earlier, several nurses perceived that a personally-felt concern for patients compelled them to offer more than just rudimentary care to those in their charge; for instance, in Bill's stated aim to develop rapport and boost

morale, or in the distinction made by Beryl between nurses who just 'do a job' and those who make an effort to engage patients. I asked nurses about how they managed to sustain more than just superficial relationships with patients, especially given the (often readily observable) volume and pace of work on the ward. Indeed, the vast majority of nurses with whom I spoke cited lack of time as a factor that impinged on their ability to always deliver the kind of care that they desired to give. Generally, talking and simply spending time with patients were identified as elements which were restricted by time pressures; this was seen to constrain nurses from entirely fulfilling the caring role.

-“No, you’ve never got enough time, erm, there’s so much that you have to get done, you’ve got the care of 6 patients and probably even more depending on who you’re looking after. So yeah, you could do with a lot more time to get to know your patients but it’s just, it’s not possible”

(Valerie)

-“Realistically we don’t have time to sit with them and have a lengthy chat with them, you know. Which is sometimes annoying. I like, er, I do enjoy chatting with patients and trying to get them to raise their spirits a bit.”

(Jonathon)

Nurses' stated commitment to going 'above and beyond' for their patients somewhat inevitably results in dissatisfaction when the nature of their work, hostage to the pressures of time, makes this more difficult to demonstrate.

“That’s frustrating, ‘cos you never feel you’re erm, you just feel that you’re touching the surface, you’re just doing what needs to be done and fire-fighting, if you like, you’re just getting the next, sort of, crisis out of the way but you never get a chance to do the basic nursing care.”

(...)

“I think as long as at the end of the day I go out and everyone’s stable, they’re not in pain, you know, they’re comfortable...unfortunately, that’s sometimes all you can do. So, the idealist in me thinks I would love to be able to do all that and make sure this is all lovely and ‘du-de-du-de-du’ but the reality is that they’re still alive (laughs)”

(Lucinda)

Busy schedules and surfeits of paperwork to complete gave rise to complaints from nurses that they lacked the time to properly engage with their patients on a personal level. However, because nurses held themselves personally accountable for the quality of care that they provide, they tended to perceive it as their individual responsibility to meet patients' emotional needs, even in the face of a challenging working environment. As the following from Lucinda

illustrates, nurses experienced personal feelings of guilt when they struggled in this endeavour:

“You have all these ideals in your head and you know what you’d like to be able to do and what you should be able to do but you can’t. That’s sometimes annoying. Like, say, you know, silly things, like, say somebody’s said ‘oh my daughter’s coming to visit this afternoon, I want to make sure I’ve had a shower and I get my hair done’ or whatever and it doesn’t happen, you feel kind of bad cos that was important to them and you’re trying to do what they want to do.”

The respondent ‘feels bad’ because she feels she has let the patient down in not responding to their personal wishes, though ‘lack of time’ is not perceived as an adequate excuse. As Bill commented, “(saying) ‘I need to do this very quickly because I need to go and see this lady who needs a wash’. It would probably be the rudest thing you can say”. Instead, nurses depended on themselves (as caring individuals) to elide time restrictions brought about by heavy work-loads and staff shortages; the means of attempting to achieve this will now be discussed.

4.3.1.7 Overcoming time pressure

A few respondents indicated that their own natural interpersonal skills could at least mitigate against the effects of time deprivations and implied that, through force of personality, they were able to connect with patients despite brevity of contact.

Poppy: *“But, even doing their admission, if their family’s there, you’ll be talking to them; it’s just through conversation, like, you’ll be changing their bed over, you’ll be talking to them. It takes 10 minutes and you could get to know them in that time”*

D: *So even with limited time you can still try and be person centred?*

Poppy: *“Yeah, you can try your best anyway. You might not get to know them really well but, you can try your best and then they’ll appreciate that a bit more.”*

Even through brief interactions, some nurses maintained that they could enhance patients’ mood by the manner in which they conducted themselves, as conveyed here by Mildred: “If you can just make them laugh for 2 minutes, even if they’re laughing at you, d’ya know, cos you’ve done something...” In these cases, nurses attempt to distil their feelings of care and concern into

actions and behaviours that are communicable in a short amount of time, seemingly recognizing the therapeutic potential of every interaction with patients; as Christiansen et al. (2015, p836) report, “even fleeting contact from nurses is viewed by patients as a compassionate connection”.

The ability to deduce, in a short space of time, that which might improve a patient’s emotional wellbeing was seen as attributable to the personal qualities of a nurse. Getting to know a patient quickly, whilst perhaps not preferable, was viewed as achievable given the right characteristics and meant that nurses could still provide relational care within time constraints.

“I do try and quickly weigh up what approach is going to work best? What do they need to hear? What’s going to reassure them? What’s their worries? If I can do anything I can to help. And it’s not necessarily addressing that directly with them but, again, sort of sussing out, ‘right, there a bit funny about this’ or ‘they didn’t like that before’ so you change it. So, I think you have to be somebody who can, who gets it, if you like, you know.”

(Lucinda)

In this statement, Lucinda maintains that “somebody who ‘gets it’”, i.e. somebody shrewd and adept at reading people (or ‘picking up vibes’ as Bill expressed it) is able to use these intuitive skills in lieu of the time that it might conceivably take others to work out what a patient needs.

More prevalent as a response to the lack of time available to spend with patients was the practice of doing things for patients outside of prescribed working hours, for instance working through breaks or staying late. As Maria testified: “Sometimes you leave kind of late because you leave some paperwork to do after; because you’re looking after the patient first and you do the records...yeah.” A similar attitude to the use of time was demonstrated by Jonathon who indicated that casual interaction with patients was a more beneficial use of time than attending to paperwork (‘notes or whatever’).

“I think if you just spend any free time that you have in the room with the patients, instead of out in the corridor, you know doing notes or whatever. If you’re just in the room when you’ve got a moment free. Just go and have a chat with one of them at least.”

Others said that they used their own free time (and, presumably, money) to provide things for patients that, while not medically efficacious, might be presumed to positively affect their emotional welfare:

"And it's not the first time you know, you've gone to the shop and you've got the patient a paper or, you know, one of my girls has gone for a break and she's gone to the shop and she's brought so and so back a bar of chocolate or a can of juice, you know, so that speaks volumes doesn't it?"

(Lillian)

These extra activities that nurses carry out on behalf of patients are, again, self-motivated; buying newspapers and chocolate is certainly not legislated for in the organization of the ward and/or hospital and so, in acting outside of these limits, nurses are providing forms of care that seemingly reflect themselves as individuals. While the organization of the hospital might curtail the extent of interpersonal caring, nurses felt impelled to act upon their own feelings of concern for patients and thus sought ways to compensate for the lack of prescribed time, namely by volunteering their own.

"You know, like, I just want the best for them and do the utmost you can to make sure that happens, and whether that's something daft like going to the shop and getting a paper for them; if that makes them happy, let's do it, it's not a problem."

(Lucinda)

Further to giving up their own time, one respondent recounted other personal sacrifices that nurses on ward 12B had made that reflected the conviction that care depends, for its realization, upon the altruism of the individuals providing it:

"Some of the staff...being the kind of speciality we are, we get lots of people who are homeless, they don't have clothes, they don't have a place to sleep and stuff like that. The staff here bring in their own food for them, they bring in their clothes for them. They go above and beyond what nurses are meant to do, you know."

(Mildred)

Lillian (quite movingly) recounted an incident in which she had taken the initiative to try to grant an idiosyncratic request from a seriously ill patient:

"I remember I had a patient not that long ago and his wife had died and he was dying himself, and she died previous and he missed her terribly and he hadn't had a boiled egg. In all the months that she'd died, he hadn't had a boiled egg. And his last dying wish was that he says 'oh, hen, I would murder a boiled'...A poached egg! It was a poached egg! ... "I would murder a poached egg and toast", so I phoned a friend and says, 'you know, see what you can do to bring me in eggs and a wee microwave and we bubbled up a wee poached egg and I gave him a poached egg and toast. And that was his dying wish."

Charge nurse Steve summarily observed: "I don't know the type of person it attracts but I just know most nurses I know, I'd say 90% of them go above and

beyond.” Again, the quality of care-provision is strongly and explicitly linked to nurses’ volition to exceed the formal limits of their occupational role.

4.3.2 Commentary

4.3.2.1 *Nursing Ideal and Service Reality*

Anybody who has read a newspaper, or watched news broadcasts, in the past decade or so will be familiar with the current pressure on the UK health service. With an increasingly aged population, often suffering from complex health conditions and with limited availability of social care, there are simply not enough hospital beds to cope adequately with demand. Indeed, the UK has among the lowest number of available beds per 100,000 people in Europe (Forster, 2017) and hospital trusts regularly run at 100% capacity (Appleby, 2016). While, in Scotland, overall bed occupancy is consistently marginally lower than in England, the trend is still towards a diminishing number of available bed places, with recent figures indicating an 82% bed-occupancy rate across Scotland (Bate, 2016). It has thus become a priority for hospitals to make discharges as promptly as possible in order to maintain the flow of patients and minimize the length of time that patients have to wait before being admitted to a ward appropriate to their needs; several newspapers have reported recently on patients waiting for several hours, and even dying, on hospital trolleys as they wait for a bed to become available (see, for instance, *Morris, et al., 2017*).

This prompts consideration of the scope of nurses’ conceptualizations of patient care and its correspondence to the wider institutional situation, encompassing the hospital and the NHS. There is arguably something of a disconnect between individual nurses who see patient care as manifested in the interpersonal relationships between themselves and their patients, as widely evidenced by the nurses interviewed here, and a health service facing increasing demands on its stretched resources, and for which ‘care’ is a matter of managing the health needs of the population.

As Dingwall and Allen (2011, p66) observe, nurses often “encounter a ‘reality shock’ when they discover that what they are actually called upon to do,

whether in hospital or community, is so far distant from what they have been led to expect". As evinced by a number of respondents in my study, nurses' idealization of the role involves significant time spent with patients at the bedside, tending *directly* to both physical and emotional needs. Most nurses expressed frustration and disappointment that other administrative and organizational tasks diminished the opportunities for interpersonal interaction with patients which was conceived of as the true essence of nursing.

Indeed, Sharon Bolton (2005) has noted a somewhat polarizing disjuncture between 'nursing' and 'managerial' identities wherein the successful realization of one precludes identification with the other. This in spite of the fact that "Nurses, at every level of the complex bureaucracy that characterizes the NHS hospital service, have long been involved in management functions" (Bolton, 2005, p6). Still, management-type activities (such as paperwork) are not readily recognized as contributing to patient care and, in many ways, are seen to detract from it by minimising the time nurses may spend in direct contact with patients. This is entirely consistent with the responses of the nurses that I interviewed who bemoaned the amount of time spent on 'managing' for care as opposed to, as they saw it, actually *doing* the care (i.e. being physically present with patients).

The discursive separation of management/administrative activities with 'actually looking after patients' echoes the findings of Brian Brown et al. (2014) who found that mental health practitioners only conceived of 'compassionate' care in so far as it involved directly interacting with patients. By contrast, organizing activities, such as paperwork, auditing etc. were seen as 'incommensurate with patient care' (Brown, et al. 2014, p393) and thus had nothing to do with 'compassion'. In their conclusion, the authors are somewhat critical of this narrow conception of 'compassion', belonging to a 'practical repertoire', which "is inwardly directed towards the life of the ward and the patients' interior worlds" (Brown, et al. 2014, p394). Brown et al. (2014, p396) argue that compassion "by means of its focus on interpersonal processes, deflects attention away from the institutional and legal constraints that are applied to patients". Briefly, the implication is that 'compassion' could

be a relevant concept in the consideration of systemic healthcare processes and not just applicable to the actions of individual practitioners at the level of interpersonal interaction.

Dingwall and Allen (2001) argue that the powerful rhetorical construction of nursing as based in interpersonal relations between nurse and patient is ill-disposed to reflect the nature of nursing work in the 21st century. The authors make the claim that nursing's emphasis on holistic relational care has been constructed in support of a specific occupational mandate that aims to establish the unique contribution that nursing makes to society. The emotion work associated with direct interaction with patients becomes "one of the things which nurses say they do that differentiates them from other health professionals and justifies their status as a separate and independent profession" (Dingwall & Allen, 2001, p65). As Bolton (2000, p18) puts it, whatever the reality of nursing tasks and duties, "the symbolic anchor of nursing practice, that is caring for patients, firmly remains".

Interestingly, Dingwall and Allen (2001) identify nursing's jurisdictional claim to holistic emotional work as a relatively recent emergence; as the nursing role has changed and expanded to include more technical and administrative tasks, the emphasis on relational aspects of the work has become more pronounced. Arguably, this represents an attempt to articulate a distinct and cohesive nursing identity, in spite of the role's multifariousness, as the occupation, formally at least, seeks to solidify professional status.

Dingwall and Allen (2001, p68), though, make the case that the "obsession with the claim to holistic emotion work" is the result of an 'occupational myth' and question the notion that holistic care, and the therapeutic use of self, are essential and inviolable elements of nursing. In particular, they are critical of the presumed relationship between 'hands-on care' and holistic emotion work, arguing, for instance that, in the past, "The nurse who bathed the patient with a fever was not performing a simple caring act but carrying out a prescribed intervention just as much as her modern successor on a drug round." It is claimed that, even though nursing used to require more direct physical intervention, interpersonal relationships with patients were, perhaps, never

actually that central to nursing's occupational licence. Nonetheless, nurses continue to appeal to a 'golden-age' in which direct patient contact was valued as the primary means through which nurses demonstrated care and concern for their patients.

However, increasingly, what nurses' actually do on a day-to-day basis (what Everett-Hughes (1971) terms the 'licence' of the occupation) provides fewer and fewer opportunities for hands-on patient contact wherein emotional work is supposedly done. The prospects for nurses to spend sufficient time with their patients in order to get to know the type of things that allow for care to be personalized and, perhaps, emotionally beneficial is constrained by practical circumstances which have necessitated nursing's role expansion, i.e. a growing sick population and constraints on public expenditure (particularly in the context of 'austerity'). Limited resources are devoted to improving the *physical* condition of patients; holistic emotion care is not actively budgeted for, demonstrating the "economic limits of psycho-social interventions" (Dingwall & Allen, 2001, p72). In short, fully attending to both the *physical and emotional* needs of patients may be an unrealistic aspiration in a publicly-funded healthcare system attempting to cope under demanding conditions.

Naturally, adhering to the occupational 'myth' associating nursing with expressive forms of personal care becomes increasingly untenable in the context of modern nursing work in which practitioners are engaging in more and more administrative and technical tasks and spend less time 'hands-on' with their patients. This is partly owing to advances in medical technology that have rendered protracted periods of hands-on care less essential, for instance the "rapid development of minimally invasive surgery" which has "radically reduced lengths of stay and post-operative nursing requirements" (Dingwall & Allen, 2001, p68). Along with the need to meet the continuous and substantial demand for hospital services, it is arguable that the reduction of the time that nurses may spend with individual patients is inevitable.

In order that nursing work does not become a source of continual dissatisfaction, nursing's mandate, entailing the valorisation of direct relational care, may require some adjustment. Currently, staff nurses appear to feel that

their primary purpose is undermined by the kinds of tasks that 'take them away from patients', while nurse-managers are made to experience their work as inherently unrewarding and as 'not really nursing'. As Dingwall and Allen (2001, p73) contend:

"...a little more realism might make for a more sustainable professional future. It may help potential nurses to understand that they are joining a profession whose work is now highly technical and likely to be increasingly so."

It may concomitantly be conceivable that, rather than posing a threat to nurses' ability to care for their patients, managerial and administrative actions may be seen as, at the very least, a constituent and obligatory part in a wider healthcare 'whole'.

In the recent work 'Against Empathy', Paul Bloom points out that people often equate compassion with empathy, believing (mistakenly, in the author's view) that "the only force that can motivate kindness is empathetic arousal" (Bloom, 2014). Taking a broadly utilitarian standpoint, Bloom argues that compassionate action can result from taking a more detached, rational perspective that doesn't require direct empathetic identification. Perhaps some of the frustration, as described, for instance by Lucinda, would be alleviated if nurses were not so strongly invested in the notion that emotional investment in patients is exclusively reflective of their capacity to care. The compassionate impulse to help people that many nurses expounded in interviews might conceivably be demonstrated in forms that transcend the immediacy of the nurse/patient relationship.

Of course, transforming the terms of occupational mandate is far easier said than done and many nurses, subjected to the "exaggerated expectations encouraged by their educators and formed amongst the public" (Dingwall & Allen, 2001, p72), will continue to aspire to an ideal of nursing that may be practically unfeasible. This ideal is sustained by public discourse; popular images of nursing, as displayed for example in television programmes, have tended to uphold the notion of nurses as providers of emotional comfort (see Theodosius, 2008, p30). It is additionally sustained by the perceived opposition between management and nursing which reinforces the idea that direct care is the principal way of demonstrating compassionate care. Perhaps, as Brown et

al. (2014) and Bloom (2016) respectively imply, the concept of compassion needs to be understood in an expanded context, beyond that of individual relationships between practitioners and those for whom they care. Managers, too, may also need to find expanded vocabularies to communicate their share in the concept and attempt to demonstrate that attending to the needs of users of the healthcare system, as a whole, can still represent a caring impetus.

4.3.2.2 Ways of Caring

Caring has often been discussed as the 'essence of nursing' (Leininger, 1984: Morse, 1990: Apesoa-Varano, 2016) yet there appears to be little consensus upon how to theorize the relationship between this (essentially abstract) entity - care - and the combination of attitudes and actions that constitute nursing. Morse et al. (1990) have attempted to outline 5 discrete perspectives of caring as it applies to nursing although, importantly, the authors acknowledge the messy boundaries and interrelations between different theorizations of care, and recognize that more than one conceptualization may be upheld by commentators, and by nurses themselves. While it would be unnecessarily exhaustive to relay each of the perspectives identified by Morse, et al., it is worth briefly recapitulating, before considering nurses' responses, the conceptualizations described by the authors, namely: Caring as therapeutic intervention, caring as interpersonal interaction, caring as an affect, caring as a human trait and caring as a moral imperative (see pp91-95 of thesis).

Within Morse, et al.'s typologies, care can refer to both practical action, i.e. doing things for the patient in response to need, and to personal disposition- feeling empathy, compassion or commitment to an ethical ideal that motivates care. In other words, caring can encompass both 'doing' and 'being'. This 'doing' and 'being' as two principal elements of care is contained in the ideal-typical notions of 'caring for' and 'caring about' (Cronqvist, et al., 2004) wherein 'caring for' represents the practical tasks that a nurse may carry out to address patient needs and which are occupationally prescribed, while 'caring about' implies a genuine, and personally derived, concern for the patient's wellbeing.

Within this heuristic, and in reference to nursing, a central debate concerns how far 'care' necessitates both of these components. We can readily conceive of 'caring for' and 'caring about' as separable entities; for instance, I may care deeply about the welfare of a sick relative and be personally invested in their recovery yet, lacking the practical skills involved in diagnosis and treatment, I would not be able to adequately care *for* that relative and aid them in that process of recovery. Conversely, as exemplified by the notion of care as the performance of therapeutic interventions, a practitioner may possess the skills and knowledge to provide the effective treatment to restore the health of my relative, though without *feeling* any especial connection to, or emotional investment in, that particular individual.

From the foregoing example, it could be credibly argued that the greater part of nursing care should consist of 'caring for' as no amount of 'caring about' can compensate for inadequacies in the practical application of therapeutic interventions. However, there is a powerful narrative in much of the nursing literature, and espoused by nurses themselves, expressing the view that real, or authentic, care entails that caring actions are underpinned by *feelings* of concern and sympathy, felt personally by the nurse. Woodward argues, for instance, that 'mere techniques and knowledge' are 'transformed' into caring when prompted by "concern, involvement, attachment and connection with the recipient" (Woodward, 1997, p1000) and, as one of my respondents affirmed; "I think, to do the job you have to care about people, erm, or you wouldn't do it." (Beryl, nurse specialist).

Certainly, in the terms of 'caring for' and 'caring about', the nurses in my interview sample strongly maintained that 'caring about' patients was essential in providing the impetus for engaging in caring behaviours with patients. It was implied that nurses lacking in genuine concern for their patients would concomitantly be lacking in the motivation, or the instinct, to provide comprehensive, individualized care. With reference to the work of Morse, et al. (1990), it would therefore seem that 'caring as therapeutic intervention' has the least relevance as a way of categorizing nurses' responses as no nurses advanced the view of care as a simple response to patient need,

requiring no especial emotional investment on the part of the nurse. The idea of caring as a moral imperative, in which caring springs from a sense of duty, was also not in evidence; nurses viewed caring as a personally-felt compulsion, and not as resulting from commitment to a predesignated moral code decreed by the practice of nursing. Even though nurses reported variability in the ease with which relations with patients might be established, none of my sample indicated that individual relationships with patients dictated the way in which care was provided. 'Caring about' others, and a general desire to help people in need, was considered to be a pre-existing character facet and allowed nurses to care for a variety of people with the same level of commitment.

Still referencing Morse, et al.'s typologies, there is a degree of overlap between the view of nursing care as an affect, and care as a human trait. Nurses, for the most part, claimed a natural predisposition to care although there was some implication that experience, in both nursing and life in general, could contribute to the development of one's emotional faculties. However, there was little suggestion that "the acquisition of knowledge and skills" through education (Morse, et al., 1990, p4) contributed to nurses' caring talent and most respondents claimed that a proclivity to care was present before entering nursing, sometimes from an early age. Thus, while it is difficult to identify a precise origin for nurses' stated personal commitment to caring, most nurses were dismissive of the claim that caring could be a learnable skill which anybody might attain.

A number of commentators have endorsed the view that, unlike other jobs, there is something unique to nursing which demands the emotional investment of those entering the occupation, although this something is more often alluded to than elucidated. For instance, Sabatino (1999, p375) writes; "More than services rendered, the difference that care makes represents an empathy, a sense of responsibility, and a way of being towards one another that is personal in nature." Arguably, however, it is difficult to specify the nature or extent of the 'difference' here referred to. Interestingly, Morse et al. (1990, p7) note that, in research instances where *patients'* views on care have been elicited, patients focused more upon the tangible, instrumental

behaviours of nurses as representative of caring, while nurses highlighted “the affectual or expressive aspects of caring actions”. Of course, patients may have limited insight into whether or not a nurse genuinely feels concern for them, yet the fact that they still reported feeling cared for could be read as evidence that ‘caring about’ is more integral to *nurses’* perceptions of care than it is to those of their patients, and that the ‘difference’ resulting from personal emotional investment is felt more by those providing care than those in receipt of it. After all, it is only the nurse who can ultimately know whether the care they are providing is ‘authentic’ or not, i.e. whether they feel genuine concern and empathy for their patients. It is pertinent, then, to inquire as to why practitioners of nursing place such value on the experience, and use, of internal emotion as a necessary component of care provision.

4.3.2.3 Caring nurse=caring person?

Part of the reason that ‘caring about’ may be deemed integral to overall nursing care is that much of our understanding of ‘care’ is developed from experience of it in the domestic sphere and precedes occupational socialization. As Nicky James (1992, p503) writes, “In the family, it is ‘caring about’ which is assumed to lead to ‘caring for’, and so ideologically family relationships provide the guiding framework.” Indeed, it has been claimed that, in their interactions with patients, nurses take relational cues from their home-life experiences (James, 1992: Staden 1998), and thus, for nurses, the division between public and private becomes somewhat indistinct. Perhaps it is the association of care with familial relationships which underscores the emphasis on personal investment in patients, as nurses seek to replicate an idealized form of caring based on emotional connectedness. As James (1992, p501) further notes “it has been assumed that ‘family care’ is necessarily better than ‘substitute’ care because of the ‘commitment and affection’ which characterises family care.

Indeed, as illustrated in the presentation of data, a number of nurses drew on their experience of care in a familial setting to explain their choice to pursue a career in nursing. Such comments evince the significant overlap between

notions of family-based care and the caring responsibility assumed by nurses in the hospital setting. Whilst James (1992) points to the fundamental structural differences between the family and formal institutions (such as hospitals) as sites of care, it seems that familial care still provides a reference point for several nurses in delineating the nature of their caring role.

It is therefore understandable that nurses almost invariably claim to have some kind of personal investment in the care that they provide to individual patients that transcends the mere performance of curative actions. In conceiving of their capacity to *work* in a caring role as, at least partly, attributable to the experience of domestic caring, nurses inevitably conflate their occupational selves and their 'private' selves to some extent. Owing to the perception that the propensity to care, as a nurse, is predicated upon a pre-existing caring disposition (often inculcated and demonstrated within the family) an uncaring nurse may, by extension, equate to an uncaring partner, parent, grandchild or sibling. In accordance with the vocational perspective, the capacity to care is universal, not particularistic.

A further, related explanation for nurses' claims to inherently 'being' (as opposed to merely 'doing') caring is that an emotional commitment to care provides a strong justificatory narrative for its physical performance. Nurses carrying out physically demanding work and some 'very unsavoury tasks' (MacKay, 1998, p64) are sustained in their ability to do so by subscribing to the idea that this work represents a means of self-actualization; the realization of an innate caring quality. Belief that one is not merely 'doing a job', but fulfilling a personal impulse, arguably allows nurses to value their work above monetary remuneration and sustains them in attending to tasks which most would view as ungratifying, in any intrinsic sense. Again, familial care may serve as something of a blueprint in that attending to the personal care of a family member, presumably (though not always), is impelled by a personally felt, deep-seated concern for the well-being of that person.

This unified sense of self, consisting of a person who 'cares about' patients and a nurse that 'cares for' patients, may furthermore be understood as refutation of the 'self-estrangement' that Arlie Hochschild claims results from the

suppression of authentic emotion in the workplace (Hochschild, 1983, pp5-8). Although Hochschild's original case study was of flight attendants, several commentators (Smith, 2012: Grey, 2012: James, 1992) have drawn on Hochschild's theory of 'emotional labour' to theorize the work of nursing and to elucidate the nature of its emotional component. Claiming nursing as a form of emotional labour necessitates that a significant part of nurses' work involves displaying emotions which do not reflect one's own inner feelings in order to generate appropriate emotional states in others. Without 'caring about', nurses would be forced to *enact* feelings, for instance, of concern and empathy, in order to 'care for' their patients; performing, rather than experiencing emotion. Feelings are thus not the nurses' own, but are acted out on in accordance with occupational demands.

Of course, it is nigh on impossible to compare nurses' external actions (including the use of discourse) with their inner-most feelings and, in this way, Hochschild's notion of performativity is hard to disprove. It could be argued that nursing narratives which stress genuinely 'caring about' patients are simply the manifestation of (very) 'deep acting', though, when theorizing on the nature of emotions, we inevitably lack means of empirical verification; again, only nurses themselves can truly know whether, on some level, they are deluding themselves. On the other hand, there is no strong basis for disregarding the narratives of nurses that describe caring as stemming from deep internal motivation. The assertion made by many of the nurses here that looking after people is a 'natural thing' derived from genuinely caring about people gives credence to the contentions of a number of authors who, in response to Hochschild's theory of emotional labour, have argued that workers, and nurses in particular, both experience, and act upon, authentic emotions in their occupational lives (Bolton, 2000: Bolton and Boyd, 2003: Theodosius, 2008) and that, moreover, for nurses, genuine emotional engagement with their work serves as the primary source of job satisfaction (Theodosius, 2008, p37).

Nursing, and the work that it entails, may thus serve as validation of some very intimate beliefs concerning the type of person one believes themselves to be.

It is arguable that Hochschild, whether intentionally or not, discounts this potentiality; that the use of emotions at work can enhance, rather than detract from, an integrated sense of self.

It is perhaps for this reason that, as Apesoa-Varano (2016, pp39-40) contends, nurses are unwilling to criticise perceived shortcomings in the emotive caring abilities of their colleagues, as this may be viewed as a personal attack, rather than as the expression of professional concern. This reluctance perhaps also acts to preserve the sense that good nursing care is dependent upon the natural characteristics of practitioners; if the quality of relational care was opened up to explicit judgement and criticism, then arguably, the imposition of formal codification is precipitated. Instead, "skilled caring remains a private, personal matter that is not easily measured or standardized, instead relying on individual discretion" (Apesoa-Varano, 2016, p40). As Lillian affirmed when discussing nurses' styles of patient interaction: "some people are comfortable with certain things more so than others and there's no... there's no right way or wrong way of doing things."

It is this sense of individuality that nurses are keen to retain and why strictly professional views of nursing work, which reduce nursing care to a set of learnable skills, are not readily endorsed. As expressed by Sabatino (1999, p376):

"When care becomes merely a countable service, something one does rather than something one is, there is the danger that it becomes a mere commodity to be dealt with, along with and like, all other commodities. Nurses in particular understand that care involves the personal presence of the caregiver"

In short, if nursing was purely about skill acquisition, theoretically anyone could do it and this damages the espoused link between being a good nurse and one's individual integrity as a person.

It is perhaps also as a result of the belief that one's caring abilities, as a nurse, reflect the fundamental character of the person giving the care that the direct receipt of thanks and praise was often cited as a primary source of satisfaction at work. While it has been argued that nurses derive an *intrinsic* sense of achievement from providing patient care, for instance, in Sharon Bolton's notion of nursing care freely given as a gift to patients (2000, p584), it seemed

apparent that nurses also greatly valued tangibly recognizable forms of recognition and gratitude from patients. Arguably, the feeling of having made a difference is more readily felt when that difference is concretely acknowledged by patients. Because nurses perceived their caring behaviours as indicative of deeply internalized feelings of compassion, to be thanked for care that they have provided represents more than affirmation of occupational competence; it is received as verification of one's virtue as an individual.

4.3.2.4 Exploitation?

So far, it has been postulated that, in claims of 'caring about', nurses sustain a commitment to their work and affirm an holistic, caring sense of self, extending beyond their occupational identity. Concomitantly however, it may be said that, in taking personal responsibility for providing relational care, nurses tacitly condone an organizational mode that restricts opportunities for holistic emotive care. 'Caring about' the welfare of a patient is, arguably, redundant without adequate means of expression, as illustrated earlier in reference to knowledge and skills; it is equally the case that time and resources are necessary for translating 'caring about' into 'caring for'. With heavy workloads and variable staffing levels, time spent with patients is often at a premium; as Sabatino (1999, p374) writes "Nurses in particular claim that there is not enough time to offer patients the kind of care that they believe is the primary responsibility of their profession and the reason why they became nurses."

The assumption of individual responsibility, by nurses, for the nature of the care that they offer to their patients is indeed, as Apesoa-Varano (2016, p41) suggests, a 'double-edged sword'. Most of the nurses with whom I spoke were keen to make clear that their caring activities were predicated on their actually 'caring about' patients, which undoubtedly gave meaning to their work and contributed to a sense of personal identity. At the same time, however, it would be hard to disagree with Apesoa-Varano (2016, p40) when she concludes that "Nurses' buy-in of the individualized model of emotive caring is exploitative as it compels them to perform skilled caring work because that is who they think they are as virtuous persons."

Unlike in Hochschild's original formulation of emotional labour, the organization does not impose 'feeling rules' (1983, chapter 4) which dictate how workers are expected to behave in their relations with service users. Instead, hospitals rely upon the natural propensity to care of the individuals that make up the nursing workforce; as several nurses in my sample attested, the nursing workforce is marked out and sustained by individuals who are intrinsically compelled to go 'over and above', 'above and beyond' for their patients. In some ways, shortcomings in the organization and resourcing of healthcare at a systemic level facilitate and support the elaboration of a nursing discourse that extolls the virtues of offering 'extra' care.

4.4 Summary of Findings: 'What Nursing's All About'

One of the central principles of CDA is that analysis should aim to show relationships between discourse and social structure. To this end, I have tried to identify nurses' discursive constructions and also determine the reasons behind these constructions, i.e. what nurses are trying to achieve through their discursive practices. The title chosen for this thesis- 'What nursing's all about'- directly reflects interview responses through which nurses seemed eager to convey what they believed to be the fundamental purpose of nursing, and the necessary attributes needed to fulfil this purpose. Several nurses specifically used the phrase 'what nursing's all about', and others made similar utterances, in pronouncing on nursing care as something which is dependent upon the personal characteristics of individual practitioners, is altruistically motivated, and is primarily manifested in interpersonal relationships between nurses and their patients. Nurses also advanced perspectives on features of their occupational context in ways that aided the rhetorical construction of 'what nursing's all about', often by specifying what nursing is not all about.

Respondents elaborated positions on several aspects of nursing in the contemporary healthcare system including, prominently, nursing education and developments therein, the meaning of professionalism to nursing, and the institutional environment of healthcare services. In expressing perspectives on all of these elements, nurses in this study appeared to be constructing, and

defending, an occupational identity to which a particular notion of caring is fundamental.

The concept of 'articulation' is a useful way of understanding the significance of nursing's discourse in relation to the elements of social practice of which they are a part. Laclau and Mouffe (1985, p105), who developed the term, describe articulation as:

"... any practice establishing a relation among elements such that their identity is modified as a result of the articulatory practice. The structured totality resulting from the articulatory practice we call discourse."

Thomas and Hewitt (2011, p1374) state that the idea of articulation is "important in understanding how symbolic and discursive resources are used in attempts to fix temporary sets of meaning within conjunctures". In short, articulation involves the rhetorical construction of elements of social practice in order to make certain claims. In this study, conceptions of nursing education, profession, and the management of care were articulated along with conceptions of 'care' in ways that allowed nurses to construct discourses of nursing care as natural, motivated by an inherent sense of compassion and as taking place at the level of interpersonal relationships.

For instance, the predominant view espoused of formal nursing education was one wherein pedagogical methods were seen as inadequate to inculcating the qualities necessary to thoroughly fulfil the nurses' caring role. Nursing education was constructed as something quite rigid and formal and, in conceiving of it as such, nurses were able to emphasise that nursing care demands natural aptitude and personal commitment which cannot simply be taught, therein discursively establishing a relationship between formal education and care in order to make assertions about the nature of nursing care. Indeed, many elements of nurses' discourse elaborated upon the perceived impediments to nursing care, in order to accentuate 'what nursing's all about'.

Similarly to formal education, salient elements of contemporary nursing practice - professional status concerns, and the organization of healthcare - were disparaged in ways that sought to retain the conceptualization of care as

internally-derived and naturally felt. The organization and management of care was cast as being chiefly preoccupied with beds and numbers, in opposition to concerns for *actual* patients. Disassociating themselves from a particular construction of healthcare management enabled nurses to construct a specific version of nursing care which foregrounded interpersonal skills; the kind of skills that, supposedly, cannot be formally legislated for or quantitatively evaluated.

Perhaps the most complex articulatory process can be seen in my interviewees' usage of the concept of 'profession' which nurses effectively disassembled in order to construct a discourse of professionalism which supported claims that their caring practices were altruistically motivated. For the majority of nurses with whom I spoke, the kind of 'professionalism' that they claimed to adopt was focused upon outward presentation and comportment; i.e. looking nice, being polite etc. The idea of nursing as 'a profession' with a formally identifiable body of knowledge, as promoted by the 'nursing professionalizers' described by Melia (1987), was not readily endorsed by the nurses with whom I spoke as an important component of their occupational identities. This sense of 'profession' was perceived as a way of formally instituting work, detracting from the contention that the quality of nursing care is attributable to personal attributes of practitioners.

Nurses therefore distanced themselves from one version of occupational-level professionalism, whilst simultaneously advocating the necessity of professionalism as outward display. Evetts (2006) has suggested that, in the cases of many groups, 'occupational' professionalism, defined by aspects such as self-regulation and autonomous practice, is giving way to a contrasting logic of organizational professionalism that reflects managerial concerns and is, effectively, a way of disciplining the workforce into "appropriate work identities, conduct and practices" (Evetts, 2006, p140). It may be tempting to review the professional discourse of the nurses in this study as evidence of this latter disciplinary form of 'organizational' professionalism (Evetts, 2006), however, nurses articulated their conception of professionalism with ideas about patient care in a way that, in fact, appears to subvert this reading.

A professional persona was, seemingly, not adopted in conformity to organizational expectations, but was defended with reference to the needs of patients in whom confidence was supposedly inspired by nurses' professional decorum. Nurses articulated a discourse of professionalism in conjunction with a discourse of patient wellbeing to further the claim that nursing care is inherently motivated by compassion. Rather than being seen as *undermining* the altruistic motivation to provide care, the conception of professionalism to which nurses appealed was effectively subsumed within an overarching discourse of compassionate care, i.e. that acting with professionalism demonstrates concern for patients.

These kinds of articulatory processes demonstrate the potential for discursive ingenuity that can result from the way in which actors draw upon concepts, particularly where these concepts are ambiguous and contestable. In this study, nurses' construction of certain aspects of nursing practice facilitated an attempt to fix a particular meaning of nursing care, though, as has been documented in other research, it is possible that discursive articulations could result in the production of an entirely different conceptualization of care.

For instance, Daykin and Clarke's (2000) study showed that nurses focused on education as a means through which their caring practices could be legitimated, in the face of a perceived threat from lower-grade workers assuming many 'basic' care responsibilities. Thus, rather than being naturally cultivated in the person of the nurse, the ability to provide nursing care was perceived to be predicated upon formal, theoretical knowledge; justifying nursing as a professional endeavour. Other commentators (e.g. Ali & Watson, 2011) have also lauded the establishment of degree-level nursing in expounding nursing care as an intellectual, rather than an innately expressive, skill.

Similarly, it has been posited elsewhere that managerial and/or organizational discourses might be articulated as an internal facet of nursing care, such as when Carvalho (2014) suggests that nurses can utilise managerial initiatives and positions of authority to instigate caring as an organizational concern. In my study, here, however, most of the nurses actively maintained that

managing for care was an activity distinct from practically engaging in it. The conclusions drawn by Brown, et al. (2014), from their study of 'compassion' in mental health care, indicate that this conceptualization of patient care might serve to distort the realization of care as a wider institutional endeavour and suggest that compassion might be recognized in a more systemic way. These examples illustrate that organizational discourses *may* be articulated together with discourses of care in constructing a view of nursing care which is fundamentally different to that upheld by the nurses in the present study.

The essential point, recognised in the concept of articulation, is that the multifarious connotations of concepts like 'profession', or 'management', can be variously utilised, through discursive practice, to serve the interests and proclivities of the actors in a given situation. In this case, nurses presumably saw value in emphasising the personal attributes that were deemed necessary to providing compassionate care and so resisted anything that might be seen to undermine the link between caring, and a nurse's innate will and capacity to provide it. The idea of caring as a professional skill might be seen to eschew the importance of a nurses' personal investment in their role and was therefore subject to reservation.

Ostensibly, the predominant views on nursing care exhibited in this study are not entirely novel. Accounts of caring as personally motivated and unamenable to formal prescription have certainly been advanced before (i.e. Woodward, 1997) and are contained in the well-established conception of nursing as a vocation. However, the means of, and impetus for, upholding this particular view of nursing care arguably reflects the contemporary situation, rather than simply reiterating enduring sensibilities. For instance, no nurses in my sample of interviewees made reference to a religious impulse in explaining their commitment to nursing, which may certainly have been in evidence not that long ago (e.g. Savage, 1995). Nor did respondents draw any explicit links between femininity and nursing care; a relationship which, historically, has explained the notion of a natural proclivity to care (Grey, 2012; MacKay, 1990). Instead, it was suggested that innate personal characteristics provided the

basis of nurses' caring attitudes and actions, rather than any group-based form of socialisation.

The ultimate aim of CDA is attempting to explain discursive practices in relation to the contexts of their construction. I have here posited that nurses, in this study, have, for the most part, adhered to a discourse which stresses caring as internally and personally motivated, and that nurses articulated this, significantly, by negating other ways in which care could be framed, i.e. as the object of professional practice and/or academic theorization, or as removed to the level of organization. In order to try to understand the perceived value in this discourse, CDA advocates that researchers look beyond texts to the wider contexts in which they are constructed, As Fairclough asserts: "text analysis alone is not sufficient for discourse analysis" (cited in Jorgensen & Phillips, 2008) because it fails to show how discourse is socially instantiated. In this vein, I suggest that there are elements of the contemporary nursing environment which might provide the impetus for nurses' discursive practices in this study. Much of what nurses said reflected, or seemed to engage with these wider elements.

For instance, nurses' ambivalence to the idea of professionalised care appears to correspond to more generally-held concerns that a professional outlook minimises the importance of compassionate care (e.g. Smith, 2012; Corbin, 2008). It is perhaps the case that refuting this charge is especially important in the current climate where nursing's recently acquired educational credentials have coincided with a raft of highly-publicised instances of care failures (prominently, Francis, 2013). Much recent commentary on nursing is contemptuous of a professionalizing impetus, supposedly cultivated through higher education, prompting 'too posh to wash', or 'too clever to care' accusations (Kelly & Smith, 2016, p112) against which nurses are compelled to defend themselves. As Smith (2013, quoted in Kelly & Smith, 2016, p98) wrote around the time of the Francis Report, nursing needs to "counter the scapegoating of nursing by drawing on the wisdom and experience of generations of nurses to show once again to the public how nurses still care". Appeals to personal integrity made by individual nurses may be seen as one

way of achieving this, especially given the tendency of the media and politicians to blame “individuals or certain groups” for failings in care (Allan, et al., 2017, p179), namely ‘nurses who don’t care anymore’. It is arguable, also, that formal steps towards professional recognition have not resulted in many tangible gains for nurses themselves and so the advantages in subscribing to an overtly professional discourse are unclear. As many of the more recently qualified nurses in my study attested, university-based, theoretical articulation of caring bore little correspondence to actual working conditions, and this may partly explain why a ‘professional’ approach to caring has not been embraced. Additionally, nursing remains relatively poorly remunerated, even as responsibilities increase which, again, renders the value of professional rhetoric questionable.

Relatedly, as MacKay (1998) has suggested, a nurse’s personal investment in the care that they provide allows them to gain a sense of work satisfaction beyond monetary reward. With unprecedented demand for hospital services, this import of individual commitment is arguably even more acutely felt because nurses feel they must rely on themselves as caring persons to elide the restrictions on personal care, as evidenced by several nurses when describing the ways in which they tried to provide ‘extra’ care, often through personal sacrifices.

It is possible to conceive of a contrasting discourse in which nurses perceive the increasing demand for services as justification for taking a more instrumental approach to care, with curative interventions being prioritized (see Dingwall & Allen, 2001). However, nurses were consistent in constructing a discourse which emphasized their own expressive caring capacities and so they sought to retain the importance of engagement in interpersonal care, despite pressures on time and resources.

The next section of the thesis draws upon the findings of my research study to further elaborate the relationship between nurses’ perspectives of professionalism and their views on care and caring. In it, I consider some of the perceived difficulties in reconciling ‘care’ with ‘professionalism’, as well as contemplating whether occupational adherence to either of these impulses is

pragmatically viable. Some other potential theorizations of nursing work are evaluated and I reflect upon the variable contextual factors that might contribute to the articulation of nursing's occupational discourse.

5. Discussion of Findings and Conclusions

These concluding chapters expand upon the empirical findings of this study and consider their wider significance in terms of contemporary nursing practices. For instance, ambivalent attitudes over the notion of 'profession' prompt discussion as to how, if at all, a professional basis for practice could effectively be recognized. It is ultimately suggested that the use of 'profession' is contextually contingent and so perhaps efforts to identify the 'source' of nursing professionalism are frustrated. In light of nurses' (in my study) discursive use of 'profession', I suggest that myriad meanings may be conveyed by the concept, including the denigration of aspects of professionalism, and that this should be borne in mind when employing 'profession' as a conceptual category. The views of nursing care as relational and fundamentally interpersonal are considered in the context of growing demand for services and the recognized need for health and social care integration. I argue that this view of 'care' is restrictive and posit that caring is realised in the combined efforts of all those involved in healthcare provision, and is not the sole responsibility of nurses. Before offering some concluding final thoughts, I outline some suggestions as to how insights from this research might be used to inform other similarly-oriented research, in particular, contemplating the possible methodological contributions of Actor Network Theory which give more explicit attention to the material bases of nursing's discursive practices.

5.1 Reconsidering Nursing Professionalism in Relation to Care

Something that these findings strikingly demonstrate is the persistent relevance of debates concerning nursing's professional status, and its occupational identity. Many of the issues surrounding the purpose, maintenance and direction of the occupation that were raised as long as 30 years ago seemingly remain fundamentally unresolved.

For instance, Melia (in 1987) posited ideological tensions between a number of factions reflecting various interests within an heterogeneous occupational group. None of these segments appears to have decisively determined nursing's outlook vis-à-vis its professional standing. The 'academic

professionalizers' (Melia, 1987, p158) may have ostensibly gained ground with the advent of degree-level entry into nursing and formal subscription to a professionally regulated code of conduct (NMC, 2015), yet, on the evidence presented here, nurses display a reluctance to describe their caring practices as founded upon a theoretical knowledge-base, or in relation to official standards. Nor however do nurses, like the 'rank and file' described by Melia, appear to have fallen back on a 'para-professional' identity gleaned from the performance of doctor-devolved medical tasks; basking in the reflected prestige of the medical profession. In fact, the nurses interviewed were largely unenthusiastic about having to perform this kind of work, even as these extended technical-medical roles become a more prevalent part of the job. Finally, the idea that nursing might have come to emphasise management functions, i.e. the planning of care and the supervision of other (lower grade workers) in its delivery, as the basis of a professional identity (Melia, 1987, p178 & pp183-184) has, too, not been realized as illustrated by nurses' apparent derogation of managerial activity and a widespread reluctance to apply for positions above the level of staff nurse.

Moreover, the continued salience of a vocational ideology has implicitly undermined the coherence of nursing's professional project, despite several commentators predicting that professionalizing tendencies would serve to displace vocational motivation in nursing recruits (Woodward, 1997; MacKay, 1998). Conversely, the nurses with whom I spoke described their work in vocational terms (both tacit and explicit), significantly, via claims that they possessed natural characteristics that made them inherently suited to caring for people. Indeed, it is possible that subscription to vocational discourse has garnered increased significance in light of nursing's attainment of some of the formal symbols of professionalism; nurses may, in fact, be keen to demonstrate that being a nurse transcends the occupation's institutional production and so seek to (re)emphasise a personal commitment to the job.

Ultimately, despite a nominal acceptance of the label of profession, the articulation of nursing professionalism remains ambiguous; Jan Savage's (1995,

p92) questions “Should nursing want to be a profession and, if so, what do we mean by it?” remain highly relevant.

5.1.2 The Problem

As Melia states, “Nursing, it seems, has problems on almost any analysis when it seeks to lay claim to the status of profession” (Melia, 1987, p182). What might be conventionally considered a primary means of claiming professional status- namely, the possession of a discrete and unique knowledge base- has, thus far, proven to be unsustainable. On one hand, nurses cannot vaunt their medical knowledge as the foundation of their professionalism as, on this measure, they will inevitably be considered inferior to doctors and cannot stake a claim to a discrete social location within the healthcare milieu. On the other hand, nurses’ *caring* role, manifest in relationships with patients, has not been embraced as constituting professional knowledge because to do so would detract from the firmly held contention that caring work is altruistically motivated, and allows nurses to act upon personal caring dispositions. Claims that caring is a professional undertaking may put at risk the notion that it takes a certain, special kind of person to be a nurse. As Apesoa-Varano (2016, p41) explains:

“...accounts of caring as requiring valued knowledge that is codified and taught (a key to its being recognized as a skill and not merely an inherent gendered talent or natural trait) imply a double-edged sword, as this knowledge and skill set may be appropriated like any other form of expertise for sale to expand medicine’s territory.”

It seems clear that nurses wish to emphasize caring as the fundamental core of their occupational identity but fear that association with ‘professionalism’ undermines the affective nature of the concept. Instead, nurses’ usage of the term ‘professional’ is limited to referring to professional ‘conduct’, rather than as having any firm conceptual underpinning. Ironically, it might be argued that nurses’ ambivalent use of professional discourse serves to re-affirm a vocational outlook; nurses claim to *behave* in a professional manner so long as this behaviour contributes to the welfare of their patients, in which nurses are personally invested as caring individuals. Thus, nurses use the idea of professionalism in a way that does not threaten the subjective status of the

care that they provide; at the same time, however, it may not do much to advance the causes of the wider occupational group, for example in relation to working conditions and pay; “nurses who may expect to be rewarded for their skilled caring work might be deemed as selfish or unscrupulous” (Apesoa-Varano, 2016, p41).

Mindful of this dilemma, some authors (Allen, 2014: Willard, 1996) have speculated on the possibility that professionalism might be articulated via a different focus that would allow nurses to present “the united front (that) is clearly required when nursing deals with other groups” (Melia, 1987, p183) without directly challenging the notion of care as being personally impelled. For instance, Apesoa-Varano (2016, p31) argues that nurses, by “emphasizing other critical roles (i.e. intermediary and advocacy), might elevate their professional status” without necessarily encroaching upon a caring ideal that centres on nurses as virtuous, caring individuals.

5.1.3 Alternative Bases of Profession

The roles that Apesoa-Varano fleetingly suggests as possibilities for articulating an alternative professional claim -intermediary and advocacy- are worthy of consideration as they appear not to require that nurses’ relationships with patients are directly circumscribed by the perceived impersonality entailed by ‘professionalism’. Furthermore, intermediary or advocacy functions are not generally considered to be the domain of any extant occupational grouping and thus might allow nurses to demarcate a discrete location within a mixed healthcare workforce.

An advocacy role could, in fact, be considered as complementary to nurses’ stated instinctive and natural abilities; nurses’ personally-felt concern for their patients and their (self-proclaimed) inherent relational skills could be considered as a prerequisite for the realization of a more formal advocacy role. Although the role of patient advocate was not explicitly mentioned by most of my respondents, a couple of nurses did make the case that, as holders of intimate knowledge of patients, nurses might be best placed to represent their interests to other professionals, namely doctors:

-“I think standing up for our patients as well with some decisions, erm, it’s not that the doctors go against the patients or anything like that but I think sometimes we’re the voice of the patients ... it’s just like, you know-we’re hands on with the patients, we know them well. You’re (doctors) making these decisions and you don’t really know the patients, as well as what we do”

(Hannah)

-“It’s important to, you know, listen to their views and, especially as nurses, we’d be the ones that are working as advocates for your patient where there’s a doctor making decisions so, yeah.”

(Brenda)

However, there are potentially a number of difficulties that might arise were nurses to more formally adopt the position of professional advocates. First and foremost, there is the possibility of discord between a patient’s wishes and that which is medically (i.e. physiologically) best for them. For instance, in the extreme case that a patient expresses a desire to die, should it really be the nurses’ place to argue for the realization of such a request? Secondly, there may arise difficulties if/when patients’ preferences come into conflict with those of the nurse or, indeed, other patients. As Willard (1996, p63) puts it, a nurse has a ‘beneficent duty’ to a number of patients whose wants and needs must all be considered, and a nurse may struggle to give equal representation to what may be highly divergent patient interests. Relatedly, the extent to which nurses can successfully advocate on behalf of their patients is limited by the resources of the National Health Service; available treatments, space, facilities and so on. This is likely to engender frustration as nurses’ efforts may be met with limited practical success. Moreover, some authors (Willard, 1996: Mitchell & Bournes, 2000) have expressed consternation that the identification of advocacy as a unique role for nurses might be expounded primarily to advance professional claims. As Mitchell and Bournes (2000, p207) propose; “...professionals are focused on achieving their goals, and this focus raises issues of serving personal interests”. In short, nurses may come to perform the role of advocate primarily in order to demonstrate professional credentials and to fulfil a professional role. Mitchell and Bournes worry that professional models of advocacy might provide scope for nurses to speak *for*, rather than on behalf of, their patients. For instance, in their roles as advocates, nurses suspecting that a patient is in an abusive relationship would feel professionally

obliged to intervene, even where a patient has not confided a wish for any such action (see Mitchell & Bourne, *ibid*).

The 'intermediary' status of the nurse is arguably a more fruitful avenue of expression as far as professional activity is concerned. Davina Allen (2014) makes a convincing case that nurses' *organizing* abilities be foregrounded as the foundation of professional practice. The organizing role describes the work of frontline nurses who "work in the sites of care and at critical service interfaces, where they navigate the interstices of healthcare systems to assemble and align the constellation of actors through which services are delivered" (Allen, 2014, p133). In short, nurses' key role is that of coordinator; bringing together the discrete components necessary to provide patient care. Allen identifies several skills that nurses must possess in order to successfully fulfil this role and which identify it as a plausible basis of claims to professional status. Prominently, the abilities of synthesis and translation are highlighted; keeping track of all information pertinent to the care of a patient and communicating applicable information to relevant groups (doctors, physiotherapists, social workers, patients themselves) in comprehensible ways when required (Allen, 2014). Allen is keen to point out that these activities consist of more than simply a capacity for remembering things; "Decisions had to be made about what to take note of and what to ignore and the relationship between different knowledge sources had to be adjudicated" (Allen, 2014, p133). Nurses' intermediary position, between different groups of professionals, but also between different forms of situated knowledge, gives nurses an uniquely influential role; as Allen (2014, p136) summarises, "they make the connections across occupational, departmental and organisational boundaries and mediate the 'needs' of individuals with the 'needs' of populations."

One particularly appealing aspect of Allen's argument is that it seeks to bring professional discourse in line with that which nurses actually do, as opposed to an exclusive focus on patient relationships which, in reality, do not constitute the majority of nursing work. Instead, the notion of professional organizing makes a virtue of the fact that nurses undertake a range of interconnected

tasks, rather than attempting to identify any one singular aspect around which a professional identity might cohere. Organizing as the basis of professionalism would, again, appear to allow nurses to maintain an essentially personal approach in their direct relationships with patients as they enact professionalism at a structural, rather than interpersonal, level. Also, this kind of intermediary work is uniquely applicable to nursing and so forms the basis of a discretely identifiable professional position in the field of healthcare work. As Allen (2014, p137) claims:

“This is clearly a holistic approach to healthcare, and a unique orientation not shared by members of other professions, but quite different from the bio-psycho-social model that has dominated nursing’s jurisdictional claims in recent history, and underpinned by a subtly different knowledge-base and skill-set.”

It could be countered that ‘organizing’ is too vague a concept to successfully elaborate in claims to professionalism as, clearly, it encompasses a range of skills, both technical and interpersonal, with no single element readily predominant. As such, there is no singly recognizable body of knowledge that can be cited as underscoring practice, unlike, for example, the relatively unproblematic relationship between physicians and the field of bio-medicine. However, it may simply be the case that the multifariousness of nursing will never accommodate a specific theoretical foundation for practice. Rather than a unique body of abstract knowledge, conventionally recognized (though disputed) as a hallmark of professionalism (Leddy & Pepper, 1993; Liaschenko & Peter, 2003), nursing’s claim to profession arguably rests on the distinctiveness of its occupational positioning, from whence it combines an array of knowledge and skills. This recognition echoes Beryl’s contention that, owing to its diverseness, the ‘nursing role is unique’ but who, along with several other of my respondents, could not accommodate this ‘uniqueness’ within a discourse of professionalism. Possibly beholden to notions of profession as referring to one clearly demarcated area of expertise, many nurses, in effect, contributed to the sense that the realities of nursing work are not easily aligned with conceptions of professionalism.

Indeed, there has been a tendency, historically, for nursing to pinpoint its *raison d’être* on a continuum ranging between technical-medical knowledge

(as with the students in Melia's study who denounced 'basic care' as 'not really nursing') and emotive caring skills, entailing an explicit emphasis on the 'nurse-patient relationship' (Dowling, 2006). Between these polarities are concepts like the 'nursing process' which have sought to elucidate the confluence of 'physical' and 'social' sciences involved in nursing diagnosis and treatment (see Hammond, 1978) but which, according to Liaschenko & Peter (2003, p490) only served to reveal "the ambivalence that nursing experiences vis-à-vis medical knowledge: we (nurses) were simultaneously striving to be like and to be distinct from physicians." This helps to explain how the potentially vast 'bio-psycho-social model', to which Allen refers, has arguably proved a problematic resource from which to derive a coherent professional identity.

However, if 'professionalism' is recognized for its utility value, as a term that explains what a specified occupational group does in practice and why this work is important, rather than merely a symbolic pursuit, there seems no reason, in theory, why nursing may not nail its professional colours to the mast of organizing work. Focusing on nurses' roles as organizers and coordinators within healthcare systems arguably circumvents the dualistically conceived relationship between expressive relational care and scientific knowledge. Both elements may be critical to nursing work but foregrounding 'organizing' as a professional endeavour presents a pragmatic means of conciliation. Nurses' organizing activities are responsive, reactive to developing need and unforeseen contingencies and it is 'organizational awareness' (Allen, 2014, p137) that dictates nursing action as much as any abstract theoretical knowledge. In this way, nursing principles might be recognized as more practical than philosophical.

If nursing were to embrace its influential intermediary position within the healthcare system as the basis of its professional credentials, the question remains as to whether this sense of professionalism could be successfully articulated alongside the caring ideal typically encapsulated in discourses of vocation. I have argued here that a 'professionalized' approach regarding direct patient care has had limited success because it openly conflicts with nurses' assertions that relational caring work depends upon an inherently

caring central self. It was therefore mooted that, by focusing on a different set of relationships (i.e. not nurse/patient) as the locus of professional work, it might be possible to retain the sense of personal commitment that nurses view as essential to the role. It might, perhaps, also be worth considering, however, that foregrounding organizational skills as the basis of nursing professionalism could risk a (re)capitulation into gendered stereotypes, albeit of a different nature, namely, women's ability (and a concomitant male inability) to 'multi-task'. Furthermore, as both Allen (2014) and Apesoa-Varano (2016), respectively, contend, the centrality of 'patient relationships' and 'emotive caring' to nurses occupational discourse might obscure the significance of other aspects of their work, even as they would appear to represent a more realistic reflection of that work as a whole.

However, taking a more longitudinal perspective, some authors have made the case that the stress on relational caring as the core, or essence of nursing is not, in actual fact, a timeless and abiding feature of its occupational identity and, as such, it might not be complete heresy to propose a recalibration of nursing's current ideological leanings. For instance, Anderson (1983, p458) claims that, before the 1970s, nurses' relationships with their patients were conducted with 'mechanistic passivity' and emotionality was notably absent from nursing literature until relatively recently; instead, the principle focus of the nurse was the physical, bodily care of patients. It is only via some historical revisionism (particularly regarding Florence Nightingale's vision of nursing) that the primacy of the caring relationship of a nurse to their patient has been contemporarily sustained. If we recognize that "the nurse's role changes more as a function of societal shifts than as a result of any actualisation of the "essential" nature of the profession" (Barker et al.,1995, p390) we may also recognize the ability for modern nursing to adapt to the social structures which determine its value.

Barker (et al.) is especially critical of nursing's' adoption of the notion of the 'caring ideology' to pronounce a core occupational identity. More than simply identifying a formal focus on 'caring' as a relatively recent development, and therefore not the very quintessence of nursing, Barker (et al.) contends that

nursing has no right to lay especial claim to the concept at all, arguing that 'caring' is not uniquely demonstrated by nurses but applies to countless areas of social life, including the work of other occupations (Barker, et al. 1995, p389). Furthermore, Barker (et al.) expresses deep concern over the apparent baselessness of such a claim on 'caring', arguing that, insofar as it relates to nursing, there is no conceptual agreement as to what it means, or the ends to which it is directed (Barker, et al. 1995, p394). A chief criticism contained in Barker (et al.)'s argumentation, but also present in other accounts (e.g. Liaschenko & Peter, 2003) is that the foregrounding of a 'caring' ideology as the essence of nursing is internally derived; that is to say, it reflects how nurses see themselves rather than the needs of the population to whom they serve. Barker (1995, p934) maintains that the core focus of nursing should be determined "by the ends they (nurses) wish to achieve; or what patients wish them to achieve." Moreover, the commitment to a caring ideology is discriminatory among different types of nursing; the perceived centrality of the nurse/patient relationship and concomitant focus on emotive caring means that the work of, for instance, surgical nursing, fails to capture the supposed essence of the occupation in that patient contact may be transitory, and the patient may not even be conscious for much of this time.

None of this is to say that nurses cannot, or should not, be caring persons or even that they should refrain from citing their caring characteristics as a motivational spur for doing the work that they do. However, the practical utility of foregrounding 'caring' as the basis of an occupational, or professional, identity is questionable in that it projects an internal sense of self-worth onto the value of the services provided. Nursing actions are valued by the extent to which they are perceived to represent a caring ideology, whereas the core activities of other occupations do not rely on such subjective assessment and, as such, are better able to elaborate the bases of professional practice as they are determined by the needs of service users.

For example, a surgeon may have been compelled to pursue such a career by inherent caring tendencies, however, this compulsion does not define the essential nature of the occupation. The application of specific knowledge and

skills determines the professional content of the job and this is explicitly demonstrable. The surgeon's emotive investment in their work does not determine the realization of professional competency (though it may provide *personal* validation). The same may be said of psychiatrists, social workers and even teachers.

If nursing does indeed want to be a profession, then arguably, it must recognize that the commitment, of individual members to a caring ideal based upon emotional connection with, or concern for, patients (or, for that matter any other set of personal ideals) does not preclude the articulation of a qualitatively different logic of professionalism; one which is more easily defined and demonstrated and which reflects the everyday realities of nursing work.

5.1.4 Alternatives to 'Profession'?

Some commentators have questioned the utility of trying to elucidate the work of nurses as a professional endeavour and have instead argued that the label of 'profession' be abandoned altogether. For instance, Liaschenko and Peter (2003) contend simply that 'work' should be used to describe the complex of activities that nurses engage in. In part, the authors' argument against the use of the term profession seems to rest on the difficulties of fitting the work of nurses into conventional, criteria-led theories of profession. In particular, they concentrate on the inability of nursing to establish autonomy over its practices, which are curtailed by the organizational structure of modern healthcare systems (Liaschenko & Peter, 2003, pp490-491). As argued here elsewhere, if we view professionalism as a rhetorical resource, rather than as the fulfilment of objective criteria (i.e. 'autonomy over working practices') then we need not adjudge nursing's professional discourse to be inherently lacking on the basis that it fails to align with prescribed criteria. That said, there is a sense in which more newly emergent professional claims are perhaps more difficult to sustain due to the proliferation of professional rhetoric in public life. As Watson (2002, p95) states; "The word "professional" is used to cover a potentially bewildering variety of things" ranging from the standard of service delivery (a 'professional' plumber for instance might be clean, efficient and polite), to denoting the

contracting out of specific business functions (e.g. IT systems maintained by 'professionals'), to simply being paid for something as opposed to doing it voluntarily (i.e. a 'professional' musician).

This context, in which professionalism is widely and variedly used, may dilute the potency of nursing's claim to professionalism, which is without the benefit of long historical establishment. This is perhaps one credible reason why striving for professional status is perhaps not worthy of such significant preoccupation. The term profession, arguably, simply signifies less than it once might have done and may not be a guarantee of the respect and prestige afforded to other traditional and well-recognised professional institutions. Perhaps nursing would be better, or just as well, served by finding alternative conceptual categories, such as 'work', that more adequately reflect nursing and its role in society. Liaschenko and Peter (2003) make the case that 'work' articulates more than 'profession' in that it can refer to all of the activities in which a nurse engages and does not privilege any one type of action or relationship.

Another factor underpinning calls to abandon 'professional' as a descriptor of nursing work is consternation over the ends to which a professional discourse is employed. The particular concern over 'profession' is that the concept is used, less to elucidate that which nursing actually does, and more to advance the internal cause of the occupation; "Striving for uniqueness can move the focus of a group's efforts on to the group itself, taking it away from those the group has intended to serve" (Liaschenko and Peter, 2003, p490) and may result in a gulf between occupational license and professional mandate. The very fact that the bases of professional practice for nursing is not self-evident and necessitates extensive debate about where nursing should focus its professional efforts is arguably justification enough to contemplate aborting this search.

5.1.5 Discursive Pragmatism

In consideration of the various and diverging perspectives on nursing's professional status found in the literature, it is apparent that there is no consensus upon what might constitute a credible professional identity for the occupation, or, even whether claiming any such identity is desirable. This uncertainty is quite plainly reflected in the conversations that I had with nurses and is perhaps best summated by Lucinda who, when asked 'Do you consider yourself a professional?' replied; "Well, I know I am but I wouldn't sort of class myself like that, but I understand what it means and what's expected of you." Several other nurses were similarly cognisant of nursing's professional project, but reluctant to fully embrace the term to describe the core content of their work. It is perhaps this ambivalence that has prompted proposals of normative solutions; i.e. identifying a fresh and distinct basis of professionalism to which nurses might more readily subscribe and which might combat indifference to professional status (Allen, 2014) or appealing to other means of conceptual categorization that eschew the need to define 'professional nursing' (Liaschenko and peter, 2003). However, these debates as to how nursing *should* define itself and the purposes that any self-definition *should* serve overshadow, to some extent, the immediate circumstances of nurses' professional discourses.

The implication of commentators pronouncing on the attitude that nursing should take in relation to its professionalism is that current nursing narratives are impoverished, but that this may be rectified by commitment to a well-theorized course of action. However, it may be the case that occupational ambivalence concerning professional identity is, in fact, a pragmatic response to the contemporary healthcare environment. Savage's questions referred to towards the beginning of this chapter concerning whether nursing should want to be a profession and what this might mean might not be answerable in *absolute terms*. The (admittedly unedifying) answer is perhaps that, under certain circumstances, nursing might endorse the idea of profession, and that the meaning of this is contingent upon particular situational factors. Subscribing to a professional identity is observable when to do so might

benefit the workforce; at other times, the articulation of a vocational discourse may be more advantageous.

For example, the nurses in Daykin and Clarke's study (2000), unlike most of the nurses with whom I spoke, were eager to emphasise the notion of nursing professionalism and cited their advanced training as providing a theoretical basis for practice; in effect, appealing to fairly conventional notions of professionalism in justifying the value of their work. In this case, nurses' professional discourse was considered within the context of NHS organizational changes wherein a new tier of healthcare assistants had been employed to undertake certain aspects of basic care, previously performed by qualified nurses (Daykin & Clarke, 2000, p351). The nurses' assertion of their professional credentials can thus be understood as a product of these structural changes, with qualified nurses keen to affirm hierarchical distinctions between ward-based staff. Under these circumstances, nurses utilized professionalism as a discursive resource to militate against the perceived threat introduced by 'skill-mix' strategies, which were seen as potentially undermining nurses' unique contribution to care (Daykin & Clarke, 2000).

It may be that future shifts in the composition of the workforce, or continued stagnation in wages will prompt nurses to (re)emphasize certain aspects of professionalism though, with the role of healthcare assistants now firmly established, the respondents in my study did not appear to be overly concerned with firmly demarcating the bases of nursing professionalism. Perhaps this reticence is similarly explicable in light of the present 'zeitgeist' of nursing.

For instance, the recent, and highly publicised, failings in care standards at the NHS Mid-Staffordshire trust have engendered a focus on whether UK nursing suffers from a 'compassion deficit' (see Stenhouse, et al, 2016), and the caring characteristics of nurses have come into question. It is not difficult to comprehend the effect that these events, and subsequent interrogations, may have had on nurses' self-perception and the articulation of their own occupational identities. Nursing narratives which stress the importance of the

inherent, caring qualities of individual nurses may be read as a response to the potential perception that nurses have become uncaring or even callous. Emphasising their own *personal* compassion allows nurses to distinguish themselves from the 'bad' nurses who would permit such deficient practices, and to distance themselves from the organization which ultimately failed to prevent them from happening. Indifference to professional aspiration is, perhaps, a necessary corollary to the affirmation of a deep-seated, personal commitment to compassionate care. Rather than an *inability* to articulate a claim in relation to professional status, it may be more that the current climate represents inopportune conditions to do so, and that nursing narratives are constructed in the service of more pressing priorities, namely, distancing themselves from complicity in poor care and assuaging public mistrust.

It is also worth considering what effect the move to all-graduate level training has had on nurses' professional outlook. Nursing's move into higher education, formally at least, represents a conspicuous means of advancing claims to professional status. The construction of professionalism at an institutional level has, arguably, afforded nurses the freedom to downplay its importance to their own occupational identities and provided a necessary backdrop for the expression of nostalgia. Nurses' ambivalence concerning the professional advancement seemingly heralded by degree-level registration may be a response to concerns that academicism threatens a caring outlook (see Mackay, 1998). Though, as Mackay (1998, p68) points out, the 'academic nurse' has long been the subject of wariness, it is perhaps the recent, *official* establishment of degree-level registration for nursing that has provided contextual relevance to the responses of several of my interviewees. Rather than being seen to jump wholeheartedly on the professional bandwagon, nurses express doubts as to the academic bases of their practice, in order to demonstrate that higher levels of education have not facilitated a fundamental change in identity.

Considering that degree-level nursing has only been obligatory since 2013, it will be of great interest to see how nurses perceive their professional status in relation to the education they receive in 10 or 15 years from now. Possibly,

when the academic aspects of nursing become more normalised and established, nurses will invest them with greater significance. Equally, it would be fascinating to see how nurses would respond were nursing's status as a graduate subject to be (by some unforeseeable means) revoked. In this respect, it is certainly worth tracking the development of the newly established apprenticeship route into nursing, and looking at how these new recruits are received and assimilated.

Ultimately, it may be that nursing's continued uncertainty surrounding its professional credentials has been protracted in response to fluctuating situational circumstances. The negotiation between a newly emergent professional impulse and an enduring vocational rhetoric has permitted shifts in emphases as nursing has responded to emergent events and changing sentiments. Whether this indeterminate state can endure is questionable (though it has been already sustained for a considerable time). Whatever descriptor (profession, vocation, work, craft) is used to categorize nursing care, it seems that, from considering the results of my own work alongside wider debates about the occupation's identity, the terms of its elaboration will likely be subject to continual modification.

5.2. The Study of 'the Professions'

That the concept of profession is multifaceted and context-dependent has been contemporarily acknowledged by writers and theorists, such as Watson (2002) who recognises the multitude of occasions on which the term is employed. In addition, new forms of professionalism have continued to be theorized, from Evetts' (2003) identification of professionalism as a rhetorical device used to impose managerial control, to the neo-institutional concept of 'organized professionalism' (e.g. Noordegraaf, 2011; Muzio, et al., 2013). However, proliferation in the use of the term 'professional' has not been accompanied by a concomitant rise in the ranks of 'the professions'. This indicates that the link between 'profession' and an occupation is by no means straightforward. Indeed, instances of occupational groups who are readily and consistently accepted as 'professions' can arguably be counted on one hand. Attempting to enumerate certifiable professions, we might get as far as doctor,

lawyer, and possibly teacher before beginning to query subsequent candidates, and even recognition of these examples owes as much to received wisdom as it does to the utilization of any kind of formal schema. The professions literature is rife with examples of ambiguous cases which we may, or may not accept as professions for a variety of different reasons, or perhaps simply depending on the mood we are in (see, for instance Abbott's discussion of beauticians, estate agents and auto-mechanics (1988, p9) or Scuilli's radical proposal that Parisian sculptors and painters in the 'Ancien Régime' represent the prototypical profession (2010)). Perhaps then, a 'sociology of the professions', per se, represents an unhelpful framework for research; specifying 'the professions' which are to be investigated is contentious and eschews a great deal of professional discourse that does not directly apply to a bounded occupational grouping. An individual can proclaim to behave professionally without making any related claim to being a member of a profession. The case of nursing demonstrates how the terms profession and professionalism have different connotations *within* a specified occupational group, and how these terms are discursively employed to achieve different things.

Attempts to concretely define a profession (via the identification of salient attributes, or indeed one single essentializing feature), or to cast professionalization as a strategy for power (closure theories) falter in relation to nursing. Any 'objective' features of professionalism such as heightened academic standards and a formalized professional code of conduct (i.e. NMC, 2015) have not simply translated into verified professional status. This is demonstrated, at one level, by the fact that few nurses in this study were eager to embrace the term to describe their own practice, including those who had qualified, or were about to qualify, with a degree, and also by the continued debate among nursing commentators around the proper focus of nursing professionalism (Allen, 2014; Paley, 2002), and ongoing discussion of whether 'profession' is even a desirable descriptor for the occupation (e.g. Liaschenko & Peter, 2003).

Furthermore, in the case of nursing, the idea that professionalization represents a strategy for occupational closure is problematic when 'care' is considered to be the basis of nursing's professional expertise. As has been discussed here at some length, the notion that caring can be encompassed within a professional framework has been (often strenuously) resisted by nurses as it is seen to negate caring as a personal expression. Indeed, the conception of caring abilities as predicated upon a nurse's personal characteristics represents an equally potent claim concerning the occupation's unique focus on care; that to be a caring nurse requires particular inherent traits that not all can possess. In this way, *resistance* to 'professionalism' might actually add greater discursive weight to the claim that nursing has an exceptional affinity with caring; its practitioners having a tacit and emotive understanding of caring, transcending that which can be professionally constituted. Consequently, disavowing professionalism as the basis of caring practices and instead arguing for the value of personal qualities serves as a means of demonstrating nursing's unique disposition for caring. As Both Apesoa-Varano (2016) and Sabatino (1999) have, respectively, observed, the professionalization of caring has been perceived as also signalling its commodification, diminishing its expressive nature which distinguishes it from the mechanistic application of learnt skills and codified knowledge.

Resistance to professionalism is arguably an important feature of 'professional talk' (Watson, 2002) and shows how individuals use the concepts of 'profession' and 'professionalism' in support of particularistic identity claims, and not necessarily in service to an occupational claim to the status of profession. This could be a pertinent consideration for subsequent research that seeks to examine discourses of professionalism. In the research reported here, nurses' ambivalence over describing their caring work as a professional activity was interpreted as a discursive strategy employed to affirm the primacy of a personal, naturally-felt commitment to caring for others. When 'professionalism' was described, it was in reference to outwardly observable behavioural conduct, engaged in to show patients that nurses were competent and trustworthy, but that could be relaxed to reveal a more fundamentally

humane concern with patients' wellbeing. In these ways, nurses' 'professional talk' was employed in service to a predominantly vocational narrative.

Even Robert Dingwall, who rightly contends that 'profession' should be analysed as it occurs in discrete occupational contexts, and not in terms of absolute significance, has referred to profession as an 'accomplishment', and endorsed research that examines how occupational groups go about staking a professional claim.

"I contend that we need to carry out further studies of what appeals are made, how they are made and in what settings they are made in such a way as to accomplish the production of an occupation as a 'profession', for the purposes of its members"

(Dingwall, 2008, p26)

What this misses is that the 'accomplishment of profession' is not necessarily the sole, or primary end, to which professional discourse is elaborated. Even within a single occupational grouping, notions of profession and professionalism can be used to perform a number of functions and this potentiality is worthy of further exploration. In nursing, professionalism has been advocated as a means of raising the profile of the occupation and attracting able and ambitious candidates (e.g. Ali & Watson, 2011), while, in other discursive contexts, has also been held culpable for deficiencies in nursing care (Woodward, 1997; Corbin, 2008).

Nursing arguably represents an unique case for study in that the proposed object of its professional knowledge, care, is also attributed to the possession of certain natural characteristics and is thus contested. This is not the case in, for instance, medicine where professional knowledge is avowedly technical in nature; it is unlikely for a doctor to claim that they just have a 'natural feel' for diagnosing diseases or for knowing which drugs to prescribe. Nevertheless, a pertinent avenue of inquiry is presented in examining the multiplicity of professional discourse and its effects upon the constitution of practice. If 'professional talk' is not simply to establish formal professional status, then it is worth asking how it operates in different contexts. One particular area for investigation might be how the connotations of 'professionalism' interact with other contextually specific cultural mores and values. In one such example,

Grenier and Mévellec (2016) make the case that the introduction of formal training for local elected officials (LEOs) contributes to a process of political professionalization which is seen to be at odds with democratic values, in particular, “the principle that all citizens can equally access elected positions” (Grenier & Mevellec, 2016, p34). As the authors report, from their case study; “resistance against the training program and the process of professionalization it entails was illustrated by several critical comments made by a number of LEOs during group discussions with the trainers.” (2016, p46).

Even within those occupations whose professional status is, for whatever reason, more firmly established, it might be illuminating to examine the consequences of their professional discourses. For example, in 2015 a photo of a US doctor visibly grieving the loss of a young patient went viral, in part because it seemed to stand in contradiction to a professional demeanour characterized by clinical detachment. A fellow doctor, Pamela Wible asserted, in an article about the impact of the photograph, that medicine is “a stoic profession that trains doctors to remain professionally distant” (Wible, 2015). Publicly crying might thus be perceived as unprofessional, though may also be welcomed by sympathetic colleagues who are, similarly, expected to observe professional distance. Discourses of professionalism impact, though may also be challenged by, the perception of events.

Another related area worthy of investigation is the relationship between ‘profession’ and the less formal elements of occupational culture. In considering the example above, while crying might be incongruent with medical professionalism, informally there might be some kind of cultural cachet in an emotional expression that demonstrates dedication to saving lives. Alternatively, such a display might be tacitly censured as signifying a lack of psychological fortitude. A former paramedic interviewed for a ‘Guardian’ article claimed that;

“Although a crying paramedic would be unreservedly comforted by their colleagues, once out of sight and earshot, eyebrows would be raised, shoulders would be shrugged and their mental resilience would be questioned. Crying would probably be considered a sign of weakness.”

(Johnson, 2017)

Outside of strictly professional competence, it would be illuminating to identify the other judgements and standards that members of occupational groups use to evaluate the attitudes and conduct of their colleagues. As Bayerl, et al. (2018, p169) write “members of a profession often have very clear views about what it means to be a teacher, designer, politician or soldier”. These views may well reflect the prominence of a number of characteristics besides work-place proficiency, for instance political views or leisure-preferences, which are seen to indicate a good fit for a particular occupational culture. The congruency between such tacit means of assessing suitability and the formal standards of professionalism suggests a fruitful research agenda for studying occupational groups; particularly those that, like nursing, are seen to be pursuing professionalism via official mechanisms, such as accreditation and attempts to establish a formal body of theoretical knowledge, and who perhaps already have strong occupational identities which precede formal ‘professionalism’. Bayerl, et al. (2018, p169) observe that “when professional values come into conflict with organizational cultures and goals, lower identification and commitment are often the result.” It would be worthwhile to see whether, in cases other than nursing, professionalism is accommodated within extant organizational cultures, is decoupled from them, or has upon them a transformative effect.

Furthermore, at a more general societal level, public trust in ‘professional expertise’ appears to be giving way to cynicism and anti-intellectual tendencies (Motta, 2017; Achenbach, 2015) which is surely affecting the operation of professional discourse. The uses of ‘professionalism’ in regard to this trend offer a pertinent area for research, especially in reference to how, if at all, ‘experts’ defend, or modify the rhetoric of professional legitimacy.

In emphasising how ‘profession’ can be used derisively, or acknowledged as in some ways restrictive, I do not intend to suggest that studying claims to profession by occupational groups is redundant, but simply that the capricious nature of professional discourse(s) be firmly acknowledged. Productive use of professional discourse is not always determined by conferring ‘professional status’.

5.3 Nursing Care

One of the striking findings of this research in relation to nurses' perceptions of 'care' is that providing care was elaborated as a distinctly individual undertaking; nursing was characterized as being fundamentally about caring, although underlying this contention was the idea that individual nurses are accountable for upholding this association. In evidence of this, it was acknowledged that some nurses were 'more caring' than others, i.e. "some people go above and beyond and some people do what they have to do ... It depends whether you want to put that extra heart in or not" (Beryl, ANS). Singular acts of benevolence (knowing how patients take their tea, honouring a request for a poached egg, buying chocolate or newspapers for patients) were cited as evidence of caring and, in some instances, as signifying a 'person-centred' approach. Without at all criticizing the intentions of nurses, it might be contended that these kinds of interpersonal interactions perhaps distract attention from the systemic concerns of healthcare.

If nursing is seen as the primary occupational group responsible for 'caring', and, as indicated by this study, readily assumes this role for itself, then its members are more inclined to feel accountable for any shortcomings in direct care provision as well as taking it upon themselves to go 'over and above' that which they are occupationally prescribed to do, in terms of relationships with patients. This impulse is reflected in my study wherein it was observed that the 'extra' care given by nurses was always directed at an interpersonal level, to make up for time spent away from the bedside. While such individual efforts might be admirable, they go little way to addressing the overall crisis in NHS care-provision brought about by an increasingly aged population with complex health and social care needs. In this context, it seems imperative that care is understood as an *institutional* response to need, and not simply as something which takes place between nurses and their patients. This has, of course, been acknowledged in the continuing efforts to integrate health and social care (see, e.g. '2017-19 Integration and Better Care Fund' (UK Department of Health and Social Care, 2017) and 'Health and Social Care Delivery Plan' (Scottish Government, 2016)) so that users can experience continuity between the

services that they use, or to which they are referred, and which is now arguably a more urgent priority than ever. It would be wrong to suggest that nurses' individualistic conceptualization of care is the most significant barrier to such integration; as Glasby (2017, p1) points out, there are more fundamental structural obstacles in need of addressing;

"... health and social care remain separate entities with different legal frameworks, different budgets, different cultures, different geographical boundaries, different accountability mechanisms, and different approaches to whether services are free or means tested."

However, if the integration of care services is to be realised, it would likely demand a recalibration in nursing's self-perception which is that it remains chiefly concerned with direct, interpersonal interactions with patients. Several nurses in this study were unenthused by office work and paperwork and certainly preferred doing practical things with and for patients which was seen to represent 'what nursing's all about'; even ward managers, who enjoy less time spent with individual patients, cited the fulfilment derived from making a direct and tangible difference to particular patients. As Dingwall and Allen (2001) have suggested, though, the diminution of time spent in direct care activities is an inexorable feature of modern-day nursing, while technical, medically-oriented tasks, as well as attendance to administrative work become more prominent. What is arguably of some importance is that these latter aspects of the work are, in fact, recognized as not merely peripheral to the 'real' nursing role, but as being vital insofar as they support the maintenance of an integrated care system. As Davina Allen has noted; "Some have estimated that 'organising work' accounts for more than 70% of nursing activity, yet it has only ever been studied as a distraction from patient care rather than as a practice in its own right" (Allen, 2014, p132). Drawing upon her own empirical research, Allen suggests that nurses are key to ensuring that information about patients is maintained across disciplinary boundaries within the health service, and yet the practices that enable this, particularly documentation and record-keeping, are not embraced as fundamental by nurses.

If health and social care services are to be effectively joined-up, then accurate, timely and informed patient documentation, along with face-to-face information-sharing with colleagues from other clinical specialisms, are crucial facilitators. It may not be a nurse who ultimately provides the majority of primary care to many patients, though their role in needs-assessment and referral can contribute to the overall efficacy of institutional care. Smooth transitions between services, wherein a patient's needs have been accurately determined and planned for, might be said to represent 'person-centred care' in a more comprehensive way than an acute focus on patients' preferences whilst in hospital. Although it may seem counterintuitive to frontline nurses, it might plausibly be argued that much of the essential care provided to a patient could actually be achieved via the indirect mechanisms to which many nurses appear averse, such as attending meetings and devoting time to completing paperwork fully and accurately.

While participation in such overtly administrative activities may be seen to be detracting from the time that nurses spend at the bedsides of patients, it can also be argued that efficient attendance to clerical matters can help to better ensure that standards of basic care are adhered to, preventing further care failings such as those investigated by Francis who, in his report (2013), made several practical recommendations regarding procedure. For example that; "Staff on all shifts, including nights, should have up-to-date knowledge of patient care plans"; "All disciplines should also be involved in all aspects of patients' care and be present at review meetings"; "Evidence-based, standardised procedures, for example surgical checklists, are to be widely used so that care is consistent." (cited by Entwistle, 2013). Despite the sentiment of some nurses that "you shouldn't need a piece of paper to tell you how to care for someone", it is arguable that a clear and rigorous approach to record-keeping could help to inculcate a 'safety culture' (Entwistle, 2013) in which the risk of fundamental breaches in care is minimized. Fawcett and Rhynas (2014, p1239) cite the importance of what they term 'human factors', i.e. "the things that enhance or reduce human performance in the workplace", in maintaining safety and contend that "Documentation, guidelines and continuing professional development arguably all help to make it 'easy to do the right

thing” (ibid). It is perhaps nurses’ focus on care as personally mandated, and as existing at the level of interpersonal relationships, that means the value of nurses’ investment in systems and processes is underappreciated. As Rhynas and Fawcett argue, a truly ‘holistic’ approach to care should entail that systems for ensuring patient safety are considered as a means of care-provision alongside interpersonal interactions; as the authors state; “It could be argued that care which has safety as a primary focus is, by its very nature, person-centred.” (Rhynas & Fawcett, 2014, p1240).

The caring narrative within nursing, however, continues to emphasize nurses’ emotional capacities and interpersonal abilities over and above their organizational skills. This, arguably, is because these values represent key sources of symbolic capital which nurses wish to maintain and which might be said to represent nursing’s principal form of prestige. Nurses, relatively speaking, are not highly remunerated and the bid to increase the social standing of the occupation through strategies of formal professionalization has been, at best, unevenly realized. Indeed, Leary (2014, p29) describes a continued perception amongst service managers that “nurses do not make decisions; that they simply perform tasks and are judged by their kindness in doing them.” In this sense, prospects for the accumulation of economic and social capital are, arguably, not encouraging.

It is therefore perhaps understandable that nurses “wear their heart, and not their brain, on their sleeve” (Odom-Forren, 2007), as kindness and empathy are central to the public’s admiration for nurses. Although trust in nursing may have been rocked by recent care scandals, it largely remains the case that praise and positive recognition for nursing is based upon practitioners’ expressively caring natures, reflected, for instance, in frequently-made allusions to ‘angels’. While many nursing writers and commentators are keen to press the point that nursing requires a sophisticated skill-set that goes beyond simply being ‘nice’ and ‘kind’ (Watson & Shileds, 2009; Watson & Ali, 2011; Leary, 2014), there is perhaps greater cultural currency in the notion of nurses as paragons of virtue.

The critical reception for Christie Watson's recently published nursing memoir 'the Language of Kindness' (2018) arguably demonstrates how the appreciation for nursing corresponds chiefly to how kind, considerate and caring it appears. While Watson documents the minutiae of nursing work, including the technical-medical and administrative aspects of the role, the book's title belies its central contention and much of the praise for the work foregrounds its emotional content. For example; "what emerges time and again is that nursing is about so much more than medicine. It's about engaging with another person in ways that go beyond administering medical care." (McDonagh, *the Evening Standard*, 2018). In the book, itself, Watson makes the kind of essentialist assertions that support the view that nursing chiefly depends for its efficacy on the emotive capacities of practitioners; e.g. "Nurses certainly use the language of the heart... And the best nursing comes from the heart, and not from the head." (Watson, 2018, p188)

Leary (2014, p29) complains that "To promote nursing as nice and kind, but not particularly aspirational, contributes to its devaluation" though this statement could be made in reverse, so that nursing's devaluation contributes to its promotion as nice and kind. Nurses' pay and status within hospitals continues to suffer in relation to medicine and so being recognized as loving and caring (often in contradistinction to medicine) represents an important means of self-affirmation for nursing. It might be speculated that improvements in pay and/or wider recognition of nursing as a discipline separate from, but equal to, medicine, might permit the articulation of an occupational identity that is less preoccupied with asserting virtuousness and is more reflective of actual nursing practice.

There is no reason why the work that nurses do cannot be acknowledged as fundamentally motivated by the desire to care for others, in the same way that the actions of any other occupational group working in health and social care may be. Nursing's claim to being a caring occupation is not necessarily undermined by the fact that nurses' direct contact with patients has become more restricted. Instead, it might be more productive to recognise 'care' as the

product of interdependent actions between a number of disciplines and service providers, of which nursing is a central component.

This is not to say that individual nurses should refrain from engaging in expressive aspects of caring if they can and if desired by the patient, but simply that such actions should not come to be upheld as the *raison d'être* of nursing as an occupation. Nurses make up the largest single healthcare discipline in the NHS; it would be unreasonable to expect each and every one of its members to be gifted with caring capacities way beyond those of the general populace, or of others working in different areas of healthcare. Moreover, the motivation to work, as well as any job-satisfaction gained from it, should not be conflated with the work itself; people who take up nursing for reasons other than to fulfil the needs of a caring disposition are still doing the same job. Furthermore, an emphasis on direct acts of caring sustains the suggestion that nurses working in certain areas, i.e. palliative care, are more caring than those working in areas with less patient contact, or in managerial positions. Finally, nursing may be in danger of being hoist by its own petard as more and more bodily care is administered by healthcare assistants or care support workers. Is it now, then, the case that it is these lower-grade auxiliary workers who exhibit the greatest levels of caring?

As Paley (2002) argues, nursing's focus on caring has developed as a means of inverting medical dominance; briefly put, nursing is caring because medicine is perceived not to be so. Yet, this dualistic conceptualization arguably has limited benefit for either occupation. Doctors might be perceived as knowledgeable and authoritative, though at the same time, be seen as reserved and aloof, while the kind-heartedness attributed to nurses can overshadow their clinical knowledge and skills. However, as Fletcher (2000, p1083) has argued, following a stint in hospital;

"A caring ethic and professionalism need not be mutually exclusive. It was interesting to witness how medical staff now seems to be able to combine both traits. Who was it who made me comfortable and cared about my wellbeing as I lay helpless in my bed? It was the medical team."

This is a singular example but serves to demonstrate the fruitlessness of delineating healthcare occupations according to how caring they are. A more

general observation on the importance of a humanistic approach to medicine is made by Branch (2014), whose endorsement of 'knowing the whole patient' and the therapeutic benefits of doctor-patient relationships reads remarkably similarly to accounts of nursing's especial focus on 'care'. Indeed, Branch's primary vignettes recount instances of a doctor crying while conversing with a patient and, later, of the author's reflections on the therapeutic value of 'touch', exemplified by a relationship with a particular patient who was dying (Branch, 2014, pp71-72).

The point being made here is not simply that doctors can be just as caring as nurses (although there is no reason to doubt this), but moreover that nursing, as an occupational group does not have any exclusive claim on 'caring', even within the narrow limits of interpersonal interactions. There is, arguably, the potential for anyone working in the care services to exhibit caring attitudes and behaviours, (including HCAs, porters, cleaners, receptionists, etc.) but the content of their work is not 'care', though it may all contribute to an overarching system in which care is provided. Any jurisdictional claims over caring can distort the recognition that it is a collaborative endeavour.

Medicine and nursing are rhetorically distinguished through a series of dualisms; between cure and care, head and heart, mind and body, instrumentality and expressiveness which obscure the full range of activity that both occupations undertake. As Treiber and Jones (2015, p158) point out; "Nurse practitioners take on the responsibilities once reserved for physicians, such as providing primary care and prescribing medications, clearly situated within the curing realm". By the same token, physicians occupy space in the 'caring realm' when, for instance, delivering bad news to patients or their families. Furthermore, there is growing recognition that care and cure are symbiotic, and not simply complementary, as exemplified by observed relationships between continuity of care and positive patient outcomes. For instance, repeatedly seeing the same GP has been linked with lower death rates (BBC, 2018), while maintaining relations with just one or two midwives is purported to decrease the likelihood of miscarriages and premature births (NHS England, 2018).

The conclusions drawn by Treiber and Jones (2015, p159) are instructive here;

“Neither caring nor curing is the exclusive domain of any one profession. If nursing wishes to become a full professional partner with medicine, with comparable accountability, responsibility, and valuation, some paradigmatic change is needed. The care/cure dichotomy is a social construction based on shared cultural beliefs that can be changed.”

Rather than taking pains to defend (figurative) jurisdictional boundaries, it might be argued that a greater emphasis on shared responsibility and collaboration represents a more productive basis for inter-professional relations. Pritchard (2017, p35) argues that healthcare has witnessed “a blurring of roles between doctors and nurses” which makes sustaining a dominant/subservient relationship more difficult, particularly as nurses take on “more responsibility and accountability in areas previously the sole domain of medicine” (Castledine, 2005, p625) such as powers of prescription.

The relatively newly established role of Advanced Nurse Practitioner (ANP), that was previously discussed in terms of a possible challenge to medicine’s professional authority (McMurray, 2010), may be instructive to this kind of argument. Whilst the blurring of clinical disciplinary boundaries may be confusing, and potentially perceived as threatening to dominant occupational groups, it is possible that roles which straddle nursing care and medicine will aid the diminution of hierarchical jurisdictional borders. ANPs possibly provide an illuminating case in point as commentators tend to agree that, whilst technically nursing staff, ANPs’ responsibilities are closer in kind to those of junior doctors (e.g. McDonnell, et al., 2015; Raleigh & Allan, 2017).

Kennedy, et al. (2015) argue, from their study, that: “ANP roles were characterised by fluid role boundaries which crossed the traditional disciplinary boundaries between nursing and medicine.” According to the authors, the work of ANPs challenges the conventionally conceived division of labour in which nursing ‘cares’ and medicine ‘treats’; ANPs, it is argued, provide genuine continuity of care by administering to both aspects (Kennedy, et al., 2015, p3300).

In order for the apparent value that ANPs add to healthcare provision to be realised, researchers have noted that, while ANP work

may efficaciously blur disciplinary boundaries, it is important that the role is not left undefined. For one, this could simply result in too much work being attempted (Kennedy, et al. 2015, p3302), and secondly, as Griffin and Melby (2006, p298) argue, conflict may occur where responsibilities are unclear. It has therefore been suggested that the scope of ANPs work responsibilities are clearly specified. Kennedy, et al. (2015, p3303) state that:

“Challenges lie in developing the ANP role which has a recognised ‘skill set’ and is also context specific to meet the needs of service models and requirements across specialisms and settings.”

This context-specificity points to a relatively novel approach to organizing and distributing the work of healthcare based on service need, and is in keeping with Baumann, et al.’s (1998) contention that patient need, not jurisdictional boundaries, should dictate the activities of members of healthcare occupations.

Nonetheless, even as the evolution of hybridized roles may signal a disruption of the ‘care/cure divide’, there remains a sense, for some, that distinguishing between nursing and medical remits is important to asserting occupational identity. A study by Williamson, et al. (2012, p1583) notes that:

“Ward nurses reported that ANPs had a positive impact on nursing practice but considered ANPs to be more closely allied to the medical rather than nursing team. They all agreed that ANPs assisted with nursing work but on the whole said that they did not actually do any ‘hands on’ nursing. However, this view was not shared by ANPs who felt their role enabled them to spend more time practicing nursing”

This illustrates, as recognized here elsewhere, how time spent ‘hands on’ with patients continues to be viewed as an integral aspect of nursing practice.

Conversely, the multifariousness of nursing work has already been commented on here; it may be that further heterogeneity in the formal roles and responsibilities of healthcare staff allows this to be more acutely recognized.

Leng (2013, p1613) has even gone so far as to state that; “Doctors are becoming more holistic in their practice even as nurses are becoming more specialized. I am hopeful that eventually the questions will not be “What is a doctor? What is a nurse?” but, rather, “What does it matter?”

While this is perhaps quite a radical proposition, it demonstrates that the disciplines of nursing and medicine have more commonalities than points of significant difference. In a practical sense, it is important that boundaries between occupational roles do not become blurred to the extent that nurses and physicians are (literally) standing on one another's toes. Castledine (2005, p625) points out that mutual understanding of roles "seems an essential feature of effective collaboration within health care." However, as Baumann et al. (1998) have argued the contributions of different healthcare disciplines should be determined by the situation of service users rather than via specific (hierarchically ordered) remits; "Less focus should be placed on what should be done by doctors as opposed to nurses, and more on how both groups can assist patients, and when patients should be allowed to assist themselves." (Baumann, et al. 1998, p1044) A collaborative pooling of multidisciplinary knowledge, including, crucially, social care services, rather than contestation between forms of practice, arguably represents a maximally user-centric solution.

It is worth briefly noting here how national policy contexts may affect future developments in this area. Since Scottish devolution, the country has pursued its own approach to health and social care, establishing 'integration authorities' with a budgetary remit for combined health and social care services (Scottish Government, 2018). The shape and constitution of multi-disciplinary care may affect existing roles and boundaries.

5.4 Development

As a researcher with no prior in-depth knowledge of nursing, I opted to study with adult nurses (the largest branch of nursing) working on a hospital medical ward, rather than focussing on a particular area of specialist nursing, although it would undoubtedly be worth expanding the themes of the present research to other forms of nursing. It might be especially enlightening to look at areas such as surgical or emergency nursing where contact and interaction between nurses and patients is of a decidedly different nature due to the condition of patients (who are likely to be less responsive) and the length of their treatment. It might well be hypothesised that the conditions that determine

how nurses and patients interact, as well as practitioners' expectations of different nursing roles, might affect the way in which the concept of care is elaborated.

Beyond nursing, similar studies of physicians in which the 'medical' conceptualization of care is investigated would complement this research. While 'care' has been theorised as elemental to nursing (Watson, 1979; Morse; 1990), the concept is perhaps underdeveloped in the context of medicine, due in a large part to the care/cure divide cited here previously. Given the contention of several commentators (i.e. Paley, 2002; Treiber & Jones, 2015; Barker, 1995) that caring is not the exclusive domain of any single occupational group, the perspectives of the various groups involved in healthcare on what caring means and entails is worthy of investigation. Because of the mutual historical relationship between medicine and nursing, doctors perhaps present the most obvious case for such study although, given the increased emphasis on multidisciplinary care (Baumann et al. 1998; Glasby, 2017), it would be valuable to elicit the perspectives on care of HCAs, occupational therapists etc. and, pertinently for those concerned with care service integration, the views also of social workers.

This research study has analysed nurses' accounts of their work, with particular attention to the discursive conceptualization of 'care' and 'profession(alism)'. In line with critical-realist ontology, this discursive content has been interpreted as it relates to the practical circumstances of nursing work; thus acknowledging that discourse obtains its sense from reference to non-discursive elements. For instance, nurses articulated positions on paperwork, the structure of nursing education and the system of admissions and discharges in order to construct narratives around the meaning of care. Thus, while the influence of extra-discursive 'things' has been incorporated into the analysis here, they have not been examined as entities in their own right. As Rioux Dubois and Perron contend "Understanding the way actors negotiate relationships with all kinds of entities in their environment (including policies and technological devices) is key in understanding the way subjective positions are formed, negotiated and mediated" (Rioux-Dubois & Perron, 2016, p13).

Critical discourse analysis is one means of understanding these negotiations, however, other approaches advocate a more explicit analysis of these 'entities' themselves.

Researchers working from an Actor-Network Theory (ANT) perspective place considerable emphasis on the role played by non-human actors in social activity and their agential capacity; i.e. the discernible effects that objects have within systems of social action. As Nguyen, et al. (2017, p811) state; "ANT views technologies as actors that have the potential to transform and mediate social relationships with other actors". Methodologically speaking, this view would entail description and analysis of the things (actors) that interact to sustain activity and discourse in a given network.

For instance, the interaction between nurses and the technologies that they use in their work may impact upon the way in which 'care' is conceptualized. Dingwall and Allen (2001, p67) observe that;

"... myths about the centrality of emotion work to nursing practice make the error of equating emotional labour with hands-on physical tending. We must acknowledge that much of what nurses actually did, which is now presented as evidence of their caring, was actually the medical technology of the time. The nurse who bathed the patient with a fever was not performing a simple caring act but carrying out a prescribed intervention just as much as her modern successor on a drug round."

Here, the authors bring attention to the fact that the popular association between nursing and emotionally oriented care is (at least partly) facilitated by the material reality of available technologies. The physical act of bathing a patient, as a means of treatment, allows the discourse of nursing intimacy to be propagated. The patient (and their condition), the nurse, the bathtub, the sponge and even the water can be considered as constituent parts in an assemblage that result in particular meanings being ascribed to nursing care. These things, and their material attributes, facilitate prolonged physical contact between nurses and patients and enable the construction of nursing care as built upon close relationships. As nursing technologies change, they arguably carry with them the potential for new modes of discourse. For instance, Watson's (2002) argument that nursing ought to be regarded as a highly-skilled profession requiring significant educational preparation is made

substantially in reference to the prominent role of increasingly complex medical technologies and the need, for nurses, to understand them.

The potentiality of research with a socio-material bent is that the influential capacity of particular actors in a network can be made available for evaluation; as Allen proposes: “In analysing actor networks it is useful to focus on a single actor and consider translational processes from its vantage point.” (Allen, 2014, p132). In a way, the critical discourse analysis here has done this with nursing accounts, looking at the productive effect of the nursing perspective on other actors, for instance, in the way that activities of ‘basic care’ are constituted as ‘caring’, while paperwork is not. In acknowledging the agency of non-human actors, an ANT approach allows for a change in perspective so that we can explicitly consider the effect that these actors have on the other parts of a network, including discursive constructions.

In relation to the previous discussion concerning interdisciplinary convergence around the meaning and administering of care, ANT methods of inquiry might be able to demonstrate some of the ways in which certain actors (human and non-human) practically facilitate or obstruct inter-professional collaboration. Examining the integration of nurse-prescribers in a North American healthcare context, Rioux-Dubois and Perron suggest that seemingly banal things (actors) such as “notifications being made, bulletin boards being updated, newsletters being released, office space challenges being sorted out ...” (Rioux-Dubois & Perron, 2016, p12) can all potentially contribute to the assimilation of nurse-prescribers within an extant network.

Indeed, one specific area in which an ANT approach may be applied to nursing research is in the study of the documents that, ostensibly, define the scope of nursing work, for instance the NMC ‘Code’ for professional standards of practice, and the RCN’s ‘Principles of Nursing Practice’, as well as the documents that form the content of nursing curricula.

As well as conducting content, or discourse analyses, of such documents in order to describe how the precepts of nursing practice are formally constructed, ANT research would focus on the document as an active element in a broader network, made up of other things, people, norms and values. Prior

(2008) advocates the importance of attending to the *function*, and not simply the content of a document, arguing:

“When we focus on function it becomes apparent that documents serve not merely as containers of content, but as active agents in episodes of interaction and schemes of social organization.”

(Prior, 2008, p824)

In this vein, future research could concentrate on the actual contexts in which documents are produced, used, and received. Especially given nursing’s overall ambivalence regarding professional status, and some nurses’ professed dislike of ‘paperwork’, it would be of value to trace the symbolic significance of different forms of documentation, throughout different strata within the occupation. As Prior (2008, p824) notes:

“... once a text or document is sent out into the world there is simply no predicting how it is going to circulate and how it is going to be activated in specific social and cultural contexts.”

In another application of ANT, Davina Allen (2014) observed the organizing work of nurses and argued that “From an ANT perspective, nurses are the ‘obligatory passage points’ in healthcare systems. Barely anything happens that does not pass through the hands of a nurse.” (Allen, 2014, p136) Nurses draw upon both their clinical and organizational knowledge to plan and coordinate patient care and are required to synthesize these logics to enable overall service delivery. For example, Allen (2014, p133) details how nurses use handover documentation to summarize the needs of patients and to manage the requisite interventions:

“Whether inscribed on scraps of paper, pre-printed handover sheets, or the unit coordinator’s book designated for this purpose, the handover record was a highly portable ‘plot summary’ of the status of individual trajectories. It comprised a synthesis and translation of information aggregated from diverse sources, plus additional intelligence necessary for managing the work.”

From this, Allen contends that the concept of ‘holism’ in nursing should be expanded to accommodate nursing’s organizing work, rather than referring simply to nurses’ relationships with individual patients. Holistic practice is not just knowing ‘the whole patient’, but understanding the whole system in which patient care takes place and acting in accordance with this.

“The reformulation of holism to incorporate nurses’ organising work provides an opportunity to rethink the nursing contribution to healthcare based on the work that they actually do, whilst also maintaining some continuity with the profession’s self-understanding.”

(Allen, 2014, p137)

The broad point here is that the discursive construction of a concept (here, for instance, ‘holism’) can be stimulated by the material reality of practices (“the work that they actually do”). Allen argues that acknowledging the import of nurses’ practical activities makes possible a reconfiguration of the idea of ‘holism’ which might present nurses with a means of better articulating their work and its value.

It might be similarly posited that realizing a more broadly constituted notion of ‘care’ is dependent on the material practices of the actors invested in its production, and the ways in which they interact. If care is to be recognised as a collaborative endeavour and not simply synonymous with nursing practice, it is arguable that some modification in the material relations between actors could be contributory. Some studies have indicated that collaborative working between doctors and nurses, which could help to bridge the binary care/cure divide, can be enhanced by changes in the material relations between actors. Castledine, for instance, cites the organization of ward rounds as a potential area in which occupational cooperation might be hindered or enabled, writing:

“Even today, the medical round in many hospital situations remains as highly structured and ritualized as it was in the past. Often the junior doctor carries the medical notes and, together with a senior registrar, presents each case. Other team members, such as occupational therapists, physiotherapists, social workers and ward staff, follow on behind.”

(Castledine, 2005, p625)

In contrast to this depiction, Castledine (2005, p625) describes an alternative approach involving greater input from other occupational stakeholders; “... the medical consultant joined the rest of the care team in a quiet room to discuss the patients’ cases before commencing his ward round.” This is a relatively simple intervention but demonstrates how the spatial and temporal arrangements (i.e. time spent in a separate room before rounds) can have an effect on inter-occupational relations. A similar point concerning interdisciplinary communication is made by Moroney and Knowles (2006) who observed that the practical organisation of doctors and nurses’ work routines

was obstructing interdisciplinary collaboration, as nurses were conducting bedside handovers at the same time that doctors were making rounds.

“Between 8am and 9am, nurses walked one way around the ward while doctors walked the other, with both groups politely avoiding each other and neither recognising the others valuable knowledge.” (Moroney & Knowles, 2006, p29).

This kind of insight perhaps demonstrates the possible contribution of research designs which place material conditions and actions at the centre of analysis. In the example above, for instance, we can see how the material circumstances of certain practices have consequences for the relations between actors. In this case, the interactions between physicians and nurses are circumscribed by the different use of space and time by both occupations. In this sense, there could be normative value in such practice-based studies in that strategies to encourage integration may be developed in conjunction with the findings. An admittedly superficial causal hypothesis might be that greater (structured) opportunities for interaction between doctors and nurses would facilitate better collegiate working relationships and communication which might then lead to some reconsideration of the care/cure divide, or of the professional hierarchy between the groups. Of course, interactions between actors are rarely this deterministic; the point is to show that material conditions do have an effect on the possibilities for discourse within a system of social action.

Equally, discourse(s) can have a constitutive impact upon material artefacts as objects are imbued with representational value; for instance, some nurses’ aversion to paperwork may be explained by the perception that it takes them away from ‘real nursing’ and thus represents a qualitatively different sort of practice. Socio-material approaches, such as ANT, are, methodologically speaking, not incompatible with discourse-oriented research such as that which is entailed by the present study. Indeed, because ANT contemplates the *interactions* between actors, it does not discount the agential capacity of discourse; as Booth et al. (2016, p114) point out, “ANT is a perspective whereby both social and technical actors are afforded the potential to be

mutually constituted with each other". While narrative-focused interview studies can illustrate some of the ways in which discourse shapes interaction with the physical environment, socio-material methods offer a corollary by describing the material influences on discourse construction.

As Elder-Vass (2015) makes clear, there are some significant ontological differences between ANT and the critical realist tradition which are too metaphysically involved to be discussed adequately here though briefly stated, ANT conceives that something's existence is dependent upon its engagement with human networks whereas most critical realists would attest that objects can exist regardless of our knowledge of them. Methodologically speaking, however, there is no fundamental opposition and, as Elder-Vass concludes "A great deal of the enormously productive empirical work that has been done under the banner of ANT is potentially compatible with (...) (a) realist approach to causation, and indeed much of it would benefit from such an approach." (Elder-Vass, 2015, p20). Attention to the agency of non-human actors is compatible with the critical realist contention that discourse cannot simply overcome the reality of non-discursive entities (recall Sayer's (2000) example of the very real dangers posed by oncoming traffic).

Some of the contemporary criticism of nursing's caring rhetoric is founded upon the observation that holistic, emotionally-oriented care simply does not represent the day-to-day practical reality of nursing work (e.g. Allen, 2014; Dingwall & Allen, 2001) and as such nursing's mandate overreaches its licence. As Noordegraaf (2011, p1358) argues in relation to professionalism, the concept "cannot be detached from service contexts" and therefore the subjective articulation of 'professionalism' corresponds to changes in these contexts. The service context in which nursing takes place is multifaceted and includes changes in the use of technology, the increased scope of the nursing role, significant changes to nursing education, increased demand for access to health services, as well as public opinion, the historical images of the occupation, extant discourse etc. Both ANT and critical realism are apt to recognise all of these factors as co-constitutive of one another. For instance, Thomas and Hewitt's (2011) notion of 'conjunctures' (referred to earlier) as a

heuristic for critical discourse analysis is not dissimilar to the idea of actor-networks; both stress the importance of accounting for context in explaining social action. Socio-material methodology simply seeks to make explicit the links between the social and the material in “its insistence that nonhuman actors make a contribution to outcomes that are traditionally treated as social” (Elder-Vass, 2015, p4).

5.5 Final Thoughts

I would like to extend my sincere gratitude to all of the nurses who were generous enough to take the time to talk to me for this study. I am equally thankful to the nurses with whom I did not formally speak, but who continued to work and, in some cases cover for their colleagues, so that I could spend valued time conducting interviews on the ward. Before undertaking this research project, I was, admittedly, somewhat ignorant as to the full array of tasks, activities and responsibilities assumed by nurses and, despite hearing and reading about the pressures on NHS services, I did not really know this played-out in day-to-day nursing practice. I would like here to end with some final thoughts of my own, being now more cognisant of the salient issues and debates within nursing.

From spending time speaking to nurses and, occasionally, watching them work, it is clear to me that nursing is a varied and demanding role which tries to meet a number of different demands and expectations. In this respect, it seems that to primarily associate the role with being ‘nice and kind’ does it a disservice. Increasing demand for primary care, coupled with the growing complexity of patients’ needs means that clinical skills and knowledge are crucial for effective nursing practice. On this basis, I can see no real objection to the establishment of nursing as a degree-level subject if this serves to equip nurses with the wherewithal to meet the challenges of our contemporary healthcare landscape.

What is arguably dubious, however, is the notion that advanced educational preparation acts as a vehicle for the 'professionalization' of nursing. Given what has been argued here concerning the (in)viability of pronouncing 'professionalism' through fulfilling prescribed criteria, I am sceptical as to whether nursing (or certain members thereof) can will its way to professional status. As advanced here, the notion of 'profession' is a discursive resource which derives meaning from its constitutive contexts. It is not an absolute state or final achievement. Indeed, one of the things this study has demonstrated is the power of the workforce to use 'professional talk' in ways that resist the imposition of a formalized professional identity. Certainly, from the majority of the nurses with whom I spoke, formal bids to establish nursing's professional credentials have not generally been endorsed or met with any great enthusiasm.

If the content of nursing classes in higher education is intended to reflect a professionalized ideal, the benefit of this is perhaps questionable. Nurses' educational preparation could arguably be more responsive to the realities of clinical practice so that the 'culture shock', to which Dingwall and Allen (2001) referred may be mitigated as far as possible. The practical challenges faced by nurses are unlikely to change in relation to whether or not it is considered to be a profession.

As far as the concept of caring is concerned, I tend to agree with those authors (Paley, 2002; Barker, et al. 1995) who have argued that nursing has no occupational monopoly on care, or a privileged right to pronounce on what counts as care. However, if a personal commitment to caring provides (some) nurses with the motivation to carry out their jobs, which is certainly suggested by my interviews in this study, then there seems no real reason to argue with the validity of this. What perhaps needs to be realised is that this caring impulse does not dictate or specify the *form* that 'caring' takes. This should be determined by the situation of those in need of help, in line with the available resources and skills of practitioners. If, as e.g. Papastavrou, et al. (2011) have indicated, patients tend to appreciate clinical competence above all else, then achieving this should be considered as a means through which nurses can

demonstrate a commitment to caring. It is arguable that an expanded conception of caring which recognizes a variety of actions and interventions, would help nurses to perceive the beneficial impact of all that they do, rather than separating their work into activities which constitute 'actual' caring, and others which are seen as subsidiary, or even antithetical to care. This also allows also that the work of doctors, surgeons, and other healthcare workers can be seen as representative of a concern with care. I don't think that nursing should abandon the notion of 'care', but do think that collectively, we need to transcend the superficial notion that caring is simply warm and smiley.

This is not at all to say that nurses should refrain from being nice or sympathetic to those in their care but this ought not to be confused with the content of their work. In my view, in fact, this realization applies to all members of healthcare occupations and could help to break down the care/cure dichotomy. Relatedly, I am not minded to disprove the contention, made by several of my respondents, that some nurses have personality traits that might make it easier to engage with patients on a personal level. This is, however, different to the claim that one needs, or ought to possess particular personal characteristics in order to nurse proficiently which might be demoralizing on occasions when nurses fail to develop rapport with patients. As mentioned earlier, nursing is a broad church and not all of its members will be gregarious, or even particularly personable, but this does not necessarily indicate a lack of care. It should not be a source of embarrassment for a nurse to recognize that some skills, like communication, may be developed and are not simply predetermined.

Nurses' resistance to PCC as a formalised approach to patient care, evidenced in this study, is based upon the perception that PCC represents an attempt to undermine nurses' natural caring abilities. Arguably, if the concept of care is reframed as an institutional endeavour, then ways of theorizing care, such as PCC, may be similarly treated. In this way, caring in a person-centred way would become the joint responsibility of all of the occupations involved in healthcare and, in my view, should be articulated as such, rather than being perceived as "something that nurses do and which characterises how (they)

think or work” (Price, 2006, p49). If ways of theorizing care, such as PCC, were pitched comprehensively at an inter-disciplinary level, focusing on how person-centred structures and cultures might be inculcated, then perhaps nurses would be more willing to invest in the concept. One can be both a compassionate person, or believe themselves to be, while engaging in systematic working practices that aim to ensure the *wider* realization of compassionate healthcare.

6. References

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Study to investigate the ways in which nurses conceptualise Person-Centred Care (PCC): Information for Participants

Thank you for your interest. Please read the following if you think you might participate in this research.

Background to the research

This research sets out to learn the meaning(s) of Person-centred care (PCC) to adult nurses working in the NHS; i.e. what kinds of ideas and actions are associated with PCC? PCC has become a highly prioritised healthcare initiative in recent years and yet arguably has not been consistently or comprehensively defined; there may therefore be a number of ways in which the concept might be understood and practiced. Primarily by talking to nurses, this research aims to find out how nurses think about PCC as it applies their work.

Who is conducting the Research?

The research being proposed forms the basis of a PhD in Sociology at the University of Edinburgh. The PhD candidate and sole investigator is Dan Hope. The project is being supervised by Dr Angus Bancroft (Sociology, University of Edinburgh) and Dr Rosie Stenhouse (Nursing Studies, University of Edinburgh). The research is ESRC (Economic and Social Research Council) funded but is the original work of its investigator.

Why have I been asked to take part?

The researcher is interested in speaking to nurses from a range of occupational bands about their understanding of PCC and particularly with those who work on a unit with a variety of patients whose stays are relatively long and where nurse/patient interaction might therefore be more than fleeting.

What will participation involve?

If you agree to take part, the researcher will get in touch in order to arrange a suitable time/place for an interview that will mainly involve discussing PCC but may also include more general questions about nursing work. The interview should take the form of a free flowing conversation and participants are encouraged to give as detailed and/or descriptive answers as they wish. Interviews may last upwards of an hour but are very unlikely to last longer than two. Interviews will be audio recorded *with the consent of the interviewee*. You do not have to answer any questions that you don't want to.

Aside from the interviews, there may be a short period of time when the researcher is present on the ward in order to give the interview data some practical context but this will be in a purely observational role and should not

disrupt nurses' working practices. *Patients* are not involved in data collection and will not be approached by the researcher.

The data collection phase (i.e. interviews and observation) of the research is intended to take place between autumn 2015 and spring/summer 2016.

Confidentiality and Assurances to Participants

- All conversation between the researcher and participants is made in confidence. This means that participants and their unit will not be identified by name, or other distinguishing features, in any written work or presentations arising from the research and the names of those taking part in the study will not be revealed to fellow participants.
- Audio recordings will be listened to, transcribed and analysed *solely* by the researcher and will not be shared with other parties. The recordings will be deleted following transcription. Verbatim quotes may be used in the final reporting provided, of course, they cannot be used to identify the speaker.
- Participants may withdraw from the study before or after interview and/or request that the data they provide not be used. Participation is entirely voluntary.
- Participants may, upon request, be granted access to their own interview transcript and can be furnished with a copy of the final research report.
- Participants will be asked to sign a form giving their consent to the study before the interview is conducted.

What are the advantages of taking part?

Your participation and responses will give an insight into the way that nurses *themselves* come to understand and practice PCC and in doing so provide a more nuanced account of the concept that recognises the influence of context and working cultures. Very few sociological studies of PCC have, as yet, been conducted so you would be contributing to a novel area of academic study.

It is hoped also that talking to a neutral (non-nursing) party about PCC and other aspects of nursing work may provide opportunities for practitioner reflection and/or be cathartic to nurses taking part.

Thanks for taking the time to read this information sheet. If you are interested in participating in this research by taking part in an interview or have further questions about the research please don't hesitate to get in touch with the principal researcher: Dan Hope, email: [REDACTED]@ed.ac.uk

Nurses' Conceptualizations of PCC-A Research Study

Form of Consent

Please read the following and sign below if you are willing to be interviewed as part of this research.

I have read the information sheet concerning this research project and am content with its conditions and assurances regarding my participation in this project. By signing below I consent to take part in an interview which will contribute to the findings of the study. I reserve the right to opt out of the study at any time.

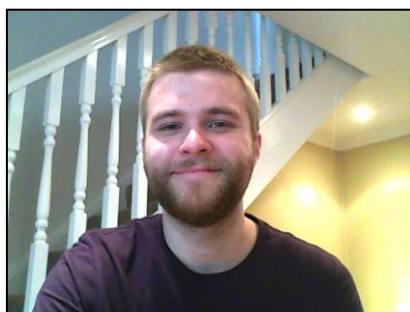
Signature

Date ___/___/___
 d m y

Thank You



PHD Research into Person-Centred Care in Nursing (Ward [Redacted])



Hello. My Name is Dan Hope. I am a 2nd year PHD student at the University of Edinburgh conducting research on the ways in which nurses think about and practice 'Person-Centred Care' (PCC). Between Autumn/Winter 2015 and Spring 2016, I am hoping to spend some time on ward [redacted] to collect data; this will mainly involving talking with nurses about the meaning of PCC.

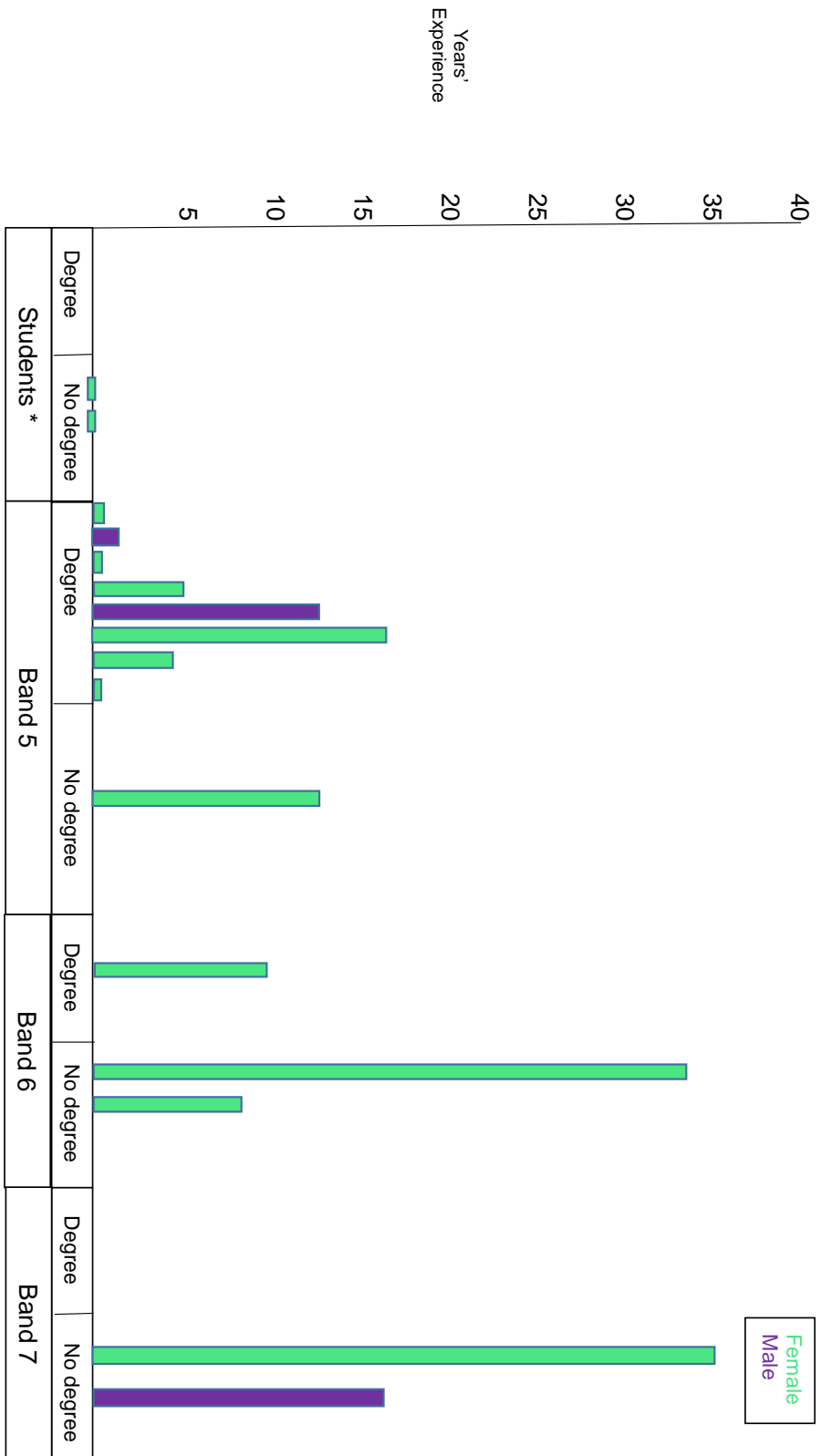
If you are a nurse on ward [redacted], I'd be really interested, and grateful, to hear your views on this subject; your input would make an invaluable contribution to my research. If you see me on the ward and have time for a chat, it would be very much appreciated.

If you would like any more information about the research or think you could be available for a sit-down interview (at your convenience) please get in touch:

Email: [redacted]@[ed.ac.uk](mailto:[redacted]@ed.ac.uk)

Tel: 07[redacted]

Thank You



* students shown as not having a degree, though both will be degree-qualified upon completion of studies