

'I Always Wanted To Be a Nurse'
How Do Sexual Health Nurses Construct Their Identities Within The
Context Of Role Change?

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Abstract

In the United Kingdom there are increased pressures to extend the role of nurses as a result of policy reform, rising demands for health care, a shortage of doctors and financial constraints within the National Health Service (Faithfull and Hunt, 2005). As nurses are called upon in times of 'crisis' to fill the skills gap, the development of nurse-led services and the consequent shifting of professional boundaries between health care groups have led to certain challenges and tensions within the discourse of modernisation in delivering compassionate, safe and effective care for people in the 21st century (Maben and Griffiths, 2008).

This thesis focuses on the nursing biographies of ten sexual health nurses (nine female and one male) in the North West of England. They describe how they came to be nurses and their experience of their on-going clinical practice as their roles and responsibilities change as a result of reorganisation. Using narrative interviewing as a means for data collection, the theoretical and interpretative framing of this study is based on Gee's (2011) theory of 'Big D' Discourse and Holland, Lachicotte, Skinner and Cain's (1998) theory of Figured Worlds, emphasising the role of narrative in identity construction and the ways in which individuals draw on the figured nature and cultural models of the nursing world.

I argue that while a recurrent narrative theme describes childhood and adolescent experiences of 'always wanting to be a nurse,' the majority of the respondents appear to have had limited choices, given their academic achievement, family backgrounds and influences and socio-economic status. The single male nurse in the sample offers an account of his career which puts the women's stories into relief, drawing attention to particular aspects of gender discourses and caring. For women, nursing was in fact, 'a respectable career for a working class girl,' and it also fitted in with being a mother. A discourse of caring is also prominent in their accounts and this underpins much of what they say about becoming a nurse and their experience of role change. I argue that whilst their strong values of caring and compassion are sometimes seen at odds with their new role, in some accounts the discourse of caring is clearly

incorporated into their developing clinical skills and knowledge. I report that not all the nurses 'embrace' role change; their stories present anxieties, conflicts and resistance around new responsibilities, power imbalances within the doctor-nurse relationship and the disruption of their figured world of nursing, which raises issues of perceived inequality of pay and some ambivalences concerning their new role.

Glossary of Abbreviations

A and E	Accident and Emergency
AFC	Agenda For Change
AIDS	Acquired Immunodeficiency Syndrome
A' Level	Advanced Level
AP	Assistant Practitioner
BASHH	British Association For Sexual Health and HIV
BBC	British Broadcasting Corporation
BBV	Blood Borne Virus
Ca	Cancer
CASH	Contraception and Sexual Health
C of E	Church of England
CQC	Care Quality Commission
DA	Discourse Analysis
Depo	Depo-Provera (Contraceptive Injection)
DH	Department of Health
DSA	Dental Surgery Assistant
EHC	Emergency Hormonal Contraception
ENB	English National Board
EWTD	European Working Time Directive
FHEC	Faculty of Health and Social Care Ethics Committee
FSRH	Faculty of Sexual and Reproductive Health Care
FW	Figured World

GCSE	General Certificate of Secondary Education
GNC	General Nursing Council
GP	General Practitioner
GPO	General Post Office
GU	Genitourinary
GUM	Genitourinary Medicine
Gynae	Gynaecology
HCA	Health Care Assistant
HCSW	Health Care Support Worker
HEE	Health Education England
HEI	Higher Education Institution
HIV	Human Immunodeficiency Virus
IAG	Independent Advisory Group
IT	Information Technology
IUD	Intrauterine Device (Coil)
LARC	Long Acting Reversible Contraception
MSW	Maternity Support Worker
MW	Midwife
NHS	National Health Service
NMC	Nursing and Midwifery Council
NMP	Non-Medical Prescribing
NRES	National Research Ethics Committee
NW	North West
OFSTED	Office For Standards in Education

O' Level	Ordinary level
PCT	Primary Care Trust
PDR	Performance Development Review
PGD	Patient Group Direction
PHE	Public Health England
POP	Progestogen-only Pill
QOF	Quality and Outcomes Framework
RAF	Royal Air Force
RCM	Royal College of Midwifery
RCN	Royal College of Nursing
RD1	Research Degree Registration
RSCN	Registered Sick Children's Nurse
SEN	State Enrolled Nurse
SHN	Sexual Health Nurse
SHO	Senior House Officer
SRH	Sexual and Reproductive Health
SRN	State Registered Nurse
STI	Sexually Transmitted Infection
STIF	Sexually Transmitted Infection Foundation Course
TOP	Termination of Pregnancy
UK	United Kingdom
UKCC	United Kingdom Central Council For Nursing, Midwifery and Health Visiting
V100	Nurse prescribing qualification for Community Specialist Practitioners from Community Practitioners formulary.
WTE	Whole Time Equivalent

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Introduction

Background

The National Health Service (NHS) is a complex organisation facing immense challenges within the current socioeconomic climate, due to service redesign and a need to meet the healthcare needs of an ageing, increasing and diverse population within the United Kingdom (UK). With over thirty years of experience in nursing and midwifery, I have observed immense change in the development of nursing roles. I have myself been part of this change agenda due to my own earlier role as a sexual health nurse in Contraception and Sexual Health (CASH) services and my more recent role as a nurse educator in higher education. A major change over the last ten years has been the development of nurse led services, with nurses extending their skills and taking on duties that were traditionally the responsibility of the medical practitioner. Given my interest around the developing role of the sexual health nurse in clinical practice, this thesis seeks to explore:

How do sexual health nurses construct their identities within the context of role change?

In order to examine this, I explored the following three research questions:

1. How do sexual health nurses perceive nursing?
2. How do sexual health nurses describe their relationships with the public, other health professionals and service users?
3. How do sexual health nurses describe their experience of role change?

I carried out this research against the back-drop of public and policy-orientated concern about 'care' or the lack of it in nursing. In February 2013, following the Mid Staffordshire NHS Foundation Trust Public Inquiry, the Francis (2013) report was published. This report was "primarily concerned with failures in an acute hospital setting and made many recommendations which were specifically addressed to the healthcare system in England" (Nursing and

Midwifery Council (NMC), 2013b, p.5). Although the Francis report had not been published, I recognised an emergent theme of 'caring' early on in my analysis and whilst I had not intended it, 'caring' turned out to be a major element of this thesis.

I collected data using the process of narrative interviews. The theoretical and interpretative framing of this study was based on Gee's (2011) theory of 'Big D' Discourse and Holland, Lachicotte, Skinner and Cain's (1998) theory of Figured Worlds. These approaches enabled an emphasis on the role of narrative in identity construction and ways in which individuals draw on the figured nature and cultural models of the nursing world. I present my analysis in two central chapters. In Chapter Four, I describe how the nurses in my sample positioned themselves as the kind of people who would enter nursing due to their personal attributes and qualities and I begin to explore the gendered nature of entering nursing. Chapter Five continues this exploration and focuses on the emergent theme of 'caring' within the analysis of role change. I argue that nurses in this study perceive the extension of their skills and knowledge, as opportunity for simultaneously extending their caring role. I also explore system and structural issues within sexual health organisations and the difficulties of finding time to care within a changing role. Tensions and conflicts within organisational change are reported by my respondents, in addition to feelings of isolation and a lack of support in the development of nurse-led services. Some respondents talked about being 'pushed' and feeling 'pressurised' to extend their role and I explore issues of exploitation and a perception by some of my respondents that they are a 'cheaper option' to fill the skills gap.

The Structure of This Thesis

In Chapter One, 'The birth of a profession,' I locate the emergence of nursing and midwifery as a legislated profession. I first present a brief historic overview which highlights the process of reform in nursing and midwifery education from hospital-based schools of nursing to the new university model of nurse education. I examine conflicting discourses of power and position, education, training, caring and compassion as these connect with the modernisation agenda in the context of a new professionalism and simultaneous public

concern that nursing has somewhat 'lost its way.' The participants in this study were all drawn from my own area of sexual health nursing, which I will introduce and its particular interface with the change and modernisation agenda within the NHS.

In Chapter Two, 'An uncertain professional status,' I review the literature on the changing role of nursing and focus on recruitment to the profession and the ways in which nurses' position themselves within a constantly changing NHS. I explore research relating to issues of gender and image, both within the profession itself and in the media and other influences such as family background that impact on aspirations towards nursing as a career option. I also explore the status of nurses within practice and focus on the changing role of sexual health nurses, as they take on more of the doctor's role in order to fill the skills gap. I recount my own personal journey and story as a nurse, midwife and educator as a backdrop for my own role, position and identity within this thesis.

Chapter Three, 'Framing the research: theory and methodology,' explains in context the theoretical and methodological framework of my research. The first section of this Chapter reviews theoretical approaches to identity, as I focus on Gee's (2011) approach to Discourse Analysis (DA) and in particular his use of Holland, Lachicotte, Skinner and Cain's (1998) concept of a Figured World. The second section addresses the methodological and practical aspects of the research, including my recruitment of ten participants and pen portraits of them. It explains the use of a narrative approach to collect 'mini stories' as insight into identity and identity change and outlines the details of the research design. Finally the third section of this chapter builds on my discussion in section one and explains my approach to the analysis of identity and role change, as pursued in Chapters Four and Five.

Chapter Four, 'I always wanted to be a nurse,' presents the first area of my analysis and focuses on the ten narratives of 'becoming a nurse,' looking through the figured world of nursing to examine 'choice' and 'positional identities.' I focus on what my informants told me about their career choices and the role of nursing in their lives. Whilst I was originally interested to explore how

nurses experienced the changes in their role in clinical settings, it quickly became apparent that each of my participants located their nursing careers within a strong emotional investment in their past. This took me somewhat by surprise, and I describe in this chapter how my understanding of role change was diverted towards these accounts, summarised in the title of this chapter. I explore the historical nature of the accounts and the reoccurring themes of status and position which permeate them. I also note an emergent discourse of caring which I pick up again in Chapter Five.

In Chapter Five, 'As a Band 6, its one step too far,' I focus on the experience of role change itself. I explore the nurse accounts of their move into the speciality of sexual health nursing and the advancement of their role, their experience of a changing organisation and how they view their role in the future. As they describe their experiences of change, the female stories frequently concern women's positions in society in general and more specific references to the status of female workers in a healthcare organisation who are often part-time. I argue that my participants clearly embrace the development of their clinical skills and knowledge and that they see these as having the potential to extend their caring roles. However, their status as a 'Band 6' nurse is a common theme and is indicative of anxieties around their new responsibilities, perceived inequities, and power imbalances within the doctor-nurse relationship.

This thesis concludes in Chapter Six, 'Responsibility and care,' as I draw together the threads and revisit my research questions. I argue that whilst generally the nurses in my research embrace new roles and the new holistic caring opportunities that they bring, there are tensions within their new status and within the hierarchy of the NHS. I summarise gender and class as important emergent themes within my analysis, in terms of choice to become a nurse and its association with caring. I argue that caring is a dominant emergent theme and I bring this up to date in light of recent health care 'failings' identified within the Mid Staffordshire NHS Foundation Trust Public Inquiry and the government's recommendations to enhance caring standards as part of the Francis report (2013). I reflect upon the research process and provide a practitioner insight into my role and position as researcher in this study. I make final conclusions and offer some recommendations for practice and further

enhancement of the body of knowledge around role change within the nursing profession.

Chapter One

The Birth of a Profession

1.0 Introduction

This chapter provides the context of this study in terms of the emergence of nursing and midwifery as a legislated profession in the UK. How nurses experience their changing role is complex and they tell their stories within multiple conflicting discourses of professionalism, power and position, education and training, caring and compassion and modernisation. I will present here a brief historic overview, which highlights the process of reform in nursing and midwifery education from an original apprentice model approach which was hospital based, to the emergence of an all-graduate university-based professional training. I will examine the relationship between the new professionalism and public concern that nursing has somehow ‘lost its way’ as a profession underpinned by the discourse of care and compassion. Finally I will introduce the speciality of sexual health nursing in which professional identity and the experience of role change is the key focus of my research. I will explore the modernisation and change agenda and examine the development of new titles and roles within a context of policy drivers and structural demands, with too many people to care for and a lack of money.

1.1 What is a Nurse?

The word ‘*nurse*’ emerged into the English language during the middle ages and it originates from the Latin word ‘*nutrire*’, to nourish, or suckle (Miles, 2002). Globally, the International Council of Nurses (2010) define nursing as the “autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well, and in all settings. Nursing includes the

promotion of health, prevention of illness and the care of ill, disabled and dying people” (no page number). The family of nursing within the UK includes nurses, midwives and health visitors (Royal College of Nursing (RCN), 2003) and registration with the NMC as its professional body, is an essential requirement not only for employment, but as a means to safe-guarding the health and well-being of the public. In 2011 there were 665,545 total registrations in the UK with more than 65% of nurses over forty years of age and 31% over fifty, which is reflective of an ageing workforce. Additionally, 9% of registrants are male and 91% female, evidencing a female dominated profession (NMC 2012b). Roles and responsibilities within the profession have evolved and developed in many ways, keeping pace with people’s changing health care needs and expectations, as well as the continued wish to feel safe, respected, involved and cared for with compassion and competence (Department of Health (DH) 2010a).

1.2 The Discourse of Professionalism

This section explores what it means to be a professional and to have professional status as a nurse or midwife. Nursing is still regarded as a semi-professional occupation and this will be discussed within the context of defining professionalism and the tensions that exist between the historic apprentice model of training versus the new university route and a move to an all degree profession. The structural repositioning of the profession will be examined in terms of change in power and status relationships with other health professionals.

1.2.1 The Nurse Role as Professional

The twentieth century was an era of professionalization and change for nursing, as it acquired professional status and prestige. In 1916, the College of Nursing was established in recognition that nurses needed some vehicle through which to organise themselves, develop their educational base and regulate their profession (Borsay and Hunter, 2012). Following a successful campaign by the

College of Nursing, the Nurse Registration Act was introduced in December 1919, with the General Nursing Council (GNC) established as a new professional body (NMC, 2013a). A register was introduced for general nurses, which was accompanied by supplementary registers for male nurses, mental health nurses, sick children and fever nurses and which started the specialization of nursing roles (Borsay and Hunter, 2012).

Traditional nurse training originated around the apprenticeship model, which was instigated by the iconic Florence Nightingale in the late nineteenth century and training was regarded as neither educational nor academic but a moral process that developed character and self-control. A good character was considered as essential for the respect of male patients with the nurse first and foremost a 'good woman' (Rafferty, 1996).

In defining what constitutes to being a 'professional' or to demonstrate 'professionalism' is not universally agreed or understood (Goodson and Hargreaves, 1996). The Oxford English Dictionary (1996) define 'professional', 'As belonging or connected with a profession, skilful and competent' and profession as a 'Vocation or calling, especially learned or scientific'. There are multiple definitions within the literature but one which captures nursing, defines a profession as a "Generic category of a particular type of occupation, usually one that involves knowledge, a service and an extended period of education, training and work experience with an experienced practitioner that has been practicing for a number of years" (Evetts, 2005 cited in Hughes, 2013 p.10). The NMC (2008a) further define professionalism as a framework for nurses to ensure safe and competent practice with a duty to care and an emphasis on adherence to the Code of Professional Practice, as a standard measure for expected professional behaviour in upholding the reputation of their profession at all times (McCarthy, 2011). Should practitioners fall foul of their Code, the consequences may imply loss of registration and income (Fletcher and Buka, 1999). Carr (2000) argues that there are five commonly cited criteria of professionalism: firstly the profession provides an important public service and has theoretical as well as practical grounded experience. There is a distinct

ethical dimension which calls for expression in a code of practice and requires organisation and regulation for the purpose of recruitment and discipline. Finally, professional practitioners require a high degree of individual autonomy and independent judgement for effective practice.

Historically, nursing has an unsteady status as a profession, depending on how you view it. In an attempt to move away from its vocational status to one of becoming a profession, nursing often remains categorised as a 'semi-profession,' which implies that full professional status has not been achieved. The traditional ideology of professionalism refers to a notion of specialist expertise and an assumption that only the professional can determine the real needs of the client (Eraut, 1994). Medicine, law, the ministry and university teaching have all claimed professional status, with some occupations considered less powerful, still progressing towards a professional status. Using law and medicine as an example, these professions hold a traditional regard as high esteem occupations that are characterised by authority, prestige and wealth. This is defined as 'classical professionalism' and refers to highly ranked, publicly recognizable and largely masculine professional status, in which other professions have tried to emulate (Goodson and Hargreaves, 1996). Nursing has traditionally used medicine as a developmental benchmark, which Andrew (2012) argues has hampered professional progression, due to its patriarchal dominance. For nursing to fulfil the criteria for full professional status, nurses should be educated to degree level, however nursing remains on the periphery of professionalism, as it is still largely viewed as a practical occupation (Watson, 2006). Nurses are the only healthcare professionals who have twenty four hour contact and therefore require an education that meets the ever changing demands of health care and one which would address the inequality of educational preparation within the healthcare team. Fletcher and Buka (1999) argue that it is difficult to dispute that nursing and midwifery occupations do not warrant full professional status, as they are now developing their skills and widening practice boundaries in areas traditionally undertaken by doctors.

1.2.2 The Midwife Role as Professional

The International Confederation of Midwives (2011) define a midwife as a person who has successfully completed a midwifery education programme that is duly recognized in the country where it is located and who has acquired the requisite qualifications to be registered and or legally licensed to practice midwifery. The Midwives Registration Act was passed in 1902 (NMC, 2013a) and within the UK a practising midwife is defined as registered midwife who has given notice of her 'Intention to Practise' in accordance with Rule 3 of the NMC (2012a) Midwives Rules and Standards. Bennett and Brown (1999) argue that the concept of a midwife is one of an independent practitioner in her own right and who is able to diagnose pregnancy and retain responsibility and autonomy for the total care of a childbearing woman, as long as events remain within the range of normality. She is entitled to call upon medical assistance but is also empowered to undertake emergency procedures whilst awaiting the arrival of medical assistance. The midwife, as a competent and independent practitioner, is therefore able to undertake a wide range of skills with some considered to overlap those of a nurse and others similar to those of a paediatrician and obstetrician.

1.2.3 The Discourse of Power and Position within Medicine

Historically, the role of the nurse has mirrored family life with young women replicating the subordinate role of women in society, under the authority of a male doctor and in providing essential support to the medical profession (Crowther, 2002). The existing culture, unjustly subordinates nursing to medicine (Whitehead, 2011) and yet Voyer (2013) argues that over the last forty years, the respective roles and responsibilities of doctors and nurses have undergone constant change. Their relationship has been re-shaped from one that was strictly hierarchical with clear boundaries and well defined roles to a more complimentary relationship and one that addresses the growing priorities of health care reforms, efficiency and improved client care. Voyer (2013) further notes that whilst roles are changing, the "stereotypes held by doctors and nurses about one another remain difficult to change," (p.16) as various aspects of patient care relationships, remains specific to nurses. For example, nurses are viewed as 'caring,' 'dedicated' and 'do gooders,' whilst doctors are

stereotyped as 'dedicated,' 'confident,' 'decisive,' 'detached,' 'arrogant' and 'poor communicators' (Carpenter, 1995, p.156, cited in Voyer, 2013, p.18). Leonard Stein's (1967) seminal paper on the 'doctor-nurse relationship' concluded that doctors and nurses do share a special relationship but it is one founded on role expectations, power and influence on territory. Holyoake (2011) argues that within nursing, the role is to show respect, act passively and never disagree with the doctor.

Nurses struggle for power and status has also been attributed to gender differences, as Ohlen and Segesten (1998) note that it is important to understand the significance of female identity when understanding professional identity. Nurses have sometimes found it difficult to demonstrate to their medical colleagues the advantages of sharing decision making on an equal basis, largely because nursing has followed a paternalistic profession, originally defined by doctors and founded on the medical model of care. Power relations have existed as women were seen in society as politically naive and subordinate to men (Wilmott, 2003). Doctors participated in nurse training in the schools of nursing and on the wards, which is thought to be partly responsible for the doctor and nurse relationship, as that of 'leader' and 'follower'. Whilst the status differences between doctors and nurses is becoming less marked, Voyer (2013) argues that some status-related conflict remains, which signals that doctors might not be "prepared to lose their symbolic battle of power" (p.20).

In exploring further the power and position of nursing, midwives anecdotally contend that they are different to the rest of the nursing profession, in that they have a unique identity and professional role. Whilst both professions have continued to evolve along-side each other and are regulated by the NMC, they are represented differently by the Royal College of Nursing (RCN) and the Royal College of Midwifery (RCM). As midwifery education has evolved with the introduction of direct entry pre-registration midwifery programmes since 1989, it is no longer a requirement to have a prior nursing qualification to train to become a midwife. Although, qualified nurses can still access shortened midwifery programmes (Borsay and Hunter, 2012). As medical knowledge and practice has developed, both professions have moved in different directions, nursing increasingly took on a support role which was characterised by

obedience to the doctor's instructions and given the predominance of women in nursing, they were seen as 'hand-maidens' to the medical profession. In contrast there was less of an expectation that midwives would function as a doctor's assistant. Historically midwifery has been very focused on a specific clear role in caring for women and their babies during pregnancy, birth and postpartum. Midwives would argue that they have greater responsibility and autonomy than nurses, taking responsibility for birth, rather than being subjected to medical authority and are likely to see themselves as autonomous practitioners in their own right. Midwives frequently work independently and provide total care to women with no medical involvement and traditionally claim that their work centres on health and wellbeing, which distinguishes them from nursing's focus on disease and illness. Nursing also has a history of assigning bedside care to semi-skilled or even unskilled staff, whereas the statutory responsibility of midwives has largely precluded handing over care to other staff.

1.2.4 Nurse Training and Education

Florence Nightingale reformed the image of nursing and laid the foundation for nursing as a profession. Born to a wealthy British family and well educated, she did not follow the traditional path of the Victorian upper class of marriage and children. History describes her as believing she had been born to dedicate her life to the service of humanity and her parents were appalled by her desire to undertake work considered improper for a woman of her class (Egenes, undated). In 1854 she took a group of upper class ladies to care for sick and wounded British troops in the Crimean War, returning to England as a heroine. In recognition of her work, the government set up a Nightingale Trust Fund and in 1860 she established the most influential and well known nurse training school for the education of professional nurses - the Nightingale School of Nursing at St Thomas's Hospital in London (Egenes, undated, Maggs, 1983). Florence Nightingales pioneering efforts to develop nursing into a respectable profession for women permeated nursing's professional identity and shaped nurses attitudes to their working lives, thus establishing nursing as a suitable vocation for a 'lady.' It was also deemed a suitable job for a working class girl,

due to its higher occupational and social status, with good career prospects that entailed a moral framework of caring (Hallam, 2000).

Student nurses received classes in theory with clinical experience on hospital wards, a further move towards the idea that her nurses might have a leading place within hospital administration (Crowther, 2002). This new style of nursing was accepted within their highly feminised roles of being disciplined and obedient and indeed Florence Nightingale encouraged this through her insistence on 'purity' and 'high moral character.' She carefully monitored nurses' behaviour and the regulation of new homes for nurses. Young nurses would have to forfeit a great deal of personal freedom to maintain a 'ladylike' existence and male access to them was strictly regulated. The matron in her role as a 'stern mother' would keep the nurses in control until they could be released, presumably in a virginal state, into their own homes. The public and political recognition of the predominately female nursing profession was seen as an important element in the fight for women's rights (Borsay and Bunter, 2012). Nursing once it had established itself as a respectable profession for ladies, started to carve itself a place in the male-medically dominated health care era (Borsay and Hunter, 2012) and with the emergence of nurse training schools and the production of nursing journals and textbooks, there was a cultural shift towards professional development for a disempowered group of workers.

The publication of the Nurses Registration Act (1919) legislated for one level of State Registered Nurse (SRN) and as a consequence many hospitals became nursing training schools, employing trained or trainee nurses (Webb, 2000). During the depression of the 1930's, registered nurses became an expensive commodity (Brown, 1992) with debate around the role and the requirement of an assistant nurse. The Second World War prompted the need to explore shortages and low pay within nursing and the Nurses Act in 1943 introduced the statutory title of 'Assistant Nurse,' a position which later became the State Enrolled Nurse (SEN) following the Nurses Amendment Act in 1961. This new role subsequently widened the entry gate to nursing, for those individuals with limited educational qualifications. In 1962, the SEN entry requirement was

declared as two O-levels, which was subservient to the SRN entry criteria of five O-levels (Brown, 1994, cited in Webb, 2000). SEN training was shorter than the three year SRN course, increasing the availability of qualified nurses more rapidly and so addressing the problem of shortages and recruitment difficulties (Webb, 2000). Whilst the introduction of a non-academic two year practical SEN training was an attempt to enhance the nursing profession as an accessible occupation to this group of women by training them in 'bedside' nursing. Nursing was promoted as a vocation rather than a job, highlighting the skills and knowledge required to undertake the role as a 'feminine ideal,' with the educational level of nursing often linked to assumptions around the education of women and the nurses' subordinate role as the doctor's assistant (Willis Commission, 2012).

Restrictions were placed upon the range of activities SEN's could undertake, such as the administration of controlled drugs, being a mentor and setting clinical standards (United Kingdom Central Council (UKCC), 2000). An old survey in 1972, that reflects the views of time, found that 83% of enrolled nurses declared that should their daughters take up nursing it should be to train as an SRN and not an SEN, which despite the blurring of the two levels of nursing, it was more progressive to become an SRN rather than an SEN (Hockey, 1972, cited in Webb, 2000). The low status of SEN's formally placed them in a subordinate position to their SRN colleagues and was seen as a reason to return to a single level of registered nurse. By the 1950s the more prevalent Senior Nurse Tutors influenced by the American model of nursing, were becoming educationalists and increasingly took control of the nursing curriculum, as more young women decided to stay on at school and chose nursing as a career. By the 1960s and 1970s, the first bachelor and master's degrees in nursing began to emerge in the UK (Willis Commission, 2012).

The Nurses, Midwives and Health Visitors Act of 1979, replaced the General Nursing Council (GNC) as existing nurse regulator with the UKCC in 1983. Its core functions were to maintain a register of UK nurses, midwives and health visitors, provide guidance to registrants and to manage professional misconduct complaints. At the same time the English National Board (ENB) was established to monitor the quality of nursing and midwifery educational courses and to

maintain the training records of students overseas (NMC, 2010a). This structure survived with minor modifications until April 2002, when the UKCC ceased to exist and its functions were taken over by the current professional regulatory body, the NMC. The ENB was also abolished and its quality assurance function was taken over by the NMC, with the legal power to make registration mandatory, set standards for education and practice and to make disciplinary decisions (Willis Commission, 2012).

The UKCC in 1986 introduced 'Project 2000,' a revolutionary approach to nurse education (Orr, 1990). A new division of labour was proposed with a single level of registered nurse that would embrace the work of the SRN and SEN (UKCC, 1987). The role of the SEN was considered no longer fit for purpose and nursing and recruitment levels were to be maintained through higher levels of education and through the development of unqualified and less expensive Health Care Assistant (HCA) roles. The proposal for the abolition of SEN training, allowed nurses the opportunity to convert to the first level of the register or if they chose not to, their registration would remain valid (UKCC, 1986). SEN training did not finish until 1992 and the opportunity to undertake the conversion course created a number of barriers. There were a lack of places to meet demand and a general reluctance from managers to release nurses from the workplace. The final demise of the SEN role, has led to years of debate within the profession, in that HCAs are now filling the skills gap, in an unregulated role, that does not have the same training or registration requirements (Cockayne et al, 2007).

A shift to university based nurse education gathered pace in the 1990s, as Project 2000 was implemented and the NHS commissioned universities to deliver nurse education through time-limited contracts. In the historic apprenticeship model of nurse training, "students were pair of hands and learnt mainly from experienced clinical colleagues who were considered often lacking in scientific underpinning, often inadequate and sometimes unsafe. There were few opportunities to develop critical and reflective thinking or learn from or to conduct research" (Willis Commission, 2012, p.12). The old training schools vanished and the growth of University Departments of Nursing was accompanied by a significant expansion in scholarship, practice development

and research. Nurse Teachers became members of the academic workforce and were required to satisfy academic and research criteria to develop and gain promotion (Willis Commission, 2012).

A further radical change occurred in 2008, when the NMC decided that the minimum academic level for all pre-registration nursing education would be at bachelor's degree level and in 2010 following extensive consultation; the NMC issued new standards for Pre-registration Nursing Education (NMC 2010a). In 2011, all pre-registration nursing programmes in Scotland moved to degree level, with England following suit from September 2013. The minimum academic level for entry to the Midwives part of the NMC register is also set at degree level (NMC, 2009) and has been a requirement since September 2008.

Tensions exist within the profession following the changes to nursing and midwifery education and its move to university based delivery. There is a variety of opinion that nurse training has become too academic, with less of a focus upon the fundamental skills of caring and that a degree is not required for the role. With the old model of training located in hospital settings, there was greater access for nurse tutors to deliver practical training at the patient's bedside and to work on the wards. The new model of university nurse education is now parallel with other professional groups and remains equally divided between theory and clinical practice. However there is increasing debate within the media, that nursing has somehow 'lost its way' and with conflicting care models and the appropriateness of teaching the modern nurse the fundamental skills of care and compassion, which will now be discussed in the next section.

1.3 The Discourse of Caring and Compassion in Nursing

The ideas about nursing carry a powerful social charge and the image of nursing continues to be a symbol of caring and of duty at the same time. Hallam (2000) argues that in post war Britain, nursing's professional identity is a discourse of white femininity and one that women actively construct and practice, in conditions and circumstances not of their choosing. Nursing is historically linked to a tradition of caring and in many societies the provision of nursing care was a role assigned to female members because women

traditionally nurtured their own infants and it was assumed that the same caring approach could be extended to the sick. With no early formal education, the earliest nurses learnt their art through oral traditions passed down through generations and from observations of others caring for the sick. In England, the care of the sick fell to 'common women,' often of lower class who were too old or ill to find any other type of work.

The NHS was born on July 5th 1948 with a fundamental aim of offering comprehensive health care for all, free at the point of delivery and funded through taxation (Willis Commission, 2012). Nursing during this period was very different: care was structured around a series of tasks, for example damp dusting, scrubbing bedpans, and bed baths and taking temperatures. Female nurses wore starched uniforms, which were more suggestive of domestic service rather than a profession and a coding of belts, badges, caps and dresses denoted their hierarchy with the doctor directing many aspects of care (Borsay and Hunter, 2012). Female nurses were perceived as 'ministering angels,' rooted within the promotion of Florence Nightingale as the 'angel of mercy,' with the good nurse invariably being seen as a self-sacrificing angel, who gave up everything to dedicate her life to caring for the sick. The bad nurse was perceived as the exact opposite, one who misused her position of power and authority to satisfy her own desires, whether these be maternal, sexual or sadistic (Hallam, 2000).

Caring and compassion are perceived to be fundamental principles of nursing practice and with increased media reports of poor standards of care, there are concerns that the modern nurse of today, does not care in the same way as their historic counterparts and that the 'angel' image is slipping. In an attempt to address such concerns, the RCN in 2012, established an Independent Commission to examine the 'health' of pre-registration nurse education (Willis, 2012). The findings did not evidence any major shortcomings in the new model of nurse education that could be held directly responsible for poor practice or the perceived decline in the standards of care. In contrast the report highlighted a key role that graduate nurses would continue to play, in driving standards

forward and in preparing a nursing workforce that is fit for the future. However recommendations did emphasise that nurse education should have a strong emphasis upon caring and professionalism and that patient safety and respect for dignity is a top priority. A fear that graduate nurses will be less compassionate and caring than nurses without a degree was not evidenced but there were major concerns over the number of care-givers who are not regulated or registered.

In recognising the need for essential skills in caring, a study by Apesoa-Varano (2007) examined the formation of professional identity in a nurse training course from both an educational and student perspective. The study concluded that whilst educators aim to socialise students towards professionalism by emphasizing the scientific and technical basis of nursing. Students identified the dimension of caring as being central to their occupational identity. With the aim of raising the profile of essential caring skills, the Department of Health (DH) (2012) launched its strategy 'Compassion in Practice' which was underpinned by six fundamental values: Care, Compassion, Competence, Communication, Courage and Commitment. The 6Cs were identified as six areas of action to support professionals and care staff to deliver excellent care and a year on NHS England (2013) report progress in that the 6Cs are being embraced and are enabling staff to reconnect with their values in clinical practice.

A major inquiry into the quality of health care within Mid Staffordshire NHS Foundation Trust resulted in the publication of a high profile report (Francis, 2013). With further concerns over health 'failings,' its main focus was to review mortality rates in comparison to other Trusts and the number of complaints over the delivery of care. Francis (2013) made 290 recommendations, including an increased focus upon a culture of compassion and caring in nurse recruitment, training and in education. The report recommended that student nurses should spend at least three months working in direct patient care before the commencement of their degree course. In response to Francis (2013), Health Education England (HEE) (2013) announced a pilot scheme, which proposed that student nurses should spend up to a year working on the frontline in order to receive NHS funding for their degree and with the aim of students understanding, if nursing and hands-on-care is right for them. General feeling

amongst the profession is that it should be hard to become a nurse and one which requires a real desire and passion for the job. It should not be accepted as a 'second best' career option and an easy route to acquire a degree qualification. Francis (2013) also recommended that the NMC as the professional body, introduce an aptitude test prior to entry, in order to explore the candidate's attitude towards caring, compassion and other necessary professional values. The NMC (2010a) introduced new standards for entry and prospective students are currently tested in literacy, numeracy, communication skills and are assessed as to their health and good character. The government has further announced that the testing of 'values' be incorporated in the selection process for all new NHS-funded training posts and with the introduction of values-based recruitment and appraisal for all registered and unregistered staff (Ford, 2013a).

The NMC (2013a) in its response to the Francis report (2013) announced three ways as the regulator to raise standards and bring about a change in culture. The first was to set standards for education and a need to highlight the importance of the values of care and compassion, alongside the essential clinical skills needed in the twenty first century. Secondly, the NMC need to ensure that nurses and midwives who join the register continue to demonstrate those key values and remain capable of safe and effective practice and by the end of 2015, the NMC will introduce a new system of revalidation for all nurses and midwives. Thirdly, there is a requirement for an effective 'fitness to practice' system to be in place, to deal promptly and fairly with those who do not demonstrate the values of care and compassion and who act in a way that presents a serious risk to patients and the wider public.

In a further response to Francis (2013), the National Institute for Clinical Excellence (NICE) has confirmed that it has been asked to provide guidance which will be published in July 2014, on safe nursing and HCA staffing levels for adult wards in acute inpatient settings (Ford, 2013b). How future guidance will be implemented, is open to debate, as current figures suggest that 26% of nurses have actively chosen to leave the profession, since the coalition government came into power. In the wake of uncertainty over NHS reforms and attacks on the professions pay and conditions of service, the latest figures from

the NMC conclude that more than 23,000 nurses have allowed their professional registration to lapse in 2012-2013, at a time when NHS Trusts are struggling to recruit and fill vacancies and with factors attributed to high levels of burnout in the NHS, second only to Greece (Maben, 2013, cited by Lintern, 2013).

1.4 The Discourse of Modernisation and Structural Change

1.4.1 Sexual Health Nursing

I now move onto explore sexual health nursing as this area of nursing provides a particularly interesting example of role change within the discourse of modernisation. With several years of experience working in both clinical practice and in the education of sexual health nurses, I have first-hand knowledge and experience of the 'changing role' and modernisation agenda. The demand for sexual health care is at an all-time high within the UK (Roberts, 2005) as there are far too many patients to care for, services are being re-designed as part of structural reform agenda and financial cuts are taking place to meet the current socio-economic climate. Due to a lack of doctors within this area of practice, sexual health nurses are now extending their skills and competency in tasks that originally belonged to the medical profession. For example: non-medical prescribing, ultrasound scanning, the insertion of intrauterine contraceptive devices (Coils) and sub-dermal implants. Nurses have been involved in the management of sexually transmitted infections (STIs) well before the time of Florence Nightingale and their role has developed from that of a technician, almoner (employed to trace and bring to treatment), counsellor and doctor's assistant, to one in which they are now able to provide first line management in nurse led clinics (Miles, 2002).

With a shortage of doctors in sexual health practice, nurses may inevitably lack choice in the development of their role, as the change agenda becomes externally driven and nurses are called upon in times of a crisis to fill the skills gap. The discourse of modernisation is therefore frequently used to covertly re-style people's jobs and pay them less. However, Miles (2002) argues that the opportunity to advance the nurse's role should be viewed as a positive career development and one that will enhance future recruitment and retention within

the speciality, as well as improving care outcomes and the range of services offered.

1.4.2 Sexual Health Policy and the Modernisation Agenda

Sexual health at the turn of the twenty first century was identified as a policy problem due to rising rates of STIs, overwhelmed services and high rates of teenage pregnancy, anecdotally suggesting a 'crisis' within the NHS. In recognition of a need for change, the future of sexual health was driven by a first ever National Strategy for Sexual Health and HIV (DH, 2001). As a ten year plan, the strategy was criticised for its biomedical focus in terms of getting the balance right between a medical and social understanding of sexual health. The strategy also suggested new ways of working with the emergence of non-professional support roles and the expansion of the qualified nurse role to meet the health needs of a diverse client population. With a pressure on STI clinics and an unmet need for sexual health services, recommendations were made that some aspects of care could be carried out by appropriately trained nurses (Bradbeer and Mears, 2003). Modernisation and workforce reform now forms a central plank of NHS policy, as part of the role re-design agenda (DH, 2000) (Bach et al. 2005).

In July 2008 the DH (2001) Sexual Health Strategy was finally reviewed, eight years after its implementation by the Medical Foundation for Aids and Sexual Health (MedFash) on behalf of the Independent Advisory Group (IAG) for Sexual Health and HIV. The report acknowledged the positive outcomes of service modernisation, in that it had established a greater effective use of the multi-disciplinary team, including the development of nurse consultants, nurse practitioners and the expansion of nurse-delivered services (MedFash, 2008). With the introduction of a new Conservative and Liberal Democrat coalition government in 2010, it has taken considerable time for further strategic direction on the future of sexual health practice to be released. In March 2013, a new Framework for Sexual Health Improvement in England (DH, 2013a) was finally published. Whilst the focus is to continue improving the sexual health and wellbeing of the population, there is minimal application within the strategy with regard to the future direction of training the sexual health workforce. Except to

make reference that services require appropriately trained staff that meet recognised professional body guidelines, such as the British Association for Sexual Health and HIV (BASHH) and the Faculty for Sexual and Reproductive Health Care (FSRH).

1.4.3 Skill Mix and Role Change

The combined Fifteenth and Sixteenth Census (FSRH, 2013a) recorded staffing levels and services within sexual and reproductive health (SRH) clinics in the UK in 2011 and 2012. With a response rate of 83% (2011) and 89% (2012) the census highlights a change in skill mix within the sexual health workforce. There was increase in the role of the Health Care Support Workers (HCSW) and a reduction in other grades. There were 110 consultants in SRH services in the UK and six vacant posts. Within the North West (NW) region, all services reported having a clinical lead in place, with a total of eight, whole time equivalent (WTE) SRH consultants in post. The main emerging theme within the NW data relates to organisational change, mergers and commissioning of integrated SRH and Genitourinary Medicine (GUM) services.

In relation to sexual health nursing posts in the NW, there has been an overall increase in Band 6 posts (Senior Practitioner / Specialist Practitioner level) (DH, 2004) and below and a significant increase of Health Care Assistants from 66 to 90 in 2012, which is comparative of the national data. This workforce census reflects an increase in skill mix, as services move towards dual trained (contraception and STI/HIV) staff and in Liverpool they are now training nurses to become Advanced Nurse Practitioners, following an agreed reduction in medical staffing (FSRH, 2013a). Nurses are now working in autonomous roles, of which many are extending their skills in the use of Patient Group Directions (PGD's), which are written evidence-based directives for the first and repeat issue of hormonal contraception to clients in the absence of a doctor and non-medical prescribing training.

Almost 90% of the work-force is female within sexual health and Campbell (2004) argues that the development of nurse- led services can achieve clinical outcomes that are equally effective as medical care. Patient satisfaction has shown to be equal or superior to care delivered by doctors, as nursing places a

strong emphasis on patient education and preventative healthcare, which are important features within sexual health (Campbell, 2004). A study by Miles et al. (2002) within a central London GUM clinic, reported that nurse-led clinics were an acceptable alternative to the existing doctor-led clinics. They concluded that specialist nurses may have greater interpersonal skills, which achieved increased patient satisfaction or that the higher level of satisfaction was an effect of the 'One-Stop' model of care, within which the specialist nurses worked.

It is clear from the latest FSRH (2013a) data that increasingly HCSWs are being introduced to bridge the skills gap and to deliver basic nursing care. Modernisation of the UK public sector is a major concern, as roles and responsibilities of workers are being reappraised, allowing employers to encourage a shift in the types of work that they undertake (Butt and Lance, 2005). The future 'de-professionalization' of some occupational groups may have an impact on professional identity, through the utilisation of a cheaper and unqualified workforce. Modernisation and remodelling are now seen as a 'must do' by the government, however the package associated with remodelling is complex involving legislative change, challenges to traditional practice, academic and professional requirements and the technological changes that are required to create a more modern workforce. Implementing and managing change in clinical practice requires committed, skillful leaders who can rise to the challenge and encourage their workforce to deliver innovative and high quality care (Wisby and Capell, 2005). Sexual health services are being stretched to breaking point, which has led to unsatisfactory waiting times, unmet client demand, low staff morale and an unsatisfactory career framework for nurses. As with nursing in general, sexual health has an ageing workforce and there is an ongoing need to consider how the next generation of nurses can be attracted into it (Miles, 2005).

1.4.4 Sexual Health Nurse Education

Since the demise of the ENB in 2002, the quality of education for post-registration nurses has become variable and Mehigan et al. (2010) argue that the days of employing nurses who have a nationally recognised qualification in

SRH have gone. Historically, nurses completed a nationally recognised family planning nurse programme, which met ENB standards and enabled employers to recognise what they were getting and the level of training previously undertaken. The provision and management of training has now devolved to higher education institutions in meeting local need, albeit without using nationally recognised titles. Some universities have developed new curricula to reflect the changing needs of the sexual health workforce, whilst others have chosen to discontinue courses altogether. Degree and Diploma courses are available at both undergraduate and postgraduate level but the content varies again due to a lack of national standardisation. The IAG (2010) notes that some courses are excellent, others are not adequate in equipping nurses to deliver sexual health in the way needed in the modern world. In 2004, the RCN (2004) developed a competency framework for SRH nursing (updated in 2009) and whilst not mandatory, this framework benchmarked roles and responsibilities and helped to establish the educational and training requirements for sexual health nurses. The need for a national standardisation of training and accreditation is now a priority, as employers become reluctant to sponsor education because of the increasing cost and timeout required from practice (Shawe et al. 2013). In an attempt to address this problem, the FSRH in November 2013, voted to widen its membership to include nurses and to pave the way for the development of a new nationally recognised Diploma qualification (FSRH, 2013b), which will introduce a new category of FSRH Nurse Diplomat (FSRH, 2013c). How this will impact on existing university courses and the requirements for this training, have yet to be released.

1.5 Summary

Nursing is a female dominated profession which is historically linked to a subservient role of woman in society, social class and the caring role viewed traditionally as women's work. With a shortage of doctors, increasing demands for health care and due to financial constraints within the NHS, there has been a shift in professional boundaries as sexual health nurses develop their skills and competencies in tasks once considered the domain of the medical profession. New roles are emerging as nurses fill the skills gap but there are tensions within the profession that nurses are increasingly seen as a cheaper commodity within

the modernisation agenda. Radical changes in nurse education and with a move to an all graduate profession, there are further concerns that the modern nurse of today is not 'fit for purpose' and equipped with the fundamental skills in caring and compassion. Both the Willis Commission (2012) and the Francis report (2013) make recommendations on the future of the profession in an attempt to resume the professional and caring image of nursing today. Against the backdrop of caring, this now leads me onto Chapter Two, as I explore and review the literature around the image and changing role of nursing and I present my own personal story and journey as a nurse.

Chapter Two

An Uncertain Professional Status

2.0 Introduction

In this chapter I review the literature further on the changing role of nursing and focus on the ways in which nurses position themselves within a constantly changing NHS and conflicting discourses of care and professionalism. As will become evident in my analysis later in this thesis, an important element of self-positioning is the gendered image of nursing, both within the profession and the media. In addition to other influences, such as family history and aspirations and the impact on nursing as a career option at the point of recruitment. Tensions also exist within service itself, in terms of the professions occupational status and more particularly so as nurses take on more of the doctor's role within the skill mix agenda of a changing NHS. Following a review of the

literature, I recount my own personal journey and story as a nurse, midwife, sexual health nurse and finally a nurse educator, as a backdrop to my own position, role and identity within this thesis. I end this chapter by setting out the central aims of my research, before moving onto the theoretical and methodological framework in Chapter Three.

2.1 'Something Like Hairdressing'

Writing as a Nurse Teacher reflecting on her personal experiences of nursing in the 1960s Lindsay (2006) notes that she had not wanted her mother's life of domestic and economic dependence but realised that ironically nursing was nevertheless a domestic sphere, albeit one which paid for her work. Having no model of nursing beyond her childhood books and her own assumptions about how nurses were regarded socially, she notes that the image of nursing is loaded with inherited meanings including mother, religious sister, conscience, intimacy and dependency (Fagin and Diers, 1983). In the 1990s, Bridges (1990) and Kalisch et al. (1982) note that nurses were variously viewed as the doctor's obedient and compliant hand-maiden, ministering angel, naughty nurse or an authoritarian old battle-axe. Sixteen years later, an online survey of 11-18 years old, found that only 2% were interested in nursing, versus 5-7% in medicine as a career (NHS Careers, 2006, cited by National Nursing Research Unit (NNRU), 2009a). The NNRU (2009) in their policy paper 'Who wants to be a nurse,' concluded that nursing lacked attraction as a career because of conflicting and stereotypical images that prevail, with few modern nursing images conveying the complexity of the role. Nursing should be regarded as a top career choice and perceived as a career with aptitude and motivation, the profession needs a clear message and refreshed campaign to attract new high calibre recruits (Maben and Griffiths, 2008). More recently, despite the soaring numbers of applications to nursing courses, many well-qualified school leavers who would be potential candidates are still being deterred by the profession's poor image (Nursing Times, 2010). Misconceptions are attributed to a lack of knowledge of routes of nursing, the nature of nursing itself and with the absence of role models to provide realistic information. A record 108,000 people applied to nursing degree courses in 2010, with a further 86,000 applying for foundation

degrees and other qualifications, suggesting there were around ten applicants for each place. This is approximately a 75% increase on previous years with a rise attributed to the economic recession as people look to re-train and seek alternative careers (Nursing Times, 2010).

Nurse education programmes do not attract the high cost of university fees because tuition is free for NHS commissioned courses, annually there are large intakes of students and the entry criteria for nursing is lower than medicine, which makes it accessible for applicants with lower academic achievement. Nursing may therefore be viewed as an attractive way to acquire an undergraduate degree and professional qualification, meaning that candidates may enter without particular aspirations to nursing or any real understanding of what the role entails. NHS London's Chief Nurse Trish Morris-Thompson (Nursing Times, 2010) expressed concern that nursing's image had been through a very 'rocky period', following high profile failings in nursing quality such as that at Mid Staffordshire Foundation Trust. She argued that there was a need to improve the brand of nursing in order to restore public faith in nursing health care and to reduce attrition rates which are estimated to be 20-28% for UK nursing courses. The DH(2010a) was also concerned that the public image of nursing was out of date in many ways and that a new story is needed to recruit suitable talent and to demonstrate that nurses are not poorly educated 'handmaidens' to doctors.

In an attempt to address such concerns, the DH (2010b) commissioned a report which explored the public image of nursing. It revealed widespread ignorance and a host of misperceptions, based on an outdated stereotype that is at best old-fashioned and at worst condescending. Nurses were positioned as down-trodden, loved but not respected and victims of their vocation, without autonomy or authority. The profession was regarded as involving nasty, poorly paid, menial work that required empathy but not expertise. The stereotypical nurse is viewed as overworked, underpaid, stoic, put-upon, passive and un-ambitious, and doing a job 'reserved for women'. Typical comments included: "A nurse is an assistant to the doctor- it's like a lower version of a doctor" (15 year old boy), "I'd equate nursing with something like hairdressing; there are some skills involved but not too technical" (Careers Advisor), "Nursing was generally not for

those who want or could do a degree” (Teacher) and “I’m not sure you need to be a leader to be a good nurse.... ..Surely doctors have the final say anyway? (Parent) (DH, 2010b, p.95).

Nurses themselves were unhappy with their public image and felt that they were seen as subservient and poorly skilled, and that standards were perceived to be in decline, leading to misconceptions that undermined the profession. Even though nurses felt their work was positive, rewarding and fulfilling, they found their public image negative, de-energizing and demoralizing. Based on recent media coverage and health care failings that have emerged within the Mid-Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2013) nursing continues to shed its ‘angelic’ image with increasing criticism that nurses frequently lack basic humanity and compassion. Nurses have gone from being viewed as ‘angels’ who can do no wrong, to ‘devils’ who appear to do little right (Griffiths, 2012).

2.2 The Gendered Nurse

Gender is a key discourse within the nursing profession due to its history as a female dominated profession. As Padilha (2011) points out, nursing has constructed and deconstructed its history over time, alongside developments in the history of women and gender relationships in professional care and educational, organizational and class practice. A study into nursing image as constructed in YouTube video clips by Kelly et al. (2011) identified three distinct nursing images: those of ‘skilled knower and doer,’ nurse as a ‘sexual plaything’ and nurse as a ‘witless incompetent individual,’ suggesting both positive and derogatory nursing stereotypes that are consistent with those found in popular mass media. Popular information about nursing is often acquired via the television (Jackson, 2009). Frequently the subject of television hospital soap dramas appear to hold a fascination for the viewing public with storylines focusing on the private workings of the hospital, its patients and professional groups. Nurses are often the most visible players alongside doctors, with a focus on the love life of the nurse rather than the role they undertake (Jackson, 2009).

This situation changed to some extent with the introduction in 1986 of the British Broad Casting Corporation (BBC) television drama 'Casualty,' which is set in an Accident and Emergency Department in a large city hospital (Hallam, 2000) and continues to be aired on prime time television on a Saturday evening. Hallam (2000) argues that 'Casualty' broke new ground in its representation of medical care on television, favouring a narrative structure where nurses and paramedic staff are attributed with agency, equal to that of doctors in the enactment of their skills and expertise. Unusually for a medical drama, Jackson (2009) notes that the programme portrays nurses as intelligent professionals, engaged in skilled work and the storylines reveal the centrality of expert nursing care in the overall patient outcome. Furthermore, male nurses move significantly into the limelight in the drama as storylines focus upon problems faced by male, gay, and black nurses. Charlie Fairhead is a Senior Charge Nurse and forms a central character in the drama, in demonstrating many of the traits associated with male doctors, including the relegation of female nurses to secondary positions. The television drama gives male nursing a higher professional status in contrast to female nurses, who conform to more traditional stereotypes, with children and domestic issues. In this sense it reflects a perception of a career pathway, which is significantly different for men and women, giving an impression that men secure higher senior positions in the profession.

A recent study by Weaver et al. (2013) explored Australian nursing students perceptions of how their profession was portrayed on medical television programmes, following up the potential link between recruitment and retention in nursing and its social image. Results showed that most students watched medical television programmes but were concerned about the negative image that they portrayed. Several students observed that the programmes featured doctors rather than nurses, with doctors represented positively and nurses negatively, since their skills were not shown. They also "disapproved of the sexual connotations in the programmes, saying that 'looking sexy' and love affairs are not the reality of acute health facilities" (Weaver et al. 2013, p.6). The findings also acknowledged the role that television plays in recruitment and retention to the profession: for some nurses watching medical television programmes helped in their decision to become a nurse.

In contrast, nursing scholars at Dundee University found that television images of nurses as 'brainless, sex mad bimbos' actually discouraged students from pursuing the profession (Summers, 2010) and argue that the media presents a physician centric world in which nurses are viewed as servants or sex objects. To give an example: a West Midlands Bus Company used a large 'naughty nurse' advert with the tag line '*Ooooh matron!*' to promote its route to the hospital, with connotations from the 'Carry on Doctor' and 'Carry on Matron' comedy films of the past, reflecting and reinforcing the image of the 'naughty nurse' and of females providing intimate care to vulnerable men. Some may see it as a joke but Summers (2010) argues that the social contempt behind the image, discourages practicing and potential nurses, undermines their claims to resources and may encourage workplace sexual abuse. Hollywood still uses the 'naughty nurse' image, including the variation that presents nurses as desperately seeking romance with physicians; for example in Grey's Anatomy and Desperate Housewives. The popular dramas have together, about twenty physician characters, but not one nurse. It is the physician characters that do many exciting things that nurses do in real life, from defibrillation to psychosocial care and the few nurses who do appear are imaged as meek subordinates (Summers 2010). With regards to nursing's fall from grace in the eyes of the public, Maben and Griffiths (2008) argue that the public's understanding of nursing is through ambiguous and contradictory images that are held about nursing and in the past, the brand of nursing was strong, with a clear identity and people knew what a nurse 'was' and 'did.' Today the brand appears to be less strong with a variety of multiple images that prevail.

A Turkish study (Karabacak et al. 2012) explored gender based differences between male and female nursing students, which like the UK is a female dominated profession. The word 'nursing' in Turkey is used to define concepts such as sister, foster, mother, wet nurse, which are all female caring roles. The study found that the male nursing students expressed discomfort in using the word 'nurse' as it was associated with women in society. The majority of students indicated that a nurse was a doctor's assistant and the tasks they performed included technical procedures such as injections and taking blood pressures. The female students also stated that a nurse is someone who stays

at the side of the patient and the majority of female nursing students said that they chose nursing because others wanted them to and cited their parents as influential, for example. The male students reported 'choosing' for different reasons, including guaranteed employment and financial gain in comparison. Academic achievement was a further influencing factor as most of the students had originally contemplated medical school or engineering and chose nursing as an alternative career choice as it had lower academic entry threshold.

2.3 Uniform as a Symbol of Professionalism

Uniforms are thought to hold personal significance for those who wear them and they act as powerful symbols representing the profession's identity and image (Shaw and Timmons, 2010). Items such as the belt, cap and buckle are often looked upon with fondness by many as they symbolise status and a group identity. A common concept is that uniforms give nurses a certain level of confidence to carry out their role and prepare the individual nurse psychologically for work. On the other hand, Sparrow (1991) found that when nurses did not wear a uniform, their assertiveness with doctors increased and they felt that doctors were more willing to involve and talk to them. A number of contradictory connotations are associated with the traditional uniform. On one hand it represents authority as a profession and social status, through reference to a religious past, with the veiled hat worn by a novice nurse evoking notions of purity and 'calling' in similarity to religious sisterhoods (Hallam, 2002). It also has a connotation of domestic service, being reminiscent of a Victorian parlour maid's dress with its stiff white apron, thick black stockings and frilly lace cap. Some uniforms include the starched Eton collar which is resonant of the male officer, suggesting identity with the military. Uniforms have developed over time, and the addition of hats, belts, badges and cuffs are thought to be indicative of the values and ideals of the generations of nursing foremothers who have represented the various aspects of nursing history (Smith, 1988). Hallam (2000) argues that the "uniform was a symbol of nursing's traditional authority and social status, those who wore it were seen to occupy a position of trust and responsibility in society" (p.135).

Research by Shaw and Timmons (2010) explored the influence of uniform on self-image and professional identity with pre-registration nurses, finding that many participants felt that it was important to be able to distinguish between different professions and their level of experience. The students argued that professions need to be clearly delineated by their uniform, not only to reduce confusion, but also to maintain a strong professional affiliation and pride. Some students wanted to be visually identified according to their year of study and some expressed the desire for a national uniform, whilst others felt that even modern uniforms encouraged nurses' subordination to doctors. A large proportion of the participants preferred to wear 'scrubs' to tunics, as they felt that they portrayed a competent and trustworthy image, commanding a certain level of respect often associated with 'prestigious areas' such as Accident and Emergency and Intensive Care. Those with a preference for a tunic or dress argued that they look smarter and showed a greater pride in the past, they felt that they made them look more professional and that their appearance had a stronger identity. Students also discussed the importance of their fob watch as symbolic of the profession. Female participants were more likely to speak fondly of the traditional uniform. Stereotypical associations caused one male student to feel embarrassed rather than proud to wear his uniform and another did not want to be seen in his uniform as he would easily be associated with the nursing profession.

A fundamental part of nurse identity, the role and symbolism of uniform is a complex issue, and a common argument for keeping the more traditional uniform is that it allows nurses to look and feel like professionals, although Morgan (2010) argues that it is time to stop focusing on nurse uniform as a means of professional identity and base self-worth on the importance of the profession's work.

2.4 Shifting Professional Boundaries and Role Change

In Chapter One (Section 1.4) I introduce the discourse of modernisation and structural change and refer to sexual health nursing as my area of interest. I have previously explored the drivers for role change within this speciality of nursing and I have discussed how nurses are developing their skills and roles

within nurse-led clinical practice. I now review the general nursing literature on role change and note similar themes to those within the sexual health nursing literature around new ways of working and the development of nurse-led services. In recent years advanced practice roles have developed in UK nursing and many nurse-led initiatives have been implemented (Faithfull and Hunt, 2005) due to several changes in the profession. For example the move to university education, increasing diversity of the nursing role, role substitution, the introduction of HCSWs and recent health reforms focusing on access, productivity and finance (Maben and Griffiths, 2008). With the impact of an ageing population and the increased prevalence of long term conditions and multi-morbidity there are major questions to be asked about how health and social care services are being organised and delivered. A large proportion of the health and social care budget is spent on staffing and therefore exploring new ways of using the workforce is becoming increasingly important (Ham et al, 2012).

Nurses have been advancing their role since the 1990s and it is likely to continue following the impact of a European Working Time Directive (EWTD) on junior doctor's availability (DH, 2010a). With a shift in professional boundaries and role re-design, nurses are advancing their knowledge, clinical skills and competency in areas once considered the domain of the doctor. The Chief Nursing Officer in 2000, identified key roles for the development of nurses, which include: having the skills to run clinics, order diagnostic investigations, prescribe treatments, make and receive direct referral, perform minor surgery and outpatient procedures (DH,2000). As a central resource in the NHS, nurses are crucial to the delivery of health care, with recommendations to expand their role based on an assumption that there are sufficient, if not surplus nurses to undertake the additional work. Given that the expansion of the numbers of doctors would be costly and lengthy, policy makers and doctors apparently saw nurses as a ready and presumed cheaper alternative (Calpin-Davies, 1999), with McKenna et al. (2006) noting a knee-jerk response in nursing to significant workforce planning problems in medicine. Nurses and midwives are also responsible for driving the change agenda as they focus on their professional development, academic education and personal accountability. Nurses are no

longer “handmaidens to the medical profession” (Wisby and Capell, 2005, p.15) but as thinking professionals who can build high levels of clinical expertise.

In looking to recast the role and vision of tomorrow’s nurse, Maben and Griffiths (2008) define the registered nurse as a skilled and respected practitioner who provides effective high quality care across a range of settings. It is vital that nurses are valued partners within the multidisciplinary team and are confident and effective leaders with a powerful voice from policy-making to the front line. Maben and Griffiths (2008) argue that the “new professionalism is built around the nurse as practitioner, partner and leader and provides a template to define the role and identity of the profession and to develop relations between the nurse, patients and other healthcare providers” (p.4). They also question if nursing has lost some of its enduring qualities: such as care and compassion, whilst navigating the complexity of an increasingly technical environment and note the need for nursing to build on its heritage and apply scientific learning within a humanistic framework.

In recent years the number of roles has increased dramatically across all areas within healthcare, yet there is a scarcity of empirical research to inform policy or the organizational context of this rapidly changing situation. A study by McKenna et al. (2006) sought to explore issues arising from the introduction of innovative nursing and midwifery roles from a perspective of healthcare managers. The findings present emergent themes of: professional identity and loss of a caring focus, concerns over the appropriate number of innovative roles required and the balance between them and the more generic staff. The findings also report a need for support within the organisation, as participants raise the problem of professional isolation and appropriate levels of clinical supervision. There were also concerns regarding a perceived value for money and unease as nurses were being used as ‘cheap doctors’ and role conflict with an intrusion into traditional medical roles. The study concluded that innovative roles can have a positive impact both on client care and professional development, but for the role to be effective there must be clarity regarding the role and support with its development and evaluation of their value for money is crucial within the current financially stringent NHS.

A review of the literature to examine the impact of professional role revision on the quality of care and outcomes was undertaken by Laurent et al. (2010). The findings note that nurses working as substitutes to doctors within defined areas of care are able to provide the same quality of care and similar outcomes and that patients are equally or more satisfied with their care. There were no obvious differences between the types of role revisions or types of healthcare settings and that role revision is a viable strategy to consider when addressing shortages within the medical profession and other challenges within the health care organisation. With a shift in traditional roles there have been reports of nurses experiencing a feeling of 'role deprivation,' due to a loss of relationship with patients and the absence of direct hands-on-care. A study by Workman (1996) into how HCAs perceive their role as support workers to qualified staff, found that qualified nurses perceive HCAs as a threat to their own roles in that they are seen as depriving them of their 'real' nursing role. The study concluded the need for clarity in role expectation and to reduce role ambiguities as a means to alleviate an avoidable stress for both the qualified nurse and the HCA.

A report by the Kings Fund (Sandall et al. 2011) explored the role of 'task-shifting' where a nurse or midwife is responsible for providing similar tasks as that of a doctor with the development of new and existing roles. The report highlights as a cause for concern, the increased role of the support worker as part of the skill mix agenda and recommends that further research is required to establish the implications of safety, quality, level of training and supervision required. Skills For Health (2011) argue that many professionals fear a loss of professional identity with the loss of some aspects of their role and notes concern that lower grade staff will not be able to perform the task as well as the professional. Suggesting that some professionals seek to defend their identity by treating HCSWs and Assistant Practitioners (APs) as subordinates, in much the same way as role conflict within the doctor-nurse relationship (Bosley and Dale, 2007). HCSWs are now part of the skill mix agenda and are increasingly delivering the majority of care as nurses extend their roles. At the point of registration a newly qualified registered nurse will commence on the Agenda for Change (AFC) pay scale Band 5, with HCSWs employed on lower grades, Bands 1- 4, (NHS Careers, 2013). Like nursing, HCSWs are perceived as a

cost-effective way of delivering care and with a move to an all graduate nursing profession, there will be a greater need for the use of support staff, freeing up professional staff at the other end of the spectrum, to spend a greater proportion of time engaged in more complex activities (Lizarondo et al. 2010, cited in Skills for Health, 2011).

2.5 My Own Personal Journey and Story

In closing this chapter I tell my own story of how I became a nurse and midwife, which led to my journey towards sexual health nursing and finally as a nurse educator. As a Yorkshire lass from a working class family, my story resonates in many ways with the ten nurses that I interviewed as part of this research. I grew up in same era, had similar experiences of the education system and undertook the same traditional apprenticeship model of nursing and midwifery training in the late 1970s and 1980s. My position as nurse, teacher and mother means that I have a shared history and identity with the nurses in my research and what they say about becoming a nurse and their changing role, relates to my own lived experience of change: in both clinical and educational practice and how this has impacted on my own professional identity.

2.5.1 School Days- 'A Suitable Job for a Yorkshire Lass'

As I reflect upon my early life as a Sixteen year old girl, I recall that my schooling days at a local Comprehensive School were a real disappointment to me, as they did not support or meet my academic needs and future career aspirations. Like many of my respondents, I also have memories of 'always wanting to be a nurse' from a very young age. However, there was no family history or role model that I aspired to or prior experience in the profession that I could relate to, in my desire to become a nurse. Being working class, going into higher education was never a realistic option for me, particularly as I was never considered to be academically bright. At the time of choosing my O' level options, I have very clear memories of the frustrations that I felt, when my teachers would not support me in the subjects that I needed to enter nursing and I felt completely let down by the education system. Looking back, the school was only interested in those students of a higher academic ability, who

could study for A' levels and had the potential to go onto university. None of my family had ever gone on to further or higher education and the working class ethos was to go out and get a job and to earn a decent wage to support your family. My father is an ex naval man, railway and factory worker. My mother has always worked and undertook manual and factory work to 'fit' around my father's shift pattern and to meet the childcare needs for myself and my younger brother. My mother is very talented in subjects such as English, Mathematics, Art and Crafts and I often tell her how she would have made a fantastic teacher. However her parents died at a very young age and coming from a large working class family, her role was to 'step up' and care for her siblings, with very little option in terms of her career choice.

At school, my teachers wanted me to learn to type and to seek office work. But I had different ideas and I wanted to study; Human Biology and the Social Sciences, subjects which really interested me. How it could be called 'choosing your options'- I will never know, because I was forced to take Chemistry, Geography and Economics, all subjects I hated. My final O' level grades were not great, but with a real determination to become a nurse I took it upon myself to seek alternative careers advice with a local Nursing Officer. I was successful in securing a place on a two year full-time Pre-Nursing course at my local Technical College and I flourished academically in the subjects that I required: Sociology, Psychology and Human Biology. The Course Tutors were supportive and inspiring and I was given the opportunity to experience working in a hospital environment for the first time and I loved it. In the spring of 1979 at the age of eighteen, I left college early, as I was successful in gaining a place on the March intake for the SRN course at my local School of Nursing. I was allowed to return during the summer term to undertake my year two examinations on the Pre-Nursing course and I passed all subjects with good grades, a real achievement.

2.5.2 Becoming a Nurse

Nursing was a popular and respectable career choice for a working class girl of my generation. As I explained in Chapter One, the old style of nurse training was on two levels: SRN (three year course) and SEN (two year course). I was

accepted onto the SRN course which required a higher O' level entry criteria, as the training had a greater focus on nursing management, as opposed to the practical bedside nursing of the SEN. Nursing as a young woman certainly opened my eyes in terms of life experience, caring and the responsibility of managing a ward. As a student nurse, the memories are still vivid in respect of my personal nursing journey which I thoroughly enjoyed. If I had to make a career choice again after thirty years in the profession, I would do exactly the same. Working on an orthopaedic ward as a first year student nurse, I will always remember nursing a young male from my own school year, who suffered bilateral amputations of his lower limbs following a major motor cycle accident and the impact this had on me personally in caring for him and his family. A real positive moment for me was being in the position of nursing my old Comprehensive School Head Teacher. The proud feelings of my personal achievement whilst nursing him, and the fact that I had actually made something of myself when the school was so disinterested in me, was a real achievement in my career. I was then and still am very proud to call myself a nurse. My parents have always been very proud of my chosen profession and my elderly father thinks that I am the 'font of all knowledge.' He sadly suffers with Parkinson's disease and takes the opportunity to tell everyone his daughter is a nurse when he comes in contact with health professionals who are caring and supporting him with his illness.

2.5.3 Wearing the Uniform

The symbolic discourse of uniform and image has always featured very strongly within our family. One Christmas I was working on a large ward which involved caring for the elderly and I remember my parents visiting the ward and their delight in seeing me in my uniform. My father remains extremely proud of his naval days, which has gained a stronger momentum during his older years in terms of his 'identity' as he positions himself in the past, with constant reminiscing over his uniform and a desire to wear his military medals at every opportunity. I can relate to the importance of uniform and image and remember vividly wearing my white dress, black 'Hush Puppy' shoes, American Tan coloured tights and my black and red cape for the first time. The significance of the three stripes you gained on your hat and uniform, for each year of your

training was a visible reminder to all in terms of your seniority as a student nurse. Upon qualification you were awarded a State Registered and School of Nursing badge to wear with pride on your uniform and the symbolic process of rank and status within the profession, continued with the wearing of different coloured uniforms, which was marked with a variety of starched hats, belts and silver buckles as your career progressed from Staff Nurse to Sister. The uniform of the modern nurse today is very different, gone are the symbols with a move towards the wearing of theatre scrubs within the clinical area, making it difficult to identify staff who all look the same. My son has recently joined the police force, and the wearing of uniform has become a symbolic talking point within our family once again. The change in the colour of his uniform from his initial role as a Police Community Support Officer (PCSO) to a regular Police Officer has impacted on his identity, position and status in the profession. PCSO work is extremely valuable and offers a supportive role in the community, but they are known as the 'Plastic Police' (Daily Mail, 2013), despite taking on increased responsibility with less training and a lack of 'power' of arrest. This unregulated support role mirrors other professions, such as teaching and nursing and the modernisation agenda of changing roles.

2.5.4 Post Qualification as a Nurse

Following qualification as an SRN in 1982, I married at the age of twenty one and commenced my first Staff Nurse post in a busy Accident and Emergency Department (A and E). My husband gained promotion with a large chemical company and we moved across the North in 1985, where I transferred hospitals and took up further work in A and E. Due to a desire to move into women's health, I left A and E nursing and completed an eighteen month shortened midwifery course and qualified as a Registered Midwife in 1986. Reflecting back, we were constantly reminded that the role of the midwife was different to nursing, as you had a stronger voice, greater- decision making power and were an autonomous practitioner in your own right. The medical profession worked alongside us and often we cared for women and their families with no medical intervention, within the realms of normality. There is clearly a tension between the midwifery and nursing profession, which I have experienced myself over the years, much the same as between health visiting and midwifery. As part of my

Link Lecturer role, I visit student midwives whilst on gynaecology placement and there still remains a cultural history in that student midwives appear to have a higher status and role in respect of their skills, autonomy and responsibility in comparison to their student nurse colleagues.

My career has taken me from midwifery practice, back to A and E nursing, whilst caring for my two young children. We had no family living locally to rely on for child care support and in A and E you could find work that 'fitted' in with your home life. For a number of years, I worked twilight shifts from 8pm to 1am in the morning, whilst my husband cared for the children. Working in a busy department, I was often late going off duty and had little sleep before getting the children up for school. As my children became older, my career took me into general practice nursing and a move to day time hours and weekends off. This was a new role that attracted a higher nursing grade and with A and E experience, I was ideally placed to work in primary care because of my transferable skills and knowledge. A large element of my work involved sexual and reproductive health and again this really suited me because of my interest and midwifery background. I went on to train as a family planning nurse, which gave me the opportunity to acquire additional hours working as a sexual health nurse in my local service and I subsequently completed a part-time undergraduate degree in sexual and reproductive health. My career later took me into academia as a full time senior lecturer in practice nursing and then sexual health. I continued my evening sexual health work with a local NHS Trust and managed a weekly clinic. This role was very demanding and stressful as the clinic was very busy, we were often short of staff and apart from the doctor, I was the only regular member of staff on duty, as we became increasingly reliant upon bank nursing staff to deliver the service. The clinic was a non-appointment system and offered a drop in service, which meant that clients could have a lengthy wait to be seen. They would therefore arrive very early and queue up outside the building before the clinic staff arrived, had chance to set up and open the doors. I was often late off duty and my role was starting to impact more on the commitments of my full-time academic post. I was required to undertake mandatory training and it was becoming increasingly

difficult to fit it all in. I often found myself in the position of having to follow up urgent client referrals the next morning in my academic role.

I continued my sexual health nurse post until December 2011, when I made a final decision to leave. I was aware that my local NHS Trust and employer was undertaking a large reorganizational structure, which involved the merger of three sexual health services into one large NHS Trust and the appointment of a new Clinical Lead. Change had already taken place in two of the services, with long serving 'bank' and 'sessional' staff being replaced with staff on greater contractual hours. Uncomfortable with this imminent change and the possibility of being made redundant because I could not commit to greater hours in the service, I felt with regret, it was time to leave.

2.5.5 Life- Long Learner

Having continually studied since leaving school I regard myself as a 'life-long learner' who thrives on the ability to acquire new knowledge and skills. I was the first member of my family to attend university and gained a first degree in sexual and reproductive health, followed by a Master's degree in Health Service Management. University education has now become a way of life, as both my children have achieved academic qualifications in their chosen careers to become a teacher and police officer. In the late 1990s with an interest in nurse education, I took up my first academic post in general practice nursing and moved in 2001 to take up employment in my current role. Working in a large School of Health, I deliver and manage courses at both undergraduate and postgraduate level and I have continued to teach where my passion lies in both midwifery and sexual health education. As with any organisation during my twelve years in post, there have been several restructures at both university and school level. On reflection I feel that these changes have affected my professional identity as a nurse and midwife. When I first came into post, I joined the Department of Midwifery Studies, which was well established within the field of midwifery, neonatal and sexual health practice. The department had an excellent reputation for delivering high quality education at local, regional, national and international level and as a past student I felt that I had a sense of belonging. Following a university re-structure our health provision was

reorganised and our department merged with other departments to form a newly created 'School of Public Health and Clinical Sciences,' and the appointment of a new Head of School. As a nurse and midwife, I suddenly found myself in a school that did not reflect my professional identity within its title. Further structural divisions disbanded the specialist subject area of midwifery, neonatal and sexual health and teams were further isolated as we relocated to different buildings as part of the new structure. A year later and following a further restructure, my new school was dissolved and we have now re-located into a new 'larger' School of Health, with a new Dean. Midwifery, neonatal and sexual health are now back together and have re-located into the same building and in terms of subject expertise and professional identity, there is once again a sense of cohesion and belonging. How long this will last is uncertain as we are going through further transitional change and we await the outcome of a new university and school restructure during 2014.

As you will see, the final part of my story highlights ongoing change in roles and the wide re- structural change agenda of which I have little choice or influence and which seems to resonate once again with my sample.

2.6 Application to the Context of My Research

Upon reviewing the literature there were no real surprises in relation to the emerging themes of career choice, stereotypical images of nursing within the media, the symbolism of uniform and changing roles. These are all very relevant to my research within the area of sexual health nursing, as significant role change is taking place to fill the skills gap. Nurses are extending their skills and knowledge in traditional duties that once belonged to the medical profession as they take responsibility for managing the whole patient journey within contraception and sexual health practice. Within this study I acquired histories through the use of storytelling and explored the sexual health nurses lived experience of role change and in order to examine this I explored the following three research questions:

1. How do sexual health nurses perceive nursing?

2. How do sexual health nurses describe their relationships with the public, other health professionals and service users?
3. How do sexual health nurses describe their experience of role change?

I now move onto Chapter Three and set out the theoretical and methodological framework for my research.

Chapter Three

Framing the Research: Theory and Methodology

3.0 Introduction

The aim of this chapter is to set in context the theoretical and methodological framework for my research. The principal aim of this study is to explore how sexual health nurses construct their professional identities during a time of organisational change in their roles, within narrative accounts of their nursing biographies. I want to use their accounts in order to provide a rich insight into their nursing history from entry into the profession, through to their current role as a sexual health nurse, which is the specialist area of practice I am interested in. In this chapter, I explain my use of discourse analysis and narrative within the context of a socio-cultural framework and focus upon the interaction between the individual and the social context that they are part of.

This chapter will be structured into three sections. The first section looks at how identity is seen and I set out my stall and theoretical framing of this study based on Gee's (2011) theory of discourse analysis and in particular his use of Holland, Lachicotte, Skinner and Cain's (1998) concept of a Figured World. My intention is to use figured worlds literature to theorise nursing identity which is influenced by the social and cultural practices that they encounter. The lens provided by Holland et al. (1998) theory of figured worlds emphasises the role of narrative in identity, and the figured nature of the nursing world and the cultural models that it participates in. Figured worlds are what we take for granted 'normal' and 'common sense,' and I am trying to understand the cultural representations which underpin and resource how nurses engage in practice by using the tools of narrative. I also refer to the work of Sfard and Prusak (2005) on narrative and identity and Bakhtin's (1981) (1986) theory of 'diagolism' (double-voicedness) and 'heterglossia' (differentiated speech) (Vice, 1997) which explores multi-voiced accounts of self with narrative (Solomon, 2012).

The second section will address the methodological and practical aspects of the thesis. It explains the use of a narrative approach to collect 'mini stories' as an insight into identity, and outlines the details of the research design. This will include the sampling and selection process, a pen portrait of the ten nurses in

the study and the interview process. Ethical governance issues will be addressed, along with the process for analysis. As a novice researcher and reflective practitioner I share my thoughts and reflect upon key aspects of my research journey.

Finally the third section builds on my discussion in section one and explains my approach to the analysis of identity. I return to a discussion of Gee's discourse analysis and the application of his interpretative tools of inquiry to the analysis of my particular data set. I use his seven building tasks of language and tools of social language, discourse, conversations and intertextuality to interrogate what nurses say about themselves and their jobs, to arrive at an overall picture of nursing and as a forerunner for their accounts of 'change'.

3.1 Section One: Theoretical Framing

3.1.1 Discourse Analysis

My decision to use discourse analysis (DA) as the tool of inquiry for this thesis rests with its 'focus on language' (Van der Riet et al. 2011). Crowe (2005) argues that within DA, language constructs how we think about and experience ourselves and our relationships with others. Historically, DA originated within the field of linguistics and by the end of the twentieth century it had been employed within a wide range of disciplines including psychology, sociology and research into professional practice such as nursing. By the 1980s and 1990s the flexibility and versatility of DA, made it attractive to a range of postmodern approaches, with a recognition that discourses were historically and culturally constructed over time and context. DA allows for the deconstruction of dominant discourses and argument for the promotion of social change by uncovering the discursive nature of everyday existence and hence challenging the 'normal' and 'common sense.' It is not considered a research method in the traditional sense but more of a process, a way of critically understanding the aspects of realities that are particular to time and culture. This enables the researcher to open up for debate the common assumptions that are deeply culturally embedded, rendered invisible and taken for granted as true. In employing DA the researcher seeks different, not better ways of 'seeing' the world (Neal, 2009).

Gee (2011) defines DA as “the study of ‘language-in-use” (p.8) and notes that there are many different approaches to DA. Some look at the ‘content’ of the language used, the themes or issues being discussed, while other approaches pay more attention to the structure of language. Thus there are different linguistic approaches to the use of DA, using different theories and different views around ‘meaning’. Gee’s (2011) own theory focuses upon meaning as a way of saying (informing), doing (action) and being (identity) and he offers a theory about the nature of language-in-use.

In using DA as a method, Gee (2011) is interested in two aspects; the first is to illuminate and gain evidence for our theory of domain, a theory that helps to explain how and why, language works the way it does when put into action. The second is to contribute in terms of understanding and intervention, to important issues and problems that interest and motivate us as global citizens. This leads me to discuss current thinking on the use of DA within nursing research, which allows us to “investigate the way that different speakers within a debate over a particular nursing-related issue, use language to frame the debate and their own interests in relation to the debate” (Smith, 2007, p.60). Starks and Brown Trinidad (2007) consider the objective of DA as an understanding of what people are doing with their language in a given situation, identifying themes and roles as signified through the use of language. Therefore the focus for the discourse analyst is the texts within which language is located. Within nursing this could include text books, nursing records, health and social care policies, diaries and transcripts of interviews undertaken with professionals, health care students, patients, carers or service users. Within DA there is not an assumption that these texts represent the ‘truth’, but that they are understood as a cultural representation of discourses that frame normal practices. The study of language can be applied to narrative, as it allows for the description of specific phenomena as well as being a way of understanding how the narrative might represent dominant discourse (Holloway and Freshwater, 2007). In using some of the tools of DA from Gee (2011), I am interested in the narrative of the ‘nurse’ and the story that they tell me about ‘the nurse’ with regard to their own story of self-positioning which is historically and socially constructed through their use of language and accounts of change in nursing practice.

In considering epistemological and theoretical perspectives within this thesis, I am taking a qualitative, interpretive and constructionist approach. Whilst I am not seeking an objective 'truth', I acknowledge there is a series of 'truths' which people hold onto and which I want to uncover. Because it is these that the nurse frames in how they see themselves and their social practices in what they take as being 'true'. Meaning is therefore not discovered but is constructed (Crotty, 1998) by both myself as the researcher and the participants during the interview process and also in the analysis of the data afterwards. During the interview process I co-construct a story with the nurse participants, who partly use words they or others have used before, but in the telling to me, they construct a new story with me. Within this dialogic process of addressing and answering our interlocutor, what emerges is 'something' generated from the space between. In their theory of Figured Worlds, Holland et al. (1998) draw on the work of Mikhail Bakhtin (1981) and his theory that we never really use our own words but endlessly recycle the words of others and make them our own, but only to a certain extent because future telling of those words will be 'imbued with other's intentions' (Irvine, undated). Therefore never saying anything unique but recycling words from others.

In this thesis I use the domain of language within a socio cultural model as a way of looking at the world and making sense of it, with narrative being used as the technique to gather the data and DA as my chosen methodology. DA is similar to other qualitative methods and takes an interpretative stance but the interpretations made are always considered subjective and reflect the researcher's own beliefs and values (Crowe, 2005). Through my focus of 'language on language' of nurses storying, I am taking a particular focus on their told identities (Sfard and Prusak, 2005) and my analysis of what it 'means' to be a nurse and what it 'means' for that role to change. I want to explore and understand how nurses use language to create and enact their identities and what discourses are used.

3.1.2 The Use of Discourse Analysis within Nursing Research

Within nursing and midwifery research, DA is gaining recognition as an alternative qualitative approach in that a 'lived experience of the individual' can

be represented directly in language (Nixon and Power, 2007). Crowe (2005) argues that particular discourses determine what happens in nursing practice and practices that occur in nursing can determine nursing discourse, with some practices attributing more importance and value than others, for example, the ability to prescribe medication (p.56). Whilst Crowe looks more locally at nurse skills and the status of role, I develop this idea further in this thesis focusing upon a broad level of understanding in general of the figured world of nursing. My focus is on the discourses that nurses draw on to position themselves within their life stories as told to me and their on-going experience of a change in a role which they may have had for several years. So for example, I focus on their accounts of how they became a nurse and what being a nurse means to them. While Crowe (2005) talks about nursing practice within the context of hospitals and nursing contexts, I focus upon 'positionality' beyond the workplace as an account of life stories outside of but also including being a nurse and the discourses that nurses draw on to build those accounts.

My objective is to explore key discourses and the context in which they emerge (Neale, 2009) within personal narratives of nursing. My chosen texts, gathered through the technique of eliciting life narratives are reviewed in the analysis to identify key discourses and connections between them. Research in this mode is considered to be best executed if the researcher has insider or intimate knowledge of the domain of the practice to be researched and can access persons within the discipline who can offer key information (Neale, 2009). This certainly applies in my case, in that I am a member of the nursing community. I would argue however that there is a weakness in Neale's (2009) view, in that it assumes that there is a 'best' or more accurate story to be gained in this way. Whilst a researcher from a different background might gather a different story in conversation with my participants, I would resist saying that the stories that I gather are 'better.' Participants might even make certain aspects of being a nurse more explicit to a non-nurse researcher. However this is not my concern, I am concerned with analysing the particular story which emerges in conversation with me, in a context of assumed shared experiences, values and assumptions and is the focus which offers a particular insight into the world of nursing.

3.1.3 Theorising Identity

The aim of this section is to explore selected theories of identity within a socio-cultural framework and to use this as an 'analytical lens' (Gee, 2000-2001) within my thesis. Through the use of narrative accounts I am concerned with how nurses perceive themselves and others, when practice around them changes. I am interested in the kind of story being told, how participants position themselves within the story, how the characters are positioned with respect to one another and how the roles of other people relate to their identity. I want to explore the cultural values, symbols and norms that identify 'being a nurse' in society and how these relate to a changing profession. The stories allow for a greater insight into their particular world and provide data for a richer understanding of their professional lives and the experience of a 'change in role.' Their stories also resonate with my experience and journey as a nurse in understanding my social class, where I came from, how I became a nurse and my own experience working as a sexual health nurse in a changing role.

I pick up elements of how identity has been theorised by various socio-cultural theorists and use this as a 'critical lens' in analysing the nature of their stories and the recurrent themes within them. I am interested in the ways of 'telling,' the people who populate the stories, intertextual reference and how the nurses within my research give voice to the discourse of 'role change' within the profession. Social identity theory, it can be argued, is a useful framework for understanding the development of professional identity which evolves over time, is concerned with the comparison of individuals and how they differentiate themselves from other professional groups, which allows for an insight into professional practice (Adams et al. 2006). Whilst I am using similar ideas, I am taking a broader view in terms of my focus on the ways in which nurses' account for their experience as part of their overall life stories, which professional practice and a change in role is just one part.

3.1.4 Identity in Socio-Cultural Research

'Identity' is a difficult concept to define and to provide a single overarching definition of what it is, how it is developed and how it works (Lawler, 2008). In trying to un-pack the meaning of identity I have picked out a number of key theorists in an attempt to explore and operationalize these ideas within my research and subsequent data analysis.

Identity has taken on a variety of meanings within the literature, drawing on a figured worlds approach, Urrieta (2007) argues that it is about how people come to "understand themselves, how they come to 'figure' out who they are through the 'worlds' that they participate in and how they relate to others within and outside of these worlds" (p.107). Gee has used a variety of definitions in his work from being recognized as a certain 'kind of person' in a given context (Gee, 2000-2001) to a "different way of being in the world at different times and places for different purposes" (Gee, 2011) (p.3). He makes further distinction in defining identity as 'socially situated identity' or 'social identity' to make it clear that we recognize and act out different social roles or different social positions in society. He outlines four ways of viewing identity, the first being 'Nature' identity, which is developed from forces in nature (for example being a twin). 'Institution identity' is a position authorised within an institution. This is quite pertinent within my research in respect of exploring how identity and position is enacted within an institution depending on the situation presented. I use the example of 'power dressing' for important meetings or the use of acronyms as a language to indicate rank, power, status and hierarchy. Gee (2011) would call these Big 'D' discourses: the way we dress or the way we enact our position as professionals may differ depending on the situation we find ourselves in. 'Discourse' identity, is therefore an individual trait recognised within dialogue. 'Affinity' identity is also applicable to nursing in that experiences are shared in the practice of sets of distinctive experiences. For members of an affinity group, there is a shared culture and an allegiance primarily to a set of common practices and shared traits. I can relate this to how I position myself as a nurse and the role I play in the interview process, as I assume my identity and position through my distinctive experience and shared experience as a member of the nursing community and my participation in discussion about care, for example.

Social research frequently argues that we do not have one single identity and that we identify with more than one identity or group (Lawler, 2008). Society is structured through the formation of various groups and at any one time an individual may belong to different groups defined, for example by ethnicity, nationality and professional roles. Several identities may therefore co-exist within an individual at any one time (Turner, 1999 cited in Adams et al. 2006) and one may have greater significance in an individual's life (Adams et al. 2006). Gee (2000-2001) also argues that people have multiple identities connected not to their 'internal states' but to their performance in society. In taking my own position, I recognise that I have several identities that are all different. I am a nurse, midwife, educationalist and mother and in having multiple identities I acknowledge that at times there could be a 'contradiction' of identity, which involves enacting more than one position. For example being a 'mother' and 'worker' are often understood as an existing tension (Lawler, 2008).

Sfard and Prusak (2005) explore the notion of identity, challenging traditional association with character, nature and personality. They argue that identity is connected to other notions such as attitudes, conceptions and beliefs, defining it as "a set of reifying, significant endorsable stories about a person, these stories even if individually told, are products of collective storytelling" (p.14). In sociological and cultural theory identity is a focus of issues of power which feature prominently when we question how discourses shape personal worlds and how individual voices combine with those of a community. In this context Sfard and Prusak (2005) use the verb 'identifying,' that is "to be understood as the activity in which one uses common resources to create a unique, individually tailored combination" (p.15). They argue that significant narratives about a person can be divided into two types of identity: actual identity consisting of stories about an actual state of affairs and designated identity which consists of narratives presenting a state of affairs which is expected to be the case, if not now then, in the future. Actual identities are told in the present, for example 'I am a good nurse'. Designated identities are stories which have the potential to become part of one's identity. These can be recognised by the use of future tense words that express wish and commitment, for example;

should, ought, have to, must, want. Narratives such as 'I want to be a nurse' or 'I have to be a better person' are typical of a designated identity. Designated identities are therefore not necessarily desired;

“One may expect to become a certain type of person, that is to have some stories applicable to oneself, for various reasons: because the person thinks that what these stories are telling is good for her, because these are the kind of stories that seem appropriate for a person of her socio-cultural origins, or just because they present the kind of future that she is designated to have according to others, in particular according to people in the position of authority and power.”

(Sfard and Prusak, 2005, p.8).

In my own analysis I use the example of paternal influence and power over 'designated identity.' Several of the nurse accounts tell of 'doing what their father told them' or (implicit) parental expectation of what was considered a 'good job for a working class girl.' In Bakhtin's (1981) terminology this can be seen as 'authoritative discourse,' words of ancestors that comes from the past and which at least in part go unquestioned.

“The 'authoritative' word demands that we acknowledge it, that we make it our own; it binds us... Its authority was already 'acknowledged' in the past. It is a 'prior' discourse. It is therefore not a question of choosing it from among other possible discourses that are its equal.”

(Bakhtin, 1991, p.342, cited in Solomon, 2012).

Sfard and Prusak (2005) argue furthermore that narratives are recycled within families as circulating stories that go round and round. “Identities are products of discursive diffusion – of our proclivity to recycle strips of things said by others even if we are unaware of these text's origins” (p.18). Narratives of ourselves are in part authored by others, and stories once told tend to acquire a life of their own as they 'change hands,' challenging designated identities formed in childhood is a difficult task since, “tales of one's repeated success are likely to reincarnate into stories of special “aptitude,” “gift” or “talent,” whereas those of repeated failure evolve into motifs of slowness, “incapacity or even “permanent disability” (Sfard and Prusak, 2005, p.18). Circulating stories in families help shape how people are constructed as certain types of people, with later generations also constructing themselves as that person. I use the example within my data set of several nurses telling about their 'parents' as nurses and the impact of this family history on their own trajectory through life.

3.1.5 Discourse

Discourse affects our view of the world in terms of beliefs, practices or knowledge that constructs reality and provides a shared way of understanding the world (McCloskey, 2008). For Burr (2003) discourse refers to a set of meanings, metaphors, representations, images, stories and statements which in some way together produce a version of events. It refers to a particular picture that is painted, for example of an event, person or class of person and is a particular way of representing it in a given light. Numerous discourses surround any object and each strives to represent or 'construct' it differently, bringing different aspects of it into focus with implications in respect of what should be done about it. How nurses represent themselves is part of the construction of the nursing world.

Gee (2000-2001) argues that discourses are ways of being 'certain kinds of people' (p.110) with discourses providing a way to define a person's 'core identity.' Gee (2011) uses the terms Big 'D' discourse as a way of combining and integrating language, actions, interactions, ways of thinking, believing, valuing and using various symbols, tools and objects to enact a particular sort of socially recognizable identity. He takes the example of being recognized as a 'street-gang member' in which you have to speak in a certain way, act and dress in the 'right' way and engage in a characteristic way of thinking, acting, interacting, valuing, feeling and believing. You have to be able to use a variety of symbols, tools and objects in the right place at the right time. One and the same person might talk, act and interact in one context to be recognized as a 'street-gang member' and in another context, act quite differently to be recognised as a 'gifted student.' The two identities may conflict with each other in some circumstances where people expect different identities from that person, as well as in the person's own mind. Discourses have no discrete boundaries because people are always in the process of creating their personal history, creating new discourses, changing old ones and contesting and pushing the boundaries of discourses (Gee, 1999). In contrast he uses the phrase little 'd' discourse to mean an instance of 'language- in-use' or any stretches of oral or written language (text) (Gee, 2011).

Within the nursing profession there are a multitude of discourses but discourses of image and the position of nursing in society is of particular current concern within media representations of nurses. The positioning of nursing within the public domain ranges from the 'angel' who is representative of kindness, having motherly tendencies and a martyr figure. To the 'battle axe' who is representative of an authoritative, overweight matron, to the 'sex symbol' and doctor's 'handmaiden' or 'servant' (Cabaniss, 2011). Symbols of these various identity positions include the wearing of uniform, while overall the dominant image of nursing position is as a female profession. Weaver et al. (2013) express concern over the impact on recruitment and retention of the inaccurate portrayal of nurses on television, arguing that "images of nursing in popular media frequently draw on stereotypes that may damage the appeal of nursing for potential students and denigrate the value and status of the profession" (p.1). Although nursing in fact remains a female dominated profession, there has been an increase of male applications into nursing in the UK (Hallam, 2002) which can be connected to a different portrayal of nursing in the BBC drama 'Casualty,' which shows the skilful aspects of nursing work (Jackson, 2009) and highlights men in central nursing roles.

3.1.6 Figured Worlds and Cultural Models

The concept of Figured Worlds was first introduced by Holland, Lachicotte, Skinner and Cain (1998) and defined as a "socially and culturally constructed realm of interpretation in which particular characters and actors are recognized, significance is assigned to certain acts and particular outcomes are valued over others" (p. 52). A figured world is not an isolated concept but is part of Holland et al (1998) larger theory of self and identity and is intimately tied to identity work, particularly the concept of identities forming in process or activity (Urrieta, 2007). Figured worlds are peopled by characters from the collective imaginings of particular groups and communities, while there are alternatives to these imaginings, we generally act as though there are not. For example we make assumptions on the basis of class, gender, race and nationality and in my own research: gender and class are closely connected with the characterisation of 'being a nurse.' The different elements of figured worlds may be organised around positions of rank, status and influence and people therefore learn to

ascribe meaning to objects, events, and discourses within a particular figured world.

Figured Worlds is one of four contexts that Holland et al (1998) suggest are sites where identities are produced. People 'figure' who they are through activities and in relation to social types that populate these figured worlds and in social relationships with the people who perform these worlds. People also develop new identities in figured worlds, which give people shape and form as their lives intersect with them (Urrieta, 2007).

Thus Figured Worlds have four characteristics:

1. "Figured Worlds are a cultural phenomenon to which people are recruited, or into which people enter, and that develop through the work of their participants.
2. Figured Worlds function as contexts of meaning within which social encounters have significance and people's position matter. Activities relevant to these worlds take meaning from them and are situated in particular times and places.
3. Figured Worlds are socially organized and reproduced, which means that in them different people are sorted and learn to relate to each other in different ways.
4. Figured Worlds distribute people by relating them to landscapes of action, thus activities related to the worlds are populated by familiar social types and host to individual senses of self".

(Urietta, 2007, p.108)

The term 'cultural model' or 'discourse model' also appears in similar accounts of identity: cultural models are for example defined as simplified images and storylines that encapsulate what is regarded as typical for a particular social group (Mallozzi, 2012). Although his earlier work drew heavily on the concept of cultural models, Gee (2011) forewent the terms cultural models and discourse models, taking up Holland et al (1998) theorisation and absorbing cultural models as part of a figured world, which he defines as:

"Theory, story, model or image of a simplified world that captures what is taken to be typical or normal about people, practices (activities), things or interactions.

What is taken to be typical or normal of course varies by context and by people's social and cultural group. A figured world is a socially and constructed way of recognizing particular characters and actors and actions and assigning them significance and value."

(Gee, 2011, p.205).

Figured worlds as theories (explanations), may be partial or inconsistent as a result of conflicting values and differences between people who use the figured world, who do not actually belong or value other people's interests better than their own. We therefore may enter some "figured worlds only temporarily, peripherally, while in others we may come to assume positions of relative power and prestige" (Urrieta, 2007, p.109). This reflects the fact that we all have diverse and conflicting experiences and that we may belong to different and contradicting groups which are influenced by a range of texts, institutions and media, that may reflect our 'best interests' in a positive or negative light (Gee, 2011). I draw upon the related idea of 'contradiction' in my analysis, noting 'contradictions' in the stories. For example between the portrayal of nursing as purely a vocational commitment to caring and a less desirable admission that nursing is a good source of income. The figured world of nursing prioritises 'care' over the importance of earning a living.

3.1.7 The Seven Building Tasks of Language

Figured worlds can be useful as a context for discourse analysis in that "we want to ask what typical stories or figured worlds the words and phrases of the communication are assuming and inviting listeners to assume. What participants, activities, ways of interacting, forms of language, people, objects, environments and institutions, as well as values are in these figured worlds?" (Gee, 2011, p.72).

Each time a person uses language, they do it in ways to make meaning, to say things and do things. The things we do and are (identities) come into existence in the world and they bring about other things in the world. Language is used to build things in the world and to engage in world building. For Gee (2011) whenever we speak or write, we build seven areas of reality, which he calls the 'Seven Building Tasks of Language,' a discourse analyst can then ask seven

different questions about any piece of language in use. These are: 'Significance' - things in life that are significant through the language used which may render things significant or less significant to signal their views, 'Practice' - activities that can be socially recognised and institutionally or culturally support endeavours that usually involve sequencing or combining actions in other specified ways; 'Identities' - the language used to gain recognition when taking on a certain identity or role which is to build an identity here and now; 'Relationships'- the language used to signal the sort of relationship we have, want to have or are trying to have with our listener, reader or other people, groups or institutions about whom we are communicating; 'Politics' – the distribution of social goods, 'Connections'- language is used to render certain things connected or relevant (or not) to others and finally 'Sign Systems and knowledge' - there are many different languages and different varieties of any one language. For example the language of mother, nurse, midwife, academic. Focusing on the Seven Building Tasks of Language and discourses as they operate to create complexity within institutions and cultures across societies and history enables a way of analysing figured worlds.

Gee's (2011) major contribution to discourse analysis focuses on his idea of 'situated meanings,' which deal with the highly specific meanings that words and phrases take on in actual contexts of use. Speakers and writers construct their utterances or sentences to guide listeners and readers towards specific meanings based on what was said and the context in which it was said. Gee argues that when we utter or write a sentence it has situated meaning. He uses the example of 'coffee':- in one context 'coffee' may mean a brown liquid ('the coffee spilled go get me a mop') or it may mean grains of a certain type ('the coffee spilled go get me a broom'), in another it may mean containers ('the coffee spilled, stack it again') or the word 'coffee' can have further meaning as a type of flavour or colour (p.66). Therefore context can affect the meaning and may range from body positioning, eye gaze, through to people's beliefs, historical and cultural settings. Gee (2011) notes that there is a question over where we cut off the consideration of context and how sure we can be that our interpretation is correct, if further aspects of context could well change that interpretation. Faced with a narrative or written language, we can consider key

words or a family of key words that we wish to analyse from the point of discourses used. I draw on these ideas from Gee (2011) within my own data analysis in terms of understanding in context. For example, when my participants tell me about 'caring', the surrounding of their story needs to be taken into account. There are multiple references from the current concern with the 'loss of caring' within the profession to self-identification as a caring person, which contribute to my overall interpretation of what it means to them to be a nurse, who they are and where they came from.

3.1.8 Researching Nursing as a Figured World

A figured world is a narrative world and one that is always changing as new people enter that world. In applying Holland et al (1998) concept of a 'figured world' to nursing, we can see the profession as historically and culturally linked to the female role - as I showed earlier in this thesis. The earlier literature already indicates nursing as a figured world in terms of what nurses' look like, what kind of people they are and how they negotiate a place in the figured world as part of structural change. Nursing identity is linked to the history of women, gender relationships and educational, organisational and class practices, in addition to the biographies of individual nurses who have shaped the world through their reputations and life stories (Padhila, 2011). Kelly et al. (2011) argue that the public discourse of nursing has the capacity to construct the identity of nurses. Its origins are gendered as women's work with connections to social class and domestic work. With a dominant focus upon femininity, there is a lack of male role models and under representation of male nurses in the profession (Rajacich et al. 2013). What the male and female participants in my research say about how they joined the profession and the factors that influenced their decision making to become a nurse, is a key interest of this research. Many public discourses depict nursing as a vocation with dedication and purpose in caring for the sick and needy and typically 'women's work' and Arthur (1992) correspondingly argued that many entering the nursing profession had a romantic vision of hospital life in caring and curing the sick. In reality it can be an unpleasant, demanding and tedious job that results in conflict between reality and such expectations. Nurses have varied educational and social class backgrounds with multiple other roles and their conceptions and

connections before they enter the profession are of particular interest in this thesis. For example, they may already have acquired a nature or designated identity as a 'carer,' with circulating stories around nursing and their suitability for the job exist and surround the participants before they even enter the profession.

Taking the theoretical position of figured worlds as Gee (2011) suggests as a useful tool of inquiry within DA, we can ask what typical stories or figured worlds the words and phrases are assuming within the conversation to the listener. This allows us to ask what participants, forms of interaction, use of language, activities, people, environments and institutions as well as values that exist within these figured worlds. Stories have shape and as natural story tellers we retrospectively construct our lives as stories; as they story themselves and construct my place in their story. My participants are trying to make sense of their lives with a strong sense of connection and continuity. Arguably there are different types of figured world: those we believe in, those we use to evaluate ourselves and others, those that consciously or unconsciously guide what we do and how we interact with others. We might espouse the beliefs of one particular figured world whilst acting according to the beliefs of another. In order to understand which figured worlds are at play, we need to consider what deeply held conscious and unconscious beliefs are in operation for people to act as they do (Gee, 2011). People learn to recognize each other as a particular sort of actor, sometimes with strong emotional attachments, value certain outcomes over others and recognize and attach significance to some acts and not others. How people enter a figured world depends on who they are; "imagined acts, courses and places of action, actors and even the whole of a figured world take on an element of rank and status according to this rational hierarchy" (Holland et al. 1998, p.58).

3.1.9 Figured Worlds and Positional Identities

The importance and influence of figured worlds are also the foundation for Holland et al (1998) three other contexts for the production of personal and social identities (Urrieta, 2007), that is negotiations of positionality, the space of authoring and world making. Positionality relates to how a world is populated

and who does what within it. There are positions 'offered' to people in different figured worlds, for example whether to be a 'loud student', 'bad student', 'successful student' or 'smart student' (Urrieta, 2007). In drawing on the concept of figured worlds which are intimately tied to identity work, Urrieta (2007) argues that we adopt the activity of 'positioning' a person in terms of power, status, rank, gender, race, ethnicity and class. Narratives are borne out of historical significance (both oppressive and liberating) as well as a distribution of power, rank and prestige that they either accept, reject or negotiate to varying degrees- the space of authoring. For example, within my own research the positional identity as 'daughter' comes through strongly in the narratives and is explored in my analysis in Chapter Four.

When we are socially identified by other people we are offered positions that we may accept reject or negotiate and we must make choices and respond (Urrieta, 2007). The third context for the production of identities is in world making; Holland et al (1998) conclude that through 'serious play' new figured worlds may come about, allowing for the possible creation of new ways, acts, artefacts, discourses and perhaps even more liberated worlds (Urrieta, 2007). Positional identities relate to a, "person's apprehension of his or her social position in a lived world, that is dependent on the others present, of his or her greater or lesser access to spaces, activities, genres and through those genres, authoritative voices or any voice at all" (Holland et al. 1998, p.127-128). In critiquing the positioning and self-positioning of nursing, we can see the role of discourses of power. For example, Roberts (2000) argues that nurses are an oppressed group and a subordinate profession to the medical profession; nurses feel devalued in their role as 'hand-maidens' due to managerial and medical domination, since their role historically has been defined in relation to physicians as 'non decision makers' who are 'care givers' reliant on doctor's orders (Cabaniss, 2011). A change in professional role from the historic doctor's assistant to one of autonomous professional practitioner will inevitably relate to their position in society, how they interact with others and their interaction of experience of such interactions (Johnson et al. 2012).

The position of nursing not only relates to the positions of other professions in terms of status and rank but a major contributor is the role of women in society

and its relationship with social class and career aspirations of working class women as a 'suitable career' choice. The role as doctor's handmaiden and servant is culturally and historically connected to the emergence of Florence Nightingale and nursing's link to the military. Nursing has for a long time been devalued as a 'task orientated profession' with all responsibility and decision making resting with the authoritative and hierarchical role of the doctor. Nursing professional identity develops over a life time; from before entry to the profession with pre-existing values and beliefs, experience of education, academic study and clinical practice. I am therefore interested in how nurses think and feel about themselves during times of change and how their identity has evolved throughout their life time from one of lay person to qualified nurse, acquiring the knowledge, skills and attributes of a professional role. Fagermoen (1977) argues that the values which underlie the professional identity of nursing and what is considered meaningful in nurses' work and nurses' stories about practice are significant. Representations of practice, self-representation as a nurse and central values are reflected in their stories, providing a rich insight into the lived world of the nurse.

3.1.10 Conversations and Intertextuality

Gee (2011) develops three further tools of inquiry into discourse, for use as 'thinking devices' that guide us to ask certain questions from a piece of oral or written language. These are social language, conversations and intertextuality. Social languages are the differing varieties of language used in discourses that allow us to express socially significant identities (for example, the language used by a nurse, doctor or midwife) and to enact different socially meaningful practices or activities (for example delivering a baby or writing a prescription). Conversations with a Big 'C' are debates in society or within specific social groups. For example: issues such as abortion, smoking or school reform are key issues that large numbers of people recognize, both in terms of what 'side' they take in such debates and what sorts of people tend to be on each side. These major themes or debates therefore play a role in how language is interpreted. The themes and values that circulate within the media and texts are the products of historical disputes between different discourses and the debate

over time constitutes a conversation that society seems to know about. In nursing a current Big 'C' conversation is the primacy of care.

Finally, when we speak or write, our words can allude or relate to other types of texts or words other people have said or written. This cross reference to another text is known as intertextuality. In instances of intertextuality, a spoken word or written text can allude to another, either in direct quotes or otherwise more subtle relation (Gee, 2011). For example, in telling a story of being a nurse, reference to a television programme such as 'Casualty' is of interest in understanding the significance of being a nurse to the speaker. Sometimes a 'text' spoken or written in one social language will accomplish a sort of switching by 'borrowing' from another text in the same or different variety of language.

A related concept in Bakhtin's (1986) theory of language is his emphasis on the multiplicity of voices, known as 'heteroglossia' or differentiated speech (Vice, 1997) in the authoring of self. He views the study of language in use as the identification of "utterance, oral or written between persons as the 'real unit of speech communion'" (p.67). Thus he asks who is doing the speaking and to whom is the utterance being addressed and in what context? This emphasises the 'addressivity' and 'answerability' of what we say, the utterance or word is always addressed to someone and anticipates a response and an answer. Discourse (a string of utterances) is dialogic and is positioned within and inseparable from a community, history or place. The dialogic nature of figured worlds, means that the vantage point and authoring comes from the 'I' but the words come from a collective experience and are already articulated by others (Holland et al. 1998). "The word in language is half someone else's, meaning that it exists in other people's mouths and other people's contexts. It only becomes 'one's own' when the speaker populates it with their own intention or accent" (Holland et al. 1998, p.171-172). Voices being socially inscribed and heteroglossic in which a blending of world views and perspectives through language may be inscribed by 'differing amounts of authority' (Holland et al, 1998) (p.182). The orchestration of such voices is referred to as 'self-authoring' (Bakhtin, 1981). For example within my own research, during the interview process it will be relevant when thinking about 'answering' and 'addressing' and the co-construction of the stories they tell.

3.2 Section Two: Methodology

In this section I will discuss narrative inquiry and its application to nursing research and then lead onto my approach in using narrative as a tool to gather my data. In support of my rationale for using narrative, I refer back to the work of Sfard and Prusak (2005) and their definition of identity as: “a set of reifying, significant endorsable stories about a person. These stories, even if individually told, are products of collective storytelling” (p14).

3.2.1. Narrative Inquiry

The word narrative derives from the Latin '*gnarus*' meaning 'knowing', while story comes from the Greek and Latin '*historia*' which also means knowing (Holloway and Freshwater, 2007). In defining narrative inquiry there are numerous definitions and interpretations within the literature, the following are central to my research approach;

“The focus of qualitative research is the gaining of insight into people’s experiences, so personal stories are valued.”

(East et al. 2010, p.17)

“It is concerned with understanding ‘an event, process or situation in a great deal of depth’ focusing on how individuals experience or understand events in their lives.”

(Llewellyn et al. (1999) p.174, cited in: Kelly and Howie (2007), p.136).

Narrative is a journey through time which is told by the ‘author,’ who tells the ‘listener’ what happens on the way. The narrator takes a reflective stance on events and processes on the journey and allows for first person stories which are rich in data. Narrative is not only linked to individual identity but to community, culture, gender, power and authority which also affect the stories people tell. Stories have a structure, which include a number of ordered constituents. The sequence commences with a ‘setting in’ which the narrator includes the character, location and time, in which the story takes place. Once the setting has been established the story can proceed with one or more episodes which link to the whole story being presented (Polkinghorne,1991).Holloway and Freshwater (2007) argue that narratives are

accounts of experience over time with an overall plot that consists of a beginning, middle and end, which may not be told in that particular order. The common features shared by narratives include; a finite time sequence, the implication of narrator and audience, links to the individual, the subjective experience of the storyteller and the story should be capable of holding the audience's interest (Greenhalgh and Hurwitz (1998), cited in Holloway and Freshwater, 2007).

Story telling has been questioned in terms of being a legitimate product in respect of 'real research.' The rigour of narrative and trustworthiness of the data requires consideration, for example, are the participants providing 'true' data and an accurate representation or is it made up? The idea of 'true' does not work in the arena of narrative, what matters is the story someone tells you. I am not in the business of finding truth but I am legitimately concerned with the story they tell to me, which might be different to what they tell themselves. I acknowledge that I can't do anything about this and I have to take their story as face value, at the time of telling. Whatever story is told, it does not matter as I am looking at the contribution and interpretation made from their stories. Individuals construct private and personal stories that link to diverse events of their lives of which they are stories about the 'self' (Polkinghorne, 1991). These are considered to be the basis of self-understanding and personal identity and provide answers to the question of 'who am I.' The narratives we produce in the context of stories about 'how we came to be' and the 'way we are' allows for us to produce an 'identity.' Identity is therefore configured over time through the narrative and is something produced, as people explain in order for us to understand their lives. In narrating a story, participants draw upon memories and not only do they interpret those memories but the memories become interpretations of themselves. It is possible to see the past and present linked in a spiral of interpretation and reinterpretation and to break down the dividing line between self and others and to view how our identities are embedded within our social world (Lawler, 2008).

McAdams and McLean (2013) define 'narrative identity' as a "person's internalized and evolving life story, integrating the reconstructed past and imagined future to provide life with some degree of unity and purpose" (p.233).

Narrative identity reconstructs the autobiographical past and imagines the future in such a way as to provide a person's life with some degree of unity, purpose and meaning. Through narrative identity, people convey to themselves and to others who they are now, how they came to be and where they think their lives may be going in the future, which has similarities to figured worlds and the notion of self-authoring. The narrative does not stand alone but refers to and can draw upon wider cultural narratives and cultural symbols to narrate movement through time and work because culturally they signify more than themselves. Qualitative researchers are concerned with the trustworthiness and authenticity of the accounts presented and there are two different levels of validity in narrative inquiry; the original story of the participant and how the researcher re-presents their story (Holloway and Freshwater, 2007). The construction of a story is likely to involve events, characters and what they do and the point of the story depends on the way it is interpreted and the mode established by the author in terms of the setting, characters, dialogue, actions and events which constitute the story (Koch, 1998). Story tellers narrate their story to the researcher, researchers in turn retell the story to the reader of the research account, which means that the story is told several times over, evolving each time (Holloway and Freshwater, 2007).

3.2.2 The Use of Narrative in Nursing

Qualitative research in nursing and healthcare has seen a growth in the use of narrative research (Jack, 2010) with 'life story' being increasingly used (Lai, 2010). It is considered appropriate for researching experience through time to inform clinical practice through the narratives of patients and staff (Bleakley, 2005). Narrative inquiry is still regarded as a young and innovative method (Frid et al. 2000) and there are several factors that have influenced the increased interest and use of narrative in nursing. This includes a back lash against the dominant discourse of evidence-based practice and a move beyond the subject-object divide. Nursing allows for a greater emphasis on reflective practice and narrative inquiry can allow for nursing work to become visible, which can influence practice through the development of knowledge and for the art and science of nursing to be appreciated (Holloway and Freshwater, 2007). Narrative inquiry is therefore concerned with discovery and illustrating how

experience matters (Lindsay, 2006). Striving to allow different voices to be heard, researchers deliberately select participants who can make this possible in order to provide good evidence of their everyday lives and the meanings that they attach to this experience (Wiklund-Gustin, 2010).

3.2.3 The Status of Narrative within My Research

The use of 'life story' and narrative inquiry was not my original intention as I was concerned with using narrative as a means of gathering data and enabling an insight into identity. I used a loose narrative approach to gather mini stories which covered lots of topics and I frequently ended up gathering 'life stories.' I was particularly interested in the kind of story being told, how participants positioned themselves in the story and how characters are positioned with respect to one another as members of the nursing and other communities. The stories that the nurses told allowed for insight into their particular world, in terms of their position and identity as a nurse. The presenting evidence allowed for a richer understanding of a 'change in role' and the stories also resonated with my own experience and journey as a nurse. Through the use of narrative interviewing, my intention was to draw on theorists from a variety of connected theoretical positions in relation to stories about nurses' backgrounds, how they had become a nurse and how they experienced 'change' in their profession. Nurses often tell stories and reflect upon their practice, their accounts provide snapshots of their nursing life, revelations about the nature of their work, the challenges that exist and the uniqueness and privileged place of working in the profession (Wolf, 2008).

3.2.4 Research Design and Methods

I have chosen a qualitative research design using narrative since this allows for the exploration of an experience, culture or in-depth situation (Gerrish and Lacey, 2006). My approach is exploratory rather than explanatory, in order to present a richer understanding of 'changing roles' within the nursing profession, through the contribution and interpretation of the stories that my informants tell. This section will discuss my research process and will discuss dilemmas and solutions that emerged. I will reflect upon my own position as a novice researcher and discuss how this influenced the research process, subsequent

data analysis and interpretation of the findings. I will also discuss the ethical governance issues that took place in relation to this study.

3.2.5 Sampling and the Selection Process

I opted to recruit ten participants to the study, using a purposive sampling and aiming at a gender mix of both male and female sexual health nurses. I knew that this was unlikely to be a 50:50 split because of the lower ratio of male to female nurses working within the profession. Purposive sampling allows the researcher to choose a case because it illustrates a certain feature or process that we are interested in (Silverman, 2013). Bryman (2004) argues that purposive sampling is, “essentially strategic and entails an attempt to establish a good correspondence between research questions and sampling. In other words, the researcher samples on the basis of wanting to interview people who are relevant to the research questions” (p.333-334). Gerrish and Lacey (2006) argue that a purposive sample is, “one where people from a pre-specified group are purposely sought out and sampled” (p.182).

I wanted to use a purposive sample because of a ‘pre-determined,’ inclusion criteria around the level of practitioner I was interested in and the focus of my central research question around ‘role change.’ As a lone researcher with limited time, I decided on ten participants as a manageable number, although I was interested in seeing in how many people actually expressed an interest in participating in the first place. I was able to conveniently and purposively select and recruit sexual health nurses into this study because of the access to information I had within my academic role. The student body ranges from the age of twenty one, which is the youngest age a post registration sexual health student could be following nurse qualification up to the age of retirement.

The level of practitioner I focused upon was ‘Dual Trained’ in both contraception and STI/HIV practice and currently working in a sexual health service, as I wanted to target sexual health nurses in a ‘changing role’ position. Therefore to be eligible for inclusion into the study, the nurses must have completed specific sexual health modules which awarded a qualification at this level of practice. These modules would have commenced delivery from

September 2008, following the implementation of a new sexual health curriculum.

Inclusion Criteria

1. Participants are registered nurses and hold a current nursing registration with the Nursing and Midwifery Council.
2. Participants have achieved academic qualification and clinical competency as a dual trained practitioner in contraception/STI & HIV management.
3. Participants were to be ex students who were not enrolled with the university on a sexual health programme during the academic year 2010/2011.
4. Participants were currently employed in a sexual health related service, which could be a NHS or non NHS organisation in the North West of England.

A computer search was undertaken with the support of the school administration team, using the specific sexual health module programme codes covered in my inclusion criteria, to create a list of all potential nurses who could be invited into the study. The inclusion dates for recruitment into the study covered a two year period of time from September 2008, when the new sexual health modules were introduced, up to the end of October 2010, which allowed for a final inclusion of potential nurses, following their successful completion at the October 2010 Assessment Board.

The search produced a list of eighty six nurses on the first sweep. I then removed fourteen from the list. Ten were excluded following a cross check of application forms for the 2010/2011 academic year of study, as they were current students. Two names had been counted twice as they were on two modules. I also excluded two further nurses on the list on the basis of my local knowledge: one had relocated abroad and the other had retired.

The rationale for avoiding current sexual health students was to minimise the impact of my dominant position in the institution as a nurse tutor and to ensure that the participants felt free and open to explore their feelings and attitudes. I did not want to create a potential conflict of interest or power imbalance as a result of my position as both a tutor and researcher. Therefore removing current students from the selection process seemed the most appropriate strategy to take. By recruiting previous students, I also acknowledge a previous power relationship in my role as their tutor and for several nurses, as their clinical colleague. There is an existing knowledge regarding my position and as we all share the same practice, they may feel that they have to say the 'right thing.' I therefore need to be mindful of how I recognise these relationships and to bear this in mind in the way they tell their story and the language they use in the analysis stage.

3.2.6 Invitation to Participate In the Study

I now had a total of seventy two eligible participants for invitation with a gender mix of sixty nine females and three male nurses. Seventy two personal invitation letters of invite were sent via second class mail from the university to personal home addresses on October 22nd 2010. This included a personal letter (see Appendix One) of invitation and a participant information sheet (see Appendix Two) regarding the study. The RCN (2011) state that a participant information sheet should be prepared to:

- Invite the reader to participate in the research.
- Use language appropriate to the potential participant group, avoiding the use of technical language.
- Include diagrams, pictures, tables and flowcharts if they contribute to an explanation of the research (p.3).

All participant documentation included letter headings and logos of both universities (my home institution and my place of study) in order to clarify the joint organisations involved. The letters gave contact details for myself as the researcher and for my Director of Studies, should further information be

required. The purpose of the research was outlined, who was involved, the length of participation required (1 to 1.5 hours), the practicalities of being involved, the choice of granting permission to audio record and transcribe the interviews or the use of field notes only. Information was provided on the storage of data and all participants were informed that they could receive a copy of their interview to check for accuracy before transcription took place. Participants were also told that they would be offered a summary of the findings at the end of the research and that all information collected would be strictly confidential and the research did not involve any access or approach to organisations via NHS or Non NHS premises.

Sending a letter of invitation offered a more personal and confidential approach. This allowed potential participants the time to read the information and to consider their decision to take part, without any pressure. I did not want to use NHS e-mail accounts or send information to their employing organisation because of the need for confidentiality. Also ethical approval for this study was based on the premise that I did not need to access NHS sites, as the study was recruiting past students from my own university. I could have used personal e-mail accounts but I did not have a full list of these. Whilst I could not be sure that home addresses had changed, the use of postage, whilst it incurred a cost, seemed the simplest method of communication. None of the letters were returned back to the university because of an incorrect address.

Negotiation of an impartial environment for interviewing was an important consideration in the research design. To maintain privacy, confidentiality and informed consent, participants were given the choice of being interviewed either in their own home or at the university depending on their preference.

3.2.7 Response Rate

Seventy two letters of invitation were sent out on October 22nd 2010 and I received eighteen personal responses via university e-mail and telephone. I provided an initial response, thanking respondents for their interest and informing them I would be in touch once I had finalised the selection process. This provided an initial response rate of 25% and included a gender mix of fifteen females and three males. Subsequently I had to remove a further four

nurses as one withdrew, as she was no longer working in sexual health; another e-mailed to withdraw and did not give a reason; and a further two nurses (one female and one male) enrolled on a semester two sexual health module from January 2011 and became ineligible. This now left fourteen potential participants for inclusion in the research, 19.4% of my original pool, with a gender mix of twelve females and two male nurses.

Mason (2002) as cited in Holloway and Freshwater (2007) argues that within narrative research, sampling can rely on very small numbers, as it is depth rather than breadth that is important. The number in the sample will depend on the research question, aims and focus of the research and if the question can actually be answered. The quality of the data has a higher priority than actual numbers recruited into the research, as the researcher does not seek for generalisation. The research is concerned more with the richness of the narratives and the observational and analytical skills of the researcher within that sample size.

I originally opted to recruit ten nurses into the study, using a purposive sampling aiming at a gender mix of both male and female sexual health nurses and I had a final pool of fourteen nurses. This allowed for a gender mix of twelve female nurses and two males. Due to time constraints and being the lone researcher, I did not have the capacity to interview all fourteen nurses and so I opted to interview eleven nurses in total following a review of the list. I selected nine female nurses who I considered could provide rich data from their experience in a diverse range of sexual health settings and roles. I also selected the two male nurses, as I wanted the best gender mix available from my sample. In relation to over recruitment (three participants) they had been informed on the participant information sheet that an agreement to participate did not necessarily mean that they would be selected because it was a small scale study. I personally contacted the remaining participants, thanking them for their time and interest.

3.2.8 Pen Portraits

Pen portraits provide an informal description of a participant and I have included a pen portrait of all ten participants in this study to inform the reader of their background and nursing experience. All names have been changed and a

pseudonym used to maintain anonymity and confidentiality. The following pen portraits are based on what I was told during the interview process and are therefore part of their story. I have picked out key data, for example: age and their employment history to provide the reader with a context of each of the ten nurses in my study.

Carolyn (Aged 52)

Carolyn left school at the age of 15 and upon leaving school didn't know what she wanted to do and therefore took a variety of jobs which included farming, factory work and working in a pet shop. She commenced three year training to become a SRN but left after nine months to care for her family when her mother became ill. She was planning to get married and return to nurse training but had to re-enter on the SEN course because of a change in the academic entry level. Upon qualification, Carolyn started to work with care of the elderly before retraining to become an SRN. She qualified as a midwife and worked as a midwifery sister for four years before later qualifying as a family planning nurse, working one evening a week in a local clinic. Following qualification as a health visitor, she later became a sexual health nurse working in a large integrated sexual health service.

Sarah (Aged 38)

Sarah commenced A 'level study upon leaving school and entered registered nurse training at the age of eighteen. Both her parents were nurses and went into the profession later on in life. As a registered nurse, she went to work in a large children's hospital and then moved to a local paediatric ward. She had considered paediatric nurse training but this did not materialise and she got married and went to work at a children's hospice. Sarah later moved to NHS Direct and stayed for three years during which time she completed sexual health training. Sarah moved into local sexual health services and then into a sixth form college to implement a young person's nurse-led sexual health service.

Amy (Aged 52)

Amy became a cadet nurse at the age of sixteen. She qualified as an SEN and it was sixteen years before she undertook a registered nurse conversion course. As an SEN, she first worked in elderly female medicine before moving into gynaecology. During this time, she was a family planning nurse and has been working in clinics since 1999. After ten years, Amy moved into a sexual health post within GUM and later took up a seconded post with the responsibility of implementing a nurse-led contraceptive service in local sixth form colleges.

Nicole (Aged 49)

After leaving school, Nicole started her A 'levels but did not finish them and went to work as a bank clerk. She began registered nurse training at the age of twenty. Her mother was also a nurse. Upon qualification, Nicole had a baby and worked as a bank nurse in gynaecology before moving to a private hospital. After eight months, she returned to gynaecology outpatients and completed a range of sexual health courses. She moved into general practice nursing whilst continuing to work in local family planning services. Nicole remains employed in general practice but has now re-located her role to an onsite GP medical centre within the 'home' university as a sexual health nurse.

Ruth (Aged 48)

Ruth left school in 1978 and worked as a carer for two years before training as a registered nurse in a large university hospital. Upon qualifying she moved location and took up her first post in A and E. She stayed for eighteen months before moving to a brand new, private hospital to gain experience in medicine and surgery. She stayed for two years, got married, had a baby and continued bank work for a further ten years. This allowed her the opportunity to move into sexual health work and to get involved in the implementation of a new screening programme and well woman clinic. She completed the family planning course and then took up additional bank work with a local NHS contraceptive service before moving into a permanent post. Ruth continued to work part-time in a range of roles, including school nursing and occupational health nursing. In September 2004, Ruth took up the post as a young person's outreach nurse,

which involved setting up a nurse-led service in a local college and she continues to work in mainstream contraceptive services.

Rachel (Aged 45)

Rachel left school at sixteen and went to train as a dental nurse until the age of eighteen when she commenced SEN training. She undertook further study to convert to a registered nurse and then worked on a medical unit for seven years. In 1997, Rachel trained to be a health visitor and took up the role of teenage pregnancy health visitor. This allowed her to become family planning trained and work one session a week. Four years ago, she took up a full time sexual health post within the same integrated service as Carolyn and she has specific responsibility for running a vasectomy service. Rachel has two undergraduate degrees in Community Health Studies and Specialist Practitioner (Health Visiting) and is qualified non-medical prescriber.

Lucy (Aged 51)

Lucy entered nurse training at the age of seventeen. Her mother was a nurse. She chose to study a combined nursing course, which included registered general nursing and registered sick children's nursing. At the point of entry, the school of nursing realised that she did not meet the age entry criteria and was short by three months. She had to stop training and then worked as a cadet and auxiliary until she turned eighteen and was old enough to re-enter nurse training on a combined nursing course. At the age of nineteen, her mother was killed in a car accident and being the eldest of four girls, she returned home on her days off to care for her family. She subsequently moved back closer to home after qualifying to continue caring for her family. Lucy's interest in sexual health originated from her work with care of the elderly. She worked with a consultant who discussed sexual health issues with patients, particularly the impact Parkinson's medication can have on sexuality and libido. She completed sexual health training at a later stage in her life, following a move into school health. Lucy has completed an undergraduate degree in Specialist Practitioner (School Nursing) and a Master's degree in Public Health and Health Promotion. She took up a role of cervical screening advisor, works in a termination of pregnancy (TOP) service in her local NHS Trust and undertakes a weekly youth clinic.

Jenny (Aged 46)

Jenny went into nursing following two weeks of voluntary work in an elderly care home with her friend, whilst in the Girl's Brigade. After leaving school, she went onto complete a Pre-Nursing course and gained five O' levels. She commenced SEN training at the age of eighteen and after qualifying took up work in theatre recovery for three years. Following her first child she returned to part-time working and then bank work in theatre to fit around her four children. She later took up a post in outpatients before moving into GUM and working as a Health Advisor. She completed sexual health training and in addition to her GUM role has worked for the national Chlamydia screening programme and works three hours per week in a local contraceptive clinic. Jenny did not convert to registered nurse status because the conversion course had ended and continues to work as a second level registered nurse in sexual health. She has completed the Specialist Community Public Health Nurse (Sexual Health Advising) qualification via portfolio assessment at a neighbouring university.

Matthew (Aged 44)

Matthew went into registered nurse training at the age of twenty four. Prior to this he had spent some time unemployed before embarking on a round the world trip which reached as far as a European city. He returned back to the South of the UK and spent time working in large supermarket chain before moving into work as a cashier clerk in a building society. A move back North saw him take up bar work and then employment with a Borough Council. Matthew took up some voluntary work in a hospital on a male medical ward in 1989 before training to become a registered nurse. Upon qualification, he took up a post in A and E nursing and then in a cardiac catheterization laboratory before leaving the profession to undertake a journalism course. He could not secure work on the kind of newspaper he wanted and returned to intensive care nursing. He later took up a post in a nurse- led walk in centre and then secured a post as Chlamydia Screening Nurse, which involved some work in GUM services and a male young offenders unit. Matthew was studying a 'top up degree' in Sexual Health Advising at a neighbouring university.

Janet (Aged 52)

Janet left school at the age of sixteen with two O' levels and her first job was as a general post office (GPO) telephonist before working in the travel industry. After getting married, she later took up employment as a doctor's receptionist in a general practice setting. She moved to take up an auxiliary post in a maternity unit and then completed an 'Access to Nursing' course at her local college before training to become a registered nurse at the age of forty three. Upon qualifying, she went to work in a hospice but only stayed around four months. Her sister-in-law (aged 52) had sadly died in the same hospice just two weeks before she took up her staff nurse post. Janet then moved into sexual health nursing and is now in the role of Junior Sister, working mainly in a GUM service.

3.2.9 The Interview Process, Schedule and Location

Six participants chose to be interviewed in their own home and four requested their interview to take place at the home university, in which I pre-booked a room to ensure privacy and free from interruption. Interviews commenced on November 19th 2010 and they were completed by February 18th 2011. My plan was to have all eleven interviews completed by March 2011 so that I could move forward on the data analysis stage and I managed to keep to schedule. The eleventh participant (male) had to cancel his interview due to his work commitments, and therefore I had to withdraw him from the study due to time constraints. At the end of the interviewing process, I had data from nine females and one male nurse.

The home interviewing process involved extensive travel across the North West region of the UK and I was fortunate in that the flexibility of my academic role allowed me to manage my diary and my interview schedule. As a lone researcher, it was imperative that I considered my personal safety and that no undue risk was taken in line with procedural guidance for lone working (University of Central Lancashire (UCLan) 2010). All interviews were completed during office hours and my contact details were left with academic colleagues and family regarding appointment times and the geographical areas I was visiting. Interviewing in the home provided a really informative experience for a number of reasons. As a practitioner, I was used to working in a city based sexual health service and visiting very remote areas of the country allowed for a

greater appreciation of the challenges practitioners face in delivering outreach sexual health services to meet client need. As I reflect later regarding my position in this research, I did feel that a different kind of story was being told when interviewing at home. Several of the participants made personal disclosures and these were all revealed during home interviews, I was a visitor and in a different position to interviewing in my own university.

3.2.10 Pilot Interview and the Use of Audio Recording

I undertook a pilot interview on university premises in September 2010 with an academic colleague (Dual Trained Sexual Health Practitioner) two months before the interview schedule commenced in November 2010. Bryman (2004) suggests that it is always desirable if possible to undertake a pilot interview to ensure that the research instrument as a whole can function well. This allowed me to practice using an audio recorder and to check out the flow and appropriateness of my interview schedule and to allow time for any amendments. Bell (2005) suggests the use of tape recording can be helpful in checking the wording, statements and quotations in terms of accuracy of a transcript. A recording allows the researcher to play it back and to listen to it several times over in order to identify emerging themes and categories. Effective communication skills are essential in the interview situation, in terms of developing a good rapport with the participant and by using an audio recorder I was able to maintain eye contact and to listen intently to what was being said. I could also follow up interesting points made, prompting and probing the participant where necessary. Recording and transcribing interviews can open up the data to public scrutiny by other researchers but it may also be useful in countering accusations that an analysis might have been influenced by the researcher's values or biases (Bryman, 2004).

As a novice researcher, undertaking the pilot interview was a crucial element of my learning experience. The interview lasted twenty minutes and I felt that my technique and questioning style was too fast. I recognised the need to slow down and to allow participants a greater response time. I also needed to adapt my questioning technique in terms of picking up on cues, language or phrases being used. Using an audio recorder for the first time was an experience in itself

as I was unsure if I had positioned it correctly on the table to pick up sound. Following advice with the University Technicians and my Director of Studies, I purchased my own equipment, a Sony Digital Recorder and I downloaded Sony Digital Voice Editor 3 to my personal computer so that I could practice at home. Initially, I found myself continually checking that the audio recording light was illuminated, as I did not want the added distraction of taking field notes. For interviewing in the university, I realised the importance of a pre-booking rooms. At the pilot stage, I did try to find a vacant room and displayed a sign on the door to avoid interruption but this did not work and there was one interruption by a colleague who was also looking for a free room, which ultimately did affect the flow and structure of the interview.

3.2.11 Interviews

The emphasis of using an in-depth interview is to allow participants to set the agenda and to listen to rather than suppress their story, which raises questions as to the actual length of the interview. Elliott (2005) suggests that around ninety minutes is the optimum time for a qualitative research interview and that if the quality of material is judged to need more than two hours, then the practical solution is to conduct a second interview. In Elliott's (2005) experience, interviews of one and half to two hours yielded transcripts of approximately twenty to thirty pages of text. I aimed therefore to allow a maximum of 1 to 1.5 hours per interview.

3.2.12 Narrative Interview

The narrative interview is the tool through which the researcher is able to gain access to the stories of those participating in the research. The narrative interview is restricted to a small number of questions from the researcher and centres on the flow of the story being told. Should the researcher interrupt on too many occasions then it is possible that the thread of the story could be lost. The stories then act as a filter and exclude what the participants do not know or choose to remember. The story is grounded on their own life experience and the 'truth' of that experience is enclosed in the stories that they tell. A narrative is considered to be the most productive when the interviewer suppresses their own desire to speak so that the participants are able to talk spontaneously

(Holloway and Freshwater, 2007). This type of interview is described by Kvale (1996) cited in (Holloway and Freshwater, 2007) as, “a journey in which the interviewer and the interview partners travel together and where the latter tells the researcher of their ‘lived world’ ” (p.76).

3.2.13 Themes and Questions for the Narrative Interviews

The following twelve questions (see Appendix Four) formulated the structure for each interview that took place with themes reflecting my literature review around; entry to the profession, image, identity, power and role change. Although I started off with these questions, I was flexible in my approach and followed through each conversation as it happened, picking up on issues raised. I tried not to contribute within the conversation and to discuss my own personal experience and journey as a nurse, which was at times difficult as I shared a history with the nurses and they were talking to someone who knew and understood what they were saying. Even though I didn’t speak about my own life as a nurse, I have to acknowledge that my use of body language and facial expression may have had an impact around the concept of ‘addressing’ and ‘answering.’ For example: smiling and nodding to the respondents could have given away my own position, as we explored key issues within the conversation. Addressing a different researcher with a non-nursing background may have elicited a more detailed response, with different data emerging, particularly as a researcher would not have understood the language and terminology used.

Each Interview Explored the Following Questions and Themes

1. Why did you decide to become a nurse and what attracted you to the profession?
2. What do you think the general public’s perception is of nurses in society?
3. What does being a ‘professional’ mean to you?
4. Tell me about your experience as a nurse and why you chose to work in sexual health?

5. As a sexual health nurse, tell me about your role and the work you do?
6. What skills do you think sexual health nurses need?
7. How might 'users' of sexual health services / other health care professionals and services view nurses?
8. In your experience what are the positive and negative aspects of your work?
9. What changes are taking place in sexual health and has your job changed in anyway?
10. Can you tell me about a recent event in practice that sums up change?
11. Do you feel more empowered or disempowered by change?
12. In your opinion how do you see the role of the sexual health nurse in the future?

3.2.14 Summary of Participants in the Sample

Table One (See p.85) provides a summary of the ten interviews that took place between November 2010 and February 2011. The participants were aged thirty eight to fifty two years of age and had a range of nursing qualifications and experience from nine to thirty six years. The age of the data set reflects changing times, roles and experience in the profession. Many of the older respondents trained in the old nurse education system and one respondent (Janet) was more newly qualified with nine years' experience from the commencement of her training. Therefore there will be old values and different figured worlds impacting on practice. As the researcher and fellow nurse, I was aged forty nine at the time of interviewing, with approximately thirty years' experience in the nursing and midwifery profession.

Table One provides an overview of the interview locations and audio recording time for each interview. The length of the interviews ranged from a total of thirty three minutes and fifty seconds (Ruth) to a maximum of one hour, twenty nine minutes and forty seconds (Matthew). There is no real explanation for the difference in the interview recording times, as all interviews used a narrative approach, which allowed for openness in terms of the stories they told. Three of the interviews lasted longer than an hour and the participants chose to talk at length around their experience and to share examples from practice.

All ten interviews were completed within the allocated time of 1 to 1.5 hours and the total data time equated to eight hours, forty seven minutes and forty four seconds.

Table One: Summary of the Ten Interviews

Interview Number and Date	Pseudonym	Age	Gender	Approximate Number of Years in Nursing	Location of Interview	Length of Recording
Interview 1 19/11/10	Carolyn	52	Female	34 years	Home	56 minutes
Interview 2 13/12/10	Sarah	38	Female	20 years	University	1 Hour 15:28
Interview 3 12/1/11	Amy	52	Female	36 years	University	37.05 minutes
Interview 4 18/1/11	Nicole	49	Female	29 years	University	36.52 minutes

Interview 5 21/1/11	Ruth	48	Female	31 years	Home	33.50 minutes
Interview 6 27/1/11	Rachel	45	Female	27 years	University	42.02 minutes
Interview 7 1/2/11	Lucy	51	Female	34 years	Home	1Hour 08:32
Interview 8 4/2/11	Jenny	46	Female	28 years	Home	41.05 minutes
Interview 9 7/2/11	Matthew	44	Male	20 years	Home	1 Hour 29:40
Interview 10 18/2/11	Janet	52	Female	9 years	Home	47:10 minutes Total 8Hours 47minutes and 44 seconds

3.2.15 Ethical Governance

The RCN (2011) Research Society have developed guidance for nurses involved in research, regardless of what form this takes or where the research takes place. When engaged in research involving human participants, nurses have a responsibility to ensure that the interests of the participants are protected. The same consideration applies to nursing students with research being undertaken by lecturers and there should be due consideration to possible power relationships and the risk of coercion. Students should be able to make an autonomous and informed decision regarding their participation and they should never be obliged to take part. The issue of power relationships in my position as a nurse tutor was an ethical concern and the strategy for overcoming this was discussed earlier in the section on the sampling and recruitment process. This could have reduced my sample significantly but in the end it involved minimal numbers. Participants also had the option to withdraw from the study at any time, even if an interview had already been recorded, they could request the removal of their data. There requires consideration of the

benefits of participating in research and I anticipate that my sample of nurses would be interested in new research that is applicable to their area of practice and role. Nine participants did indicate on their consent form, that they would like a summary of the research findings

The University Code of Conduct for Research (UCLan, 2008) requires staff to be aware of and agree to comply with its Code of Conduct of Research. The University is committed to conducting research in accordance with the seven principals of public life, identified by the Nolan Committee (Her Majesty's Government, 1995): selflessness, integrity, objectivity, accountability, openness, honesty and leadership. The four principles framework (Beauchamp and Childress, 2001) is widely considered as a standard theoretical framework from which to analyse ethical situations and is used widely within the nursing and medical profession. These guiding principles can be applied to research and I have used these as the ethical framework for my research:

- Respect for autonomy- respect for the decision- making capabilities of autonomous persons, enabling them to make reasoned informed choices.
- Beneficence – the principle of acting with the best interest of the other in mind.
- Non-maleficence - the principle that 'above all, do no harm'
- Justice- a concept that emphasis fairness and equality amongst individuals.

Diener and Crandall (1978) cited in Bryman (2004) suggest similar guiding principles of research: whether there is harm to participants, whether there is a lack of informed consent, whether there is an invasion of privacy and whether deception is involved. The use of narrative as a research model can give rise to ethical issues in relation to obtaining informed consent from people who are considered to be 'giving away' their data to the researcher and how the researcher then manages that data with respect. Narrative ethics are considered to be different from statistical ethics in that personal narratives are associated with the meaning that an individual attributes to their life experience and personal identity. Depending on the relationship with the researcher, the

use of narrative provides a personal approach in which it allows permission to 'talk' and the opportunity to disclose concerns they may have or memories they wish to re live. It is not only the interview process that may have an effect on the participant but the way in which their story is analysed and interpreted, which may be positive or negative and therefore needs to be done sensitively so as not to allow the narrative to become intrusive and damaging (Holloway and Freshwater, 2007).

My relationship to the participants and the ethics of responsibility of disclosure became apparent during my research journey. As a nurse, midwife, educationalist, mother and researcher I acknowledge that I have multiple identities which are central to my role in this research and in the interpretation of the data. I was in a privileged position of listening to personal stories and on many occasions I questioned my 'position' and the participant's relationship to me, as conflicting tensions of my identity became apparent. Several of the participants confided in me, particularly when interviewing in their home and they disclosed 'off the record' very personal information before and after the audio stopped recording. As Bryman (2004) notes interviewees sometimes 'open up' at the end of the interview just as the recording device is being switched off. This happened on a number of occasions and the personal disclosures were often unrelated to the study. The participants clearly felt comfortable in telling me very sensitive and emotive aspects about their personal lives in which I had no prior knowledge of and one participant described the experience to me as being 'cathartic.' The disclosure of information seemed to emerge naturally in general conversation and for some participants they may have offered to disclose key aspects of their lives in terms of their lived experience as a parent, carer and nurse.

Having taught and worked with some of these nurses, their stories were a complete surprise to me and at times put me 'out of my comfort zone' as I listened and we chatted about what they had said. My experience can be compared to Wiklund-Gustin (2010) who argues that the narrative interview may also become a caring situation in that participants become relieved in terms of sharing their experiences with the researcher and that a participant's self-disclosure will require the researcher to be mindful of creating unnecessary

distress throughout the interview process. Holloway and Freshwater (2007) argue that researchers participating in narrative research also engage their emotions and are not neutral or distant but empathetic and close to the narrators. This was certainly the case for me and I used my personal journal to reflect upon my feelings in these situations.

As a registered practitioner, I am duty bound by my Professional Code of Conduct (NMC, 2008) which states, “You must respect people’s right to confidentiality,” (p. 3) and therefore I would not wish to disclose this information in my research for fear of distress to any of the participants involved. What it did highlight is that rich data can be provided ‘off tape’ or ‘off the record’ which may be very important but disclosures require care and consideration as to how that information is used. In health care, the remit of confidentiality is not ‘absolute,’ and the nurse researcher must be mindful of potential disclosures which may highlight a participant is ‘at risk’. The NMC (2008) Code states that, “You must disclose information if you believe someone may be at risk of harm in line with the law of the country you are practising in” (p.3). This would involve the researcher informing the participant the reasons for disclosure and for them to seek further advice in terms of acting in the client’s best interests. In my experience the disclosures made were not of a professional nature but more related to family and life issues. None of the respondents were at ‘risk of harm,’ had this been the case then I would follow university and professional safe guarding procedures.

3.2.16 Ethical Approval

All documentation used in this research has been reviewed and approved by the ethics committee at both the home university, where the study is taking place and at the university where I am registered as a doctoral student. In 2010 I requested permission from my Head of School to undertake a research study in my own school and was granted permission to access data for the sole purpose of recruiting participants.

Home University

The first step of the research process was to acquire full ethical approval via my University Faculty of Health and Social Care Ethics Committee (FHEC) as the research was being undertaken within my own organisation. This is an essential requirement for the commencement of a research activity on humans or animals and which involves faculty staff or their students (UCLan, 2008). This was a fairly straight forward process and on March 3rd 2010, I submitted the required documentation and research proposal to the FHEC (see Appendix Five). A response was received on March 25th 2010, which outlined three conditions that required amendment before further consideration of the study. Two recommendations were given (see Appendix Six) and there was a preference that these would be addressed but I was informed that ethical approval would not be withheld, should I have decided not to address one or more of the recommendations.

Conditions

These included a minor amendment to the wording on the participant information sheet, consideration of over recruitment into the study and how such selection would take place. Participants needed to be informed that even if they agreed to participate, they may not necessarily be selected as it is a small scale study. Finally, I was required to clarify holding of the data. Following advice with FHEC and my Director of Studies, I was able to confirm that the data will be held for five years after analysis and stored in a locked cabinet on the main university site, within the Faculty Research Office.

Recommendations

I was asked to consider my offer of home interviews and that appropriate consideration should be given to 'lone worker' conditions to ensure that no undue risk was taken. My response was that I would put strategies in place to ensure my personal safety was in accordance with the university procedural guidance for lone working (UCLan, 2010).

An interesting recommendation suggested how I could strengthen the narratives. From a research point of view I was interested in the identities of

sexual health nurses and the FHEC recommended that I consider viewing their identity also from the perception of users of the service and more generally, society. It was felt that these too have their narratives to which the narratives of the sexual health nurses are linked. It was suggested that the study could be strengthened by recognition of these narratives, both of other individuals (users, other health workers) but also of societal 'meta-narratives' about sexual health and pregnancy. My response was to thank the FHEC for their comments but this was a small scale study and whilst it would have been useful to include a wider user perspective, I was unable to extend my data collection. I took on board the usefulness of the comments from the FHEC and decided to incorporate the perception of other voices within the design of the study. I subsequently revised the narrative themes and included two further questions (Question Two and Seven) (See Appendix Four) which focused upon the general public and service user perception of nurses in society, which relate to my literature review around the perceptions of nursing.

I provided a written response to the FHEC conditions and recommendations in the template provided, following further discussion with my Director of Studies. I sent the revised participant information sheet and supplementary documentation as requested (see Appendix Six) and I received FHEC final approval (See Appendix Seven) on May 12th 2010. A copy was forwarded immediately to my Student University to support the ethical approval process with that organisation.

Student University

Because I was registered as a doctoral student and undertaking Phase B, the thesis element of the programme, I required further ethical approval. This process was not so straight forward. I submitted documentation to the University Ethics Committee on March 3rd 2010 (see Appendix Eight) and there were concerns that I required NHS ethical approval, despite receiving a copy of the conditions and recommendations from the FHEC on March 25th 2010. My intentions I felt were clearly outlined in the research proposal, in that my aim

was to interview past students from my own university and a condition was that I would not approach any health care premises. I discussed their concerns further with the FHEC and I was again informed that NHS Ethics was not a requirement for this study. I still required further documentary evidence to gain ethical approval with my Student University and so I wrote to the National Research Ethics Service (NRES) on March 26th 2010 and sent a copy of my research proposal and supporting documentation. I received a formal written response on April 16th 2010 following consideration by the Chair (See Appendix Nine). It was confirmed that my project was not considered to be research according to the NRES and therefore did not require ethical review by an NHS Research Ethics Committee. A scanned copy of the letter was subsequently forwarded to my student university, which allowed for the ethical approval process to move forward quickly. On April 23rd 2010 my Research Degree Registration (RD1) was finally confirmed by the Faculty's Research Degree Subcommittee.

3.2.17 Confidentiality

Participants were informed that all information was strictly confidential and that any information leaving the university had names and addresses removed, which included the audio recording files sent to the transcribing service. Quotes from interview transcripts could be used in the final write up but there would not be any reference to their personal identity or organisation and this would remain anonymous. At the end of the study, I aim to disseminate the findings and publish in professional journals and participants were reassured that any quotes used from transcripts would remain anonymous with no reference to their personal identity in the study. As a registered nurse, I am bound by the NMC (2008) Professional Code which states that, "You must respect people's right to confidentiality," (p.3) and it was important that I upheld the participant's confidentiality at all times. Changing the participant's names and attempting to try to select suitable pseudonyms proved more challenging than I expected. I knew the participant's ages and I felt that I had to select an appropriate name that reflected their year of birth, as I was looking for some sense of accuracy. To support me on this, I accessed the Baby Centre and Baby Center websites to research the Top UK Baby Names (Baby Centre, 2011a) and 100 Most

Popular Baby Names of 1960 (Baby Center, 2011b) and 1970 (Baby Center, 2011c) and subsequently selected alternative names from these lists. To maintain the anonymity of all staff within the transcriptions, names were also changed and a pseudonym given. The name of locations, towns/ cities, universities/colleges and health care organisations were renamed, using for example: City X, City Y, Hospital X and Doctor X.

3.2.18 Consent

Informed consent is bound by ethical and legal frameworks and the belief that everyone should be treated with respect taking into account; ethnicity, gender, disability, religious beliefs, culture, language and a level of understanding (RCN, 2011). Because of my position as the only researcher in the study, the responsibility for gaining informed consent with the ten participants rested with me. The consent form (see Appendix Three) had been approved by both universities and it is important for potential participants when consenting to realise that there is an expectation that they will comply with the requirements of the research as detailed in the participant information sheet and consent form. If they don't then there could be implications for the quality of the research (RCN, 2011).

The consent process was completed by the researcher at the commencement of each interview and I went through the participant information sheet again to ensure clarity on the process that was to follow and to allow the opportunity for questions. Participants were informed that their participation was voluntary and that they were free to withdraw at any time without giving a reason. Whilst the signing of a form has become standard practice in confirming that a participant has freely given their informed consent to participate in the study and that a signed form provides good evidence that a discussion has taken place, it does not prove that consent is truly informed and therefore legally valid (RCN, 2011). All ten consent forms were signed and all participants agreed to their interview being recorded. None of the participants requested a copy of their interview recording to check for accuracy before the transcription process took place and nine participants requested a summary of the research findings. The consent

form was signed and dated by the researcher and participant and a copy was kept by both parties.

3.2.19 Storage of the Data

The University Code of Conduct for Research (UCLan, 2008) state that researchers are required to keep clear and accurate records of the procedures followed and the approval granted during the research process. All primary data should be securely stored for at least five years unless otherwise required by contractual terms or guidance of relevant professional bodies in paper and or electronic forms as appropriate, after completion of the research project. The appropriate storage of data was a condition within my ethical approval and I was required to confirm that all my data is held on the main site of the home university. I will comply and keep the data for five years after the analysis stage and it is stored in a locked cabinet in the main research office. In accordance with school guidelines, academic staff are issued with encrypted pen drives that are password protected and are used for the transferring of data. To further protect the security of my work, I have ensured that all electronic devices, for example my home and work computer, tablet and smart phone are all password protected.

3.2.20 Transcribing the Data

Upon completion of my interview schedule, I had a total of 8 hours, 47 minutes and 44 seconds between the ten participants. After the first two interviews were completed, I had a go at transcribing the interviews, verbatim and by hand, repeatedly listening to the recordings. Gerrish and Lacey (2006) suggest that this provides a useful opportunity to start the process of 'immersion' within the data. Although I was at an early stage of the transcription process, I was soon able to pick up on emerging themes and very soon came to realise how time consuming this process was going to be. In Elliott's (2005) experience, interviews of one and half to two hours yielded transcripts of approximately twenty to thirty pages of text (15,000 to 20,000 words). I decided at this point to contact a professional transcribing service, which had been recommended to me by a fellow researcher and I subsequently paid for the professional transcription of all ten interviews. All the audio files were copied to a Compact

Disc (CD) and with personal identification removed they were sent via recorded delivery to the transcribing service in May 2011. The transcriptions upon completion were returned to me in electronic format as a word document via my works e-mail address and the CD was then posted back for safe storage in a locked cabinet with all my other research documentation.

I cross checked all of the ten transcripts for accuracy by listening through the recordings again and adding in words that were not understood by the transcriber. Often the amendments related to medical terminology and these were soon corrected because of my medical knowledge. With Participant Two, the last line of the interview had some words missing from the transcript; for example, “no I’ve quite enjoyed it actually,” but missing “very cathartic,” which was an important reflection of the story telling process. It was also helpful for time on the recording to be indicated on the transcript, which made amendments easy to locate.

Whilst the transcripts highlighted any pauses that took place during the interviews, they did not indicate important aspects of language analysis, which I picked up on during the cross checking process. For example, the use of local accents, laughter, sarcasm, changes in voice tone and background interruptions such as a door bell, phone ringing, bread maker beeping and family member interruptions. Bryman (2004) argues that qualitative researchers are not just interested in what is said but the way a person may say it. Following the transcription process, I was then left with ten stories to analyse and interpret.

3.2.21 Trustworthiness and Authenticity in Narrative Research

Narrative researchers are concerned with the trustworthiness and authenticity of the accounts they present in terms of the reality of the participants. Freshwater and Holloway (2007) argue that there are two different levels in which to discuss validity in narrative inquiry, the original story of the participants as well as the representation of that story by the researcher - the account of the researcher is also a narration. As a researcher, I need to acknowledge that participants may have bad memories, are muddled or they may over-dramatize their story to create an effect. Narrators can make mistakes and occasionally they may tell deliberate lies. From a research perspective, as long as the participants identify

with the ideas they present, the researcher should be able to develop knowledge from the stories they bring. Whilst I am unable to verify the 'truth' of their story, I am interested in how the nurses describe their world and their reality as they view it from their perspective.

3.2.22 My Role in Narrative Inquiry and Reflections of a Novice Researcher

In reflecting upon the interview process, there were some lessons to be learnt. I started to use a personal reflective diary and this proved invaluable during the post interview stage as I often made notes whilst sat in my car or at home after visiting a participant. I was quite nervous at the start of the interview process and my confidence grew with more interviews that I completed. I remained anxious in using the audio recording equipment, as I was completely reliant on this for data collection. I wanted to create an informal setting so that I could listen and make eye contact without the use of field notes. All was going well until I completed interview four, on playing the recording back, panic set in as I thought I had lost crucial data and I had wasted my participant's time. On searching the equipment further, I found that I had saved the interview in another folder and with hindsight I should have taken brief field notes as a back-up strategy in the event of any equipment failure.

During the interviews that took place in participants' homes, I was confronted with a range of interruptions and background noises that became more evident on playing the recordings back. For example: the noise of washing machines, radios, bread makers, telephones and interruptions from family members, pets and even a window cleaner on one occasion. These interruptions did affect the flow of the interview in that I had to pause the recording and then pick up where we left off. This meant that the participant and I were momentarily distracted and this may have affected the quality of data provided at that moment in time. Whilst I was fortunate in the fact that I could hear the recordings clear enough for transcription, researchers need to be mindful of situations that could potentially affect the quality of the data should these situations occur.

3.2.23 My Position

The participants knew my personal history because of my role in both academia and clinical practice. We both shared knowledge and a stand point, they were telling their story to me as a researcher but also as someone whom they viewed as part of their community. Their accounts inspired me as they often talked about achievements in their nursing career. At times it was really difficult not to engage in the conversation and to share stories together of our nursing experience. I tried hard to ensure that I was not leading in the questions that I asked and that my interviewing style was consistent across my sample. This was difficult as I frequently felt that I could place myself in their stories due to our similar experiences and feelings about the profession. As a practitioner researcher, I acknowledge that I am involved with the data as I am deeply part of the nursing community in respect of its culture and history. The researcher has to uncover their pre-suppositions and experiences in the area of the proposed study and hold them at bay so as not to prejudice the study but realistically it was impossible not to bring in my own feelings or any element of bias into the research. In an attempt to keep a foot outside of the interview and to ensure an element of rigour and transparency, I tried hard to ensure that I did not share my own experience of being a nurse so that I could observe myself and the participant (and the dialogic process) from a reflexive standpoint. As part of the analysis, I needed to identify my own contexts so that I can understand how my own views and beliefs may influence the interactions that I have with the participants and how I situate myself within the study.

3.3 Section Three: Tools of Inquiry As An Analytical Framework

Returning to the theoretical framework that I outlined earlier, this section discusses my process for analysing the data from the ten interviews using a system that was consistent across the whole data set (Mason, 2002). Although my research involved only a small sample, this is not a significant issue in DA since important patterns can emerge even within small samples. Indeed using a large sample can create an unmanageable amount of data without adding to the analytical outcome (McCloskey, 2008). The initial first sweep through the data was very practical and non-theoretical. I did not use a computerised system, instead I read and re-read the transcripts looking for emerging themes and stories and taking what was said at face value. I compared the series of

narratives, checking the main features and identifying common elements so as to develop a collective story of 'being a nurse.' For example, I noticed that a number of interviewees talked about 'always wanting to be a nurse.' For the second stage of my data analysis, I used a more interpretive and theoretical approach using insights from the work of Holland et al. (1998), Bakhtin (1981, 1986) and some of Gee's (2011) tools of DA.

Taking an interpretive reading of the data involves constructing or documenting a version of what one thinks the data may mean or represent or what one can infer from it. From my own research perspective this involved reading through the narrative interviews, identifying the norms or rules within which the interviewee is operating or discourses which they draw upon to explain or account for their experiences, beliefs and desires to become a nurse. I was mostly concerned with what I saw as the interviewees' understandings or their versions and accounts of how they positioned themselves within the figured world of nursing. Reflecting on my own position as researcher and nurse, I located myself as part of the data as I sought to explore my own role and perspective in the generation and interpretation of their stories. My analysis also seeks a reading of the data which captures or expresses my relationship with the interviewees' (Mason, 2002). By arguing 'reflexively and multi-vocally' it is possible to become aware of a meaningful range of perspectives, experiences and standpoints, including my own and to show sensitivity to a range of interpretations and voices in my data (Mason, 2002).

The basis of my thesis is on identity and I therefore chose to use figured worlds as a major lens on my data, using various tools from Gee (2011) to explore the figured worlds of my participants. In particular I am looking for reoccurring themes around position and designated identities. I am interested in how the stories are populated through the use of language and key discourses that emerge within Big 'C' Conversations, Big 'D' discourse and intertextual reference. Bakhtin's (1981) concept of 'answering and addressing' (Irvine, undated) will be explored to analyse my own positional identity. The utterance as both an author (respondents) and addressee (me as researcher and nurse). The addressee can be an immediate participant – interlocutor (someone who takes part in a conversation either formally or informally) in an everyday

dialogue, a differentiated specialist, opponent, enemy, subordinate, superior and so forth. The composition and in particular the style of the utterance depends upon to whom the utterance is addressed, how the speaker (or writer) senses and imagines his addresses and the force of their effect on the utterance (Bakhtin, 1986, p.5). Therefore the feature of utterance means that we never purely own the words we speak, it is recycled. The 'word in language' is half someone else's, it exists in other people's mouths, in other people's concrete contexts, serving other people's intentions; it is from there that one must take the word to make it one's own (Bakhtin, 1981, p.223-294).

In my analysis, I anticipated that each nurse would have their own unique story to tell but that they would also have a shared story in respect of their professional identity and as a member of the nursing community. Within the figured world of nursing, the profession has been historically viewed as subordinate to the male dominated world of medicine and I aimed to explore gender and power issues in far greater depth. I anticipated that a number of cultural models would emerge and I noticed that many stories referred to a long-held childhood desire to become a nurse. Other factors such as: gender, roles, class and culture, image and uniform would be combined within a Big 'D' discourse. I also noticed how the nurses told stories about how they 'did' nursing, how they talked about themselves and in particular the changing role of nurses. Overall, I was interested in how they positioned and reposition themselves in their 'storying.' I also noticed micro-level use patterns, for example the reoccurring use of phrases such as: 'we,' 'you know what I mean' and 'us' by the respondents. Their positioning of me as a 'nurse', who shared their history and journey in the profession was also important in my analysis.

3.3.1 An Example of Deconstructing a Story – 'Hairdressing'

As an example of my analysis process, I end this section with an overview of an emerging theme which took on considerable significance in the overall analysis and provides an example of how I deconstructed participant's stories to arrive at a more interpretative analysis. This analysis built on the work of Sfard and Prusak's (2005) concept of 'circulating stories' that exist in families and the

meaning of designated identities as not a “matter of deliberate rational choice” (p.18).

Early on in the analysis process, I was looking at relationships and groupings and noticed that what some of the nurses said, contradicted other parts of their stories. Several of my respondents had told me at the beginning of their account how they had ‘always wanted to be a nurse’ drawing on the cultural model of nursing and a vocation that drove their choice of occupation many years later. Upon further inspection of the data, it frequently emerged that there was a contradictory element of the story, nursing was not necessarily their job of choice. In two cases hairdressing was indirectly and passingly mentioned as a contrasting job option. I saw these elements of their stories, indicative of ‘actual’ and ‘designated identities’ and the ultimate ‘choice’ as illustrating multiple influences:- the power and influence of their parents as originators of an ‘authoritative’ discourse (Bakhtin, 1981) and of social class and gender in terms of what is considered a suitable and ‘proper’ job for a working class girl. Jenny’s story illustrates this complexity:

I wanted to be a nurse actually from about fourteen. And I was in the Girl’s Brigade and me and my friend, it was Easter holidays, and we decided to do some voluntary work in an old folk’s home for two weeks and I absolutely loved it, really loved it. And I thought no I want to be a nurse. Prior to that it was a hairdresser and my dad said, “You’re not being a hairdresser.” So in them days you did what your dad did. He just saw it as a dead end job and he said, “You’re not standing over a sink washing somebody’s greasy hair all day and that was that.”

I asked Jenny what her father thought about nursing as a career choice:

Oh I think he was chuffed, yes. I think he’s quite proud of the fact that, because my sister’s a nurse as well.

So Jenny had wanted to be a hairdresser (actual identity) but the influence of her father and his implicit view of hairdressing as a dead end job is clear. Of course, nursing can also involve ‘washing greasy hair’ as it is part of the caring role but this her, ‘designated identity,’ is based on a cultural model of nursing, which sets it apart from hairdressing, as a suitable, more respectable job for a working class girl of which her father can be proud.

Amy also talks about how her friends (Significant others) in her figured world, influenced her to become a Cadet Nurse at the age of fifteen, despite a lack of desire on her part to become a nurse:

Well it is something I never wanted to be. It wasn't a vocation; I applied to be a Cadet Nurse because my friend did when I was 15. I didn't even know what one was and that was way back in 1974. I got on she didn't but it must have held some interest for me because I'm still here after thirty odd years.

I asked Amy what job she would have wanted to do and like Jenny she told me about parental pressure from her mother this time but a very similar contrast with hairdressing:

I always wanted to be a hairdresser and then when I was 15 my mum said I wasn't doing that. She said, "You're on your feet all day, its poor money and you work late Christmas Eve," so when I said I was going to be a nurse, she never said a word.

Pride in a respectable profession is also evident here, despite the fact that it too involves being on one's feet and working late on Christmas Eve.

Amy went onto say:

My Aunty once said my Granddad would have been proud of me doing that because he always wanted my Aunty to be a nurse.

Comparison of these small pieces of data from Jenny and Amy's narratives indicated that there were similarities and reoccurring themes in their stories, which could be interpreted in terms of Big 'D' discourses (Gee, 2011). The emphasis on nursing as a suitable job for a working class girl and one that the family would be proud of, resonated also with my personal journey as a nurse. Indeed 'hairdressing' has now come to acquire 'significance' and 'meaning' as an internal conversation between myself and my Director of Studies. When we say the word 'hairdressing' we both have an understanding of what the story holds and means for us, which we could construct and reconstruct around what has been already told.

3.4 Summary

This chapter focused on setting out the theoretical and methodological framework for my research, explaining my use of DA and narrative and how it fits within the context of a socio-cultural framework. I use the tools of figured worlds and have explored the ideas of several theorists, including Holland et al. (1989), Sfard and Prusak's (2005), Bakhtin (1981, 1986) and Gee (2011) which I draw upon during the data analysis process.

I have divided the interpretation of my data into two chapters (Four and Five) to structure the emerging themes from entry to the profession to the experience of changing roles. Chapter Four: 'I always wanted to be a nurse,' draws upon the cultural model of nursing, as my data analysis explores themes of: early childhood experience, academia, what is considered a suitable job for a girl, television role models, images of nursing and caring. Chapter Five: 'As a Band 6 its one step too far,' moves into the area of sexual health nursing and continues the emergent theme of caring, which refers back to the iconic nurse that many of my interviewees said they wanted to be. I explore the discourse of change, institutional identity, power and positionality and I focus on working relationships, shifting professional boundaries and the tensions and conflicts of role change.

Chapter Four

'I Always Wanted To Be a Nurse'

4.0 Introduction

In this first analysis chapter I analyse the ten narratives of 'being a nurse' in terms of my informants accounts of their career choice and the role of nursing in their lives, which links to theories and stories of what is normal. At the outset of this study, the framing of the research question was to analyse how sexual health nurses' describe their on-going clinical practice and to evaluate the complexity of how they construct their professional identity and role change within the context of strategic and organisational change. Whilst I was originally interested in the role, it became apparent that each of the nurses had a strong emotional investment in their past which took me somewhat by surprise. All the narratives were historical in nature and whilst not all the respondents said that they had an initial desire to enter nursing as a school leaver, there were reoccurring themes around status, position and a discourse of caring.

Looking through the lens of the figured world of nursing, the main focus of this chapter relates very much to 'choice' and 'positional identity.' So what follows in my analysis, moves from their assertions or desire to become a nurse and the lack of choice demonstrated. Several informants made their choice to become a nurse as a little girl, which suggests a pure desire to be one but others in fact gave far more complex reasons, which share certain characteristics of 'positional identity.' They tell their story as a lack of choice, a practical job, missed parental opportunity and not doing very well at school. So it is not just that they 'always wanted to be a nurse,' any more than other little girls did but it was because of the limited options open to them and the most respectable job they could do.

Several of the nurses, tell of initially wanting to become hairdressers (actual identity) but parental influence and perception, viewed nursing as an occupation with higher professional status for a working class girl (designated identity) which represents a set of values that recur in their stories and which is linked to the symbolism of image and uniform. Matthew was the only male nurse in the study and he gives a slightly different story. This made me notice things about the female respondents as he appears to have a strong sense and active

choice to become a nurse, which draws upon his particular cultural model. There is evidence of intertextual reference within his story, possibly because he is male, as he justifies his choice to become a nurse, more than the female respondents. Within my analysis there was evidence of Big 'C' conversations and the discourse of caring by the majority of the respondents. Caring as a motif is interesting because the nurses talk about recent events in their lives and the loss of caring in nursing, as a result of a greater emphasis on academia and the tensions this brings. Several of my respondents also gave some very emotional and sensitive accounts of being a 'carer' and the impact on their family and 'lived world' as a nurse. Money was also an emerging theme within the data, which in fact they all need but it is not the 'done thing' to talk about in respect of becoming a nurse. It was more important to put forward their identity as a 'carer' and nursing as a vocation, which is gendered within their stories. Matthew also talks about women as natural carers and he in fact makes it very clear that he isn't one and nurses in a very different way.

Analysis in this chapter will focus upon the following emerging themes: early childhood experiences, experience of academia, nurse entry, the image of nursing, male role models, caring in nursing and finally a suitable job for a mother. Both analysis chapters will be similarly structured, building on two levels of analysis. Beginning with the emerging key themes to evidence, I applied Gee's (2011) tools of inquiry around figured worlds and cultural models, situated meanings, Big 'D' discourses, Capital 'C' conversations and intertextuality to arrive at an overall picture of nursing identity as a forerunner for accounts of change.

4.1 'I Always Wanted To Be a Nurse'

All the respondents located their personal stories in time, with Sarah, Janet and Ruth providing an interesting and unexpected account of their early childhood experience and their desire to become a nurse from a very young age.

Sarah and Janet tell of 'dressing up' as a little girl and getting their first nurse's kit:

I suppose it had always been something, as a little girl, I had my nursing kit and my little uniform (Sarah).

Well it stems back from being five years old and getting my first nurses' bag and outfit for Christmas, so from being five I wanted to be a nurse (Janet).

Ruth also recalls her early childhood memory;

Well I always wanted to be a nurse from when I was very, very young, that was the only thing and I don't know what it was or why. But from very young I remember at primary school having to think what I was going to do when I grew up, that's what I was going to do and throughout I never wavered, that was my goal.

There was a recurring use of the word 'always' within the data, however the respondents often told a slightly different and contradictory story about why they became a nurse, as they continue to relate the details of their family backgrounds and educational careers. It appears in fact, that nursing was for many the only option if they wanted to gain a high status job. This was particularly related to the available jobs for women and as we shall see, for girls from working class backgrounds, who were not seen as academic. Many of the respondents make reference to their family and they presented this as a casual influence on their career choice. Recurring themes emerged around the desire to please their family and in making up for missed parental career opportunities and how their parents wanted them to have a greater opportunity in life.

Carolyn tells of how her mother 'always wanted to be a nurse'

I think my mum maybe prompted me to say, she'd always wanted to be a nurse, had I thought about nursing? So I went for, it was an interview in those days and a test, that was how you got in.

I asked Carolyn if her mother was a nurse:

No my mum wasn't a nurse but it was just the fact that she's always wanted to be one that maybe she encouraged. Well I suppose she was in the Army to start with, you know, they were at the end of the war, she had me when she was 19, so I guess her chances, and then my brother at 20, you know, and that was it, she was married at 19. I suppose her career was limited for her at that time, so I suppose she was quite happy for me to think about maybe something that she'd wanted to do, so it was quite good prompting.

Jenny and Amy discussed the importance of getting a 'proper job' in comparison to other career choices such as 'hairdressing,' which was indicative of their 'positional identity' with regards to social class, women's status in society, getting a stable job and earning a decent wage. This data was used earlier in Chapter Three (3.3.1) as an example of deconstructing a story and

gives an example of a contradictory element of their story. Nursing was not necessarily their job of choice and in both cases hairdressing (actual identity) was indirectly and passingly mentioned as a contrasting job option. This was indicative of 'actual' and 'designated identities' and the ultimate 'choice' which illustrates multiple influences:- the power and influence of their parents as originators of an 'authoritative' discourse (Bakhtin, 1981) and of social class and gender in terms of what is considered a suitable and 'proper' job for a working class girl.

Jenny describes her experience:

I wanted to be a nurse actually from about fourteen. And I was in the Girl's Brigade and me and my friend, it was Easter holidays, and we decided to do some voluntary work in an old folk's home for two weeks, and I absolutely loved it, really loved it. And I thought, no I want to be a nurse. Prior to that it was a hairdresser and my dad said, "You're not being a hairdresser," so in them days you did what your dad said. He just saw it as a dead end job. And he said, "You're not standing over a sink washing somebody's greasy hair all day" and that was that.

I asked Jenny, what her father thought about nursing as a career choice:

Oh I think he was chuffed, yes. I think he's quite proud of the fact that, because my sister's a nurse as well

In contrast Amy describes how she did not want to become a nurse but was influenced by her friends rather than her parents to become a cadet nurse at the age of fifteen:

Well it is something I never wanted to be. It wasn't a vocation; I applied to be a Cadet Nurse because my friend did when I was 15. I didn't even know what one was and that was way back in 1974. I got on she didn't but it must have held some interest for me because I'm still here after thirty odd years.

I asked Amy what job she would have wanted to do and a similar story of parental pressure and authoritative discourse emerged:

I always wanted to be a hairdresser and then when I was 15 my mum said I wasn't doing that. She said "You're on your feet all day, its poor money and you work late Christmas Eve." So when I said I was going to be a nurse, she never said a word.

Again, lost opportunities in the past emerged as Amy went onto say:

My Aunty once said my Granddad would have been proud of me doing that because he always wanted my Aunty to be a nurse.

Nursing as a career choice appears to be held in higher esteem than other jobs and it is particularly contrasted to hairdressing in these accounts. This is particularly true when we consider that nursing is also a job where you are on your feet all day, it is not particularly high paid and includes working shifts and at times 'working late on Christmas Eve.' Thus we can perhaps interpret the narrative 'motif' of 'always wanting to be a nurse' since being a little girl as a device which covers for other motives. Class, gender and academic success are all in the background, influencing the range of positional identities for these women.

Sarah and Lucy both had family members in the nursing profession, indicating once again the nature of positional identities in their cultural context and circulating stories of the profession (Sfard and Prusak, 2005). Sarah talks about her family's knowledge of the 'industry' as both her parents were nurses and pressurised her to get a 'proper job':

The honest reason I became a nurse is my mum told me, I wasn't going to mess about and not get a proper job, I was going to do my nurse training. So I got kicked into it by my mother with the thing, that if I didn't like it I could leave at any time, as long as I found something else to do before I left. So I think it was the case of that was the industry everybody at home knew, so that was a good one to send me in to.

It appears that Sarah did not have a particular desire to go into the nursing either and also had limited options on leaving school:

I wasn't pressurised into it but it was a case of, well there's your options, it's either work hard and get yourself in Uni, do your nurse training or come up with something else you're going to do. And I didn't work very hard with my A' Levels and I didn't come up with anything else, so I became a nurse.

Lucy however holds onto her story of an early childhood desire to become a nurse but links this to the fact that her mother was a nurse:

My mum was a nurse and I think it must be genetic. I always, from the age of 10 and below wanted to do something medical. I first wanted to be a psychiatrist but then decided it might send me round the bend and went back to nursing and stuck with it.

By contrast Nicole also had no real desire to become a nurse, even though her mother was in the profession and again, nursing appears to be a 'default' option – an available positional identity for one in her situation:

I think I became a nurse by default really because I was at college doing A' Levels. I didn't really like that, so my mum said I couldn't leave until I got a job. So I went out and got a job but that was in a bank, I think I was just coming up 20. So I did a couple of years in the bank, I hated every minute of it, worst bank clerk in history.

So I thought, I'm going to have to get out of here and my mum's a nurse. So although I'd never had any massive incline to be a nurse, I did it on a whim really. I just thought, I've got to get out of the bank, so I'll go and be a nurse.

I just didn't think it was me, I don't actually know, it just never appealed to me. I've stayed 29 years and actually, I can't honestly say I enjoyed the training. The only reason I stayed was because everybody said I'd never make a nurse. But I mean obviously once I qualified I did enjoy it.

Rachel's story suggests that positional identity of being a nurse needs to be based on particular values. She started her early career as a dental nurse from the age of sixteen and provided an interesting narrative about her desire to become a 'real nurse':

I left school and I went to do my dental nurse training at 16, because I wanted to leave at 16 and that was the only job. So I did my dental nurse training, the DSA it was in those days, and finished when I was 18, but it was rubbish pay, so I thought I'd be a real nurse.

I asked her what she meant by being a 'real nurse':

I mean when you're young, I was mercenary, it was the money, literally that was all it was because I liked being a dental nurse.

Her choice of the word 'mercenary' suggests a distaste for going into nursing just for the money and that there has to be other values, which becomes evident later in my analysis, when a discourse of caring emerges.

Apart from the pay, I wanted to know if anything else had attracted Rachel to nursing:

No, it just seemed an advancement of my career at the time.

Her response suggests that she now has different values and is distancing herself from those former values.

4.2 'I've Done Quite Well for Myself'

Many of the respondents tell of their schooling days and consider themselves not to be academic. They tell stories of alternative employment and their academic success or failure in terms of achieving the qualifications required for

nurse entry. Lucy, Amy and Jenny all undertook Cadet Nursing or Pre-Nursing courses at the age of sixteen to gain the qualifications required for nurse entry, whilst the other respondents were more academic and studied for 'A' levels or took up different employment upon leaving school. Eight of the respondents had commenced nurse training by the age of twenty, Matthew started at the age of twenty four and Janet at the age of forty three. Their stories link to positioning and circulating stories (Sfard and Prusak, 2005) and are another feature of self-positioning and designated identity as not being academically strong. It was not the 'done thing' for a working class girl to go onto to university which links to the discourse of power, privilege and status in society. Nursing therefore emerged as a good option, given their school experience and or academic qualifications. Interestingly though, once the nurses had qualified, they were propelled into academia as they developed their clinical skills and knowledge, which impacted upon their professional identity. Several nurses went onto complete undergraduate and Master's degrees and yet still did not consider themselves academic, suggesting a tension between the figured world of traditional nursing and its move into higher education.

Carolyn spoke about her early experience on leaving school and not having a 'thirst for knowledge' as undertook a variety of jobs:

Well I'm going back now 40 years or more and I'd left school at 15 because we'd moved from City X to City Y so it was sort of in the middle of the time when people were doing the equivalent of GCSE's and what have you. So it was a matter of maybe going to school just for a few months and then leaving school and finding a job. So I tried various things for about four or five years, from working on a farm, in a shop, in a factory, pet shop, making chocolates, you name it I did it and I didn't know what I wanted to do. I didn't have a thirst for knowledge at that time, I was more trying to find my way as a teenager, making new friends and in a new town etc.

Amy expressed how proud she felt to be a nurse and described a school reunion she attended some years ago, which is suggestive of nursing as a compensation for not doing academically well at school:

I once went to a school reunion, it was just as I was about to start the conversion course and I saw one of the teachers. And I'd seen him years ago, he came visiting, I don't know if it was a relative or somebody he knew that was on my ward. So he knew I was nursing and he was asking me if I was still nursing and he just said I'd done quite well for myself. So I'm quite proud of what I've achieved.

In describing her schooling experience and the school's expectations of her, she tells of her struggle with mathematics, identifying herself as academically weak:

That I wouldn't amount to much, I was only mediocre if that, I was next to the bottom form all the way through. I'm the first to admit that my maths are shocking, the only thing that I tend to get right is my drug doses, I'm alright with my decimal points, anything else I'm useless. I don't know whether I should say this on tape, but as for working out your drip rates, with the experience I just look and I know whether it's going too fast or not enough, I struggle with the actual calculating of it, I never get that in my head. It used to be a struggle when I was trying to explain it to students, I'd get somebody else to do that for me because I didn't want to get it wrong or come across as being thick.

Jenny describes a similar experience of school:

I didn't actually do very well at school because I didn't study hard enough. So I went on, they did the Pre-Nursing course then, which really was just re-sitting your O' Levels, but you went to, you had some experience in hospitals and nursing homes and things like that.

Lucy despite completing an undergraduate and postgraduate degree still considered herself not to be academic, which is an important indicator of the relationship between nursing and academic achievement:

I'm not, I'm more practical, I think I've learnt to be, is more the thing. I find it difficult putting pen to paper, I find it difficult writing things down. I'm more of a thinker.

I think I'd learnt some of the skills probably and I vowed after my degree I'd never go there again. I said, I'm not signing up for the Master's; I'd go probably to, not certificate but diploma level. So I did so many modules and they were doing dissertation workshops, so I went to the dissertation workshop and the tutor looked at me and he laughed. And I said, look I'm sat here but I'm still not saying I'm doing my dissertation but I thought, well I've come this far.

I asked Lucy if she had any thoughts on studying further for a PhD, her response being:

No, absolutely not. I've done my bit.

Which suggests Lucy did not enjoy academia despite her success and achievement.

Janet was the most recently qualified nurse in the study, entering nursing at the age of forty three as a mature student and had been qualified for six years. She tells of her 'envy' of seeing nurses in their uniform and her constant desire to

become a nurse, which she regarded as being out of her sights and part of her academic positioning:

I left school with two O' Levels; I never thought it was within my sights really to be able to be a nurse. So I always used to be green with envy when I saw people in their uniform, you know, I always wanted to do it.

Janet went onto her experience as a school leaver and makes further reference to her figured world and the positions within it:

There was those that were going to Uni and there was only probably two that I knew of, nobody from my school went on to University. So you left with what you had and you got what you could in a job. I went to be a telephonist, a GPO telephonist that was my first ever job.

Janet later moved into the travel industry and at the age eighteen relocated to get married. But her desire to become a nurse was re-captured later in her life:

A friend of mine worked as a Practice Manager in a doctor's surgery and she said that they had a receptionist post coming up and I should apply. So I thought, its one step nearer to medicine type thing. I loved that but I always wanted to be the Practice Nurse and not the receptionist. So I used to help the doctor when he did minor ops and stuff like that, I always volunteered to do all that kind of stuff. I would chaperone the doctors as the receptionist but still, I did anything that I could do that involved working in that side. And then after a few years a post came up in maternity for an auxiliary. And I thought, right well I'm going to take it one step further and see how I go.

She goes into explain how she was further influenced to enter nursing, by a student nurse on her ward who was forty two and told her about doing an Access Course. Significantly she still did not believe that she was capable of succeeding on the course;

So I looked into the access course, got accepted on the access course, didn't need the qualifications then, I had to just work towards this. I didn't think for a minute I would be able to do it.

I asked her to tell me how this course had prepared her for nurse entry:

Well they said it was sort of like the first year really, I had to do assignments and you had to do presentations and all sorts of, maths, loads of different things. I loved it, I absolutely loved it. Actually, doing the college course was the best thing really because it sort of made me realise that, you know what, you really could do this. And I so enjoyed doing it because I'd never studied before and at school I got those two O' Levels by pure fluke really.

Janet went onto to commence her general nurse training in 2002 and told me that she was not the oldest student in her cohort as there was another student in her fifties.

4.3 'A Nurse on the Ward Or Nurse In The Office'

Several of the respondents spoke about the selection process for nurse training and tell of how they just 'wanted to be a nurse.' They demonstrate a lack of cultural capital to actually find out about the different types of nurse training, unless someone told them and they told stories of how they did not understand or negotiate their way into SRN training and instead they entered the profession at SEN level. Historically, SEN training was a shorter two year course with a lower academic entrance, which had a more practical focus as the 'bedside nurse.' SRN training was a three year course and focused more on patient and ward management, viewed by some of the respondents as a 'nurse in the office':

Jenny's describes her experience of entry to the profession:

I applied to do my nursing, things didn't work out quite as I'd planned then because I had a friend whose mum was an enrolled nurse. And my friend said to me, she said, my mum said "If you put on it, enrolled nurse/SRN, which it was then, you'll definitely get in for either." And I was just desperate to get in because in them days there was a waiting list, you could be waiting quite a while. So I put both but by the time I'd actually finished my pre-nursing course, I had got my five O' Levels then. And I went for the interview and when you're young you don't question things do you? And she just said "Oh so you've applied for enrolled training then haven't you?" And I just said "Yes." And I should have said I would have liked to do the SRN if I could and I think they just wanted to fill the courses. So that's how I ended up doing my enrolled nurse training.

Rachel gives a similar account and tells of how she first trained as an SEN:

Well I did my shortened training straight afterwards because I didn't realise at the time, when I went to my interview and they said "Do you want to be a nurse on the ward or a nurse in the office?" And I said "A nurse on the ward" not realising the difference, so I went and did it straight afterwards.

I asked following her registered general nurse training, if she felt that she was a 'nurse in the office,' her response was:

No, not at all.

Amy commenced her SEN training in 1983 and also recognised the SEN course to have a greater practical focus than the SRN training:

It was more practical. We did all the same, what do you call it, the practical side, the exams, I can't remember what they were called now, except the ward management- we did all the other ones.

After sixteen years as an SEN, she went onto complete the enrolled nurse conversion course when nurse education became a single level of registration. I was interested to know if she felt that nursing had changed with regards to the academic entry criteria and her comments are reflective of self-positioning:

Definitely, a change in society, everything changes and I think there seems to be more academic things. I think if I was to try and get on in nursing now, with the qualification I had when I started, I wouldn't have a cat in hell's chance because I never considered myself to be quite bright.

A recurring theme and tensions of the change in nurse education became evident with a move into university and away from the traditional hospital based Schools of Nursing. Rachel considers the nurse entry process to be less select and with a greater number of mature students entering the profession due to a change in career and possibly reflective of the current socio-economic climate, there is perhaps less of a sense of vocation as a chosen career:

Probably not the same when I did my training, so it was seen as quite select. I think a lot more people do it now don't they? And the selection process doesn't seem as robust as it did, that's probably somebody looking back. There wasn't many mature students then, you know, there was hardly any, whereas there is a lot more mature students now, people going into it as a second career, things like that.

Jenny felt that nurse education had now become too academic:

I think a lot of it is the way they're trained now, it's very much academic and maybe they don't see it as important, you know, spending that special attention to the basic needs, that process has to be taken over by somebody maybe who isn't as qualified. But it's almost like, maybe sometimes they don't see it as their important role or their important thing, that that's part of being a nurse you should be doing.

Janet had the most recent experience of the nurse education system, entering the profession as a mature student at the age of forty three and had been qualified for six years. She also felt that the training had too much focus upon academia:

Well I'm just not sure about the training I just think sometimes that it's not done the right way. Sometimes I think it's the people who take them on as students. Yes, they're sort of looking more to the academic side of things, as opposed to whether or not they can actually care for people because I think that's, in my view, that should be the leading aspect. I know the academic side is important but I think that it's too heavily weighed on the opposite side.

She tells of her continual desire to be the 'bedside nurse' that links to the discourse of caring:

I did, well the obvious bed changing and all that sort of thing, but it was, all the way through I didn't want to be a staff nurse because you remember there used to be staff nursing enrolled and I wanted to be, what they called, the bedside nurse. So being an auxiliary was very like that and I loved it but I wanted to know why and wherefore and what you're doing that for and can I watch you do this. So one day the Sister took me into the office and she said "Janet, you're wasted, you're wasted, go on and do something else." And I said "No it's too late for me now, I'm too old I can't do it."

4.4 'I Think We Should All Have Hats and American Tan Tights'

Nursing image and the importance of uniform was a key theme that emerged within the data and was highly symbolic of who the nurses are. Status matters for everyone, especially a working class girl and the uniform appears to be symbolic of a kind and respectable nurse, which identifies 'proper' nursing and may well be compensation for not doing well at school. Their uniform has impacted upon their professional image and identity as a nurse, particularly so in changing times, with a move away from the traditional uniform to one of wearing hospital 'scrubs.' Sarah locates her feelings in the past and provides a classic picture of the traditional uniform as a symbol and indicator of professionalism:

I'm very sort of traditional, I think we should all still have hats and American nylon tights on but I think it's about image, the way you present yourself. Oh I'd have my cloak back tomorrow because that's why I wanted to be a nurse, to have the hat and cloak.

To me it's professionalism because if somebody's in a uniform and they're all neat and tidy, we had a nurse tutor that used to come along and say, hair's too long, hair net, that buns not tight enough, hair net, you're coloured tights aren't right, get them changed for tomorrow. And I think that instilled in me, I would never have had anything other than black hush puppy shoes to wear to work on the ward and my American tan tights and my uniform at a certain length.

For Sarah, uniform has a double meaning, it shows a strong symbol of identity, but she also says:

The honest reason I became a nurse is my mum told me, I wasn't going to mess about and not get a proper job.

Following her recent experience as a relative visiting her husband in hospital, she describes how she felt at seeing the uniform:

....and I was like that, oh no they've got trainers on.

Sarah works as a sexual health nurse within a young person's college setting and I asked if her team wore a uniform (she laughs) and says:

Yes, I've got us into uniform. I mean I'm very sort of old fashioned. I've got us back into uniform in the college, one because the students wanted us in uniform. I mean I'm really proud of my profession and I think I was really proud of my cloak and my hat (laughs again).

She tells me that in order to enhance client access to her college sexual health service she had asked young people for their views on wearing uniform:

They wanted to come in and see a nurse who they knew was a nurse because they felt more confident asking me for condoms or about sexual health if I was in a uniform and I was obviously a nurse. So I didn't go for hat and dress and cloak, which I probably, left to my own devices, would have done, so we've just got tunic and trousers.

The new uniform had been implemented for around eight months and she felt it was a positive move:

Yes, basically because you don't have to think about what to wear for work as well. So it's dead easy, you can throw it on and you're messing around doing Chlamydia tests, pregnancy tests, fitting implants.

Sarah went onto explain that when undertaking health promotion work, the nurses adopted a more casual look, wearing jeans and hooded sweat shirts with 'nurse' written on the back. She tells of a more casual and approachable image that lessens the barrier to communication when working outside the clinical environment and across the college. In interpreting the use of laughter with Sarah, this appears to demonstrate some social significance regarding uniform. In defining the scientific meaning of laughter it is thought to be part of human behaviour regulated by the brain in helping humans clarify their intentions in social interaction and providing emotional contexts in conversations. "Laughter is used as a signal for being part of a group – it signals acceptance and positive interaction with others" (Wikipedia, 2009). The use of laughter during interaction is also thought to be useful in managing

delicate and serious moments and can provide a 'truth revealing cue' within a conversation. With Sarah the values she places on uniform suggests that this is an indicator of her nursing identity and a shared value of the figured world of nursing. But there appears to be conflicting and multiple voices at play, as she does not appear consistent in the wearing of her uniform, for example when she adopts a more informal dress code. Sarah's use of laughter may therefore be suggestive of her anxiety or conflicting tensions over the subject of 'uniform.' She may have felt embarrassed or even an apologetic for her traditional and strong sense of value about the nursing profession.

4.5 The Public Image of Nursing

In attempting to acquire further data around the concept of nursing identity and image, I asked the respondents what they felt were the general public's perception of nurses in society today and there was a mixture of both positive and negative responses regarding the stereotypical image of the profession:

Sarah had mixed views and interestingly mentions the stereotypical 'sexy nurse image':

I think they perceive us as being positive. There's two aspects, I think the main one is that it's sort of like a very caring noble profession to sort of be in. I've never had any negative comments about the fact it's a nurse. They seem to think you know everything and you've got encyclopaedic knowledge.

I think there is that aspect of the sexy nurse and they're all up to have a good time but I think that's more of a joke, I don't think that's the perception

Sarah went on to tell of her experience working with the general public at NHS Direct, a twenty four hour, nurse led telephone advice service:

They'd phone up and say, I suffer from, and you'd go, okay, put them on mute and you'd be there, say somebody get me a dictionary and they'd be going, oh they know everything those nurses because then you'd go, oh right, so the symptoms are, de, de, de, and they'd go, oh yes. They had the expectation that if they said to you, the doctor gave me the pink tablets, you'll know what they are. So I think the general perception is it's a very caring noble profession that it's under staffed and nurses work hard.

Janet interestingly felt that the general public have placed nurses on a 'pedestal,' but has concerns that this image may be slipping:

Well the way I always viewed nurses was they were the font of knowledge and totally, totally committed to the patient care and that's how I still think. I mean

the old saying that it's not a job, it's a, whatever the word is, a vocation, I still believe it is. I think they sort of pedestal, but I think these days, more and more, I don't know whether it's because it's being voiced more, that people are getting a bit disgruntled.

Amy feels that the public view nurses with high esteem:

I still think, they've always seemed to hold nurses in high esteem, they always seem to value the profession as a whole, even when there's adversity such as when there was the Beverly Allitt thing, they seem to identify that that wasn't the norm, it was a rare instance and I don't really think it shook the public's faith in nurses. They expect us to have high standards.

I went onto to ask Amy what she meant by the phrase 'high standards,' which brought in the value of image and uniform:

In everything I think, in being professional and things. I think sometimes I've heard, like my family members, you know like my mum and dad and that, in my day when we were training it was hair off the collar, couldn't be short, now you see them with their different coloured hair, tattoos and everything and I think sometimes that can be a bit intimidating.

Despite the changes in how she felt nurses looked and dressed today, Amy remained positive on the public view of nursing:

I don't come across any derogatory comments from anybody. You do get your odd ones who you will, you can't get on with everybody and personality clashes and things but for the most part I think the public still view us with a relatively high, you'd need to read the papers, they're always going on about how we should be paid more and things like that don't they?

Lucy located her thoughts around public image within the history of nursing, gender roles and the position of women in society:

I think people always have respected the nursing profession. Well I'm saying always, no, if you go back far enough, historically, nurses weren't respected were they because of where they came from. But I think, certainly through my life span, nurses have been very much respected because of what they do because of the caring and because of the professionalism.

Well if you go back historically they were often drunkards etc, it depends how many hundred years you go back doesn't it? I suppose it's with the advent of Florence Nightingale and people like Mary Seacole that you start to gain, or a little bit of respect, I think it was a long time coming because women were second class citizens, let's be honest.

Jenny felt that older members of the public still view nurses as 'Angels,' which again links to the discourse of caring:

I think the older generation still think, you're almost like an angel, you know. I think they just think, because they see nurses as people who care and, you

know, want to look after people. And I think as soon as you say, "Oh well I'm a nurse," I don't know, they feel safe and comfortable.

Several of the respondents tell of the negative perceptions of nursing image and Nicole felt that this was wavering:

I don't actually think we're viewed as well as we used to be. Well my friend says that his experience of nurses is that they're all fat and lazy.

Two of the respondents discuss the recent media representation of nursing around poor standards of nursing care, which again links to Big 'C' conversations and the discourse of caring:

Ruth expresses her thoughts around nursing in the media:

I don't think it's as good as it was, I think it's changed. I think in some ways the bad press, especially when you look at the papers about care of the elderly and about people not being fed and not having basic care done. And I think in some ways because we've moved away from some of that basic care

I think certainly, the trouble is that the press always pick up on the negative side and don't actually put the positive sides and unfortunately the negative sides, when you look at hospitals being dirty and risk of infections and not getting the care, I think that reflects badly on nurses.

Jenny provides a similar account:

Having read quite a few stories over the past few years, a couple of years in particular, in the paper, it saddens me when I read the stories and I only read one the other day, how the profession seems to have changed and that caring attention to just the basic needs don't seem to be being met. And I think people who hear and read this, you'll hope it doesn't give them a negative thought on what nurses are like now.

4.6 'Being Charlie Fairhead'

Matthew was the only male nurse in the study and so it was interesting to compare his story to the nine female narratives. Matthew gives a slightly different account of how he experiences the figured world of nursing and his position within it. The cultural model of nursing is female and he tells more of a story of active choice to enter the profession in comparison to other respondents in the study. His message to me was 'I am not gay' and uses phrases such as 'Jack the Lad' and 'male,' his figured world is heterosexual and he tells of being male in a female world. Matthew draws on other models to

identify as a nurse and uses intertextual reference to male models within medical television dramas.

Matthew entered nursing at the age of twenty four having left sixth form he had no idea what he wanted to do and states that he:

Just bummed around basically, I spent quite a bit of time on the dole.

He stayed at home stayed with his parents for a year and describes how:

They got fed up of me, so they effectively booted me out.

Matthew highlights active choices that he made in his life and gives an account of his move to a large northern city (because his grandparents were located there) and it was also home to the football team he supported:

So I went to City X, ended up doing a lot more time on the dole but in some ways it helped, it was me coming out of myself, the fleeing the nest element was important and probably because I was a little low in self-confidence and social skills and all that kind of thing.

He eventually started to save for a round the world trip, but spent all his money in one European city and located back to the South of England to stay with his sister and brother in law. He secured employment in a supermarket over Christmas and then went to work as a cashier clerk in a Building Society. He expressed his northern roots and recalls how he missed living in the North of England:

I missed people saying hello and nodding and smiling at you in the street.

Re-locating back to the city of his football team, he commenced hospital volunteering work on a male ward in 1989:

My personal circumstances at the time were, I'd not gone to University after sixth form but there was still sort of an academic bug sort of tugging away at me, as it were. I wasn't really sure what I wanted to do generally so it was important I did something that had variety.

I spoke with somebody that my father knew, who used to be in the RAF, and I think both he and his wife had been nurses in the RAF so I just went and had a cup of coffee one evening and spoke to him and he said you need to get some voluntary work done. So I organised some voluntary work at Hospital X and I went, I can't remember, I think it was twice a week of an evening, only for a couple of hours, and I was very good at what I did because it was a male medical ward and the first thing that hit you was the smell of wee.

It would appear from his story that this was hard work but he stuck with it. Matthew talks about a lack of motivation for money, which is important given what I notice about the female narratives. He chooses nursing as a career (or he says he does) for different reasons and invokes the Big C 'caring' conversation. Later on, he says he's not tactile and describes caring in a different way to the women in this study:

I'm not particularly motivated by money and therefore I thought it would be nice to, a good thing to do something that helped other people that benefited other people, that kind of thing.

In identifying as a nurse, Matthew uses intertextual reference to male nursing models and he talks about television programmes such as 'Angels', which was a BBC soap drama that focused upon the lives of student nurses and ran from 1975 to 1983 (Wikipedia, 2013a). There is also significant reference to 'Casualty' a BBC medical drama which is the longest running emergency medical television drama in the world, which commenced in September 1986 (Wikipedia, 2013b) and still airs as prime time viewing on a Saturday evening on the BBC. His story particularly resonates with a male Charge Nurse called 'Charlie Fairhead', played by the actor Derek Thompson, who he considered to be a positive role model at a particular time in his life when he was unsure about his career. In describing Charlie, his account tells of the character traits, rank and seniority of a male role model, working in the female world of nursing:

I must have watched some television programme and thought, well let's try, in fact there were some, this would be in the late eighties, there were some television programmes around about that time.

I went to ask Matthew if he could remember the name of the television programmes he watched:

Well the one that I watched, which was in the very early eighties, possibly even in the late seventies, would be Angels, which I think might have been set in Liverpool certainly there was a male nurse in that who was scouse. So I was aware of previous models and, of course, Charge Nurse 'Charlie' in Casualty.

Well I think from memory he was always a Charge Nurse, he might have been a senior staff, I think he was always a Charge Nurse. The main female character was Duffy wasn't she, and she was a Senior Staff Nurse and then she became a Sister. So it's just the nature of the programme, I've not watched it since, after I started working in A and E.

Interestingly, his response 'wasn't she' makes reference to the fact that he knew I was a nurse, with an assumption perhaps that I had seen these programmes. There was no clarity of this within the interview and I let Matthew continue with his story. But I knew exactly what he was talking about because I had watched both programmes as a student nurse.

Matthew continued to talk about Charge Nurse 'Charlie' as a positive male role model, all reference to his figured world, who he is, his values and the significance those values play in his life. He provides a very interesting account, which is more explicit in detail than the female nurses and he talks very much about nursing being a female world and the portrayal of male seniority within it:

So whether or not it was particularly any character traits that Charlie had been given, he did seem to be sort of caring, he did seem to be relatively calm under pressure, so those were sort of positives. Nursing is a female world, it still is and it always has been and always will be but nevertheless there was a positive role model, in terms of the seniority of it. The calm confidence, which he exuded, sort of the way he put his hand into his pockets while he was thinking and so on, that created a positive image and I thought, well, if that's nursing then fine.

He makes reference to gender discourses, intertextuality and Big 'C' conversations around his gender, identity and caring. Once qualified as a registered nurse, Matthew went to work in Accident and Emergency but stated that he no longer watched 'Casualty':

I went into A and E, I stopped watching Casualty because I found that I was too busy looking at, I was picking at details, that kind of thing and so on. And after a while, the basic premise of it, you know, it's a drunk driver climbs into his truck and sets off, you know what's going to happen to him. After a while that kind of lost its lustre as an entertainment for me. But at the time it was all very exciting and it was one of the more popular programmes on television.

Accident and Emergency appears to have had great significance in his nursing career as continued to give an account of his experience:

It's probably the only time in my working life that I couldn't wait to get to work. I'd go in early and I'd come home late and if there were talks and lectures, education or whatever, I would hang around and sometimes I'd be there until 6 o'clock, having finished at half 3.

Matthew's positional identity as a male nurse was expressed further as he communicated more about his figured world of nursing. He talks about his

sexuality and positions himself clearly as a male nurse who is heterosexual, through his use of language;

Well speaking as a male nurse, and when I was a male nurse, we male nurses at Hospital X, we had a reputation, I'm struggling to remember now, but I guess if I could think of thirty male nurses, there was only one that I know of that was gay. At the time it was almost, some of the lads they almost had to over compensate by being Jack the Lad or giving this impression of being Jack the Lad, possibly because at the time, which I don't think that is the case now, I think possibly nursing twenty years ago was more so viewed as a feminine pursuit.

It's not a question of questioning your own sexuality, it's a question more of how close you want to get in touch with your feminine side, if that makes sense. I think twenty years ago it was, I didn't feel that many people were looking at me and questioning my sexuality and, to be honest, I wasn't that bothered if they did. I wasn't one of those that felt I had to over compensate. Interestingly enough, it was arguably, amongst my friends and so on, it was the more masculine ones that felt they had to over compensate, rather than perhaps me, I'm fairly middle of the road. I view myself as sort of fairly middle of the road, average male.

He tells of the increasing number of male nurses now in the profession but still makes intertextual reference to 'Charlie':

These days I think there are so many all-male nurses and down the years there have been many more, well Charge Nurse Charlie, I think if Casualty's still on television I'd be surprised if Charlie's not still in it.

4.7 'I'm Instinctively a Carer'

A recurring theme within the analysis was the Big 'C' conversation around the discourse of caring and the strong sense of value in terms of how the nurses position themselves. What it means to be a 'proper or real nurse' was evident within the data, which still invokes the concept of caring, despite the public's perception that standards of care are falling. The stories they tell are about 'caring' as something women do but also about what they have to do in everyday life. For example, Carolyn tells of her early experience of nurse training and in trying to balance caring for her sick mother, she made a decision to leave to earn more money:

So I'd been doing it about 10 months and my mother became ill, I had to take over at home, I'd always had to do a lot of housework etc at home anyway, even during my nurse training and I found it all too much. So I left thinking at the time, you can't earn any money being a nurse, I want to earn more money than this, and I went to work in a nursing home, which I met quite a number of

trained nurses, nice people, made friends, and after about twelve months I realised I'd made a big mistake. So, one of the nursing sisters encouraged me to go back into nursing.

Carolyn's account is interesting as she took up lower paid work in a nursing home, despite her desire to earn more money.

Lucy's story of caring initially shocked me as I was not expecting her to disclose such personal information and it initially put me out of my comfort zone, as I was unsure how to respond. In giving her account she relates to the sudden death of her mother (also a nurse) following a road traffic accident when coming off night duty and how she became the main carer in her family and considers that she is 'instinctively a carer':

She was killed going off night duty, skidded on black ice. I was 19, I was the eldest of four girls, which was another reason I came straight home because I used to come home all my days off because I was the oldest. My youngest sister was 7, the week before it happened. I mean it's nothing I wouldn't have instinctively done anyway, I think it's very much in my nature, but yes I've been caring for family members until really this last couple of years, since I was 19.

Sarah expresses her values of caring and how these qualities attracted her to the nursing profession:

I'd always liked sort of people and sort of like the caring side. I'd sort of always had animals and sort of like wanted to be a Vet at one stage until I decided that wasn't what I wanted to do. So I've always sort of been somebody that would listen, chat, look after, enjoyed the caring side.

In contrast several of the respondents gave accounts of their experience of witnessing poor standards in care, particularly Jenny who describes her experience of working in a nursing home:

I took a job on a nurse agency and I've never in my life worked in a nursing home, and that was an eye opener for me, I was horrified actually at the standard of care in some of them. I couldn't believe it really.

Janet the most recent nurse to qualify, describes how she struggled with the practical side of her training because of the poor standards of care she witnessed and how she went onto work in a hospice after qualifying because she considered it to be 'proper nursing,' which is indicative of her figured world of nursing:

I didn't particularly enjoy it. I loved the Uni side of it but the placements in the first year I found quite difficult

I went onto ask why:

Well it wasn't what I anticipated it was going to be. I thought that everybody, every nurse would have the passion and the want to care the way that I did and I found that that they didn't.

Her first placement as a student nurse had been 'care of the elderly' and she gives an account of her witnessing poor standards of care:

Oh lots of horrendous, some horrendous things, and I used to go into Uni and speak to my tutor, because you reviewed at every placement didn't you with your tutor and I used to say, I'm sorry but this isn't for me, I don't want to go any further because it's not what I thought it was. And if that's what being a nurse is, I don't want to do it. But I found some really bad, poor care really.

She completed her training because of her tutor's ongoing support:

My tutor kept saying, but you'll be able to make a difference when you go out there, which I felt as a student was a huge responsibility because I'm just me and I didn't see how I could make a difference on my own.

I was due to qualify in the March and in the December this job came up at the hospice because you're always looking aren't you, when you're a student. It's the proper nursing, what I call proper nursing, which is what I thought would, and I thought, if everybody who works in a hospice is going to have the same mind set as me, because you wouldn't be there otherwise.

I asked her what she meant by 'proper nursing' and she tells of her traditional values and cultural model of caring:

Just looking after people, just making, my greatest achievement is the bed bath, the chat, the doing of the hair, making them feel better.

Upon qualification as a registered general nurse, Janet went to work in a hospice, which she considered to be her ideal of 'proper nursing' but only stayed around four months due to a difficult time in her life:

I practically had a nervous breakdown, Yes, well my sister in law died in the hospice two weeks before I started. So two weeks before I went in my new qualified uniform, I had been the grieving family, she was only 52. My mentor was the nurse who'd looked after my sister in law. So it just got, I couldn't do it, I couldn't do it. It was the combination of my personal memories and my inability to be able to close off and shut off from it.

I asked what she meant by this:

Well they used to say you need to be able to close the door of the hospice and forget what's gone on and I couldn't separate the two. So it was with me 24/7. I wasn't able to work, it was horrendous.

Janet was still grieving due to loss of her sister-in-law and her story evidences the difficulties she found in switching from bereaved relative to her 'caring role' as a nurse.

Nicole provides a different account of caring from a relative's perspective and refers back to a particular discourse of nursing in which she feels that today's modern nurse education is not meeting the values of her figured world of nursing and she makes significant reference to my position as a fellow nurse, through her use of language (aren't they, you know, we):

I have to say, my experience of nurses, when I've not been a patient but as a relative, that I don't think they are perhaps, they're not taught the same. I think they're not as hands on, I think they're more, much more clinical aren't they, they're taught much more, you know, in Universities. And I think they don't want to do the same jobs that we were taught, you know, we were taught to actually nurse.

I asked her to explain what she meant by this and asked her who she thought was providing the care:

Well give out the bed pans, do the background, bed bath, all the basic nursing care.

Well I think the healthcare assistants are doing it more and more aren't they?

I wanted to know if she thought there had been a shift in the caring role:

Yes, absolutely and I think some of the nurses think it's beneath them to do some of the menial, what they consider menial tasks. I think maybe yes they're more career minded, much more want to climb up the ladder. And as I say, I don't think they're taught the empathy that we were, you know, when I've asked people, they've actually been quite rude, you know, when you're asking something about a relative and you think, well I'm just a concerned relative. I would never have spoken to anybody like that when I was on the ward, I just wouldn't have done.

Nicole's account relates to similar themes that have emerged earlier within the data, which are the values the nurses adhere to and they don't like values that relate to careers or money. They take preference to the vocation of caring and the desire for 'proper' nursing is fed by the Big 'C' conversation about the standard of care which is closely related to identity, gender and the values of the figured world of nursing.

Janet further tells of her concerns over the standard of nursing care and the word 'properly' is evident once again as a recurrent word that emerged within the data:

I think the standards have dropped and I think it's all to do with money but obviously in a lot of different ways, the lack of a leader and just somehow I feel standards have lowered. I loved to work with a Sister who was in charge, just because she liked things to be done properly and expected things to be done properly and that's how I am at work even now. They say that about me all the time. You know, I am very fussy about how things are done and I like things to be done the right way.

I asked if she felt other colleagues had the same approach:

No, not everybody, No, I'm not ashamed of having high standards and I won't alter. I won't alter to fit them, you know, I expect them to, but that's where I have problems mentoring because I still have this feeling that everybody's got this same passion to learn and passion to do well.

Matthew as the only male nurse in the study, also talks about the discourse of caring, which is different and given within the context of being male. He expresses that he is not tactile but cares in a different way:

Largely because it's correct, a lot of nursing is the art of communication, its things like patience and empathy, and these are the kinds of things, which I think females possess more naturally than males. That doesn't mean to say that a man can't be a gentle caring nurse, they'll do it differently. Personally I'm not very tactile, there are some guys who are naturally tactile, I'm not one of those and it took me a little while to work out that actually no, if I'm not naturally tactile it will be wrong and come across as wrong and false and insincere for me to start doing, just because I'm a nurse and so on. And being tactile, I don't necessarily mean, you know, I wouldn't rub patient's feet or calves, you know, the nice calming, damp cloth across the forehead, those kind of things, an arm round a shoulder when, those kind of things, neither would it be a crushing handshake and so on but it took me a while to find my own feet.

4.8 'A Suitable Job for a Mother'

The role of women was a strong theme that emerged within my analysis, as many of the female respondents gave a personal account of marriage and their positional identity as a wife, mother and carer. Nursing is a profession that provides care twenty four hours a day, seven days a week, three hundred and sixty five days a year and which allows for flexible working for women with children and other caring responsibilities. Several of the nurses gave personal accounts of the type of nursing work they undertook, which was often greatly

influenced by their childcare arrangements. For example, Sarah went to work for NHS Direct as it offered a higher grade salary, the opportunity to train in sexual health nursing and family friendly hours but she tells of how she missed the direct patient contact:

It was just really different. I think it probably came at the right time for me because I was having a real crisis about whether I still wanted to be a nurse and whether it was right for me and whether it fitted in with family life and kids and what I wanted to do.

So I went to NHS Direct because it was a Band 6 and also they'd let me do twilight shifts, which fitted in with the kids. I missed the patient contact, which really surprised me because I didn't think I would. I enjoyed the aspect of NHS Direct, that you've got your headset on, you've got your screen on, and while talking to that patient, that was your patient time and you didn't know that there was fifty other calls waiting to come through, you could spend two minutes if that's what it needed or you could spend an hour talking and helping that client when they were on the phone.

What I didn't like was not being able to actually, the hands on. It was just a little bit too remote for my liking but the positive side of it; I managed to get the study time to put myself through my sexual health training while I was there so it had benefits.

Rachel gives a further example of training to become a Health Visitor because of the family friendly hours it attracted with working Monday to Friday, 9am to 5pm and weekends off.

Jenny describes working on the nursing bank so that she could maintain her nursing skills and how this type of work fitted in with her childcare needs:

I left to have my first child and I went back to work when he was nine months old, I went back into theatre two days a week for three months on a temporary contract. And then, luckily for me they had, they'd started up, it was fairly new then, a bank system, where nurses could go on it and they would ring you if they were short, which really was my life saver through certainly having my children because I could keep in nursing, keep up to date and work really when it suited me.

She then moved to working twilight shifts which fitted in well with her growing family:

So I did twilight shifts then, which was half eight till two in the morning. And I did that for two years, I also took on another contract doing just half a day a week back in recovery in theatre. By then I'd had three children and then I was starting to do nights, a full night shift, then I'd sleep while they were at school or nursery. I tended to do just two a week and then I was expecting my fourth one, fourth child so I just carried on with nights.

4.9 Conclusion

In summarising the emerging themes that were evident in my analysis, there is quite a lot about why they became nurses but it is not clear apart from Matthew, that they actually had many choices given their schooling experience, academic success, family influence, social status and gender discourses. Parental influence and authoritative discourse was also a strong theme around power and influence and a designated identity. The nurses did not really need to tell me about their father's influence, as I was from the same generation and understood what it meant in finding a 'suitable job for a working class girl.' My research shows a strong value on caring and how the nurses position themselves which links to the demise of nursing as a caring profession and role change, which will be analysed further in Chapter Five. The Big 'D' discourses that emerged relate to perceptions of what it means to be a 'proper' nurse and how they position themselves as 'instinctively a carer.' The nurses had concerns that the public image of nursing was slipping, particularly with recent 'failings' in the media of poor standards of care and how the health care assistant is now taking on duties previously undertaken by the 'bedside' nurse.

The nurses in my research, care strongly about their profession and take professional pride in how their image is portrayed. They have strong cultural values which is sometimes contradictory, whilst they would prefer to be seen as entering the profession as a true vocation, they also need money to support their family but it is not really the 'done thing' to talk about it. The stories presented in this chapter, could quite easily have been my story as the findings mirror my personal feelings and experience of nurse entry, academic struggle, wearing the uniform and attitudes around caring in modern nursing today. My position was to sit back and not give an opinion and at times this was difficult as I wanted to engage fully in the discussion that took place. I had multiple identities as a nurse, mother, educator, care and researcher and I could see myself switching between roles, as I reflected upon my own personal values and figured world of nursing.

I now move onto Chapter Five of which my analysis builds on themes that have emerged already and explores the changing role of the sexual health nurse

Chapter Five

'As a Band 6, Its One Step Too Far'

5.0 Introduction

In this chapter, I focus on the experience of role change for the nurses. The NHS is a complex organisation facing immense challenges within the current socio-economic climate due to service redesign and the need to meet the health care needs of an ageing, increasing and diverse population within the UK. In what follows I explore the nurses' accounts of their move into the area of sexual health nursing and the advancement of their role, their experience of a changing organisation and how they view their role in the future. As they describe their experiences of change, the female nurse stories frequently concern women's positions in society in general and more specific references to the status of female workers in a healthcare organisation who are often part-time. The analysis suggests that whilst sexual health nurses are clearly developing their clinical skills and knowledge, not all embrace the changes: they comment on anxieties around their new responsibilities and on power imbalances within doctor-nurse relationships. This disruption to their figured world of nursing raises issues of perceived inequality of pay and some ambivalence's concerning their new role. As professional boundaries shift with the

development of nurse led services and the emerging role of the Health Care Support Worker (HCSW), the discourse of care is still visible but changes focus in order to fit new roles and responsibilities. The case of Matthew, as the sole male in the sample, puts the other cases into relief and in doing so draws particular attention to the issues of gender and work in this area.

5.1 'I'd Always Done Everything to Fit In'

Many of the female nurses couched their descriptions of their sexual health nursing careers in terms of choice but their explanations also frequently detailed how sexual health nursing fitted in with a need for job flexibility around their child care arrangements, particularly as many of the clinics had evening sessions.

Ruth tells of an opportunistic move into sexual health nursing following 'bank work,' itself an option for a nurse with young children:

I'd got married, I got pregnant and then I worked on their bank for ten years. And that's where I got into sexual health because when I had the children and I worked on the bank, they were starting up a new health screening programme and a new well woman clinic. And they needed somebody who would do the well woman side of it.

Completion of further training, allowed her to take on further part-time work within local sexual health services covering sabbatical leave, which finally left a vacancy when the incumbent's husband moved away:

And I'd only been on the bank about a month when one of the nurses was going off on a six months sabbatical, so they asked me to cover the clinic for six months, which I did. And then when she came back her and her husband, who was a doctor, moved away, so then I got the job.

Continuing with her sexual health work, Ruth used her training and skills to move into school nursing, which she describes as 'perfect,' because it fitted in with having a young family:

One of the school nurses, who I worked with in family planning, said she was retiring and persuaded me to apply for the school nurse post. And because my daughter was six and my son was four and he was just starting school, it seemed perfect that I could go and work part time, school nursing, with school holidays off.

Rachel also gives an account of fitting work around childcare as her daughter grew up, beginning with night work and moving into health visiting, which also 'fitted in,' because it was Monday to Friday, day time hours.

Like I'd always done everything else to fit in, you know, worked nights and things like that and then went into health visiting to fit in.

Like Ruth, she had the opportunity to train further as a family planning nurse and worked one session a week in sexual health services. Unlike Ruth, however she talks about interest in the job, as well as convenience:

And so I sort of then started doing one session a week, as well as being a health visitor but I found that more interesting.

Rachel's use of the word 'interesting,' introduces another theme in the interviews, while fitting in around childcare priority, job choice on the basis of interest is possible.

Janet was the most recent nurse to qualify and previously had completed an access course at her local college prior to nurse entry. She gave an account of choosing sexual health as a topic for her course work because it 'fascinated' her:

Well when I was at College, at College X, when you had to do a presentation on health, everyone was doing breast cancer, I did sexual health. I did gay sex and I went and got condoms and did a condom demonstration, things like that. I just found it fascinating, teenage sexual health as well, I just found that really fascinating.

Lucy also talked about interest in her account of working with care of the elderly:

I first got interested in sexual health when I was in care of the elderly. I was very aware that you get young stroke patients and people with Parkinson's, the Parkinsonia drugs affect the libido etc. So you would get issues around this and it was a taboo subject really for that generation to talk about. And I worked with a consultant and she was very down to earth and would discuss these things, and rightly so, and that's what first sparked my interest. And I went on a day about sexuality while I was in care of the elderly, sexuality in healthcare. And that's really, I think, where my interest started.

Lucy's story extends beyond her own personal interest here to invoke a Big 'C' conversation about openness and sexuality, suggesting something of a commitment to sexual health nursing as part of a wider agenda.

Nicole and Amy gave similar reasons for moving into sexual health nursing, from their prior interest and experience of 'always' working in women's health and gynaecology but the theme of part-time flexible working remains a recurrent theme, as Nicole tells me:

I've always done women's health because I've always worked in gynae, right from qualifying. I qualified and had a baby, then I went back on the bank on gynae and then I stayed on gynae for a long time, 12/13 years, something like that.

However there were other issues for Nicole about her choice of job. After finishing with bank nursing, she moved to a private hospital but 'hated it and needed to get out quickly. I asked her why she disliked working in the private hospital and her explanation invokes standards of caring and responsibility in her critique of how private patients were nursed:

It was very different, I think it's not safe, I know that's a big sweeping statement but you can't nurse people in single rooms. Maybe it was just the hospital I worked in but there was very much the mentality of, if a buzzer went and they weren't your patient nobody would answer it, do you know what I mean, even if you were on your dinner, sometimes they'd call you from your dinner and say, you've got to go and see to this patient. There just wasn't the same cover. I think they're fine for a minor op, if you're just having a quick, you know, but I think for major ops, all that was covered was like a senior SHO over-night. So if there's a major massive medical emergency, I think it was scary.

Amy's story is similar to Nicole's in that she also says that she is interested in gynaecology work but again the recurring theme of 'bank work' as a way of meeting childcare needs is evident:

Well, as I say, I've always been interested in gynae and then I went there on the bank initially because my kids were pretty young at the time.

Amy had worked in the same service for a long time and talks about how her enjoyment of the job, which offsets her frustrations about change and a lack of success in gaining promotion:

I did gynae for twenty one years and I just felt, even though I applied for promotion, I was always passed over for one reason or another. And I got a little bit cheesed off really I think and there was a lot of changes going on, so I just thought, well I'd like to just try a different area. I've never thought about leaving sexual health because I do enjoy it, a lot of people, certainly the public, when you're doing your cytology or your screenings, "Oh I don't know how you can do this job," but I don't know, you can't really explain it. You enjoy it and somebody has to enjoy it to do it.

Frustrations arise again as Amy invokes a Big 'C' conversation around part-time work and employment opportunities, family planning was a way of increasing her income:

I applied for full time but because I was contracted for three hours family planning, they wouldn't let me do full time, so I had to do 34.5. About a year into the post I was told I was discriminated against and I could actually have full time if I wanted but I declined that because I was on a higher band in family planning so I made my money up there.

As the only male nurse in the study, Matthew's account of how he moved into sexual health work is strikingly different. While working as a nurse practitioner in a nurse-led walk-in-centre, the opportunity to undertake some training in sexual health arose. Matthew describes himself as liking to have variety in his work and a need to change direction at times. Unlike the female respondents, he describes making active choices for change, in contrast to their more opportunistic accounts. Finding work that is family friendly and flexible does not arise in Matthew's story but neither does he express the same enthusiasm for this speciality:

I came into it slightly by accident. Obviously, you can probably tell from the variety of things that I've done, there is not one thing to which I am drawn, in terms of complete working life or in terms of my nursing career as such. I do like variety and sometimes if I've felt I'm getting pigeon holed, there's almost something inside me that says, I've got to punch out of this and change direction.

Matthew invokes different values in terms of his choice for entering sexual health nursing; rather than talking about interest or enjoyment, he talks personal and professional development opportunities and how sexual health training might be useful:

One of the reasons that I think I enjoyed it was because the personal professional development was very good. There was some courses available at University X and I asked for them, was put on that, that was I think it was called, Sexual Health and STIs. And as part of that, we were doing Chlamydia screening under the National Chlamydia Screening Programme anyway, so it kind of fitted in nicely that I wrote one of my, I think it was two assignments on there, two essays, one of them was on the National Chlamydia Screening Programme. So I read up on it, found the concept quite interesting. So it didn't immediately turn me into a sexual health convert but it certainly increased my awareness of it as an issue and as an area of health that perhaps I'd not thought about that much. It's like most people, your sex life is something sort of separate but I was viewing it through professional eyes and I thought, actually yes, it has demystified it a little bit, and it was useful for general nurse practicing.

Matthew later moved into a Chlamydia Screening Nurse post, due to the opportunity of a young person's service being located directly next door to the Walk-In-Centre, where he worked. His account of a conversation with the Head of Service is again suggestive of a greater choice and the ability to change direction, in contrast to the female respondents:

But I did become a little bit jaded, I'd been there four years and speaking with the Head of the Young Person's Service next door, it was an interesting conversation, "Well you could perhaps always come and work for us," and I kind of followed that up and there was a post available. I can't remember whether I didn't apply soon enough or I didn't get it, I wasn't interviewed for it but then it came back up and it was suggested that I apply for it again, I applied for it again and I got it, as a Chlamydia screening nurse.

In contrast to the others, Matthew appears quite strategic in his career pathway, and whilst the female respondents also talk about career change, they relate this more to home in terms of location, hours and child care needs.

5.2 'Doctor Knows Best'

The theme of working relationships recurred throughout the data, and acted as a backdrop for the nurse's views on their changing role. Several of the respondents discussed the doctor-nurse relationship and their feelings of being in a subservient role to the medical profession and still being perceived so, to some extent. The nurses' self-positioning runs in tandem with resentment about not being paid appropriately and the word 'handmaiden' and the phrase 'cheaper option,' in reference to their new roles were particularly evident within the female narratives. Invoking Big 'C' conversations around positional power, gender, institutional identity and equality, again set into relief by Matthew's rather different account.

Sarah talks about her early experience of working with a Senior Consultant and her feelings of subservience, having to take a task orientated approach to her role and a lack of power and involvement in decision-making. These observations provide a backdrop for a story of embracing change in her role:

Doctor's hand maiden to start with, very much so, that somebody would come through, you basically did their weight, their blood pressure, spoke to them about why they were at clinic and then send them through to doctor. I did my training in Town X with a Senior Consultant and the two nurses were very much doctor's hand maiden, very sort of subservient really. I mean he was lovely and he was a great doctor to train with, he was lovely, but it was very much, you

couldn't make a decision, you didn't do anything, everything was, doctor did it. And then over the years it has progressed, probably, and I am very grateful it has progressed because, to be honest, I probably wouldn't have stuck with it for long if it had stayed like that (laughs).

Although Sarah suggests that the role has changed in this respect, Carolyn describes similar assumptions (on the part of the clients) that 'doctor knows best,' which she feels still exists:

I think they perceive that the doctor knows best, better than the nurse still, I think that's still there in some places.

I asked her why and she referred to tensions around power and models of patient care, which build on cultural models of doctor and nurse (self) positioning in terms of roles, authority and institutional identity:

I think it's to do with power, that the doctors maybe portray they have the last word. I think with a nurse, I think sometimes they will give a client or a patient more time than they actually have to give because that's the caring side of nursing, whereas a doctor I think will put his clock on and look at the logical side, the scientific side of what he's doing, which is not a bad, you know, it's got to be the right way, they wouldn't see as many clients. So sometimes we're our own worst enemies in that way.

Carolyn herself appears subject to discourses about the balance of caring and 'logic,' finding it difficult to sustain a critique. Whilst she also talks about being a 'handmaiden' and a lack of recognition for her skills, she appears to subscribe nevertheless to the perception that nurses were unable to take on more extended roles:

Well the doctor mainly did most of the decision making. I think the nurses weren't recognised for the skills that they had and maybe the qualification wasn't extensive enough for them to take on board any more than they did.

Jenny introduces a further note of ambivalence in her account of role change, while it is a 'massive step forward,' it is also a potential site of exploitation as she talks about nurses being a 'cheaper way' in the development of nurse-led services to fill the skills gap:

I think massive changes for the qualified nurses themselves. I mean very much it was just assisting the doctor, you know, now they're nurse led clinics where you're diagnosing, you're treating. I mean that's a massive step forward really. I think because they've been allowed to, because obviously it's cheaper, and nurses have pushed for it more I think and maybe voiced their opinions, you know, that we're capable of doing this and would it be a good idea to let nurses be more involved? But I think the cost thing has been a big thing because it is a cheaper way.

Jenny and Carolyn's 'heteroglossiac' multi-voiced accounts of their own developments in nurse-led services and the conflicting positional identities that define the changing roles of nurses, lead to simultaneous resistance and approach to change as they are pulled in several directions. On one hand Jenny talks about nurse-led services being 'cheaper' within the context of embracing role change, which nurses have pushed for, whilst Carolyn talks of nurses being 'our own worst enemies' in respect of the 'caring side of nursing' and giving more time, then they can actually spare.

Nicole introduces a further note of ambivalence around the future increase in nurse led services. The recurrent theme of nurses being perceived as a way of 'saving money' was evident in her account:

I think certainly there's going to be a lot more nurse led clinics, because nurses are cheaper (laughs) well nurses are doing a much, nurses are training, doing much more training, you know, you can do prescribing, you can do all the sexual health courses to treat.

I think it's a way to go. I know there's a lot of talk about it being but I still don't think there's the money there. I think yes if they do set up these big hubs and people can have full time jobs, I think perhaps more so than it used to be, but I think there's a long way to go certainly. I think it's all at the moment about just saving money.

Amy appears more positive about role change. Like several of the respondents she recognises that nurses are perceived as a cheaper option but in acknowledging a shortage of doctors, she positions herself differently in terms of having 'more or less the same skills' but less background knowledge:

I hope it continues to develop because the doctors are in short supply. I mean nurses, whilst I think we see ourselves as a cheaper option than doctors and we're doing more or less the same skills, they have more knowledge background and doctors are in short supply, so I think they'll try and sort of do it more of a nurse led thing with just one doctor eventually. I don't think they'll actively recruit more doctors, not in the near future but in years to come I think.

In contrast with the female nurses, Matthew does not raise the same issues around 'doctor knows best,' or nurses as a cheaper option. This is not to say that he is oblivious to the issues of positioning and he does invoke a Big 'C' conversation about gender roles, as I have already noted in Chapter Four. While the female respondents appear to be less aware of gender issues (or at

least they do not refer to them), Matthew talks about being mistakenly viewed by clients as a doctor because he is male:

Commonly they ask if I'm a doctor, because I'm middle aged and male.

I wanted to explore this further and I asked Matthew what reaction he received from clients when he informed them that he was not a doctor:

I usually explain who I am, I usually try and simplify it because it's, I'm a Chlamydia screening nurse, I'm doing some work for GUM and not fully that experienced, I'm just here to help out for the day, something along those lines and if they feel comfortable with me then few of them have expressed it. Obviously females have, they would rather have a female examine them, perhaps if there's not a chaperone but broadly speaking, again it's just the same as any other nursing.

He repeats here his view, that this is just the same as any other type nursing, his account doesn't express the same level of interest and love of the job as those of the female respondents.

5.3 'Other Health Professionals Think It's Not A Proper Job'

I received mixed responses to my question about how other health professionals viewed their sexual health nurse role. Some respondents felt that the role was devalued because it was not acute nursing, with sexual health often perceived as the 'poor relation' or 'Cinderella' service,' due to a lack of financial investment and modernisation. Others gave more positive accounts of effective partnership working with colleagues who perceived them to be highly specialised and knowledgeable in their role.

Amy, Nicole and Carolyn all gave similar accounts that introduced the theme of professional hierarchy, with stories of a lack of respect versus being valued, and of sexual health nursing not being considered a 'proper job.' For example, Amy says:

Well I think we're a Cinderella service. I don't think they think we know that much, we're alright when they want something but we're not considered priority and things like that. I don't know, I think it's this, going back to the surgery thing, they're the, what's the word, the top, they're at the top of the tree, they're more deserving, you know, they come first and then there's like this little pecking order and I always felt, gynae wise, we were always lower down, and used to get medical sleep outs and things.

Later in her account, she talks about how she was pleased to 'get her own back' and challenge her medical colleagues assumptions of her lack of skill and importance, diminishing theirs at the same time. She also seems to enjoy 'shocking' them in terms of what she can do in her role:

And it made my day when we had, there was a medical patient who actually had a uterine prolapse, and it needed packing and pushing back in. So I kind of got my own back and when they rang up at first I said, "Oh I said, oh you can't do that, well you're generic nurses aren't you?" Anyway I went over and did it and I just asked, I said "Is anyone coming so I can show them how to do this, because I don't know if we'll be able to come over every day to do this." And the look of, absolute horrified look about actually inserting fingers into someone's vagina and pushing her uterus back in but I kind of got my point across that, okay you don't know anything about this, but don't expect us to know everything about your specialism when you're handing over. So they were kind of alright after that, but yes, just sort of like little things like that, where we weren't considered to be as important.

Carolyn also thinks sexual health has been viewed historically as a Cinderella service but then invokes more of a positive account with regards to the changing role and status of the sexual health nurse:

I think as a profession now, sexual health is a recognised service that isn't quite the Cinderella service it may have been thought of historically.

I think we were the Cinderella nurses for the service, whereas now they're recognised as nurses that are specialist sexual health professionals, they can offer a service that maybe other people can't. And the fact that your background is as a trained nurse gives it some status.

Nicole's story highlights further hierarchical tensions and describes her colleague's views of sexual health nursing as the 'poor relation' and 'not a proper job.' Her account also relates to professional status, values and respect between day and evening staff:

I think other health professionals think it's not a proper job, you're just dolly around doing family planning, do you know what I mean? It's not acute nursing is it? It's not considered, I think it's still very much the poor relation isn't it? And certainly sort of the experiences actually in the family planning clinics in the evening, the staff that work there during the day see us very much as, well I think a nuisance more than anything else. And certainly I don't think they respect what we do.

However there were some positive accounts of partnership working particularly in terms of other health professionals' acknowledgement of their level of expertise and knowledge and in their involvement in training other staff.

Rachel works in a large primary health care centre and describes how she is involved in mentoring and training other staff in recognition of her expertise:

I mean we've got good relationships at Health Centre X because obviously there's a Walk in Centre above and they send everything down that should be for us, rather than keeping it. If they went upstairs they would send them down, just purely because they feel we're the experts. We are mentoring them upstairs, because obviously they do prescribe out of hours and EHC and things. Well we are mentoring them and we've trained a couple of them in implants, so that they could 'quick start' although they're not doing enough to be confident enough.

Nicole's colleagues also appear to view her as the sexual health expert but while she mentions taking the additional responsibility of working on her own, she is keen to note that part of her expertise lies in long experience and that there are limits to her knowledge:

So I mean people, like GPs and nurses, will know what I do, especially within, very much within the locality will know who I am and what, I mean part of that is the fact you've been here so long. But I mean they'll ring if they want advice and support, they'll know you're the one to pick up the phone and ask.

Well they think I know everything. Yes, they see me as the sexual health guru and I keep saying to them, look, you know what I mean, you know, I am working on my own, yes I've done courses but I don't know everything.

Ruth also gives an account of how her role is validated by others, although this is still within the context of hierarchies where 'even' GP's contact her for her skills but these are 'open-minded' ones:

I've got a very good working relationship with school nursing but that's possibly because that's my background anyway. But also, in this area, because we've built up the community contraceptive nurses, we work really, really closely with the midwives, with the health visitors and even some GPs will actually contact me and ask me to follow somebody up, you know because there are some GPs who are really open minded and if there's a problem they've asked me to contact them, which is really good.

While Ruth appears to be more reflective about the positioning of doctors as higher in the hierarchy, Jenny subscribed more obviously to assumptions about their superiority when I asked her if she felt that doctors embraced the changing role of the nurse. Whilst she says they are supportive, she appears to still hold a view that the doctor is 'all-knowing' in her eyes, with a higher level of knowledge and skill:

I think, from my experience, they've been very supportive in that role yes. And then they feel then that their time is spent seeing patients that require their level

of knowledge and skills and, you know the nurses can see the ones that maybe didn't need to see the doctor.

5.4 'A Step Too Far'

The development of nurse-led services in sexual health is a key element of the change agenda, the experience of which is tempered by ambivalence and an ongoing discourse of what are appropriate skills and roles for doctors and nurses. The nurses constantly positioned themselves in relation to doctor's jobs, consequently under-valuing the job of nursing in its own right. Whilst they continued to express pride in their work and show a keenness to extend and develop a more complex role. Several of the respondents expressed uncertainty about two particular practices: non- medical prescribing and coil insertion. They frequently talked about their concerns and lack of confidence in relation to this additional level of responsibility given their current grade and pay, whilst Amy alone talked more confidently about her new skills and role.

Carolyn first explains what she means by 'nurse-led' services, as in taking responsibility for a holistic care approach:

It means that, there is a doctor there but the nurse can actually take on her own clients and make decisions about how to help them best, look at the whole picture and what sort of contraceptive choices the client would like to have and help them make those choices in their best interests. So you can actually do a lot more than you did earlier, so that's quite satisfying.

She lists all aspects of her role as 'quite matter of fact,' and appears proud of having these skills:

First issue, emergency contraception, POP's, Depo and then we do Implanon fitting and Implanon removal, we do cytology, pregnancy testing and screening, Chlamydia screening, that's on the contraceptive side. And then the full sexual health screen for Gonorrhoea, Chlamydia, HIV and Syphilis, treatment for warts, herpes treatments and treatments for BBV, use of the microscope, treatments for thrush. We do the Hep B programme and screen for Hep C and then there are, if they want a HIV test on the same day, we do same day testing.

Nicole gives an account of working alone in a University GP setting, she later refers to Patient Group Directions (PGD's), which are written directives that authorise 'first' or 'subsequent' issue of hormonal contraception in the absence of a doctor:

Not pure nurse led because there are doctors on site and we can always ask, although how much they'll know is debatable, you know, sometimes I'll have to ring up GUM if I'm not sure because they don't know either. But yes, it's very much a sort of nurse led service that is down to me, whereas I think, obviously, at the evening clinics it's completely different. There's a doctor there and we're guided very much by PGDs, whereas here we're not, it's more protocol based, much more flexible here at the University.

Amy's account of role change suggests that she enjoys challenging the cultural model of nursing and assumptions of the division of labour between doctors and nurses. As earlier in her account, she likes to 'shock' with some of the things she can do:

I don't think they expect nurses to do as much as what we do, and sometimes a few have been quite shocked when you say, I mean more often than not you're telling them who you are when they come in and your regular clients know you are, but occasionally you forget to say who you are and what you do and then they say something and it triggers your mind, you know, we're only human and we all have bad nights. But yes, I think they are quite shocked at some of the things we do. "Oh you can do, oh can you do that so I don't have to go to my doctor?"

However she also talks about the value of nursing and the discourse of caring as a different role in that patients are more comfortable with nurses, suggesting that doctors are not as good at communicating:

I think patients are more comfortable with nurses than they are with doctors, they open up more. I think nurses can get more out of patients. I think a lot of people think they're wasting a doctor's time and feel they've got to go in and go out and don't want to take up too much of their time. So I think they feel more at ease with nurses.

Amy and Ruth also give accounts of their experience and use of PGD's. Amy challenges the Contraceptive (Depo-Provera) injection PGD, asserting her own professional judgement in terms of responsibility in her new role:

I also always think what I would want and I would not expect to do anything or someone to do something or take the advice if I'm not prepared to do it myself. Take the Depo, for instance, I personally wouldn't have it after 40 and I wouldn't recommend any of my relatives to have it after 40 so even though our PGDs say 45, I don't promote it after 40, I'm not happy with it.

Ruth also talks about having a 'big responsibility' and her initial feelings of being 'frightened' and 'scared' in a role that she had not done before:

When I think back to when they started to say about us doing PGD's and issuing emergency contraception and there was a lot of like oh no we're not doing that, that's a doctor's role. And we took that on board and then the next thing they introduced was like the repeat issue. And it was like, I'm never going

to be a first issue nurse, that's not my job, and yet now nurses, it's like the expectations. Initially, I think because we were all a little bit frightened by it, to be honest, and it was a little bit scary, you know, we were suddenly having, to take on a role that we hadn't done before and I think it is a big responsibility.

Ruth's ambivalence is more common than Amy's confidence, reflecting how the nurses position themselves as unable or afraid to step in 'the doctor's role' even though they talk about the value of what they do.

Jenny similarly recognises her new skills and knowledge but is cautious of overstepping the mark. She plays down this new level of responsibility:

That's changed massively, as I say, because I was just assisting in clinic and now I feel, you know, I'm very much involved with treating people, doing the examinations, so I feel my knowledge is expanding all the time and constantly learning. But I think it is important, as a nurse, you know, it's good that we have these extra or this kind of chance to expand our knowledge, but you've got to also know your limitations and I think that is important.

5.4.1 Non-Medical Prescribing

Prescribing is a skill that has traditionally been attributed to the medical profession. Nurses are now undertaking non-medical prescribing training and sexual health nurses are increasingly getting their own prescription pads. Several respondents described their feelings and attitudes towards this change in role, with particular reference to their academic ability and the additional responsibility it brings.

For example, Nicole suggests that she is 'not clever enough' to complete the course defining herself within a discourse that 'doctors are cleverer.' In contrast though, she does recognise how useful this skill could be in practice, as she already completes prescriptions but then has to get a doctor to authorise them:

Yes, I've got huge concerns about doing it. It's just the time factor and I'm not quite sure I'm clever enough to do it. Yes, everybody I've spoken to says it's a really difficult course and yes, I am a bit reluctant but yes, I think it would help massively if I could do it because it is, because what happens is that I would do a prescription, go and speak to the doctor and they would authorise it.

As a Health Visitor, Rachel had already completed a nurse prescribing qualification for Community Specialist Practitioners and could prescribe from a limited Community Practitioners formulary (V100). As a sexual health nurse,

she then completed a further non-medical prescribing course, which allows her to prescribe from a wider formulary as part of her role. I asked her how she had felt, prescribing for the first time:

Well I did prescribe before as a Health Visitor but only V100s, yes it was a bit scary now. And especially like because a pharmacist rang me up and said; "You know you're not allowed to prescribe twelve months?" They said, you know, "You're supposed to check the blood pressure." I said, "Well the Faculty guidance is we can give twelve months supply," you know but you start panicking thinking, perhaps the law's changed.

She goes on to give me an impressive list of what she can do now that she is a prescriber and how her role has changed in terms of offering a 'full service' to clients, returning to a prominent theme of the importance of holistic care:

I'm more of an independent practitioner now, I can kind of, not do what I want but I'm not tied to the PGDs now I'm prescribing and I can offer a full service, you know, I can do a screen or a smear or everything or take somebody's, you know, if somebody turns up and their coil's half hanging out, you know, I can take it out. I can do something about it.

5.4.2 Coil Insertion

Coil insertion is a new and advancing skill for sexual health nurses, externally driven by a shortage of doctors in the field and increased client demand. Some GP's previously trained in coil insertion are no longer maintaining their FSRH competency requirements and therefore sexual health nurses in some areas are now being trained to fill the skills gap. The majority of the stories describe a range of issues from being 'pushed' into the role and it being a 'step too far' in terms of risk and level of responsibility. Many of the nurses were employed as a Band 6 nurse and expressed concerns about taking on this task on their current level of pay and grade. Others had concerns over isolated services and a lack of medical support and backup as a safety requirement for this skill.

Rachel gave an account of how GP's are not maintaining their competency in this procedure and the impact this was having on client demand, due to a shortage of doctors and a lack of money in the service:

Yes because the GPs just, I mean I think it's twelve they've to fit in a year, they're just not getting, they're not keeping the right competences up.

Some ladies are ringing up two and three months on the run at the start of their period to get in and they're not getting in, and that is purely because the doctors aren't being replaced. The doctors, we used to have quite a lot of doctors that did 'sessional' and we had a couple that would do an extra session but the money for all that's gone now. There's no doctors that want to go into sexual health.

She describes a feeling of being 'pushed' into acquiring this skill implying that it is inappropriate on her grade:

Not on a Band 6, but it is being pushed because there is some training sessions, I don't know if you've seen, there's been a huge flyer around.

Reference to Band 6 arises in other accounts - as Nicole says, it is 'one step too far really':

I don't know why I shy away from, I think it's as a Band 6, I feel it's one step too far really.

Whilst not directly relating her account to coil insertion, Janet picks up on the issue of grading and role expectations. She talks about promotion and moving from a Band 5 to a Band 6 role and the extra responsibility that this brings. She also wants to draw the line at giving HIV results and the emotional work involved:

Going from a Band 5 to a 6, you have to start doing things like the health advising role so that's an additional role. And then obviously people, if you're in clinic with junior staff, you're classed as the senior person so everything goes through you. It is an expectation if you're a Band 6, yes, that you do the health, I mean the junior staff do it to a degree, dispensing medication and stuff, but we have to do things like give HIV results, you know, counselling HIV patients that are at risk and giving HIV Positive results, which, I don't like that. It's such a life changing thing, it's not like saying you've got Chlamydia, here's some antibiotics.

Lucy was the sole respondent who was in fact trained in coil insertion and she also undertakes trans-vaginal scanning, which is a unique skill for a sexual health nurse. Her account not only describes the tensions of accountability on a Band 6 role but she also describes how she was 'left holding the service,' when the Consultant resigned. However whilst she presents a certain pride in her role, overall she thinks she is insufficiently supported and includes jobs that she is not paid to do:

Yes, I do trans-vaginal scanning for early pregnancy. I fit coils on a Band 6. I worked with a consultant and eventually she resigned so I was left holding the

service. We then had another doctor with us and she'd started to learn to scan, so there was the two of us scanning. It's very specific what I do.

She describes further her frustrations regarding her pay and a 'lack of recognition' for what she does:

The negative aspects are lack of recognition for what I do. I just feel I want a fair wage for what I do and I've felt that for a long time. And it's not that I'm not at all supported in that, it's just the support's not very fast (laughs). So there again, it's frustrating and I think I've felt that.

Carolyn is fearful of the procedure going wrong because of her experience in practice but says she would not be averse to training if she was younger:

Although I was a midwife I've always been a bit dubious about the coil fitting, just in case it went wrong, perforated uterus or something like that. Because we've seen a few people collapse over the years but usually it's just cervical shock rather than anything sinister. But I suppose if I was starting now, or I was twenty years younger, and I was still in contraceptive work, I'd probably maybe go for it and maybe see how I felt after the training.

Sarah works in a college setting and also had concerns around coil fitting due to the isolation of her service and a lack of medical support if things went wrong:

I just think because we're so isolated, I mean it's bad enough trying to get clinical waste picked up without sort of integrating anything else but I think because we are so isolated, taking on a skill like that without having the backup of doctors for while we're getting used to the skills etc, I think we would be far too isolated.

Ruth picks up a different issue and attributes her resistance to coil fitting, to the fact that she may not get enough experience to maintain her competency levels whilst working in a young person's service. Despite the doctor wanting her to do it, Ruth resisted on the basis of not complying with the need to fill a skills gap, which would not constitute a consistent element of her role:

Doctor X did want me to do that, I have resisted and sort of said no I wasn't prepared to do coil fittings. And the reason, I gave her and when she's looked on it she agrees with me, but my reasoning behind that is, we don't fit very many coils in under 18s and I don't think I would be able to maintain my level of competency to make me a good practitioner, therefore I don't think that's something that, at this moment, I should take on board.

Amy was more confident in her approach than the other respondents and talks about taking on this skill at some point in her career. She describes her colleagues' anxieties in somewhat pejorative terms summing up the situation about attitude and confidence:

It is something that I would personally like to have a go at, at some point. I think from speaking to some colleagues it's something that frightens them to death and they wouldn't touch it with a barge pole, but I think if you get the right training and you feel confident enough, then I think you'd be ok.

Mathews says very little about actual sexual health nurse role change in terms of his own personal experience but as before he highlights gender issues in his account of being a 'senior male nurse' in a nurse-led walk-in-centre. He notes that the skills of 'decision-making' and 'diagnosing' have 'traditionally always been the male role':

Essentially, I was in the Walk in Centre, nurse led clinic. And in terms of learning how, we would support each other, and because there were no doctors there, because it was all senior nurses, and many of the senior nurses were, obviously they were experienced practice nurses, but there were quite a few that had worked in intensive care and A and E, places where you actually, as a nurse you have to make decisions, even to the point of diagnosing, which traditionally has always been the male role.

5.5 'You've Got to Be A Really Good Communicator'

The respondents' accounts tell of moving into new roles and the fact that they now had options and could do more for their clients without having to continually refer onto other practitioners. But as already illustrated, they were caught between the positives of more comprehensive caring and the experience of manipulation and exploitation of external pressures to develop their role. A recurrent theme was the importance of 'communication skills' which they saw as fundamental for the job and which they didn't feel doctors did as well as nurses.

Matthew describes how his role has become more clinical and further supports the positive aspects of caring, particularly in treating clients with STI's:

My role is changing, it's changing within the last two or three months to be much more the clinical person, rather than sort of standing behind the tables at universities and colleges, I'm much more now the person that needs to seek out the positives and get them treated and the partners, do the partner notification.

The positives are, just generally, what I've always gotten out of nursing, which is the general feeling that you are helping someone- you're doing another human being well by what you do.

Two of the respondents gave very positive accounts of making a difference in terms of a role change, skills development and a holistic approach to care in meeting client need.

Rachel's story tells of how she engaged with a client with a number of health needs and how, with her dual training in contraception and STI/HIV management, was able to offer a full service rather than refer on to other practitioners:

A working girl had come in for some contraception, just been released from prison, drug user. So she came in to a contraceptive session for advice for a copper coil because she was in liver failure but actually because I was GU trained I could, I said, she'd never had a smear, so I did a smear, screen, bloods.....

She'd opportunistically come with a prison worker so for her it was a good outcome because she managed, nobody else needed to get involved, she was engaged poorly with other professionals, so the fact that she'd engaged, had everything there and then because we'll probably never see her again.

Amy also provides a positive account of role change and job satisfaction in caring for a client in GUM services:

I had an instance in GUM actually last year, a lady, she was in her 40s, she'd had a hysterectomy, she was under the impression she'd had it for cancer but she couldn't remember the diagnosis because they were telling her when she was still coming round from an anaesthetic.

So with her permission I assessed the histology, so that I could perhaps reassure her and let her know if she needed to have smears. So yes she wanted me to do that, came back with the histology, she'd just had it for fibroids, no Ca or anything.

The relief in her, she just burst into tears, she was so relieved and so glad she'd come, and I think that is probably one of the most job satisfactions I've had because she went out of our department a completely different woman.

A recurrent theme within the data was the importance of effective communication skills and the need for sensitivity within their role. There was a perception on the part of some of the respondents that this was a skill that doctors were not particularly good at, in contrast to sexual health nurses.

Janet talks about the need for effective communication in her role and the positive aspects of talking to her clients:

Need to be able to communicate really well because it's a really, obviously, sensitive, difficult sometimes, and that's what I love, the challenge of having somebody coming in and looking at the floor and not being able to talk to you, and then as they're going saying, see you Janet.

Ruth also talks about communication but brings in the importance of being approachable and having a sense of humour, especially when working with young people:

I think we've got to have a really good sense of humour, I think that's the first one and I think you've got to be a really good communicator and I think you've got to be really approachable. I think, especially working with young people, I think their first impressions of you is really, really important. And I think, if you come across as being unapproachable, they just shut down and so that's really, really important. But I do think in sexual health you've got to be very sensitive as well, you've got to pick upon people's body language and how they are and you've got to pick upon the vibes that they send out to you that like, don't go there and build up the relationship before you start to maybe do some of the difficult stuff. So I think the communication is the really big one.

Sarah gives a slightly different account of how she uses her communication skills, when teaching clients how to take the contraceptive pill:

You've got to be very good at conveying the information in lots of different ways because we also have a variety of intellect groups and sometimes it's actually the very clever students that have the most problem how to take the pill. So it's about being able to describe one thing in about a hundred different ways, to make it stick with that person.

In contrast, Lucy couched her approach to caring from a feminist perspective:

I do what I do for the women. I think women have a right to be able to control their fertility.

The emergence of Health Care Support Workers within sexual health services was also a focus of attention with respect to caring. Both Amy and Carolyn discussed the implications of increasing Health Care Support Workers in sexual health practice, which is the backdrop to the whole skills change agenda as they take on greater aspects of nursing care.

Amy says that Health Care Support Workers are now taking on the 'menial tasks' of her role:

Well they're assisting with the procedures, they're also doing pregnancy testing, they're doing the Chlamydia screening, a lot of the menial tasks for nurses, the one's that I work with take that on board.

Carolyn gives a further account of a cheaper workforce as she talks about the receptionists in her service being trained as Health Care Support Workers which has parallels to nursing in terms of taking on more responsibility for less pay:

What has changed, what has made a difference is that the receptionists now are being trained up to be healthcare assistants because of the shortage of staff. They're doing healthcare assistance, as in sexual health and contraception. So they'll be chaperone for the doctor, setting up the trolleys.

Both these accounts highlight a shift and re-delegation of nursing duties to unregulated Health Care Support Workers to fill the skills gap, as nurses now advance their role in other areas of sexual health practice.

5.6 'Less Time to Care'

Despite their foregrounding of caring as they describe their new roles, sexual health nurses pay a price for their extended role and the possibility of more holistic care is off-set by other issues. I asked all the respondents what factors were driving the change agenda and how this impacted upon their role. They responded in terms of time pressures, government targets, and financial constraints, staffing levels and increased client demand and expectations.

Sarah is alone in suggesting that caring has changed, now that she's doing the job that doctors used to do and therefore has less time to care:

No, I think it's moved on because there aren't any doctors, so the service has had to move on. I mean as a client accessing a family planning clinic, I went and had a coil fitted and was giving a cup of tea and a chocolate biscuit afterwards and told to sit there for half an hour, which was lovely but you couldn't do that in clinic now (laughs). I mean that was very nice and it was very, you did feel very valued as a client but it's changed. I mean we didn't do Chlamydia screens, not very many nurses were doing smears, we definitely weren't doing implants and you weren't doing first issues. A lot of places you weren't even doing the morning after pill, so it has considerably, the skills that have progressed as we've gone on.

The shortage of staff was a recurrent theme and like Sarah, Carolyn talks about time pressures following the introduction of a computerised appointment system:

I think what's changed, I've had to see that in the last few years because there's been less staff, less time, you're time watched to a degree because you're on an IT system so you're only allowed so many minutes to see a person.

So if one has a problem you obviously deal with it and you have to forget about the time and make sure you do your job at the right standard that you should be working towards but you end up feeling stressed because you're behind all the way through. And that happens most of the time. So you can't see people on time, which is unfair to them.

She describes conflicts and tensions in delivering a quality standard of care, which is offset by daily time pressures, as clients wait for long periods of time to be seen and competition within the organisation of who can see clients the fastest:

It's stressful to think that, well they'll be an audit probably done at some point on how the clinic's run and anyone can actually look at your clinic and see how long you've taken to do everything. And there might be a little bit of competition around that. Within the organisation, you know, oh I can do mine in ten minutes, she takes twenty.

Nicole talks about working late and in contrast to Carolyn, attributes the long waiting time for clients or the fact that they may be turned away to the impact of offering a 'drop in service' without an appointment system, which then reaches capacity:

There's no appointment system, people have to wait a long time, they're frustrated, they're often sent away because we can't do what we want to do for them. Yes, we end up working late, it's very pressured. It's not computerised.

Targets, financial constraints and client expectations, invoke further tensions and pressures within the changing sexual health nurse role. As Lucy says:

Targets now obviously financial pressures, people's expectations, I mean the profession's changed because people, we're in a society now that expect things to happen quickly, we've got increased expectations, we've got advanced knowledge and smaller purse strings and that brings pressure. And it brings conflicting priorities, you know, you're having to work within that climate and I think that's a lot of what's to do with it.

5.7 Sexual Health Nursing: Embracing Change

Despite the drawbacks, my respondents generally seemed to think that they are doing a better job and that they can provide a better caring role within the advanced competencies of sexual health nursing.

Lucy gives an account of being positioned by the Consultant she works with, as an agent of change, who seems very willing to develop her role and practice:

I think the nature of what I do sums up change. Yes, I mean six years ago I was a contraceptive nurse, now my role has evolved to one as a specialist TOP nurse. And it has just evolved, I mean the Consultant I worked with said, "We'd always known there was a need for a service in South" and she said "The clinic was becoming quiet," one of the clinics, which meant it was in danger of being taken away, and she said "You know, I think we should do this". And I just said

“Okay right, alright well what do we do?” And she said to me afterwards, she said “I knew you’d be alright” because she said “You’re a change agent.” She said “There’d be none of this, well we can’t do that or we can’t do that,” it was more a fact of okay well how do we do it then, what do we, how do we sort this out, how do we take it forward?

Nicole works in two organisations, a University general practice and an NHS Trust sexual health service and compares her position within the two organisations. She says has little impact on the change agenda in the NHS Trust, but in general practice, change is often led by her or she is consulted in the process:

I think everybody’s a little bit nervous about change to begin with, although I think it’s quite empowering really. Well if it’s change that you have any impact, if you can actually have any input as to what change, I don’t feel very empowered by the change in the Trust but I do here because it’s often led by me or certainly in discussion with me.

Jenny also felt empowered by change and talks about how proud she is of what she does, although her account is reflective of her self-positioning as a nurse working in a service that is run by a doctor:

Definitely empowered really, it makes you feel quite proud really of what you do, you know, that the doctor who runs the service knows and feels confident that her staff have the knowledge to do the clinics and to do what they do. So I feel really proud of what I do and that we’re allowed to do the clinics.

Janet was the lone voice, in talking about her overall dislike of change, she appeared less confident in her account and does not like it when people leave:

I just have a strange feeling that it’s just all going to change and I am not big on change, I don’t like change. I don’t know something in my personality. I don’t like it when people leave.

While the female respondents often talk about ‘values’, Matthew was more focused on ‘good employment’ and talked about change from the perspective of preventing him from ‘furthering’:

On balance, from my own perspective as a very experienced nurse, I’m not too scared of losing my job, as it were. I’ve been in the NHS eleven years so I would have a reasonable redundancy package, were that to be the case. As I’ve said before, I could take a sharp left and go to orthopaedic nursing. Most of what I get out of nursing is still in there, instead of thinking about discharges and ectopies on cervixes and so on, I’d be thinking in terms of external fixators and hip screws and that kind of thing. I’ve plenty of transferable skills so I’m not concerned in terms of my employment, I’m concerned in terms of how these changes might prevent me from furthering what I’m doing in my current post but I do have supportive managers, which should offset that.

Finally, I asked the respondents what the future held for the development of sexual health nurses and the overall feeling was that the development of nurse led sexual health provision would continue to meet the increasing demands of service re-design, a shortage of doctors and increasing client need.

Sarah commented on the uncertainty of change within the NHS but her account is reflective of an increasing demand for nurse-led sexual health services, particularly outreach provision and dual training in contraception and STI/HIV management, to meet client need:

Well I don't know, I think the way the NHS is changing who knows? I think it's going to become more and more dual, sexual health and contraceptive together and sort of everybody be a sexual health nurse, whereas before it was family planning, GUM. I think it's going to be very much a combined dual role. And I think, I mean I would like to think they will develop the services into places where it's needed, such as like colleges etc, making it accessible and making it part of life really.

As the sexual health nurse role develops, there is pressure to continue learning and Jenny sums this up:

I think as a nurse the pressure is definitely on that you have to be showing that you're continually learning and developing and keeping yourself up to date. It's definitely not a job that you can just sit down and think well I've done it all now,

Rachel talks about the role expanding even further in her service, with the possibility of introducing a Nurse Consultant in sexual health. Whilst she does not expand on this, the role of the Nurse Consultant (Band 8), blends a proportion of higher level clinical care, research activity and educational and management responsibility within the role:

I think in Town X, we'll probably have a Nurse Consultant in the next couple of years.

Ruth, alone, felt there would not be significant change within the sexual health nurse role, as they had developed so far already:

I don't know because I think actually we've developed such a lot in the last few years because if you look at the fact that we have got nurse led clinics now and we have got nurses doing screening, which we never had before. I think we've come up such big leaps that actually possibly now it's the little steps and the tweaking and the little improvements to services, rather than the big leaps that we've had in the past. So I don't know that there's going to be massive changes.

Finally Lucy noted the importance of remaining a clinician and not losing sight of what is happening in clinical practice:

I'm still a clinician and I work for X but I am very, I very firmly believe that there has to be a reality check and I'll always have one foot firmly on the floor in clinical practice.

I see too much of people rising up, I don't think it's, it's not a criticism, I think it's the nature of the beast. They lose track of actually what the reality is in clinical practice. And I think you've always got to say to clinicians, "You know, I think I'm a change agent," I've learnt that as I've gone along, I'm very much for, you know, we've got to change, things are progressing the whole time but if somebody turns round and says, "Well actually we can't do that," I think you've got to say, "Okay well why?, So talk me through it and let's work this out."

5.8 Conclusion

This chapter has shown how the nurses talk about enjoyment in their work with the female respondents having a particular interest in the specialism. They clearly want to do a good job and they like the fact that they can do more and explain more to people and they tell positive stories of making a difference in providing a holistic approach to care. But they also tell of being caught between caring and the manipulation of being exploited, perceived as a cheaper option and not paid to take the risks, which the new role may bring, particularly when they talk about Coil insertion. There are tensions in practice and the data reflects Big 'C' conversations around resistance, power and status, as sexual health nurses take on greater responsibility and accountability in their role.

All of the respondents talk about change and it was interesting to observe that there was no negativity around the role itself, rather negativity emerges in relation to organisational and system issues, such as targets and time pressures within their role. The female data focuses more on identity and self-positioning within the job itself but also the importance of being strategic about the 'fit' between work and family life. Matthew illustrates a strategic approach too, in terms of his career and professional role development with no mention of family life. Nevertheless, he is more likely to talk in general terms about gender issues.

As I showed in Chapter Four, caring is a dominant theme and frames much of how the nurses in this study described their changing roles. However, it would

seem that they find it difficult to step outside a cultural model of doctors being better than nurses. Their accounts of shifting professional boundaries relates to a self-positioning, which uses doctors as a benchmark, usually in a way which are detrimental to themselves. While the discourse of care is subsumed into the positives around role change, they also express ambivalences around pay, grading and confidence. Despite the fact that they say they have the ability to develop the necessary skills, they also play them down, assuming deficit rather than difference or complementarity of roles in comparison to doctors.

As in Chapter Four, these stories resonated with my personal experience as a nurse and as a working mother in finding work that 'fitted in' with family life and in caring for two young children. I also have experience as a sexual health nurse within a changing role, as I developed and advanced my clinical skills to deliver and manage nurse led clinics. The work is very challenging and at times isolating, particularly in an evening and at weekends when you may be presented with complex client health care issues and you are working alone without medical support. I return to these issues in Chapter Six, where I summarise my findings and present recommendations from my research.

Chapter Six

'Responsibility and Care'

Conclusion and Recommendations for Professional Practice

6.0 Introduction

In this concluding chapter, I present the findings from my analysis and examine how sexual health nurses construct their identities within the context of role change. My original research questions focused on gathering data on the nurse's perceptions and descriptions of their jobs:

1. How do sexual health nurses perceive nursing?
2. How do sexual health nurses describe their relationships with the public, other health professionals and service users?
3. How do sexual health nurses describe their experience of role change?

However, the course which I eventually followed in my research entailed moving beyond descriptive answers to these questions: employing the theory of figured worlds in tandem with Gee's Discourse Analysis tools enabled a deconstruction of the dominant discourses which emerged from my analysis of the answers to these questions. I discuss this process, my findings, contributions to the theory and conclusions here.

Discourses are historically and culturally constructed over time and context and I became interested in the discourses surrounding the 'nurse' and the narratives that the nurses in this study told me about their own self-positioning in the figured world of nursing, historically and socially constructed through their use of language and accounts of change in nursing practice. In this chapter I take the opportunity to revisit the theorisation of identity and self and how my nurses come to figure out who they are through the worlds they participate in and how they relate to others within and outside of these worlds. I return to Gee's (2011) tools of Discourse Analysis and Holland, Lachicotte, Skinner and Cain's (1998) concept of figured worlds as a powerful analytical lens to illuminate and interpret my findings. I look at positionality and the constructs and conflicts of past identities which appear in the nurses' narratives and I will argue that exploring the discourse of care is an integral part of understanding role change. I end this chapter by reflecting upon the research process and my part in it. I also draw on my role as a nurse educator to present my recommendations for professional practice and some concluding thoughts.

6.1 Figured Worlds and Positionality

Figured worlds is not an isolated concept, but part of a larger theory of self and identity and is useful as a tool for studying identity production in socio-cultural contexts (Holland et al. 1998). The use of figured worlds as a theoretical framework allowed me to analyse how my nurses come to make sense of themselves in a changing profession, and the findings demonstrate a strong emotional attachment to the past 'history in person' (Holland et al. 1998), dependent upon who they are and their social history. Positionality as a context of identity refers to the positions 'offered' to people in different figured worlds. Thus "Positionality is inextricably linked to power, status and rank. Social position has to do with entitlement to social and material resources and so to the higher deference, respect and legitimacy accorded to those genders, races, ethnic groups, castes, and sexualities privileged by society." (Holland et al. 1998, p.271).

A striking feature of the nine female accounts was the way in which they located their choice to be a nurse as being made early on in their lives and, for some, in childhood. Their positional identity of 'daughter' was strongly evident within their accounts of their career choices, illustrating the 'authoritative' discourse (Bakhtin, 1981) of parental influence and missed parental opportunities. These accounts also reflected their position as young working class women who had not necessarily been viewed as academically strong. Low academic achievement and a perception of nursing as a high status occupation were therefore all influential factors in entering nursing as a 'suitable job for a working class girl' of my generation. Nursing, I found, is also described as a 'suitable job for a mother' which can be 'fitted in' around the demands of parenting. Whilst my nurses spoke of their enjoyment and interest in their work, they also described in elaborate detail their involvement in 'bank work,' night duty and part-time posts, all of them flexible working which supported the primacy of family and child care commitments in their positional identities. Thus whilst my nurses talked about choices and in some cases, 'always wanting to become a nurse', my analysis suggests that there was less choice involved than they actually claimed as they took up positions which were deemed suitable for

them, given their gender, educational achievements, their background and social class.

I found that the nurses' description of why they entered nursing was often also couched within discourses of the kind of person who you would want to see in nursing. They often told stories identifying themselves as having particular personal attributes and qualities, and some talked at length about their experience as carers within their own families, positioning themselves as experienced and 'natural' carers. The connection between these ascribed personal attributes and experiences and caring as a fundamental feature of nursing was a dominant theme. Many of the nurses emphasised the importance of communication as a key element of their caring role, privileging this aspect of their roles above the many skills and competencies which they also had. Indeed, I found that some were in fact wary of taking on more skills due to the increasing responsibility and lack of support in their changing role, whilst others resented what they saw as 'exploitation' as they took on jobs which previously had been undertaken by doctors.

Positionality was frequently indicated within accounts of the doctor-nurse relationship as the doctor's 'handmaiden' or as a 'cheaper option' to fill the skills gap. Hence the shift in professional boundaries which role change leads to was accompanied by tensions and conflict as the nurses self-positioned within the modernisation agenda. Whilst many embraced new opportunities to extend their caring identities, the female nurses in my sample continued to position themselves as subservient in relation to the doctor. In general they continued to hold the view that 'doctor knows best,' benchmarking themselves against doctors and producing accounts of their professional selves as deficient rather than different, despite what they said about their superiority in the essential nursing qualities of caring and communication. They told stories of their 'Institutional Identity' (Gee, 2000-2001) and the positions that held authority within their organisations. Nursing has traditionally used medicine as a developmental benchmark: Andrew (2012) argues that this has hampered professional progression due to an assumption of patriarchal dominance within medicine and its high professional status which is characterised historically by authority, prestige and wealth.

My nurses' accounts also highlighted a public discourse of nursing which contributes to construction of identities in nursing (Kelly et al, 2011) as an oppressed group within medicine, despite its move to an all graduate profession and the advancement of nursing roles. Nursing, I argue, is located within a deep-rooted culture that is difficult to change due to its historic connections and the gendered and subordinate position of women in society and its intrinsic links to social class, domestic work and caring for the sick. What my nurses told me about their relationships with other health professions, and their resistance to them, suggests that their positional identities were also rooted in assumptions of power and knowledge imbalances between nurses and doctors.

6.2 Image, Gender Discourses and Caring

The analysis of several of the female accounts identified a discourse of the 'real' or 'proper' nurse. What was meant exactly by this was unclear, but the importance of self-positioning and the gendered image of nursing, both within the profession and media was evident. Gender is a key discourse in the nursing profession due to its history as a female dominated profession and for the most part my nurses framed their identities within the public's perception of nursing. They talked about being placed on a 'pedestal,' held in high esteem and described as 'Angels', an image which is rooted historically within the promotion of Florence Nightingale as the 'angel of mercy' in which the good nurse is invariably seen as the self-sacrificing angel, who gave up everything to dedicate her life to caring for the sick (Hallam, 2000). Wearing the traditional uniform also played a major role in their definitions of self, symbolising for them a professional image of the kind and respectable nurse. They talked with some fondness about wearing their belt, hat and cloak and a certain dislike of a move to wearing hospital scrubs. Thus the uniform appeared to hold personal significance for some as a representation of the profession's image, positionality and links to femininity.

The discourse of care was a major emergent theme within my research and was central to my analysis on role change within sexual health nursing in terms of a conflict between perceptions of the centrality of caring and the discourse of modernisation. The discourse of modernisation and workforce reform now forms

a central plank of the NHS, as part of the role re-design agenda (DH, 2000) (Bach et al.2005) and within the North West (FSRH, 2013a) there has been an overall increase in Band 6 posts (Senior Practitioner/Specialist Practitioner level) (DH, 2004) and below and a significant increase in Health Care Assistants, which reflects the national pattern. Sexual health nurses are now working in autonomous roles in which many are extending their skills in areas that have traditionally been within the domain of medicine. In general, the nurses presented positive accounts of their changing roles, in terms of the ability to do more for clients and so making more of a difference to their care. Many described how they could now extend their ability to provide a complete approach to caring and in management of the whole client journey on a Band 6 role. They seemed to think that they were doing a good job, expressing pride in their new skills and showing a keenness to develop their role further. However, there were tensions and conflicts, specifically around banding, pay and appropriateness of the skills demanded by their new role and respect for the work that nurses do.

The figured world of nursing arguably prioritises 'care' over the importance of earning a living, but conflicts and tensions over being valued and rewarded for the work that nurses do as part of their changing role were evident in this research. These conflicts were evident in their self-positioning within new roles: for some the issue of a 'Step too far on a Band 6' concerned money and their resistance to being exploited as a cheaper alternative option to doctors as part of the modernisation and role change agenda. For other nurses, being 'pushed' to change their role was described as too challenging, falling outside of the 'natural' role of nursing. The nurses in this study thus differentiated themselves from doctors in a number of ways. The essential role of communication and caring as a fundamental component of nursing was frequently invoked as something that nurses did well, in contrast to doctors. By the same token, certain skills were seen as 'belonging' to the role of the doctor, even though they were now part of the nurses' new expanded roles. They made reference in this regard to two particular practices: coil insertion and non-medical prescribing. They described feelings of being 'pushed' into these new developments and voiced their concerns over the increased responsibility and

accountability that taking on these skills would bring. To a certain extent they were seeming to limit themselves possibly because of strongly-held identities which did not extend to doing these particular jobs. Thus their accounts overall showed ambivalence about role change with anxieties over the level of risk, working in isolation with a lack of medical backup. They also worried about the problem of having 'less time to care' due to their changing role towards diagnosis and client management, since care as traditionally defined was now being addressed as part of the skill mix agenda by lower grade Health Care Support Workers. They related this to concerns over the quality of Health Care Support Worker training and staff shortages in which the financial constraints of the NHS and resulting regimes did not allow them to care appropriately. They also reported that new systems and new ways of working created further tensions, which could make caring difficult at times. Some reported concerns over new computerised appointment systems and monitoring of the length of time that they spent with clients, which changed their relationships with clients, particularly in the sphere of care. Thus a major finding of the research was the role of the discourse of care in understanding how sexual health nurses construct their identities within the context of role change.

6.3 The Contribution of My Research to Theory

My analysis was based on a blend of the figured world literature (Holland et al. 1998) and some of Gee's (2011) tools of Discourse Analysis, which enabled me to explore the constructs of nursing identity and to understand the cultural representation of discourses that frame nursing practice within a changing role. Discourse Analysis allows for a focus on language and for the deconstruction of dominant discourses. Taking a particular focus on what it 'means' to be a nurse and what it 'means' for that role to change, I was able to explore how my nurses positioned themselves within their story, with respect to others and how the roles of others related to their construct of professional identity. Gee's earlier work drew heavily on the concept of cultural and discourse models but his more recent work employs Holland et al's. (1998) concept of figured worlds, which I used in the context of "A socially and constructed way of recognising particular characters and actors and actions and assigning them significance and value" (Gee, 2011, p.205). Gee's tools of inquiry into discourse are useful thinking

devices which enabled me to ask certain questions of the data. The concept of 'Big C' conversations was an important tool in analysing the role of major debates in nursing such as the primacy of care, image and gender equality. Intertextuality provided another tool which enabled me to make sense of Matthew's explicit reference to a popular television drama 'Casualty' and its role in his particular history in person.

The usefulness of these tools and their interface with figured worlds is illustrated by the juxtaposition of Matthew's story, as the lone male in the sample, with that of the women. Matthew's story was clearly different from the others and indeed he presented himself as different. The role of gender and gender roles in identities of nursing was a strong emergent theme within my analysis: many of the female nurses interwove their accounts of nursing with highly personal accounts of marriage and their positional identities as a wife, mother and carer. Lucy for example, described herself as 'instinctively a carer', telling me about the sudden death of her mother at a young age. The eldest of four girls, she described her experience of becoming the main carer for her family. Sarah gave a personal account of the type of nursing work she undertook in NHS Direct and later in a college setting, which was greatly influenced by her childcare arrangements. In general, the female accounts presented strong cultural values which were sometimes contradictory. Whilst they preferred to be seen as entering nursing as a true vocation, they also told me about how they needed to earn a living and fit the job around their home life. As I have argued above, their stories suggested little about making choices. In contrast, Matthew gave a more active account of career choice: he told me that he was not particularly motivated by money, and he did not discuss his family or outside responsibilities. He also used the discourse of care differently within references to Big 'C' conversations about gender differences, identity and caring. While he made explicit reference to gender roles in society, he also described women as 'natural carers', positioning himself as 'not being tactile' or fitting the traditional description of the nurse as carer. Indeed, he made intertextual reference to the television drama *Casualty* in order to locate himself as a man in a female dominated profession. Although it is impossible to generalise from Matthew's account in terms of his choice to become a nurse and the way he describes

nursing and his career progression, the different picture of nursing that he presents draws attention to various themes in the female accounts which are suggestive of how their own self-positioning is influenced by dominant discourses of gender.

6.4 Reflection upon the Research Process

Reflecting upon my own position in this research, my role was important as the respondents knew who I was and my background as a nurse and academic. They spoke to me as though they knew my views and that I agreed with theirs and their perception of our shared history as nurses was often evident in their use of language and medical terminology. The nurses were from my own generation and apart from Janet, we had all experienced the old traditional model of nursing training. Their stories resonated with my own identity and personal journey as a nurse, particularly around the emergent themes of early childhood experience, educational achievement, social class and finding suitable work as a mother. I acknowledge that using a different researcher with no knowledge of the interviewees or of a nursing background may have produced very different data and conclusions. As I have already noted, the nurses in my sample were all of a similar age and generation of nurses. It would have been interesting to compare these findings with a sample of younger and newly qualified nurses, who had a different experience of the nurse education system and profession.

My sample included one single male participant (Matthew) who acted as a foil for understanding of the female accounts, particularly around gender differences. Whilst I am clearly unable to generalise about male nursed experience of role change, the differences between Matthew's account and the female nurses indicates that using a different sampling process with a larger number of male nurses may have presented a different picture in terms of gender, role and organisational change. These observations suggest positive useful future research.

6.5 Recommendations for Professional Practice

This research has provided me with a greater insight into nursing as a career and sexual health nurses experience of their job role, which I would want to address as a nurse educator. Reflecting upon my doctoral journey as a novice researcher, whilst it has been extremely challenging to complete this thesis on a full time post, it has been most rewarding. I have developed new skills and knowledge and with a greater understanding of the research process, I have now transferred these skills into my teaching role as a nurse educator. I am starting to develop greater research links within my own higher education institution and with a newly acquired passion for research, my intention is to develop further and to pursue post- doctoral research opportunities as they arise.

6.5.1 Training

The nurses in my research show concerns around the need for appropriate training and support in their developing role and the greater responsibilities that it brings. Although I know that my nurses would have mentors as they expand their role, only one respondent mentioned her own role as a mentor. There was no reference in the data regarding appropriate mentorship preparation and support in clinical practice for the development of skills acquisition as part of sexual health nurse training and their changing role. As a nurse educator, I teach 'role change' as part of the sexual health curriculum but this research has widened my understanding of the personal impact of role change and the tensions, conflicts and anxieties that it brings. The findings from this research can further inform nurse teaching and in the preparation and support for mentors. Coil insertion and non-medical prescribing are new skills that nurses are being asked to do and I argue for a review of their grading and appropriate recognition of their role and not as a way of saving money. Extensive training, mentorship and medical support should also be an essential requirement for role change in nursing. Universities also need to provide an on-going programme of continuing professional development for future training of the sexual health workforce, using innovative delivery techniques such as e-learning and online chat rooms to facilitate ongoing academic support and development. The findings of this study can also be raised at Sexual Health

Lead Nurse meetings, as part of the wider discussion around role change and the modernisation agenda of sexual health services.

Nurse training and professional qualifications are almost on par with doctors, yet my research indicates that nurses still feel that they have a lower status to doctors. I am unsure if this position will ever change due to the historical nature of nursing, its gendered image as 'women's work' and lower professional status to medicine. With a move to an all graduate profession, only time will tell if this will make a difference to its position and hierarchical status in the healthcare system. This suggests a need to stand up and speak more, with a greater recognition and branding of what nurses do or to raise the profile of nursing, so as to instil some confidence back into the profession. The image of the nursing profession has, I feel taken a backward step since the public inquiry into the Mid Staffordshire NHS Foundation Trust (Francis, 2013) and recent negative media press that nursing has lost the traditional values of delivering basic care. My analysis took place before the Francis (2013) inquiry but my data had already demonstrated a strong value and commitment to caring. I argue that my sample of nurses' care very much about their image and others' perception of their role. Nursing must therefore remain an attractive career option for high calibre students and not one that is viewed as a lesser option for applicants of a lower academic ability.

Francis (2013) recommended that any person providing direct physical care should be regulated and the government have accepted that all people providing personal care should have the skills to do (DH, 2013b). Future student nurses will now be required to work as a Health Care Assistant for up to a year before they are interviewed for a place on a nursing course. The government believes that this will allow students to find out if they really do 'want to be a nurse' by firstly gaining 'hands-on' experience. It is recommended that aspirant student nurses should also undertake aptitude testing, which assesses their attitudes towards caring, compassion and other necessary professional values. Values testing will therefore become mandatory in the future, for all NHS funded training posts, including appraisals for all staff (Entwistle, 2013).

The NMC (2013b) as regulator for the nursing and midwifery profession has in its response to Francis (2013) recognised three ways that it intends to play its part in raising standards and bringing about a change in culture which are critical to improving patient safety and in making healthcare client focussed. Firstly it will continue to set standards for the education of those wanting to be nurses and midwives and these will highlight the importance of the values of compassion and care, alongside the essential clinical skills needed in the twenty first century. Second, it will need to ensure that nurses and midwives who join the professional register demonstrate the key values and remain capable of safe and effective practice throughout their careers. A new system of revalidation or continued fitness to practice will be implemented by the end of 2015. Thirdly, the NMC needs to have effective systems in place via its fitness to practice directorate, to deal promptly and fairly with those nurses and midwives who do not demonstrate those values of compassion and care and who act in a way which presents serious risk to patients and the wider public.

Health Care Support Workers are now becoming an integral part of the sexual health workforce who, like sexual health nurses also require appropriate training and support. Francis (2013) has also made recommendations for their training and regulation, however the government has subsequently rejected a process of regulation, requiring the NMC to focus on its core function as regulator for nurses and midwives (DH, 2013c). The Cavendish Review (DH, 2013b) an independent review into Health Care Assistants and Support Workers in the NHS and Social Care settings has recognised 'unacceptable variations in the competence' of the support workforce (DH, 2013b, p32) and has recommended that Health Education England develop a 'Certificate of Fundamental Care' in conjunction with the NMC, employers and the skills sector. This will provide assurance that support staff receive high quality training and that they have the skills required for the delivery of compassionate care, in an effort to raise the status of caring (DH, 2013b).

6.5.2 Systems and Support

The introduction of new systems can create problems during role change, due to a lack of support, feelings of isolation and a lack of involvement. The

experiences of new computerised appointment systems or in some cases a lack of appointment systems and the stress of being monitored, illustrated a lack of understanding of the nurses' role. NHS systems are target driven and there is a greater need to focus on improving health outcomes and care delivery. The nurses in this study also reported feeling 'pushed' into taking on more of the doctor's role. Together, these findings suggest a need for a stronger voice within the profession. Indeed Francis (2013, p.106) recommended the need for 'exceptional leadership' with nurses being visible to their clients and that staff should work alongside colleagues as a role model and mentor, developing clinical competencies and leadership skills within the team. Training and continuing professional development for nurses should include leadership training at every level from student to director, which will facilitate a greater understanding and participation in the change process. Nurse-led services, as part of the modernisation agenda, are here to stay and nurses require an infrastructure to support them at organisational level.

6.5.3 NHS Structures

The nurses in my research gave positive examples of their changing role and their new opportunities for making a difference in the delivery of client care. However, whilst the values of caring within my research suggest that care is obviously important, there needs to be recognition that it is more difficult within the circumstances in which they are working. Many of my nurses were not happy with what they saw as exploitation in terms of doing far more with less pay. Several were employed on a Band 6 post and saw the extension of their skills around coil insertion, as a 'step too far' on their current grade and level of pay. In my own experience of thirty years in the profession, I would argue that their claims are well founded and I understand the conflicts of their role. Additionally on the basis of my own experience of working in a community nurse-led service, I understand their feelings of isolation and a lack of support in their changing role. Working as a sexual health nurse often entails working unsocial hours in the evening and at weekends, times when there is less medical support around. I have seen emergency situations, when clients have become increasingly unwell following Coil insertions by trained medical practitioners and I support the nurses in their argument that this is 'a step too far

on a Band 6' post. How to address their grading and appropriateness of their role within in the current financial constraints of the NHS is difficult but in an ideal world, I would recommend that nursing pay scales are re-visited. This research indicates that nurses would feel better if they had a greater voice, increased training opportunities with effective support mechanisms in practice, more recognition and respect for what they do and importantly an appropriate level of pay for the new responsibility and increased risk as part of their new and changing role.

6.6 Concluding Thoughts

Despite the stories in the media, my research has found that 'caring' and 'compassion' is alive and well and not an issue for the nurses in this study. We need to recognise that caring is important to nurses and as I have shown, mine are happy to extend their role and embrace the extended opportunities for caring that it brings. Caring is difficult in the current context and there appears to be less time to care. The nurses in this study were also not necessarily confident and report feelings of being abandoned and isolated as their role changed. Caring as a twenty four hour service is everybody's responsibility and yet evidence from the Mid Staffordshire NHS Foundation Trust public inquiry has shown that there is still a culture of blame, which has resulted in a spate of negative publicity aimed at nurses, threatened client confidence and challenges to the profession (Nursing Times, 2013). There is clearly a lack of recognition of what nurses do and the modern profession needs to focus on re-branding its self-image. My research has reassured me that nurses place 'caring' as the most central part of their changing role and as a fellow member of the nursing community, I take immense pride in my profession and I am truly proud to call myself a nurse.

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Appendix One

Participant Invite Letter

October 22nd 2010

Re: Research Study

'How do sexual health nurses perceive their role and identity during change?'

Dear

I am currently studying for a Doctorate in Education at Manchester Metropolitan University and I am now in the research phase of this course which builds upon two years of prior doctoral work. As you are well aware we are currently working in a changing profession and as a nurse educator and sexual health nurse with over thirty years of experience, I have observed many changes in how nurses undertake their role. I am therefore writing to ask for your participation in this study as I am very interested in finding out about your own personal experience as a sexual health nurse during this period of change and what it means for you in relation to your role and identity.

I have enclosed an information sheet which outlines the purpose of this study and why you have been invited to participate. Please do take time to read this information and do not hesitate to contact me or my Director of Studies, Professor Solomon at Manchester Metropolitan University via telephone on (0161) 2475670 or e-mail y.solomon@mmu.ac.uk if you would like further information.

Your participation is very valuable to me and I do hope you decide to take part in this work. I look forward to hearing from you.

Yours sincerely

Debbie Wisby: Senior Lecturer: Sexual and Reproductive Health

School of Public Health and Clinical Sciences/ Brook Building: Room 206

Telephone: (01772) 893887 dawisby@uclan.ac.uk

Appendix Two

Participant Information Sheet

Study title: ‘How do sexual health nurses perceive their role and identity during change?’

You are being invited to take part in a small scale research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear

or if you would like more information and take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

I am currently studying for a Doctorate in Education at Manchester Metropolitan University and I am now in the research phase of this programme which builds upon two years of prior doctoral work. As you are well aware we are working in a changing profession and as a nurse educator and sexual health nurse with over thirty years of experience, I have observed many changes in how nurses undertake their role in an attempt to reduce the rising rates of unplanned pregnancy, sexually transmitted infections and HIV. I am therefore very interested in finding out about your own personal experience as a sexual health nurse during this period of change and what it means for you in relation to your role and identity, as I undertake this study over the next two years.

Why have I been chosen?

You have been asked to act as a potential participant in this study as a qualified nurse with a current registration on the Nursing and Midwifery Council register. You will also have studied and successfully completed one of the following post-registration clinically competency based sexual health programmes at the University of Central Lancashire since implementation of the new curriculum in September 2008. As a sexual health nurse, it is professionals who work at this level of practice that I am particularly interested in for the focus of this study.

MW2715/MW2602

University Advanced Certificate Contraception and Asymptomatic Screening in Sexually Transmitted Infections and HIV (Theory and Practice).

MW3041

University Certificate Asymptomatic Screening in Sexually Transmitted Infections and HIV Contraceptive Practitioners

MW3642/MW4063

University Certificate First Issuing of Hormonal Contraception in Practice

This is a small scale study of which I anticipate around 10 participants. I will be contacting more participants than actually take part and therefore you may not necessarily be selected if willing to partake in this study, as I aim to select a representative cross section of Sexual Health Nurses.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. I aim to interview at least 10 nurses, so your participation is very valuable to me.

What will happen to me if I take part?

If you agree to take part in this study I would ask for just 1 to 1.5 hours of your time so that I may ask you some questions about your experience as a sexual health nurse. This study will **not** involve any access or approach to your organisation via NHS or Non NHS premises. Interviews will be arranged at a mutually convenient place, which for example could be on university premises or at home.

With your permission the interview will be recorded and then I will transcribe it. Please feel free to ask me to stop recording at any time during the interview where you can review or edit the tape if you wish. If you prefer for me not to record the interview then this is not a problem as I can alternatively take notes as we proceed throughout the interview. I will send you a copy of the transcript before I analyse the data so that you can check for accuracy and make any amendments to what has been written. When I have made any amendments requested I will provide you with a final copy of the transcription so that you may keep it.

In addition to this I will be able to provide you with a summary of the research study findings when I have completed the study. If you would like a copy then please complete the relevant section on the consent form, but please be aware that this may be some time after your interview.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential. Any information about you which leaves the University will have your name and address removed so that you cannot be recognised from it. In addition to this any quotations from your interview transcript that may be used in the final write up of this study will not make any reference to your personal identity or organisation and will be completely anonymous. During the research study any tapes or personal details will be kept in a locked filing cabinet in the Research Office at the University of Central Lancashire. These will be kept for five years upon completion of the study and then they will be destroyed.

What will happen to the results of the research study?

Upon completion of this study, I will write the results up in the format of a thesis which forms the final part of my Doctorate in Education. Following on from this it is anticipated that I will aim to publish some of my results in professional journals where once again any quotations from your transcript will remain anonymous so as to ensure no reference is made to your personal identity or organisation.

Who has reviewed the study?

Prior to commencement of this study, all the documentation has been reviewed and approved by the ethics committees at both the University of Central Lancashire where the study is taking place and Manchester Metropolitan University where I am currently registered as a doctoral student. As an academic member of staff, permission has also been granted by my Head of School in the School of Public Health and Clinical Sciences to undertake this study and access university data for the sole purpose of recruiting participants into the study.

As an ex student, what happens if I decide to return to study at the University of Central Lancashire?

Your participation in the study as a previous sexual health student will not affect your eligibility to apply for further study at the university and I do not anticipate any power issues that may reflect upon my role as a nurse educator with sexual health nurses who have participated or expressed an interest in this study. As a participant you can make the decision to withdraw at any time in the study. If you have already undertaken an interview at the point of returning to study, then you have the right to request that this data is excluded from the study.

Contact for Further Information

I would like to thank you for consideration to participate in this study. If you would like any further information, then please do not hesitate to contact myself or my Director of Studies at Manchester Metropolitan University of which the contact details are outlined below.

If you are in agreement to take part in this study, then you will be asked to sign a consent form of which you will be given a copy to keep along with this information sheet.

Thank you once again
Yours sincerely

Debbie Wisby

Debbie Wisby

Contact Details

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Appendix Three

Participant Consent Form

Study Number:

CONSENT FORM

Title of Project: 'How do sexual health nurses perceive their role and identity during change?

Name of Researcher: Debbie Wisby

Please initial box

1. I confirm that I have read and understand the information sheet dated
(version) for the above study. I have had the opportunity to consider the
information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time
without giving any reason.
3. I understand that any quotes used the write up of this study or for use in Journal publications will
not refer to my personal identity.
4. I agree to take part in the above study.
5. I agree to my interview being recorded.
6. I would like to review a copy of my interview transcript to confirm accuracy
7. I would like to receive a summary of the findings at the end of the study

Name of Participant

Date

Signature

Name of Person taking consent
(if different from researcher)

Date

Signature

Researcher

Date

Signature

1 for participant; 1 for researcher;

Appendix Four

Narrative Interviews: Questions and Themes

1. Why did you decide to become a nurse and what attracted you to the profession?
2. What do you think the general public perception is of nurses in society?
3. What does being a 'professional' mean to you?
4. Tell me about your experience as a nurse and why you choose to work in sexual health?
5. As sexual health nurse tell me about your role and the work you do?
6. What skills do you think sexual health nurses need?
7. How might 'users' of sexual health services / other health care professionals and services view nurses?
8. In your experience what are the positive and negative aspects of your work?
9. What changes are taking place in sexual health and has your job changed in anyway?
10. Can you tell me about a recent event in practice that sums up change?
11. Do you feel more empowered or disempowered by change?
12. In your opinion how do you see the role of the sexual health nurse in the future?

Appendix Five

Home University

Faculty of Health and Social Care Ethics Committee Application

Version One

Faculty Ethics Committee (FHEC)

FULL PROPOSAL APPLICATION FORM

This application form is to be completed prior to commencing any research, commercial or other activity for which, on completing the '[Activity checklist](#)', any 'Yes' responses are recorded.

Please complete/delete the sections below, as applicable, e-mail with relevant accompanying documentation to ROffice@uclan.ac.uk.

For further details, please see the [FHEC Guidance notes](#).

1. Background details	
Project title / Thesis Title	'Sexual Health Service Modernisation and Role-Redesign' How do Sexual Health Nurses Construct their professional identity within the context of strategic and organisational change?
Chief UCLan Investigator / Director of Studies / Main Supervisor	Debbie Wisby (UCLAN) Directors of Studies: Manchester Metropolitan University Professor Yvette Solomon / Una Hanley
School	School of Public Health and Clinical Sciences
Chief Investigator and Institution (if led from outside UCLan)	
Student (if applicable)	Debbie Wisby
Student Programme (if applicable)	Doctor of Education: Manchester Metropolitan University
Other UCLan Investigator(s) / Supervisor(s) (if any)	None
Date of application	5/3/2010
Anticipated date of end of project	Summer 2012
2. Type of application	
Full Proposal:	
initial application *	
If this is an initial application , is it:	
a subsequent stage of project previously-approved full proposal?	No *
a re-application following non-approval of an earlier full proposal application?	No *
* Please delete as appropriate	
If this application relates to a project which has previously been reviewed by FHEC (either for an ethics governance check or for full approval), please supply the corresponding FHEC reference number(s) from your decision letter(s):	

3. External approval	Please tick any that apply
Has your project been approved (or given a positive opinion) by: an NHS Research Ethics Committee [§] the Department of Health Patient Information Advisory Group (PIAG) a properly-constituted ethics committee [#] at another UK University a properly-constituted ethics committee [#] of an organisation other than the NHS or a UK University	<input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> ✓ Ethics Application submitted to MMU Awaiting RD1 confirmation by MMU <input type="checkbox"/>
If you have indicated that your project has been approved by one or more of the above, please ensure that you include an electronic copy of the corresponding approval letter, together with related information (e.g. approval of an amendment), amongst the documentation submitted to the Research and Bid Support Office . If you do not have this letter electronically, please scan your letter, using a University photocopier if necessary.	

4. Accompanying documentation	Please tick any that apply
Study proposal (or trial protocol / bid proposal / RDSC2 form / NRES or other external ethics committee application form) (Mandatory)	<input checked="" type="checkbox"/> Research Proposal (Assignment 5: Doc Ed included & summary)
Summary of practical ethical issues (Mandatory , unless included in above document)	<input checked="" type="checkbox"/>
External REC 'approval' / positive opinion letter(s) / PIAG approval letter	<input type="checkbox"/>
Information Sheet(s) ⁺	<input checked="" type="checkbox"/>
Consent Form(s) ⁺	<input checked="" type="checkbox"/>
Covering letter	<input checked="" type="checkbox"/>
Questionnaire(s)	<input type="checkbox"/>
Interview schedule(s) Narrative Themes	<input checked="" type="checkbox"/>
Focus Group agenda(s)	<input type="checkbox"/>
Details of other data collection methods	<input type="checkbox"/>
Summary of changes (amendments / response to conditions only)	<input type="checkbox"/>
Other (please list): Letter of Invite, Associate Head of School Permission To Undertake Study	<input checked="" type="checkbox"/>

[§] Note that **exemption** from NHS ethical review does not constitute **approval**: you should tick 'Yes' the corresponding box *only* if the letter received from NRES includes the words '**positive opinion**'.

[#] A properly-constituted ethics committee must include at least one member independent of the organisation or professional group.

⁺ It is usually necessary to provide both an Information Sheet and Consent Form for every stage of a study including human participants. One exception to this is most types of survey, for which a covering letter with the return of questionnaire is usually an acceptable alternative. Additionally, there will be studies where consent from the participant is difficult or impossible: in such cases, it is important to justify the approach taken to obtain consent – in some cases it may be appropriate to provide an assent form either in addition to or instead of the consent form. Please consult the University's Ethical Principles at

http://www.uclan.ac.uk/information/research/research_degrees/files/Research_ethical_principles_june07.doc
and the [FHEC guidance notes](#) for further details.

Appendix Six

Home University

Faculty of Health and Social Care Ethics Committee

Response: Version Two

25th March 2010

Dear Debbie

Re: Faculty of Health & Social Care Ethics Committee (FHEC)

Application - (Proposal No.415)

Following review of your proposal 'Sexual health service modernisation and role redesign' How do sexual health nurses construct their professional identity within the context of strategic and organisational change?', the FHEC has requested that the attached *conditions* be addressed prior to further consideration of the approval of the project. If *recommendations* are also listed, the FHEC would prefer that they are addressed, but approval would not be withheld should you decide not to address one or more of these recommendations.

In your response to FHEC, please ensure that, in addition to including updated documentation (including a new application form) you complete the attached grid, indicating:

- how you have responded to the conditions
- whether you have adopted any of the recommendations, and, if so, how you have addressed these.

Please do not resubmit documentation which you have *not* amended.

Please number your documentation submitted to address these conditions (and recommendations, if appropriate) as Version (Number) 2 and also highlight any changes made within the document

Yours sincerely

Peter Robinson

Deputy Vice-Chair

Faculty of Health Ethics Committee

Response to FHEC Application - Proposal No 415 (Version No.2)

Condition	Applicant Response
<p>1. In the Participant Information Sheet under the heading “Do I have to take part” the sentence “will not affect your standard of care you receive” needs removing as this is not a patient project.</p>	<p>Participant Information Sheet amended (See version 2 attached).</p>
<p>2. As it is planned that 10 participants are required, yet more (85?) potential participants may be contacted then it is advisable to make this clear on the Participant Information sheet and state that although you agree to take part in the study, you may not be chosen. It will also be worth saying on the Information sheet how such selection will take place.</p>	<p>Participant Information Sheet amended regarding potential participants and the selection process (See version 2 attached).</p>
<p>3. Regarding the holding of the data for 5 years after the analysis – FHEC suspect the data will be held in a research office (presumably at MMU) not that of the researcher per se, and as such the documents should be changed in case any change in the researcher's location to an off-site one may otherwise create consternation in this professional group. Please make it clear that the documents will remain on site.</p>	<p>This study will be undertaken at UCLan within the School of Public Health and Clinical Sciences. Having checked with the Faculty Research Office at UCLan and my supervisor at MMU. The data will be held for 5 years after analysis onsite at UCLan and stored in a locked cabinet within the Faculty Research Office (see version 2 of research proposal attached).</p>
Recommendation	Applicant Response
<p>1. FHEC note that the researcher offers participants the possibility of home interviews and suggest that appropriate consideration should be given to 'lone worker' conditions to ensure no undue risk is taken.</p>	<p>I have considered that I as a lone researcher, I have offered the possibility of home interviews. To ensure that no undue risk is taken I will ensure that strategies are in place to ensure my personal safety and protection is in accordance with the UCLan Lone Working Guidance For All Employees. This will include ensuring that my School Office (and home/family) especially if working out of office</p>

	<p>hours, are aware of my whereabouts, location sheet, and interview times. I will also have the use of my own personal mobile phone and car for travel purposes (see version 2 of research proposal attached).</p>
<p>2. The applicant may wish to consider that from a research point of view the identities of SHN staff result not only from their own perception of their identity, but also from the perceptions of users of the service and more generally society. These too have their narratives to which the narratives of the SHN staff are linked. The study could be strengthened by recognition of these narratives, both of other individuals (users, other health workers), but also of societal 'meta-narratives' about sexual health, pregnancy etc. Policy also contributes to these narratives.</p>	<p>Thank you for your comments regarding the perception of service users. This is a small scale study and whilst it would be useful to include a wider user perspective, I am unable to extend my data collection.</p> <p>I have considered these comments and have decided to incorporate the perception of other voices within the design of the study and the sexual health nurse participant interview. I have therefore revised the narrative themes for discussion and have subsequently included two further questions which focus upon general public and service user perception of nurses in society (see research proposal and narrative themes version 2 attached).</p>

Appendix Seven

Home University

Faculty of Health and Social Care Ethics Committee

Approval Letter

12th May 2010

Dear Debbie

Re: Faculty of Health & Social Care Ethics Committee (FHEC)

Application - (Proposal No.415)

The FHEC has granted approval of your proposal application 'Sexual Health service modernisation and role design. How do sexual health nurses construct their professional identity within the context of strategic and organisational change?' on the basis described in its 'Notes for Applicants'.

We shall e-mail you a copy of the end-of-project report form to complete within a month of the anticipated date of project completion you specified on your application form. This should be completed, within 3 months, to complete the ethics governance procedures or, alternatively, an amended end-of-project date forwarded to Research Office.

Yours sincerely

Peter Robinson

Acting Chair

Faculty of Health Ethics Committee

Appendix Eight

**Student University
Application for Ethical Approval**

Application Number...Debbie Wisby

Date...March 5th 2010

APPLICATION FOR ETHICAL APPROVAL

Introduction

All university activity must be reviewed for ethical approval. In particular, all undergraduate, postgraduate and staff research work, projects and taught programmes must obtain approval from their Faculty Academic Ethics committee (or delegated Departmental Ethics Committee).

APPLICATION PROCEDURE

The form should be completed legibly (preferably typed) and, so far as possible, in a way which would enable a layperson to understand the aims and methods of the research. Every relevant section should be completed. Applicants should also include a copy of any proposed advert, information sheet, consent form and, if relevant, any questionnaire being used. The Principal Investigator should sign the application form. Supporting documents, together with one copy of the full protocol should be sent to the Administrator of the appropriate Faculty Academic Ethics Committee.

Your application will require external ethical approval by an NHS Research Ethics

Committee if your research involves staff, patients or premises of the NHS (see guidance notes)

Work with children and vulnerable adults

You will be required to have a Criminal Disclosure, if your work involves children or vulnerable adults.

The Faculty Academic Ethics Committee meets every--- and will respond as soon as possible, and where appropriate, will operate a process of expedited review. Applications that require approval by an NHS Research Ethics Committee or a Criminal Disclosure will take longer - perhaps 3 months.

1. DETAILS OF APPLICANT

1.1 Principal Investigator:

Debbie Wisby (Part-Time Doctorate of Education Student in Phase B)

BSc (Hons) Sexual & Reproductive Health, MA Health Services Management,
Registered Nurse / Midwife. Registered Nurse Tutor.

Current full-time academic post

Senior Lecturer: Sexual & Reproductive Health

School of Public Health and Clinical Sciences

University of Central Lancashire (UCLan), Preston, Lancs, PR1 2HE.

(01772) 893887 dawisby@uclan.ac.uk

Sexual Health Nurse: 3 hours per week

1.2 Co-Workers and their role in the project: (e.g. students, external collaborators, etc) Manchester Metropolitan University (Institute of Education, Doc Ed Supervisory Team

Director of Studies:

Professor Yvette Solomon
Tel: (0161) 24725670
Email: y.solomon@mmu.ac.uk

Una Hanley
Tel: (0161) 2472293
Email: u.hanley@mmu.ac.uk

For the purpose the study: ex sexual health students from UCLan will be recruited as participants into the study

1.3 University Department/Research Institute/Other Unit:

This research study will be undertaken within the School of Public Health & Clinical Sciences at the University of Central Lancashire (UCLan).

Permission has been granted by the Associate Head of School (**see e-mail forwarded with this application**).

Application for ethical approval has been submitted to the Faculty of Health Ethics Committee at UCLan.

2. DETAILS OF THE PROJECT

2.1 Title:

Thesis Title:

'Sexual Health Service Modernisation and Role-Redesign'

How do Sexual Health Nurses Construct Their Professional Identity Within The Context of Strategic and Organisational Change?

Study title:

'How do sexual health nurses perceive their role and identity during change?'

2.2 Description of Project: (please **outline** the background and the purpose of the research project, 250 words max.).

See attached research proposal which outlines the study in detail.

Describe what type of study this is (e.g. qualitative or quantitative; also indicate how the data will be collected and analysed). Additional sheets may be attached.

Qualitative study using narrative enquiry (**see attached research proposal**)

2.3 Are you going to use a questionnaire? No

Narrative Interviews: an outline of questions / themes have been attached.

2.4 Start Date / Duration of project:

As soon as ethical approval is granted (Spring 2010).

I aim to complete phase B (Thesis) of my Doc Ed within 2 to 3 years of commencement of this study

2.5 Location of where the project and data collection will take place:

School of Public Health and Clinical Sciences, UCLan.

2.6 Nature/Source of funding

None required

2.7 Are there any regulatory requirements?

No

3. DETAILS OF PARTICIPANTS

3.1 How many?

At least 10 Ex Sexual Health Students

3.2 Age: From age 21 up to 65

3.3 Sex: Mix of male and female participants.

3.4 How will they be recruited?

(Attach a copy of any proposed advertisement)

See attached research proposal.

3.5 Status of participants: (e.g. students, public, colleagues, children, hospital patients, prisoners, including young offenders, participants with mental illness or learning difficulties.)

Ex Sexual Health Students that have studied at UCLan since September 2008

3.6 Inclusion and exclusion from the project: (indicate the criteria to be applied). **See attached research proposal.**

3.7 Payment to volunteers: (indicate any sums to be paid to volunteers).
None

3.8 Study information:

Have you provided a study information sheet for the participants? **YES**

See attached invite letter and information sheet for participants.

3.9 Consent:

(A written consent form for the study participants **MUST** be provided in all cases, unless the research is a questionnaire.)

Have you produced a written consent form for the participants to sign for your records? **YES**

Please see attached Consent Form.

4. RISKS AND HAZARDS

Please respond to the following questions if applicable

4.1 Are there any risks to the researcher and/or participants?

(Give details of the procedures and processes to be undertaken, e.g. if the researcher is a lone-worker.)

The researcher is a lone worker and interviews will be completed outside of the NHS organisations in a mutually agreed environment for example on University campus or in the participant's home if preferred.

4.2 State precautions to minimise the risks and possible adverse events:

My university employer will be aware of my location for health and safety reasons if working off campus and in the evening or at weekends

4.3 What discomfort (physical or psychological) danger or interference with normal activities might be suffered by the researcher and/or participant(s)? State precautions which will be taken to minimise them:

Participants will be invited into the study in a voluntary capacity of which they have the right to withdraw at any time. They will invited to participate at a time and location that is mutually agreed by the participant/researcher.

As the researcher, this study will be undertaken within my own time management and diary constraints as a full-time academic member of staff. I am allowed annual study leave as part of my role and I will be applying for a sabbatical once I progress later into the study as time out for the 'write up phase'. I am fully aware of the study commitments and the need to work also in my own time to complete this Doctoral programme.

5. PLEASE DESCRIBE ANY ETHICAL ISSUES RAISED AND HOW YOU INTEND TO ADDRESS THESE:

Please see attached research proposal which discusses any potential issues in detail.

This study will not be using any NHS data or approach/access to any NHS or Non-NHS organisations, therefore on taking advice from my own Research Office at UCLan, I have been informed that NHS Ethical approval is not required as I am using ex students for the purpose of this study.

6. SAFEGUARDS /PROCEDURAL COMPLIANCE

6.1 Confidentiality:

Please see attached research proposal which discusses in depth these points.

- (a) Indicate what steps will be taken to safeguard the confidentiality of participant records. If the data is to be computerised, it will be necessary to ensure compliance with the requirements of the Data Protection Act.
- (b) If you are intending to make any kind of audio or visual recordings of the participants, please answer the following questions:
 - a. How long will the recordings be retained and how will they be stored? **(See proposal)**

- b. How will they be destroyed at the end of the project? (**see proposal**)
- c. What further use, if any, do you intend to make of the recordings? (**see proposal**)

6.2 Human Tissue Act:

The Human Tissue Act came into force in November 2004, and requires appropriate consent for, and regulates the removal, storage and use of all human tissue.

a. Does your project involve taking tissue samples, e.g., blood, urine, ha etc., from human subjects? **N/A**

b. Will this be discarded when the project is terminated? **N/A**

If NO – Explain how the samples will be placed into a tissue bank under the Human Tissue Act regulations:

6.3 Insurance:

The University holds insurance policies that will cover claims for negligence arising from the conduct of the University's normal business, which includes research carried out by staff and by undergraduate and postgraduate students as part of their courses. This does **not** extend to clinical negligence. There are no arrangements to provide indemnity and/or compensation in the event of claims for non-negligent harm.

Will the proposed project result in you undertaking any activity that would not be considered as normal University business? If so, please detail below:

No

6.4 Notification of Adverse Events (e.g., negative reaction, counsellor, etc):

(Indicate precautions taken to avoid adverse reactions.) **N/A**

Please state the processes/procedures in place to respond to possible adverse reactions.

In the case of clinical research, you will need to abide by specific guidance. This may include notification to GP and ethics committee.

Please seek guidance for up to date advice, e.g., see the NRES website at <http://www.nres.npsa.nhs.uk/>

SIGNATURE OF PRINCIPAL INVESTIGATOR

DATE:

Debbie Wisby

March 5th 2010

.....
SIGNATURE OF FACULTY ACADEMIC ETHICS

DATE:

COMMITTEE CHAIRPERSON:
.....

APPENDIX

Checklist of attachments needed:

1. Participant consent form
2. Participant information sheet
3. Full protocol
4. Advertising details
5. Insurance notification forms
6. NHS forms (where appropriate)
7. Other evidence of ethical approval (e.g., another University Ethics Committee approval)

Appendix Nine

National Research Ethics Service Letter



National Research Ethics Service

North West 7 Research Ethics Committee - Greater Manchester Central

3rd Floor
Barlow House
4 Minshull Street
Manchester
M1 3DZ

Telephone: 0161-025-7825
Facsimile: 0161-237-8427

16 April 2010

Ms D A Wisby
Senior Lecturer
Course Leader: Sexual Health
School of Public Health and Clinical Sciences
Brook Building: Room 206
University of Central Lancashire
Preston
Lancs
PR1 2HE

Dear Ms Wisby

Full title of project: **'Sexual Health Service Modernisation and Role Redesign'**
How do Sexual Health Nurses construct their professional identity within the context of strategic and organisational change?

Thank you for seeking the Committee's advice about the above project.

You provided the following documents for consideration:

Email dated 26 March 2010
Research Proposal Summary (Version 2: April 2010)

These documents have been considered by the Chair, Professor S Mitchell.

I enclose a copy of our leaflet, 'Defining Research', which explains how we differentiate research from other activities. Professor Mitchell has advised that the project is not considered to be research according to this guidance. Therefore it does not require ethical review by a NHS Research Ethics Committee.

This letter should not be interpreted as giving a form of ethical approval or any endorsement of the project, but it may be provided to a journal or other body as evidence that ethical approval is not required under NHS research governance arrangements.

However, if you, your sponsor/funder or any NHS organisation feels that the project should be managed as research and/or that ethical review by a NHS REC is essential, please write setting out your reasons and we will be pleased to consider further.

SL24 Project not considered to be research
Version 4.0, April 2009

Where NHS organisations have clarified that a project is not to be managed as research, the Research Governance Framework states that it should not be presented as research within the NHS.

Yours sincerely

K. Osborne

K Osborne (Mrs)
Committee Co-ordinator

E-mail: kath.osborne@northwest.nhs.uk

Enclosure: NRFS leaflet – 'Defining Research'