PATIENT INVOLVEMENT IN THE ASSESSMENT OF PRE-REGISTRATION ADULT NURSING STUDENTS PRACTICE

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Abstract

Background: Patient involvement in practice assessment was first introduced in 1996 but failed to establish itself as a routine part of nurse training. Fourteen years later, in 2010 the UK Nursing and Midwifery Council restated this requirement in response to concerns that university-based nursing education was not producing caring and compassionate nurses. This concern speaks to two enduring discourses around the professionalisation of nursing. First, there is a discourse of nursing as a caring vocation, predicated upon a model of practical, ward-based training. Second, there is a discourse of nursing that regards it as an adjunct medical profession, predicated upon technical-scientific education.

Aim: To critically explore how these discourses influence and affect the contributions, involvement and subject positions associated with patients and their involvement in the summative assessment of pre-registration adult nursing students during hospital placements.

Methods: This study adopted a poststructuralist logics approach that involved analysis of documentary and narrative texts. Six patients, six adult nursing students, six mentors and six nurse lecturers from one UK university and one acute hospital placement provider were interviewed using semi-structured interviews (24 in total). Hajer's ten analytical steps guided data analysis.

Findings: The empirical characterisation of patient involvement as a social logic identified three distinct sets of practices, logics of experientialisation, protectionism and systematisation. These social logics demonstrate the on-going tensions between patient and practitioner appraisals of patient involvement. The analysis of political and fantasmatic logics demonstrates how boundaries between vocation versus

technical-scientific nursing are established and maintained to create a hegemonic normative frame that constitutes patient involvement as a solution to ‘fix’ nursing.

Conclusion: This research demonstrates that involvement of patients in practice assessment remains largely tokenistic, in no small part due to tensions between discourses of vocational and technical-scientific nursing. It is not until these tensions are addressed that patient involvement will be able to fulfil its real potential for patients and for the nursing profession.

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LIST OF ABBREIVATIONS

CCG	Clinical Commissioning Group
CHC	Community Health Council
CHRE	Council for Healthcare Regulatory Excellence
CNS	Clinical Nurse Specialists
CQC	Care Quality Commission
DA	Discourse Analysis
DH	Department of Health
ENB	English National Board for Nursing, Midwifery and Health Visiting
ESCs	Essential Skills Clusters
GNC	General Nursing Council
GP	General Practitioner
HCA	Healthcare Assistant
HCPC	Health and Care Professions Council
HE	Higher Education
HEE	Health Education England
HEEoE	Health Education East of England
HEI	Higher Education Institution
LCE	Logics of Critical Explanation
LETB	Local Education and Training Board
NA	Nursing Associate
NHS	National Health Service
NICE	National Institute for Clinical Excellence
NMC	Nursing and Midwifery Council
OSCE	Objective Structured Clinical Examination
PDT	Poststructuralist Discourse Theory
QAA	Quality Assurance Agency
QC	Queen's Counsel
RCN	Royal College of Nursing
RGN	Registered General Nurse
UCAS	Universities and Colleges Admissions Service
UK	United Kingdom
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting

Chapter 1: Introduction

Introduction

This introductory chapter provides a brief contextual overview of nurse education in the United Kingdom (UK) and patient involvement within pre-registration nursing programmes. The chapter also gives an account of my own research journey that resulted in me adopting Glynos and Howarth's logics approach (2007) to present a critical, discursive explanation of patient involvement in the summative assessment of adult nursing students' practice. Finally, the chapter presents an overview of the structure of thesis.

Situating the researcher

I am a registered general nurse (RGN) and a senior lecturer of adult nursing, whose area of expertise is mentorship and healthcare education. I commenced my nurse training in 1988 at a district hospital in the East of England. At that time, my training followed an apprenticeship format where I was employed as a student nurse with training provided by the hospital's own School of Nursing. My training consisted of blocks made up of two weeks' classroom-based practice preparation, including taught sessions on anatomy and physiology, nursing theory, care and treatment, 10 weeks out on placement and two weeks' classroom-based consolidation. Assessments included written assignments and four mandatory practical assessments (general patient care; aseptic technique [wound care], medicines administration and ward management), finished with an end-point national examination set by the English National Board (ENB), the educational arm of the then regulator, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC). My initial nurse training resulted in a professional rather than an academic qualification, nevertheless I have engaged in academic study gaining a Higher Education Diploma

in District Nursing, a BSc (Hons) degree in Community Nursing and a Masters degree in Interprofessional Healthcare Education.

As a District Nurse and mentor to students I had routinely asked patients for their thoughts on students' performance and attitudes, but this had been mainly informal and at a consultative level of involvement. It was not until I came into academia in 2005 as a senior lecturer in nursing that I became aware that the Nursing and Midwifery Council (NMC) (the professional regulatory body that replaced the UKCC in 2004), required Higher Education Institutions (HEIs) to evidence patient and service user involvement in curriculum development and delivery, but at this point the NMC only required HEIs to evidence service user and carer involvement in assessment, which tended to be at an HEI-based curriculum development level rather than formal involvement of patients during practice placements.

The impetus for this study came from my personal experience of being asked whether I minded having a fifth-year medical student observe a hospital consultation and possibly complete a physical examination. I had not appreciated how difficult I would find it, on the one hand as a patient, I felt embarrassed and awkward, but as a lecturer I felt it would have been hypocritical to refuse. I became conscious of how much the situation and environment disempowered me, the fact that my General Practitioner (GP) had felt I needed to be seen by a medical consultant had made me adopt an acquiescent position in deference to the assumed expertise of the consultant. Consequently, I became interested in how patients are positioned within institutional hierarchies, how the environment, actors' subject positions and identities might influence patient involvement in shared decision-making.

In January 2010, the NMC launched a UK-wide consultation on new pre-registration nursing education standards, followed by a series of roadshows held

across the UK. I attended a roadshow in Luton, where Garth Long, NMC education advisor, led a lively discussion with assembled NHS provider organisations' Directors of Nursing, nurse academics, lecturers from HEIs and nursing students on the NMC's requirement for patients to be formally involved in the assessment of students' practice during placements. The NMC cited events such as Mid Staffordshire as a reason for educational reform (NMC, 2010a; 2013; 2015, 2016) and it was as a result of this debate that I began to question my own assumptions of patient involvement in nurse education and, in particular, practice assessment. Media reported distressing accounts of patient neglect at Mid Staffordshire NHS Foundation Trust, where relatives, patient groups and politicians began to question nurses' ability and motivations to care. What followed was the re-emergence of the debate as to whether nursing should be a practically trained vocation or an academically educated profession, reflective of comparable deliberations that followed the announcement that pre-registration programmes were moving from diploma and degree (Delingpole, 2009; Fleming, 2009; Fletcher, 2009; Johnson, 2009; Beer, 2013). I was reminded of similar episodes from the late 1980s when nurse education transferred from hospital Schools of Nursing into Higher Education (Orr, 1990; Jowett, 1994; Hamill, 1995; Meerabau, 2001), where media headlines drew on a discourse of vocation to constitute HEI educated nurses as 'too posh to wash' (BBC, 2004a, 2004b; Carvel, 2004) and 'too clever to care' (Gill, 2004; Templeton, 2004). These contestations of HEI-based nurse education and technical-scientific nurses make the contingency of the nurse identity visible, but it also illustrated that the social construction of nursing as a group identity involves a recurring cycle of dispute, resistance, and sedimentation.

Offering a new perspective

While previous studies illustrate the benefits and challenges of involving patients in the practice assessment of pre-registration health and social work students, these have been predominantly qualitative and based on the experiences and perceptions of key actors (Morgan and Sanggaran, 1997; Frisby, 2001; Kemp, 2001; Bradshaw, 2003; Bailey, 2005; Speers, 2008; Davies and Lunn, 2009; Jha *et al.,* 2009; Masters and Forest, 2010; Stickley *et al.,* 2010; Dearnley *et al.,* 2011; Debyser *et al.,* 2011; Stickley *et al.,* 2011; Speed *et al.,* 2012; Speers, 2012; O'Donnell and Gormley, 2013; Naylor *et al.,* 2015; Speers and Lathlean, 2015; Anka and Taylor, 2016; Haycock-Stuart *et al.,* 2014; 2016). Nonetheless, there appears to be a paucity of research relating specifically to patient involvement in the assessment of adult nursing students' practice during hospital placements (Duygulu and Abaan, 2013; McMahon-Parkes *et al.,* 2016).

In this study, I wanted to look beyond participants' perceptions and explore how the patient and nurse identities were constructed by the different actors involved in the practice assessment process. I was interested in discovering how these identities are discursively constituted, the commonalities and variabilities between different actors' constructions of those identities, and how the contestation surrounding the professionalisation of nursing might impact on actors' subject positioning and power relations within the practice assessment process. This thesis adopts Glynos and Howarth's logics of critical explanation (2007), an evolution of Laclau and Mouffe's political discourse theory (1985), to offer a critical explanation of patient involvement in the practice assessment of pre-registration adult nursing students undertaking placements within one UK district general hospital. This approach not only enables me to provide a characterisation of patient involvement as

a social practice within a regime of nursing, it also allows me to look at the politics behind this initiative and consider how actors have engaged with a fantasy of the practical-caring vocational nurse to resist and contest the professionalisation and academicisation of nursing.

Background

Pre-registration nurse education in the UK is provided by HEIs, as either undergraduate or post-graduate degree programmes. The professional regulatory body, the NMC, approves all HEI programmes, prescribing a comprehensive set of educational standards, including standards of proficiency that students must achieve by the end of the programme in order to join the nursing register (NMC, 2010b; 2016; 2018). All pre-registration nursing programmes are delivered in partnership with healthcare providers, with courses divided equally between theory and practice (2,300 hours to be spent on each), with students completing practice placements in a number of different settings including hospital, community, primary care, private, independent and voluntary sectors.

Care and compassion have been constituted as fundamental affective attributes of a nurse, traits that are closely associated with a socially constructed image of nursing as a primarily vocation-based occupation. The meanings of these two constructs are often closely associated when related to healthcare. Compassion is constituted as an emotion or emotional response to others' suffering, while the meaning of care in this context, is associated with the resultant actions that compassion to others can motivate (Ekman, 2014; Jones and Pattison, 2016). Within healthcare, care and compassion are sometimes presented as a single concept that tends to be discursively associated with nursing, with nursing constituted as the 'caring' profession. Yet care and compassion are not unique characteristics of nurses,

indeed care and compassion are both constituted as essential affective attributes for all health professionals (Francis, 2010, 2013; NHS Constitution, 2015; HEE, 2016a – see Chapter 3 for a more detailed exploration). From the introduction of hospital-based, vocational apprenticeship nurse training in the mid-1800s, professional registration in 1919, the move to Higher Education pre-registration diploma programmes in the late 1980s (known as Project 2000), to nursing's transition to an all graduate-level entry profession from 2013, nursing has continued to struggle in its attempts to reconstitute the nurse as an academically-educated, technical-scientific health professional (Traynor, 2013). These evolutions could all be considered as defining moments in the professionalisation of nursing, but they also represent moments where the profession's attempts to reconstruct nursing as a technical-scientific profession have resulted in a recurring pattern of resistance, contestation and sedimentation.

This thesis offers a critical explanation of patient involvement in practice assessment, but to do so also requires an analysis of social actors' discursive constitutions of the 'nurse' as different social constructions and sedimented norms may affect patient involvement in practice assessment. Hallam (2002: 35) argues that the public image of nursing can act as a 'barometer' of professional status, but despite nursing's professionalisation attempts, the public continues to constitute nursing as a vocational, female-gendered and low status occupation (Takase, *et al.,* 2006). One challenge is that nursing care is often difficult to define, indeed, Latimer (2014: 543) describes care as the 'mysterious quality of nurses' work' that might help to explain the contingency of the nurse identity and why different social actors engage in a vocation-profession debate. However, policy makers have also participated in 'politicised language games' to demand attitudinal change (Bell, *et al.,* 2015: 14) that

has placed greater emphasis on the assessment of nursing students' vocational behaviours and affective competence, rather than students' technical, cognitive or professional competence.

While nursing has endeavoured to raise its professional profile and hierarchical position, defining moments have also been triggered by external events, such as Mid Staffordshire NHS Foundation Trust. Mid Staffordshire hospital hit the headlines in 2009 because of higher than expected patient mortality rates. Initially, this was attributed to management failings and chronic understaffing (Healthcare Commission, 2009; Francis, 2010), however the Healthcare Commission, and subsequent independent and public inquiry reports (Francis, 2010; 2013) expressed concern over the standard of nursing care. Consequently, the tension between the construction of nursing as a practical-caring vocation or technical-scientific profession re-emerged with politicians and patient groups such as Patient Association and Cure the NHS employing a discourse of vocation to contest the professionalisation and academicisation of nursing. In response, the NMC published new pre-registration nursing education standards (NMC, 2010b) that required nurse mentors (nurses who have received additional training to support nursing students in practice) to actively involve patients in their summative assessment of students' competence and fitness to practice.

Patient and service user involvement in nurse education has increased over recent years with the NMC requiring HEIs to include patients and service users throughout course development and validation (NMC, 2011; NMC/Mott McDonald, 2013). Patients have been increasingly involved in course planning, teaching and assessment, however their formal involvement in student assessments has often been based in the HEI, for example Objective Structured Clinical Examinations (OSCEs)

that involve either standardised or simulated patients where healthy individuals role play a particular lecturer-defined patient type or scenario (Cooper and Mira, 1998; Shawler, 2008, Jha *et al.,* 2009; Morgan and Jones, 2009). The criticism of this approach is that these assessments remain situated outside of 'real life' and as such lack the authenticity of providing patient care within a bustling practice setting. Whereas, involving real patients during their hospital admission can provide pre-registration students with insight into individuals' care experience and the patients' interactions with the multi-disciplinary team. Not only does this offer the opportunity for students to reflect on their professional development, it also provides mentors with invaluable feedback on students' attitude, confidence, compassion and professional values. Hence, by making concerted efforts to involve patients in practice assessment, students can gain a 360˚ review of their practice, which elicits important supplementary feedback on the aspects of care that patients' value and expect in today's health professional workforce (Wilkinson and Fountaine, 2002).

Patient involvement centres on the concept of experiential expertise or lay knowledge that situates patients as experts through experience rather than experts through formal qualifications, education and training (Williams and Calnan, 1996). Such expertise draws on the knowledge patients gain from managing their own health as well as their lived experiences of hospital care and personal interactions with health professionals including nursing students (Hartzler and Pratt, 2011). In terms of nurse education, patients' experiential expertise is seen as a vital part of pre-registration students' professional socialisation through which students learn the cultures, values, roles and responsibilities associated with professional practice, facilitating a refinement of their conceptualisation of self and the construction of professional identity (Cohen, 1981:14; Felstead and Springett, 2016). Research

exploring the impact of patient involvement on students has predominantly focused on their involvement in the academic setting, nevertheless this has been associated with students' having 'light bulb moments' that subsequently increases levels of self-awareness (Hughes, 2017:9), the ability to critically reflect on practice (Happell and Roper, 2003; Chambers and Hickey, 2012; Scammell *et al.,* 2016), increases students' sensitivity to patient need (Morgan and Jones, 2009; Towle *et al.,* 2009) and helps students contextualise theory into practice (Rees *et al.,* 2007; Jha *et al.,* 2009; Chambers and Hickey, 2012).

While patients' experiential knowledge is viewed as a distinct benefit in terms of teaching and learning, in regard to practice assessment the credibility and authority of patients' experiential expertise has been questioned. Henriksen and Ringsted (2014) found a clear distinction in power relations based on the value students attached to professional and experiential knowledge. In the HEI, patients often identified themselves as experiential educators, however in practice, due to the nature of their individual circumstances and the hospital environment, individuals tended to adopt an acquiescent patient identity. Interestingly, the construct of the nursing student identity also changed, moving away from a student- learner identity, which they adopted in the HEI setting, to a student-nurse identity when out on placement in the healthcare setting. Although students recognised patients' expertise in relation to their own health condition, health professionals and pre-registration students were assumed to possess 'correct objective knowledge that is superior to patients' subjective and experiential knowledge' (Henriksen and Ringsted, 2014:13). Other studies have reported mentors' and students' concerns that patients lacked the necessary professional, clinical and academic knowledge to be able to make meaningful contributions to the summative assessment of students' practice (Felton

and Stickley, 2004a; Chambers and Hickey, 2012). While Anka and Taylor (2016) contend that even though the drive for patient involvement in practice assessment has afforded patients a voice, mentors and academics remain in control of the final summative decision.

Within the acute hospital context, studies indicate that many institutional practices remain profession-centred despite health policy promising a consumer-led NHS (Klein, 2013; Tritter and Koivusalo, 2013). Similarly, although nurses may acknowledge the importance of patient involvement in principle, in practice there are times, especially when patients are unwell, that patients allow health professions to take control (Spence Laschinger *et al.,* 2010; Griscti *et al.,* 2017). According to Chiovitti (2011), nurses can subsequently find it difficult to relinquish control due to their professional accountability and ethical responsibility to protect patients from harm. Patients in hospital can also be subject to what Foucault (1977) describes as disciplinary power or the 'clinical gaze', where the subjectivity and agency of patients is lost through professionals' on-going surveillance of the patient's medical condition. The same could be said of nursing students during practice placements where students remain under the 'assessment gaze' of their mentor. Patient involvement in the summative assessment of nursing students could be seen as adding an additional layer of surveillance that could result in students feeling under constant scrutiny from mentors, patients, their families and carers.

Some of the reason for this disjuncture might be explained by the complexity of involving patients. Several ethical dilemmas have been attributed to patient involvement, in particular the difficulties of asking patients for feedback on individual students' competence and performance while the patient remains reliant on the student and mentor for care. Some patients fear that giving poor feedback could

negatively affect the care they receive, whilst others may give students positive feedback due to feeling vulnerable and powerlessness (Twinn, 1995; Crisp *et al.,* 2006; Speers, 2008; Stickley *et al.,* 2010). In contrast, Haycock-Stuart *et al.,* (2014) found the patients' position changed from being a recipient of care to an assessor, a position that was contested by students who queried the suitability, vulnerability and capability of patients to be able to provide a fair, reliable and objective assessment. Students were concerned that patients could use the assessment as a mechanism to criticise care rather than providing constructive feedback on their performance. Students also expressed anxiety that patients may be unwilling to criticise due to fear of repercussions or that mentors' selection of patients would be too heavily biased towards the student, effectively reducing the assessment to a tick box exercise. Stickley *et al.* (2010) advocate that patients would be best involved in the formative 'review' of student performance rather than the summative assessment of competence, a recommendation also made by Haycock-Stuart *et al.* (2016). This recommendation appears to be drawn from students' and mentors' concerns that critical patient feedback is often overridden by students and mentors, who use the patient's condition to negate patient assessments. In addition, Stickley *et al.* (2010) highlight participants' concerns that critical feedback could have a detrimental effect on student confidence, but they also found a significant power imbalance between the patient, student and mentor during the practice assessment process.

Outline of the thesis structure

To illustrate how my thesis is structured I provide an outline of the remaining chapters.

Chapter Two defends the adoption of Glynos and Howarth's poststructuralist logics of critical explanation as an appropriate research method to critically explain the emergence of patient involvement in practice assessment. This chapter discusses the development of a documentary archive, the collection of empirical data, participant selection and recruitment, ethical principles and a detailed account of the analytical processes adopted.

Chapter Three shows how different actors have problematised nursing and technical-scientific nurse education that has contributed to the emergence of patient involvement in practice assessment. This chapter examines the political processes by which the vocation-profession dichotomy has emerged and how technical-scientific nurse education has been questioned, resisted and constituted as a problem.

Chapter Four explores the historical and contemporary constructions of the patient identity and illustrates how the patient identity and subject positions have been constructed and reconstructed across UK health policy, professional regulatory body education standards and HEI policy. The chapter considers the differences between the concepts of patient, public and service user involvement and presents an archaeological and genealogical review of four constructions of the patient identity since the creation of the National Health Service.

Chapter Five presents an articulation of two dominant social logics – logics of experientialisation and protectionism, and a counter-logic of systematisation that emerged from participant interview data and characterised patient involvement in practice assessment at one particular moment in time. The chapter provides a detailed account of each logic with extracts from the empirical data to illustrate the on-going struggles and tensions between nursing as a practical-caring vocation and nursing as a technical-scientific profession.

Chapter Six considers the political and fantasmatic logics that characterise the emergence and resistance against patient involvement in practice assessment. It shows how different groups of actors formed equivalential chains to link individual demands into a universal demand for educational reform. The chapter sets out how actors drew from political and fantasmatic logics to create an antagonistic frontier that cast technical-scientific nursing and nurse education as a threat to compassionate patient care. The exploration of actors' storylines and the formation of discourse coalitions illustrates how different groups of actors have attempted to articulate a hegemonic normative frame that constitutes HEI-based, technical-scientific nurse education as a problem and patient involvement in practice assessment as a solution.

Chapter Seven examines whether the true/true hegemonic normative frame represents the particularities of study participants and whether the introduction of patient involvement in practice assessment provides them with a sense of totality. This chapter focuses on the analysis of the degree to which participants accept or deny the hegemonic normative frame and suggests significant positional drift as participants considered the different contexts of patient involvement.

Chapter Eight concludes the thesis by drawing together three key findings, lack of resolution in the vocation-profession split, situational context and boundary protectionism risking tokenistic involvement. Consideration is given to the employment of a logics approach within nursing research, along with reflections on the potential limitations of the study, the implications for nursing and nurse education and identifies area for further research.

PART ONE: DISCOURSE THEORY AND METHODOLOGY

Chapter 2: Researching patient involvement in nurse education - Logics of Critical Explanation

Introduction

This study is situated within the poststructuralist paradigm and utilises Glynos and Howarth's (2007) discourse theory approach, Logics of Critical Explanation (LCE). The chapter starts by exploring the ontology and ontological framework that underpin LCE, before moving on to consider the five interconnected phases of the logics approach: problematisation, retroductive explanation, logics, articulation and critique. This discussion will include a justification for the incorporation of Hajer's concepts of discursive storylines, discourse coalitions and socio-political resonance that I have used to support the analysis of political logics within this thesis. A presentation of the research method and design, the development of the documentary archive, collection of empirical data, participant selection recruitment and interviews, ethical principles, as well as a detailed discussion of my analytical approach follow this. The chapter concludes by considering strategies to enhance the quality and rigour of this study.

When deciding on an appropriate methodology, it is important that it centres upon the research aims and objectives rather than a preference for any particular approach. The aim of this study was to critically explore the contributions, involvement and subject positions associated with patients and their involvement in the summative assessment of pre-registration adult nursing students during hospital placements. The research objectives were to:

- Identify how patients are positioned within regulatory standards, educational and government policy
- Critically explore the contributions and subject positions as identified by patients

- Examine the similarities and differences between the contributions and subject positions identified by patients, nursing students, nurse mentors and nurse lecturers

- Explore the patterns of power relations within and across the various discourses and identified contributors

- Consider how the identified contributions and subject positions influences the practice assessment process[i]

At the start of my PhD journey I spent a significant amount of time considering the appropriateness of a number of methodologies including grounded theory, case study, narrative inquiry as well as discourse analysis. I also reviewed the research literature to investigate the research paradigms other researchers had employed in their exploration of service user and patient involvement in nurse education and practice assessment, the majority of which had adopted a qualitative approach focusing on the perceptions, perspectives or experiences of service users, patients, students, mentors and lecturers (for example Cooper and Mira, 1998; Bradshaw, 2003; Felton and Stickley, 2004a; Rees *et al.*, 2007; Speers, 2008; Davies and Lunn, 2009; Jha *et al.*, 2009; Stickley *et al.*, 2010; Debyser *et al.*, 2011; Dearnley *et al.*, 2011; Speers, 2012; Duygulu and Abaan, 2013; Haycock-Stuart *et al.*, 2014; Pal *et al.*, 2014; Naylor *et al.*, 2015; Speers and Lathlean, 2015; Haycock-Stuart *et al.*, 2016; McMahon-Parkes *et al.*, 2016).

Although I was interested in how patients contributed to the practice assessment process, my interest was sparked by the NMC's introduction of the 2010 *Standards for Pre-registration Nursing Education,* and their following guidance document (NMC, 2011). This had emphasised the requirement for HEIs to demonstrate how service users and carers were actively involved, not only in curriculum design, delivery and assessment within the classroom, but made clear that the NMC expected service users to be explicitly involved in the practice assessment

of students during practice placements. I therefore wanted to find a methodology that would enable me to not only consider how patients contributed to practice assessment, but one that would also allow me to explore the power relations and subject positions of those involved in that assessment.

Two discourse analysis approaches, Fairclough's critical discourse analysis (1995) and Foucauldian discourse analysis were considered but discounted. Critical discourse analysis is influenced by 'critical linguistics' (Smith, 2007) and I felt that a linguistic approach would focus too heavily on the linguistic features within the text, rather than enabling me to explore participants' subject positions. In contrast, a poststructuralist approach using Foucauldian genealogical discourse analysis (Foucault, 1972) could produce a social critique of patient involvement to reveal the ways in which power relations and subject positions between patients, health professionals and the government had shifted over time. However, this approach would only allow me to provide an explanation of social change (Crowe, 2005), rather than an explanation of the politics underlying patient involvement and the ways in which patient involvement is characterised in practice today. In order to critically explore the contributions and interactions associated with patients and their involvement in the summative assessment of nursing students during practice placements, I needed to adopt a methodology that would enable me to not only examine how patient involvement is characterised as a social practice; but one that would also illuminate actor identities, subject positions and power relations within that process. Glynos and Howarth's Logics of Critical Explanation (2007) is primarily used as a discursive approach within political science, and facilitates the exploration of three main logics; the social, political and fantasmatic. The attraction of LCE (as a form of poststructuralist discourse theory) is that this approach would

not only enable me to illustrate how the practice of patient involvement was characterised as a social practice, it would also allow me to investigate how and why patient involvement has been rearticulated as an essential component in the practice assessment of nursing students.

Ontology

This particular approach to discourse analysis sits within a poststructuralist paradigm, which assumes that our knowledge of self, others and the world around us is constructed through discourse depending on the social, cultural and historical context we live in. Poststructuralist theories have developed from the 1960s in the writings of Derrida, Lacan, Foucault, Deleuze, Laclau and Mouffe amongst others, generating much debate and discussion in regards to poststructuralists' position on ontology (Howarth, 2013). Ontology is defined as 'the science or study of being' and relates to the nature of reality, whilst epistemology refers to the study and nature of knowledge (Blaikie, 2010). Howarth (2013) suggests that such definitions promote an essentialist or positivist view of social sciences, arguing that ontology is not necessarily compatible with political discourse theory. Therefore, the ontology of poststructuralist discourse theory (PDT) is described as 'anti-essentialist' with an 'anti-foundationalist' epistemology (Torfing, 2005:13). Unlike positivism, the ontology of poststructuralism is not focused on capturing the objective truth of a fixed social reality, rather it centres on the belief that reality remains situated and partially fixed, therefore it is only ever possible to interpret reality as it is constructed through discourse (Taylor, 2001). Laclau and Mouffe (1985:108) provide a useful clarification:

> 'The fact that every object is constituted as an object of discourse has *nothing to do* with whether there is a world external to thought, or with the realism/idealism opposition. An earthquake or the falling of a brick is an event that certainly

> exists, in the sense that it occurs here and now, independently of my will. But whether their specificity as objects is constructed in terms of 'natural phenomena' or 'expressions of the wrath of God' depends upon the structuring of a discursive field. What is denied is not that such objects exist externally to thought, but the rather different assertion that they could constitute themselves as objects outside any discursive condition of emergence.'

Therefore, discourse analysis allows for the exploration of actors' perceptions of reality as a social construct, by examining how those perceptions of truth are made possible through the interlinking relationships between linguistic signs (Radford and Radford, 2005). At this point it is important to illustrate the distinction between discourse analysis and discourse theory. Although there are similarities, according to Howarth (2005:336) discourse analysis is primarily an ontical inquiry that examines the ways in which practices and identities are represented and constituted through discourse. In contrast, discourse theory operates at an ontological level:

> 'where the concept of discourse specifies the necessary presuppositions of *any* inquiry into the nature of objects and social relations …. [it] specifies the interweaving of words and actions into practices, the contingency of all identity, the primacy of politics, and so forth' (Howarth, 2005:336)

PDT builds upon Saussure's structuralist theory of language that posits reality is a social construct where meaning is not generated from the ways in which linguistic signs are associated with a particular object but is derived from its relationship with and differences from other signs. Saussure (1959: 114) presents language (*la langue*) as a 'system of interdependent terms in which the value of each term results solely from the simultaneous presence of the others', which has been equated to that of knots in a fishing net. The meaning attributed to each knot can only exist because of the other knots surrounding it (Jørgensen and Phillips, 2002), with knots or *signs* forming an arbitrary bond between a concept (signified) with a sound-image (signifier) as illustrated in Figure 1.

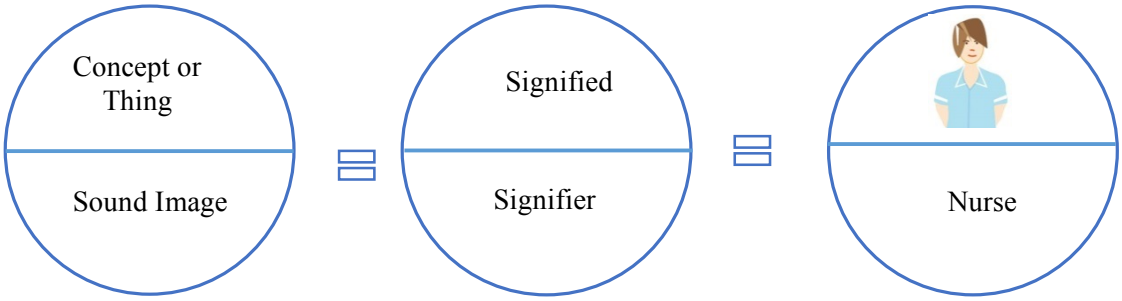


Figure 1 The formation of a linguistic sign

Thus, a picture of a woman wearing a uniform might signify the idea of a nurse, however the question comes to be one of how have these particular objects or practices come to signify a nurse?

The fishing net analogy suggests that meaning is fixed within the structure, however poststructuralists, such as Derrida, Laclau and Mouffe argue that the structure of language can never be fixed as social and institutional structures remain vulnerable to dislocations and political interventions, therefore they remain contingent and can only ever gain partial closure. Hence, poststructuralist theory centres on impossibility and negation, where the signifying structure remains lacking. As Gibson-Graham notes:

> '… language does not exist as a system of differences among a fixed set of signs. Rather the signifier-signified relationship that generates meaning is continually being created and revised as words are recontextualised in the endless production of texts. The creation of meanings is an unfinished process, a site of political struggle where alternative meanings are generated and only temporarily fixed. Political struggles destabilise the fixities of meaning associated with a particular order' (Gibson-Graham, 2000:96)

Unlike other social constructionist epistemologies, poststructuralists consider that differences in power relations can also affect and influence the ways in which actors discursively construct the world around them. Howarth and Stravarkakis (2000:4) suggest discourse is inherently political, in that:

> 'discourses are concrete systems of social relations and practices that are intrinsically political, as their formation is an act of radical institution, which involves the construction of antagonisms and the drawing up of political frontiers …. they always involve the exercise of power, as their construction involves the exclusion of certain possibilities and the consequent structuring of the relations between different social agents' (Howarth and Stavrakakis, 2000:4).

My interest, in terms of patients' contributions to the practice assessment process was not only in how patient involvement is discursively constituted within policy and practice, but I also wanted to explore the power relations between patients, health professionals, nursing students and nurse lecturers within the hospital and educational settings, how power was exercised and participants' subject positioning within practice assessment. Therefore, LCE facilitates the deconstruction of taken for granted assumptions of regimes or practices within nursing, care and nurse education. In doing so it then becomes possible to provide not only a critical explanation of patients' contributions to the practice assessment process, but also how and why various dislocatory events have led to different groups of actors questioning the standards of nursing care, nursing students' professional behaviours and HEI-based nurse education.

LCE Ontological Framework

PDT's ontological position is based on five key points: 1) meaning is acquired within and through discourse, 2) identity depends on discursive construction, 3) meaning is discursively constructed and contested, 4) meaning is not essential or a given, 5) meaning can be constructed in different ways so can never be fixed (Howarth, 2013). Figure 2 represents Glynos and Howarth's underpinning ontological framework for LCE, where the social space is divided into four distinct dimensions, across two axes: the political-social and the ideological-ethical (Figure 2).

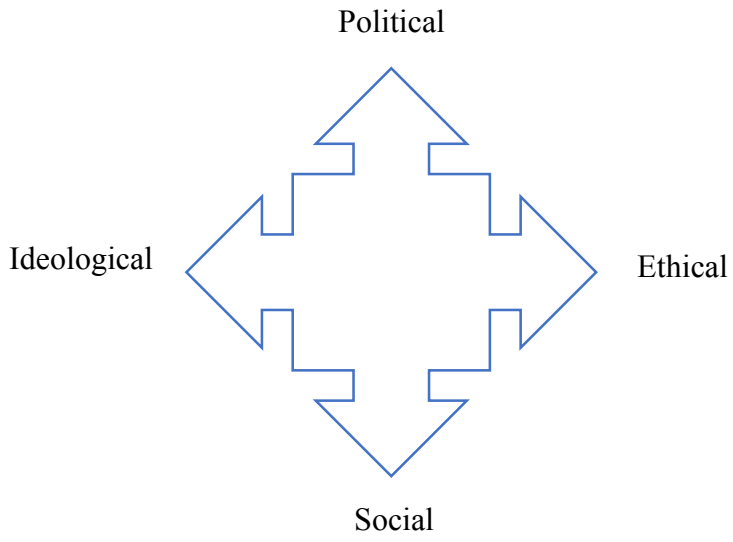


Figure 2: Four dimensions of social reality (Glynos and Howarth, 2007:112)

The political dimension is not restricted to politics at a government or state level, but encompasses the wider political activities that provide order to society. The political foregrounds radical contingency as it illuminates the struggle to persuade or force others to accept the hegemony of a particular storyline (discourse) in order for it to become naturalised and ultimately accepted as the norm. As a result, the researcher is able to illustrate when, how and why regimes or practices are challenged and the on-going hegemonic struggles that may ensue. This allows me to study how involvement discourses are contested, as well as setting out how and why different groups of actors attempt to get others to accept one particular narrative. The social dimension denotes the situations where subjects remain unaffected by radical contingency. They remain so immersed in sedimented social practices or institutions they do not challenge the rules that govern those practices (Howarth, 2008), for example this could refer to the practice of involving patients in practice-based education and assessment.

The ideological-ethical axis is associated with the logic of fantasy and subjects' mode of enjoyment (Glynos and Howarth, 2007:119). The ideological dimension is attributed to the way in which subjects are either unaware of the radical contingency revealed during dislocation; or they actively engage with a certain discourse or practice as they attempt to cover up and conceal that contingency. The contingency of social relations is subsequently dismissed through the recognition and misrecognition of the undecidibility of those relations, which enables subjects to present a picture of normality before the effects of dislocation can be felt (Glynos, 2008; Howarth, 2008). In relation to patient involvement in practice assessment this would relate to the way that actors struggle with the competing fantasies of practical-caring, vocational nursing versus technical-scientific, professional nursing. Finally, subjects can also respond ethically. The ethical dimension refers to the ways in which subjects remain attentive to the radical contingency of social relations, but still struggle to resist the tendency to fantasise (Glynos, 2008: 291). Dislocation, social antagonism and public contestation are inherent to building our understanding of how practices are situated across these four dimensions.

Dislocation is situated within the political dimension and effectively exposes the radical contingency of a discursive structure and the identities and objects within it. Dislocatory events represent moments of crisis either where tensions have arisen, where there has been a significant situational change or when something has gone wrong. Howarth (2000) describes this as both a 'traumatic' and 'productive' process, 'the moment when the subject's mode of being is experienced as disrupted' (Glynos and Howarth, 2007:110). Changing social situations or practices can become dislocatory events, such as public NHS scandals, as they reveal an impossibility or lack within nursing and nurse education practice. Consequently, nurses, patients and

the public have felt threatened, as the contingency of the nurse and patient identities is made visible. Debates surrounding events at Mid Staffordshire NHS Foundation Trust and concerns over the increasing academicisation of nursing have 'decentred' the structure through which our understanding of nursing, patient care and the nurse-patient relationship is constructed. These dislocatory events have revealed the lack within identities that has resulted in subjects (nursing students, nurses, patients, nurse academics) undergoing a form of 'identity crisis'. Consequently, the government and the NMC have felt compelled to act, whilst nurses, patients and the public began to identify with certain political projects in order to restore structural stability.

Systems of social practices and social relations are intrinsically political as their formation involves the construction of antagonisms and the drawing up of political frontiers and boundaries between 'insiders' and 'outsiders' (Glynos and Howarth, 2007; West, 2011). Following dislocatory events, subjects often articulate a number of grievances to those in authority in an attempt to restore structural order. If these requests are ignored or are acted upon inadequately, grievances can become demands that subsequently become political when they 'publicly contest the norms of a particular practice or system of practices in the name of a principle or ideal' (Glynos and Howarth, 2007: 115). Glynos and Howarth identify two types of political demands; the first - a radical demand arises when a practice or regime's fundamental norms are publicly contested; for example, nurse leaders' demands for nurse education to move into higher education challenged the fundamental rules of nurse education in the 1980s. The second – a hegemonic demand that represents a generalised or universal interest of a collective rather than the particular interests of individual actors or groups of actors (2007:116). For example, the demand for HEIs to assess prospective nursing students' abilities and motivations to care at recruitment

was a hegemonic demand as it represented the collective interests of patient groups, service users, and the public rather than the interests of the profession or nurse academics. While dislocation is associated with the political-social axis (Figure 2), public contestation, another element of the political process, is associated with the ideological-ethical axis. As well as contesting the norms of an existing practice or regime, an exploration of how those norms are contested can illustrate how and why antagonisms are publicly articulated to expose the ways in which actors attempt to symbolise the political.

A Logics approach

Glynos and Howarth's Logics of Critical Explanation (2007) builds predominantly on Laclau and Mouffe's ideas of hegemony and radical contingency. Hegemony is described as one form of politics that explains the way in which political actors gain consent for a particular project or social order and gain power in order to establish a practice as 'common sense'. Thus, hegemony involves power and the power relations between different groups of actors in order for one group 'to establish authoritative definitions of social situations and social needs, the power to define the universe of legitimate disagreement, and the power to shape the political agenda' (Fraser and Bartky, 1992: 179). Radical contingency, the other key concept of PDT, relates to the impossibility of objects and identities to attain constitutive fullness (Laclau and Mouffe, 1985). The impossibility of a fixed totality means that the possibility of new or alternative representations is ever present; effectively there is always an 'outside' where surplus elements can provide numerous opportunities for the construction of new meaning.

Within PDT, discourses are considered historically constructed and contingent as discourses always remain vulnerable to political forces that have been previously excluded as well as the effects of dislocatory events. Glynos and Howarth (2007) posit that LCE offers an approach that enables researchers to examine the relationship between social structures and political agency, as well as the role of interests and identities in explaining social actions, the characterisation of social change and the interconnections between meaning and social practices. The logics approach, founded on a social ontology, attempts to encapsulate the four dimensions of social reality (the social, political, ideological and ethical). It is therefore an interpretative method of social inquiry that centres on understanding and explaining the emergence and logic of discourses and the socially constructed identities discourses granted to social actors (Glynos and Howarth, 2007).

Glynos and Howarth base their conceptualisation of logics on Wittgenstein's idea of the 'language game' where meaning of elements or discourses are set by the informal rules that effectively governs the ways in which we use language, actions, things and subjects to interpret the world around us. They associate this idea with 'the grammars of logic' that represents a 'set of family resemblances' that helps to illustrate how these games and the rules that govern them are played out (Glynos and Howarth, 2007:134). The aim of LCE then is to reveal the 'essence' of a regime or practice in order to illustrate 'what makes it tick' as well as explore the other ways in which social actors may constitute the same phenomena. They caution that the logics approach should not be used to determine a definitive 'truth' or the veracity of actors' truth-claims, rather '*the logic of a practice comprises the rules or grammar of the practice,* as well as *the conditions which make the practice both possible and vulnerable'* (p136 – original italics). LCE therefore enables the researcher to

consider the conditions under which the institution of a practice or regime of practices was made possible; the political struggles that preceded its institution and the processes that ensured that a practice or regime of practices were maintained or its hegemonic status questioned. The Logics approach encompasses five key steps: 1) Problematisation; 2) Retroduction; 3) Logics; 4) Articulation; 5) Critique. That is not a step-by-step methodology; rather Glynos and Howarth state that LCE requires an interconnection of all five.

Problematisation

One of the attractions of the LCE approach is that it is problem driven, rather than being steered by a specific theory or methodology (Howarth, 2005; Howarth, 2013). Drawn from Foucault, problematisation:

> 'is a question of a movement of critical analysis in which one tries to see how different solutions to a problem have been constructed; but also, how these different solutions result from a specific form of problematistion' (Foucault, 1984: 389).

Hence, problematisation enables the researcher to look beyond the current 'truth' to reveal how problems and solutions have evolved at 'specific times and under specific circumstances' (Deacon, 2000:127). The process starts with consideration of how nursing and HEI nurse education has been presented as a problem, thus providing a 'history of the present'. It is only after gaining an understanding of a problem's contemporary construction one can go back to explore how nursing and nurse education were problematised in the past, and how those historical problematisations relate to current nurse education and patient involvement practices. Archaeology and genealogy are two important processes within problematisation. Archaeology illustrates how the structure of the present has evolved from the past, whilst genealogy re-establishes 'the various systems of subjection; not the anticipatory

power of meaning but the hazardous play of dominations' (Foucault, 1991:83). Howarth (2000) presents the role of the archaeologist as an outside 'spectator' who lays out a history of discourse in order to describe the rules that formed and structured it, but an archaeological analysis offers little analysis or critique. Whereas, the purpose of the genealogist is to offer 'cures for the problems of contemporary societies by examining their historical emergence and formation' (Howarth, 2000:72). Therefore, problematising nursing and nurse education through a genealogical lens allows for the recognition of the ways in which power and domination have contributed to the ways in which discourses, identities and institutional practices have been constituted, and how alternative possibilities have been excluded.

Retroductive Explanation

Retroduction is an important step within the logics approach as it enables the researcher to question why regimes of practices appear as they are but also to move beyond what is observable in order to provide a non-determinist, interpretative explanation about what might underpin those practices (Olsen, 2009). Whilst Glynos and Howarth (2007) agree with critical realists' idea of retroductive reasoning, they argue that the realist approach leans towards positivism, which is incompatible with the idea of intrinsic structural contingency. In order to achieve this type of explanation, Glynos and Howarth offer a post-positivist perspective through a 'logic of retroductive reasoning' that involves the production of a provisional hypothesis (Howarth *et al.*, 2016). That hypothesis is then tested using:

> *'*a to-and-fro movement between the phenomena investigated and the various explanations proffered. In this way, an initial chaotic set of concepts, logics, empirical data, self-interpretations, and so on, at varying levels of abstraction, are welded together, so as to produce an account which, if it removes our initial confusion, can constitute a legitimate candidate for true or falsity' (Glynos and Howarth, 2007:33-34).

Hence, reductive explanation not only plays a part in constructing theory, it also offers a greater understanding of how regimes and practices have been problematised from an empirical, theoretical and paradigmatical perspective. My provisional hypothesis was that differing constructs of the patient and nurse identities situates patients, nursing students, nurse mentors and nurse lecturers in shifting power relations and subject positions within the practice assessment process.

Logics

Glynos and Howarth (2007:133) use logics (social, political, fantasmatic) as their basic units of explanation, which when articulated together are able to characterise and explain a social practice or regime. By utilising a logics approach I will be able to illustrate how a regime or practice have been contested, transformed, maintained and instituted in order to explain how the professionalisation and academicisation of nursing has been problematised. Logics are a way of explaining, evaluating and criticising those practices and regimes by capturing the rules that structure them and the ontological conditions that make the rules. However, Glynos and Howarth warn that logics are not a mechanism with which to establish or validate truth, rather a logics approach reveals the way in which the rules and grammars of a practice are characterised, how social actors are discursively positioned within that practice and can illuminate actors' self-interpretations of their own roles, responsibilities and actions.

Social Logics

Social logics allow us to examine the characteristics of a given functioning practice or regime within a specific historical context and the rules that are in operation within that practice or regime. It allows us not only to characterise *what* a social practice is,

but is also enables the researcher to examine *why* and *how* those practices have emerged and how they are sustained (Glynos and Howarth, 2008: 12). Over time the contingency of consumerist discourses within HEI and healthcare settings has become obscured so that now patient involvement appears as a sedimented and natural practice. Social logics determine how the regime of patient involvement and more specifically how the practice of patient involvement in practice assessment is characterised across the HEI and practice settings, and the extent to which it is deemed acceptable or unacceptable. Glynos and Howarth (2007) recognise that within any social logic there is a degree of self-interpretation both by research participants and the researcher, however social logics provide the opportunity to look beyond those self-interpretations to explore the different ways in which practices and regimes are characterised by different groups of actors.

While patient involvement has become an established regime of practice within HEI nurse education and NHS institutions, at the time of data collection (2013) patient involvement in practice assessment of nursing students at the University had only just been introduced. As a result, some participants had not yet had direct experience of this new assessment practice, but were able to offer projected characterisations of this emerging practice. Glynos, Speed and West (2015) state that the exploration of 'projected' social logics is appropriate when proposed policy reforms are yet to become fully realised in practice. By adopting this approach, I am able to examine how the regime of patient involvement is characterised within HEI education practices and in hospital nursing practices; while projected social logics facilitates my analysis of 'imagined alternative practices' (Glynos, Speed and West, 2015: 48).

Political Logics

Social logics look at the synchronic aspects of a practice or regime, in other words they reveal the characterisation of a practice at one particular moment in time. Whereas, political logics considers the diachronic (over time) characteristics by illustrating a practice or regime's emergence, contestation or transformation over time. In contrast to the social logics that looks at the rules underlying a practice or regime, political logics shows the processes through which that social practice or regime has been constituted or contested (Glynos and Howarth, 2007: 142). According to Glynos and Howarth (2007: 142):

> 'the very institution of a new regime or social practice presupposes the possibility that a previous social order is successfully displaced from its hegemonic position and thus de-instituted. In short then, political logics are integral to the processes of contestation and institution of social practices and regimes.'

Political logics therefore, attempt to provide an account of the emergence and formation of a system or practice. The analysis of political logics can then illustrate the effects of dislocation by demonstrating the moment when actors become aware of the contingency of a given social practice, setting out how that dislocation is discursively presented. Thus, political logics facilitate the exploration of power within the political by differentiating this into logics of equivalence and difference (Laclau and Mouffe, 1985). However, it is important to acknowledge that this analysis is looking at the wider political landscape and is not entirely centred on government or party politics. Therefore, within the logics approach, politics refers to the way in which the social is continuously being reconstituted, revealing the temporality of meaning. Furthermore, political logics can be used to demonstrate how society is constantly being reorganised as prevailing discourses are changed or

reproduced and can go some way to explain the emergence of social practices and how these may be contested or transformed (Jørgensen and Phillips, 2002:36).

As discussed earlier in this chapter dislocation can result in public and political contestation, where the contingency of a social practice or subject identity becomes visible. The ensuing political struggle can result in different groups of actors demanding change. This struggle can be illustrated by the consideration of logics of equivalence and difference. The logic of equivalence effectively simplifies the structure by portraying different groups' identities and demands as equivalent when confronted by a common enemy or threat (Howarth, 2008), thus creating a political frontier between two oppositional groups. Hence political logics are able to elucidate the way in which political alliances are forged and how different groups of actors form discursive coalitions in order to draw together their own particular demands into a single unified demand or political project (Howarth, 2005: 323). Each group's demands remain separate, but it is through the creation of a unifying demand that the groups become temporally equivalent. In an attempt to illustrate this, I have adapted Howarth's figurative example (2000:107) to this thesis - the demands of NHS managers (M), government (S), public and patient groups (P) and some non-graduate nurses (NGN) are made equivalent (M=S=P=NGN) by their opposition to the threat of graduate nurses and HEI undergraduate nurse education (GN). Consequently, the differences between NHS managers, politicians, patients, the public and non-graduate nurses dissolve as the threat graduate nurses represents negates them, GN = − (M, S, P, NGN), joining them together in opposition (see Chapter 7). Howarth (2000:17) argues that such discursive unity can only be created because of this shared negation between equivalent groups.

A logic of difference has the opposite effect, it highlights an increasing complexity and expansion of the signifying space as chains of equivalence are broken down into defined and separate elements in order to weaken the antagonistic political frontier and maintain the existing structure (Glynos and Howarth, 2007: 144). Rather than creating a 'them' and 'us' scenario as seen in the logic of equivalence, a logic of difference breaks down equivalences into 'divide and rule' where individual groups' demands remain separated preventing the articulation of a more powerful universal demand. In regard to nurse education an example of a logic of difference would be nursing leaders' demands for nurse education to move away from vocational training into higher education. This demand was negotiated and accommodated by the government, thereby averting the creation of an antagonistic political frontier. Both logics of equivalence and difference are ever present within any political struggle and can therefore illuminate the formation, strengthening and weakening of political frontiers.

Storylines and discourse coalitions

One of the challenges of identifying the political logics within this study is that the universal demand was not for the expansion of patient involvement into practice assessment, instead I suggest the demand was for the revocationalisation of nursing. The NMC response to such a demand was to revise the 2004 pre-registration nursing education standards (NMC, 2010b) and latterly, to resurrect the requirement for patients to be involved in assessing nursing students' competence within the practice setting (English National Board (ENB), 1996a; NMC, 2011). But the link between the universal demand and NMC response are not as clearly articulated within policy documents and actor narratives as might be found during a concerted political protest or campaign. Nevertheless, it is possible to analyse how different groups of actors

identify with policy actors' hegemonic project and how discourse coalitions constructed HEI nurse education and the academically prepared nurse as a common enemy or scapegoat (Griggs, 2005).

The work of Hajer (1995: 12-13) was particularly helpful in this regard. Hajer's study on the politics of environmental discourse in the UK and the Netherlands analysed the discourse coalitions that developed between a wide range of social actors who had never met or agreed a specific political strategy. My study is similar in that each group of actors remained unconnected and there were no efforts made to join forces to form one coherent, collective voice of protest. As in Hajer's study each group of actors appears focused on their own particular storyline, which they have employed politically to debate the quality of HEI nurse education and patient care. For example, politicians, the media and NHS managers adopted a '*practice before theory'* storyline; in contrast, a storyline of '*care and compassion'* emerged from patient groups, while non-graduate nurses used a storyline of '*vocation*'. What this illustrates is the ways in which the same problem was discursively constructed differently by each group of actors, but also that they all helped to sustain and give socio-political resonance to the storyline that the professionalisation and academicisation of nursing were responsible for poor patient care; it is that increasing resonance that produces a political effect. Hajer (1995:56) defines a storyline as:

> 'a generative sort of narrative that allows actors to draw upon various discursive categories to give meaning to a specific physical or social phenomenon. The key function of storylines is that they suggest unity in the bewildering variety of separate discursive component parts of a problem […] Political change may therefore well take place through the emergence of new storylines rather than re-ordering understanding.' (Hajer, 1995:56)

Storylines can therefore become 'essential political devices' that actors employ in their attempts to suture a fragmented identity in order to gain structural closure. Thus:

> '...this process of constructing or framing political problems is a highly significant element of the political process. Actors try to impose their views of reality on others, sometimes through debate and persuasion, but always through manipulation and power' (Hajer, 1993:45)

A discourse coalition refers 'to a group of actors that, in the context of an identifiable set of practices, shares the usage of a particular set of storylines over a particular period of time' (Hajer, 2006: 70). The discursive power of a storyline is gained, not through the way in which separate elements appear to fit together, but from the way that discourse structures these elements in such a way that they appear to 'belong together, thus actors 'may not understand the detail of the argument but will typically argue it 'sounds right'' (Hajer, 1995: 66-67). This 'discursive affinity' increases the resonance of a storyline, which can result in 'discursive contamination' as elements merge into each other. Consequently, not only can storylines highlight the subject positions of each actor, but they also enable the researcher to explore where each group apportions 'blame' and their acceptance of policy actors' hegemonic normative frame (Hajer, 1995: 65). Hence storylines can be thought of as 'essential political devices' that actors employ in their attempts to gain support for their own worldview, in order to cover over a fragmented structure and attain discursive closure (Hajer, 1995: 59-62).

Fantasmatic Logics

Fantasmatic logic or logics of fantasy tend to operate on an ideological level, highlighting the ideological investments people have in certain fantasmatic narratives that give them a sense of enjoyment (*jouissance*), thus binding them together with one another. And so, fantasmatic logics are able to show why actors become gripped

by an existing or forthcoming practice or regime exposing contingent social relations, whilst also demonstrating how and why that contingency might be concealed and naturalised within a given practice. As well as providing a way to understand why actors have become gripped, fantasmatic logics enable us to examine the force behind politically-driven signifying operations, the degree of resistance against change within social practices, and the determination of the speed and direction of that change (Glynos and Howarth, 2008: 12). Fantasy effectively conceals the radical contingency of social relations in one of two ways; a beatific fantasy may be used to suggest a way that promises to overcome a threat or obstacle to our enjoyment, thus offering a 'fullness-to come'; or a horrific fantasy where the threat or obstacle is constituted as immovable, subsequently heralding a disaster, and a loss of enjoyment. For example, the beatific fantasy image of a practical, caring vocational nurse is used to demand changes to HEI nurse education that promises to overcome the threat of the horrific fantasy of the academic, 'too posh to wash', professional nurse.

Fantasy works at both an ontological and ontical level. Ontologically, fantastmatic logics can illustrate the effects of dislocation on the social and how meaning is only ever partially fixed. Whereas at an ontical level fantasy can hide the radical contingency of social practices that occurred following recent NHS care scandals. This study examines fantasy from an ontological perspective. Following such dislocatory events, fantasy can serve to reduce actors' anxieties caused by the sudden awareness of their own fragmented identity and reduce the impact of contingent social relations (Glynos, 2008). Therefore, fantasmatic logics can diminish the dislocatory effects of the political dimensions of a practice, by 'pre-emptively absorbing dislocations, preventing them from being the source of a political practice' (Glynos and Howarth, 2007: 145).

Glynos and Howarth (2007: 149) suggest that the fantasy can be associated with an image, a narrative or both, which they illustrate with reference to the 'Hogggenheimer' cartoon image that appeared in South African newspapers during the years of Apartheid. Hoggenheimer, an image of a fat, cigar smoking, mine owner was used to underscore an horrific fantasmatic narrative against British imperialism and increasing capitalism that was presented as the reason for racial oppression. In my study the horrific image of the HEI-educated, technical-scientific, graduate nurse (too posh to wash and too clever to care) has been presented as being responsible for draining away patients and the public's positive experience (enjoyment) of healthcare services. Policy actors subsequently offer a number of solutions including the expansion of patient involvement into practice assessment, alongside a beatific narrative that promises these solutions will replace that horrific image with a vocation-driven, patient-centric nurse. These images do not have to be 'true' in a theoretical sense; they only need to be considered typical in order for it to have an effect (Glynos, 2001: 209). Hence, fantasmatic logics promise the 'fullness to come' once the obstacle; those we deem responsible for our lack of enjoyment – the HEI educated, graduate nurse – have been identified and removed.

Actors engage in fantasmatic narratives based on their desire for a return to the familiar, as described by Zizek (1989:118):

> "Fantasy appears then as 'Che Vuoi?" to the unbearable enigma of the desire of the Other, of the lack in the Other; but it is the same fantasy itself which, so to speak, provides the co-ordinates of our desire – which constructs the frame enabling us to desire something. The usual definition of fantasy ("an imagined scenario representing the realisation of desire") is therefore somewhat misleading, or at least ambiguous: in the fantasy-scene the desire is not fulfilled, "satisfied" but constituted (given its objects, and so on) – through fantasy we learn "how to desire"'.

Fantasmatic logics enable us to explore how different groups of actors identify with or resist certain political narratives, how they interpret the politics surrounding nurse

education and patient involvement, and how different actors either accept or contest patient involvement in practice assessment as an emerging social practice. Thus, fantasy either 'covers over or conceals the subject's lack by providing an image of fullness, wholeness or harmony, on the one hand, while conjuring up threats and obstacles to its realisation on the other' (Glynos and Howarth, 2007: 130). By creating a scapegoat - the antagonistic other - fantasmatic narratives can simplify the political struggles between opposing groups into 'them' and 'us' or perceived opposites such as caring / uncaring, compassionate / non-compassionate, vocational versus professional (Holtzman, 2013:4).

Articulation

Articulation forms a fundamental part of discourse analysis as it explains the ways in which different actors struggle to reduce possibilities in order to fix meaning, how meaning can become naturalised or contested, as well as revealing the ways in which the contingency of meaning becomes visible. Laclau and Mouffe (1985: 105) describe articulation as 'any practice establishing a relation between elements such that their identity is modified as a result of an articulatory practice'. Elements or floating signifiers are devoid of meaning and therefore can be ascribed different meaning depending on the discursive context it is situated in (Jørgensen and Phillips, 2002).

Articulation also relates to the identification of nodal points (empty signifiers), or 'privileged' signifiers or reference points ('points de caption' in the Lacanian vocabulary) in a discourse that binds together a particular 'chain of significance' (Howarth and Stavrakakis, 2000: 8). For example, 'nursing' acquires meaning by being articulated around the privileged signifier 'health care', which forms a nodal point within a discursive structure, but it could be ascribed a different

meaning if that articulation is constituted around a nodal point of 'motherhood'. The process of articulation therefore demonstrates how these elements or floating (non-fixed) signifiers are linked together in chains of equivalence or chains of difference into discourse; it is only through such articulations that the meaning and an articulation of reality are constructed. To illustrate this Laclau and Mouffe (2009:159) use an example of a football:

> 'If I kick a spherical object in the street or if I kick a ball in a football match, the *physical* fact is the same, but its *meaning* is different. The object is a football only to the extent that it establishes a system of relations with other objects, and these relations are not given by the mere referential materiality of the objects, but are, rather socially constructed.'

This shows how it is possible to articulate elements or floating signifiers in innumerable ways, yet they remain non-necessary and contingent. In comparison, an empty signifier is 'a signifier without a signified' (Laclau, 1996:36), in other words an empty signifier is a sign that is not specifically linked to a given concept (signified), therefore has not particular meaning attributed to it:

> 'An empty signifier can, consequently, only emerge if there is a structural impossibility in signification as such, and only if this impossibility can signify itself as an interruption (subversion, distortion, etcetera) of the structure of the sign' (Laclau, 1996:37).

Thus, empty signifiers expose a lack or absence of totality and are useful in illustrating how the claims and demands of certain groups purport to represent the views of the whole. Laclau (1996:44) states that such claims to the universal materialise as a 'hegemonic operation' where the empty signifier comes to represent the particularities of a given group in their attempts to regain a sense of fullness or totality, although this remains impossible. Hence, empty signifiers illustrate the political struggles and the 'exclusionary limit' (Laclau, 1996:37) within a system of signification that represents the failure of that signifying system. As a result, politics,

through logics of equivalence and difference, is made visible as '…the constitutive impossibility of society can only represent itself through the production of empty signifiers' (Laclau, 1996:44). Through an exploration of empty signifiers as nodal points it is possible to explore power relations, the formation of antagonistic frontiers between opposing groups and the exclusion of an 'antagonistic other'.

Normative and Ethical Critique

Critique is the fifth stage of the LCE approach. Critique is not an external process, it remains connected with the phenomenon being studied and the narratives constructed by participants and presented by the researcher. Glynos and Howarth (2007) describe it as an immanent process situated within the narratives and practices we are trying to explain. They argue that the source of critique is closely related to the notion of contingency, that it is the exploration of the social, political and fantasmatic logics that reveals the moments of contingency within the structure. These moments make visible the way in which groups of actors build political frontiers or identify the antagonistic other and they also highlight how actors invest in fantasy in their attempts to hide that contingency. The logics approach effectively exposes the contingency of dominant discourses, where the role of critique is to illustrate how those exclusions are played out within the narrative.

Glynos and Howarth (2007) identify two forms of critique: Normative and Ethical. Normative critique relates to the social and political dimensions of social reality (Figure 2) and offers an onto-political interpretation and forms a fundamental part of the logics methodology through which the researcher is able to propose alternative normative orientations or counter-logics, however any normative critique remains contestable and contingent (Glynos and Howarth, 2007). This style of critique provides an explanation of subject positions in relation to dominance and

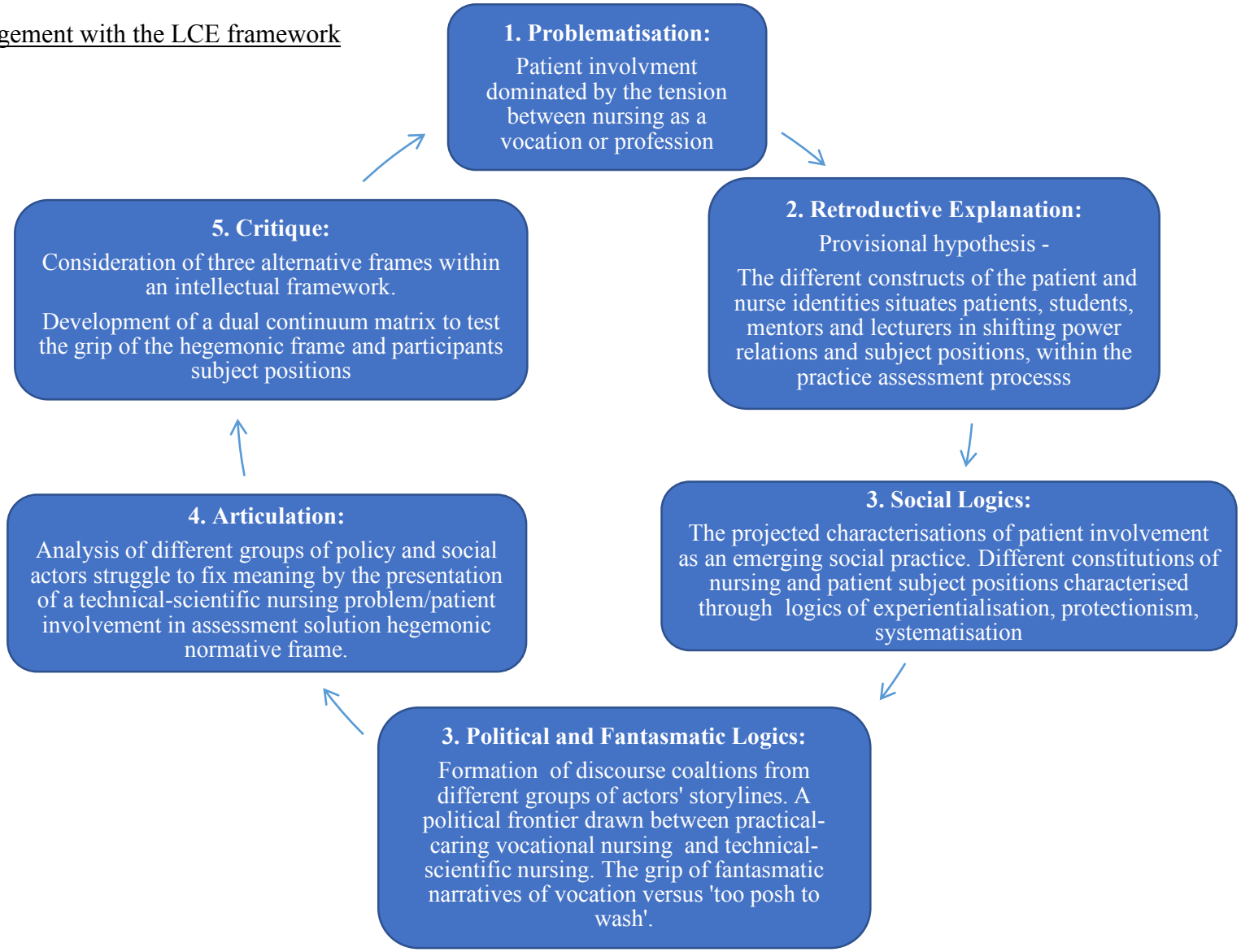
power (Glynos *et al.*, 2009), therefore in order to offer a critical explanation of any given social practice it is important to look beyond the dominant consumerist discourse and recognise that some actors may position themselves outside of that dominant discourse and offer alternatives in order to characterise patient involvement differently. Articulation and critique are interconnected, which facilitates the naming of social logics by drawing together a number of diverse or heterogeneous elements that enables alternative or counter-logics to be identified. Counter-logics are then employed to contest the dominant social logics; thereby offering an illustration of how actors' experiences of dislocation differ (Glynos and Howarth, 2007: 194).

In contrast to normative critique that focuses on the 'more plural, collective and democratic dimensions of social life' (Glynos and Howarth, 2007: 196), ethical critique relates to the ideological and ethical dimensions of social reality to provide an explanation of how each group of actors identifies with the regime of patient involvement within the HEI and hospital setting, and the expansion of patient involvement as an emerging assessment practice. Ethical critique enables the researcher to evaluate the ideological dimension of a regime or practice by examining how different groups of actors engage with the fantasies underlying social and political practices that promise to suture and close their fragmented subjective identities.

Figure 3 demonstrates how I engaged with the logics framework to develop my research. I present this as a circular process as LCE should not be considered as a linear method, rather it is iterative and progressive and involves the researcher engaging in a series of repeated 'critical encounters' with the texts (Steacy, *et al.,* 2016). Steacy *et al.* posit that such iterative analysis facilitates the development of an 'ever-deepening set of meanings that continuously enrich as well as potentially upset

previous interpretations and framings' (Steacy, *et al.,* 2016:169). Hence, the repeated engagement with the texts promotes a reflective, self-critical approach where meaning is continually reframed as the researcher visits and revisits each stage of the logics framework throughout their analysis (Steacy, *et al.,* 2016).

Figure 3: Engagement with the LCE framework



Methods and Research Design

An early criticism of poststructuralist discourse theory was that as a new and evolving research approach, there was 'a lot of work to be done before it can claim to constitute a fully-fledged paradigm with a distinctive set of theoretical concepts, research strategies, and methods' (Torfing, 2005:3). And although Glynos and Howarth have attempted to provide a clearer framework, Marttila and others argue that some methodological weaknesses remain, including a lack of clear guidance on methodological and analytical processes involved in identifying social, political and fantasmatic logics (Marttila, 2016:123; Cruickshank, 2012).

Developing a documentary archive

Nevertheless, one of the strengths of LCE is that all text can be considered as data, therefore a wide range of data sources including professional literature, images, speeches, online blogs, interviews, artefacts and architecture can be used (Howarth, 2005; Cruickshank, 2012). I used what Howarth describes as reactive (participant semi-structured interviews) and non-reactive linguistic data (documents, speeches, blogs and media reports) to uncover the practices involved in accepting, contesting or resisting political and professional hegemonic discourses. By examining not only the patterns that emerge within the discourse, but also the omissions and silences I was able to explore the mechanisms through which meaning was constituted, contested, fixed or subverted (Howarth, 2005:341). Participant interviews provide an opportunity to produce 'thick descriptions' of patient involvement practices, thus revealing the complexities surrounding the involvement of hospital in-patients in assessing students' competence in the practice setting, the subtle power relations at play during assessment, the hegemonic struggle between the different groups of actors and the contingency of identities and subject positions.

Howarth (2005) advocates the gathering of a documentary archive or 'corpus' as an essential first step, something Hajer (1995) describes as 'desk research'. The purpose of this first stage was to review relevant Government and regulatory body papers, inquiry reports, newspaper articles and other educational and policy documents to provide an outline of the current subject positioning of patients and service users, as well as the levels of patient involvement already established within health professional education. The documentary corpus was then analysed to explore policy actors' use of storylines, fantasy and discourse coalitions employed to sustain or contest the vocation/profession debate. The selection of documents was an intuitive rather than objective process guided by the research. Nevertheless, in terms of my work in the early phases of my doctoral studies I recognised that a limitation of including documentary data was the inherent risk of becoming overwhelmed with the amount of data retrieved, especially in regard to its subsequent analysis, therefore I developed a inclusion / exclusion criteria to support and justify my selection (Table 1).

Documentary Data Inclusion Criteria	Documentary Data Exclusion Criteria
UK sources	Non-UK sources
Patient and public involvement Government policies, white papers, press statements published after 1979	Non-PPI Government department policies, white papers, press statements published before 1979
>1986 Education-based Professional and Regulatory Body Standards and Circulars Transcripts of Parliamentary debates, statements and Prime Minister's questions related to nursing, nurse education and standards of NHS care Nursing and nurse education related Government department policies, white papers, press statements National newspaper and media reports related to nursing, nurse education and standards of NHS care.	<1986 Non education –based Professional and Regulatory Body Standards and Circulars Transcripts of Parliamentary debates, statements and Prime Minister's questions other than nursing, nurse education or standards of NHS care Non nursing related Government department policies, white papers, press statements Non UK and local newspaper and media reports

Table 1: Documentary data inclusion / exclusion criteria

Within this study I started by gathering government and regulatory policy documents advocating patient involvement in healthcare, service delivery and design from 1979 and the introduction of Community Health Councils, as well as documents relating to pre-registration nursing education from its transition into Higher Education in 1986. My rationale for such documentary analysis is that pre-registration nurse education and government health policy are inherently interconnected. Nursing students spend half of their course out in practice caring for patients, therefore, unlike other university students, government health policy has a significant impact on the ways in which nursing students constitutes the patient identity, learn about patient care, it influences mentors and nurse lecturers approaches

to teaching and role modelling patient involvement, and governs the planning, delivery and evaluation of pre-registration health professional education programmes within the HEI and practice settings. Following this I then searched media and newspaper archives to explore how nursing and nurse education had been constituted and reconstituted over time, as this would illustrate how the public's constitution of nursing was influenced by media reports following each disclocatory events. The triangulation of data sources (documents, media and interviews) allowed for a deeper exploration of patient involvement and its constitution within political, professional and education discourses, thus enhancing the credibility of the study (Bowen, 2009). The emphasis here was not to achieve documentary data saturation, but to enable me to contextualise the problem by identifying some emerging patterns within the discourse (Howarth, 2005).

I carried out a document search using the University library, various academic databases such as CINAHL, the British Nursing Index, Medline, Cochrane Library and Nexis. I used Hansard Online to search parliamentary debates and political speeches, alongside internet search tools to access other documentary data from patient groups, the Royal College of Nursing (RCN) and NMC. Search terms included 'nurse', 'nurse education', 'vocation', 'care', 'compassion', 'graduate', 'degree' along with the phrases 'too posh to wash' and 'too clever to care'. Truncation (*) and Boolean operators such as AND, OR and NOT were used to widen and narrow each search so that the most relevant documentary data was retrieved. Nexis was particularly helpful in searching UK national newspaper data. Table 2 outlines the search strategy and search results, while Figure 4 presents how nursing was problematised across UK newspapers. Finally, Figure 5 illustrates the fluctuations in the number of reports on nursing and nurse education from 1986-2018

that appear to correspond to key disclocatory moments for nursing; the announcement of HEI-based nurse education (Project 2000) in 1987, the publication of the UKCC *Fitness to Practice* report in 1999, the announcement of graduate-entry level nursing in 2009, and the publication of the Francis reports in 2010 and 2013.

Nexis Database Search Terms	Number of reports	After removal of duplicates, non UK reports	Problematisation Vocation versus Professionalisation	Problematisation Care and Compassion
Nurse OR Nursing AND education AND care AND compassion	348	76	58	55
Nurse OR Nursing AND education AND degree AND graduate	218	13		
Nurse OR Nursing AND 'Project 2000' AND vocation	787	74		
Nurse OR Nursing AND 'too posh to wash' AND 'too clever to care'	25	7		

Table 2: Nexis database search results

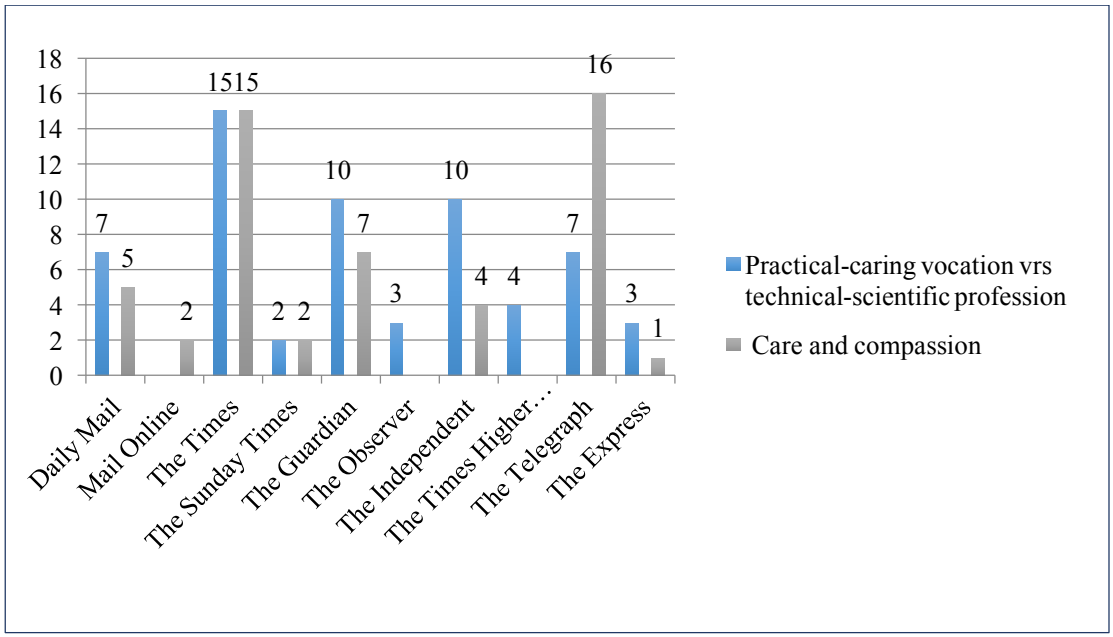


Figure 4: The distribution of data across UK newspapers

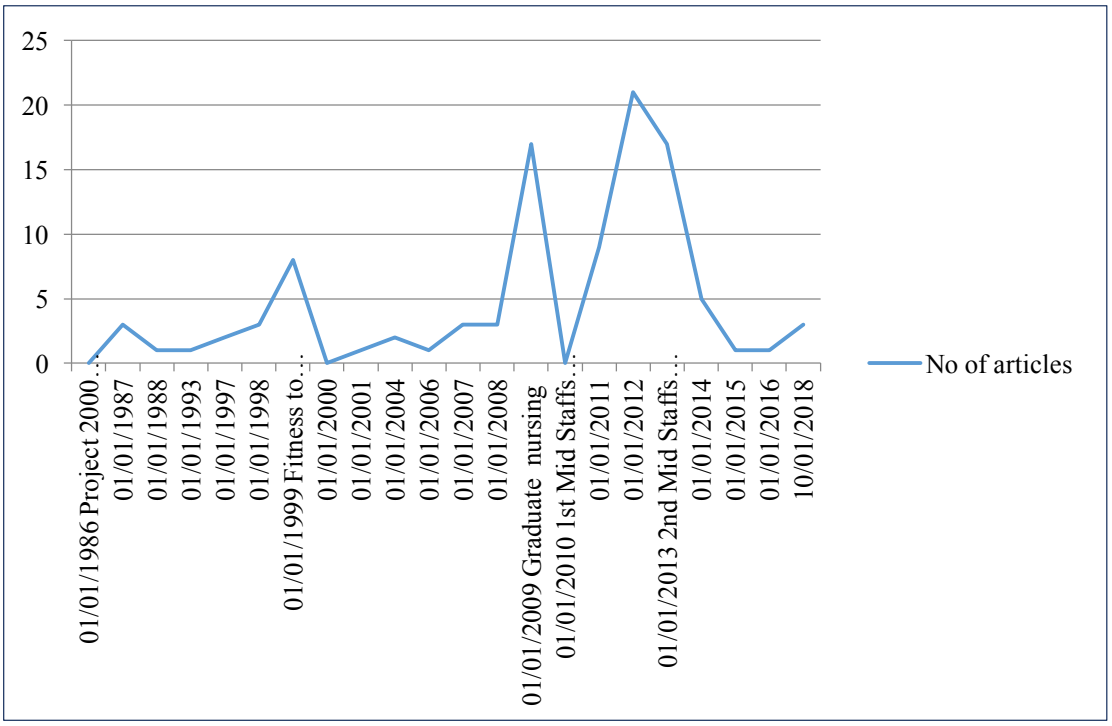


Figure 5: Fluctuations in UK newspaper reports concerning nursing and nurse education (1986-2018)

Limitations of documentary and media data

The benefits of analysing documentary and media data have already been described earlier in this chapter, however it is equally important to acknowledge the limitations of using such data. Bowen (2009:32) cites a number of limitations including 'low retrievability' where the access to some documents might present a number of challenges. The purpose of my search was to explore data that was in the public domain as this was most likely to have influenced the views of participants; therefore my search predominantly focused on online resources and databases. Nonetheless, this did limit access to internal regulatory body and government documents. While I did contact the NMC to request copies of specific archived material, it was not possible to find out if any other archived documents relating to patient involvement in nurse education or practice assessment existed. A limitation associated with the inclusion of media data, especially when researching policy

change, is the extent to which the media is able to influence policy makers or the policy making process continues to be disputed (Saraisky, 2016). Another limitation is that newspaper articles can suffer from inherent selection and description bias as reporters and editors purposively select the events covered and determine the way in which those events are portrayed depending on the newspaper's political position (Earl et al, 2004; Ortiz *et al.,* 2005). However, this study does not explore the media's influence over policy makers, rather my analysis of the documentary and media data enabled me to examine the extent to which media reports reflected the ideological investment of key policy actors that could have influenced the ideological beliefs and social perspectives of the research participants.

In preparation for my problematisation and genealogical review of nurse education and patient involvement I produced a timeline (see Appendix 1) that recorded the educational and political developments in nursing and nurse education from Florence Nightingale's first UK School of Nursing in the mid-1800s to the recent introduction of nursing degree apprenticeships. What this revealed was a continuous ebb and flow of debate between the vocational and professional basis of nursing and the role of academia in nurse training. This thesis concentrates on the period following the transition of nurse education from hospital-based apprenticeship to HEI-based academic programmes, and the emergence of the 'too posh to wash, too clever to care' rhetoric.

The collection of empirical interview data

Whilst the analysis of documentary texts was important in setting out the context of service user and patient involvement as constituted by policy actors such as the government and the NMC, the overall aim and objectives of this study required a discursive exploration of patient involvement practices by actors involved in enacting

that policy at the micro level within a hospital and HEI setting. Overt observations of the interactions between patients, students and mentors in practice could have provided additional situated data, however this was discounted as I felt there was a risk that observation could have a negative effect on patients who were already experiencing a period of increased vulnerability due to their hospitalisation, while students might also be experiencing increased vulnerability because of the addition of an outside observer into an already observation-based practice assessment. Therefore, I made the decision to conduct interviews with actors involved in the practice assessment process, namely patients, nursing student, nurse mentors and nurse lecturers. I approached one HEI within the East of England and one of its associated acute hospital placement providers and sought permission from the University's Head of the School of Nursing and Midwifery and the hospital's Deputy Chief Nurse (Appendix 2 and 3). Permission was granted and ethical approval was obtained from the University of Essex (Appendix 4), North West / Liverpool East National Research Ethics Service [NRES] (REC reference 12/NW/0823 IRAS Project ID 95765 – Appendix 5), and the hospital Research and Development committee (RandD reference 2012STU005 – Appendix 6).

Access and participant recruitment

As with other interpretivist methodologies sample size within discourse analysis tends to be small (8-20 interviews) due to the large amount of data that can be generated and the associated time required for transcription and in-depth data analysis (Georgaca and Avdi, 2012). As a problem-driven methodology the focus was more on determining which participants I needed to approach to answer the research aims and objectives in order to produce an in-depth analysis of the logics and discourses at play. This reflects Spencer and Ritchie's (2012) view that it is the

composition of a sample within qualitative or interpretive research that is more important than the actual number of participants selected. The analysis of interview data from key actors engaged in the practice assessment process strengths the credibility of this thesis as this helps illustrate how patient involvement is characterised as a social practice, how and why different groups of actors have sought to construct equivalent relationships and the ways in which discourses have been articulated through empty and floating signifiers (Griggs and Howarth, 2013).

I was aware that my position as a senior lecturer could have resulted in participants feeling obligated to take part especially if I directly approached potential participants, equally it could have resulted in people declining to be involved in the research. To mitigate against this, potential participants were recruited through designated gatekeepers using specific inclusion/exclusion criteria (Table 3). Within the hospital Clinical Practice Facilitators, who hold and maintain the NMC mentor register, acted as gatekeepers for the recruitment of nurse mentors. The recruitment of adult nursing students came from an announcement posted on the pre-registration adult nursing course area on the university virtual learning environment and through personal tutors. Adult nursing lecturers were recruited in response to an invitation email sent out by the Head of Division for Nursing and Midwifery.

Patients		Students		Mentors		Lecturers	
Inclusion	**Exclusion**	**Inclusion**	**Exclusion**	**Inclusion**	**Exclusion**	**Inclusion**	**Exclusion**
Experience of acute hospital care within the last 12 months Patients over the age of 18	No experience of acute hospital care Unable to give informed consent Patients under the age of 18	Adult nursing students identified by the HEI as members of the selected hospital's cohorts	Child health, mental health, midwifery students Students from the other HEI base sites Students from other HEIs Any HEI students who have had the researcher as personal tutor	Mentors and sign off mentors who are 'active' on the Trust mentor register	Mentors and sign off mentors based in theatres, post-operative recovery and intensive care	Lecturers who are registered with the NMC as adult nurses	Lecturers who are solely registered with the NMC as Child Health, Mental Health Nurses or Midwifes

Table 3: Participant inclusion / exclusion criteria

Recruiting hospital patients was more challenging as the permission from the hospital was on condition that I recruited patient participants through Clinical Nurse Specialists or via the hospital Patient Panel rather than in-patients from the wards. I felt it was important to recruit patients who had had a recent hospital experience as this increased the likelihood that they would have had some interactions with nursing students during care delivery, so my initial aim was to recruit patients through the Specialist Nurses. I contacted 19 Specialist Nurse within the hospital, but only two responded. Although both were positive and keen to support the study only one patient was recruited using this approach. Recruitment of five additional patient participants was from the hospital Patient Panel and University Patient Forum. The Chairperson of each group offered to act as gatekeeper but asked me to attend their

next meetings so that I could outline my study as they felt this would give members the opportunity to meet me face to face, which may result in people being more interested and willing to take part. Each Chairperson then sent out participant invitations and information sheets to group members. From this, two patient participants were recruited from the University forum and three from the hospital patient panel. All participants who expressed an interest were provided with a participant invitation letter (see example − Appendix 7), information sheet (see example − Appendix 8) and consent form (see example − Appendix 9). All 24 participants (see Table 4) who were interested in taking part were given one week to consider their participation and were given the opportunity to contact or meet with me to discuss their participation and answer any questions. Everyone returned signed consent forms prior to interview. Twenty-four participants were interviewed over a five-month period (July to November 2013), with each interview lasting between 50 minutes and one and a half hours. The interviews were semi-structured with topic questions drawn from the desk research and documentary archive (Appendix 10).

	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5	Participant 6
Patient	HEI Service User Forum member 65-70 years	Hospital Patient Panel member 65-70 years	Recently discharged from hospital 25-30 years	Hospital Patient Panel member 70-75 years	Hospital Patient Panel member 30-35 years	HEI Service User Forum member 75-80 years
Student	Semester 1, 3rd Year	Semester 1, 3rd Year	Semester 1, 2nd Year	Semester 1, 3rd Year	Semester 2, 3rd Year	Semester 2, 3rd Year
Nurse Mentor	Band 5 Apprentice trained	Band 5 HEI-educated	Band 6 HEI-educated	Band 6 HEI-educated	Band 6 Apprentice trained	Band 5 HEI-educated
Nurse Lecturer	Lecturer Apprentice trained	Senior Lecturer HEI-educated	Lecturer Apprentice trained	Senior Lecturer HEI-educated	Lecturer HEI-educated	Senior Lecturer HEI-educated

Table 4: Research Participants

I was very conscious that I needed to ensure that participants felt their contributions to this study were appreciated and recognised. I was also aware that for patients taking part this could involve a greater degree of inconvenience, therefore to reduce this, patient participants were given a choice of interview venue; the education department at the hospital, the local university or at their own home. The time and date of each interview was mutually agreed at the convenience of participants. This was in line with recommendations from McLaughlin (2009a) who reiterated the need for researchers to compensate patients for any additional expenses incurred. With that in mind I was able to secure funding from the University of Essex Research Endowment Fund to provide patient participants with a £10 gift voucher, cover travel costs (at public transport rate of 19p/mile) and hospital or university car parking charges.

Ethical considerations

Ethics in research is a wider concept than gaining approval from university, hospital and NRES ethics committees. In terms of data collection this can be ethical concerns over the use of interviews that elicit personal accounts, especially when patients are involved, as participants were being asked to reflect on a time in their lives where they had been unwell and had required an acute hospital admission. The possible revelation of traumatic experiences meant that ensuring participant autonomy, beneficence, non-maleficence, confidentiality and justice were of paramount concern. Ensuring that participants had had the opportunity to read through the information sheets prior to interview and ask questions was important so that individuals could make an autonomous decision to take part or not, and give informed consent. Consent cannot be considered a given, it needs to be discussed, participants' needs accounted for and the researcher should be prepared to renegotiate if necessary (Lewis, 2003a).

All participants were assured anonymity. In order to protect confidentiality and anonymity anyone interested in taking part in the study was asked to email the researcher directly to ensure that their interest was only known to the researcher and not to the designated gatekeepers. Participant details were held on a database on a password-protected computer that only the researcher could access. The database was deleted at the end of study. In terms of confidentiality at the start of each interview each participant was asked to provide a pseudonym as I had intended to use these in the presentation of interview extracts within the findings chapters. The use of pseudonyms also ensured that participants were anonymised during transcription and analysis, however I later decided against using pseudonyms within the final thesis as my adoption of an LCE approach was concerned with offering a critical explanation

of how and why patient involvement has emerged an educational practice, rather than making claims about individual participants.

Managing Risk

The management of risk is another fundamental ethical concern within research. For this study there were minimal risks envisaged, however I was mindful that any participant could highlight examples of poor practice or express anxiety that could compromise patient care or students' practice assessments. As a NMC registrant myself, I am bound by my professional Code of Conduct not only to do the best for the patient but to report practice that puts patients at risk (NMC, 2015). Therefore, each participant information sheet set out my own professional obligations to inform the HEI or hospital management if NMC registrants or nursing students breached the NMC Code of Conduct (2015) or if any disclosures led me to believe that their health and safety or those of others was at immediate risk. Fortunately, no such incidents occurred during the study.

The physical safety of participants and researcher must also be assured especially when conducting interviews in participants' homes, the hospital education centre as well as the university. Interviews held at the hospital and university were scheduled during working hours and reception staff were made aware of the purpose of room booking and the timings of each interview, but not the names of the participants. Where rooms were known in advance, participants were informed prior to interview. Three patient interviews took place at their homes and followed the lone working principles advocated by the NHS and Susie Lamplugh Trust (NHS Security Management Service, 2009). A protocol was drawn up to ensure that a lecturer colleague of the researcher was aware of the research schedule, the anticipated duration of each interview and where the interview was taking place.

Participant Support

It was essential to maintain participants' rights, dignity, respect and well-being throughout and after the study. It is therefore important that participants have additional sources of support made available to them other than myself, or my PhD supervisor. Frost and Cliff (2004) warn that despite participants giving informed consent they may not be fully aware of the depth of discovery interviews can produce. It was therefore important to provide some time at the end of each interview to debrief, here participants were given the opportunity to reflect on their experience and contributions, as well as another opportunity to ask questions or make additional comments if they wished to (Hammersley, 2014). Nevertheless, Hammersley (2014: 533) contends that the use of debriefing in discourse analysis is problematic because of the way that individuals think about a social practice and how problems may have arisen. Additional support was made available for patients from the Patient Advocacy Liaison Service at the hospital; nursing students could access support from their personal tutors; the hospital's Clinical Practice Facilitators were available to nurse mentors and lecturers could access support from the university's Head of Division.

Participant Interviews

Unlike other interpretivist methodologies, discourse analysis is not concerned with participants' experiences, feelings, attitudes or perceptions of a social practice (Hammersley, 2014). Rather, qualitative interviews can provide significant primary texts that assist the researcher by illustrating the degree to which any discourse coalition or hegemonic project has gathered momentum to either grip the actors directly involved or show how it was contested or resisted. Consequently, interviews allow for an exploration of participants' discursive positions and can highlight participants' positional shifts following dislocatory events. Nevertheless, the use of

interviews within discourse analysis have been criticised by some who argue there is a danger that participants could provide responses they believe the researcher wants to hear (Phillips and Hardy, 2002). Yet, discourse analysts do not attempt to explain or justify participants' responses or actions, rather interviews provide important linguistic data that can illustrate how participants engaged with the various problematisations of nurse education and the constructions of patient involvement as a potential solution within a 'local discursive context' (Alvesson and Skoldberg, 2000:193). The purpose is to look beyond personal perspectives and examine the ways in which participants engage with or confront a number of different discourses surrounding the problem, practice or regime of practices. The focus of the interviews is on making visible just how groups and individual participants use language to construct their understanding of nursing, nurse education, assessment, professional competence and patient involvement; while illuminating the ways in which participants constitute identities, move between different subject positions and how they utilise discourses to represent patient involvement in practice assessment (Potter and Wetherell, 1987; Kvale, 1996). Consequently:

> 'How interviewees appear to represent reality in specific interview situations has less to do with how they, or reality, really are (or how they perceive a reality out there); rather, it is about the way they temporarily develop a form of subjectivity, and how they represent reality in relation to the local discursive context created by the interview' (Alvesson and Skolberg, 2000:193)

Hence interviews can be considered 'naturally occurring' texts (Potter and Wetherell, 1987).

Interview Management

Each interview lasted between 50 minutes and one and a half hours and the interview process was the same for all participants. Each interview started with a

briefing to go over the study information sheet and participants were given another opportunity to ask questions. Informed consent was rechecked, participants were reminded that the interview could be stopped at any point and that they had the right to withdraw from the study at any point. Interviews were recorded on a digital Dictaphone, downloaded using encryption software and stored on a password-protected computer. Interviews were downloaded immediately and the recording erased from the Dictaphone. Recordings were then listened to several times before transcription, with memos used to record my initial thoughts on the characterisation of patient involvement practices, formation of chains of equivalences, articulation of grievances and demands, subject positions and hegemonic dimensional drift. Interviews were then transcribed verbatim and analysed using the LCE framework.

Development of a topic guide

As alluded to earlier, my line of questioning was based upon the problematisations presented by my prior analysis of policy actors' narratives and the discourses used to constitute service user and patient involvement within government and regulatory body policy. In deciding upon my style of questioning I wanted to elicit a wide discussion as patient involvement in practice assessment did not appear as a clearly articulated universal demand, therefore it was important to explore the debates that surround the introduction of this initiative. Scripting an interview topic guide was a useful tool to help keep me on track and helped maintain a degree of consistency between interviews (Appendix 10). Nevertheless, Holloway and Galvin (2017) encourage researchers to be flexible in their use of topic guides so that the structure of each interview is determined and controlled by participants. Subsequently, the topic guide is used to ensure that similar data is collected from each interview, while the sequencing of questions can change depending on

participant responses. I incorporated what Kvale (2009) describes as thematic and dynamic questions. Thematic questions are useful when considering the 'what' or theoretical concepts underpinning a research topic; whereas, dynamic questions explore the 'how' and can help to support an on-going dialogue between interviewer and interviewee. As well as the interview topic guide, I incorporated different types of questions, such as introductory, direct, indirect, specifying, probing and follow up, which provided some flexibility so that the conversation between interviewer and interviewee had a natural flow. The use of interpreting questions and silences enabled me to clarify participants' responses and was also intended to provide time for participants to consider the question and reflect on their experiences (Kvale, 2009).

The questions were organised into three levels:

1: Macro level –quality of hospital care; views on nurse education

2: Meso level – patient involvement in rating hospital quality; patient involvement in nurse training

3: Micro level – personal views about patient involvement in practice assessment

The purpose of this approach was to gather data that offered a wider perspective of the politics and discourses at play surrounding HEI nurse education and patient involvement. A pilot interview with a nurse lecturer was undertaken in order to review and refine the interview questions and to ensure the adequacy of the interview schedule (Polit and Beck, 2006).

The challenges and limitations of interviews

A strength of the LCE approach is that it is a useful framework to analyse power and politics surrounding the introduction of new NMC educational policy, but given the recognised challenge of potential power imbalance that can occur within

research interviews (Anyan, 2013) I felt it was important to also consider my own position within the interview process. During the interviews I became conscious of how my subject position changed, not necessarily in how I positioned myself, but also how each participant constructed my identity and position. For example, patient participants tended to position me either as a 'student' or as a 'nurse'; mentors and lecturers appeared to position me more as a 'colleague' or 'lecturer', whilst to students I remained a 'lecturer'. I now recognise that the ways in which participants constructed my identity and subject positions may have facilitated freer conversation for some, but conversely, on occasion it had a restrictive effect on both the participant and myself as the following two extracts from my reflective journal illustrate:

Extract from reflective journal – 3rd September 2013 following interview with Mentor 2

Just some observations after the interview really. The participant was very nervous and was worried about giving the 'wrong' answers. When I chatted about it afterwards she said she was aware I was a senior lecturer and that made her feel a bit more anxious that she needed to provide the 'right' answers. Personally I had found the interview quite difficult, sometimes feeling like I was leading the questions and I was trying really hard to sit back and not say anything but tended to jump in because I guess I wanted to reassure her that she was doing ok. I need to be more mindful of how participants might position me within our conversations.

Extract from reflective journal – 11th October 2013 following interview with Patient 6

Before I started recording the interview I went through the information sheet again and gave Patient 6 an opportunity to ask me any questions or clarify points. She asked me how long I had been a nurse for before becoming a senior lecturer. I found this really interesting, firstly that my first introduction to her had been when I had attended the HEI's Service User Forum to explain my study and rather than being seen as a PhD student, Patient 6, a retired nurse, saw me more as a nurse than anything else. During the interview she reminisced about her own nurse training and afterwards was asking questions about how my training had differed from hers and from current nurse education. I had made a concerted effort to remain neutral throughout the interview and position myself as a student researcher, but it was interesting that at the end of the interview Patient 6 states she felt able to talk to me about her experiences and views because I was a nurse.

That is not to say that participants were powerless, as according to Brinkman and Kvale (2005) interviewees do have power over what they say and how they respond, so can have considerable influence over the outcome of the interview. In response, I tried to maintain a neutral position and stay 'on script' by not offering an opinion or hypothesis to avoid unconsciously influencing interviewees' narratives. That being said, it was important to avoid being overly structured as the purpose of qualitative interviews, according to Mason (2002:62) is explore how knowledge, understanding and meaning is constructed and reconstructed through a co-productive, interactive, situated context.

Using interviews in discourse analysis can present a number of challenges. For example, as a novice researcher the variability of participants' narratives with different actors telling different stories meant that I was faced with many different narratives that needed to be drawn together in order to reconstruct the social, political and fantasmatic logic. Participants did not present consistent stories and their views and opinions on nurse education and patient involvement varied considerably throughout the interview. Talja (1999) noted that this can present specific challenges when using interviews in discourse analysis and advocates that the researcher step away from attempts to constitute participants' stories as accurate records of their beliefs or actions. Instead, Talja advises discourse analysts to recognise the importance of participants various '*reflexive, theoretical, contextual and textual'* accounts in order to facilitate the exploration of the variability and inconsistencies across discourses. Another challenge was that while interviews were not conducted in the practice education setting, some did take place in the HEI and the hospital education centre; therefore it is possible that by situating interviews within the

organisations that some may have a vested interest, the situational context could have influenced participant responses.

Validation

Within qualitative research it is considered good practice to involve participants in validating their contributions by checking their interview transcriptions and commenting on any initial findings to allow for the 'correction of impressions' (Reason and Rowan, 1981:248). Angen (2000) suggests that many qualitative researchers employ participant member checking in an attempt to validate a 'fixed' truth or reality; however, discourse analysis falls within an interpretivist paradigm, therefore such validations assume that participants are conscious of how they are discursively positioned within a given social practice (Georgaca and Avdi, 2012). Georgaca and Avdi contend that most interviewees are not fully aware of the discourses at play or how they are positioned within them, making it impossible for them to validate their narrative contributions. Instead, I followed Alshenqeeti's (2014) advice by avoiding asking leading questions, taking notes during interviews to supplement the data, conducting a pilot interview, and providing participants with the opportunity to summarise and clarify key points at the end of the interview.

Analytical Process

Data analysis should be a continuous process and therefore each step of data collection should be considered as part of the analytical process. As alluded to earlier in this chapter, analysis within a logics approach is not restricted to the analysis of documentary and empirical data; analysis is intertwined across problematisation, retroduction, logics, articulation and critique. Potter and Wetherell (1987:168) describe the challenges of discourse analysis as 'riding a bicycle compared to

conducting experiments', meaning that it is an interpretive rather than systematic approach that involves 'a lot of careful reading and rereading'. Nevertheless, Hajer (2006:73-74) provides a number of useful steps for discourse analysts that I found particularly helpful in guiding my own analytical approach (Table 5).

Analytical Steps		Application
1	Desk Research (Documentary archive)	To provide an introduction to the phenomenon and practices under study. Includes: review of government and NMC documents, newspaper articles, inquiry reports, other educational and policy documents to provide an outline of the current position of service users and patients and their involvement within nurse education.
2	Helicopter Interviews	This involves interviewing a small number of key players – NMC or government representatives. This step was omitted as this study explores service user/patient involvement at a micro (hospital placement) level, rather than the macro (NMC or government) level.
3	Document analysis	Exploration of how storylines are employed within government and NMC policy, media and inquiry reports. Emergence of structuring discourses and the process of events.
4	Interviews with key players	Central actors involved in the political process (patients, students, mentors, lecturers). Provides a better understanding of how different actors interpret patient involvement in practice assessment. Can illustrate how cognitive shifts of position came about.
5	Sites of argumentation	Searching for data that accounts for any argumentative exchange such as parliamentary debates, independent or public inquiries, healthcare commission, care quality commission, parliamentary health ombudsman, patient representative/campaign groups.
6	Analyse for positioning effect	An analysis of how actors are positioned within the discourse, how actors 'get caught up in the interplay', and how and why positions may have been contested, forced or adopted. This study focuses on the positions of individuals, different groups of actors and the position of nursing within education and HEI practices.
7	Identification of key incidents	Necessary in order to understand the dynamics of the discourse and their associated political effects.
8	Analysis of practices in particular cases of augmentation	This aims to go beyond actors' and researcher's self-interpretations. It involves returning to the data to see whether 'what is being said can be related back to the practices in which it is said'.
9	Interpretation	The development of an account of discursive structures, the interpretation and critical explanation of a social practice (s).
10	Second visit to key actors	Participant checking of interpretations.

Table 5: Adaptation of Hajer's ten steps of analysis

According to Hatch (2002:148):

> 'Data analysis is a systematic search for meaning. It is a way to process qualitative data so that what has been learned can be communicated with others. Analysis means organising and interrogating data in ways that allow researchers to see patterns, identify themes, discover relationships, develop explanations, make interpretations, mount critiques, or generate theories. It often involves synthesis, evaluation, interpretation, categorisation, hypothesising, comparison, and pattern finding'.

The process is both informal and formal. Informal analysis began during the formation of the documentary archive (see example – Appendix 11), but it also occurred during each interview and afterwards as each interview was transcribed. Formal analysis involved reading and re-reading documents and transcripts, and repeatedly listening to the interview audio files so that I could discern the nuances of both the written and spoken text. I began by noting the emerging discursive patterns, chains of equivalence, grievances and demands, the drawing of political frontiers, and the effects of the discourse and identifying how various actors were positioned within regulatory standards, educational and government policy (Research objective 1).

Documentary Analysis

From this my analysis moved to coding the documentary and media data. However, both sets of data generated a large amount of text, which at the start of the analysis process appeared somewhat overwhelming. In order to make this more manageable I used a multi-layered approach, returning and re-analysing the data several times (Step 3, Table 5), which allowed me to refine codes and sub-codes as the analysis progressed. Initially I used the computer qualitative data analysis software MaxQDA to help organise, manage and code the data. I had already identified preliminary codes from my initial reading of the documentary archive, which I then applied to the

documentary and media data, an example of which is illustrated in the following screenshot (Figure 6).

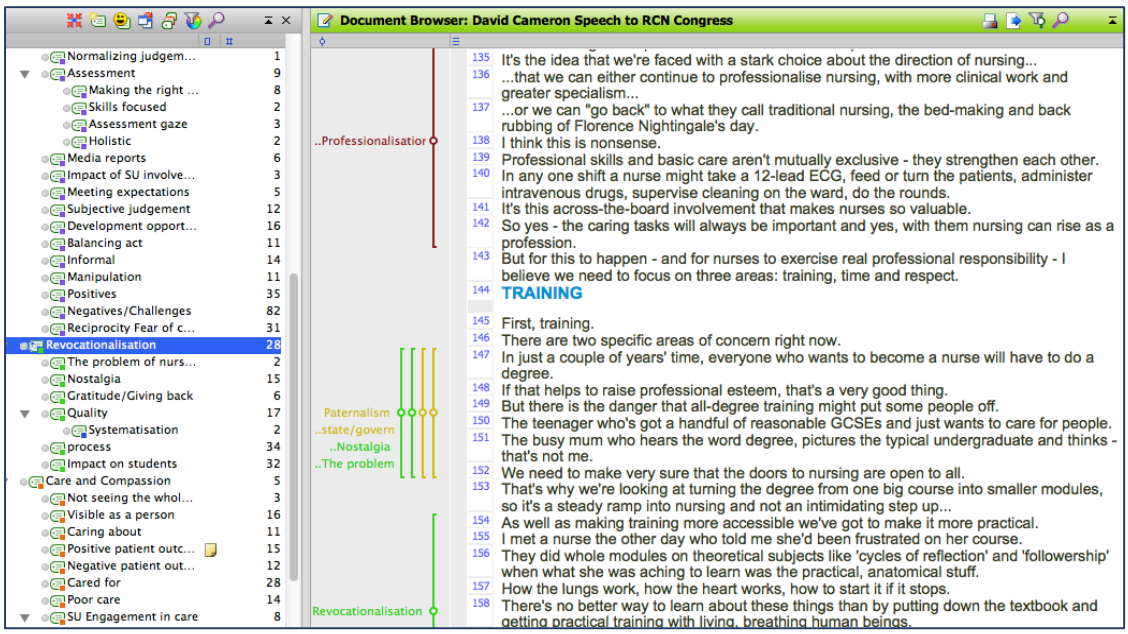


Figure 6: Screen shot of documentary analysis coding

For the second layer of documentary analysis I returned to the data to explore the emergence of storylines across policy actors' discourses. I examined how different groups of policy actors formed discourse coalitions (logic of equivalence) in order to create an antagonistic political frontier to combine different actors particular demands into a unified demand for the revocationalisation of HEI nurse education. By examining actors' storylines I was also able to identify how other actors' employed different sets of storylines in their attempts to contest and resist the constitution of HEI-educated nurses as the 'antagonistic other' (logic of difference). Finally, I undertook a third layer of analysis that involved revisiting actors' narratives to explore how different groups of policy actors used fantasy to support the formation of those discourse coalitions and how fantasmatic narratives were used to offer the prospect of a fullness to come and a desire for change.

Empirical Data Analysis

For the analysis of participant interviews I employed a similar multi-layered approach (Steps 4-9, Table 5). Again I used the computer qualitative data analysis software MaxQDA to code the narrative data, an example of which is illustrated below (Figure 7):

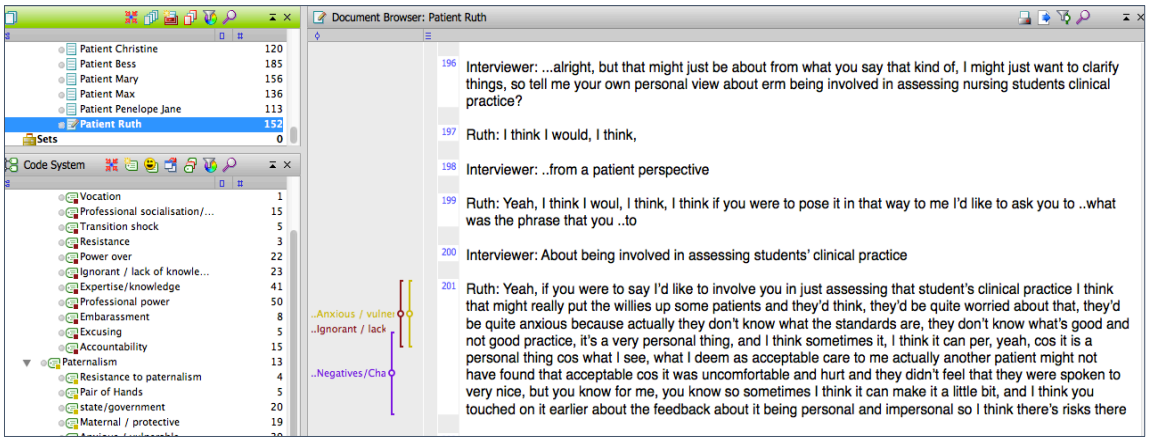


Figure 7: Screen shot of interview analysis coding

(Participant pseudonyms to protect confidentiality)

The purpose of this first layer of analysis was to explore how patient involvement was characterised as a social practice, whilst revealing the ways in which participants engaged, resisted or contested policy actor discourses on HEI nurse education and patient involvement (Research Objectives 2, 4, 5).

For the second layer of empirical data analysis I used McCormack and McCance's (2017) conceptual person-centred nursing model as an analytical framework (Figure 8). This model provided a useful illustration of how public, political and professional expectations of nurses have been constituted through a patient-consumer discourse. My analysis here centred upon identifying the similarities and difference between the positions offered by participants against this conceptual frame in order to discover how the practice of patient involvement in

nurse education and the practice assessment process was characterised (Research Objective 3).

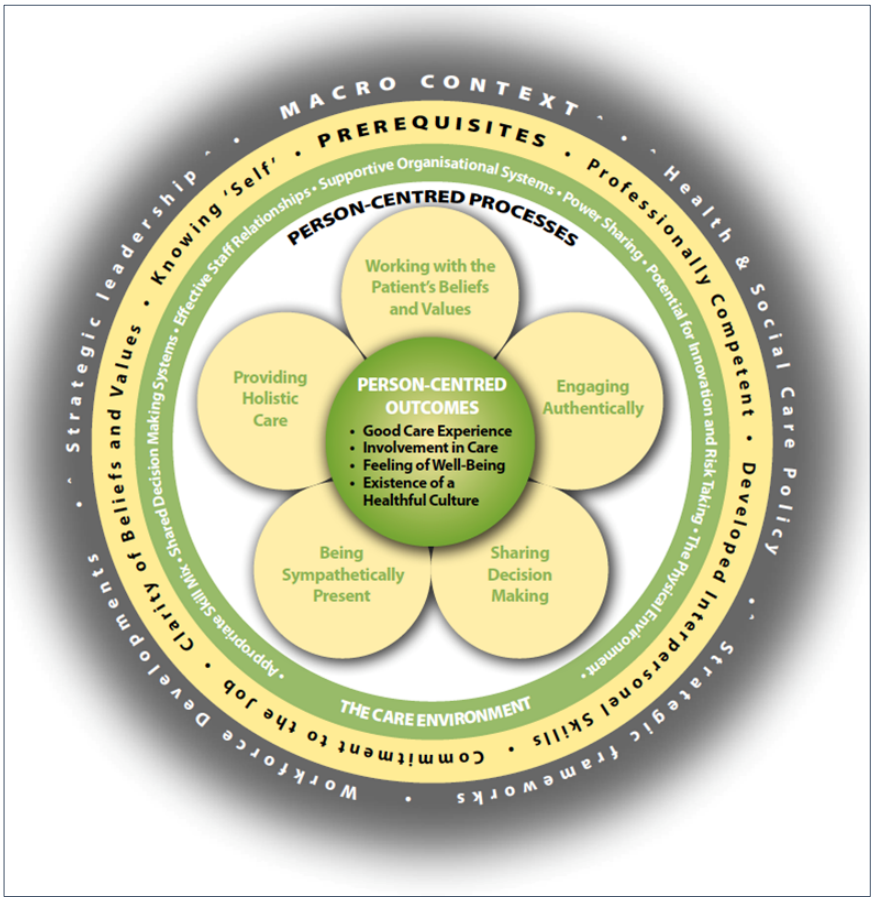


Figure 8: Patient centred model of nursing care

(Taken from McCormack and McCance, 2017:263) [Image reproduced with kind permission from John Wiley and Sons]

Having analysed the discourses that constituted the various articulations of HEI nurse education and patient involvement, I then turned to analysing the subject positions within those discourses and where participants were positioned in regard to their acceptance of or resistance to the hegemonic framing of involving patients in practice assessment. The concept of political logics (and the formation of antagonistic relationships) is relevant here. The documentary analysis examined the drawing of political frontiers and unifying demands between political and policy actors; now my analysis turned to explore whether those same or new antagonistic relationships,

particular and universal demands emerged at a micro level. At this point I began to find the limits of using MaxQDA as it was not easy for me to distinguish the similarities and differences across the interview data. I needed to use an approach that enabled me to view participant narratives side by side; therefore, data was transposed to EXCEL spread sheets for this third layer of analysis (Figure 9). LCE and discourse theory assumes that all identities are inherently lacking therefore this analytical approach made visible the degree to which participants engaged with and employed fantasy in an attempt to 'suture' the social space and fix meaning of practices and identities.

PATIENTS	STUDENTS	MENTORS	LECTURERS
P1: Christine	**S1: Charlotte**	**M1: Sandra**	**L1: Melanie**
That's a very big area isn't it because obviously some patients are only in short term and some are obviously long [term] like ..certainly erm seriously ill people or elderly erm I'm not sure really I think in the end it has to be the health professionals who have to make that decision erm if they're not safe to practice something will have flagged up and the whole ..and there should be some records to that effect	I think they should be involved in feedback [to students] but all I keep thinking is how are the OSCEs going to work? [one off assessments in practice] because you don't have time, you don't even have time to have your own interviews with your mentor	There is all the national standards and all the best practice and things like that but it is as a nurse knowing that I have done my very best for that patient in the interests of that patient. That I have maintained standards, be it cleanliness erm, I'm, going back to what was embedded in me was dignity, respect, compassion erm, we approached patients in a different way to what I, that I've noticed a lot of students doing now because nursing was the 'caring' profession whereas I think it's got a different slant on it now, or perceived to have. Erm and we were taught to go up and greet our patient by name, we used a lot more eye contact, a lot more touch, a lot more sort of expression I don't know	Interviewer: What about erm, patients and service users being involved in rating the quality of the nursing care that they have received? Melanie: Yes I think they should be, yes, for the same reasons you know, they're experiencing it, we've got our expectations as educators and I mean we try to meet standards and the only way really we're going to really understand about meeting standards is how effective it is at the front line if you like and the actual patient / service user contact with which ever member of the health care profession that might be and students are part of that so

Figure 9: Example of third layer data analysis (Participant pseudonyms to protect confidentiality)

The final level of analysis involved me drawing together these first three layers of analysis in order to illustrate how policy actors had constructed a problem (nurse education) /solution (patient involvement) hegemonic normative frame (see Chapter 6). I then returned to the participant interviews to analyse where each was positioned within the hegemonic frame and the degree of positional or dimensional drift that could suggest their acceptance of or resistance to the problematisation of nursing.

Research Quality and Rigour

LCE like other PDT and discourse analysis approaches is an interpretative, multi-layered process, yet as with other qualitative methodologies there is an expectation that discourse methodologies also demonstrate credibility and rigour, both in terms of process and analysis (Crowe, 2005). Credibility can be enhanced through the incorporation of extracts from the data to support analytical claims, alongside detailed interpretations that illustrate how documentary and interview data have been drawn together within the analysis to produce a critical explanation of patient involvement as a social practice (Spencer and Ritchie, 2012). I followed Howarth's (2005:339) recommendation for triangulation by incorporating different research methods (interview and textual analysis) and comparing different types of data (primary and secondary). It is important to remember that discourse analysts do not attempt to offer objective, authentic truth (Nixon and Power, 2007). Nevertheless, Gill (2000:180) argues that demonstrating rigour remains important as:

> 'unlike some styles of analysis, which suppress variability or simply gloss over instances which do not fit the story being told, discursive analysis requires rigour in order to make analytical sense of texts in all the fragmented, contradictory messiness'.

To support my LCE research approach and the analysis of the data I employed Nixon and Power's (2007:76) discourse analysis rigour framework as a checklist to make certain that each stage of my study was transparent and clearly articulated:

1. Clear research question: Is it appropriate for DA?
2. Clear definition of discourse and species of DA
3. Effective use of theoretical framework – clarity and explicitness in epistemological and ontological positioning
4. Transparency in analysis methods and application of theory to the analysis
5. Clarity in selection talk / text

6. Concepts / criteria / strategies to guide analysis

I found this particularly helpful in ensuring that I provided a clear justification of my methodological and analytical approach, whilst providing a detailed explication of the research process.

Reflexivity

Reflexivity is another important element in ensuring research quality and rigour. Discourse analysis research is reflexive in terms of how the researcher acts on the world and how the world acts on the researcher (Taylor, 2001). Therefore, it was important for me to be self-aware and reflexive in order to see myself as an actor situated within the research and nurse education contexts. The purpose of reflexivity within an interpretivist paradigm is not to see oneself as outside of the researcher, but it is about recognising the value of one's own interpretations and how these contribute to the understanding of the research topic (Angen, 2000). Howarth (2005:339) warns prospective discourse analysts of anticipating meaning and awarding 'false consistency' to participant discourses. Unlike other research methodologies, it is important to recognise the impossibility of full research and researcher objectivity in that:

> 'There are no objective observations socially situated in the worlds of – and between − the observer and the observed. Subjects, or individuals, are seldom able to give full explanations of their actions or intentions; all they can offer are accounts, or stories, about what they did and why' (Denzin and Lincoln, 2008:29)

Therefore, it was important to acknowledge my own situated position as a developing researcher, qualified, registered nurse and nursing lecturer in order to reflect on how my own educational and professional practices, discourses and language might impact on my interpretation and analysis of other discourses, identities and subject positions.

Becoming aware of my own subject positions (nurse, lecturer) within the research were important considerations for me to reflect upon. During my own research journey, I recognise that I had positioned myself as a university student and novice researcher; however for participants they may have identified me through my current professional role as a senior lecturer at a university. Given that this study is focused on patient involvement and the assessment of nursing students I had to be aware of the potential for unequal power relations between myself and participants and the potential influence this could have on participants during the interview, therefore it was important for me to conduct my research reflexively. So whilst my various subject positions remain relevant to the way in which I conducted each interview, it was important for me to avoid influencing participant responses by not sharing my own experiences or situations (Taylor, 2001). The use of a reflective research journal allowed me to note my reactions after each interview, as well as my thoughts and interpretations throughout the duration of the study. Glynos *et al.* (2009) suggest that this type of reflection situates the researcher as part of the research process as a co-producer of the interview narratives, as it is the interaction between the researcher and interviewee that constructs the narrative and interviewees' constitution of social reality. My own development as a researcher was additionally enhanced by utilising what Cooper and Burnett (2006:125) describe as 'discursive reflexivity' through research supervision. Reflective discussions with my supervisor enabled me to clarify my position within the study, and assisted my critique of my own analytical assumptions and research practices.

Conclusion

This chapter has provided a rationale for the selection of poststructuralist discourse theory and Glynos and Howarth's Logics of Critical Explanation. A detailed exploration of the logics approach, its ontological foundations and a detailed explanation of the five phases within the logics framework were presented. The LCE approach was selected because of its ability to characterise patient involvement as a contemporary social practice, to explore the underlying politics that have led to that constitution and considers how much fantasy contributes to the construction of identities, subject positions and power relations.

Hajer's ten analytical steps (2006) were employed as a framework to guide the study. Two data collection strategies were adopted in order to gain a comprehensive understanding of patient involvement in practice assessment. The first data collection approach involved the collation of a documentary archive including government and regulatory body policy, inquiry reports, professional and regulatory body documents, patient group publications, and media reports. The second involved conducting a series of semi-structured interviews with the key actors within the practice assessment process, namely patients, nursing students, nurse mentors and nurse lecturers. The chapter outlined the adoption of a multi-layered data analysis approach and the outcomes from that analysis are presented in the forthcoming chapters.

PART TWO: BACKGROUND

Chapter 3: Problematising the Profession versus Vocation Debate in Nursing

Introduction

My research explores patient involvement in the practice assessment of nursing students during acute hospital practice placements. By utilising a logics approach this thesis explores the interplay between social, political and fantasmatic logics in order to gain a greater understanding of different discursive constructs underlying patient involvement in practice assessment. This methodology advocates a problem-driven approach therefore this chapter will examine how different social actors have constituted the continuing professionalisation of nursing positively and negatively.

Problematisation is closely affiliated to the work of Foucault and can be described as:

> 'the ensemble of discursive and non-discursive practices that make something enter into the play of true and false and constitute it as an object of thought (whether in the form of moral reflection, scientific knowledge, political analysis, etc.)' (Foucault, 1988:257).

Problematisation is one element of the LCE approach, where rather than focusing on a singular, distinct element, it focuses on processes of problematisation and the various ways in which different actors have constituted the professionalisation of nursing and HEI-based, technical-scientific nurse education as a problem. This is an important phase of the LCE approach as it supports an analysis of how various potential solutions, in this case patient involvement in the practice assessment of nursing students, have arisen from specific forms of problematisation (Foucault, 1997:119). For example, the idea of nursing as an academic discipline goes against a historically constructed and sedimented image of nursing as a feminised, vocational occupation. As such, nursing and caring have become discursively linked through the

employment of a gendered, vocational discourse that has resulted in a normalised image of the nurse who displays affective behavioural traits of care and compassion, in preference to displays of professional knowledge and technical competence. This chapter examines the processes by which the vocation-profession dichotomy has emerged and how the continuing professionalisation of nursing through higher education 'at specific times and under specific circumstances' has been 'questioned, analysed, classified and regulated, whilst others have not' (Deacon, 2000:127). The utility of applying a problematisation framework to my own study is that it enables me to explore the naturalised or taken for granted truths surrounding nursing and nurse education and examine how the professionalisation of nursing that constitutes nursing as an academic profession continues to challenge the perceptions of nursing.

This problematisation begins with a genealogy of nurse education and a discussion of how the professionalisation and academicisation of nursing has been articulated within political and public narratives from the introduction of formal nurse education in the 1860s, through to recent debates surrounding the appropriateness of nursing moving to a graduate entry profession. This suggests social actors have been using a normative frame to make sense of it and adjudge whether it is appropriate for nursing, as a historically feminised, vocational and subordinate profession to be constituted as clever and university educated. Whilst I recognise there are a number of areas through which the professionalisation of nursing could be problematised, for the purposes of this chapter I will concentrate on three pivotal issues that I believe underlie the constitution of HEI nurse education as a problem. First, I consider the work of Tronto (1993) and Mol (2008) to explore the constitution of care as a nursing practice, to illustrate how nursing has been articulated in ways that prioritise capacity to care over the need for technical

competence, evidence-based practice or theoretical knowledge. Second, I consider how care, compassion and vocation continue to be constituted through a female-gendered discourse that foregrounds a sedimented, historically constructed image of nursing as a female profession. Finally, I examine how the professionalisation of nursing has been problematised as different actors resist the potential challenge this could bring to existing hierarchical structures within the NHS. I see these three areas as pivotal as they make visible the contingency of the nurse identity and models of nurse education. These three problematisations highlight the on-going tensions between the external (public) historical construction of nursing as a practical-caring vocation that delivers care, and the internal (professional) construction of nursing as a technical-scientific profession that manages and co-ordinates care delivery.

The technical-scientific profession versus practical-caring vocation debate

In this next section I compare the definitions of vocation and profession to illustrate the differences between the two constructs that underpin these problematisations of nursing. Throughout the history of modern nursing there is a perpetual tension between these two characterisations of nursing. This tension forms the central thread of this thesis as I explore how these characterisations have been set in opposition to each other, and how patient involvement in practice assessment has been constructed as one of a number of solutions to ensure that vocational values remain central to nursing. It is therefore important when considering the debates based on 'too posh to wash', 'too clever to care' rhetoric to first examine what constitutes a vocation and profession from a sociological perspective.

Historically the image of the nurse has been one of vocation, obedience, subservience, morality, care and compliance (Yam, 2004; Cabaniss, 2011), which remain fundamental components of both public and political discourse today.

Nursing and regulatory discourses continue to view vocation, care and compassion as essential skills (Chambers and Ryder, 2009; NMC, 2007a; 2007b; RCN, 2010), however a tension arises where a discourse of vocation is used to contest the professionalisation and academicisation of nursing by setting them as opposites; a nurse is either vocational and caring *or* technical and uncaring. Indeed, public, media and political discourses appear confused between the organisational demands for nurses to be educated professionals and the images of nursing portrayed in the media that continue to reinforce an historical identity that remains centred on maternalism and vocation (Cohen and Bartholomew, 2008). Generally, the media and politicians have drawn on a patriarchal discourse to constitute the vocational nurse as 'good' and the HEI-educated, technical-scientific nurse as overly qualified, lacking compassion, and driven by a desire for a career (*Hansard*, 1999, 2009, 2012; Dalrymple, 2009; Delingpole, 2009; Chapman and Martin, 2013; Pearson, 2017). Despite professional and regulatory bodies' attempts to adapt the nurses' role to current healthcare demands and to construct an image of nursing more in tune with the realities of practice within modern healthcare services, the image of nurses portrayed within media and political narratives may have contributed to the public's disquiet over the continuing professionalisation of nursing (Rezaei-Adaryani *et al.,* 2012).

There are several definitions of vocation in the literature, but I focus on two that I feel are particularly relevant to this study. In the first, vocation can be seen as an individual's commitment to following a career or profession:

> 'Vocation is an occupation which the individual is supposed to feel and does feel towards the content of his professional activity, no matter in what it consists, in particular no matter whether it appears on the surface as a utilisation of his personal power, or only of his material possessions (as capital). (Weber, 1930:54)

This suggests that vocation, when related to our occupational role, acts as a 'modality of performance' where a student who is training to be a nurse, endeavours to be the

best nurse that they can be (Weigert and Blasi, 2007:21). Vocation comes from the Latin *vocatio,* meaning the inclination to follow a calling or occupation (Millan, 2009). It tends to be associated with self, as we are motivated to follow our own goals in order to seek personal reward and satisfaction, but vocation is also associated with vocation-for-others. Rather than focusing on nursing for personal satisfaction and reward, which has been associated with the HEI-educated nurse, vocation-for-others centres upon seeking external reward and the establishment of group status. Public service, of which nursing is a part, is constituted as a 'vocational calling' through a discourse of 'vocation-for-others', thus, a good public servant seeks to provide for others before themselves. Indeed, Florence Nightingale attributed her own journey into nursing as a calling from God. However, Bauman (1998:8) warns that vocation has come to represent a 'power struggle in everything but name, a battle to force the working people to accept, in the name of the ethical nobility of working life, a life neither noble nor responding to their own standards of moral decency'. In nursing, political demands for nurses to recognise their vocational origins could be construed as evidence of a power struggle between an increasingly politicalised profession critical of reduced NHS funding, lack of resources, pay and conditions, and the government.

But vocation can also be defined in relation to vocational training; a hands-on, on-the-job apprenticeship style education focused on producing a skilled NHS workforce for the NHS labour market. This type of vocational preparation allowed people from predominantly working-class backgrounds to join well-respected and reasonably well-paid occupations (Bosch and Charest, 2008). According to Bosch and Charest (2008: 430) rather than being linked to preparing workers for a particular occupation, vocational education has been associated with lower status, intermediate

skilled professions, where tertiary education has tended to be deemed unnecessary as these professions were inclined to attract the 'academically weak'. They assert that the intermediate position of nursing within institutional professional hierarchies could account for why HEI-based nurse education has been perceived as too theoretical. Colley *et al's,* study (2003) explored vocational learning cultures at three vocational and education training sites in the UK, specifically three two-year vocational courses; Childcare, Healthcare and Electronic and Telecommunications Engineering. They found a marked difference in students' ideologies of practice and professional identities. In the caring occupations, the dominant ideology was one of 'sacrificial femininity'. Thus, care was constituted through a female gendered discourse that foregrounded affective and moral behaviours associated with managing feelings and displaying altruistic behaviours such as cheerfulness and warmth, in order to appear nice or good (Colley *et al.,* 2003:488).

Following on from this exploration of how vocation has become intrinsically linked with nursing, I now contrast that against the idea of profession to illustrate how nursing has been constituted into two distinct constructs. The concept of 'profession' has evolved since the early functionalist definitions of a profession, for example Parsons (1954), which centred on distinguishing the individuality or distinctness of a profession, against other occupations. Trait approaches (Greenwood, 1957; Millerson, 1964) provide a set of characteristics that are useful when trying to determine if nursing can be considered a profession. Traits which are deemed unique to a profession include the development of a unique body of professional knowledge, codes of conduct and ethics, setting of entry criteria, HEI-based educational preparation programmes; professional registration; profession-specific language and the setting of professional norms and values through professional associations (Saks,

2012). Both functionalist and trait theories have been criticised however, for failing to acknowledge the impact of conflict and the protection of professional authority (Larson, 1977; Freidson, 1994), while presenting an altruistic view of professions without the acknowledgement of the economic or social gains associated with professional status (Evetts, 1999). Johnson (1972) argues that rather than displaying traits of altruism and vocation, professional status is centred upon elitism, exertion of professional power over clients, labour markets and the maintenance of economic monopoly. Feminist theorists on the other hand, suggest that professions continue to be dominated by male-oriented professions who use their position and power to perpetuate the subordination of women within the division of labour (Abbott and Meerabeau, 1998). Current thinking however, has moved away from attempts to define unique characteristics of professional groups towards consideration of the influence of bureaucratic organisations on professions' practice (Suddaby and Muzio, 2015). Yam (2004) contends that sociological theories of professions cannot easily be transferred to nursing as professional status is often attributed to professions biased towards scientific or biomedical knowledge. While nursing continues to be constituted as a caring profession a nursing specific definition requires the pragmatic combination of care with biomedical and socio-science knowledge.

So far within this chapter I have defined vocation (unskilled), contrasted that with the idea of a profession (skilled) highlighting the difference and consequential confusion between the idea of vocation and the idea of profession. However, while such definitions are often used to categorise occupations into institutional hierarchies, I posit that a possible solution to this may be to consider the processes of professionalism rather than the issues of the profession. The study of professionalism aims to identify the characteristics associated with professional practice. Not only

does professionalism encompass education, training, technical skills, knowledge creation, and autonomy it also encapsulates a number of behavioural characteristics more closely attributed to vocation, including ethics and values (Keeling and Templeman, 2013). Therefore, the issue appears to be more about how the profession of nursing is constituted, that nursing either involves pragmatic, experiential learning (vocation), or it can be competency-based HEI learning (profession).

Nevertheless, events at Mid Staffordshire and a number of other inquiries have questioned the professionalism of a number of health professionals including nurses (Commission for Health Improvement, 2002; Age Concern, 2006; Healthcare Commission, 2007; 2009; Care Quality Commission, 2010; Francis, 2010, 2013). While investigation and inquiry reports into Mid Staffordshire (Healthcare commission, 2009; Francis, 2010) concluded staff shortages and organisational culture were to blame, Mid Staffordshire created a moment of crisis that the Government appeared to use to effectively shift blame away from a policy-driven target culture onto health professionals, more specifically nurses and nurse education as the primary locus of the Mid Staffordshire failings. These debates presented a fantasmatic logic of vocationalism, which was constituted as the core characterisation of nursing practice, whereas logics of professionalisation and academicisation were presented as horrific threats to high quality patient care, a possible reaction against the purported danger of 'clever women'. The historically constructed image of a 'good' nurse was articulated as vocational, female, caring and compassionate, whilst the HEI-educated nurse, the antagonistic other, was constituted as professional, overly academic and uncaring (Nightingale, 2013). Indeed, a cursory review of the literature reveals that criticisms of nursing students being 'too posh to wash' and 'too clever to care' have been repeated across nurse education reviews and media reports

from the mid-1990s (Jowett, 1994; Hamill, 1995; UKCC, 1999; Meerabeau, 2001; Hall, 2004; Salvage, 2007; Fletcher, 2009; Johnson, 2009; Santry, 2010; Patteson, 2012; Chapman and Martin, 2013; Hawken, 2015).

An important component of my methodological approach is the need to analyse and deconstruct one's own assumptions through 'a dialectical interrogation of one's own familiar position' (Alvesson and Sandberg, 2011). Through my exploration of nurse education from the 1860s to the present day (Appendix 1) I recognise that I had assumed that the anxieties attributed to student nurses being 'too posh to wash' first emerged in the late 1990s following nurse education's transition to Higher Education through the introduction of Project 2000 and that this debate had only re-emerged following the Mid Staffordshire scandal. My recollections of my own experiences as a student nurse in the late 1980s, just as Project 2000 was introduced, were of considerable debates amongst registered nurses and students as to the merits and faults of this initiative. What I had not previously considered was how influential this professional socialisation had been in my own acceptance of this narrative as 'true'.

In reality, the professionalisation of nursing has been a source of contention that can be traced back to Florence Nightingale and the setting up of the Nightingale School at St Thomas' Hospital in London in 1860. Perhaps the typical practices and attributes of some 19th Century nurses prior to this nursing reformation are illustrated in Charles Dicken's novel 'The Adventures of Martin Chuzzlewit' in which the nurse, Sairy Gamp, is presented as an alcoholic, ignorant, depraved working-class woman who was unable to gain employment elsewhere (Mackintosh, 1997). This image of the nurse as uncaring, unreliable, deviant and immoral prevailed throughout the nineteenth century with nurses being afforded a similar position in society as

prostitutes (Hargreaves, 2008; McNally, 2009; Rezaei-Adaryani *et al.,* 2012). This is perhaps reflective of patriarchal social structures at the time, where social attitudes did not regard women who worked as upstanding characters of virtue.

I argue that the Crimea War in 1854 was a pivotal dislocatory event, which resulted in a significant revision of nurse identity. Howarth (2008) suggests that a dislocatory event can illustrate the 'unevenness' of an identity. Therefore, for nursing the Crimea War and more precisely the poor quality of care within military field hospitals signified the moment when politically the acceptance of the then norms of nursing practices were contested, instigating significant change. Florence Nightingale, seen as a pioneer of contemporary nursing, took 38 upper-middle class women to Scutari to manage the army hospital and provide care to the sick and wounded soldiers (Bostridge, 2011). Her actions were viewed as both philanthropic and heroic in stark contrast to Dickens representation, and on her return Florence started a formal apprenticeship-style nurse training scheme that placed great emphasis on the development of nurses' moral character, basic instruction in biological science and clinical nursing practice. The very popular Dickens' characterisation was replaced with one of an altruistic, kind, obedient, intelligent woman who displayed selfless dedication to nursing her patients. Public, political and nursing narratives began to reconstitute nursing as a vocation, which made it an attractive alternative for middle class women from working as governesses. This also offered an alternative to the way patriarchal male discourses had previously controlled women's access to the labour force, consequently, the number of women applying for probationary (student) nursing posts rapidly increased (Cockayne, 2008; NMC, 2010c).

Mrs Ethel Bedford-Fenwick, Matron of St Bartholomew's Hospital in London, and founder of the Royal British Nurses Association, founder and first president of the International Council of Nurses in 1888 (Kings College, 2016) first called for the professionalisation of nursing through nurse registration. Central to this campaign was the desire for self-governance in order for nursing to take control of its own affairs (Witz, 1992), including ownership of nurse education, the introduction of a national standardised curriculum and a national 'finals' exam for entry onto the nursing register (Cockayne, 2008). Nurse leaders, such as Bedford-Fenwick and others, employed a professionalisation discourse to call for probationary nurses to have an enhanced theoretical underpinning to their practice, as well as moral training (Cockayne, 2008). Consequently, nursing knowledge became a combination of practice and theory and this caused concern for some within the medical profession. In 1897 a letter was published in the *British Medical Journal* stating that in terms of nurse training:

> "...the theoretical side has been overdone; the style and method of training being on the same lines as those of the medical student, have not proved equally suitable to the sick nurse, whose work is essentially practice and whose efficiency depends more on skilful handling and observation than on acquaintance with the minutiae of physiology or anatomy. A bad style of nurse has resulted from this false training and is on the increase" *(*Anon, *British Medical Journal* 19th June 1897).

Resistance to the increased professionalisation of nursing surfaced again during the interwar period as the Nurse Registration Act was finally granted royal assent in 1919 after a 30-year battle (Abel-Smith, 1960), but the introduction of specific entry criteria for professional registration was blamed for a significant drop in the nursing workforce (Dingwall, *et al.,* 1988). After the Nurse Registration Act men were excluded from registering as nurses and nursing was deemed an unsuitable occupation for married women; firstly because nurses were expected to 'live in' so

that they could be called to cover shifts if needed (Abel-Smith, 1960), and secondly, society expected married women to dedicate their time to running the household and raising a family (Greener, 2008). Therefore, hospitals urgently needed to attract a steady supply of young single women. The General Nursing Council (GNC) had, for the first time, stipulated all prospective nurse probationers (nursing students) had to have a secondary education or sit an entrance exam (Abel-Smith, 1960:154), which meant for many uneducated women nursing was no longer accessible. In effect the professionalisation of nursing had closed off nursing as a form of social mobility for lower class women reconstituting it as a profession for middle class women who had better access to secondary education.

The GNC criteria stayed in place for 19 years, however by 1938, a chronic shortage of nurses, combined with continued pressure from some major London Hospitals, led to the government suspending the General Nursing Council's entry criteria. At that time, the General Nursing Council was led by hospital Matrons, therefore the lack of resistance against such a suspension could have been the result of patriarchal institutional structures that reinforced medical dominance that meant Matrons were not powerful enough to stand up to the patriarchy of medicine (Witz, 1992). Alternatively, Matrons may have adopted a pragmatic position in order to ensure hospitals were adequately staffed rather than supporting higher educational entry criteria for recruits. Their concern was not necessarily about stopping the professionalisation of nursing, but that their own needs and the needs of the employer were fundamentally more important. Nurses' lowly place in the hospital hierarchy, positioned as subservient and obedient still prevailed at this time therefore there is little evidence that nursing protested against this move. In 1945 the GNC sought to reinstate their entry criteria; however this was refused, as recruitment into nurse

training had not improved (White, 1985). Nursing's lack of political power become apparent as despite continuing requests, the suspension of the GNC entry criteria stayed in place until 1962 when the Minister for Health agreed to the reintroduction of a minimum entry criteria of two O levels or for those without qualifications, an entry test (White, 1985).

The 1964 Platt report (RCN, 1964) recommended nurse education move away from hospital-based Schools of Nursing into higher education in an attempt to make nursing more attractive to the increasing numbers of young women accessing university (Ousey, 2011). The Briggs Report (Committee of Nursing, 1972) repeated this recommendation arguing that nursing needed to move away from an apprenticeship framework to an educational strategy more aligned to medical degrees. In 1985 the Judge Report (RCN, 1985) demanded the transition to higher education, which heralded in the introduction of *Project 2000* in 1989 (UKCC, 1986a). Project 2000 nursing students would now spend up to 70% of their time in the classroom and it was this lack of practical focus that was criticised by some who feared the loss of vocational emphasis and the creation of an 'Americanised' 'academic' nurse (UKCC, 1986b). This problematisation was not necessary based on the fear that academic nurses lacked the ability to care and be compassionate, but it does suggest a growing tension between an emerging constitution of nursing as a profession and a sedimented vocational image where nursing was constructed as a practical-caring vocation.

The demands from the profession for HEI-based nurse education attempted to reconstitute the nurse identity to one of a non-gendered, educated professional, however such attempts lead to tensions between nurses' rearticulation of their role and public expectations based on a historical and romanticised social identity (ten

Hoeve *et al.*, 2014). The new generation of technical-scientific nurses began to be constituted as incapable or unwilling to meet patients' personal care needs (Jowett, 1994; Hamill, 1995; UKCC, 1999). In this vein, the phrase 'too posh to wash, too clever to care' was the focus of a debate at the 2004 Royal College of Nursing (RCN) congress. The debate was based on anecdotal evidence that a small minority of students 'don't want to do holistic care − washing patients' feet and backsides and keeping their mouths fresh' (Carvel, 2004). What the RCN debate suggests is that academically educated nurses' ability to care was now being construed as a problem from within the profession (Bircumshaw, 1989; Carvel, 2004). Thus, the introduction of Project 2000 exposed new factions that had begun to emerge from *within* nursing itself, as non HEI-educated nurses constructed HEI-educated technical-scientific nurses as an internal adversary and threat to a sedimented vocational and caring nurse identity (Mackay, 1993; Bradshaw, 2001; Traynor, 2013).

This last articulation of the practical-caring vocation versus technical-scientific profession debate was in fact sparked by the government's announcement that registered nurses would have to pick up around 20% of junior doctors' work as a consequence of an agreed reduction in junior doctors' hours (Rosenstrøm Chang *et al.*, 2004). Although the motion at the RCN congress was rejected by a majority of 95%, it does demonstrate how some within the profession felt increasingly threatened by the academicisation of nursing and by the advancement of technological competence required within a rapidly changing healthcare system (Meerabeau 1998; Fealy, 2004). It could also suggest that nursing was continuing to constitute itself as a subordinated profession that could account for why some nurses did not considered themselves as a group that could take on traditional medical tasks. Certainly, the media constructed a 'too posh to wash' narrative based on the anecdotal stories of

students refusing to provide personal care. Although the profession acknowledged these occurrences were rare, the media's use of professional anecdotes promoted the construction of a simplistic causal relationship between HEI education and declining standards of patient care (BBC, 2004a, 20004b; Hall, 2004; Scott, 2004).

Media reports reflected a female-gendered discourse that revealed additional tensions between a fantasy of vocation-for-others (the practical, vocational nurse), and the fantasy of vocation-for-self (the HEI educated, academic, professional nurse). In the quote below, Phillips, a journalist for the tabloid newspaper *Daily Mail*, employed a gendered discourse to suggest nurses themselves have not demanded HEI education, but rather nurses had lost their sense of vocation because nurse leaders' 'feminist thinking' had resulted in those at the top of the profession seeking equality with doctors. Her intentions may well have been to shock however it is reflective of the media representation of nursing at the time. A gendered discourse characterised nursing and caring for patients as a female occupation, whereas education and professionalisation were discursively constructed as masculine pursuits more associated with professions such as medicine:

> 'Nursing is not a job but a vocation. That means it is governed by a sense of moral duty to the patient rather than by the self-interest of the nurse …That sense of vocation lay at the heart of Nightingale's vision … Under the influence of feminist thinking, its leaders decided that nurses were treated like skivvies by doctors, who were mostly men. To achieve equality for women, therefore, nursing had to gain equal status with medicine. So, nurse training was taken away from the hospitals and turned into an academic subject taught in universities. This directly contradicted an explicit warning given by Florence Nightingale herself, that her 'sisters' should steer clear of the 'jargon' about the 'rights' of women', which urges women to do all that men do, including the medical and other professions, merely because men do it, and without regard to whether this is the best that women can do.' That, however, was exactly what the nursing establishment proceeded to do. Since caring for patients was demeaning to women, it could no longer be the cardinal principle of nursing. Instead, the primary goal became to realise the potential of the nurse, to deliver equality with the male-dominated medical profession.' (Philips, 2007).

Here HEI education and professionalisation are considered incompatible with nursing; the nurse's role is constructed as a practical, vocational, caregiver, whereas the educated doctor is there to cure (Jecker and Self, 1991). What I have illustrated within the first part of the chapter is how the professionalisation of nursing has been contested and problematised from the birth of contemporary models nursing to the transition of nurse education into Higher Education. I will now consider how HEI-based nurse education was problematised following the announcement that nursing was to become a graduate level entry profession in November 2009 (DH, 2009).

Prior to this 2009 announcement I could find little evidence to indicate that patient or service user groups particularly engaged in the vocation – profession debate. However, the move to graduate status continued to be constituted as a professionalisation strategy by nursing leaders (Hayes, 2012). What emerges is different actors at a different time adopt the same tropes to resist and contest the on-going professionalisation of nursing. For instance, the Patient Association expressed concern that nursing would no longer be considered a vocation, accusing nurses of seeking 'personal prizes of nurse specialisms' and 'ignoring the needs of the sick, vulnerable and often elderly patients' (Fletcher, 2009). Similar sentiments were echoed in the media:

> 'even if degrees did have any intellectual merit, nurses shouldn't be wasting their time doing them. Not because all nurses are incredibly stupid but because nursing isn't that kind of a profession. Nursing is – or should be – a vocation for people who want to get closely involved with the care of patients. People who aren't too grand to change a bedpan or make sure that the patient isn't thirsty. People so selfless that they're not bothered by their low pay or the fact that they can't swan round in white coats with clipboards like doctors' (Delingpole, 13th November 2009, *The Telegraph*).

By using the term 'if degrees did have any intellectual merit' and 'not because *all* nurses are incredibly stupid' (*my emphasis)* Delingpole positions the majority of nurses as unintelligent and asserts that by raising educational standards further that

this would potentially denigrate the academic credibility of a university degree. This quote again reveals the tension between the practical-caring vocation and technical-scientific profession meta-logics of nursing. A horrific logic of academicisation characterises undergraduate nurse education as creating professional nurses who would become 'too grand' to care, whereas a logic of professionalisation presents nursing's demands for enhanced education and professional status as an attempt to rise too far above nursing's normalised construct as a vocation-based, caring-giving profession. The vocational traits of selflessness are reiterated, with surprise that nurses would want reasonable financial recompense and career development.

This goes some way to illustrate that nursing has always been and remains a contingent and contested identity. Such questioning over whether nursing is or should be a vocation or profession reveals the nurse identity as contingent. If we look at this from another perspective, it implies that rather than constituting nurses as having aspirations to reposition themselves within professional hierarchies of power, Delingpole employs a gendered, vocational discourse to construct nursing as a practical occupation better suited to women because of their natural predisposition to care. In contrast, he constitutes doctors as better paid, intellectually superior and in charge, all of which are masculine-gendered, professional characteristics. What perhaps compounded the strength of these types of articulations was that the NMC announcement came only eight months after the Healthcare Commission published its report into unusually high mortality rates at Mid Staffordshire NHS Foundation Trust (Healthcare Commission, 2009). Stories emerged of poor standards of patient care, neglect, poor communication and a failure to listen or act on complaints, with relatives and patients directly criticising doctors and nurses for their lack of care and compassion. But, more importantly the criticism of nurses may have gained socio-

political resonance because care and compassion are constituted as female, nursing-related tropes rather than male, doctor-related tropes of expertise, knowledge and cure.

Media reports had initially attributed care failures to government health policy that imposed NHS financial targets, which they cited as being responsible for Mid Staffordshire hospital's excessive mortality rates (Smith, 2009). Yet the impact of nursing staffs' failure to provide even adequate levels of care was presented as a breach of trust between nurses and patients. Events at Mid Staffordshire were constructed as a symptom of a possible systematic failure of the NHS, as well as a breakdown of trust between patients and health professionals. The following quote from Prime Minister's question time (18th March 2009) illustrates how the Prime Minister constituted care through a discourse of consumerism, but the effects of the government's sovereign power added political resonance to the existing horrific HEI educated nurse / nurse education storylines:

> 'Everyone who uses the national health service has a right, if they put their faith in the NHS at that hospital, to expect the highest standards of treatment. These were not the highest standards of treatment. They have now been investigated, and they fell far short of the standards that people expect … Whatever happened at that hospital is unacceptable and should never be allowed to happen again. I too have looked at all the details of evidence in this report, which also says that nursing standards were poor but they were never discussed or identified as being poor … There are no excuses for what happened in Stafford hospital – no excuses at all' (Gordon Brown – *Hansard* 2009)

Attention was subsequently moved away from blaming government health policy that had promoted the marketisation of the NHS, to censoring the conduct, professionalism and accountability of individual doctors and nurses (BBC, 2009a; Schlesinger and Dolan, 2010; Triggle, 2010). Mid Staffordshire could therefore be interpreted as a dislocatory event where there was a tacit admission of previous professional (UKCC, 1999; NMC, 2005) and policy rhetoric (DH, 2006a; 2008;

2009) that had promised higher standards of patient care (through the continuing professionalisation and academicisation of the NHS workforce), appeared to have failed.

In response, the Health Secretary commissioned an independent inquiry (Francis, 2010) that was subsequently heavily criticised, with accusations of a government cover-up. The independent inquiry report highlighted systemic organisational and strategic failures which resulted in a management culture focused on meeting targets over patient care (Francis, 2010). Despite public concern over a perceived decline in nursing standards Gordon Brown (the Labour Prime Minister), and Andy Burnham, (then Secretary of State for Health) blamed hospital managers obsessed with achieving Foundation Hospital status in preference to ensuring the provision of quality healthcare. When Gordon Brown addressed nurses at the RCN Conference in April 2010 there was no mention of Mid Staffordshire, instead he praised the dedication, commitment and compassion of nurses, describing the profession as 'guardians of the British people's most treasured institution and most precious values', 'our country's heroes' whilst reiterating nurses' central role in the future development of the NHS (Brown, 2010). Conservative opposition leader, David Cameron, possibly responding to increasing public and media disquiet over the extent of care failings revealed during the independent inquiry, stated nursing had become too academic, to the detriment of the traditional 'hands-on' vocational image. He promised that if successfully elected into government he would demand that nurse education returned to teaching vocational values and practices. Nurses, students and nursing unions reacted angrily accusing David Cameron of insulting nurses, ignoring the realities of practice and of being unfamiliar with contemporary nurse education (Santry, 2010; Andrew, 2012).

As the failings of individual practitioners began to overshadow the failings of government policy, so the NMC's capability to sanction practitioners came under increased scrutiny. Prior to 2011, despite being legislatively accountable to the Government's Privy Council, the Council for Healthcare Regulatory Excellence (CHRE) (now the Professional Standards Authority) monitored NMC practices, but there was no clear mechanism in place to hold the NMC to public account. It was only after recommendations made by the House of Commons Health Committee that annual accountability hearings, introduced after the Harold Shipman inquiry, were extended to include the NMC (House of Commons Health Committee, 2011). The NMC is now required by legislation to 'have proper regard' for 'the education and training of nurses, midwives and other healthcare professionals' (NMC, 2017a), with three key objectives set by the Government's Privy Council and Department of Health:

- To protect, promote and maintain the health, safety and wellbeing of the public
- To promote and maintain public confidence in the professions regulated under this order
- To promote and maintain proper professional standards and conduct for member of those professions (NMC, 2016)

The questions over the NMC's fitness to practice procedures had already been a cause for political concern back in 2008 (*Hansard*, 2008). In response, the government commissioned a CHRE review that concluded the public could not be assured that the NMC could adequately protect them from incompetent or uncaring nurses. Within their review CHRE examined the NMC's role in setting educational standards and while they were supportive of the introduction of a UK-wide Quality Assurance Framework for pre-registration programmes, CHRE advised that NMC reviewers should actively seek the views of patients on the care they had received

from nursing students (CHRE, 2008:12). In March 2011, CHRE audited the NMC and concluded there were *'significant risks that the NMC will not always protect the public or maintain confidence in the professions'* (House of Commons Health Committee, 2011:6 original italics). A subsequent report from the House of Commons Health Committee (2011:6) also found:

> '… a number of sources of evidence which suggest significant problems with poor care. The on-going public inquiry into the Mid Staffordshire NHS Foundation Trust is uncovering poor standards at one Foundation Trust; unfortunately, it is unlikely that the experience of this Trust is unique. The Health Service Ombudsman has raised significant issues with the care of older people, particularly in acute hospitals. Following our report into complaints and litigation, the Committee remains very concerned about the standard of basic nursing are for older people in hospital'

In response, the NMC argued that their fitness to practice processes were dictated by government legislation that hampered their ability to conclude disciplinary hearings in a timely manner and urged the government to make legislative changes (House of Commons Health Committee, 2011). While the Health Committee confirmed the government proposals for legislative change, the committee and Department of Health called on the NMC to develop a 'programme of action' that would result in higher standards of patient care and improved patient outcomes (House of Commons Health Committee, 2012).

Criticisms of nurse education however, did not relent and in April 2012 the Royal College of Nursing announced a UK-wide review of pre-registration nurse education to ascertain 'the form and content of education and preparation needed to provide a nursing workforce that was fit for health and social care services in the UK' (RCN, 2012). The wider acceptance of the horrific fantasmatic narratives surrounding HEI-based, technical-scientific nurse education was evident in some of the oral and written evidence submitted to the Willis Commission (Willis Commission, 2012):

> 'There is a perception amongst some patients that because nurses are trained more widely in technical clinical skills, they do not feel that fundamental care is

> sufficiently advanced for them to consider a full part of their role. There are also concerns that the emphasis on theoretical learning, rather than well supervised practice does not give nurses the skills and experience they need to provide care' – Patients Association' (Willis Commission, 2012:23)

Nevertheless, the review concluded that nurse education could not be held directly accountable for poor practice or declining standards of care. The commission found no evidence to support the idea that degree-level registration produces less caring or compassionate nurses than previous educational models. The report defended the academicisation of nursing through discourses of quality and patient safety, with the call for nurse educators to embed 'a caring professionalism that has patient safety as its top priority' (Willis Commission, 2012:6). Here Lord Willis adopted a compatibilist position where contemporary nursing practice was constituted as a combination of vocation *and* profession. This suggests a move away from previous political rhetoric that situated nursing within policy promises of individualised patient care, however, Willis recognised patient safety was dependent on more than a nurses' ability to care, indeed Willis criticised the failure of placement providers to recognise their responsibilities as educational partners. He concluded that the major issues were a lack of consistency in the standard of mentorship in practice placements. In his view, the role of the mentor had been consistently undermined due to organisations failure to recognise and value mentorship, the impact of continual under-staffing, increased levels of skill mix and mounting bureaucracy.

The Willis Commission Report appeared to exonerate HEI nurse education from the declining care standards, but the report was criticised for failing to include patients and representative groups, who continued to suggest that HEI-based nurse education created 'technocratic, desk-bound managers who delegate patient care to inexperienced care workers' (Kirby, 2012). Others criticised the Council of Deans, a body of academics from across the nursing, midwifery and applied health

professional HE sector, assertion that the commission report absolved nurse educationalists, stating that care remained an almost invisible construct within many pre-registration programmes:

> 'There is no single quick-fix for this crisis in nursing and every nurse in practice, education, research and management needs to step up and play their part. Nursing education cannot simply clutch at its Willis security blanket and wait for the health service culture to change, for the Francis Report recommendations to become reality, for the public to change their mind about nursing, or for any other perfect alignment of societal and professional planets' (Darbyshire and McKenna, 2013)

This perhaps illustrates the extent to which political logics were at play. Nursing was becoming a point of contestation in terms of how nursing, its role, responsibilities and identity were being reconstituted, between groups of social actors who formed alliances to demand educational reform and the deprofessionalisation of nursing. It appears that HEI-educated nurses were being held responsible for an apparent decline in the standards of patient care within acute NHS hospitals; along with nurse academics and leaders who had demanded continuing educational progression and academicisation.

Despite Willis' assertions that technical-scientific nurse education was essential for the provision of high quality patient care Griffiths *et al.* (2012) found, in their study on service users views of nurse education and graduate nurses, that participants' responses emphasised a perceived need, on the part of the service users, for a level of emotional connectedness with nurses. It was that emotional connection that resulted in service users feeling adequately cared for, and this was felt to be best reflected in a vocational rather than professional discourse. Although participants recognised organisational challenges, the perception that HEI nursing faculties focused on teaching theoretical knowledge over skills, attitude and professional values was significant. This suggests that service users and carers were beginning to

reflect media and political rhetoric that constituted over-educated nurses as the problem responsible for declining standards of patient care. Despite subsequent reviews concluding that the commercialisation and target culture of the NHS had led to unsafe staffing levels, with systemic failures at board level (Berwick, 2013; Keogh, 2013) nursing continued to be the profession most held to account. What these debates suggest is a continuing struggle between a deeply embedded historical social construct of nursing as a practical vocation versus nursing's attempt to reconstitute itself as an educated profession.

The Constitution of Care and Compassion

The first part of the chapter presented a genealogical review of the tensions between the constitutions of nursing as a vocation or profession. The chapter now moves to consider the constitution of care and compassion, and how these two concepts have become more closely associated with nursing, in comparison to other health professions. In keeping with the LCE approach, in this section, I argue that in healthcare, the concepts of compassion, care and caring act as floating signifiers that link together with others to form chains of equivalence that helps us attribute meaning to nursing and the nurse identity. As a consequence, care and compassion have been constituted as the fundamental vocational attributes and behaviours expected of nurses, such that the association between nursing and compassion has become normalised. However, in order to gain a full appreciation of the tensions between vocation and professionalisation, and the installation of patient involvement in practice assessment, it is necessary to consider how care and compassion are constructed and how different social actors use those constructions in their problematisations of nursing.

Care

Care is constituted as a role and responsibility of all health professionals and one that is regularly articulated within professional and political health discourse (DH, 2012a, 2015; GMC, 2014; NMC, 2015; NHS Constitution, 2015; HCPC, 2016; HEE, 2016a). Yet while the NHS Constitution (2015) provides a definition of compassion, (one of six core NHS principles), a definition of care is not presented. Care - as a fundamental professional value, only appears within the Department of Health's *Compassion in Practice: a vision and strategy for nurses, midwives and care staff* (DH, 2012a: 13), possibly in response to a number of critical reports over the standards of nursing care within acute hospitals (Age Concern, 2006; Healthcare Commission, 2006, 2007, 2009a, 2009b; Francis, 2010; Patient Association, 2009; 2010; 2011; Care Quality Commission, 2011; Health Ombudsman, 2011). Compassion in Practice described care as one of six fundamental professional values (the 6Cs):

> 'Care is our core business and that of our organisations, and the care we deliver helps the individual person and improves the health of the whole community. Caring defines us and our work. People receiving care expect it to be right for them, consistently, throughout every stage of their life' (DH, 2012a: 13)

Here care constituted in a vocational context, it is not a craft or skill, but a core vocational commodity. Yet while *Compassion in Practice* sets out a care philosophy it does not provide a clear definition or conceptualisation, which may reflect the degree to which care has become a hegemonic discourse within health and social care practices, to the extent where the meaning of care has become a sedimented and assumed norm.

The Oxford Dictionary (2018) definition of care is 'The provision of what is necessary for the health, welfare, maintenance, and protection of someone or

something', while the World Health Organisation (2018) employs a quality discourse to offer a similar definition:

> "the extent to which health care services provided to individuals and patient populations improve desired health outcomes. In order to achieve this, health care must be safe, effective, timely, efficient, equitable and people-centred."

Within these two generalised definitions care is constituted as a product of provider organisations that results in measureable outcomes, whereas the inter-relational aspects of care is less prominent and neither make reference to care as a business. What this suggests is that care, in its broadest sense, is related to the provision of services to meet patient needs, yet there are distinct differences found between medical and nursing definitions. Medical dictionaries draw a clear distinction, where medical care is considered 'the provision by a physician of services related to the maintenance of health, prevention of illness, and treatment of illness or injury' (Mosby's Medical Dictionary, 2009), whereas nursing care '…refers to procedures or medications which are solely or primarily aimed at providing comfort to a patient or alleviating that person's pain, symptoms or distress, and including the offer of oral nutrition and hydration' (Segan's Medical Dictionary, 2006). These illustrate the differentiations between professional conceptions of care, medical care is constituted as a provision of service and the management of patients' bio-physical needs, in contrast the constitution of nursing care that is centred on the promotion of patients' well-being and attending to their psycho-social needs.

This distinction may account for why care theorists appear to have come predominantly from nursing, for example Leininger (1978; 1991), Watson (1979; 1984), Benner (1984), Roach (1984; 1997; 2002), Boykin and Schoenhofer, (1993). Many conceptualise care as an inter-relational, psycho-social-spiritual and emotional construct within nursing practice:

> '… the dominant intellectual, theoretical, heuristic and practice focus of nursing, as no other profession is so totally concerned with caring behaviours, caring processes and caring relationships than nursing' (Leininger,1978:33).

> '… practical science of caring … practical knowledge is to know for the sake of doing with a focus on clinical orientated nursing science.' (Bottorff, 1991:29)

> *'... a nurturing way of relating to a valued other towards whom one feels a personal sense of commitment and responsibility.'* (Swanson, 2012:165, original italics)

However, the ability to care for others is not exclusive to nursing. Although care is constituted as a fundamental principle shared across all health professions (Roach, 1997; Smith, 2013; Bivins *et al.*, 2017), care underpins a number of other non-health disciplines such as theology, philosophy, humanities and social sciences among others (Lewis, 2003b). While this would seem to indicate the hegemony of care as a social practice, in an LCE approach, the meaning of care can only ever be temporarily fixed, therefore the constitution of care associated to each professional group remains contingent. Consequently, even if different actors, including patients, nursing students, mentors and lecturers, articulate care by linking together similar floating signifiers, these signifying chains could also include a number of different floating signifiers, therefore the caring practices, roles and responsibilities of each profession can, and will, be constructed differently. Hence:

> *'Shared caring-healing meanings are like rainbows, where each colour is unique and each colour adds perspective to the whole'* (Lewis, 2003b:39).

Despite this, Groothuizen *et al.,* (2018) found that while compassion is cited as a common virtue across nursing, medicine, health and social care, care is predominantly situated within a regime of nursing practice, beside other 'nursing' virtues such as devotion, kindness, loving, obedience and loyalty.

Some have criticised the assertion that care and caring are synonymous to nursing. For example, Smith (1990) argues that the employment of a vocational

discourse to conceptualise care negates nursing's theoretical foundations. She argues that nursing continues to be viewed through a nostalgic lens that uses sentiment to foreground the 'art' rather than the 'science' of nursing. Similarly, Rogers (cited in Smith, 2013:45) contends:

> '… it's about time that we began to value knowledge of some sort … what we do is care, but before we can do, we have to know'.

In contrast Turkel *et al.,* (2018) warn that contemporary models of healthcare are in dangers of creating a 'science of caring', where the marketization of healthcare promotes a reductionist approach to care that centres on what can be observed, measured and documented. This suggests that despite numerous attempts by academics to conceptualise care it still remains largely subjective and unformulated (Paley, 2001; Swanson, 2012).

Morse *et al*'s (1991) comparative analysis of 35 definitions of care identified five important components: caring as a human characteristic; an affect; a social interaction; a moral necessity and a therapeutic intervention. Jecker and Self (1991) take this further by suggesting care can be split into two distinct dimensions: caring *for* and caring *about*. They postulate that nursing incorporates the instrumental, interactive, and relational dimension of care - *caring for*, reminiscent of mothering and nurturing – a logic of vocation. Although doctors and allied health professionals also *care for* patients, their interactions with patients tend to more sporadic during an acute hospital admission. Jecker and Self suggest that medicine encapsulates the expressive dimension of care - *caring about*, through diagnosis, treatment and review and co-ordination of care (i.e. multi-disciplinary referrals, case conferences) - logic of profession.

Within nursing, nurses have constituted caring as the process through which nurses acknowledge suffering and work with patients to plan, implement and evaluate effective care strategies that promote recovery and improve patient outcomes (RCN, 2010). One definition cited within the literature is from Tronto (1993) who defines care as:

> '... everything we do to maintain, continue and repair our 'worlds' so that we can live in it as well as possible. That would include our bodies, our selves and our environment, all of which we seek to interweave in a complex, life-sustaining web' *(*p103)

Building on from Nodding's concept of care (Nodding, 1982), Tronto's *Ethics of Care* divides care into four distinct phases (Table 6). However, these phases, underpinned by four sub-elements, articulate care as an emotive vocation-based activity that only requires individuals to display affective traits of awareness, willingness, provision and consideration. Each element of care is viewed as essential, yet knowledge is not considered an important aspect of any phase, indeed competence is articulated as having the skills to provide care but the need to have a theoretical, evidence-based knowledge in order to care is not represented.

Phases of Care	Elements of Care
Caring about	Attentiveness: an awareness of others' needs
Taking care of	Responsibility: displaying a willingness to respond to and meet needs
Care giving	Competence: having the skills to provide quality care
Care receiving	Responsiveness: considers the individual's position and perspective, recognise the potential for abuse in care

Table 6: An Ethics of care (Tronto, 1993: 126-136)

Care is perhaps less easy to define than the ethics framework suggests. While Tronto's definition and phases of care position her within the vocational school, she appears to ignore the fact that care could be associated with professional practice. Caring is described as an intrinsic element of humanness therefore it must incorporate more than just simply meeting the patients' physical needs. Mol (2008) in her exploration of the logic of care suggests 'good' care often equates to a physical act and that it is this physicality that makes care visible to patients, e.g. vocation. However, professional practice evidenced through nurses' underpinning knowledge and the ethical behaviours required to care are harder to convey. This again illustrates the tensions between practical-caring vocation and technical-scientific profession. Using Tronto and Mol's assertions, vocational care is constituted as a physical act, one that is easy to see and feel. In contrast, professional care, i.e. knowledge, care co-ordination, is subsumed within that physical act. Professional care subsequently becomes a hidden aspect of health professionals' practice and as such it becomes more difficult to identify and value. The subjectivity surrounding conceptualisations of care is recognised by Mol, who contends:

> '… defining 'good' and 'better' does not precede practice, but forms part of it. A difficult part too. One that gives ample occasion for ambivalences, disagreements, insecurities, misunderstandings and conflicts. Nobody ever said care would be easy' (Mol, 2008:87)

Paley (2001) agrees, but argues this subjectivity is derived from theorists and researchers explorations of health professionals perceptions of care processes, behaviours and attributes that can only produce ever expanding lists of attributes, characteristics and constructs rather than attempting to elucidate and define care itself. He asserts that this creates an on-going aggregation of 'things said' that can never be contested, and as a consequence, (Paley argues), empirical testing of care theories becomes impossible.

Compassion

Compassion derives from the Latin 'compati', meaning to suffer with (Jones and Pattison, 2016). But in the same way that definitions of care appear elusive, the same has been said for compassion, which has been associated other vocational attributes such as caring, empathy and sympathy (Van de Cingel, 2009; Bramley and Matiti, 2014; Schofield, 2016; Gilbert, 2017), indeed compassion is constituted as a fundamental part of care within a number of theoretical models (Dewar, 2011). This association can be seen in Chambers and Ryder's assertion that care incorporates an 'essence' that manifests as reciprocity between patients and professionals, borne from an emotional response and sense of humanity from the professional to the distress or suffering of the patient (2009:2). This 'essence' is often displayed through small peripheral acts, which may go unnoticed, but if lacking, as seen at Mid Staffordshire and elsewhere, its absence then becomes palpable (Dewar, 2011). Therefore, while care is considered a physical action in response to suffering, compassion has been defined as a virtue, a vicarious emotion and an attitude (Perez-Bret, et al., 2016).

Goetz *et al.,* (2010:351) states that:

> 'Compassion is defined as the feeling that arises in witnessing another's suffering and that motivates a subsequent desire to help. This definition conceptualises compassion as an affective state defined by a specific, subjective feeling, and it differs from treatments of compassion as an attitude … This definition also clearly differentiates compassion from empathy, which refers to the vicarious experience of another's emotions'.

Jazaieri *et al.* (2013) highlight that current definitions constitute compassion from three perspectives: compassion for others, compassion from others to self and self-compassion. They argue that compassion for others is not necessarily as straightforward and easy as one might assume, especially if to do so threatens your own self-interest or the interests of the group. Compassion from others to self can strengthen relationships and promote a sense of emotional connectedness. Finally,

self-compassion refers to an individual's ability to recognise their own suffering and distress and being able to be kind and caring to self, without criticism or judgement. Compassion is subsequently conceptualised as a multi-dimensional process (Jazaieri *et al,* 2013; Strauss *et al,* 2016) (Figure 10):

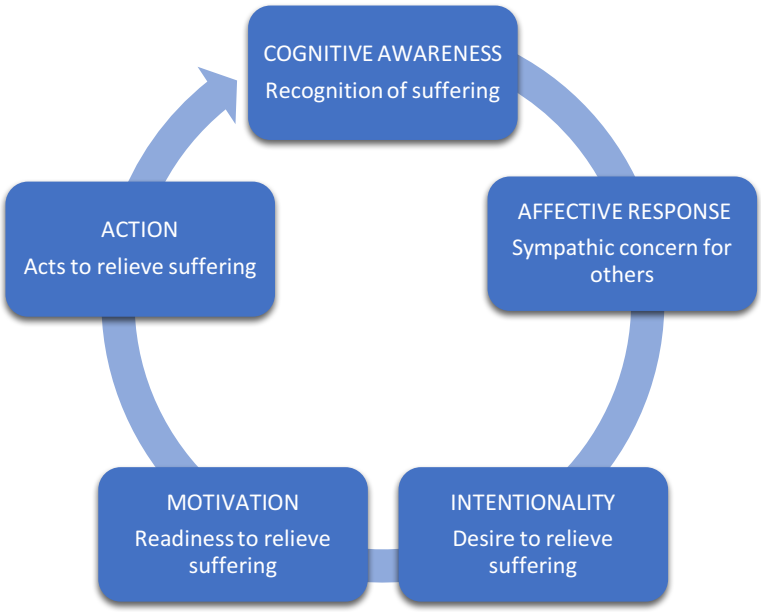


Figure 10: Compassion as a multi-dimensional process

In relation to healthcare, the NHS Constitution (2015:5) presents compassion as a key principle of good practice, reflecting those processes identified in Figure 10, advocating that all NHS staff:

> '…ensure that compassion is central to the care we provide and respond with humanity and kindness to each person's pain, distress, anxiety or need. We search for things we can do, however small, to give comfort and relieve suffering.'

However, the Department of Health's vision and strategy for nursing, midwifery and care staff places more emphasis on the first two dimensions that constitutes compassion more as an emotional response / value and does not appear to acknowledge the intentionality or motivational aspects:

> '…how care is given through relationships based on empathy, respect and dignity – it can also be described as intelligent kindness, and is central to how people perceive care' (DH, 2012a: 13).

This may reflect the constitution of compassion as an essential affective attribute and personal trait for all healthcare professionals (DH, 2012a; NHS Constitution, 2015), where compassion is constructed as a sense of emotional connectedness between two individuals through which one gains an empathetic understanding of another's suffering (Gilbert, 2017). Lazarus (1991:289) theorises:

> 'In compassion, the emotion is felt and shaped in the person feeling it not by whatever the other person is believed to be feeling, but by feeling personal distress at the suffering of another and wanting to ameliorate it. The core relational theme for compassion, therefore is being moved by another's suffering and wanting to help'

Compassion is constituted through a discourse of vocation that reflects a type of altruism originating from within religious orders where compassion was a demonstration of piety and self-sacrifice, however others argue compassion is an egotistical construct where those who alleviate suffering seek to be judged as 'good' (Van der Cingel, 2009; Straughair, 2012). In relation to nursing, not all patients are in crisis but many display varying degrees of helplessness to which nurses are expected to respond, the difficulty is that poor staffing levels often result in the mechanisation of care and the emotional connectivity between nurse and patient is lost. Dewar (2011) identified seven key dimensions of compassion and compared these against patients' perceptions of good nursing care (Table 7).

	Dimensions of Compassionate Care	Patient Perceptions of Good Care
1	Compassionate care is a subjective experience	• Being valued and recognising individual needs • Attentiveness • Managing symptoms • Eye contact
2	Recognition of the human experience and preserving integrity	
3	Acknowledgement of the person over the illness	
4	It is dependent on the quality of the relationship	• Being offered choice, opportunities to be involved and some control about decisions • Spending time with the patient
5	Recognition of patient vulnerability and suffering	• Being able to freely express emotion • Communicating information • Respect, privacy and discretion • Accepting frailties • Verbal reassurance
6	Requires emotional connections and interpersonal skills	
7	It relies on the ability to relate to patient need	• Kindness, warmth, genuine • Translating knowledge into individualised care

Table 7: Seven dimensions of compassionate care

Table 7 illustrates how patients equate good care to emotional connectedness and feelings of acknowledgement as a subjective agent. It is the failure of nurses to recognise and act on an individual's vulnerability with compassion that Dewar (2011) argues results in patients accusing nurses of immoral behaviour and feelings that the profession has failed in its duty to care.

It is possible that perceptions that nursing was becoming academic rather than vocational (Meerabeau, 2001; 2004; Ten Hoeve, *et al.*, 2014) contributed to the recommendations of a number of government-commissioned reviews and inquiries that emphasised the need for a return to patient-centred, compassionate nursing care (Francis, 2013; Berwick, 2013; Keogh, 2013; Bubb, 2014; Willis, 2015). Lord Willis (Willis, 2015), in a pre-registration nurse education review commissioned by the government, reiterated political rhetoric that nurses and nurse educators should be reminded of their vocational roots, whilst calling for a greater focus on a co-productive models of care, stating: "care and compassion are what matters most". The Willis Review called for patients, families and carers to have greater involvement 'as a resource' in curriculum design, delivery and evaluation. However, the positioning of patients as a 'resource' appears to objectify their involvement and it is unclear why patients and service users were not constituted as key stakeholders within the educational process. Acknowledgement of HEIs' requirement to evidence service user and carer contributions to programme design; teaching: recruitment and selection; practice learning (experiences and simulations); student assessments and policy development is reinforced, but there is no acknowledgement of the patient/service users' role in assessment within practice assessment, rendering them invisible in that process.

Scandal has been routinely used by the government to reinforce the education/care dichotomy and to justify the importance of patients in the monitoring of health professionals' practice and standards of care (NMC, 2013; DH, 2013a; Paley, 2013; Hewison and Sawbridge, 2016). Hewison and Sawbridge (2016) contend that following Francis (2010, 2013) politicians made deliberate attempts to undermine HEI nurse education by creating a 'moral panic' that nurses were no

longer caring or compassionate. Terms such as ‘tragic’, ‘horrific’, ‘shocking’, ‘betrayal’, and ‘terrible’ are used to perpetuate political rhetoric of a broken nurse education system, which works to garner public support for other government directives such as prospective students being required to gain care experience prior to training (DH, 2013b). However, the idea that the professionalisation and academicisation of nursing leads to poor care has not been borne out in practice. Aiken *et al*’s (2014) observational study across nine European countries (England, Belgium, Finland, Ireland, Netherlands, Norway, Spain, Sweden and Switzerland) concluded that for every 10% increase in bachelor’s degree nurses there was a reduction in the likelihood of a patient dying post-surgery by as much as 7%. These findings reflect those of a number of other studies (Aiken *et al.*, 2003; Van den Heede *et al.*, 2009; Cho *et al.*, 2015) yet these studies have failed to make any impact on the profession vocation debate.

It is not only nurses that have been criticised for their lack of compassion; doctors have also found themselves under increasingly levels of scrutiny post Mid Staffordshire, with demands for medicine to take a more humanistic approach (Fernando, 2016; Jeffery, 2016). Jeffery (2016) suggests a persistent positivist culture in medicine has continued to promote a bio-medical and technical-scientific approach to patient care, while the mechanisation of healthcare systems has encouraged an instrumental approach that has led to the objectification of patients (De Zulueta, 2013). While there has been support for the introduction of compassion and empathy within medical curricula and practice, Jeffery (2016) contends that there has been little evidence of sustained change in doctors’ attitudes or behaviours in practice, noting that research has predominantly focused on conceptualising compassion in nursing, whilst research within other health and social care professions has centred on

students fostering self-compassion or preventing compassion fatigue (Bivins *et al.,* 2017). De Zulueta (2013) suggests that while the ethics of care and compassion are essential virtues in medicine, students' professional socialisation in practice can encourage students develop a professional detachment from patients as a strategy to protect themselves from emotional distress.

The drive to improve health professionals' attitudes towards the provision of compassionate care has become enshrined in health discourses as a solution for the decline in hospital standards, however health professionals, including nurses, are required to manage contradictory demands for increased efficiency and clinical effectiveness on one hand, and compassionate, individualised patient-centred care on the other (Dewar, 2011). Paley (2014) argues that the recommendations from Francis (2013) resulted in a 'belt and braces' approach to change professional culture within the NHS. However, Paley is also critical, stating that while the report highlighted a lack of compassionate behaviour, there was little or no exploration of staffs' motivation. He contends that it is possible for compassionate staff to become blind to patients' needs, thus appearing uncaring and non-compassionate. To support his argument Paley cites a number of social experiments such as the Good Samaritan (Darley and Batson, 1973) and Stanford Prison experiment (Zimbardo, 2007) as examples of 'inattentional blindness', where an individual's attention can be so focused on a previously assigned task that they do not see what else is happening around them that might need their attention. He describes outside commentators' disbelief at nurses' apparent lack of compassion as an 'illusion of attention', where outsiders assume they would have act differently if in the same circumstances. Nevertheless, the same social experiments have suggested that once outsiders are put in the same scenario, under the same circumstances and pressures they do not behave

as they had previously predicted and if pre-occupied will also fail to notice other things around them. Therefore he questions the assumption that HEI educated nurses lack compassion, instead he believes that nurses' motivation to be compassionate could have become compromised by dehumanising institutional cultures, environmental factors and role-modelling of ritualised, task orientated behaviours (Paley, 2014), something that has also been identified in medical students (Groothuizen *et al.,* 2018). Consequently, values-based recruitment and the mandatory requirement for HEIs to teach care and compassion across health and social care pre-registration programmes might be ineffective in changing sedimented care practices due to the power of professional socialisation and the 'hidden curriculum' (Dewar and Christley, 2013; Lim, *et al.,* 2013; Rankin, 2013; Paley, 2014; Jeffery, 2016; Greeno, *et al.,* 2018).

The Government's focus on policies to mandate compassion – such as the 6Cs and NHS Constitution – have helped to convey the idea that health professionals lack compassion (Bivin *et al.,* 2017). In addition, the social construction of the nurse that situates them at the patients' bedside may have resulted in compassion being constituted as core professional attribute in nursing. Bivin *et al.* (2017) argue that this, and nurses' subsequent lack of power within institutional hierarchies, has made it easier for politicians and the media to criticise nurses more than any other profession. Writing from a doctor's perspective they suggest:

> 'The knee jerk clamour for restored or increased levels of compassion in nursing in response to each episode of bad care is conditioned by our long and uncomfortable history of delegating the low status, unpaid emotional labour of caring to nurses, initially as women, then as subordinate professionals … Only latterly – and still gradually – has the clinical environment moved towards mutual respect for each discipline's contribution' (Bivin, *et al.,* 2017:1025)

The evolution of nursing; from taking instruction from doctors to becoming a profession creates further tensions between a sedimented vocational identity and a

professional identity as a knowledgeable provider, leader, policy developer and co-ordinator of care (RCN, 2014; NMC, 2017b). The failings highlighted at Mid Staffordshire have resulted in the renewed contestation of the nurse identity, as various groups of actors have used these events to suggest nurses have lost their sense of compassion and willingness to care (Health Ombudsman, 2011; Adam and Smith, 2012; DH, 2015a; Hunt 2015). By presenting 'the compassionate caring nurse' as a beatific fantasy, the government was promising a 'fullness to come' (Glynos and Howarth, 2007) where the threat of nurses who are 'too posh to wash' would be removed. The difficulty for nurses is that the meaning attributed to compassion and care is yet to be clearly articulated within professional discourses, possibly reflecting the tensions between the constitutions of care as vocational, whereas cure is professional. Without this the notion of compassionate care remains subjective and open to interpretation (Mol, 2008; Rydlo, 2010).

Nursing as a gendered profession

The previous section has shown how care and caring have been constituted as fundamental traits of nursing. In this next section I move to consider how different groups of actors have employed a gendered discourse to problematise technical-scientific nurse education. The genealogical review has demonstrated how the professionalisation of nursing has been resisted by a number of social actors. It is interesting how different actors have constituted nursing through a gendered discourse, which they have used to problematise nurse education. In the next part of the chapter I consider how nursing and care has been and continues to be associated with women, and how the constitution of nursing as a feminine occupation may have contributed to those problematisations. By positioning nursing as a gendered profession, I am not suggesting that nursing is a 'female' profession, indeed over the

last decade there has been a concerted effort to de-gender nursing's professional identity in order to recruit more men into adult, child health nursing and midwifery (Stanley *et al.*, 2016). Nevertheless, it is important to consider how the social construction of nursing continues to perpetuate a feminised nurse identity and how discourses of care and vocation are being articulated within political and public debates surrounding HEI nurse education.

Gender has been defined as 'the socially constructed roles, behaviours and attributes that a particular society considers appropriate for men and women' (World Health Organisation, 2017a) and it is through gender socialisation, a process that occurs during early childhood, that such gender differentiations become normalised. Human characteristics or traits do not originate from any specific gender orientation; however, these traits do become associated with a particular gender through the socialisation process and these stereotypes are then linked to individual occupational groups. This can be seen within nursing where typically feminine gendered, vocation associated traits of kindness, sympathy, and nurturing are articulated as essential nursing attributes that continue to situate nursing within a gendered discourse (Crespi, 2003; Aranda *et al.*, 2015). Nursing has not always been constituted as a feminised profession, in the middle ages nursing care was often provided by monks, and later during Victorian times men worked as nurses within workhouse infirmaries, asylums and voluntary hospitals. However, by the mid-1880s nursing began to be constituted as a female occupation through the reintroduction of deaconesses and the influence of religious nursing sisterhoods (Mackintosh, 1997). Mackintosh (1997) asserts that the adoption of a sisterhood model in the UK by Florence Nightingale and others, effectively excluded men from nursing, while it affirmed patriarchal

divisions of labour where caring for the sick was perceived as a natural occupation for women.

Florence Nightingale set up the Nightingale School of Nursing at a time when women's position within society prevented the majority of women from accessing anything other than basic education. Opportunities for middle- and upper-class women were often restricted, with those whose families could afford a more extensive education encouraging their daughters to develop feminine 'accomplishments' such as singing, dancing, deportment and languages in preparation for marriage (Hughes, 2014). Derogatory terms for those who sought education, such as 'blue stocking' categorised intellectual, educated women as unfeminine and when universities did eventually open their doors to women, the fear was that such levels of education would render them unmarriageable. Victorian England was based on a strict patriarchal 'separate spheres' social structure, where women were constituted as the weaker sex, inferior physically and intellectually to men and they were excluded from all political, economic and legal affairs (Balanza, 2015). Therefore, the notion of nurses being educated in subjects such as anatomy and physiology, pharmacology and care management would have been unthinkable. For nurses to develop intellectually was to threaten man's cerebral superiority and was viewed as unacceptable as it challenged the dominant position of men in contemporary medicine (Hughes, 2014).

The professionalisation of medicine incorporated the employment of strategies for occupational closure by which women were deliberately excluded through a constitution of female ineligibility. Such 'occupational imperialism' ensured that nursing and midwifery were the only health-related occupations available to women, women were subsequently placed in a subordinate position to

male doctors and it was doctors that remained in control over the division of labour (Witz, 1992). However, although Gamarnikow (1991) agrees that male doctors continued to maintain their hierarchical position by subordinating women through a patriarchal discourse, she suggests Florence Nightingale and other nursing leaders actively engaged with feminine ideologies in order to construct nursing as 'femininity in action'. The constitution of care as a feminine attribute enabled nurse reformers to legitimise their demands for change, so by constructing nursing as an occupation for women, Gamarnikow contends nurse professionalists used gender to empower change in order to take control of nurse education and determine a specific nursing career structure. In contrast, doctors used gender to resist and suppress the professionalisation of nursing.

Today the gender gap within some traditionally male gendered occupations (Chemistry, Physics, Engineering, Maths) is beginning to narrow, in some cases this has even been reversed. For example, in the year 2016, women (51,000) outnumbered men (34,545) in terms of university applications in medicine and dentistry (59.62%: 40.38%) (UCAS, 2016), however the reversal of traditionally female gendered nursing profession is not evident in UCAS applications in 2017, with 47,790 applications from women (90.15%), compared to only 5,220 from men (9.85%) (UCAS, 2017). While a detailed breakdown of which field of nursing practice these students applied for (Adult; Mental Health; Learning Disabilities or Child Health nursing) cannot be determined from UCAS data, it does imply there remains a strong belief in the public imagination that nursing is something women do. Despite the profession's attempts to construct a non-gendered nurse identity to attract men into nursing, the number of men in adult nursing has remained static for the last 15 years at around 10% (Williams, 2017), which suggests nursing has remained a gendered

profession (Davies, 1995; McLaughlin *et al.*, 2010; Zamanzadeh *et al.*, 2013; McIntyre and McDonald, 2014).

The continuing constitution of nursing as a gendered occupation means that it remains associated with feminine stereotypical traits of caring, kindness and deference that continue to be viewed as essential nursing attributes over and above academic knowledge and clinical competence (Francis, 2013; Department for Business, Innovation and Skills and DH, 2014; Aranda *et al.*, 2015). The challenge is that knowledge and competence are traits associated with professional, masculine gendered occupations such as medicine, law and academia (Davies, 2003; Aranda *et al.*, 2015). Therefore, a tension arises between nursing's historical construction as a vocational occupation for women and nursing's desire to be acknowledged as a non-gendered, educated profession that frames this particular problematisation.

The Struggle for Professional Status

The final problematisation being considered relates to how the professionalisation of nursing has been resisted and contested. Historically, nursing and nurse education has undergone a significant period of professionalisation from village healers, deaconesses, Nightingale's nurses, the setting up of apprenticeship education programmes, professional registration and, since the late 1980s, the development of nursing as an academic discipline (Andrew *et al.*, 2014). The accusation that the professionalisation of nursing has resulted in declining standards of care is not new and there has been a consistent anti-academic narrative from the 19th Century onwards (McKenna *et al.*, 2006).

HEI nurse education is firmly established across Europe, North and South America, South Africa, Australia, New Zealand, Asia and the Middle East, yet debates concerning the credibility of HEI-based nurse education in the UK continue

(Curtis, 2013). Interestingly, in some other countries nursing has also been used a political device by some governments to push forward their own political agendas. For example, D'Antonio (2004:383) asserts that in France the professionalisation of nursing was actively supported by the French government in their attempts to diminish the influence of the Catholic church and nursing sisterhoods, while in South Africa it was envisaged that professionalisation would result in middle-class support for apartheid government policy. Nevertheless, resistance against the on-going professionalisation of nursing through HEI-based education is evident worldwide (McPherson and Stuart, 1994; Jackson and Daly, 2004; Kidder and Cornelius, 2006; Råholm *et al.*, 2010) although the declining resistance in some countries could be attributed to the earlier introduction of baccalaureate degrees.

Notwithstanding government rhetoric and regulatory body directives there appears to be little evidence available that directly correlates reported incidences of poor care to graduate pre-registration nurse education (Willis Commission, 2012; Willis, 2015). Despite this, HEI nurse education has been constituted as 'the problem' and the Conservative/Liberal Democratic Coalition and subsequent Conservative Governments' contestations of the professional nurse identity have gone some way towards creating a sense of public unease by presenting a continuous narrative that HEI-educated nurses lack the vocation and compassion required to provide safe patient care (Swinford, 2014). Despite a lack of supporting empirical evidence for this assertion, political discourse constitutes vocational attributes (care and compassion) as essential elements to ensure patient safety over nurses' technical competence and theoretical understanding (DH, 2012a).

The challenge for nursing in terms of constructing a distinct professional identity is that nurses continue to work within a medical sphere of practice, in that

doctors diagnose and prescribe, while nurses act as the conduit co-ordinating care delivery to ensure the patient receives the treatment prescribed. Following the transition into higher education nursing was afforded the opportunity to present itself as an emerging profession through increased academicisation and credentialisation (Davies, 1995). Credentialisation is the process through which nursing was able to move beyond the requirement to demonstrate substantive practical competence, achieve recognition through an academic qualification, while enabling the profession to formalise the substantive knowledge required for professional nurse registration, thus enhancing nurses' positional power (Brown, 2001). The academicisation of nurse education offered direct competition for professional status, a rebalancing of power relations within health and political institutions as well as an enhanced position within professional labour markets (Witz and Annandale, 2006). In doing so not only has nursing used this credentialising tactic to take on greater managerial responsibility, but also it has seen nurses take on additional clinical tasks historically associated with medicine. Nursing had begun to define its own specialisms requiring similar levels of expertise and education as doctors for example community matrons; nurse practitioners; nurse endoscopists; nurse consultants among others (Leonard, 2003).

However, the professionalisation of one profession is often associated with the deprofessionalisation or proletarianisation of another. Deprofessionalisation is defined as the deliberate erosion of a profession's status, autonomy and authority, while proletarianisation relates to changes in institutional structure in terms of division of labour, where professional roles, tasks or authority to act are transferred to lower skilled or unqualified staff (Yam, 2004). The introduction of independent nurse prescribing offers an interesting case in point. Non-medical prescribing was a key

policy initiative set out in the NHS Plan (DH, 2000a) as a strategy to improve patient care, access to treatment and offering greater patient choice. Prescribing historically personified the role of the doctor (Wainwright, 1994), however the introduction of nurse and independent prescribing appeared a deliberate strategy by the government to remove medicine's monopoly over prescribing practices; and an attempt to proletarianise medicine through the transference of prescribing to nursing, thus challenging the dominance of medicine within hierarchical institutional practices (McCartney *et al.*, 1999).

Nurses welcomed nurse prescribing, however doctors expressed concern that patients would be put at risk from nurses whose pharmacological knowledge and educational preparation was seen as inferior to that of medicine (Horton, 2002; Pulse, 2006; Martin, 2007), whereas others saw the introduction as a concerted threat to medicine's clinical autonomy (Britten, 2001). McKinlay and Arches (1985) suggested that capitalist economic policy was pushing forward the erosion of medicine's professional status even before nurse prescribing was introduced, but others argued that medicine's continued dominance over the division of medical labour and its maintenance of control over clinical practice would in fact prevent the proletarianisation of the profession (Britten, 2001).

As nurses have taken on more medically associated tasks, so care has been delegated to Healthcare Assistants (HCA) and Nursing Associates (NAs). In 2015 the government announced the introduction of a new role, the Nursing Associate (DH, 2015b). NAs are to be registered with the NMC after the completion of a two-year work-based apprenticeship including a Foundation Degree. Unlike HCAs, the NA is constituted as a role to 'fill the gap' between HCAs and registered nurses to provide practical 'vocational' hands-on patient care. While NAs will be working under the

direction of a registered nurse, they are expected to be able to work independently, be evidenced-based, research aware, demonstrate fundamental nursing principles, provide patient-centred care and administer medicines (DH, 2015b; HEE, 2016b). Government-commissioned reports and nursing unions have raised concerns about chronic understaffing and unfilled registered nurse vacancies (Berwick, 2013; Keogh, 2013; RCN, 2015; UNISON, 2014; 2015), therefore the introduction of these support roles, rather than increasing student commissions or enhancing registered nurses' pay and conditions, suggests the government chose to introduce a cheaper, less educated alternative. The government has not yet indicated how the introduction of NAs will enhance the patient's care experience or patient's health outcomes, instead the government has employed a discourse of commercialism to herald this initiative as a alternative route into nursing for those who wished to learn on the job rather than study at University (DH, 2015b). However, medicine and allied health professions, have not been immune to proletarianisation, with all health professions seeing the introduction of 'Assistant' and 'Associate' roles (DH, 2000c; 2006b; 2012b; Changing Workforce Programme, 2003; Chartered Society of Physiotherapy, 2014). Thus, the focus appeared to be more on meeting NHS providers' demands for more staff by creating a new and less expensive care worker.

This new role effectively proletarianises registered nurses by removing 'hands-on' care to a lesser-trained workforce. This proletarianisation could lead to a reduction in registered nurses as patient care could be provided by a cheaper NMC-regulated alternative. Another interpretation could suggest that the government has accepted nurses demands to be recognised as an educated profession, as the NHS England website emphasises that by transferring care responsibilities to NAs registered nurses will be able to 'spend more time using their skills and knowledge to

focus on complex clinical duties and take a lead in decisions on the management of patient care' (NHS England, 2017). Thus, this reinforces the idea that care is both practical and vocational and does not required HEI-based education; hence HCAs and NAs now represent the vocational aspects of nursing. But it also distances registered nurses from care, as nurses are constructed as skilled, knowledgeable care managers rather than care givers despite the government's previous rhetoric calling for the revocationalisation of nursing.

What I have sought to demonstrate is how the professionalisation of nursing through the transition of nurse education into higher education and the subsequent expansion of nursing roles have been constituted as a threat. Hull and Jones (2012) suggest that the continuing drive for the professionalisation of nursing through a credentialist strategy presents the same issues nursing faced in the 1920s. They conclude that two contingent professionalising discourses have been at play, with nurse leaders and educators employing a professionalising discourse to constitute nursing as a profession to push for graduate status; and in contrast, service managers have used the same professionalisation discourse to redirect the authority of vocationalists towards a culture of general management (Hull and Jones, 2012:97). Yet, despite these professionalising attempts it is the logic of vocation that continues to dominate the characterisation of nursing practices. Hull and Jones attribute this domination to the way in which the continually changing and diverse social interests of external parties forever determine nursing. This suggests then that because each group of actors have their own particular demands of nursing, the tension between practical-caring vocation and technical-scientific profession are ever present and have never gone away.

Possible solutions

These problematisations have all, in some way, influenced demands for educational change (an in-depth analysis is provided in Chapter 6), leading to a number of possible solutions being advocated, including involving patients in assessing students' practice (Figure 11).

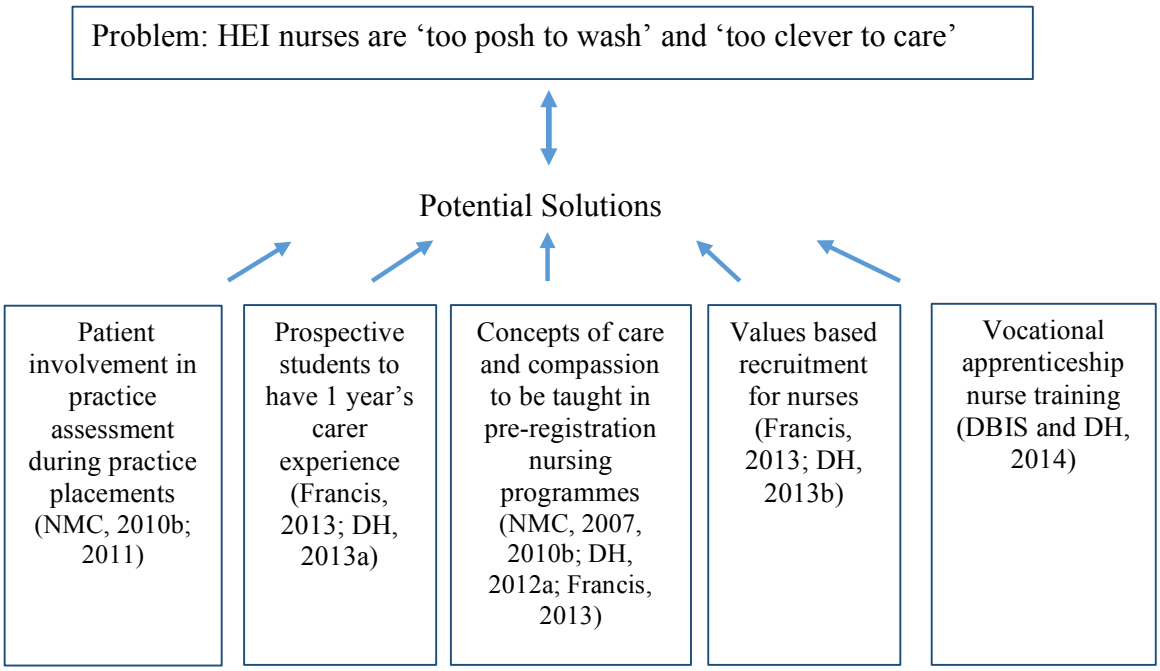


Figure 11: HEI Nurse education policy solutions

Figure 11 illustrates a number of policy initiatives that have been implemented to tackle the 'problem' of HEI nurse education. The majority were introduced in response to recommendations made by Francis (2013), but the increased socio-political resonance that occurred after the Mid Staffordshire public inquiry report was published resulted in this becoming a watershed event (or dislocatory moment, Glynos and Howarth, 2007) for nursing. This appears to have rejuvenated the horrific storyline that HEI-educated nurses were 'too posh to wash' and 'too clever to care' with concern that this horrific fantasy may be coming true. The expansion of patient

involvement to include ‘real’ patients into the assessment of nursing student practice when actively receiving treatment in hospital or in the community is the focus of this thesis.

Conclusion

Within this chapter I have demonstrated how the tensions between nursing as a practical-caring vocation versus a technical-scientific profession have contributed to problematisation of nursing and HEI nurse education. I have illustrated how the vocation/profession debate re-emerged following the establishment of nursing as a graduate entry profession and recent NHS scandals. By adopting a genealogical lens, I have shown how these problematisations have been articulated and rearticulated from the introduction of formal, vocational models of nurse education to contemporary academic undergraduate pre-registration programmes. The next chapter examines how the social construction of the patient identity and subject positioning within healthcare has evolved in order to gain a greater understanding of how the patient may be positioned within the practice assessment process.

Chapter 4: Passive disempowerment to involved partnerships: A genealogy of patient involvement

Introduction

In this chapter I explore the historical and contemporary constructions of the patient identity to illustrate how the patient identity and subject position has been constructed and reconstructed across UK government health policy, professional regulatory body educational standards and HEI policy. The chapter begins by considering the 'service user' and 'patient' identities to highlight the distinctions between the two and provide a rationale for my decision to refer to patients throughout the thesis. I then present an archaeological and genealogical review of four constructions of the patient identity/subject position since 1948 and the creation of National Health Service. This chapter goes on to draw a distinction between public and patient involvement, before examining how professional regulatory bodies and Higher Education Institutes (HEIs) utilise patient involvement to offer patients deliberative and participatory involvement in HEI-based nurse education. Finally, I will demonstrate that in hospital-based practice assessment patients have not tended to adopt a patient-citizen position. Instead, I will argue that in hospital-based nurse education there is an additional tension between the NMC and HEIs constituting patients as consumers of education and nursing practices that can promote an entrenched paternalistic approach to patient involvement. Consequently, I will show that the concept and practices of patient involvement and patients' subject positions are different dependent on the situational context, thus revealing a tension between patients' experiential assessments of students' practice in comparison to mentors' professional assessments.

Definitional issues

In 2010, when I started my PhD journey, the educational standards from the NMC (NMC, 2010; 2011) did not draw any distinction between patient and public involvement, instead they used the term 'service user'. As a nurse and nurse lecturer I am used to both terms, patient from my time as a practicing nurse, and service user within my academic practice. I therefore had initially decided to use 'service user' throughout the thesis as I felt that this reflected the current political and professional discourse within health policy, service delivery and nurse education. According to Beresford (2005a: 471) 'service user' has become a generic term to describe people who are eligible, have or are receiving health or social care service, yet Barnes and Shardlow (1997) state that 'service user' combines citizenship with consumerism and only emerged after the marketisation of public services. Nevertheless, I found it interesting that during participant interviews it became clear that the majority described service users as 'patients' when discussing service user involvement within the hospital setting. Indeed, the dictionary definition of 'patient' is 'a person who is receiving medical treatment from a doctor or hospital' (Collins Dictionary, 2017a). Therefore, as this thesis offers a critical explanation of how service users − those people admitted onto hospital wards − are involved in the assessment of adult nursing students' practice, I chose to reflect the narratives of the participants and refer to patients throughout the thesis.

As a registered nurse, nurse lecturer and occasionally a patient I already possess established ideas and images of the patient through personal and professional socialisation. As already touched upon previously, the formation of identity occurs predominantly during childhood through our direct experiences of being a patient, for example receiving childhood immunisations or visiting a GP, as well as through

education and the influence of those around us. Therefore, while we may not have had experience of being a hospital patient, we begin to understand who and what the patient is through those interactions with health professionals, as well as through books, television, occupational role-playing and education. This continues to develop influenced by our personal sociocultural experiences, relationships with others, and for me, my interactions with nurse teachers, nurse mentors, patients and the multi-professional team during my nurse training (Kroger *et al.,* 2010). Hence, my understanding of the patient not only frames my professional perceptions of the patient as a group identity in terms of expected behaviours, characteristics, roles and responsibilities, but it also influences how I, as a subjective patient, interact with health professionals and engage with current health policy.

As I have illustrated, it is common for us to categorise ourselves into a group identity based on the position or group we feel most associated with (Stets and Burkes, 2000). Each identity has its own specific meaning, which governs attitude, behaviours and perceptions of associated social norms, and cultures, which, by individual interpretation, also governs the nature of relationships with health professionals and policy makers. Therefore, if we display symptoms of illness or disease we may affiliate ourselves to a group identity of being 'sick' (Parsons, 1951), while those seeking advice from a health professional may identify himself or herself as a 'patient' or 'client'. Nonetheless, establishing the patient as an objectified identity is more challenging and complex. Across healthcare settings, there are already an array of identities and subject positions highlighted within the literature (Baggott *et al.,* 2005; Speed, 2006; McLaughlin, 2009b; Barnes and Prior, 2009; Simmons *et al.,* 2010), however these are often presented as single entities and conjure up different images of essentially the same individual. But, if individuals are

constrained to a solitary persona this presents a one-dimensional image of a patient that fails to acknowledge the other facets that influences who they are as individuals and how they engage with health professionals.

Therefore, in reality all of us are multi-faceted and hold multiple identities and subject positions depending on who we are interacting with and the social context in which we find ourselves (Davies and Harre, 1990). I agree with Foucault (1982) who suggests that rather than deliberately selecting an identity one feels more affiliated to, the individual or 'subject' is produced through dual experiences, one formed through the empirical connections made with the world and the other through 'ascesis' or spiritual discipline, how individuals use transcendental constructs such as religion, policy or professional discourse in order to understand how to behave in an acceptable manner (Coveney, 2012). What I have come to realise is that I had not really considered where 'the patient' comes from or who 'the patient' is? Is there a common patient identity? Are there set rules and boundaries that govern patient involvement? Although the term patient is inherently used within healthcare in hospital and community settings (rather than mental health, learning disability services or social care), there has been little exploration around the identity or subject position of 'the patient' within nursing literature. The problem with not fully understanding how the patient is constructed is that 'the patient' is sometimes constituted as an objective group identity rather than an individual subjective being.

In terms of developing an understanding of 'the patient' identity it is constructed through the differing statements found within individual, government, medical and nursing discourse within the context of patient care and patient involvement. Foucault (1972) suggests that such statements are contextual − in other words, they change over time. As society, culture and our knowledge base evolves so

statements change, meaning that, in the context of this study, how we objectify 'the patient' is never static but is continuously being updated and reframed. Objectification does, however, enable the patient group identity to become visible and offers a space for the patient to occupy within society; it is only after this process, as 'the patient' becomes part of regular discourse that the patient's place, as a subject, is known and accepted (Foucault, 1993). Once accepted there are key roles, actions and responsibilities aligned to that position influenced by the political, historical and societal context relevant to that particular discursive practice and where the subject has been positioned. This subsequently shapes the content of what is said, when it can be said, the relationships between individuals, and the various subject positions within the discourse and the authority given to each social actor within it (Neville, 2008). The next part of the chapter illustrates how the patient has been discursively constituted and reconstituted over four distinct epochs or time periods.

The evolution of the patient identity

Much of the literature surrounding the patient identity and subject positions within healthcare appear to be focused on medicine rather than nursing. This may reflect the constitution of nursing as the 'caring' profession where the nurse-patient relationship is characterised through emotional connectedness, which could explain why nursing research appears to focus more on the interpersonal aspects of the relationship such as the complexity of the nurse-patient relationship (Turkel and Ray, 2000) or the formation of therapeutic relationship (for example, McQueen, 2000; Van De Heever *et al.,* 2015), rather than power relations or the construction of identity. It might also reflect the dominance of medicine over the rest of the professions. In the previous chapter I have shown that nursing has been problematised by some because of its positioning within the sphere of medical practices. Rather than medicine referring

specifically to doctors, medicine has been defined as 'the treatment of illness and injuries by doctors and nurses' (Collins Dictionary, 2017b), therefore, in order to provide additional context, I have aligned each patient identity with Sielger's (2011) 'four ages of medicine' (Table 8).

Patient Identity	Time Period	Four Ages of Medicine (Siegler, 2011)
Passive Dependent	1948-1974	Paternalism
Patient Consumer	1974-1997	Autonomy
Patient Citizen	1997-2010	Bureaucracy
Involved Partner	➢ 2010	Shared Decision Making

Table 8: The discursive evolution of the patient identity

Drawing on work by the Spanish medical historian Pedro Laín Entralgo, Sielger suggests that the doctor-patient relationship can be separated into four discrete chronological 'ages' of medicine in America, Canada and Western Europe. Although he does not account for significant differences in health care funding between countries, this still provides a useful classification of the four epochs of the patient identity identified above. I now provide a brief outline of each 'age'. According to Sielger (2011:13) the age of paternalism (the age of the doctor) emphasised health professionals' authority over patients who remained passively dependent, trusting in the expertise and moral status of the professional. The age of autonomy (the age of the patient) rearticulated care as a social right that afforded patients a degree of freedom and agency that heralded a subtle shift in the power relations between health professionals and patients. Here the health professional was reconstituted as a public servant, while the patient became the consumer of health services. The third age, the age of bureaucracy (the age of the payer), encapsulates an

era when medicine and health professionals became increasingly accountable to hospital managers and the government and the patient positioned as a citizen focused on the greater good of society. Finally, the age of shared decision-making reflected changing health policy where health professionals and patients were constructed as collaborative partners in care. The next part of the chapter considers each of the four patient identities in more detail.

Passive Dependent

Prior to 1948 healthcare in the UK was based on a payer/vendor model where the patient sought and paid for medical services, while the doctor, as vendor, offered their services for a fee (Rivett, 2014). In 1948 the newly-elected Labour government announced the launch of the Welfare State and National Health Service, funded through central taxation rather than social insurance that guaranteed free health and social care from the cradle to the grave. Except for the private sector, the majority of health provision became state governed. By creating a mechanism for central funding, the previous payer-vendor system had included public involvement in the management and development of local services but the nationalisation of health services removed that level of involvement, thus the patient's position within institutional hierarchies and practices was weakened as patients lost their consumer position and with it their ability to choose (Klein, 2013). While some patients remained active in the management of community and co-operative hospitals, patients and the public were not included in the consultations for the new NHS. Bevan undertook 20 conferences to consult a range of stakeholders directly affected by the introduction of the NHS Bill including doctors and nurses, however patients were not seen as being directly affected so were not consulted (Socialist Health Association, 2009). The dominance and power of medicine within new NHS

institutional hierarchies and the patients' lose of position as the paying consumer most likely perpetuated the objectification and subordination of patients within public and political discourse.

The social contract between the state and medicine, which predominated in the period before 1948, was reconstituted during the formation of the NHS. Instead of contracts between the government and individual doctors, hospital doctors were contracted to work under the auspices of the new National Health Service in return for financial and regulatory power (Light, 2010). The government now had a social and legal obligation to provide health and welfare services to the public, giving patients the right to health and welfare free at the point of delivery. What is interesting is that during the formation of the NHS and as medicine grew more dominant the patient appeared to become increasingly passive. Patients no longer had the opportunity to comment on how hospitals were run or help to determine what services the NHS would provide, the effect was that patients began to be objectified as a body presenting for physical examination rather than a paying customer of medical or nursing services. The loss of a subjective consumer identity reduced patients' abilities to choose their own healthcare; instead doctors under the auspices of the welfare state and the NHS made the decisions based on their own professional expertise. Armstrong (1983) attributed patients' subsequent passivity to the increased emphasis on the clinical examination for diagnosis and asserts that:

> 'The clinical examination thus fabricated the body and through its rituals privatised it and made it passive. If the patient accepted this gaze then its effects were achieved yet even resistance to the gaze produced the same result because resistance was itself based on the notion of the body as a discrete and personalised object. Thus, the body was held in, and constituted by, a field of surveillance from which it could not escape' (Armstrong, 1983:103)

The patient subject position within political and professional discourses subsequently evolved due to the changing context of health service provision. Before the NHS

patients had personally 'invested' in their local services both financially and emotionally giving many a sense of ownership (Mold, 2010; Morrow, *et al.,* 2012). When the health service became nationalised the personal emotional investment and commitment from patients reduced as their position shifted from payer-for-care to recipient-of-care. The relationship and power balance fundamentally shifted to one where the government and professionals took a parental authoritarian role, while the patient's subject position moved towards passive-dependency, where the passive-dependent patient was constituted as accepting of doctors' higher authority and expert knowledge. While some within the medical profession had begun to acknowledge the importance of understanding a patient's individual personality and patient expectation in the mid 1960s, medical and political discourses continued to position the patient as a passive dependent (Armstrong, 1983).

As medical care in hospitals became increasingly systematised, so did nursing where patient care was often rountinised and task-oriented, something that Greenberg and Zaranda (1975) suggest was perpetuated by the dominance of medical discourse within hospital-based nurse education. While nursing was constituted through a discourse of care, nursing was predominantly based upon a helping relationship. Within this nurse-patient relationship, such discourses (care and helping) constituted the patient as a passively dependent 'helpee' who was 'directed, controlled or cared for' by the nurse (Jenks, 1970:24). This suggests that while the constitution of nursing, care and patients centred on the development of relationships, nursing discourses during this period constituted nurses in a position of authority and control over the caring relationship. This appears to reflect the institutional hierarchies of the time, where nursing was considered an auxiliary profession to medicine rather a

profession in its own right, and as such nurses were expected to follow doctors' instructions in preference to the patient's wants (Cody, 2003).

The emergence of the patient consumer

Consumerist health policy first emerged in the early 1970s, which led to the setting up of Community Health Councils (CHCs) in 1974 (Barnes and Cotterell, 2012). The purpose of these councils was to provide a formal mechanism that enabled the public to be involved in ensuring local health services met local needs. A third of CHC membership was from local voluntary bodies that acted on behalf of those members of the community who were often marginalised, for example the elderly and those with mental health conditions (Klein, 2013). Klein (2013:84) suggests that CHCs effectively 'institutionalised the voice of the consumer', however the CHCs predominant focus was at a health policy and institutional level rather than at the care interface. Indeed, Mold (2012) argues that despite the intentions of supporting the patient rights movement, within institutional practices medicine's dominant position remained unchanged.

The dominance of paternalistic models of care was evidenced up until the 1980s when the new Conservative government led by Margaret Thatcher, introduced the concept of health consumerism and the internal market (Griffiths, 1983; DH, 1989). By introducing the internal market, the government hoped to increase competition in order to drive up quality whilst reducing costs, encourage service innovation whilst improving responsiveness to consumer need (Rivett, 2014). The NHS was now split between provider services (hospitals, GPs) and purchasers (Regional and Strategic Health Authorities) resulting in a patient-consumer model based on a proxy-consumer approach where services were bought by a designated purchaser i.e. the Health Authority, on behalf of the local population. This saw the

relationship between government, service providers and the public move away from central leadership towards a market model that encouraged patients to engage in active consumerism that encompassed additional consumer rights and privileges (Fredriksson and Tritter, 2017). Indeed, Kennedy (1981) suggests that changing health policy and patient expectations was already beginning to shift power away from health professionals. Patients were no longer constituted as passive dependents but healthcare consumers who had the social right to engage in shared decision-making about their care and be more involved in developing healthcare services, resulting in another refinement of the patient identity.

The concept of the patient-consumer was in stark contrast to previous political discourse in which the patient was constituted as passive-dependent. The power relations between patient, professional and government had tended to objectify patients that might explain the adoption of a passive dependent patient identity, but now political discourse had reconstituted the patient as an active consumer. Although medical discourses attempted to absorb the idea of patient-consumers, the professional dominance of medicine sustained patients' subordinate position (Häyry, 1991). An important question is whether the majority of patients saw themselves as consumers of health services? If a 'consumer' is defined as someone who creates a service through demand for an end product (Bradshaw, 2008), some patients may not have wished to be seen as demanding or be seen as 'using' valuable national resources (Simmons *et al.,* 2010).

Health consumerism is associated with neoliberal ideas that moved the emphasis away from health services being administered by government towards a more liberal approach through which citizens are able to exercise freedom of choice (Peterson and Lupton, 1996). Yet, McLaughlin (2009b) remains cynical as to the

motives for consumerism arguing that rather than improving health services for patients and promoting true public involvement, such policy changes were directly aimed at reducing the monopoly of health professionals (Evans and Harris, 2004). The outcome of Conservative government policy under both Margaret Thatcher and John Major, was the introduction of management hierarchies, increased scrutiny through audit and target setting, performance management and a drive towards a more efficient and effective health service (Barnes and Prior, 2009). This directly challenged the prevailing professional dominance and suggests a political drive to replace society's sedimented trust in professionals due to their education and expertise, to one where trust had to be earned (Salter, 2004).

Through the introduction of consumerism and an internal market the government introduced several white papers in order to bolster patient-consumer involvement in planning health services and service delivery. *The Patients Charter* (DH, 1991) set out the basic rights and standards patients could expect from the NHS and later in 1992 *Local Voices* (DH, 1992) invited local communities to be involved in service development and the allocation of resources within health and social care. Various consultation strategies were introduced such as citizen juries, focus groups and health panels, but these attracted heavy criticisms for being unrepresentative with local disadvantaged groups often being excluded (Forster and Gabe, 2008). This change in political rhetoric towards patient empowerment was slow and did little to change the patients' position within health or professional discourse (Martin, 2008). Such radical changes to the NHS can foster feelings of discomfort and resistance, which Tritter (2009) suggests resulted in protracted delays in actively involving patients within the commissioning process. Yet, Conservative economic policy continued to promote the benefits of consumerism to the wider population and with

this gradual reshaping of UK culture, associated norms and values combined with government reforms moved the NHS from a paternalistic, protectionist provider to one in which patient-consumers were given a legitimate right of involvement (Salter, 2004).

Although consumerism introduced both civil and social rights to people, the government also expected individuals to take on some responsibilities and to some degree, be accountable for their own health. The change within the level of public consultation and the participation of voluntary agencies and patient groups within policy development at both a national and local level facilitated some public input into the way services were developed and managed. Nevertheless, the extent to which each individual could exercise their consumer rights remained a source of discussion, as far from seeing an increase in collaboration and partnership, overall individual health consumers tended to remain predominately passive (Evans and Harris, 2004, McLaughlin, 2009b, Calnan, 2010, Klein, 2013).

The reality of individuals becoming health consumers was fraught with difficulty and was sometimes an uncomfortable concept to grasp. The idea of health consumerism would suggest that the patient is seeking to buy health services directly from the professional, with the patient having the final say on whether to purchase services or not (Salter, 2004). What this does not take into account is the knowledge required in order for the buyer to know if the service is appropriate, effective or affordable. In reality patient-consumers are often prevented from directly purchasing health services, may have limited choice, and might continue to be constituted as passive-dependents within professional and patient discourse (Evans and Harris, 2004, Newman and Vidler, 2006; Tritter and Koivusalo, 2013). Salter (2004:13) contends that the Conservative government never intended for patients to become

part of health policy, arguing that this exclusion was the result of a deliberate state-medical alliance. He suggests that this collaboration worked to ensure that the patient remained in a 'subordinate market position' ultimately assisting the management of patient demand over service and resource availability.

In terms of nursing practice, while the idea of individualised patient care had been mooted into the UK in the 1970s and 1980s, task-oriented nursing, with the objectification of the patient into a series of tasks appears to have prevailed (Woodward, 1998). Nevertheless, the adoption of organisational models of care in the late 1980s, such as team nursing and primary nursing, rearticulated nursing as a patient-centred profession rather than a functionalist occupation focused on completing patient associated tasks (Ellis and Hartley, 2008). Patients were now constituted as 'experiencing subjects', yet they remained subordinate to health professionals and thus remained subject to nurses' surveillance (May and Purkis, 1995:286). Team nursing aimed to humanise the patient experience by allocating patients to smaller teams of nurses, with specific tasks being allocated to individual nurses under the supervision of a nurse team leader (Kron, 1981). But, according to Grinspun (2000) the marketisation of health services actually encouraged the fragmentation of patient care that she suggests resulted in a gap between patient expectations and the practicalities of caring in a market-driven healthcare system. This might help explain the criticism from some that patients perceived they had less contact with registered nurses using these new nursing approaches, where it was sometimes unclear who was responsible and accountable for their care (Thomas, 1992). In comparison, primary nursing saw patients allocated to an individual 'named' nurse who was responsible for overseeing that patient's care for the whole shift (Thomas, 1992). This model centred on the delivery of individualised patient

care that promoted a patient-consumer identity, however there was some professional resistance against such a fundamental change in the nurse-patient relationship dynamic. Health consumerism went some way to revert to the pre-NHS nurse-patient relationship where the nurse was paid by the patient to provide them with nursing care. The idea of the patient-consumer does not appear to have been criticised directly within the nursing literature at the time, but instead resistance against a reconstituted patient identity appears in the criticism that patient-centred models of care encouraged nurses to become overly involved with patients and created conflict between primary nurses (Thomas, 1992).

Although team and primary nursing aimed to place the patient at the centre of their care the premise appears to have been more on improving care processes, job satisfaction and staff efficiency rather than actually involving patients in decisions about their care (Woodward, 1998). Woodward (1998) contends that nursing practices often reverted back to task-oriented traditions as that helped nurses feel in control of an increasingly busy ward environment, but it also could be interpreted as resistance against nurses' loss of professional authority over care. As the medical model had reduced the visibility of the patient into bodily systems, the continuing systematisation of care still constituted the patient as passive-dependent, where care 'tasks' were done to rather than with them (Webb, 1981). The subordination of the patient was evident in a study by Hewison (1995), where he observed over 100 nurse-patient interactions and found that nurses used a variety of different strategies to control and protect their dominant position during care delivery. First, nurses' overt power was evident in their use of language, from issuing instructions to admonishing undesirable behaviour; second, nurses often determined patient activities rather than the patients themselves; third, nurses used persuasion through repetition, questioning

and persistence in response to patient's refusing aspects of care (Hewison, 1995:79), and finally, the most common way that nurses exerted power over patients was by controlling the care agenda by offering patients limited choices, all of which had already been determined by the nurse. Similarly, Henderson (2003) found that while the ideology of patient-consumerism appeared to have become an accepted norm within hospital nursing practices, the majority of nurses remained reluctant to engage in collaborative, shared decision-making with patients, in their belief that as educated professionals 'they knew best' (Henderson, 2003:504). Rather than an outright resistance against the reconstruction of patients as consumers, nurses' reluctance may have been professional resistance against the way in which the nurse-patient relationship and nursing's own professional identity was being reconstructed and transformed. An alternative view would be that within institutional hierarchies of power, what little power nursing did have centred upon nurses' authority over 'care', whereas doctors' maintained greater authority over 'cure'. It is possible that nurses' deferential positioning against medicine could account for nurses' failure to empower patients, as resistance against such a policy change effectively helped maintain the *status quo* (Hewitt, 2002).

The Patient-Citizen

So far, this chapter has shown that while government health policy positioned patients as consumers of health services, long-established functionalist nursing practices were slow to change. In this next section I examine the emergence of a patient-citizen position. In 1997 an incoming Labour government expanded the neo-liberalist ideas of consumerism with patient-led initiatives continuing under the auspices of widening community involvement and citizen partnerships (Morrow *et*

al., 2012). Built on the ideals of citizenship, the patient subject position within the NHS moved towards being:

> 'active and individualistic rather than passive and dependent. The political subject is henceforth to be an individual whose citizenship is manifested through the free exercise of personal choice amongst a variety of options' (Miller and Rose, 1993: 98)

Despite the incoming Labour government promises to scrap the NHS internal market and reinstate a profession-led NHS (Greener, 2003), the scandals of Bristol Royal Infirmary and Alder Hey Children's Hospital in the early 2000s had changed patients' attitudes towards health professionals prompting the government to adopt the previous Conservative government's neo-liberalist consumerist rhetoric (Forster and Gabe, 2008). Dent (2008) suggests that these scandals enabled the government to exploit health professionals' increased sense of vulnerability. Subsequent political and media accusations of continuing bureaucratic and professional paternalism further weakened health professionals' position; hence their ability to resist further NHS reforms was reduced (Crinson, 1998; Forster and Gabe, 2008). This suggests that patients were used as a political device to drive through NHS reforms as the expansion of consumerist-focused health policy made it increasingly difficult for health professionals to be seen to be against the patient-citizenship agenda and patients' rights to greater levels of involvement (Clarke, 2005). Salter (2004) contends that the dominance of patient empowerment and involvement within political discourse effectively outmanoeuvred medicine affording the government significant political advantage over doctors especially.

Thus, patients remained central within political discourse. With continuing public unease surrounding the quality of NHS service provision, the government became increasingly accommodating by including patients in the development and application of government policy in order to be seen to be listening and acting on

patient concerns (Klein, 2013). Several key patient consumer groups were involved in the production of the white papers *Public and Patient Involvement* (DH, 1999) and *The NHS Plan* (DH, 2000a) that both promised greater patient involvement in treatment, access to information and monitoring of service delivery in a new patient-centred NHS. But it also introduced greater controls over professionals through the introduction of new performance targets, clinical standards, increased accountability and more significantly a change to doctors' contracts (Kemp, 2010; Klein, 2013). The Labour government set out to improve NHS governance and established a series of new organisations with a remit of ensuring a unified approach to evidence-based practice [National Institute for Clinical Excellence], quality monitoring and standard setting [Commission for Health Improvement] (Forster and Gabe, 2008).

One of the first areas of medical dominance that was scrutinised under the guise of NHS governance was the professions' control over the use of medical knowledge. Up until the 1990s the majority of knowledge within health was produced, reviewed and sanctioned internationally by the medical profession. This monopoly on the generation of expert medical technology continued to support the dominance of medicine, as it often remained unchallenged (Klein, 2013). As autonomous practitioners, doctors were in a position of medical authority to choose treatment based on clinical need and professional opinion. The patient discourse was still based upon historical NHS terms of reference meaning that the public continued to have an expectation of free healthcare at point of delivery and the best care offered by expert practitioners. However other important aspects had changed, the patient-consumer subject position had given patients the authority to question doctors' clinical decision-making and to take some, although minimal, control over choice (Learmonth *et al.,* 2008). Nevertheless, at the beginning of the NHS neither

politicians, professionals nor the public could have envisaged the scale of technological and treatment advancements made within healthcare. Doctors and patients have subsequently been able to choose from an ever-expanding treatment portfolio that has in turn led to public concerns over geographical variations in care and political concerns over spiralling costs.

Doctors' dominant position within hierarchical institutional practices provided medicine with an elite status that could account for a sedimented acceptance that doctors' assumed expertise guaranteed high quality care, yet practice continued to vary widely between practitioners with no real consensus on which treatments equated to best practice (Timmermans and Oh, 2010). The government had already tried to control NHS spending by constraining health professionals to a supply and demand model of healthcare with the introduction of general management in 1983 (Griffiths, 1983) however; Salter (2002) asserts that this was continuing to prove unsuccessful. The suggestion of raising taxes to pay for NHS budgetary increases would not have been popular therefore the government had to find another way to reduce NHS expenditure, and therefore if the government could reduce the dominance of medicine by removing doctors' right to determine best practice, the government determined spiralling costs could be contained (Salter, 2002).

The National Institute for Clinical Excellence (NICE) was set up in 1999 to review all new medical technologies to ensure their effectiveness against cost and patient outcomes. NICE was essentially rationing access to treatment, but it is difficult politically for any government to talk about rationing in the context of a free universal service. Therefore, while the function of NICE was to ensure value for money, it effectively controlled patients' access to medicines and services. Previously General Practitioners had been tasked with 'rationing' health services and

had controlled access to care since 1948. What NICE represented was an extension of rationing into a government body, reducing the autonomy of medicine. Now government health policy focused on ensuring value for money (Salter, 2004) and there appeared to have been an implicit assertion on behalf of the government, that GPs were not doing enough, therefore the government needed to step in and take this in-house. Expert knowledge is constituted as a central component of professional power so by introducing an independent, but government-endorsed body to review the quality and efficacy of medically-led research, medical authority and control over the body of specialist knowledge was no longer completely under professional control. Medical autonomy for treatment decisions was now coupled with increased accountability to the government and therefore the public.

In 2007, David Cameron, then Conservative opposition leader articulated the change to patient-citizenship as almost a coming of age. Narratives based upon consumerist patient and public involvement began to construct an equal patient-professional relationship as one between autonomous adults, where professionals were required to accept the patient as an '… active agent of their own life' who would 'become doers, not the done for. Responsible, engaged, informed – in a word, adult' (Cameron, 2007). Such narratives attempted to move away from historical institutional hierarchies where the expertise of professionals was privileged over the experiential knowledge and expertise of the patient, to one where the patient-citizen was constituted as an equal partner and an essential stakeholder through a transformative co-production discourse (Needham, 2008). In 2008 the Health and Social Care Act (DH 2008a) established the Care Quality Commission, a single, integrated regulator for health and social care, which began operating in 2009. Their role was to monitor the quality of health care services within the public and private

sectors to ensure that services meet quality and safety standards, and to ensure better patient outcomes. Consequently, the patient was reconstructed as a citizen with the right and responsibility to raise concerns about quality of care, NHS services and the competence of professionals. Certainly, patient representative groups such as the Patient Association had become significant players within political and patient discourses and given the credence government and professional groups gave to their concerns, the patient position continued to move towards partnership and collaboration. By 2009 the government introduced payment by results where providers were paid a fixed price based on patients' treatment and clinical condition. Subsequently the patient experience was emphasised within NHS key quality performance indicators (Klein, 2013), although some argued that attaching monetary reward for patient and public involvement reinforced manipulative, tokenistic inclusion rather than promoting true partnership working (Coulter *et al.,* 2014; Dent and Pahor, 2015; O'Shea *et al.,* 2016).

Mid Staffordshire NHS Foundation Trust hit the headlines in March 2009 following the publication of a highly critical Healthcare Commission report that investigated higher than average mortality rates at the hospital (Healthcare Commission, 2009). The report's findings, and those of the following independent and public inquiries (Francis, 2010; 2013) found that staff concerns over standards of care alongside patient and family complaints were consistently ignored or negated by the Trust's board. However, there was also criticism of the Patient Forum, who, despite having been informed of concerns by a number of Forum members failed to take those concerns forward (Francis, 2013). Mid Staffordshire perhaps provides another example where patient and public involvement became subsumed into an institutional agenda that focused on achieving government targets and institutional

objectives rather than quality review and enhancement of care services (Forbat, *et al.,* 2009; O'Shea *et al.,* 2016). Within this scenario the patient position became one of a quasi-professional – meaning patients had become socialised into mimicking the culture and practices of managers within the Trust (Dent and Pahor, 2015:551; O'Shea *et al.,* 2016). Dent and Pahor (2015) argue that although quasi-professional patients may feel more familiar with institutional practices and organisational terminology their relationship with professionals and managers remains paternalistic as it ensures compliance of patient forum members. Hence, the patient can become reconstructed as a management partner and as a result the 'independent critical voices' of the patient-citizen risk being lost (Croft *et al.,* 2016:125).

The emergence of the patient-citizen identity might suggest that patients were developing a greater awareness of their social and civil rights to health and healthcare. Political narratives were promoting active patient and public involvement in healthcare, while placing professional knowledge under greater scrutiny. Needless to say, the medical profession reacted with suspicion and some saw the move as a political strategy to subvert medical authority and professional autonomy (Timmermans and Oh, 2010). Interestingly, despite the political drive for greater partnership with patients there is little evidence to demonstrate that this led to improved patient outcomes either in quality or health (McLaughlin, 2009a; Fredriksson and Tritter, 2017). Indeed, the Commission for Health Improvement found that public and patient involvement was not a fundamental component within many NHS organisations (Forster and Gabe, 2008). Despite the move towards partnership and the devolvement of power back towards patients, Gosling (2010) warned of tokenism through which patient compliance, containment, coercion and incorporation appeared to be the focus. She argued that negative consequences

remained for patients if they went against the views of service providers and implied that patient involvement was being reduced to a 'tick box exercise' as providers concentrated more on meeting government targets and legislative requirements.

Patients as involved partners

In 2010 the political discourse was again reset with the election of the Conservative-Liberal coalition government. One of the first white papers published was *Equality and excellence: Liberating the NHS* (DH, 2010a) in which the government laid out its plans to devolve power back to patients and frontline health professionals. The focus remained on quality improvement, however the paper also reassured health professionals that their position in driving forward healthcare would be restored. The underlying discourse suggests an attempt to placate public and patient concerns over the direction of the NHS and their continuing lack of opportunity to make informed choices and genuine contributions to service development. One way the government chose to address this was to restore the link between patients as consumers, service commissioners and healthcare providers. The white paper set out the government's intention to cut back central control of the NHS with the delegation of service commissioning to local GP consortia or clinical commissioning groups (CCGs). It made explicit that patients and professionals were in joint command of the NHS with patients central to care decisions, highlighting individual's social rights to health care with the notion of 'no decision about me without me' (DH, 2010a:13). Despite this assurance this ideal was not clearly articulated within the *Health and Social Care Bill* (DH, 2011) a criticism highlighted during the House of Lords Committee stage review (DH, 2012c). Patient involvement as a collective phenomenon was evident, but the processes to support individual patient engagement remained tenuous and it was unclear within the Bill amendments how this was strengthened.

The Bill also introduced an independent NHS commissioning board accountable for ensuring government standards and targets were met, as well as being responsible for resource allocation and monitoring of GP consortia. This saw the end of Strategic Health Authorities and Primary Care Trusts and the introduction of the external market through which private providers and social enterprises could bid to provide NHS services; the transfer of public health services from the NHS to local authorities and the setting up of Monitor, a new economic regulator (DH, 2011; Pollock and Price, 2011). These reforms attracted serious criticism not only from across the health professions, but from patient groups, managers, charities, the King's Fund and the NHS Executive (Appendix 11). Patient groups were supportive of the government's commitment to enhance the 'patient voice' but warned that the level of tokenism, in regard to active, meaningful patient participation could not continue. Mental health charities' biggest concern was that, as with previous legislation and government policy, the details of how patients should be involved was lacking, continuing the huge variations in public engagement across the UK. Without a clear strategy for consortia and other agencies to actively work in partnership with a true representation of the patient population it was unlikely that true patient collaboration would result (Kirsh *et al.,* 2010).

Public anxiety about the new Bill led to an online petition that attracted 179,466 signatures urging the government to scrap the bill (Petitions, 2012). The Patient Association (2012a) highlighted their concerns about increased competition and warned of a significant change between the General Practitioner and patient relationship. Concern was raised that doctors would no longer be so inclined to work in the patients' best interest but would have an overriding focus of balancing the books. Several patient groups engaged in a media campaign demanding the

government clarify the areas of service commissioners' responsibility for patient involvement. This campaign was successful and the Bill was subsequently amended. Now both the NHS Commissioning Board and CCGs have a legal duty to ensure that they promote the involvement of patients and their carers in treatment decisions and decisions surrounding disease prevention and diagnosis (National Voices, 2011). These changes had the potential to reconstruct the patient subject position and power relations with the patient constituted as an equal partner. Yet, O'Shea *et al.'s* (2016) investigation into the level of public representativeness within CCGs and patient and public involvement reference groups found that despite government rhetoric suggesting widening opportunities for patients to directly influence service commissioning, the practical application of patient involvement remained under the control of managers and clinicians. Their findings mirrored previous criticisms that involvement strategies often exclude the most vulnerable and disenfranchised sections of the population (Warren, 2008; Beresford, 2013). Therefore, for some patient involvement continues to be tokenistic (O'Shea *et al.,* 2016; Snyder and Engström, 2016) where patient involvement is presented through statistical data as evidence of compliance with legislative requirements, but without demonstrating commitment to the principles underpinning it (Boyle and Harris, 2009; Carter and Martin, 2016).

Hospital managers' failure to respond to patient and patient involvement group concerns was a fundamental finding of the Mid Staffordshire inquiries (Francis, 2010; 2013). The government used these findings and previous care scandals to reconstitute patient involvement through discourses of safety, accountability and compassion (DH, 2013a, 2013b; Synder and Engström, 2016), but the government also placed greater emphasis on enhancing individual patient

involvement in shared decision-making in care planning and delivery (DH, 2013a. 2013b). The 2012 NHS Constitution had only offered an NHS pledge to work in partnership with patients, families, carers and representatives; however, following Francis' recommendations, the Constitution became a mandatory set of standards for all NHS organisations (DH, 2013b). Recommendation 40 of the Francis report (2013) called for organisations to review qualitative patient satisfaction data as well as quantitative statistical data. Yet, patient satisfaction and Friends and Family test data continues to be presented as descriptive statistics. Qualitative data tends to be collected via the NHS Choices website using a star rating and although there are individualised responses from Trust Patient Experience Teams or Chief Executives there is little evidence to show how this type of patient feedback directly improves services or care delivery (Carter and Martin, 2016).

Despite the on-going assertion that patients should be involved in decisions about their care, studies have found institutional and nursing practices within acute hospitals continue to be process driven, which some suggest perpetuates paternalistic approaches to care (Griscti, *et al.,* 2017; Papastovrou, *et al.,* 2015; Tabiano *et al.,* 2015). Despite the patient-as-involved-partner position being established in health policy, in practice Aasen *et al.* (2012) suggest nurses still find it difficult to relinquish control. Issues such as increasing workload, lack of staff and institutional demands continue to be cited as barriers to effective patient involvement (Nota *et al.,* 2016; Papastovrou, *et al.,* 2015; Tabiano, *et al.,* 2015; European Commission, 2012; Foss, 2011). The European Commission undertook a study across 15 European countries including the UK, and concluded that despite political and professional rhetoric, patients and professionals did not understand patient involvement or what it actually entailed. They concluded that health professionals continue to retain a position of

authority as the majority of patients and professionals saw it as the professionals' role to invite patient involvement, which suggests it is yet to become a sedimented professional practice. Griscti *et al.* (2017) concludes that patient consumerism still presents a direct threat to nurses' professional authority and in such situations entrenched patriarchal institutional practices continue to privilege nurses over patients. Therefore if that is the case it is possible that patient involvement in practice assessment could also represent a threat to mentors' professional authority.

My exploration of the construction of these four patient identities reveals the way in which 'the patient' identity and position within health policy and institutional practices has been constituted, resisted, transformed and instituted. Despite government policy promising a greater emphasis on a patient and public involvement within a patient-centred NHS, Klein (2013) argues that government policy has done little to reduce professional control over the organisational running of the NHS. Others suggest the public are being presented with an illusion that patients are being afforded real choice and real involvement (Tritter, 2009; Fredriksson and Tritter, 2017). Therefore, while patient involvement is constituted through a discourse of empowerment, at a micro level (on the wards) it appears more complex and challenging than at a meso level (institutional) where patients are involved through surveys and patient forums (Angel and Frederiksen, 2015). This is perhaps indicative of a continuing tension between patient involvement, based on individual's personal participation in making decisions that protects their own interests, and public or patient-citizen involvement, based on promoting the greater good for a population. The next part of this chapter explores the differences between these two involvement ideologies.

Distinctions between Patient and Service User Involvement

Having discussed the four patient identities, I now examine the theoretical and conceptual differences between patient and public involvement to help illustrate the challenges associated with the NMC's amalgamation of these terms to 'service user' involvement. As I alluded to earlier in this chapter, the term 'service user' predominates NMC educational standards (NMC, 2010) and extends into HEIs involvement strategies as well. This is potentially challenging as this combines two similar concepts that have some distinct differences between them that do not appear to have been acknowledged. These differences could have a fundamental impact on the effectiveness of patient involvement within the practice assessment process. *Patient* involvement positions the patient as an involuntary consumer whose perspective and decisions are focused on their own care or on those immediately around them, for example patients being involved in assessing students' practice during a hospital admission. Involvement is therefore on a personal level based upon the knowledge gained from their patient experience, their involvement in care decisions and the extent to which the care they receive takes account of their individual needs and preferences (Beresford, 2002; Fredriksson and Tritter, 2017). In contrast, *service user* or public involvement does not rely on people having had a recent patient experience, instead service users are positioned as 'public policy agents' constituted through a discourse of citizenship that articulates involvement around preserving society's rights to health, representing and protecting collective societal interests and strategic and operational service development and health policy (Martin, 2008; Fredriksson and Tritter, 2017). An example would be members of the public who have made the choice to join a HEI service user group. However, Fredriksson and Tritter (2017:96) assert:

> 'patient involvement is a reaction to medical paternalism and the patient's limited capacity to manage their own care, whereas public involvement draws on democratic theory and is a response to the democratic deficit, voter apathy and declining trust in public institutions'

They argue that there are several ideal-type distinctions between patient and public involvement in terms of role, perspective and decision-making, involvement resources, unit of action, type of interest, legitimacy claims, representativeness claims, accountability claims and finally responsiveness claims (see Table 9). At first glance, there appears to be a clear demarcation between patient and public involvement, yet in practice these boundaries remain blurred. In part, this might be explained by hospitals and HEIs practices driven by legislative and regulatory body standards that require the adoption of both approaches; a consumer approach where patient involvement is predominantly through surveys and the friends and family test and a democratic-citizenship approach that provides patients and service users, as the tax-paying public, the opportunity to influence strategic policy and service delivery (Martin, 2008; Forbat *et al.,* 2009; Tritter, 2009; Gibson *et al.,* 2012; Renedo *et al.,* 2015; O'Shea *et al.,* 2016).

	Patients	Public
Role	Service User Based on illness: right to access, information, consent, choice, privacy, confidentiality etc.	Public policy agent Based on citizenship: Rights, duties, participation, identity
Perspective / **Decision focus**	Health and well-being of self, family, friends or a particular interest group Decisions about own treatment and care Decisions about improvements in the clinical setting	Welfare and well-being of general public. Strategic decisions about health services Decisions on local and national policy Improvements at organisational level
Involvement **Resource**	Experiential knowledge from being a service user	Collective perspectives generated from diversity
Unit of Action	Individual and/or collective	Collective and/or individual
Types of Interest	Sectional Interest: Independent of group Focus on a single issue	Societal interest: Independent of individual interests. Public interest groups
Legitimacy Claim	Internal Output: effectiveness of care / quality of results (individual level) Input: Decision making and policy development	External Input: Decision making and policy development Output: effectiveness / quality of results (collective)
Representativeness	Typical, substantive	Statistical / descriptive, symbolic
Accountability	Performance, social	Political and democratic, social
Responsiveness	Direct: Provider and staff compliance to patient needs, values and preferences	Indirect: Policymakers general compliance with citizen preferences and expectations of the NHS and public policy

Table 9: Ideal type distinction between patient and public involvement (Fredriksson and Tritter, 2017:97)

This brief overview of these two involvement approaches helps illustrate that changing consumerist and citizenship discourses have been engaged to reconstitute

the patient identity, patient positioning within institutional hierarchies and levels of involvement within the NHS. The challenge is that the impact of patient involvement remains unclear as evaluations continue to adopt quantitative approaches measuring output, be that financial or service change, rather than an analysis of qualitative data to examine if involvement has resulted in the promised shifting of power between patients, health professionals and policy makers (Carr, 2012:45; Mockford *et al.,* 2012; Coulter *et al.,* 2014). At the beginning of this chapter, I referred to 'service user' as being defined as everyone who is eligible to use, is using or has used health services. But patients are also referred to as services users within HEI nursing faculties and NMC educational standards, yet patients are not directly receiving or paying for services from HEIs in terms of studying for an academic or professional qualification, so who is the service user within an HEI nurse education context?

The constitution of service user in HEI nurse education

The promotion of consumerist ideology is not restricted to just health and social care, its influence has been felt across the public sector including Higher Education. As the NHS began to recognise the patient as a consumer and partner in care so HEI service user involvement in the form of student engagement emerged from political discourse. From the mid 1980s the dominance of academics in determining HE course provision came under political scrutiny as the government attempted to reduce public spending (Williams, 2013). The reduction of government funding for Higher Education, the introduction of '*competitive pressure'* and student tuition fees repositioned students as consumers of education. The marketisation of higher education meant that HEIs had to become much more responsive to the needs of the student-consumer by providing high quality, value for money education (BIS, 2011; Kandiko and Mawer, 2013). But, while HEI students are perceived as the primary

consumer of education, in nurse education up until September 2017 nursing students had not paid tuition fees, course fees were centrally funded with nursing students receiving a NHS bursary, effectively shifting their position from student-consumer to student-employee.

The student nurse cannot be classified into a single identity as they hold a multitude of different identities and subject positions depending on whether they are interacting with nurse lecturers, mentors or patients and the social context they are in, i.e. attending classes at the HEI or out on practice placements. Nursing students often affiliate themselves to a specific group identity even before they start their nursing programme. It is rare to find a student that has not already identified with a specific field of practice (adult, children's, mental health or learning disabilities nursing) they wish to 'join', whether this is unconsciously reinforced during the selection and recruitment process or is deliberate is a matter for debate; but what is clear is that prospective nurses undergo a process of self-categorisation during which students begin to establish an aspiring professional identify. This might include an acceptance of associated nurse identities and subject positions, which provides them with a sense of belonging to nursing as a social group rather than the student body (Stets and Burke, 2000). This could lead to a significant separation between how nursing students are positioned within an educational context compared to their positioning within the practice setting. Nursing students present a different identity to that of traditional HE students in that their educational focus is on the development of professional competencies in order to join the NMC register, whereas the attainment of a nursing degree is sometimes seen as secondary, something to be completed in order to become a nurse. This differs from other health professions such as medicine where the academic attainment is seen as an essential forerunner to practice (McKay

and Narasimhan, 2012) and most likely reflects the vocational, practice-based origins of nursing.

As stated above, the drive for increased commercialisation of higher education has situated students as consumers of education, which has led to HEIs having to demonstrate and evidence student engagement in programme design, evaluation and development (QAA, 2015). Nursing faculties of course are no different but they have the additional pressure of demonstrating compliance to NMC educational standards (NMC/Mott McDonald, 2013), while managing the increasing expectations of employers and the public. Historically pre-registration nursing curriculum development concentrated on meeting the prerequisites of the NMC and those of local employers. The transition of nurse education to higher education increased these demands as nursing faculties came under the external scrutiny of the Quality Assurance Agency (QAA), the NMC, and Local Education and Training Boards' (LETBs) quality monitoring and improvement frameworks (HEoE, 2014). This complicates the traditional HEI consumer-led quality agenda as not only are nursing course teams expected to evidence student and employer engagement, health and social care faculties are unique in their requirement to evidence patient, service user and carer involvement in curricula development. This requirement positions patients as essential stakeholders who have influence over every aspect of the nursing programme alongside the primary consumers of nurse education, the student.

Consumers by association

I have already set out how government health policy has positioned the patient as a consumer of health services and illustrated that within Higher Education the student assumes the consumer position. However, within nurse education rather than presenting a dyadic relationship between the educational provider and the student-

consumer, a quadriad relationship exists between the HEI, student, practice partners and patients. As health policy in the 1990s pushed forward the notion of consumerism within the NHS, the then nursing regulatory body, the UKCC moved away from professionally-determined nurse training, recognising the contributions patients could make as experiential experts of care, to the development of students' nursing practice (Felton and Stickley, 2004b; Lathlean *et al.,* 2006; Skilton, 2011). A professional education discourse has constituted patients as indirect or associate consumers of nursing education as they receive care from nursing students on placement, therefore government and regulatory body policy positions them as key stakeholders in the development of nursing curricula and nurse education policy (ENB, 1996a; DH, 2003; NMC, 2004, 2010b, 2018; NMC/Mott MacDonald, 2013). In principle, this appears relatively straightforward however regulatory requirement for HEIs to incorporate service user feedback into the practice assessment of nursing students (NMC, 2010b) fundamentally changes the dynamic between student and patient.

Patient and service user involvement in health professional education was emphasised in *'Real Involvement: working with people to improve health services'* (DH, 2008b) and '*A High Quality Workforce'* (DH, 2008c). As a result, CHRE made explicit their expectation that service users would be involved in 'the design and delivery of education programmes and that any course evaluation, has taken the views of patients into account' (CHRE, 2010: 22). This was later consolidated in three key reports (Francis, 2013; Berwick, 2013; Keogh, 2013) that led the Health Education England (HEE), the then commissioners of pre-registration healthcare programmes, and the NMC setting up public, patient and service user groups to help shape the direction of nursing and nurse education (NMC, 2015; HEE, 2014). The

HEE set up a Patient Advisory Forum and Patient and Public Voice Partners in the autumn of 2014 and the following year, the NMC established an Education Advisory Group to include patient representation and a Patient and Engagement Forum that had more than 100 representatives from patient groups, patient advocates and health charities. This was a step forward but a closer examination of recruitment strategies and advisory group minutes (HEE, 2014; NMC, 2015) suggests a consultative approach to patient involvement by the NMC, and HEE recruitment strategies that may have restricted the inclusion of some marginalised groups. Despite the aim of both organisations to position patients and service users as co-producers of education, the risk remained that this was part of a universal tokenistic 'tick box' response to government policy (Douglas, 2010, Naylor *et al.,* 2015). Interestingly, by January 2018 these forums appear to no longer exist, instead the NMC provides an online link to a newsletter and an invitation to members of the public to either attend Council meetings, read NMC papers online or attend fitness to practice hearings.

This marginalisation of patients is not just restricted to the HEE or the NMC. Indeed, although academic institutions have been required to demonstrate patient involvement in curriculum planning and delivery for a number of years, HEI structure, policies, internal and external politics, language and resources to support effective patient involvement and engagement in healthcare education remain a contentious issue (Douglas, 2010; McCutcheon and Gormley, 2014; Naylor *et al.,* 2015). HEIs are now expected to evidence much more inclusive patient involvement from influencing the selection, admission, progression and completion of nursing students to the design, delivery and evaluation of nursing programmes. While acknowledging the criticisms that patient groups often fail to provide a true representation of society (Beresford and Branfield 2012) individual members of the

public purposefully choose to become involved in nurse education at an institutional level. They do so from a position of wellness or stability that affords them a degree of personal autonomy and agency. Such engagement is often situated within the HEI setting, therefore it is less likely a person will adopt a passive-dependent position as the clinical context is removed, replaced by an educational focus where academics and patients are both aiming to enhance student learning and development. Individuals who engage in patient forums have made a deliberate choice to represent themselves, firstly as individual citizens but secondly as a patient from a historic perspective, therefore this disassociation from the actual in-patient hospital experience suggests that engagement is more likely to be a reflection on their past patient experiences rather than on their situated reality.

Patient Involvement in the Assessment of Practice

The move to an academically-prepared nursing workforce has been a source of contestation as a sedimented image of a practical, vocation-centred nurse has been transformed into a professional, academically-educated nurse that has been discursively constituted as 'too posh to wash' (Gill, 2004; Scott, 2004, Thomas, 2005; Salvage, 2007; Fletcher, 2009; Rafferty, 2009). As trust in health professionals, more especially nurses, declined nursing was under increasing pressure to show that nursing was evidence-based and delivers successful patient outcomes, whereas nurse academics had to be seen to be addressing political and public discomfort that falls in standards could have been the result of the professionalisation and academicisation of nursing (Hakesley-Brown and Malone, 2013).

In 2007 the NMC commenced a review of pre-registration nursing education to coincide with a Department of Health review on a nursing career structure. Initially the new standards encapsulated policy demands for greater service user involvement

in nurse education within the HEI context (NMC, 2010b), however following the publication of the Mid-Staffordshire independent inquiry (Francis, 2010) the NMC later introduced the requirement for patients and service users to contribute directly to the practice assessment of students (NMC, 2011). This has resulted in a number of challenges for HEIs and service providers especially as the NMC has not stipulated either the method or focus of service user involvement within the practice assessment process (Willis Commission, 2012). The Willis Commission warned that the increased involvement of service users in practice assessment required careful monitoring in order to safeguard patients who are increasingly vulnerable due to ill health and care requirements. Stacey *et al.,* (2012:482) raised further concerns stating that:

> "…until appropriate research evidence is available, it will not be possible to provide direction, thus leaving curriculum planners to implement service user involvement in assessment unsure of where to start, without a sound evidence base and with the possibility of involving service users in a tokenistic manner in order to 'tick the box'"

There have been considerable benefits of patient involvement in health education highlighted within the literature, for example curriculum development, classroom teaching and student assessments using Objective Structure Clinical Examinations or within dedicated education units in practice (Speers, 2008; Jha *et al.,* 2009; Eskilsson *et al.,* 2015). But what has also been highlighted is the need for patients to be adequately prepared for teaching and assessment together with appropriate remuneration for time spent. Indeed, Beresford (2005b) considers these to be essential in order to establish true partnership working, trust and reduce professional dominance between academics, health professionals and patients.

Within the HE context patients selectively engage in the education of nursing students and can choose whether or not they wish to be involved in any HEI-based assessments, but within a hospital the patient position shifts from being an involved

educator to acquiescent receiver of students' practice for a number of reasons. Firstly, hospital in-patients, for the most part, are there due to necessity rather than choice therefore their first intent is to receive diagnosis and treatment so that they can return home as soon as possible. Secondly some patients adopt a 'passive' patient position, which can be perpetuated by institutional and nursing practices that disempower individuals. For example, the physical layout of ward areas into shared six-bedded bays where privacy is limited; institutional practices that unconsciously result in patients changing into nightclothes, the 'uniform' of the patient and the objectification of the individual into a patient group identity. Finally, clinical practices based on historical professional hierarchies can perpetuate a culture of profession-centredness rather than patient-centredness through which the patient becomes depersonalised and objectified with an expectation of accepting professional advice and direction. This objectification can result in tokenistic participation in care and practice education. Despite the push for nurses to actively involve patients in making decisions about their care inhibiting factors such as patient vulnerability, patients' willingness to participate and a general passivity in the way participation is attempted by nurses are likely to influence the level of patient participation in the practice assessment of nursing students during ward placements (Stacey *et al.,* 2012; Tabiano *et al.,* 2015).

Conclusion

This chapter began by examining the construction of the 'patient' and 'service user' identities in order to highlight the similarities and differences between them. By illustrating these distinctions this chapter showed how the patient is more closely associated with people receiving acute hospital care and provided a rationale for the use of the term 'patient' throughout the thesis. This was followed by an

archaeological and genealogical review of the construction and reconstruction of the patient identity and subsequent subject positioning within health policy, institutional and nursing practices.

I have shown how patient consumerism aimed to provide a useful counterbalance between government and health professionals, but I have also demonstrated how, despite positive regard to patient involvement, issues such as workload, lack of staff, time or unwillingness to relinquish control has resulted in nurses recurrently returning to embedded paternalistic approaches to patient involvement and task-oriented approaches to care. Finally, the chapter considers how patient involvement in the assessment of pre-registration nursing students is complicated by the NMC's reference to 'service user' involvement that amalgamates two very different concepts − *patient* and *public* involvement − into one generalised, yet incompatible concept. I have suggested that within HEI nursing faculties service user involvement is more complicated as within the HE sector it is the student who is considered the primary consumer of HEI education, whereas hospital in-patients become consumers by association with little to no direct input into curriculum development.

PART THREE: CRITICAL EXPLANATION

> 'The notion of logics is understood in a very specific way, as capturing the point, rules and ontological preconditions of a practice or regime of practices, and as opposed to causal laws, mechanisms and contextualised self-interpretation" (Glynos and Howarth, 2008:165)

Part three of this thesis presents an inter-relational review of the social, political and fantasmatic logics that together provide a 'critical explanation' of the institution of patient involvement in the practice assessment of nursing students at one HEI (Glynos and Howarth, 2007). This approach involved the naming of three key social logics – *experientialisation*, *protectionism* and *systematisation* that characterised patient involvement in practice assessment as a social practice (Chapter 5). In contrast, political logics can be seen to create the conditions of possibility for patient involvement, by creating alliances between different actors (e.g. the government and NHS). Political logics focus on those alliances and how these are fostered or blocked. To facilitate that political logics encompass logics of equivalence that illustrate how different groups of actors are mobilised to form alliances and create political frontiers. By forming chains of equivalence individual demands for change can be unified or made equivalent, which enables the identification of a common enemy or antagonistic 'other' – such as HEI-based nurse education and 'academic' professional nurses (Chapter 6). Such logics of equivalence are however inter-dependant on a logic of difference, that show the strategies groups employ in their attempts to break up those equivalential chains into multiple particularities in order to maintain the status quo (Howarth, 2008).

To support the articulation of the political logics I explore the ways in which various actors have attempted to constitute the problem of HEI nurse education and how they have positioned patient involvement as a 'true' solution to that problem. I illustrate how actors present this as a hegemonic normative frame that forms one of

four possible floating signifiers around which our understanding of nurse education and patient involvement in practice assessment is constructed. A true problem/true solution hegemonic normative frame then acts as an empty signifier to unify groups of actors against the threat of HEI-educated, technical-scientific nurses who have been constituted as lacking in care and compassion. The four-signifier framework enriches the logics approach as it helps to explain how HEI nurse education and the idea of an academically-educated professional nurse has been contested, normalised or transformed by demands for change.

Logics of fantasy highlight the ideological investments that different actors have made in the different storylines (some beatific, some horrific) that gave them a sense of enjoyment or terror and that effectively bonded groups together (Chapters 6). An exploration of fantasmatic logics equally illustrates their opposition to the horrific image of the non-compassionate, HEI-educated nurse that must be excluded. This horrific figure represented all of that was wrong with nursing, and although this took different forms within political, public and media discourses, this horrific figure fundamentally remained the same (Howarth, 2013). What is key is that the HEI-educated, technical-scientific nurse was perceived as draining any sense of enjoyment away from the job of nursing (as a technocractic medical machine) and thus was presented as the scapegoat who was blamed for all that was wrong with hospital patient care. By removing the non-compassionate, professional, HEI-educated nurse, the beatific narrative suggested that a utopia would result in patients 'enjoying' care that was person-centred, individualised and vocationally based. Rather than constituting care as the provision of technical interventions led by professional nurses, a fantasmatic logic of vocation subordinates nurses by constituting care through a gendered discourse. That constitution continues to construct nursing as a

feminised occupation associated with nurture, empathy, compassion and emotional connectedness. But there is also beatific fantasy of the technical-scientific professional nurse, one who is medically informed, who can prescribe, co-ordinate and lead care. An analysis of fantasmatic logics is not on identifying one beatific fantasy, but instead it examines how one particular fantasy gets a grip over others. The question is, within the contestation between the beatific promise of the technical-scientific professional nurse, versus the beatific promise of the compassionate, vocational nurse, which fantasy holds sway over the other?

The last findings chapter, Chapter 7, analyses the way individuals are interpolated into different subject positions within discourses, and how this impacts on actors' perceptions of the roles and responsibilities associated with those positions. Interpolation in this context relates to the institution of power, where rather than determining one's own identity and subject position within a given discourse, other actors use dominant discourses such as consumerism, vocation or professionalisation to construct a subject's social position (Marttila, 2016). I examine each participant's discursive positions in relation to representations of the 'true' problem (HEI nurse education), 'true' solution (patient involvement in assessment) hegemonic normative frame. This analysis reveals significant positional movement as participants considered the different contexts of patient involvement that exposes the on-going instability of the true/true normative frame and the underlying friction between the construction of nursing as either a practical vocation or academic profession.

Chapter 5: The Characterisation of Patient Involvement in Practice Assessment

Introduction

This first findings chapter presents an articulation of two dominant social logics – a logic of *experientialisation* and a logic of *protectionism* − that emerged from participant interview data and characterised patient involvement in practice assessment. The chapter starts by providing a brief genealogical synopsis of regulatory body standard requirements for service users and carers involvement in the assessment of nursing students' practice. This is followed by a detailed analysis of each logic, illustrated with extracts from the empirical data. Finally, the chapter considers a third social logic, or more accurately a counter-logic, of *systematisation* that make visible the 'marginal practices' that have been subsumed by the two dominant social logics (Glynos and Howarth, 2007:194). The consideration of counter-logics allows for a fuller critique of patient involvement in practice assessment by examining actors alternative ideals and values, and demonstrates how different groups of actors' have problematised or opposed patient involvement as a normative practice (Glynos and Howarth, 2007). Throughout the chapter, extracts from the empirical data will be used to illustrate the logics and the on-going struggles and tensions between vocation and profession.

A synopsis of the regulatory service user involvement requirements

In order to appreciate the patient involvement practices that these social logics represent it is helpful to provide a brief overview of service user involvement within nursing's regulatory body standards. Since 1996 the NMC (formally the UKCC and English National Board [ENB]) had required HEIs to demonstrate service user involvement within all areas of curriculum development (ENB, 1996; NMC, 2004).

Although the ENB (1996) had advocated service user involvement in student assessment, it did not specify which type of assessment – academic or practice, neither was there any indication of whether that related to inviting individuals into the HEI to assess students or asking patients to assess students in the practice setting.

What has emerged from a review of regulatory standards following the creation of the NMC, is that the previous ENB requirement for service user involvement in student assessment was not adopted by the NMC in its subsequent 2004 revision of the pre-registration standards (NMC, 2004). Consequently, Mott MacDonald, the organisation commissioned to carry out course reviews on behalf of the NMC, continue to audit HEIs' involvement of service users and carers in programme development and delivery on a biennial basis, but a review of their involvement in student assessment was notably absent (NMC/ Mott MacDonald, 2009). Interestingly, when the NMC published the 2010 standards for pre-registration nursing education, programme providers were again required to 'make it clear how service users and carers contribute to the assessment process' (NMC, 2010b:82), although, as with the previous ENB guidelines, the NMC did not specify the ways in which service users could contribute, whether this related to academic or practice assessment and in which context – HEI-based or practice-based. It was only later, in March 2011, eleven months after the publication of the first Francis report (Francis, 2010), that the NMC provided some clarification in an advisory document, '*Advice and supporting information for implementing standards for pre-registration nursing education'* (NMC, 2011). The NMC constituted service user and carer involvement in student assessments as a 'new requirement', stating:

> 'Programme providers must make it clear how service users and carers contribute to the assessment process. Being involved in assessment in a meaningful way, without placing inappropriate responsibility on them, can be challenging and, where service users and carers do contribute, the outcome

> should not rest on their judgement alone. …….There may also be issues of validity and reliability of their judgements, which may cause anxiety for students. Notwithstanding these issues, many programme providers are beginning to find innovative ways of enabling service users and carers to make an effective contribution to the assessment of students.' (NMC, 2011:60)

Examples of new involvement activities included the use of hand-held electronic devices to record patient feedback; service user and carer testimonials; mentors approaching service users directly; involvement in HEI-based practice assessment such as OSCEs and service user involvement in the assessment of videoed scenarios (NMC, 2011). Despite these suggestions, there remained a distinct lack of clarity on what aspects of a student's practice service users and carers were being asked to assess. In the above statement the NMC positions the programme provider in control, placing nurse academics in a dominant position with the power to *enable* service users and carers, rather than promoting a collaborative partnership approach.

The NMC's revival of the now fourteen-year-old principles could be attributed to the normalisation of the patient-consumer subject position that reflected their constitution as healthcare consumers and partners in care. But it also could have been a reaction by the NMC to the negative publicity around the publication of the Duffy report (2003) that concluded some nurse mentors were not failing underperforming nursing students, as well as criticisms over the quality of nursing care highlighted within a number of reports from the Healthcare Commission (2006; 2007), Care Quality Commission (CQC, 2010; 2011), and the independent Mid Staffordshire NHS Foundation Trust inquiry report (Francis, 2010). All of these reports highlighted what appeared to be an alarming decline in standards of patient care, and a failure of health professionals to listen to patients' concerns within UK hospitals. Unlike the Healthcare Commission and CQC reports, the personal stories recounted in the first Francis report (2010) were widely reported in mainstream media creating a narrative that health professionals could no longer be trusted to put patients' interests first and

that nurses were no longer identifiable against a sedimented, vocational subject position where nurses had been constituted as '*angels*', '*caring*', and '*kind*' (Ten Hoeve, *et al.*, 2014). The NMC, possibly in an attempt to be seen to be in regulatory control, took action. By reintroducing service user involvement within practice assessment the NMC could be viewed as attempting to reposition itself as a responsible regulator and responsive public protector by reminding HEI nurse academics of the demand for service users to be included in the education of the future health workforce. Thus, potentially undermined the on-going professionalisation of nursing by instilling a discourse that the patient, not the nurse mentor, might know best. The consequence is that the nurse, is repositioned as a vocational construct, which becomes restricted to caring for the patient (as the patient sees fit), rather than operating as an expertly informed, evidence-based professional who may have a good (or even better) understanding of what might be in the patients' best interest.

Social Logics

Practical-caring vocation and technical-scientific profession could therefore be considered as two social logics that characterise nursing as a regime of practices. The current debates surrounding graduate entry-level nursing and HEI nurse education are indicative of a hegemonic struggle that attempts to separate vocation and profession into two opposing constructs. An exploration of this struggle frames the whole thesis, however the thesis does not offer an analysis of these social logics specifically. Instead, the thesis is focused on offering a critical explanation of patient involvement in practice assessment as a social practice *within* a regime of nursing. Therefore, the logics of vocation and profession act as meta-logics that not only characterise nursing as a regime but also can be shown to envelop and influence the educational practices

that sit within that regime, including mentorship, patient involvement and practice assessment (Figure 12).

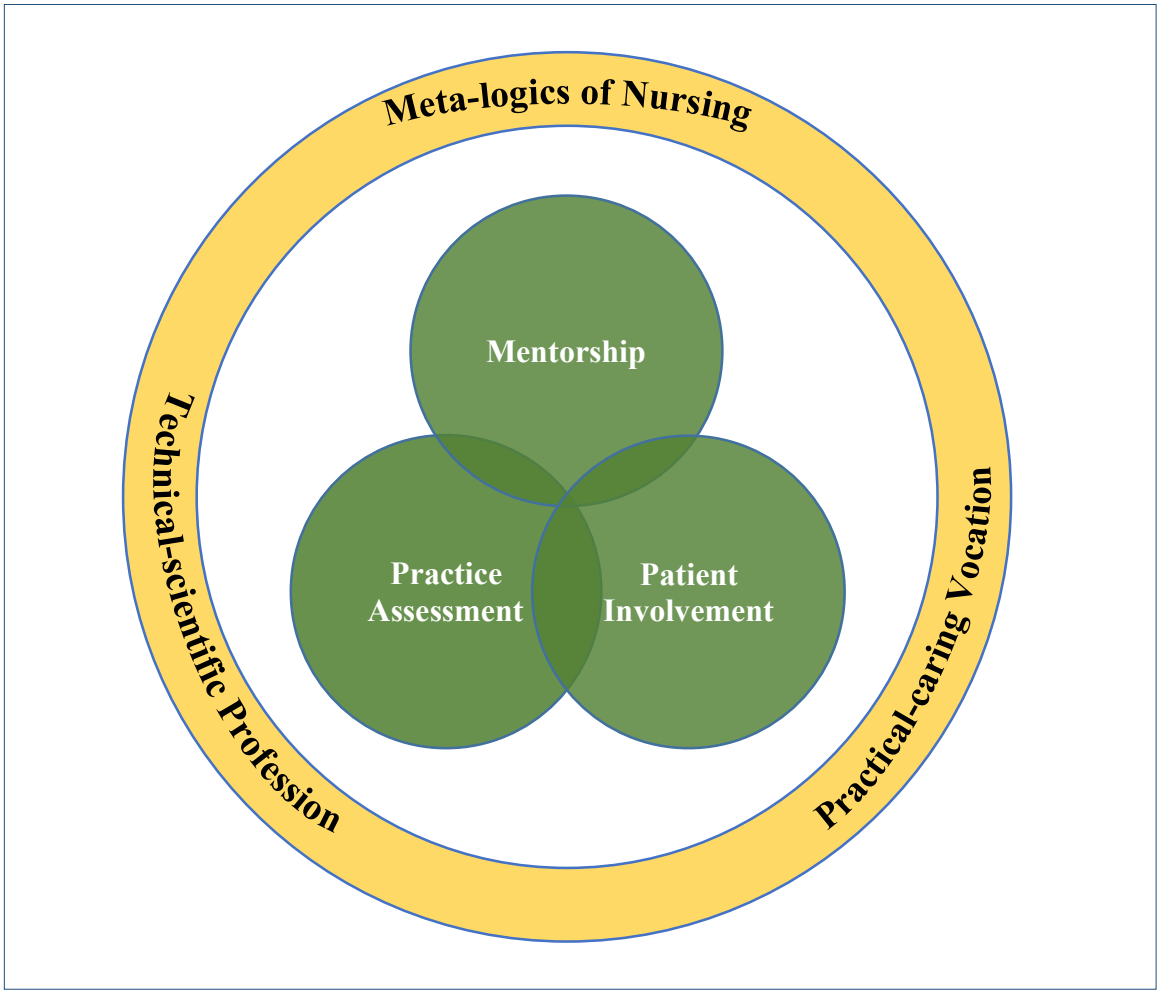


Figure 12: Vocation and profession meta-logics

As alluded to in earlier chapters, the tension between logics of practical-caring vocation and technical-scientific profession has helped to constitute patient involvement in practice assessment as a strategy to enable patients, as primary consumers of health services and associate consumers of nurse education, to influence and moderate nurse mentors' professional judgement of nursing students' practice. The assessment of students' technical, affective and professional

competence is a fundamental part of pre-registration nursing education, therefore my analysis of the social logics pertaining to patient involvement considers the characterisation of involvement practices and examines the degree to which those tensions are reflected within participant narratives. On the surface, patient involvement might appear to be a sedimented practice, but rather than taking a surface approach to examine how and why this practice has become naturalised or contested, the use of logics enables an examination of the rules or grammar of that practice, and the 'conditions which make the practice both possible and vulnerable' (Glynos and Howarth, 2007:136).

Dominant logics

The dominant social logics that characterised patient involvement in practice assessment were *experientialisation* and *protectionism*. Experientialisation comprised a number of quality monitoring and assessment activities where patients were engaged in dialogue with mentors, students or lecturers with the intention of inducing a positive change in students' caring behaviours. This involved consideration of patients' subjective experiences and their experiential expertise being recognised and valued by those immersed in healthcare delivery and nurse education. The logic of protectionism consisted of various strategies actors employed to avoid risk, whether that be to themselves or others. The chapter now moves to consider each of these logics in detail.

Logic of Experientialisation

The social logic of experientialisation describes the dominant discursive patterns and practices that emerged from participant interview data, that positioned patients as experts by experience, best placed to assess the quality of nursing students' care

delivery, especially students' affective competence and vocational attributes. This logic privileged the patient's position as a consumer of students' practice where their engagement in a tripartite dialogue with the student and mentor was considered an effective strategy to induce behavioural and attitudinal change, *instilling vocational values*. Fundamental to this was the *reciprocal exchange* between the patient, student and mentor where each group of actors recognised the interdependence of their relationship during the assessment process, as the patient's reliance on the student for their care was reversed as students became reliant on positive patient feedback during practice assessment.

Instilling vocational values

From the problematisation of nurses becoming too academic or 'too posh to wash', patient involvement as a hegemonic project aims to ensure that nurses understand and appreciate the patient experience. The demand for nurse education to concentrate on vocational values was characterised through a logic of experientialisation. By positioning patients as experts of experience, their feedback to students were considered essential for patient-centred nursing and to ensure the installation of vocational values, such as caring and compassion. Patient involvement as a mechanism to instil such values was articulated by a number of participants.

For example, Patient 4 (Extract 1) employed a gendered discourse to present a historic image of a vocational, female nurse whose most important attributes were feminised vocation-associated behaviours and gestures in preference to theoretical-scientific knowledge or technical skill. Extract 1 shows Patient 4 drawing from a logic of experientialisation to emphasise patient involvement as the best way to instil those behaviours. Students' ability to develop nurturing or vocational behaviours were constituted as traits of a '*super nurse'*, traits that had a direct impact on how

Patient 4 experienced care delivered by the student. The assessment of vocational values was prioritised where the ability to convey patient-centredness was through non-verbal behaviours, '*the little extras'* such as touch and eye contact. Here the personal relationship and interactions between the student and patient were considered essential in helping the patient '*feel more cared for, more secure'*, thus the emphasis was on humanising the patient's hospital experience by recognising the subjectivity of the patient.

Extract 1
P4: It's very much eye contact, tone of voice, the odd little gesture, be it verbal or touching your knee or something, you know … (Lines 681-619) … it won't be that you know I think she's a super nurse she knows really what she's doing, because I suppose in a way you almost accept that that is how it should be, it's the little extra bits that make it so, make you feel more cared for, more secure, eh … more sure that you're going to get out quickly (smiles), you know (Lines 630 – 633)

Extract 1 demonstrates a distinction between the patient's expectations of hospital treatment compared to nursing care. Patient 4 appeared to accept a degree of objectification as a hospital patient within systematised institutional practices. Here systematisation refers to a number of managerial approaches where care is broken down into systematic processes in order to improve efficiency, cost effectiveness, service performance and patient outcomes (Close and Scott, 2008). There is a sense of acquiescence to this process *'you almost accept that is how it should be'*, yet the logic of experientialisation prioritised an expectation of an emotional connection with students and a need to feel cared for and safe in a situation where patients' vulnerability is increased. This indicates a cake and eat it position, where the patient expected the nurse to be technically competent (*this is how it should be*) but also to be caring and compassionate (so professional and vocational). The gestures described

above are reminiscent of the moral virtues espoused by Florence Nightingale and suggest that the patient assessed the student against a norm of vocational nursing rather than against professionally defined competencies. In terms of the analysis of patient participant discourse, the image of a good or caring nurse constituted through a discourse of vocation was the discursive frame that dominated.

The following extract (Extract 2) reveals a contingent nurse identity illustrating a struggle between Patient 3's acceptance of nursing as a practical-caring vocation and nursing as a technical-scientific profession. Again, the logic of experientialisation emphasised the patient assessor's role in the installation of vocational values, where the patient assessed students against an image of a 'good' nurse with '*a nice bedside manner'*. This corresponds with Extract 1 to suggest that perhaps patients don't really know what to expect from the nurse, because of the contradictory discourses that are also present. In contrast, academic study, historically constructed as a masculine activity, is presented as incompatible with good nursing, hence education is constituted as an obstacle or threat to a quality patient care experience. The hegemonic struggle between caring vocation and technical profession is made visible through the constitution of HEI-educated students as academically able but practically weak and potentially incapable.

Extract 2
P3: Yeah I think that it would be better if they spent more time with the people to know whether you're actually capable of being a nurse kind of thing cos you know, you could study as far as you know, you could continue studying but it doesn't mean you're any good at what, like being good with people or having a nice bedside manner, you'd have more, more practice on patients, more time spent with them so they, you know that's definitely what you want to do I think (Lines 280-284)

This may reflect the strength of political and media storylines that created a horrific fantasy of a technical-scientific nurse as opposed to a beatific fantasy of practical-

caring nurse. Despite degree pre-registration nursing programmes being available since the 1960s, the majority of patients, with the exception of Patient 5, who reflected on care provided by a male nursing student, still constituted care through a female-gendered discourse. The art of caring was seen as synonymous with nursing but for most participants being able to care was not enough, students were also expected to display a desire to care, foregrounding the experientialisation logic. Therefore, the idea that students may want a professional career with financial reward becomes incompatible with the construct of the vocational nurse.

Students' reiteration of the value of patients providing feedback on their vocational values and ability to care *for* patients shows that the logic of experientialisation underlined the patients' position as consumers of health services and nurse education (Extract 3). Student 2 drew on this logic to outline areas of their practice where they felt patients could contribute to the assessment process. The interpersonal dynamic between student and patient was considered an important element of care, where practice learning was constituted as a reciprocal exchange between the student, who assesses and provides care to the patient, and the patient, who assesses and provides feedback to the student.

Extract 3
S2: ... just your level of care really, whether you've done everything you should, whether you've respected their dignity and covered them up when they should, and talked to them properly and not talked down to them like a baby or child, whether you're friendly, whether you're happy, not miserable, you know things like that really, just … and whether they feel confident in your care really, you know, they were quite happy for you to give them an injection or ... or whatever you're doing to them, that they're happy with you providing that (Lines 421-427)

Extract 3 shows how patient involvement reminded the student of the subjectivity of the individual, rather than the patient being absorbed into a collective, objectified

group identity. The extract illustrates how the logic of experientialisation encouraged the student to adopt a person-centred approach to care and actively listen to the patient, attend to the patient's feelings and experiences. The patient's feelings and experiences of care were prioritised and show how a logic of experientialisation encouraged the student to focus on the manner in which they delivered care and how it was personally experienced by the patient. Nevertheless, extract 3 suggests a degree of normalisation of a practical-caring vocation image of nursing.

In contrast, in the following extract Student 4 appeared unsure as to whether vocation actually constitutes a good nurse.

Extract 4
S4: …care and compassion are very important I'm not saying it isn't, communication would be very, very important but I'd like to hear people talking a little bit more in nursing about competency not just care and compassion. Did you feel confident the student was fulfilling their role properly? Did you feel safe? Did you feel they had knowledge? Did you feel that they had read your notes and were aware of what your condition was and how it affected you? I would like to see that there. I don't want it just to be 'Did they smile and pat you on the shoulder?' and there's a fear that's what it would be reduced to and whilst that is the most important thing it's not everything…I used to think before I did my course, I thought I would, it's much more important to erm, to be caring and compassionate, and I always said, you know, but now I think, well actually in an ideal world I'd have a competent, caring and compassionate nurse, but I'd much rather she was competent, if I had to choose between the two, because I'd like to know that actually the drugs that she's giving are the right dose and at the correct time, and that the IV she's putting up, she knows what she's doing, and that if I'm deteriorating she'll bleep the doctor before I've gone into sepsis. So if I had to choose between the two I want competency, not just caring and compassionate (Lines 649-665)

Here vocational care and compassion are separated from professional competence and although the extract emphasises the logic of experientialisation, it also shows a degree of concern that patient involvement within practice assessment could become perfunctory and reductionist. For Student 4 nursing was constructed through the linking of signs associated with vocation, such as '*care*', '*compassion*' and '*communication*' but she also drew from a professional discourse to include

competence to construct a contemporary nurse identity. Thus, extract 4 reveals a fractured nurse identity, which Student 2 attempted to suture by characterising contemporary nursing as a combination of the logic of practical-caring vocation *and* technical-scientific profession. Initially Student 4 appeared to have accepted an historical construct of nursing that foregrounded vocational traits of care and compassion. However, when situated from 'within' the profession, Student 4's position shifted as she began to identify herself as a technical professional nurse. Therefore, her understanding of nursing was contested, rearticulated and reconstituted by her exposure to professional discourses, which may have led to her questioning her previous acceptance of a normalised 'caring and compassionate' nurse identity. As a result, her understanding of nursing and healthcare has been reconstructed and the primary value she attributed to care and compassion appears to have diminished, or been rebalanced in relation to other more professional competencies. Although vocational traits continued to be constituted as important, the power of professional socialisation from practice placements may have resulted in Student 4 constituting competency as the most essential nursing attribute. Extract 4 shows the extent to which the student resisted popular rhetoric that positioned vocation and profession as polar opposites. Her narrative suggests a degree of confusion and concern with this type of polarisation. Instead, Student 4 characterised competency as a combination of vocation *and* profession, where care and compassion are constituted as core professional attributes, but it is the professional nurses' theoretical-scientific knowledge and technical competence that ultimately protects patients from avoidable harm.

Reciprocal exchange

Patient involvement in practice assessment was constituted as a social reciprocal exchange between the patient, student and mentor, where all parties become dependent on each other for a positive outcome. This reciprocal exchange was also characterised through a logic of experientialisation. For example students became dependent on patients' experiential assessment of their vocational values and mentors' professional assessment of their technical competence, whereas patients remained dependent on students' and mentors' delivery of care. In practice patients, students and mentors were involved in various chain-generalised, indirect reciprocal exchanges (Molm *et al.*, 2007). For example, involving patients in the assessment of students' practice engaged all parties in a chain of indirect exchange where the student gave care to the patient − benefiting the patient; the patient gave experiential feedback to the mentor – benefiting the mentor and the mentor then gave the student their practice grade – benefiting the student. Although the patient may not necessarily have received a direct benefit immediately, the benefits could come later when they receive care from a different student, assessed by a different patient, at a different time. However, the introduction of a regulatory requirement for mentors to involve patients in their assessment of students' practice suggests a more direct reciprocal exchange where the patients and student try to benefit each other but without knowing whether or not the other will reciprocate. The logic of experientialisation emphasised the development of indirect reciprocal exchanges between the patient, student and mentor. In practice, this exchange was negotiated for the benefit of all, although those benefits were not necessarily distributed evenly.

Patient and student participants drew on the logic of experientialisation to emphasise how patient involvement could lead to immediate benefits for mentors and

in the longer-term reciprocal benefits for patients (see Extracts 5 and 6). This logic prioritised the importance of gathering '*other people's opinion'* by positioning patients as assessors-by-experience. Although more reticent and unsure about the patient role in practice assessment, patients, students and lecturers constituted patients as consumers of students' practice. As a consequence, the patient role was presented as an adjutant to the mentor, where the value of their input was attributed to enhancing the objectivity and reliability of the assessment, not only by offering an assessment of students' affective and vocational behaviours (caring, compassion, empathy, respect), but by providing an assessment of the quality of students' care. Although the outcome of patient feedback may not have a direct or immediate benefit to the patient there appeared a sense of beneficence that engaging in the assessment process would benefit students and other patients in the future.

Extract 5
P3: ...Well you know, it's good to have other people's opinions on a person because you might really like that person, think they're really capable and somebody who's actually been treated might find that you were difficult or that they did things sloppily or things, and that would be a good opinion to have because you might only see one part of that person, whereas the patient would see the other, you know see whether they're actually fit to go on to do … I can't explain it, I don't know the word, treat other people, yeah, so that's why it could be good because you get an input into it and you know you're sending someone out, being part of something that does help other people (Lines 919-926)

Extract 6
S5: I think it would help in the fact that I'd be able to see it from the other point of view as well. I'm always seeing it from 'oh is my mentor going to say I'm competent to do that?' or 'is my mentor going to sign that skill?' It would actually be nice to have feedback to say actually the patient felt that you have a really good bedside manner, that patient felt you could have explained more what you were doing, they didn't feel comfortable, and that could help I suppose, that could help with some of the complaints if we actually see it from the side of the patient (Lines 688-695)

Extract 6 shows that for the student, the logic of experientialisation promoted a complete assessment of their practice, combining the mentors' professional

assessment of their technical and cognitive competence with a subjective patient assessment of their vocational values and affective competence. Here practice assessment was initially characterised, as a profession-led, predominantly skills- and competency-based activity that rendered the patient invisible, constituting them as an objective learning resource rather than a subjective patient-educator. Subsequently, such a mentor-led approach appeared to reflect a systematisation of nursing practice that foregrounded the student's achievement of regulatory and professionally determined competencies and as a consequence the chain of reciprocal exchange only included the student and the mentor. Although there is an obvious reciprocal benefit to the student using this type of systematised approach, the logic of experientialisation emphasised the importance of a patient-centred approach and an appreciation of the subjectivity and inter-relational dynamic between patients and students. Extract 6 suggests that patient involvement in practice assessment can effect change in student behaviour resulting in a greater appreciation of the patient experience, with an added potential to reduce hospital complaints. This is interesting as this might also point to a site of resistance to the dominance of patient involvement if students' begin to place more value on patients' experiential and vocation focused assessments than mentors' assessment of their technical competence. Consequently, patient involvement could then constitute a risk to mentors' educational position, their professional authority and influence over the student, their practice and professional behaviours.

Extract 7 shows how the logic of experientialisation accentuated patient involvement in assessment as a reciprocal exchange that benefits the mentor by identifying *'issues with some students that perhaps we couldn't pick up on'*. Again Mentor 6 constituted patient involvement through a health consumer discourse,

presenting the patient assessor as '*perceptive*' and '*intuitive'* whose subjectivity meant that they were able to determine students' motivation, '*manner*', communication and interpersonal skills. This again infers a dichotomy between a mentor's professional assessment and a patient's subjective assessment where both are looking for different qualities from the student. But it also suggests that the professionalisation of nursing may have resulted in mentors failing to take into account the patient experience when assessing students' practice prior to the introduction of formal patient involvement, or if they did this was predominantly informal, tokenistic involvement that may have had little or no influence over the mentor's final assessment decision.

Extract 7
M6: I think patients are very perceptive and they know when somebody wants to be there, if they're keen, they're willing, and a lot of it is intuitive whereas I think when we're mentors we have to have evidence and we have to prove things, whereas ultimately it's the patient's experience is paramount and if they don't have to have, they can use a lot more subjective matter and say 'oh I didn't find his manner appropriate' or 'he was a bit rude' or 'he rushed everything a bit', so I suppose that side would maybe, demonstrate issues with some students that perhaps we couldn't pick up on (Lines 1063-1070)

Interestingly patients, students and mentors all considered reciprocal benefits from a subjective, person-centred perspective. The reciprocal benefits were less evident in lecturers' discourse; nevertheless in extract 8 Lecturer 3 drew from a logic of experientialisation to constitute patient involvement as an 'awakening' that suggested mentors had only just become aware of the need to involve patients in practice assessment. Extract 8 implies that prior to the mandatory requirement to involve patients, patients were constituted as unseen components of the assessment process that situated them outside of mentors' assessment discourse. However, while it could be argued that patients were involved just by being physically present during

the assessment, their objectification constituted them more as docile learning objects that excluded them from the decision-making process inferring a non-participatory, manipulation level of participation, that reflects the findings of previous studies (see Stickley *et al.,* 2010; Speed *et al.,* 2012; Haycock-Stuart *et al.,* 2016). Lecturer 3 adopted a consumerist discourse to constitute the patient's experiential 'point of view' as a direct benefit to the mentor by offering an assessment of students' affective behaviours, such as communication and attitude.

Extract 8
L3: Well, I think it helps the mentor, it may help the mentor think about other aspects that they wouldn't have thought about because this is from the patient's point of view, you know. From that patient's point of view that nurse was brusque, but actually what the mentor saw was someone that was very efficient, and got on with the job and as far as she's concerned that's good. So it's about awakening them to a possibility of, erm, the patient's view point sort of thing, whereas they might not have thought about that before. (Lines 1017-1023)

While the logic of experientialisation appears to emphasise benefits to those actors directly involved in the actual assessment process, Extract 9 shows that any personal direct reciprocal exchange could have a wider benefit.

Extract 9
L1: So I think it will enhance patients, and their … I would hope, their sort of trust and appreciation and their confidence in education and nurse education and in the NHS, so, and then for the students I think it's getting a different perspective, you know, it's not just down to the mentor who they may not have worked with a considerable amount of time, but it's also another opinion, you know, the user, service user, patient and how they've experienced it (779-785)

This extract shows the potential that experientialisation could have on changing people's perceptions of technical-scientific nurse education. Lecturer 1 drew on a logic of experientialisation to not only constitute patient involvement as a strategy to enhance the quality of practice assessment and patient-centred care, but to suggest

wider-ranging indirect benefits where involvement could help re-establish patients' trust in technical-scientific nurse education.

In summary, the logic of experientialisation prioritised the patient subject position of 'experts by experience'. All participants drew on a consumerist discourse to constitute patients as consumers of students' healthcare practice whose subjective expertise afforded them a right to participate in the assessment process. The value students and mentors attributed to patients' subjective assessments of students' affective behaviours and the installation of vocational values implied that a patient-consumer identity is beginning to replace an historical acquiescent patient identity within nursing discourse. Participants engaged with a market discourse to construct care as a reciprocal exchange where each actor involved in practice assessment received direct and indirect benefits. In the next part of this chapter I will demonstrate that a number of participants engaged with a logic of protectionism in order to resist, contest or transform patient involvement in practice assessment.

Logic of Protectionism

> 'underlying the principles of licensure is the assumption that the public cannot judge whether practitioners of the licensed professions are qualified or competent' (Hazelkorn and Christoffel, 1984:105)

The logic of protectionism consisted of various strategies students, mentors and lecturers employed to maintain professional control and resist the push towards formalised patient involvement. This logic makes visible the tension between the constitution of patient assessment as subjective, experiential and vocational, and mentor assessment, constituted as educated, objective and professional. Nursing students, mentors and lecturers tended to adopt a position of benevolent protectionism in order to determine whether a patient should be involved or not. This implies that despite patient involvement rhetoric from the government, NMC and

nurses themselves, when it comes to practice-based nurse education and practice assessment it is the professionals that have remained in control and that the vocational push is illusory. This logic involved a degree of *risk management* where participants prioritised the management of possible psychological harm to both the patient and student. Another protectionist strategy involved *picking the right patient*. Here choice was restricted due to a sense of obligation to the NMC (NMC, 2015), where mentors were deemed to be professionally accountable to protect vulnerable or unwell patients from avoidable harm, implying that for some participants, involving patients in practice assessment constituted a risk to patients. The logic of protectionism also highlighted historical power relations and subject positioning of patients, students and mentors in the assessment process. Patient involvement was constituted as a potential professional risk in terms of maintaining mentors *professional authority*, therefore one approach to manage this risk consisted of involving patients in an informal dialogue about students' vocational attributes rather than engaging them in the formal (summative) assessment of students' professional competence.

Risk Management

The previous articulation of the social logic of experientialisation has shown there exists a co-dependent relationship between the student and patient, hence patient involvement may remain reliant on established power relations and subject positions within the clinical context. This co-dependency can result in patients feeling obliged to provide positive feedback either through a sense of gratitude for care received or anxiety that critical feedback could result in the negation of any reciprocal benefits to themselves. The logic of protectionism emphasised the need to adopt a range of risk management strategies to mitigate such harm. One risk management strategy

employed was the continuation of involving patients in providing informal feedback during individual care episodes. In the following extract (Extract 10) the logic of protectionism emphasised the patient's passive-dependent subject position, from which the student assumed patients would be more likely to be untruthful due to their lack of understanding of educational language and assessment processes.

Extract 10
S3: I think you get feedback from patients all the time in an informal process, which could be more valuable because it's more honest. It's what they think, they don't, they're not thinking 'oh I have to say yes or I'll get them into trouble', they're not put on the spot to answer carefully worded questions that they might feel 'oh did they mean this or this?' erm, they don't have to rate them out of 10, you know. They tell you all the time if they're tired, not comfy, you know, some patients are more vocal than others (smiles). (Lines 642-647)

Extract 10 shows how the logic of protectionism functioned to offer a rationale for the continuation of an informal approach. It illustrates that the experientialisation of practice assessment encouraged the student to value the honesty and subjectivity of patient feedback, yet the student negated formal involvement because of patients' physical and psychological vulnerability. Although this could be interpreted as the student's benevolent protection of the patient, it is more indicative of an attempt by the student to maintain the status quo, thus protecting herself from the risk of critical patient assessment that could adversely affect her passing placement.

The logic of protectionism meant that mentors became focused on managing risk in order to protect both the patient and student (Extract 11). Interestingly the majority of participants constituted nursing students as pre-professionals, yet when asked specifically about patient involvement in summative practice assessment this changed. In the following extract, the mentor constituted students and patients as vulnerable, non-professionals positioned outside of the sphere of professional nursing practice. Subsequently the patient becomes dependent on the mentor's benevolence

to protect them from any potential repercussions from the student, while the mentor manages risk to the student by objectifying patients' subjective feedback, almost delegitimising the experiential expertise of the patient. Interestingly, the mentor appeared to adopt a maternalistic position, where the mentor assumed, based on their relationship with the patient and the student, to understand 'the will of another without explicit communication' (Specker Sullivan, 2016: 439). Maternalism is often associated with motherly characteristics, however Specker Sullivan contends that in terms of nursing, maternalism is not gender-specific, nor is it associated with motherhood or nurturing. Instead, maternalism is relational where decisions made are based on an established relationship and an assumed understanding of the patient's views and preferences. Nonetheless, Christensen and Hewitt-Taylor (2006) caution that maternalism does little to empower patients as they remain in a subordinate position to the nurse.

Extract 11
M1: there would have to be somebody else there I think for protection of the student and the patient and would your students be able to take it in the way that it was meant rather than taking it personally, because as a mentor you taught to give the feedback and to be constructive and help your student on the way, and I don't know whether patient to student I could see it doing a lot of damage (Lines 1247-1251)

What is interesting is that neither the mentor (Extract 11) nor lecturer (Extract 12) referred to a specific patient; rather individuals became objectified into a collective, patient or student group identity. There was an assumption by the lecturer that patients '*wouldn't want to say anything bad about the student'* and this was mirrored across all participant interviews.

Extract 12
L3: I think there will be patients who won't want to do it Interviewer: Why? L3: erm … because I think they wouldn't want to say anything bad about the student and they'd rather not do it than say anything bad or not good. I think patients will be more inclined to be generous or be positive rather than negative and then it will be up to the mentor to balance that, I think, you know, it's the patients who, they don't like to say anything bad because they feel that they're going to be treated badly (Lines 1057-1065)

The hierarchical positions and power relations between the mentor and patient are clearly articulated within these extracts. By adopting a patient group identity the patients' position as experiential experts and subjective agents in the assessment process, which was emphasised within the logic of experientialisation was lost. By subsuming individuals into a collective group identity, the patient was not constituted as an experiential assessor at all; instead the patient continued to be articulated as vulnerable, indecisive and acquiescent. In comparison, the mentor was placed in a position of professional authority, constituted as the only assessor who could manage risk by ensuring '*balance*' between patient and mentor feedback. Both Mentor 1 and Lecturer 3 assigned the same level of risk to the assessment process, in that patients may fear retribution from either the student or the wider nursing team, since by the nature of their admission onto a hospital ward patients are situated in an alien environment where professionals continue to dominate institutional practices (Frosch *et al.*, 2013; McMahon-Parkes *et al.*, 2016). In Extract 13, Student 1 drew on the logic of protectionism to constitute patient involvement as a potential hazard to student progression due to a lack of patient education and accountability.

Extract 13
S1: The patient might feel like, erm, they can't say what they really feel, they feel pressurised into saying certain things, erm, they might even lie about it, they might you know not, well not tell the whole truth because they feel bad that the 18-year-old student 'oh my granddaughter's that age I don't want to hurt her feelings' and then it's not going to be truthful is it? So, I think the mentor has a professional role, so when they give feedback to the student in their placement, in their documents I think they feel like they're behind this uniform, so they can, they need to tell the truth, they're bound to tell the truth, you know legally they have to, and it's their signature that says well you're safe to continue, and if anything goes wrong they might come back to me. Whereas the patient might think 'Oh I just don't want to hurt their feelings, dear little girl' you know. I don't know I think, I think the nurse, the mentor has more to lose almost, whereas the patient they'll just have this anonymous feedback on the student go off home never to be seen again (Lines 1629-1640)

Within this narrative the student positioned herself as the child, the 'little girl' with the patient taking on an almost parental, protective role of not wanting to *'hurt their feelings'*. These tropes are really striking as they show the mobilisation of different presentations of actors. Previously in the logic of experientialisation patients, students and mentors characterised nursing students as archetypally female, whereas within the logic of protectionism patients and students characterised nursing students as archetypically young or childlike. But this extract also suggests the student was protected by the mentors' professional accountability to the NMC and HEI *'to tell the truth, they are bound to tell the truth'*. Interestingly, this could be read as a rejection of the vocational caring discourse and an endorsement of the technical-scientific discourse. Ultimately, for this student, it is the professional judgement of the mentor not the vocational judgement of the patient that is seen as the most valuable because the patient is constituted as a subjective, emotion-based assessor. The distinction is drawn between the role of the professional mentor-assessor and the experiential patient-assessor, thus promoting an isolationist rather than collaborative assessment. Extract 13 infers that while benevolent protectionist

strategies, such as anonymised patient feedback were employed to manage risk for patients, the student remained vulnerable to unfavourable or untrue patient feedback.

Picking the right patient

Concern about the meaningfulness of patient involvement in nurse education can be seen in Extract 14. The contingency of patient involvement is made visible, as the lecturer appears to contest the positioning of patients as collaborative partners.

Extract 14
L2: People come into the forums sometimes and say this is what we're going to do what do you think? And the forum says oh yeah that's great, and then off they go and say oh we've asked the service users and they're fine with it, so but yes, I'm sure like with anything if you've written something and somebody says well what have you thought about this? If you don't want to listen you don't (Lines 815-819)

Lecturer 2 acknowledged the *'value'* of patient involvement, but then questioned colleagues' acceptance of patient involvement and the positioning of patients as 'experts by experience' warning *'we need to be quite careful about not just putting them on a pedestal and saying we're going to listen to everything you say because you're a service user',* perhaps illustrating Gosling's (2010:34) point that service user involvement can become:

> ' …a conditional invitation to join someone else's ball game where the rules and posts are already set. You can join the game as long as you play ball. We are expected to always be on our best behaviour and not to upset anyone. It relies on the premise that as responsible partners we are all of us good obedient citizens who will learn the inclusion game, stick to the rules and play fair. Naughty citizens don't get to join in.'

Extracts 15 and 16 reflect the protectionist logic where the mentor and lecturer both position patients as lacking the knowledge needed for full engagement in the assessment process. These extracts suggest a degree of manipulation, in the sense that the professional selects those patients they deemed suitable, negating

patient involvement if the patient's assessment of the student differed from their own professional opinion.

Extract 15
M6: ...I think it could be open to bias, I think if you could pick, if you picked the right or wrong patient and I think it could be dangerous that some patients are quite dissatisfied with nurses and, not for any, necessarily so much our fault, but, you may just negative feedback because it's hor … they don't want to be there, it's a horrible experience, and you know, they just want to be home, so I suppose it depends how you pick the patients (Lines 1074-1079)

Interestingly, earlier in the interview when I discussed the principle of patient involvement in practice assessment, the mentor's narrative inferred a normalisation of the patient-consumer position and as such '*ultimately, the patient's experience is paramount'* (see Extract 7). In contrast, Extract 15 shows how the logic of protectionism encouraged the mentor to adopt a gaming strategy, which was neither empowering nor democratic for the patient. If we look at practice assessment as a game, then patient involvement requires the mentor and the patient to form a cooperative coalition with a common purpose, which is the assessment of the student's professional *and* affective competence. This is based on the assumption that both actors are constituted as rational, intelligent decision-makers (Myerson, 1991), where both perceive a positive benefit to themselves as well as the student. Therefore, both parties will be playing the game to achieve a personal sense of equilibrium (positive reciprocal benefit). However, as already illustrated within this chapter, the mentor and patient have different expectations, roles and adopt different subject positions, and it is the mentor and student that form an alliance against the uninformed patient. Gaming therefore relies on a degree of mutual understanding of the game being played. However, historically patients have been positioned as resources within the assessment game rather than actual players, therefore the mentor

is constituted as the dominant 'arbitrator', who is then able to control the assessment and mitigate against risk by selecting the '*right*' patients.

Extract 16
L6: I think it depends on the mentor. I think there are some really good mentors who are very strong and they know and understand education very well. I think they would use the feedback well to support their decision, which is what you want. But I think a lot of mentors actually don't, aren't with the student enough for whatever reason; they're too senior or they're pressurised or whatever, and er, and I think those mentors often look to others to help guide their assessments, other staff nurses which is ok to a point, and I think they might well look to the patient too much to assess how well the student's done, when I think a patient is there just to guide you about from a patient perspective not to do a full summative assessment about competence and hidden aspects of nursing which patients don't see, I don't think, how can they do that? I don't think they can but I think some mentors would definitely be swayed, be persuaded perhaps away from the decision they were going with by particularly poor feedback there's a chance that could happen, it doesn't sound very fair to students (Lines 2087-2099)

Extracts 15 and 16 characterise a logic of protectionism and suggest that professionals (mentors and lecturers) perceived patients as lacking a clear understanding and appreciation of what constitutes professional practice. This lack of knowledge was articulated as potentially '*dangerous'*, giving students a *'false sense of achievement',* whereas the nurse mentor was positioned as more objective and reliable purely down to their professional status. In comparison, patient assessments of students were presented as *'subjective'* and prone to '*bias'*. It is interesting that none of the mentors interviewed felt that patient feedback alone would result in them failing a student in practice; in fact, all commented that if they judged the student technically competent they would only use patient feedback to highlight areas for improvement, but would not fail the student despite patients' negative comments. A degree of professional protectionism is evidenced in Lecturer 6's narrative but from a slightly different perspective. Here the suggestion was that mentors '*would definitely*

be swayed' to change their assessment decision if patients gave negative feedback about a student.

Professional authority

Patient involvement appeared to be dependent on the mentor's ability to actively and transparently include the patient in the decision-making process. The logic of protectionism shows that this had the potential to be challenging, despite the rhetorical promise of patient-centred care and shared decision-making as the gold standard for effective patient involvement (Shay and Lafata, 2015).

A key challenge within nurse education is that patient involvement takes place across two boundaries, the classroom and practice placements. HEIs and acute hospitals are both incredibly complex, highly institutionalised organisations, whose practices circulate around historically constructed professional hierarchies that significantly influence the subject positioning of patients, and subsequent levels of involvement. Both institutions have their own distinct routines and language that have the potential to restrict patient autonomy thus stripping away individual identities. Consequently, the relationship between patient and professional can became unbalanced in favour of the professional, which promotes a subservient patient subject position. Patients therefore can become reliant on mentors to lead their involvement within the assessment process, provide them with the necessary information about nursing curricula, student competences, and educate them on their role as patient assessors. Such dependence can result in the patient's voice not being afforded equal status to that of the mentor despite rhetorical institutional and regulatory body promises. This could be indicative of a degree of boundary protectionism by mentors in an attempt to emphasise the professional uniqueness of their educational role which, rather than promoting a collaborative, inclusive

assessment prioritised an isolationist assessment approach. According to Orchard (2010: 250) isolationism in nursing occurs when actors have:

> 'such in-depth exposure to each other, they develop what is termed 'in-group' alliances to each other. Those who reside outside of these in-groups are considered out-group members and in turn, are not afforded the same level of trust as occurs with their in-group colleagues'.

Not only does this infer a disjuncture between the role of subjective, amateur patient-assessors and objective, professional mentors, it also implies the attainment of vocational nursing qualities are seen as a rite of passage and that nurses can only really regard themselves as professional (i.e. not vocational) once they have demonstrated sufficient vocational skill, even though mentors may see this as of secondary importance. This disjuncture is perpetuated by the hospital ward environment, the subject positions of each actor, their underpinning knowledge and attitude towards nursing, care and nurse education, alongside differing motivational factors that set the nurse mentor in a position of power that potentially gave them considerable influence and control over the practice assessment (Extract 17).

Extract 17
P2: I think it depends a lot on the mentor because if the mentor is able to assess that some … because some patients … you know statistics, you know by luck you could get a, sort of ten bloody-minded patients who by luck happened to be in that month and not next month, so I think the mentor needs to be someone who's really experienced so they can ask the patients for feedback but they need to make sure the feedback is properly … which is difficult because obviously it then gives the mentor an awful lot of power because they can say whether it's genuine feedback or it's not … (Lines 1579-1586)

Extract 17 shows the mentor constituted as the manager of the assessment process, thus the mentor remained responsible for determining which patients were involved and retained control over the final assessment decision. Yet, the extract also illustrates how the patient expected the mentor to manage the reciprocal exchange in order to give positive benefits to the student. It is interesting that Patient 2

characterises patient selection as involving a degree of luck and that '*bloody-minded patients'* would make inappropriate assessors. Here the mentor subject position is akin to that of a parental guardian whose role, when involving patients in assessment, included protecting students from *'bloody-minded patients'*. Bloody-mindedness refers to someone who 'makes things difficult for others and opposes their views for no good reason' (Cambridge Dictionary, 2017) consequently, such patients were constituted as deliberately obstructive and a threat to students and the assessment process. This extract reflects sedimented institutional hierarchies where the patient was expected to defer to the mentor due to their professional authority as a trained assessor, thus their technical expertise; knowledge of nursing and practice-based nurse education was constituted. As a result, practice assessment was itself constructed as a profession-led consultative process rather than a collaborative mentor patient activity. Hence, the benefit to patients within the reciprocal exchange was not considered, as the patient position remained deferential to that of the *'really experienced'* mentor.

Government rhetoric promotes the idea of patient involvement as a liberating process, yet within large institutions such as the NHS and HEIs, patients and students can remain objectified and repressed through a number of profession-controlled institutional practices. Repressed individuals can subsequently lose their identity and become amalgamated into a group identity rather than remaining individualised subjects. Patient involvement could therefore present a false benevolence, resulting in patients feeling grateful at being given the opportunity to take part as opposed to equal partners. The risk is that by handing down some responsibility for assessing students, patients may feel increased levels of anxiety and stress (Shennan, 1998, Speers, 2008, Stickley *et al.*, 2010). Friere (1970) suggests the 'oppressed' can also

display fatalistic attitudes where they may wish to be involved but then highlight their weaker position by seeing themselves as ignorant and deferring back to mentors who they perceive to be in a more powerful position (see Extract 17).

According to Foucault (1980:39) 'power reaches into the very grain of individuals, touches their bodies and inserts itself into their actions and attitudes, their discourses, learning processes and everyday lives' and is a central component of human relations. He viewed power as omnipresent, and as something that could neither be possessed nor given to others. Nevertheless he also asserted that power relations are contextual, and that the dominant group, in this case mentors, may create a number of mechanisms that help to maintain their control over social practices. Within the hospital and HEI environment, both patients and nursing students experience disciplinary power; 'a type of power that is constantly exercised by means of surveillance' (Foucault, 1980:104); patients experience surveillance through the *clinical gaze* via measuring and recording of clinical observations, whilst students experience surveillance through an *assessment gaze* as their progression is continuously measured against professional and patient expectations, pre-determined practice competencies, and prescribed regulatory and academic outcomes. Patient involvement within practice assessment adds another layer of disciplinary power, not only are students under the normalising gaze of their mentor but also the experiential gaze of the patient that has the potential to fundamentally change the patient / student relationship.

Extract 18
S5: I suppose I kind of, I'd like some feedback, but I wouldn't like to feel like I'm on show the whole time, sometimes I just want to enjoy it, you know what I mean? I just want to sit back and just enjoy giving patient care and not feel like I'm being .. but d'you know what I mean, some feedback would be great, it just depends how much it's going to be, is it going to be like on every ward, on every placement you're on and you're going to have ...and like, is it going to be every day? Is it like once a week? Do you know what I mean, it's just been nice to go in and as I say, enjoy it rather than feel that 'oh that's another assessment' or something else that .. and when you're being assessed as soon as someone says 'oh you're being observed' I mean not even 'oh you're being observed' straight away you're not yourself are you? Straight away I won't, I mean, if I went in to a patient and was going to sort of help them, and you have, you have a bit of, you know a bit of banter with them I'd think 'Oh golly, I don't know if I can say that' do you know what I mean? And it would feel false I'd kind of feel like 'oh I'd better not say that in case, oh god in case..' and, you know, what I mean, and you just can't enjoy yourself can you, you can't … I don't know if you'd be able to enjoy the role as much (Lines 751-765)

Extracts 17 and 18 suggest that assessment could place students in a dependent student-learner position, in direct contrast to their position as a student-nurse in practice where the patient is often dependent on the student to assist them with their care needs (Figure 13).

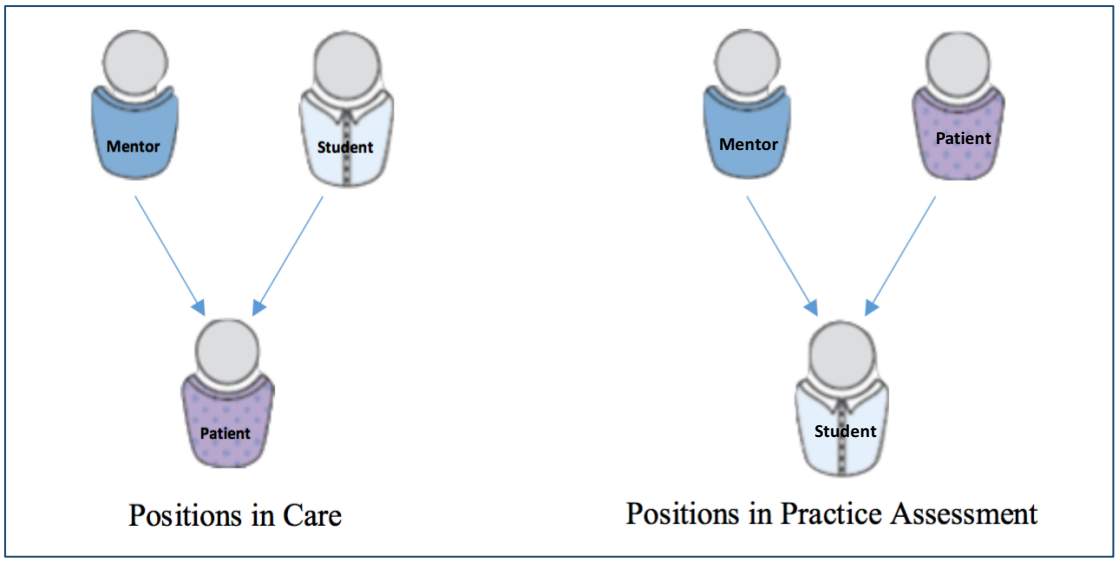


Figure 13: Patient and student positional changes from care to practice assessment

Figure 13 illustrates how the development of reciprocal relations during practice assessment has the potential to change sedimented hierarchical positions between patients, students and mentors, as the authority to assess students is shared between mentors and patients, thus the patient displaces the student's hierarchical position. Extract 18 underlines the idea that 'the judges of normality are present everywhere' (Foucault, 1977:304), and that patient involvement, when constructed as an additional surveillance tool can result in students feeling under pressure to perform, particularly as they remain ignorant as to which patients will be involved in their assessment.

As well as patients, the mentor in Extract 19 also positioned herself as guardian protecting students from negative direct or indirect reciprocal exchanges where patient feedback was constructed as potentially harmful to student confidence and '*downright mean'*. But it also reveals a tension between the credibility of the patient and mentor as objective assessors. This extract prioritises the professional expertise of the mentor over the subjective, experiential expertise of the patient. Consequently, there was less value placed on patient assessment, as the mentor constituted patient feedback as subjective and emotional, whereas the mentor employed a professional discourse to presume her own objectivity and credibility.

Extract 19
M3: I think you know, it, it could give, it could quite easily give a student a false sense of achievement of being you know, much more able than they are, but then you also get a nice grumpy patient that the student's bent over backwards to do everything for who just doesn't want to know, and just says 'no' you know, 'whatever' and it can destroy their confidence as well, and you think actually you've done everything you can but that patient was just being downright mean, you know and it's, but then also we, you know, it's going to be subjective in the fact that we'll probably pick the patients so we'll pick the ones we want to pick (Lines 1327-1334)

Therefore, the logic of protectionism emphasised the mentor's dominant position in the assessment process. In the following extract, the patient legitimises the mentor's professional authority to minimise any potential risks to the student that may come from the patient's limited and sporadic contact with the student. Extract 20 insinuates that patient assessment may only provide a limited overview of students' vocational behaviours, thus patient involvement in itself presented a risk precisely because of the subjective nature of that assessment resultant of the infrequent exchanges between the patient and student during her two-day hospital admission.

Extract 20
P4: I don't think again that patients should be involved in the assessment of a nurse because I don't think their involvement with any individual nurse is sufficient to be a good judge as to whether that nurse is a good nurse or not. They might be able to say 'well as far as I was concerned on the two days I was in hospital she was perfectly polite and kind and generous' and so on, that doesn't tell you a thing about whether this is a good nurse or not (Lines 1200-1205)

Here Patient 4 appeared unsure about the veracity of their involvement in summative assessment and their abilities to discern whether a student is *'a good nurse or not'*. Patient 4 expressed discomfort at the personal level of engagement required in the assessment process, which unlike patient satisfaction surveys that couch opinion on a whole care episode, required patients to provide feedback on the clinical practice of an individual. This discomfort may be a consequence of the patient assessor role not being part of a sedimented patient identity and assessment practices, but could be coupled with an anxiety around being responsible for making the wrong decision.

Extract 21 provides an example of the tensions between the concept of patient involvement as an experiential assessment of the vocational quality of students' care delivery and the mentor's assessment of professional competence. Despite

acknowledging that mentor assessments are compromised due to lack of time with the student, it is the patient's lack of time with students that the mentor constituted as a risk. Hence, this extract reveals the contingency of the logic of experientialisation, and the on-going tensions between the meta-logics of a nursing regime – the logic of practical-caring vocation and technical-scientific profession. It shows one way of protecting students against a risk of an unfair patient assessment was for the mentor to assert their professional authority by representing patient assessments as judgemental, reductionist and unsound.

Extract 21
M3: If I think I don't get enough time with my students how on earth does the patient get enough time with my students? I think it's a very, it's going to be very judgemental, even more judgemental, I don't think it's going to be a sound base, I think it will be literally face value, 'have you been nice to me, yes tick', have you not been nice to me, were you friendly to me, yes' you know, it's, it's going to be very … very short and sharp, they don't see them for long periods of time, patients you know can come and go within a 24 hour periods is that enough time to, to know whether a nurse is competent? To be able to say that they're competent to go on? Just because you're friendly does that mean you're actually competent? Does that mean, you know just because you're a nice person to chit chat to and you came and said hello and helped them with a wash in the morning does that mean you're a nurse? (Lines 1304-1314)

Students and lecturers also drew from a logic of protectionism from the perspective that patients had not received any preparation for their assessor role, nor did they have the underpinning professional understanding of students' practice assessment documentation and NMC professional standards (Extracts 22-24). The professional role of the mentor, who had attained a specific qualification to undertake the role, positioned the mentor as the educated expert, whilst the patient was positioned as an uneducated informant.

Extract 22
S2: ..well for one thing they won't know … well they might, it depends on how it's done but they might not know the level you're at and what you're … you know, if you're in your first year and you're not doing very much at all, you're just washing them and … that sounds fine, but they might have bigger expectations of you and then 'well actually she didn't do this and she didn't do that, and she didn't..' and so they might have more expectations of you than actually your mentor would at that stage of your training and they might think you're really quite incompetent to carry on because you've done this and you've questioned that. So they might not have a good enough understanding of the level you're supposed to be at and where you're expected to be at that point. So I'm not sure they should be the ones who should decide whether you go on, I think it's good to have their feedback and the comments but I'm not sure if they should have that kind of responsibility on your career (Lines 606-618)

Student 2 (extract 22) also drew from a logic of protectionism to suggest that patients' lack of knowledge about nursing and nursing curricula resulted in patients' expectations being set too high, that was constituted as a risk to the student as uninformed patient feedback might be more critical than the mentors'. While she also used this logic to constitute patient-assessors as uneducated, there is a suggestion here that the patient might be too informed about what they should be expecting in terms of qualified nurses' actions and behaviours, but that they lack the understanding to be able to measure their expectations against students' particular stages of training. This student's anxiety seemed centred upon being judged against a sedimented societal nurse identity where the student's own subjectivity, as an autonomous agent is lost.

This internal/external divide is also evidenced in extract 23 where the lecturer draws on a protectionist logic to constitute patients' lack of understanding of professional '*jargon*' as a potential threat.

Extract 23
L1: It's er, making sure that there is erm, the patient is understanding what is meant by the assessment, erm, I mean educators and mentors know about our sort of terminology, just like nursing has its own terminology and we always try to encourage not to speak in jargon, equally patients have got to understand fully of what's being asked of them, so they're you know, they're not blinded by jargon, that sort of thing (Lines 817-821)

Educators and mentors were constituted as knowledgeable with an assumption that professionals were fully cognisant with nursing education 'terminology' and 'jargon', whereas the constitution of the patient as passive bystanders renders them as ignorant of '*professional jargon'* something that has already been acknowledged as a barrier to effective patient involvement (Beresford, 2012). This again illustrates the contingency and professional contestation of the patient-assessor role and highlights the tensions between patients' experiential, vocation-focused assessments and mentors' professional, technical-focused assessments. Interestingly, there were no demands from either Student 2 or Lecturer 1 for mentors to inform or educate patients about nursing, the assessment process or the professional competencies expected of students. Instead, the logic of protectionism was employed to protect the mentors' position, thus reducing patient involvement to tokenistic, non-participation.

Extract 24
L4: I think it is, it is valuable, but equally there is a danger that if service user feedback is positive it influences the feedback and the object…, the view of the mentor as well. I think if I'm being really critical about it I suppose, the mentor is the professional, who's undergone professional training and is professionally registered to assess individuals, so therefore do we need a third factor in that? That's not to say that the third factor isn't valuable and it couldn't be of interest but equally in knowing the kind of hawthorn effect, I'm not sure that it wouldn't bias people and therefore is, would not be counter-productive (Lines 1023-1030)

Extract 24 positioned the mentor as the accountable judge who has '*undergone professional training and is professionally registered to assess*

individuals', but mentors were also constituted as the most visible assessor to the student, someone that the student had an established formal educational relationship with. Within these extracts the student is also constituted as subordinate and passive within the assessment process, with a sense that the assessment is done *to* students rather than *with* them, negating the construction of higher education and practice-based learning as student-centred.

In summary, the logic of protectionism helped illustrate the tension between the role of the patient in assessing students' vocational practice and mentors' professional responsibility and accountability to ensure students are competent in all areas of nursing practice. Within this logic, patients' experiential expertise, subjectivity and sporadic interactions with students were constituted as risks to the validity and objectivity of mentors' practice assessment and to students in terms of course progression and their professional confidence. I have also shown that participants engaged in the logic of protectionism to minimum risk by downplaying the value of patient involvement and continuing to position the mentor as the professional, educated authority on competency assessment. In the final part of this chapter I will consider how various actors have contested and attempted to weaken these dominant logics through a counter logic of systematisation. Logics of experientialisation and protectionism are rather contradictory logics therefore the counter-logic of systematisation works to determine and facilitate their dominance.

A Counter Logic of Systematisation

The social logics of experientialisation and protectionism illustrate how patient involvement in assessment is characterised as a practice within a regime of nursing. Nevertheless, in presenting a detailed critique of these two dominant logics consideration needs to be given to competing or counter logics that illustrate how

participants have opposed and problematised their dominance (Howarth, *et al.*, 2016). This final part examines a counter logic of systematisation and explores the self-interpretations of participants that project an alternative understanding of patient involvement.

From the introduction of general management in the NHS in the 1970s, government health policy has demanded greater institutional accountability to demonstrate cost effectiveness. As a result, the NHS has seen the introduction of a number of marketisation strategies built around an economic-based efficiency model focusing on measuring targets, performance and the installation of evidence-based practice, rather than supporting a holistic patient-centred approach to healthcare. Miles (2009:944) describes such practices as 'radical reductionism' that helps to create a 'fetishisation of science', privileging scientific inquiry over other approaches. This 'scientific fetishism' not only relates to the quality assigned to evidence-based practice but also to government health policy and institutional quality governance practices that promote scientific data analysis as the best way to measure NHS performance. A reductionist approach is often taken when attempting to understand the performance of complex organisations, therefore the totality of the NHS is thought to be better understood by breaking it down into measureable components − clinical outcomes, mortality and morbidity statistics, productivity, efficiency, service capacity, patient satisfaction data – that can be reconstituted to provide a picture of overall performance (Glynn and Scully, 2010).

NHS institutional management practices have subsequently systematised patient involvement methods through the use of patient satisfaction surveys as this provides a means by which NHS organisations can demonstrate patient involvement to external reviewers including the public. The systematisation of quality governance

processes aims to promote uniformity in order to present a consistent and comparable overview of quality at a local, regional and national level. A counter-logic of systematisation is evident in the following extracts:

Extract 25
P3: In a way it's kind of annoying cos you just want to leave, but to be fair they need to know what you think of it, you know, it's not that much of an inconvenience, all you've got to do is tap on the screen what you think out of 10 I think it was, and that's, you know that's not too hard. And it helps people know what, you know, what you think of the place and keep it, if you think it's not clean enough, all that kind of thing (Lines 238-242)

Extract 26
M6: We do the, erm, patient satisfaction surveys they give a certain number per ward that have to be done each week. And I believe there's like feedback sheets they get as well, and the patient groups who co-ordinate and get like information and then they do their own reports as well, erm. I suppose you do try and give them, when you're going round, when you're doing the drug round, you ask how people are during the day and if they've got issues you try to address them (463-468)

There is an argument that such systematisation ensures that health professionals actively engage patients in the evaluation of care delivery, however there is an inherent risk that by reducing care to a tick box exercise the individual experience of each patient is disregarded and becomes absorbed into anonymous objective statistical data. This is reflected in Extracts 25 and 26 where a systematised approach to patient involvement entailed the completion of a computer-based survey, which reduced patients' hospital experience to a series of numerical scores set against pre-determined quality statements. Despite this reductionist approach, all patient participants reflected on moments where they had had the opportunity to engage in conversations with health professionals about their experiences of care, however few recognised this as patient involvement.

Similarly, within HEI practices the counter-logic of systematisation prioritised the reduction of professional nursing practice and patient involvement into

a series of prescribed measurable tasks and competencies. According to Rauner and Maclean (2008:17) the systematisation of professional competencies is a particularity of vocational training, which may account for the contingent tensions between professional and vocational nursing. For example, patient involvement in the assessment of students' practice has been constituted as a strategy to re-establish vocation as a core nursing attribute, however the demand from the NMC for the formalisation of patient feedback has resulted in many HEIs adopting a systems approach to patient feedback incorporating checklists or attitudinal scores. The following extract draws from a counter logic of systematisation to contest formal patient involvement:

Extract 27
S3: … a lot of the time they go 'oh aren't you lovely' or 'thank you so much it's been wonderful here and everyone's so nice' and they try and give you a kiss or something…but I think you get that kind of feedback all the time when you're, especially if you're doing things like personal care, helping someone have a wash you're in very close contact with them, and they're not going to, you're not going to have that reflected by a structured survey or a tick box exercise

This extract suggests the most valuable feedback was given during intimate moments of care between the student and patient, although the social logic of protectionism, as discussed early, suggests that patients were more reticent about given negative feedback. There is also a suggestion that students valued qualitative comments that might not be recorded following a systems approach.

The impact on systematised care practices has resulted in shorter hospital stays (Jensen *et al.*, 2017), which were seen as having potential consequences on a patient's ability to effectively engage in assessing students within a busy hospital setting, characterised within the following quote from Patient 4:

Extract 28
P4: It's hit and miss isn't it. It depends what mood I'm in at the time, whether she said something unfortunately about my puss cat that she hates and I like. I don't think it's fair on the nurse for that level of involvement, for we have, for we patients have the power of success or failure. Now if you're saying that that's only going to be a very modest percentage of the marking towards her pass or fail then that probably alright, but bearing in mind that the whole ethos behind hospitals these days and, and our contact with nurses is 'get them in, get them out' how many people are going to have sufficient contact with an individual nurse to make any fair assessment or judgement of that nurse? The ones that have been in for weeks on end maybe but they're going to be few and far between, most people aren't in hospital longer than 2 or 3 days, how can I possibly judge on 2 or 3 days, it's not fair (Lines 1220-1230)

Extract 28 illustrates concern that such process-driven institutional practices may negate the ability of patients to provide *'any fair assessment or judgement'*, due to a lack of contact with students, despite their willingness for feedback to count towards a summative assessment of student competence. Informal patient feedback as illustrated in extract 28, is based on a personal interaction at the moment of care, however formal patient feedback is likely to be abstracted away from the student and relies on patients' reflecting back on care received, therefore the spontaneity and clarity of that feedback may be compromised by a lack of continuity, feelings of vulnerability, a mismatch of expectations, and a lack of understanding of nurse education and the assessment process.

In summary, a logic of systematisation acts as a counter-point to the assumption that the logics of experientialisation and protectionism are necessary and inevitable (Glynos and Howarth, 2007:194). It illustrates how patients, students, mentors and lecturers instituted patient involvement from a wider institutional perspective and how the systematisation of patient care, nurse education and patient involvement in practice assessment subsequently revealed the contrast between patient involvement ideology and its institution as a social practice. Therefore if we accept that within patient involvement a logic of experientialisation can also facilitate

the operation of a logic of protectionism, then a counter-logic of systematisation serves to contest and weaken those dominant logics.

Conclusion

This chapter has analysed the way in which the articulation of two social logics – a logic of experientialisation and a logic of protectionism, and a counter logic of systematisation characterised patient involvement practices within nurse education and the assessment of nursing students' competence in practice. It examined the similarities and differences between how patient involvement practices are understood by patients, nurse mentors, students and nurse lecturers, and explored the power relations between the different groups of actors. Patient involvement practices were characterised by a constant shifting of power between patients, students and mentors depending on sedimented institutional practices, clinical context and patient acuity.

This chapter revealed the contingency of patient involvement in practice assessment. Although patients, students, mentors and lecturers acknowledged the value of patient feedback, students, mentors and lecturers resisted patient involvement by constituting their assessment as subjective and emotional. The logic of experientialisation suggested nurses' authority was contingent upon them being seen vocationally. However, vocational values almost became a rite of passage, resulting in patients' subjective assessment of students' affective competence being subjugated by the mentors' professional authority to assess students' professional competence. This chapter also demonstrated that while there was an acceptance of the patient-consumer identity in regards to patient involvement in healthcare and nurse education at an institutional level, the historical power relations between patients, students and mentors were still at play within practice assessment. A historic

subordinate patient position was compounded by the dependency patients had on mentors and students during hospital admission where patient participants constituted themselves as clinically and situationally vulnerable. This vulnerability suggested patients were much more likely to acquiesce to mentors who they considered to have the professional and educational expertise to assess students' professional competence.

Patient involvement in assessing students' practice was described as subjective rather than critical or rational, thus perpetuating an unequal power relationship with mentors within the assessment process. Students themselves, by the very nature of being situated as the 'learner', were placed in a subordinate position to their mentor, and thus remained dependent on the mentors' judgment in order to progress towards professional registration. This chapter has illustrated that the patient and student subject positions within practice assessment are in a constant state of flux. Patient involvement creates a sense of co-dependence between each group of actors that changes the relational dynamic as students become more aware and attentive to the subjectivity of the patient. The next chapter examines how patient involvement has 'recruited, governed and gripped subjects' (Glynos and Howarth, 2007:173). I will examine how patient involvement has been politically instituted within nurse education in the UK, and how the beatific promise that patient involvement will create an active patient-consumer of care *and* education, has been re-articulated as a strategic to ensure the return of the caring vocation-centric nurse.

Chapter 6: Vocation or Profession? Antagonisms, frontiers and fantasies

Introduction

This chapter considers the political logics that characterise the emergence of and resistance against patient involvement in practice assessment. The operation of political logics of equivalence and difference are inherent parts of this political process. As discussed in Chapter 2, the logic of equivalence simplifies the structure by showing how different actors or groups of actors link together to show their opposition against 'an other' across an antagonistic frontier (Laclau and Mouffe, 2001). It is this creation of a 'them and us' scenario that enables social antagonisms to become evident between associated actors and a common adversary. The creation of the adversarial 'other' can be described as a two-way process. In this study, this was manifested in the way that different actors, such as politicians and patient groups sought alliances against a profession deemed 'too posh to wash' and 'too clever to care'. However, it is also possible for nursing leaders to form alliances with HEIs to constitute vocationally trained nurses as the adversary who were attempting to block the emergence of a technical-scientific nurse identity. In contrast, the logic of difference weakens those alliances by breaking the chains of equivalence that link together individual groups particular demands into one universal demand. This logic subsequently highlights the contiguous relationship between particular groups of actors' demands, keeping those demands 'distinct, separate and autonomous' (Glynos and Howarth, 2007:145).

While the social logics of experientialisation, protectionism and systematisation characterised patient involvement during one moment in time, my analysis of the political and fantasmatic logics will show how the professionalisation of nursing and patient involvement in practice assessment has emerged and been

contested over time. However, as explained previously (Chapter 2), the analysis of political logics within this study was not straightforward. Although there has been a well-established political movement calling for a patient-centred NHS, patient centred care and patient-centred professional education, it is more difficult to discern the political origins behind patient involvement in the assessment of nursing students' practice. What is apparent is that different actors have problematised nursing using a number of discernible storylines. These storylines become political when joined together to form discourse coalitions, but they also become fantasmatic as they present an 'imaginary promise of recapturing our lost/impossible enjoyment' (Stavarkakis, 2005:73). For example, after the transition of nurse education into higher education, storylines of '*nursing is a vocation not a profession'* and '*practice over theory*' characterised a beatific fantasmatic logic of the practical, more caring vocational nurse; whereas after the scandal of Mid Staffordshire, the storyline focused on HEI-educated and graduate nurses lacking care and compassion, an horrific opposite − the 'too posh to wash, too clever to care' technical-scientific nurse. Therefore, the political and fantasmatic logics are drawn from an examination of the storylines various actors employed in their attempts to articulate HEI nurse education as the problem and patient involvement as one solution and how this has been presented in a hegemonic normative frame.

This chapter will demonstrate that various actors drew on two political logics of equivalence - logics of *vocationalism* and *consumerism* to demand HEI nurse education be predicated on practical skills, care, compassion, vocational values and the patient experience. Additionally, a political logic of *professionalism,* played out a logic of difference, can characterise nursing organisations, nurse educationalists and nursing leaders' discourse coalitions as they pushed back against these demands. I

will also illustrate the grip of two fantasmatic logics, a logic of *the caring vocational nurse* and a logic of *the technical-scientific nurse* that highlight actors' ideological investments that binds different groups of actors together. In the final part of this chapter I suggest that while political and policy actors' might present the problem/solution as a hegemonic normative frame the situation is far more complex. I subsequently consider how those actors have attempted to articulate nurse education as the problem and patient involvement as a solution. I will demonstrate that actors' presentation of this normative frame as a possible empty signifier, seeks to dominate political debate, but I will argue that this domination overshadows three other possible characterisations of nurse education and patient involvement. In the final part of this chapter I present the normative frame against the three alternatives within a four-quadrant problem/solution intellectual framework and will show how the three alternative articulations (floating signifiers) could characterise the situation differently.

The antagonistic other

In this section I introduce the concepts of the 'antagonistic other' and the drawing of political frontiers, which underpins my analysis of the political logics within this chapter. An important aspect of the political dimension of social reality is that the political logics of equivalence and difference are always inherently interconnected although one will eventually dominate. This is largely dependent on how the social space is divided through processes of contestation across dislocatory moments (Howarth, 2000; Norval, 2000). These moments, such as the events at Mid Staffordshire Hospital, make visible contingent social practices that consequently reveal the possible contingency of patient involvement in practice assessment. Laclau and Mouffe (1985) claim all identities are over-determined, in other words an

identity's meaning can be interpreted differently according to the situation or context. Hence, during such moments of crisis the nurse identity can become dislocated as the sedimented image of the nurse as caring and compassionate is found to be lacking, revealing its opposite contingent identity (as demonstrated in the previously presented genealogy, see Chapter 3). This then highlighted the fundamental split in the nurse identity where some politicians, patient groups and nurses drew on a fantasmatic logic of the practical-caring vocational nurse to construct an horrific alternative, the technical-scientific professional nurse that became associated with 'neglect', 'cruelty' and being too 'academic' (Francis, 2010, 2013). Hence the 'technical-scientific nurse' was then presented as the antagonistic 'other' that not only blocked the patient identity, (thus preventing them from being what they want to be – visible, involved, and cared for) − but was also constructed as a threat (by diploma and apprentice-trained nurses).

The drawing of political frontiers

The drawing of political or antagonistic frontiers is inherently a part of politics that helps to distinguish identity and 'organise the political space through the simultaneous operation of the logics of equivalence and difference' (Norval, 2000:220). The dominance of a logic of equivalence can lead to the construction of clear boundaries and the construction of an enemy – the antagonistic other that divides competing groups into 'them and us'. Political discourse enables different groups of actors to find unity within their individual interests in regards to the professionalisation and academicisation of nursing that establishes a political frontier that attempts to exclude the 'antagonistic other' and thereby deepens antagonistic relations. In contrast if a logic of difference dominates then those antagonisms are weakened, political frontiers fails to materialise making it difficult to dichotomise

actors into two opposing camps (Norval, 2000). Political frontiers often become visible during moments of dislocation and can be described as:

> '…those mechanisms through which social division is instituted, and 'insiders' distinguished from 'outsiders'; it defines opposition; it dissimulates social division; it makes it seem that the institution of social division is not itself a social fact' (Norval, 1996:4-5)

The drawing of frontiers subsequently enables groups and individuals to articulate specific demands for change. These demands do not need to be the same and may not necessarily go together, however they do allow for the particularities of each individual demand to be either substituted or combined through a chain of equivalence to present one unifying demand in common opposition against an adversary. For example, a unified demand for the vocationalisation of nursing combines the particular demands of NHS managers and nurses for newly qualified nurses to possess more practical skills (Mackay, 1989; 1993; Jowett, 1994), doctors' demands to halt the academicisation of nursing (Horton, 1997) and the Patient Association demands for HEIs to teach students care and compassion (Rayner, 2008).

Hence, there are a number of different actors who have a political opinion on the state of nurse education. However, it is difficult to identify any specific period where either a particular or a universal demand for greater patient involvement in the assessment of nursing students has been clearly articulated. What is evident is that each group of actors have presented different storylines on what they consider nursing to be and the impact HEI-based, technical-scientific nurse education has had on the quality of patient care. This has given rise to the formation of unconventional coalitions between actors and it is these discourse coalitions that 'develop and sustain a particular discourse, a particular way of talking and thinking about … politics' (Hajer, 1995:13). Documentary analysis found that while social and political actors told their story differently, a number of recurring storylines emerged. These

converged to create discourse coalitions that form two complementary logics − vocationalism and consumerism (both logics of equivalence) and a logic of professionalism (a logic of difference) (108). Hence, vocationalism and consumerism represents different actors unified demands for nursing to be more practical, vocation-based and patient-led, whereas professionalism represents a logic of difference that the excluded 'others' employed as they attempted to break up the unified demands for educational reform and undermine the consolidated support for the revocationalisation of nurse education.

Logics of Equivalence	Storylines
Vocationalism – A universal demand for the acquisition of practical skills and vocational attributes over academic knowledge	Nursing is a vocation
	Practice before theory
	The heart of nursing is care and compassion
Consumerism – A universal demand for nurse education to reflect the needs and expectations of NHS providers, patients and service users	Patient assessment will instil compassion
	Need to restore public trust
Logics of Difference	**Storylines**
Professionalism – Emphasis on differences. HEI nurse education encompasses education, training, technical skills, knowledge creation, autonomy, ethics and professional values as well as practical skills and vocation	Education transforms care
	Care, compassion and intelligence are compatible and necessary

Table 10: Political logics and actors' storylines

1990 – 1999: The contestation of technical-scientific nurse education

From setting out how political frontiers help to establish boundaries that attempt to exclude an antagonistic other, in this next section I show that different political and policy actors employed competing storylines as the idea of HEI-based, technical-scientific nurse education was resisted by some, and defended by others at two particular points in time. First, I consider the contestation during the period 1990-1999 following the introduction of HEI-based nurse education and Project 2000. The resistance against nurse professionalisation then appeared to abate, until 2004-2013 where the consideration of further academicisation lead to the next period of contestation that I examine in this chapter.

Competing storylines: vocation and practice over theory vis-à-vis education transforms care

The storyline '*Nursing is a vocation'* first emerged in the mid 1800s and can be seen to evidence the on-going antagonisms and hegemonic struggle surrounding the professionalisation of nursing (Orr, 1990; Jowett, 1995; Hamill, 1995; Cutherbertson, 1996). In the following extract (Extract 27), Richard Horton, a doctor and medical columnist in *The Observer* newspaper, insinuated that nurses pursuit of higher education was an attempt to rearticulate their professional identity away from the art of caring towards a science of nursing, which he suggested was a bid to gain unnecessary professional credibility.

Extract 29	*Storyline: Nursing is a vocation*
	Political Logic of Equivalence: Vocationalism
	Under the right-thinking and well-meaning guise of professionalising nurses, and by turning their work into science akin to medicine − we risk displacing plain and simple (and decidedly non-scientific) caring. Nurses can do both without becoming pseudo-doctors. Richard Horton, writing in *The Observer* 30th March 1997

The patriarchal dominance of medicine is evidenced in this extract as Horton employs a medical discourse to disassociate higher education with nursing and constitute caring as '*plain*', '*simple*' and '*decidedly non-scientific'*. Medical practice and academic study are made equivalent and there is a suggestion that rather than nursing defining its own independent sphere of practice, the transition of nurse education into higher education was the profession's attempt to move away from care towards cure.

While Horton himself cannot be described as a policy actor, his position as a doctor and Editor-in-Chief of *The Lancet* offered a platform through which medicine's concerns could be articulated. Although Horton positively associated education with the expansion of nurses' roles and clinical responsibilities, medicine was constituted through a scientific discourse thereby legitimising medicine as an authentic academic profession, separate from nursing. As a profession nursing was not articulated at all, instead the on-going professionalisation of nursing and the possibility that nurses would be educated in medically associated academic subjects was articulated as a threat to medicine's position as the 'curing' profession. This extract suggests that rather than nurses' transition into higher education being viewed as a positive advancement that could complement and support medical practice, the technical-scientific nurse continued to threaten entrenched doctor-nurse subject positions within institutional hierarchies. Consequently, an antagonistic frontier was drawn between nursing as a caring, non-scientific vocation and medicine as curative, science-based profession.

Around the time of Horton's article there was increasing criticism of the Government's failure to address declining standards of hospital care, increased waiting lists, rationing, low morale and a significant nursing recruitment and

retention crisis (Klein, 2013). A UKCC report published at the time claimed that the struggle to staff the NHS meant that students were often used as 'pairs of hands' to fill the gaps and provide fundamental patient care, to the detriment of learning the skills required for qualification (UKCC, 1999). This may account for the new iteration of an old storyline that initially emerged in 1989, where HEIs were accused of putting theory before practice, a possible deflection strategy by a government under pressure. This re-emerging storyline is evidenced in Extract 30, where UNISON, a trade union representing public service workers including registered nurses, enrolled nurses and healthcare assistants, accused nursing leaders of tipping the balance of pre-registration nurse education too far towards academia.

Extract 30	*Storyline: Practice before theory*
	Political Logic of Equivalence: Vocationalism
	The balance has been tilted too much. We are turning out people who are more academically able but don't have the clinical expertise to do the job in the workplace. There's a cadre of the upper echelons of the nursing profession that is very much bent on professionalising nursing by having the training as close to the doctor model as possible. Paul Chapman, UNISON quoted in *Times Higher Education*, 9th October 1998

Extract 30 echoes the sentiments from the previous extract and it is interesting that both Horton and UNISON talk about an uneven balance weighted more towards technical-scientific profession than practical-caring vocation. However, this also suggests that neither were completely rejecting the academicisation of nursing but were indicating that this should be done carefully so that nurses' caring duties were maintained. In contrast to Extract 29 the logic of vocationalism is evidenced as an internal struggle between the nurses in the workplace and the 'upper echelons of the nursing profession'. Consequently, nursing was split into two opposing camps, those who practice and those who lead. And it was those who led that were vilified for

having ideas above their station, whereas the rank and file were presented as just wanting to care for patients. This attempts to undermine the legitimacy of the HE movement, suggesting it was led by an out-of-step leadership without the broad support of the membership. HEI nurse education was presented as an additional threat to the status quo, as the academic qualifications required to study nursing would have meant that some nurses who qualified before the 1980s would not have met the entry criteria of many HEIs. Therefore, rather than technical-scientific nurses being constituted as the antagonistic other, in this extract it was nurse leaders' ambitions for enhanced professional status that were considered a threat.

While the storyline remains the same in Extract 31, this extract shows that employers, (the NHS Confederation), drew on a logic of vocationalism to place more importance on the acquisition of '*practical skills'* as opposed to students attaining the theoretical knowledge that underpins nursing practice. The expectation that newly-qualified nurses should be '*streetwise*' is perhaps indicative of the staffing crisis at that time. Although extract 31 comes from an UKCC-commissioned review published towards the end of 1999, it reflects the internal political debates in the NHS at the time and the potential power and political influence of the socio-political resonance created by this particular storyline.

Extract 31	*Storyline: Practice before theory*
	Political Logic of Equivalence: Vocationalism
	When newly-qualified nurses arrive in our trusts, they are not ready to practice. There are deficits in a variety of ways, some to do with practical skills, and some to do with what some of our members have characterised as 'simply not being streetwise', not being ready for what it is like with shift patterns, multi-professional working, dealing with difficult situations. NHS Confederation quoted in UKCC Fitness for Practice report (1999:40)

Extract 31 is interesting as it suggests that the emphasis was on missing practical skills and not knowing the job of nursing. Hence employers appear to have prioritised nurses' experiential craft knowledge over knowledge gained from scholarly activity in university. Although the NHS Confederation's criticism was targeted at *Project 2000* and HEI-based, technical-scientific nurse education there was no acknowledgement of NHS organisations' role or responsibility to support students in becoming '*streetwise*'. The stance of the NHS Confederation indicates an alliance between Trust managers, who were demanding newly-qualified nurses be proficient rather than competent in order to meet the needs of the NHS, and apprenticeship-trained nurses who saw the academicisation of nursing as a potential threat. By highlighting the deficits in HEI-based nurse education and the potentially widening theory-practice gap, the NHS Confederation as the employer representative, was able to demand greater employer engagement in curriculum development and delivery to ensure that newly-qualified nurses were fit to meet what they felt were the immediate needs of employers, rather than the needs of patients or of the profession.

The logic of vocationalism is evident in Extract 32, where a frontier was drawn between '*bedside*' vocational training – and the ability to give '*tender loving care'* (TLC) and technical-scientific nurse education, where learning in '*a lecture hall'* was associated with turning nurses into '*cut price doctors'*, reflecting Horton's construction of the technical-scientific nurse as a threat to a sedimented vocational image of nursing.

Extract 32	*Storyline: Practice before theory*
	Political Logic of Equivalence: Vocationalism
	Making nursing a degree course means that for three years the trainees are at university instead of the bedside. Nursing has always been an apprenticeship training, and should remain so. You cannot learn tender loving care in a lecture hall, and that basically is what nursing is all about – along with the

	required knowledge of course. Nurses should be nurses, and not cut price doctors. Retired nurse – Letters to the Editor *The Daily Telegraph* (Mills, 1998 cited in Bradshaw, 2001:110)

Extract 32 demonstrates what Glynos and Howarth (2007:147) describe as a fantasmatic 'have your cake and eat it' logic. This retired nurse has an expectation that nurses should focus on TLC, but she slips in 'required knowledge' but does not qualify what that required knowledge was or how nurses might best attain that knowledge. Interestingly she drew a professional boundary around nursing and differentiated it from doctors. In a way she downplayed nursing, painting them as inferior to doctors, thus buying into the patriarchal medical discourse.

Although these are only three examples, the recurrence of the '*nursing is a vocation'* and '*practice before theory'* storylines formed a discourse coalition where a discursive alliance developed between trade unions, NHS employers, nurses and doctors. The persuasive socio-political resonance this discourse coalition created is evident in Extract 33, where Frank Dobson, then Secretary of State for Health, drew on a logic of vocationalism to position himself as the political overseer converting actors' particular demands into a unified demand for educational reform. Dobson appeared to also claim ownership of the issue by suggesting nurses felt that newly-qualified nurses lacked practice skills. By taking ownership Dobson was positioning himself as the professions' representative, where he had no right. What we can see from these extracts is that the nurse identity was constituted from chains of equivalence between practical-caring nursing associated with the bedside – apprenticeship − tender loving care – required knowledge, in contrast to the negative antagonistic opposite, the technical-scientific nurse, who was linked with university – lecture halls – inessential knowledge – pseudo /cut price doctors.

Extract 33	*Storyline: Practice before theory*
	Political Logic of Equivalence: Vocationalism
	Many nurses, when they qualify, think that they lack the practical skills necessary on a ward. The transfer of responsibility to the education sector from the health service has broken the old links between individual hospitals and nurses in training, to the disadvantage of both. Many nurses and nurse managers recognise the need for change, so I hope to carry the profession with us − but reform there must be Frank Dobson – Labour Health Secretary House of Commons Debate. 11th January 1999 (Hansard, 1999)

An anti-academic, deprofessionalisation rhetoric appears to emerge where nurse professionalists and educationalists were accused of widening the theory-practice gap, moving students away from the bedside and putting their own ambitions above those of the patients and the NHS (Tattam, 1991; Humphreys, 1996; Corbett, 1998). Chapter 3 has already illustrated the extent to which nursing and nurse education has been politicised since the late 19th and early 20th centuries. Although it could be argued initial campaigns were successful, nurses' demands for professionalisation have not ceased, as might have been anticipated. Instead, nurses continue to make political demands; for better pay, better working condition, a defined career structure and higher levels of education, therefore the extent to which the professionalisation of nursing remains something of a political football across all political parties is perhaps indicative of continuing resistance and contestation of an educated professional nurse identity. Hence, the tensions between practical-caring vocation and technical-scientific profession have not dissipated; rather these seem to re-emerge during times of political crisis in the NHS.

Frank Dobson's announcement of educational reform and the subsequent publication of '*Making a Difference'* (DH, 1999), set out a new nurse education framework before the UKCC had published its own commissioned review of pre-

registration nurse education (UKCC, 1999). In a pre-emptive move the Government had already informed the Commission of its proposed reforms and the date of its introduction, September 2000. This presented the UKCC with *a fait accompli*; the Government was effectively demonstrating its sovereign power over the profession and its regulatory body and there was little the Commission could do to resist the Government's demands for flexible routes into nursing, an increased practice component, and a service-led curriculum. NHS managers had been demanding greater resources, more staff and control over nurse education, while the Government needed to reinforce its alliance with NHS managers to ensure the success of its NHS modernisation plans. The Government, by drawing equivalences between these demands through a political logic of vocationalism shifted the responsibility for declining NHS services onto technical-scientific nurse education by strengthening and legitimising a 'buyers' revolt' (Light, 1988). This meant that the position of HEIs changed, no longer was education provider-driven, instead a buyer-led revolt subsequently reduced the autonomy of nurses to determine the curriculum. The development of a political frontier created antagonistic relations between a reforming Government and NHS service providers on one side and education on the other (Figure 14). This could be interpreted as demonstrating the Government's intent on deflecting blame onto HEIs who were subsequently held responsible for failing to teach the requisite practical skills, reducing students' time in practice and promoting unrealistic academic ideals (Kenny, 2004).

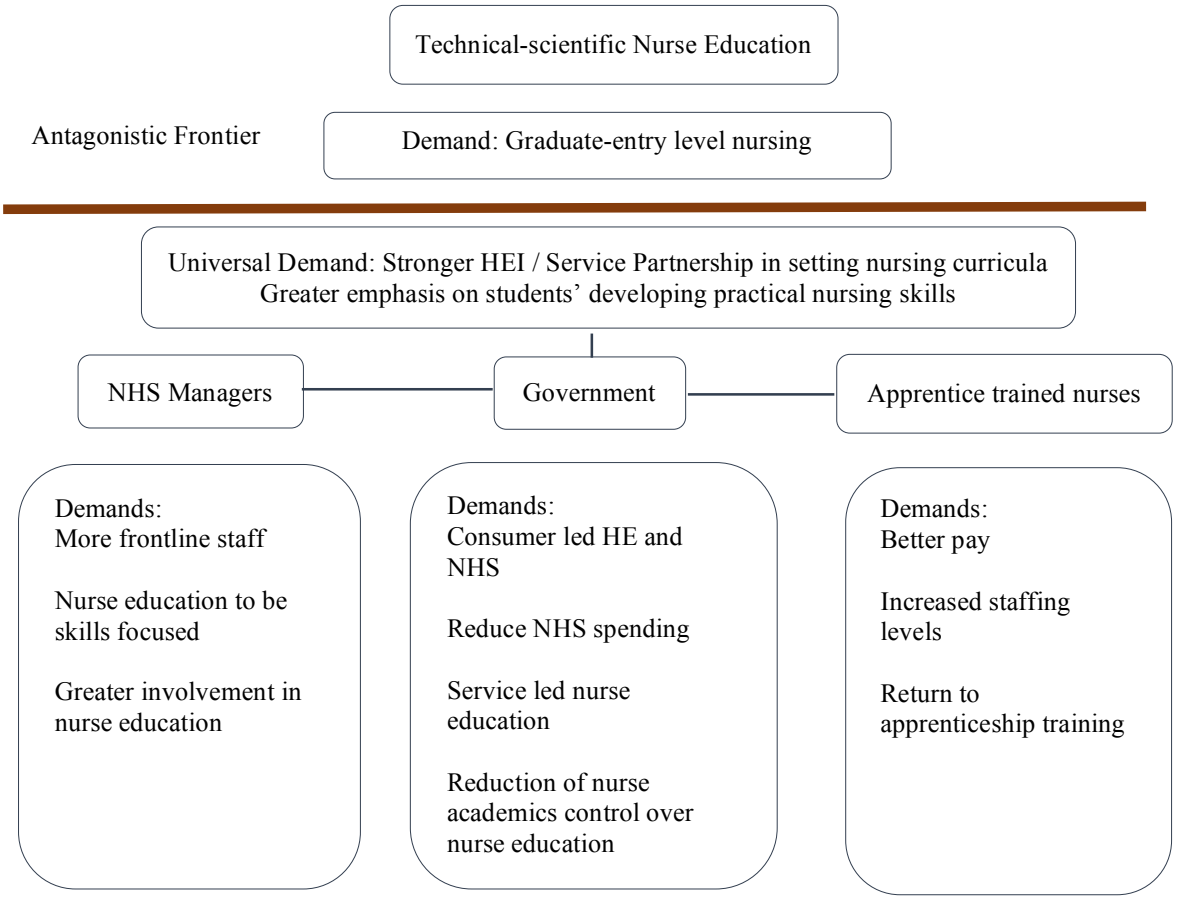


Figure 14: The antagonistic frontier between vocation and professionalisation

Figure 14 illustrates that the particular demands of social actors for educational reform appealed to the Government as the main strategic policy maker. As the socio-political resonance intensified, the Government became increasingly aware of the hegemonic articulation of those storylines. In response the Government's universal or hegemonic demand drew equivalences with those particular demands, legitimising them by masking over their differences, hence providing the direction for policy reform. It also shows the dichotomisation of the social space into two opposing camps, NHS managers and apprenticeship-trained nurses on the inside (vocation) and technical-scientific nurse education (profession) on the outside.

While a logic of equivalence attempted to conceal differences and create an antagonistic frontier, a political logic of difference attempted to differentiate and break those chains of equivalence that had bound the demands of different groups together to maintain their particularity. A differential logic of professionalism subverted the 'them and us' by highlighting what was shared between a practical-caring vocation and a technical-scientific profession (i.e. there is no difference in respect of care), whilst simultaneously emphasising the opportunities associated with professionalisation and HEI nurse education, such as nurses' increased adaptability to change and the implementation of evidence-based practice (Extract 34).

Extract 34	*Storyline: Education transforms care*
	Political Logic of Difference: Professionalism
	While misgivings may exist about fitness for practice at the point of registration, there is much agreement that the current programmes produce registrants who are better able to adapt and change and implement evidence-based practice than those trained under the old apprenticeship-style model. UKCC Fitness for Practice (1999:4)

In Extract 34, the UKCC recognised the '*misgivings*' of others, but it employed a beatific '*education transforms care'* storyline to emphasise the advantages of technical-scientific nurse education, setting it apart from the '*old apprenticeship-style model'* but without creating an antagonistic frontier. The UKCC drew from a logic of difference in its attempt to break up the universal demand by highlighting the 'differing expectations … of the employers and the professions' and 'the greater demands … for technical competence and scientific rationality' (UKCC, 1999:3). It is interesting that in this extract the UKCC also appealed to the government's demands for greater NHS efficiency and effectiveness by positioning technical-scientific nurses as the agents of change. As might be expected of nursing's

regulatory body, the UKCC highlighted the opportunities offered by undergraduate pre-registration programmes, such as making nursing a more attractive career option for young people, meeting Government targets for higher education and enhancing service delivery by producing nurses who were critical thinkers and decision makers. Nevertheless, the equivalential logic of vocationalism predominated.

2004 to 2013 – The contestation of a graduate nurse identity

Competing storylines: Care, compassion vis-à-vis the compatibility of care, compassion and intelligence

Despite the Government's reluctance to support the expansion of degree level pre-registration education the incoming Labour Prime Minister Tony Blair (elected in 1997) appeared to align himself with nurses by identifying the profession as a key player in driving through Labour's NHS modernisation reforms (DH, 2000a; DH, 2000c; DH, 2000d), i.e. as a key ally against the vested interests of the medical profession. Ministerial and political discourses boosted the professional status of nurses and conveyed the Government's apparent faith and commitment to nurses, describing the profession as 'the lifeblood' of the NHS. The storylines of '*nursing is a vocation'* and '*practice before theory'* appeared to subside by mid-2000, instead Government health policy reforms drew on a differential logic of *professionalism* to cover up the differences between apprenticeship and HEI models of nurse education to constitute nurses as knowledgeable, competent, assertive and politically astute professionals (DH, 2000d). Yet, in many ways the articulation of nurses as leaders and change agents went some way to position nurses away from the bedside.

In 2004, it was during the Royal College of Nursing Congress on 11th May that saw the tropes of practical-caring vocation versus technical-scientific profession re-emerge. Two weeks before Congress Charlotte Gill, a journalist from the *Daily*

Mail reported on a forthcoming Congress debate where nurses were being asked to vote on whether activities such as personal care should be delegated to healthcare assistants (Gill, 2004). This debate, and Gill's article, drew from a fantasmatic logic of the 'technical-scientific academic nurse' that heralded a refinement of the *'nursing is a vocation'* storyline into a beatific *'the heart of nursing is care and compassion'* storyline. The vocation storyline had not disappeared entirely; rather the storyline was modified to reflect the new contestations surrounding nursing leaders' on-going demand for nursing to move towards becoming a graduate entry profession. It also demonstrates the strength of the beatific fantasy where care and compassion are constituted as essential nursing characteristics that can only be acquired through vocational-training. The sedimented social construction of nursing as a feminised caring profession, coupled with the persistent dominance of medical patriarchy continued to constitute academic education and 'more technical tasks' through a masculine-gendered discourse that subsequently placed technical-scientific education outside the sphere of nursing. The new emphasis on specific female-gendered vocational values suggests that the generalised *'nursing is a vocation'* storyline had failed to create a sustained discourse coalition or generate enough socio-political resonance to form chains of equivalence between different actors' particular demands. Extract 35 illustrates how the storyline had subtly changed and moved away from nurses' lacking practical skills or being unprepared for the realities of practice. In this extract Gill's narrative presented the technical-scientific academic nurse as a potential threat to the sedimented role of the nurse, based on a historical vocational image of nursing centred on female-gendered caring tasks.

Extract 35	*Storyline: Care and compassion is the heart of nursing*
	Political Logic of Equivalence: Vocationalism
	Logic of Fantasy: The technical-scientific nurse
	The traditional caring role of the nurse could soon be a thing of the past. Nursing staff will vote next month on whether they should give up providing basic bedside comforts and concentrate instead on more technical tasks. They will decide whether jobs such as bringing a patient a cup of tea, holding their hand or giving them a bed bath should be done by healthcare assistants. Charlotte Gill, *Daily Mail* 26th April 2004

Extract 35 shows that equivalences were drawn between care, bedside comforts, providing tea, handholding and bed baths to construct a beatific, caring almost mothering nurse identity. The threat is not perceived to be HEIs, but the 'new breed' of technical-scientific *graduate* nurses they have produced, thus the contingency of the nurse identity was made visible and the threat that this graduate nurse put on patients' sense of enjoyment of the 'basic bedside comforts' of caring. Noticeably, the actors involved in previous debates were predominantly politicians, NHS managers and health professionals, but by 2004 the resistance against the professionalisation of nursing included patient groups and was redirected onto nurses and their relationship with patients (Meerabeau, 2004). Actors' storylines were now concentrated on nurses' personal motivations and ambitions that exposed the contingency of social relations. The force and degree of resistance against changes within nurse education was now extending into the regime of nursing practices, which could account for why the Patient Association, as an independent patient advocacy charity (established in 1963 after the thalidomide scandal) only joined the nurse education debate at this point (Extract 36).

Extract 36	*Storyline: The heart of nursing is care and compassion*
	Political Logic of Equivalence: Vocationalism
	Logic of Fantasy: The caring vocational nurse
	… holding someone's hand is caring and much more important than pretending to be a doctor. I don't object to nurses being academic but they are not learning what is the core of nursing and that is love and care. Claire Rayner, President of the Patient Association quoted in *Daily Mail* (Gill, 2004)

As illustrated in figure 14 previous contestations had divided the social space into two opposing institutions – the NHS (service) and the Government on one side and HEI nurse education on the other. Extract 36 shows that the tensions between the social meta-logics of nursing – practical-caring vocation and technical-scientific profession –were now being individualised (see Chapter 5). So, while the threat posed by HEIs remained this was overshadowed by the construction of a new, more tangible threat of graduate nurses not caring. Interestingly, the questioning of technical-scientific nurses' legitimacy and the accusations that graduate nurses were more interested in '*pretending to be doctors'* than caring for patients was still evident in this extract. Nevertheless, this was not dissimilar to professional and union discourses from the late 1990s, and seems to suggest continuing medical hegemony (see Extracts 29, 30, 32). But this time, Claire Rayner employed a gendered discourse, drawing on an equivalential logic of vocationalisation to constitute female-associated attributes of '*love and care'* as the priorities of the nurse and that any academic learning should be based upon those vocational values. As seen in previous extracts care (feminised vocation) and academic learning (masculinised professionalisation) are presented as opposing constructs.

Around the same time the NMC published findings from Kathleen Duffy's seminal work '*Failing Students'*. This research, funded through a UKCC research scholarship, highlighted incidences where under-performing students had been passed as safe to practice despite their supervising mentors having concerns about their students' level of competence (Duffy, 2003). The resultant media headlines '*Warning of sub-standard nurses'* (BBC, 2004) and *'Nursing chief criticises few 'too posh to wash'* Carvel, 2004; Hall, 2004) drew equivalence between Duffy's findings and debates at RCN Congress that reignited the practical-caring vocation versus technical-scientific profession debate. This was compounded when, despite the RCN President presenting graduate level nursing as the 'vision' for the future, congress delegates voted against it, employing a political logic of vocationalism to resurrect a historic argument that any advancement in academic status would preclude '*many able and capable people*' from becoming nurses. This could also be shown to speak to discourses of social mobility for women, whereby nursing was seen as one of a limited number of ways out for working-class women, and that academicisation worked to make nursing more middle-class. Interestingly, this illustrates that the same debates keep re-occurring time after time.

The failure of the RCN vote shows that the professionalisation of nursing continued to create a sense of confusion where the '*nursing is a vocation'* and *'the heart of nursing is care and compassion'* storylines also characterised a beatific logic of fantasy that continued to grip many within the profession. Here the old battle lines were being redrawn and the old debates resurfaced. Technical-scientific nursing was presented as a continuing threat to some with a fear that nurse academics would focus pre-registration nursing programmes on academic disciplines and social sciences in detriment to teaching the practice or art of nursing. Indeed, Burke (2003) argued that

universities were keen to adopt nursing because it represented a guaranteed source of additional income. So here we see HEIs construed as an external force outside of nursing, mobilised to make the professionalisation project viable for their own financial gain. Nevertheless, the '*nursing is a vocation'* storyline was replicated in HEIs where 'traditional' academics remained reluctant to recognise nursing as an equal academic discipline (Burke, 2003).

John Reid, Secretary of Government for Health from 2003-2005, in a speech to RCN Congress initially drew from a political logic of professionalism to dismiss the horrific fantasmatic narrative that nurses were becoming 'too posh to wash' (Extract 37). But, this extract also evidenced a compatibilist logic that says nurses could have HEI undergraduate education but on condition that nurses continued to do the caring work as well.

Extract 37	*Storyline: Education transforms care*
	Political Logic of Difference: Professionalism
	Some people tell me if we try and educate nurses more it will somehow reduce their willingness to care, to nurse. But, actually there's more we can do to make sure nurses can be all you can be. But let's not forget you're never too clever to care John Reid Labour MP – RCN Congress 11th May 2004

His speech drew from a political logic of professionalism, as a logic of difference used to present a '*education transforms care'* storyline as he announced the Government's intention to 'encourage more nurses to develop special skills in prescribing drugs – something that is great for their careers, the NHS as a whole by freeing up time for doctors, and, of course, for patients'. However, this does not necessarily represent an acknowledgement of nursing as an educated transformational profession, rather it reflects a recurrent gender-based narrative that continued to constitute nurses as tools to ease doctors' workloads (which one could associate with

the odd adage of nurses as doctors' assistants or 'handmaidens'), where the benefits to patients were barely acknowledged. Alternatively, it could also be interpreted as a deliberate Government strategy to support the on-going proletarianisation of doctors (i.e. not about nurses at all), where nurses were being used as a legitimation device for a policy aimed at reducing the professional dominance of medicine, while exploiting a cheaper and less political alternative workforce (in terms of labour costs) (Nancarrow and Borthwell, 2005).

Extract 37 is framed through a discourse of sovereignty, where the underlying narrative asserts Government power over nursing by reminding nurses that 'you're never too clever to care' - this implies an implicit anti-intellectualism position. This statement appeared to reaffirm nurses' historic subordinate and gendered position with the Government adopting a parental role in order to remind nurses that their first duty was to 'care', rather than to 'know', while assigning medical tasks over to nurses without negotiation or consideration of the subsequent impact on nursing practices. Rather than supporting the on-going professionalisation of nursing the government was using nurses to minimise the impact of the European Working Time Directive, which had capped junior doctors' hours to 58 hours a week. Despite apparent government support the emerging storylines put pressure on the NMC to address concerns that nurse education was focused too heavily on academic attainment rather than practical ability, which it did during a fitness for practice review in early 2005 (NMC, 2005). Coinciding with this, in April 2005 the Department of Health's Standing Nursing and Midwifery Advisory Committee published a report recommending a radical review of nurse education to 'ensure that nurse and midwife education is fit for the future' (DH, 2005b:7). However, this position paper could be construed as an attempt by the government to strengthen its

alliance with nursing by promising to 'enable them to begin preparing to be the leaders and health improvers' (DH, 2005b: 2).

The NMC review seemed to accept that HEIs appeared to give insufficient attention to teaching practical skills and affective, professional behaviours, but given the socio-political resonance of the vocationalist discourse coalition it would have been difficult for the regulator and nurse academics to be seen to be doing nothing. Nursing had to be seen to be listening in order to reassure patients and maintain its alliance with the Government, while HEIs needed to be seen to be responsive to political demands as they remained, at that time, financially dependent on Government commissions of pre-registration programmes. Later in 2005 the NMC began a consultation on proposals that arose from their review that included the question 'The NMC should explore ways in which lay people (including service users and carers) could be involved in the assessment of practice'. Interestingly, 38% (504) of respondents either disagreed or were unsure about the benefits; with the majority citing that lay people were potentially biased and not suitably trained or experienced (Ball, 2006). The NMC's interim solution was the introduction of Essential Skills Clusters (ESCs), a set of additional practice-based assessed competencies based on concerns raised by a number of care investigations – care and compassion; communication; organisational aspects of care; infection prevention and control; nutrition and fluid management; medicines management, which the NMC assured would ensure 'new qualifiers are capable of safe and effective practice' (NMC, 2007b: 1).

These actions by the NMC characterised a political logic of professionalism as a logic of difference, as it attempted to cover over the demand for a practice-centred nursing curriculum. This perhaps illustrates the strengthening grip of the

fantasy that nurses had become 'too posh to wash', which made it increasingly difficult for nursing to argue that HEI nursing students were *not* becoming 'too posh to wash' or 'too clever to care', as to oppose it would effectively disavow the need for HEI-based, technical-scientific nurse education. Interestingly, the introduction of ESCs followed the publication of the Department of Health's *Modernising the Nursing Careers* (DH, 2006a) in which the four Chief Nursing Officers from across the UK sought to maintain the Government's alliance by reminding nurses of the Government's 'major investment' since coming to power in 1997 (i.e. increased student commissions, the introduction of nurse prescribing, modern matrons, community matrons and nurse consultants). On the one hand this could be viewed as the Labour Government recognising the contributions of nurses to the NHS. The policy was framed against the Government's wider 'modernisation' agenda, thus nurses were reconstituted as 'modern', 'flexible' and happy to move across into different organisations and sectors (DH, 2006a:16). But on the other, it provides another example of a buyer's revolt, where nurses continued to be used as a political tool to support the Government's continuing blurring of boundaries between profession groups that reduced the risk of professional revolt against quite substantive NHS reforms.

In September 2008 the NMC announced that all pre-registration nursing programmes in England would only be offered at undergraduate level from September 2013 (Scotland, Wales and Northern Ireland had moved to graduate level entry some years earlier), yet there appeared to have been little political debate at that point. In March 2009 media coverage followed the publication of the Healthcare Commission's investigation (Healthcare Commission, 2009) into higher than expected mortality rates at Mid Staffordshire NHS Foundation Trust (BBC, 2009a;

Anon, 2009; Laurance, 2009; Smith, 2009). Subsequently, nine days later the Commission published another damning report into ten hospitals that had worse mortality figures than Mid Staffordshire (Healthcare Commission, 2009b). Interestingly it seems that only Mid Staffordshire has persisted within health discourses that suggests different parties continue to score political capital from it. By August 2009, the Patient Association had published *'Patients not numbers, people not statistics'* that catalogued 16 representative patient stories where they described the 'the dreadful, neglectful, demeaning, painful and sometimes downright cruel treatment their elderly had experienced at the hands of NHS nurses', (Patient Association, 2009:1), thus focussing on the derelictions of caring practices, not on the dereliction in terms of medical treatment. Up until then media reports had highlighted an institutional target culture and poor hospital management, but it was the Patient Association and Cure the NHS, a campaign group set up by Julie Bailey after her mother died at Mid Staffordshire, who determined that these explanations could not account for such 'horrific' and 'appalling' patient experiences. A discourse coalition was beginning to develop between patient groups, politicians, UNISON and nurses. While the antagonistic other still appeared to be HEI-based nurse education we can see from the following extracts how this was displaced by a new threat – practice-based nurse education.

Actors' storylines were now suggesting that nurse education was failing to teach students the practice of care and compassion. The King's Fund, an independent charity think tank on UK health policy, held a workshop with health service staff and academics to explore how compassionate care was enabled and hindered in hospital (Firth-Cozens and Cornwell, 2009). A political logic of vocationalism is evidenced from workshop participants' assertions that nurses' lack of compassion may indeed

be associated with the 'values instilled in clinical training', hence care (practical vocation) is constituted as incompatible within clinical training (technical-scientific education). However, this claim appears to be contradicted later in the report when it is concluded that newly-qualified nurses held strong patient-centred ideals, but that these ideas were quickly eroded by the institutional systematisation of nursing practices. What the King's Fund report evidenced is a new nuance in the dichotomy between vocation and profession, where the demand for nurses to have greater practical skills is replaced by a demand for greater compassion. Here, we see the emergence of patient involvement in assessing nursing students' compassion as a possible solution (Extract 38).

Extract 38	*Storyline: Patient assessment will instil compassion*
	Political Logic of Equivalence: Consumerism
	Assessment is an important part of training, and we perhaps need new ways to assess compassion. Perhaps the only way compassion can be assessed is by asking the patient if they feel it was given. The regular use of such an assessment with constructive feedback throughout training and even beyond would be a powerful way of keeping compassion on the agenda for both staff and patients alike. The King's Fund (Firth-Cozens and Cornwell, 2009:11)

The King's Fund drew from a political logic of consumerism, to assert that current HEI practice assessment strategies were failing to determine students' levels of compassion. But what is interesting is the assumed ripple effect that patient involvement could have beyond the individual student. By requiring nurse mentors to actively involve patients in the assessment process this extract implies that this could have a wider influence and promote compassion in practice to other hospital staff, to the immediate and long-term benefit of patients.

As I have illustrated, political practices continued to revolve around the vocation or profession debate. I have already suggested the Labour Government formed an alliance with nurses in order to gain the support of the biggest group of health professionals to push forward NHS reforms. But, the political rhetoric of nurses as transformational change agents was not apparent in the Conservative opposition leader's speech at the RCN Congress (Cameron, 2009). Instead David Cameron repackages technical-scientific nursing in a way that makes it appear less academic, but continues to conflate education with caring (Extract 39). While this extract appears to be drawn from a political logic of vocationalism, Cameron offers a compatibilistic half way alternative of smaller and more practical modules (that does not really stand up to scrutiny).

Extract 39	*Storyline: Practice before theory*
	Political Logic of Equivalence: Vocationalism
	In just a couple of years' time, everyone who wants to become a nurse will have to do a degree. If that helps to raise professional esteem, that's a very good thing. But there is the danger that all-degree training might put some people off. The teenager who's got a handful of reasonable GCSEs and just wants to care for people. The busy mum who hears the word degree, pictures the typical undergraduate and thinks − that's not me. We need to make very sure that the doors to nursing are open to all. That's why we're looking at turning the degree from one big course into smaller modules, so it's a steady ramp into nursing and not an intimidating step up... As well as making training more accessible we've got to make it more practical. David Cameron, Conservative Party Leader, 11th May 2009 – RCN Congress Speech

Here, David Cameron constitutes nursing through a gendered discourse as an occupation for nurturing women – the busy mum. The subsequent articulation that nurses (as women) *'just care for'* patients demonstrates how the discourse of nursing appears closed to any sense of disciplinary framework, so that nursing continued to

be pushed back to being constituted as a non-technical form of practical caring (with a strong feminine emphasis). A political logic of vocationalism is characterised by Cameron's assertion that a nursing degree needed to be simplified and practical in order for these non-typical female students to successfully complete the degree. Yet, despite the rhetoric that potential students were being put off by higher education, the actual number of students applying to study nursing across the HE sector suggested the opposite with over 35,000 applicants in England in 2009 (all branches of nursing) compared to just over 10,000 in 2007 and 5000 in 2000 (Buchan, 2011).

The Government's announcement confirming graduate-level entry to the NMC register (DH, 2009) deployed a beatific storyline of '*care, compassion, and intelligence are compatible and necessary'* to push against the vocation / profession frontier by highlighting the potential advantages associated with graduateness, such as enhanced decision-making skills needed to make high-level judgements about patient care (Extract 40). The contrast between the Labour government's position in support of the academicisation of nursing and David Cameron's rebuttal of it may be indicative of the Conservative party leader engagement in oppositional politics in order to be seen to be against Labour government health policy and NHS reforms.

Extract 40	*Storyline: Care, compassion and intelligence are compatible and necessary*
	Political Logic of Difference: Professionalism
	By bringing in degree-level registration we can ensure new nurses have the best possible start to meet the challenges of tomorrow. Degree-level education will provide new nurses with the decision-making skills they need to make high-level judgements in the transformed NHS. This is the right direction of travel if we wish to provide higher quality care for all Ann Keen, Labour Health Minister (DH, 2009) – *Nursing set to become all graduate entry by 2013.* Press release 12th November 2009

Indeed, extract 40 reflects the Labour government's health policy rhetoric and also illustrates their willingness to endorse nurse leaders' demands for a clear career structure, including graduate status and parity with other graduate health professions, for example, Physiotherapy and Radiography. An emerging alliance between the Government and nurse leaders was evident in the inclusion of endorsements from Dame Christine Beasley, Chief Nursing Officer for England; Dickon Weir-Hughes, NMC Chief Executive and Dr Peter Carter, RCN Chief Executive and General Secretary.

UNISON was less supportive of graduate nursing, possibly because this move appeared to shut off existing flexible routes into nursing for HCAs that they represented. But instead of the '*Practice before theory'* storyline cited ten years previously, Gail Adams, the union's head of nursing, drew equivalences between the nurse, society, care and compassion (Extract 41). In this extract Adams disassociated academic knowledge (profession) from care and compassion (vocation) and although she attempts to create a division between academia and practice is apparent, the drawing of an antagonistic frontier is less obvious. As seen in Extracts 37 and 39, Adams presents a compatibilistic logic by suggesting that nursing 'shouldn't be *solely based* on their level of academia' (my emphasis), thus she appears to contradict her resistance against graduate nursing by suggesting nursing should be a mix of both academic theory and vocational practice that, similar to Cameron's narrative, does not really stand up to any degree of scrutiny.

Extract 41	*Storyline: The heart of nursing should be care and compassion*
	Political logic of equivalence: Vocationalism
	Logic of fantasy: nursing as a practical-caring vocation
	Our concerns throughout have been to make sure that the profession, whether you're a nurse or a midwife, that we're actually reflecting the society that we care for and I think one of the concerns that colleagues have had is about making sure the right emphasis is placed on the care and compassion that nurses give and that shouldn't be solely based on their level of academia. Gail Adams, Head of Nursing UNISON – 12th November (BBC, 2009b)

In the following extract (Extract 42) the Patient Association's resistance against the professionalisation and academicisation of nursing continued to reflect the '*heart of nursing should be care and compassion'* storyline they had adopted in 2004 (see Extract 36). What is interesting in this particular extract is how the 'fact' that academia is antithetical to caring is constructed and maintained by actors, such as Adams, deploying a fantasmatic logic of nursing as a practical-caring profession to present vocation-focused nursing as a beatific fantasy and technical-scientific nursing as the horrific alternative. Thus the idea that academic nurses will not care comes from a patriarchal notion of science as a rational and masculinist discipline, while nursing and care continues to be constituted as emotional and feminine pursuits. The contrast between discipline and pursuit is interesting as it suggests one is learned and the other is vocational.

Extracts 41 and 42 perhaps best illustrate the development of a discourse coalition as both groups of actors presented the same storyline differently. UNISON adopted an advocate position to protect apprenticeship-trained and diploma nurses from any potential impact from the introduction of degree programmes; whereas the Patient Association employed a discourse of advocacy to protect patients from nurses

with the wrong attitudes towards patients' basic care needs and from HEI nurse academics and educators who had 'got it wrong'.

Extract 42	*Storyline: The heart of nursing should be care and compassion* *Storyline: Practice before theory*
	Political Logic of Equivalence: Vocationalism
	Logic of fantasy: Too posh to wash and too clever to care
	The basics of nursing care are dignity, compassion and, above all safety. Since the introduction of Project 2000, which shifted training from the bedside to the classroom, nurses look at the personal prizes of specialisms and have been allowed to ignore the needs of their sick, vulnerable and often elderly patients. These new proposals risk making the situation worse. It need not be like this – for patients and trainee nurses alike. With a combined diploma and degree system, there is still enough room to move up the hierarchy and make career progress. Making it degree-only sends out the wrong message, especially when the Government knows there are problems following Project 2000. The academic must be secondary to the practical. Only then will patients get the nurses they want and trust – the right ones with the right attitude. It must never become more important to write about care than to give it. If our nurses do not have the basics of training, the costs of care will soar because of infection rates and overblown bureaucracy. Patient Association 12th November 2009 quoted in *The Guardian* (Bowcott, 2009)

In Extract 42 the Patient Association redrew the antagonistic frontier between technical-scientific education and practical-caring vocational training. Thus far the Patient Association had opposed technical-scientific (HEI-based) nurse education, which was predominantly diploma level, yet this extract appears rather contradictory. On the one hand the diploma level model of nurse education continued to be constituted as a threat to compassionate care, yet on the other the Patient Association seemed to be attempting to maintain the status quo by calling for the continuation of a '*combined diploma and degree system*'. The grip of the 'too posh to wash too clever to care' fantasy is evident in their assertion that degree-level nursing could produce non-compassionate, uncaring nurses. But the issue could also be about

protecting class interests (nursing as a solid profession for working class women) and the caring vocation discourse works effectively to counter the technical-scientific discourse. Here the storyline had subtly changed where previous concerns that all HEI-based nurse education had been overly academic was now focused on the new undergraduate degree programmes. This illustrates how understanding of HEI-based nurse education was based on a historically construction of traditional taught university degrees, hence the expressed unease that HEIs would only produce nurses who can '*write about care'*. This draws on a fantasy image of the university as a place of scholarly learning, a recurrent trope across the problematisations of nursing. As a consequence university learning is constructed as lacking any kind of vocational relevance therefore HEI education and nursing continue to be constituted as incompatible. This sedimented assumption was used to suggest that graduate nurses would put patients at greater risk of hospital acquired infections, yet failed to acknowledge that nurse education had been within higher education for 20 years by this point, and had a very practical focus.

On 24th February 2010 the independent inquiry into the failings at Mid Staffordshire NHS Trust were published (Francis, 2010) and although this report did not directly criticise technical-scientific nurse education, the publication of witness accounts of patient neglect added force to the horrific fantasy of 'too posh to wash, too clever to care'. The media subsequently drew on this fantasmatic logic to highlight nurses' failure to provide adequate patient care and their lack of compassion (for example Triggle, 2010; Boseley, 2010; Schlesinger *et al.*, 2010). In contrast, the Prime Minister's Commission on the future of nursing and midwifery in England '*Frontline Care'* report, published a month later, continued to demonstrate the government's determination to strengthen the alliance between government and

nursing by constituting nurses as central 'in the design and delivery of 21st century services' (DH, 2010b:2). This alliance is also evidenced by the Government's continuing support of degree nursing as 'the right way forward to secure high quality care, strong leadership, and parity with the rest of the UK, other professions and other countries' (DH 2010b:4). Nevertheless, the political power of a discourse coalition, drawn from the re-emergence of the '*nursing is a vocation'* storyline and the horrific fantasy of '*too posh to wash'*, began to weaken this alliance as the competence and skill of nurses to lead and transform patient care was contested.

In May 2010 a Conservative-Liberal Democrat Coalition government came to power which saw a significant shift away from a modernisation rhetoric that positioned nurses as allies central to NHS reform, to one of service improvement and patient safety that reconstituted technical-scientific nursing and HEI-based nurse education as the antagonistic other. The Coalition and successive Conservative governments appear to have used the political resonance generated by NHS scandals not to fix the resource issues in the NHS, but to personalise the debate down to the character of individual nurses. This could be interpreted as an attempt to form closer reciprocal alliances with patient groups and the public, whilst demonstrating the government's sovereign power over nursing and another example of a 'buyer's revolt'. The Mid Staffordshire public inquiry portrayed the NMC, RCN and HEI nursing faculties as self-serving institutions that have failed in their duty to protect the public (Francis, 2013), thereby presenting nursing in a same vein as medicine post-Shipman (Tingle and Mchale, 2012; Hutchison, 2016). As a consequence for taking action against a nursing profession that had appeared to lose sight of its core values the government had the opportunity to gain significant public support.

The resistance against undergraduate nurse education could be indicative of the continuing fantasmatic grip of the storylines that constructed nursing through a nostalgic fantasy of vocation, altruism and self-sacrifice. Milligan (2003:382) states that identity is often closely attached to a specific place that offers actors a sense of spatial continuity. In relation to nursing and nurse education the public tends to still associate nurses with the acute hospital environment (ten Hoeve, *et al.,* 2014), however the shift of nurse education into HEIs disrupted that continuity, that in a way resulted in a loss of attachment and a contested the idea of a site-specific nurse identity. Nostalgic narratives often emerge following contestation of a sedimented identity as nostalgia enables actors to compare the beatific memories of a 'good past' – a practical-caring, vocationally-trained nurse − against a horrific future – an uncaring, academically-educated, technical-scientific nurse, something that has been exploited by the Coalition and Conservative governments. It is the cumulative effect of each of these separate events, reports, campaigns and nostalgic storylines, culminating with the scandal of Mid Staffordshire Hospital and the announcement of graduate pre-registration nursing programmes that created a powerful socio-political resonance to an horrific fantasmatic narrative. To illustrate my point, consider the noise generated by beating on a drum. If you beat a drum with one stick the resulting noise is relatively low, however if each event is represented by the addition of another drumstick the combined noise or socio-political resonance becomes louder and harder to ignore (Figure 15).

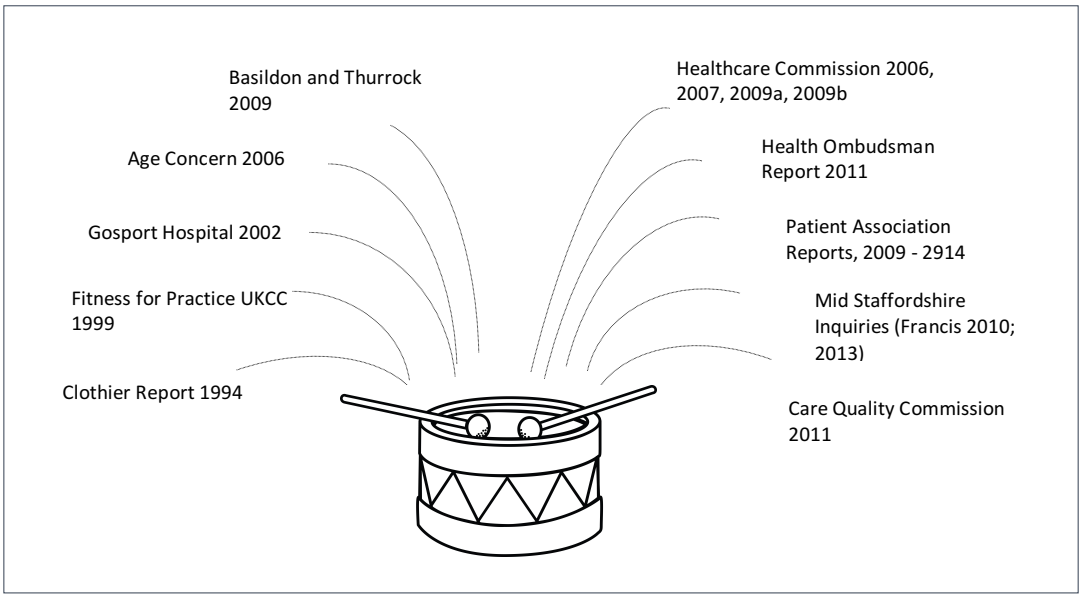


Figure 15: The building of socio-political resonance

Storyline: The need to restore public trust

This storyline reflects how trust was mobilised as an issue, where the idea of untrustworthy professionals was used to deflect blame away from untrustworthy politicians and gain political capital. Due to the social constructions of the nurse and patient identity, and the change in power dynamics where patients are often reliant on nurses to provide very personal care, trust between patients and nurses has become an established ethical value within nursing practice. The operationalisation of trust has been described as 'a state involving confident positive expectations about another's motives with respect to oneself in situations entailing risk' (Boon and Holmes, 1991:194), therefore trust becomes a conditional construct dependent on patients' experiences of hospital care, nurses' commitment to care and nursing's professional reputation, which forms the foundation of any nurse patient relationship (Sellman, 2006; Rutherford, 2014).

Lewicki and Bunker (1996:120-123) proposed a three-stage transitional model that forms the basis for the evolution of trust within professional relationships. The first stage – calculus-based trust – involves actors calculating the value of being seen as trustworthy over the risks to one's personal and professional reputation if that trust is violated; the second stage – knowledge-based trust – develops over a sustained period of time and is based on actors' abilities to predict others' practices and behaviours. This level of trust is more robust as minor violations of trust are likely to be forgiven if a viable explanation is provided; and finally, the last stage – identification-based trust – results in each individual or group of actors understanding and appreciating each other's needs and therefore able to act on each other's behalf. In terms of the nurse-patient relationship it is based on two levels; firstly, nursing is an occupation whose role is socially constructed and the dominance of this construction plays out in the way we are socialised to understand occupational roles during childhood. Therefore as patients we believe that we know and understand the roles and responsibilities of the nurse and therefore we have an expectation of what constitutes good quality nursing care. Part of this social construction that there is a strong sedimented belief that nurses' always act in the patients best interests and will act on their behalf, as an advocate, when patients are at their most vulnerable or incapacitated. As a consequence of the increased socio-political resonance, the narratives surrounding events at Mid Staffordshire were constructed to represent a breach of trust between patients and nurses, and patients and nurse educators. The explanations of understaffing and under-resourcing were not seen as acceptable excuses for the behaviours of individual nurses and reports of poor care were no longer considered one-off events as reports suggested the problem was systemic

across health and social care (Healthcare Ombudsman, 2011; Sawbridge and Hewison, 2011).

In many ways, the publication of the 2010 NMC Standards for Pre-registration Nursing Education came too late for nursing, as it could be argued that the NMC, in order to maintain their own credibility, had few options but to be seen to intervene to reprimand and remind nurses of what should have been core nursing values. Nursing and nurse academics therefore had little choice but to go along with the reintroduction of patient involvement within practice-based summative student assessments (Extracts 43). To do otherwise would only confirm the horrific fantasy.

Extract 43	*Storyline: The need to restore public trust*
	Political Logic of Equivalence: Consumerism
	The NMC standards on patient and public involvement in pre-registration education must be fully implemented, as a vital step in putting the experience of patients and the public at the heart of nurse education. Willis Commission (2012:40)

Extract 44	*Storyline: The need to restore public trust*
	Political Logic of Equivalence: Consumerism
	Service users and carers must also be engaged as active partners in care rather than passive recipients. This 'co-production' should underpin both education and practice. We will promote existing good practice in patient and service user engagement in curriculum design, student recruitment and student assessment among our membership, giving members opportunities to learn from one another and from best practice in this area. Council of Deans (2013:6)

Extract 44 suggests that despite significant consumerist government health policies and professional regulatory standards, the institution of a patient-led NHS and shared decision-making in care had so far failed as a hegemonic project, although 2013 saw the new Health and Social Care Act come into force, based on a white

paper (DH, 2010a), which called for patients to be at the centre of everything done by the NHS (Health and Social Care Act, 2012). Furthermore, this extract infers that nurses in practice had managed to maintain professional control over care and consequently their dominant position within nurse-patient relationship that sustained service users' and carers' passive-dependent subject positioning in practice-based nurse education. The Council of Deans drew from a political logic of consumerism, as a logic of equivalence, to suggest that many HEIs were already demonstrating '*good practice'* and engaging service users and carers in certain aspects of healthcare education. Extract 44 indicates an attempt to draw a frontier between education and practice partners, with the Council of Deans constituting practice as a potential obstacle to patient involvement by its failure to involve service users and carers as '*active partners in care'*. This constitution speaks to the discourse coalition that emerged between patient groups, politicians, UNISON and some nurses highlighted earlier in this chapter (p 220), and could suggest academics attempts to deflect blame back onto practice.

Interestingly, the Council of Deans considered HEIs as the architects of *'best practice',* but it is also interesting that the Council chose to use the term 'engagement' rather than involvement. While these terms are often used interchangeably they do have slightly different meanings. According to Parsons, *et al.,* (2010) patient engagement is more closely associated with the concept of partnership and co-production, leading to the establishment of equal, balanced relationships between patients and professionals at an operational level. In comparison, Parson's *et al.,* equate patient involvement with more formalised processes and active participation through patient groups and forums at an

institutional level. This suggests a failure on behalf of nurse academics to acknowledge these differences and the effects of situational context.

Nevertheless, one of the difficulties for nursing is that political demands often result in criticism of nurses' individual morals, professional values and behaviours. Technical-scientific nurses have subsequently been portrayed through a fantasmatic logic that constitutes nursing students as selfishness, neglectful, overly ambitious, too clever to care and too posh to wash. This has been compounded by nursing's continuing low institutional status, the lack of a strong body of nursing research, and the limited professional credibility of care due to the persistent belief that care is an innate feminised behaviour rather than an academic or technical skill. Despite nurses' attempts to attain professional recognition within the NHS, political power continued to centre on reciprocal political alliances (or equivalences) between the government, management, medicine and the public. Such alliances were based on a 'mutual exchange of political benefits' (Salter, 2001:872), through which the government had been able to instigate changes in nurse education, effectively reinforcing the government's authority and legitimacy over nursing and nurse education. Successive governments appear to have been mindful that the professionalisation and academicisation of nursing risks significantly increasing the profession's standing with the public and could, consequentially, increase nurses' political power especially if nurses' alliance with the public were simultaneously strengthened. As the largest profession within the NHS a stronger nursing profession presented an increasing threat to the instigation of health policy. Therefore, the government had a vested interest in trying to break down the nurse-patient alliance by strengthening its own alliance with the public through consumer-centred health policy.

So far, this chapter has shown that various groups of social actors have resisted and contested HEI education through the drawing of an antagonistic frontier between vocation and profession. I have illustrated how different political and policy actors formed a number of discourse coalitions by drawing together a number of particular storylines that characterised a political logic of vocationalism, as a political logic of equivalence. This logic revealed how a united demand for educational reform initially centred upon a fantasmatic logic of the caring, practical nurse that promised a 'fullness to come' if the threat of HEI-based technical-scientific nursing was overcome. I also demonstrated how actors' used this fantasy to construct an alternative horrific narrative that was used to create a boundary between the social meta-logics of nursing, enabling actors to constitute technical-scientific nurses as 'the enemy'. The horrific fantasmatic narratives of HEI-educated, technical-scientific nurses becoming 'too posh to wash' predominated from 2004 and there was evidence of an internal struggle from within nursing itself as the introduction of graduate-entry level nursing threatened the position and status of non-graduate nurses. I have shown that during this later epoch, a compatibilistic 'have your cake and eat it' logic emerged. Nevertheless, the fantasmatic logic of the technical-scientific nurse was still articulated as an horrific narrative to present the newly-qualified *graduate* nurse as the threat.

The second political logic of consumerism, another a logic of equivalence, was less dominate despite being a significant narrative within successive governments' health policies. This equivalential logic became visible after events at Mid-Staffordshire hospital that mobilised policy actors, such as the King's Fund, NMC, Willis Commission and the Council of Deans to construct patient involvement in practice assessment as a possible solution. Throughout my analysis I have shown

how a number of professional actors drew from a political logic of professionalism, as a logic of difference in their attempts to push back against the criticisms against of HEI-based nurse education and cover over the demands for reform. Nevertheless, the grip of the fantasmatic logics supported the dominance of equivalential political logics and the creation of a new hegemonic normative frame.

In the final part of the chapter I move on to consider how various actors have used these contestations in an attempt to construct a new hegemonic normative frame that constitutes technical-scientific nurse education as the 'true' problem and patient involvement as a 'true' solution. I set this normative frame within a four-quadrant problem/solution intellectual framework that maps out the different conflagrations of the discourse coalitions set out in this chapter. I use this framework to illustrate how the different framings of problems and solutions were enacted in practice and examine three alternative articulations or floating signifiers that could characterise the nurse education and patient involvement differently. In chapter 7, the final findings chapter, I will test the intellectual framework to analyse the degrees by which research participants were either gripped by or resisted the 'true' problem / 'true' solution normative frame.

The struggle for signification

This final section will outline how these actors struggled to turn the true problem/true solution floating signifier into an empty signifier or nodal point. Figure 16 represents a map of how different nodal points, presented as quadrants, came into action, and how different lines of equivalence were drawn/redrawn, embedded or backgrounded. The four quadrants therefore represent alternative discursive explanations for the dominance of particular explanations. Thus the true/true floating signifier (Quadrant A) is presented with three alternate competing floating signifiers (Quadrant B: the

problem is true and the solution is false; Quadrant C: the problem is false but the solution is true; Quadrant D: the problem is false and the solution is false) that all have the potential to become nodal points (empty signifiers) that attempt to ascribe meaning to the various problematisations of nurse education and the emergence of patient involvement. As floating signifiers however, the four quadrants are devoid of meaning and only attain meaning from the discursive context they are situated in. Therefore the meaning attributed to each is constantly shifting depending on the context and how the demands associated with them are perceived (MacKillop, 2016). In relation to this study, it then becomes possible to analyse the way participants articulate the four quadrants depending on their discursively situation/location, subject positions and their acceptance of or resistance against, sedimented constructions of the nurse and patient. So far in this chapter I have shown that a number of different actors have attempted to construct and articulate quadrant A as a tendentially empty signifier or hegemonic normative frame, in order to justify their demands for change. I will now explore opponents' attempts to resist and contest the hegemony of quadrant A by the construction of three alternative and competing floating signifiers (quadrants B, C and D).

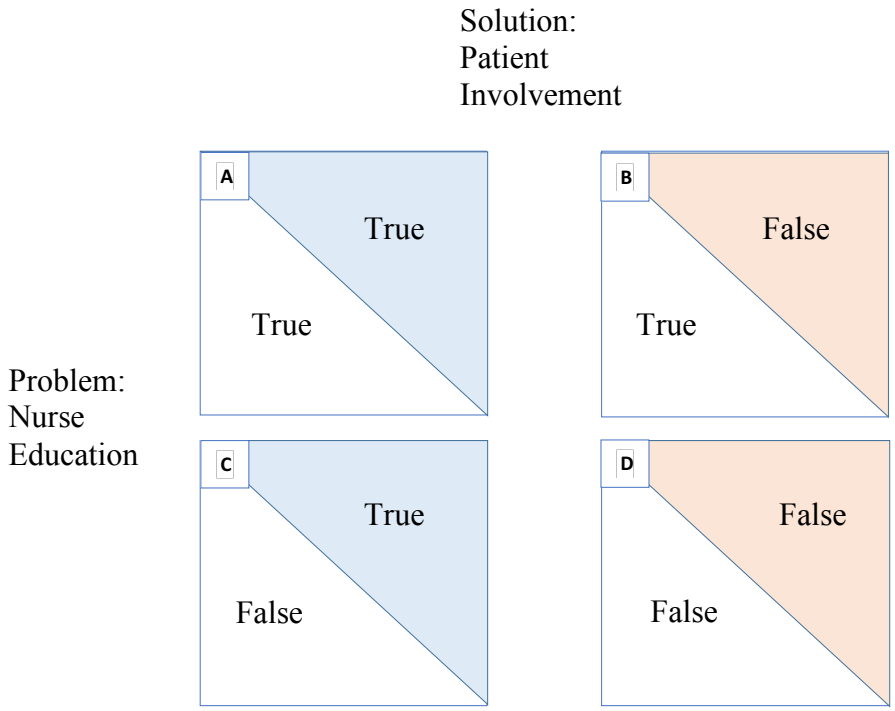


Figure 16: Problem/solution intellectual framework

Patient Involvement as a hegemonic normative frame

Quadrant A: True/True

The installation of patient involvement in practice assessment was centred on the social logics of experientialisation and the political logics of equivalences – vocationalism and consumerism. Yet what is interesting is how, politically, different actors have attempted to mobilise the true problem / true solution (quadrant A) as an empty signifier. In nursing there remains an underlying, historically constructed narrative that perpetuates the myth that nurses are 'born not made' (Aiken, 2012). Multiple political, patient group and media grievances about poor standards of patient care were articulated through chains of equivalence to form a universal claim that technical-scientific nurse education has created overly academic nurses who are 'too posh to wash' and 'too clever to care'.

According to Lincoln (2014) the persuasiveness of a disruptive discourse depends on the rhetoric that surrounds it, performance, timing and its position in relation to other competing discourses. In this instance an equivalential logic of vocationalism is set in direct competition with a differential logic of professionalism. Consequently, critics of nursing employed a political logic of vocationalism to evoke historical sentiments of nursing to draw attention to a perceived lack in nursing and nurse education. By focusing social actors attention on the past myths can give actors a sense of affinity with a historically constructed identity, be that of nurses or patients, and as a result when the contingency of a sedimented identity is revealed actors may develop a sense of otherness, confusion and disassociation. The effect means that rather than associating with a connected social system actors become separated into different competing groups. This separation can be seen within nursing where divisions have become visible between pro-HEI and anti-HEI nurses; the political and public debates surrounding nursing and technical-scientific nurse education may have also exposed an accepted patient-consumer identity as contingent. Therefore, the emergence of a contested nurse identity threatens the public's understanding and trust in the nurse-patient relationship, thus threatening patients' sense of 'enjoyment' that nurses will care *for* them when in hospital. For example, Gillett (2014) explored British newspaper's nostalgic constructions of nurse education and suggests that journalists drew from a gendered discourse of vocation to demand a return to a mythical 'golden era' of practical, vocational, hospital-based nurse training, something that was reflected in the empirical data that I discuss in more detail in chapter 7. As I have already illustrated within this chapter various groups of political actors have adopted this myth in their attempts to make claims about nursing's professional status, problematise nurse education and legitimise

demands for change. Myths are often used as actors try to suture a fragmented identity in order to legitimise social practices and stabilise the social space. By rearticulating dislocated elements into a new objectivity this 'golden era' myth offers a narrative 'for which successful claims are made not only to the status of truth, but what is more, to the status of *paradigmatic* truth' (Lincoln, 2014:23, original italics). In other words, the formation of myth goes beyond rhetoric or headline slogans to present an authoritative 'model of' and a 'model for' reality from which actors then discursively construct society (Lincoln, 2014). This subsequently works to exclude any alternative or competing truths, for example the authority of various actors' vocational myth-based narratives excludes the nursing profession's own professionalism narrative.

So how has the problem (nurse education) and solution (patient involvement) emerged as a truism? According to Foucault (2000:131) all societies have their own 'regimes of truth' that set out 'the types of discourse it accepts and makes function as true'. Although discourses in themselves are neither true nor false, the truth or falsity of discursive statements is influenced by the status and power of the speaker (Goswami, 2014:9). For example, discourses of accountability, governance, risk and patient safety gained power from Sir Robert Francis' position as Chair of the two Mid Staffordshire inquiries and from his professional status as a barrister and Queen's Counsel (QC). This power cannot be attributed to Sir Francis himself directly, but from the way society is structured that attributes barristers and QCs in a position of power, through which they are delegated democratic accountability. Thus, his appointment by the Labour and Coalition governments, delegated the government's political authority to investigate, sanction and hold to democratic account those he deemed responsible for failures in patient care. Likewise, Claire

Rayner, in her position as broadcaster, journalist, retired nurse and President of the Patient Association, gave political and media narratives an increased sense of believability by reminding the public of the harm poor care had on individual patients and their families. As these truth claims gained acceptance it became possible for other configurations to be discounted due to the grip of a myth narrative. Consequently, those that did put forward alternative scenarios were positioned as defending the indefensible (Delingpole, 2009; Santry, 2010; Darbyshire and McKenna, 2013).

The NMC, in a possible response to a seemingly increasing grip of the horrific 'too posh to wash' fantasmatic logic extended patient involvement to the assessment of nursing students' practice. Originally patient involvement was constituted through discourses of partnership and consumerism, and within a policy context this was presented as an ideal opportunity to embed a co-production culture before students became socialised into sedimented profession-centric practices during practice placements (Greacen, 2010; Scheelbeli *et al.,* 2010; Butler and Greenhalgh, 2011). The concept of co-production was first introduced in the 1970s to illustrate the extent to which service providers failed to recognise service user agency in decisions about care delivery. Co-production aims to break down historical hierarchies of power that position patients as passive recipients of care, whilst promoting a collaborative, individualised approach where patients become contributory partners based upon principles of shared decision-making (Realpe and Wallace, 2010; Glynos and Speed, 2012). Therefore, by involving patients in pre-registration education it was envisaged that students would have better communication, active listening, empathy, reflection, patient empowerment and relationship building skills (Hughes, 2017; Scammell *et al.,* 2016; Rees *et al.,* 2007),

all deemed essential co-production competencies (Boyle and Harris, 2009:14; NESTA, 2012; Baim-Lance *et al.,* 2016).

Political, media, and patient grievances suggested that nursing, as a self-regulating profession, could no longer be trusted to ensure that the right students, with the right professional and affective attributes joined the professional register. Consequently, it could be suggested that the NMC's extension of service user involvement into practice assessment was designed to address the apparent deficits in nursing and dampen increased criticism of their regulatory performance (CHRE, 2008; 2010; House of Commons Health Committee, 2011). By asking patients to make judgements about students' practice, they provide a subjective review of students' professional values and behaviours, whilst mentors continue to assess students against a set of professionally-determined competencies and essential skills (Happell *et al.,* 2014). The anticipated effect of this additional surveillance was that students, rather than focusing solely on achieving defined clinical outcomes, would become equally attentive towards developing professional values, patient-centredness and interpersonal skills; so in effect a combination of technical-scientific and practical-vocational skills. Despite the potential benefits to enhance nursing students' observable behaviours and interactions with patients, other than increasing patients' perceptions of being cared for and cared about, there is little evidence that patient involvement in practice assessment will afford any material benefit in regard to better patient outcomes and shortened length of stay in hospital. In contrast, there is substantial evidence that suggests the academicisation of nursing has had a positive effect on patient outcomes and mortality (Aiken *et al.,* 2003; Aiken *et al.,* 2008; Aiken *et al.,* 2014; Cho *et al.,* 2015).

Patient involvement in practice assessment is currently drawn from a political logic of consumerism, which reconstructs patient involvement as a potential strategy to 'fix' the nursing problem (Firth-Cozens and Cornwell, 2009; Willis Commission, 2012; Francis, 2013). Policy actors therefore appeal to us as individuals by promising that by strengthening patient involvement in the practice element of pre-registration nursing programmes our own personal patient experience will be improved. However, although the desire for greater participation may be both psychologically and philosophically appealing, the theory that patient involvement in assessing students' practice will result in demonstrable changes in nurses' caring attitudes relies on the acceptance that the representation of both the problem and solution are true (Figure 16 – Quadrant A).

Figure 16 illustrates the true/true relationship (Quadrant A) as I have already outlined in this chapter. It is predicated upon an acceptance that the nature of the problem in contemporary nursing is HEI-based, technical-scientific nurse education. It is further predicated on the assumption that the dominant solution to this problem is patient involvement. Not, as might be expected that training be moved out of universities, but rather that more practical skills be incorporated into university-based nurse training. Again, this is in keeping with the compatibilistic fudge first identified by Cameron in 2009 and endorsed by others. This problem-solution formulation serves as a discursively constituted hegemonic normative frame that is subsequently used to foreground and defend one particular worldview (McAdam *et al.,* 1996). This view is defended against the views of, and possible challenges from, competing groups such as nurse academics and educators. Thus, this normative frame represents a promise of the fullness to come, that patient involvement in practice assessment is the most desirable resolution to the nursing problem in order for society and patients

to regain a sense of enjoyment in their health care, i.e. to believe and trust in nurses again. The potential strength of this normative frame has made it almost impossible for nurse educators to argue against it as policy actors could present this as an attempt by professional academics to retain control and power over the curriculum and profession. Nevertheless, Foucault argues such a framework can never epitomise an objective truth, rather it can only represent:

> '… the ensemble of rules according to which the true and false are separated and specific effects of power are attached to the true … it's a matter not of a battle "on behalf" of the truth, but a battle about the status of truth and the economic and political role it plays' (Foucault in Rainbow, 1991:74)

However, what is of interest is not only how different actors discursively construct the problem and solution as true, but also how different actors' regimes of knowledge might influence what they consider to be true or false. Pedagogical and social practices then serve to emphasise and strengthen the 'will to truth'; however it also relies on institutional support, in this instance support from the Department of Health, NHS employers and professional regulatory bodies (NMC, HCPC, GMC). Foucault (1981:55) contends that institutional support and distribution of the will to truth pressurises and constrains other discourses. Therefore, it is important to look outside of the dominant true discourse in order to explore the backgrounded alternatives.

Opponents' attempts to destabilise the hegemonic normative frame

Quadrant B: True/False

Quadrant B represents a dyad where although the problems attributed to technical-scientific nurse education may be constructed as true, patient involvement in assessment may not be presented as a viable solution due to the subtle differences in the patient subject positions within the HEI in comparison to the hospital setting.

Patient involvement certainly appears to have the potential to challenge profession-centric institutional practices and shift organisational cultures towards a more patient-centred approach, however individual patients' desire for active involvement remains a contingent concept. It is already recognised that during hospital admission individuals may choose to adopt a certain patient position depending on the situation they find themselves in, however this position is never fixed, therefore patients may fluctuate between passivity and active involvement within any single hospital admission (Clarke *et al.,* 2007). Within a hospital environment, a patient's willingness to be actively involved in the assessment process may be affected by the level of dependency they have on either the mentor or the student for their care. It is likely that at some point during their admission patients may become fully or at least partially dependent on students that could significantly shift the balance of power away from the patient (Strandberg *et al.,* 2003). This physical and emotional dependence can promote patient passivity either through their acquiescence to the perceived expertise of the nurse, their acceptance that care may have to be routinised (Salter, 2004) or from a fear of repercussions or exploitation (Speers, 2008; Happell *et al.,* 2014).

Regan de Bere and Nunn (2016) found that whilst patients were keen to be involved this was often instigated as a top-down, academic-led initiative resulting in patients being positioned as objects-of-learning rather than partners-in-learning. The 'silo cultures' within institutions effectively isolated patients from educational, academic and professional discourses, which may prevent patients, mentors and students from forming an equal and balanced relationship within the practice setting (Stickley *et al.,* 2010). Consequently, although patient feedback can be an indicator of students' professional values and affective skills, their feedback and willingness to

be involved is dependent on their perceptions of the quality of the relationship between themselves, the mentor and student.

Trusting relationships can take time to build, but with the average length of patient stay now only five days (NHS Digital, 2016) students may only have sporadic interactions with patients with limited opportunities to develop any meaningful educational partnership (Burford, 2008; Speed *et al.,* 2012; Duygulu and Abaan, 2013). Studies show that unlike patients who are involved within the HEI setting, the amount of information and training patients in hospital are given about their education role in practice is negligible (Oflaz and Vural, 2010). As such, whilst patient involvement in the academic side of nurse education is articulated through discourses of consumerist and participatory democracy, the transient and episodic nature of patients' interactions with students in practice could reduce the validity and reliability of patient assessments.

Quadrant C: False/True

Quadrant C represents a false/true scenario where the problem of non-compassionate care is not directly attributed to HEI nurse education, but patient involvement in practice assessment is still constituted as a solution. This solution rests on the assumption that patient feedback on affective behaviours such as care, compassion and patient-centredness, has the potential to make students more aware of the essentiality of affective competence in nursing practice. By reintroducing patient involvement to practice assessment, the potential is that by the end of a three-year pre-registration programme patient involvement in monitoring the quality of nursing care could become a naturalised nursing practice.

Patient involvement in nurse education is already constituted as an essential strategy to embed a consumer culture and patient-centred practices into a developing

nurse workforce (Turnball and Weeley, 2013). Learning from patients' experiential expertise is considered a vital part of students' professional socialisation as it enables students to learn the cultures, values, roles and responsibilities associated with professional practice, facilitates a refinement of their conceptualisation of self (Cohen, 1981:14) and construction of their own professional identity (Felstead and Springett, 2015). The ethos of patient involvement centres upon health professionals recognising patients as 'experts by experience' therefore actively involving patients in practice assessment could help reinforce this subject position by offering the opportunity for students to learn *about, with and from* patients rather than learning *to do to* patients (Tew *et al.*, 2004). The reintroduction of patient involvement in practice assessment has been discursively constructed as the most appropriate strategy to ensure that students learn to recognise and meet the needs and expectations of individual patients. Policy actors have employed a consumerist logic to promote the idea that by making patient involvement in practice assessment mandatory students will accept the ethos of partnership working and translate this into practice (NMC, 2010b; 2011). The triadic assessment relationship between the patient, student and mentor therefore has added potential to shift the balance of power within traditional professional hierarchies that could result in involvement moving from political rhetoric to becoming established institutional practice.

Quadrant D: False/False

Quadrant D offers the opposite view that the academicisation of nursing has not created nurses who are 'too posh to wash' or 'too clever to care' and is not responsible for recent care failings. This configuration would suggest if nurse education is not the problem then patient involvement in practice assessment will do little to improve the quality of care in hospitals. In contrast to quadrant A that

indicates the position of key political actors, quadrant D incorporates groups of social actors from nursing and academia that have offered an alternative true discourse in defence of nursing and technical-scientific nurse education.

The idea that nurse education is the root cause of declining standards of care has been, and continues to be contested (Willis Commission, 2012; Beer, 2013; Berwick, 2013; Keogh, 2013). Lord Willis, Chair of the RCN commissioned '*Quality with Compassion'* pre-registration nurse education review (Willis Commission, 2012) accused the media of creating the horrific fantasy of 'too posh to wash, too clever to care', in order to apportion blame despite there being little evidence to support it:

> 'Such comments were predicated on the assumption that the move to an all-graduate education programme for nurses would result in the recruitment of less caring and less compassionate nurses. Today the vast majority of nurses are not graduates. If poor care is occurring today, it is not because we have graduates. In fact, it will not be until 2013 in England that all entrants as registered nurses will be graduates. Making the bland assumption that by expecting higher educational attainment of nurses means you will get less care and compassion is absolute nonsense' (Lord Willis of Knaresborough, *Hansard*, 2012)

The assertion that technical-scientific nurse education is the problem has in turn been openly criticised by the Council of Deans for Health (2013). The Council criticised the Mid Staffordshire public inquiry on three counts; firstly, they questioned its failure to recognise the potential impact that the 2010 NMC *Standards for pre-registration nursing education* (NMC, 2010b) could have on the development of students' affective competence, especially care and compassion; secondly, they noted the inquiry failed to call any witnesses from the nursing faculty at Staffordshire University; and finally they criticised the inquiry for failing to determine whether there was a correlation between the type of pre-registration programmes nurses at the Mid Staffordshire Hospital had undertaken and the standard of care patients received.

What was acknowledged within the Francis reports (2010; 2013) was the impact of chronic understaffing, patient acuity and lack of resources had on staff

morale, which research has shown can all contribute to staff burnout and compassion fatigue (Michalec *et al.,* 2013). Newly-qualified nurses have been described as suffering a 'crisis of competence' (Cherniss, 1980) as some struggle to make the transition from student to staff nurse, and Nolte *et al.,* (2017:6) found that increased levels of compassion fatigue were directly associated with nurses' emotional detachment from patients, resulting in an inability to exhibit compassionate behaviours (Russell, 2016). Therefore, rather than pre-registration nurse education failing to instil caring and compassionate behaviours in students, this suggests that a lack of on-going support and supervision after qualification can have a significant bearing on nurses' ability to care and patients' perceptions of feeling cared for (Michalec *et al.,* 2013).

Conclusion

This chapter has considered, through an exploration of political and fantasmatic logics, how technical-scientific nurse education and more recently graduate nurses have been constituted as the antagonistic 'other' that prevents patients from receiving patient-centred, compassionate care. This chapter illustrated a shift in political alliances, from initial resistance against the professionalisation of nursing to the acceptance of Project 2000 as nurses became part of a political strategy to prevent a demographic staffing crisis, as governments used nurses' professionalisation demands to further reduce medical dominance within the NHS. My analysis has shown that a number of dislocatory moments, including recurrent NHS financial crises, chronic staff shortages and hospital care scandals have consistently been used to present an horrific fantasmatic image of the HEI-educated, technical-scientific nurse as a threat to patient care. Political and policy actors has drawn equivalences from patients, employers and media demands to deflect responsibility for declining

care standards onto technical-scientific nurses, accusing them of being ‘too posh to wash’, whilst nurse leaders and educationalists were accused of trying to turn nursing into an elitist profession.

This chapter also demonstrated that alliances between different groups of actors created antagonistic frontiers that initially set nurse education as a fundamental threat to care by failing to equip newly-qualified nurses with the requisite practical skills. By examining how these frontiers and alliances have shifted in response to increasing socio-political resonance, this analysis has shown the demand for patient involvement in practice assessment was drawn from political logics of vocationalism and consumerism, and a fantasmatic logic of the caring vocational nurse. The NMC, in order to reassert its position had to be seen to be admonishing a wayward profession; hence the introduction and rearticulation of patient involvement as a normalising practice. Finally, this chapter set out how policy actors attempted to organise the discursive field around a true problem/true solution floating signifier, and how those who contested this normative frame drew together three alternative floating signifiers. The following chapter will analyse the degree to which patients, students, mentors and lecturers accepted or resisted the true/true hegemonic normative frame, and the extent to which this frame gained or lost credibility as an empty signifier.

Chapter 7: The ebbs and flow of acceptance, resistance and contestation

'The idea of citizen participation is a little like eating spinach: no one is against it in principle because it is good for you' (Arnstein, 1969:216)

Introduction

Within this thesis I have demonstrated that a number of disclocatory moments have exposed the contingency of the nurse identity (see Chapters 3). I have shown that there has been tensions between nursing as a practical-caring vocation and nursing as a technical-scientific profession since the mid 1800s, and that this contestation has ebbed and flowed over this period where sometimes a vocational identity has dominated and at other times a professional identity. More recently nursing might be characterised by a move towards a compatibilistic context where vocation and profession are combined. Nevertheless this combination still draws from a beatific logic of 'a vocational nurse' as someone who tends to a patient's physical (personal hygiene; toileting; feeding) and emotional needs (care; comfort; empathy) that continues to grip a number of actors by presenting vocational values and affective competence as more significant to the patient experience and quality of care than the development of nursing as a distinct academic subject (Kelly *et al.*, 2012). Nursing and its associated roles and responsibilities are discursively constructed through a discourse of care (Mol, 2008), where care is constituted as female, practical, emotional and vocational, rather than male, technical, rational and professional. As a consequence, the nurse's ability to display the 'right' values and behaviours is presented within public, political and professional discourses as essential nursing traits (Von Dietze and Orb, 2000; NMC, 2010b, 2015; DH, 2012a). Consequently, for many this historical constitution of care and nursing as a synonymic relationship signifies the 'true' representation of the profession. Indeed, caring has been

described by nurse theorists as giving 'nursing its heart and soul. Without caring, nursing is but a collection of highly skilled tasks and endeavours – a recognisable body but without an animated soul' *(*Brykczynska, 1997: 4).

In this context care and compassion are signs partially fixed around the nodal point of identity − 'nurse' (Laclau and Mouffe, 2001). A nodal point of identity is described as an empty signifier that when linked with other signifiers form chains of equivalence that gives meaning to an identity. Within this analysis these nodal points can represent either an identity based on a fantasmatic logic of − the caring vocationally-trained nurse (Figure 17) or, in opposition, an identity associated with a fantasmatic logic of – the uncaring, academic, technical-scientific nurse (Figure 18). These logics on their own are neither beatific nor horrific, instead it is 'the role of fantasy to actively contain or supress the political dimension of a practice' (Glynos and Howarth, 2007:146). Therefore actors draw from fantasmatic logics as they try to maintain 'reality' and close off the radical contingency of social relations (Glynos and Howarth, 2007:147). Figure 17 and 18 show that media discourses pre-1990 had drawn from a beatific fantasy of 'a caring vocational nurse' that promises a 'fullness to come' if the threat of HEI-based nurse education is overcome, while post-Mid Staffordshire discourses changed to present a horrific fantasy of 'an uncaring, academic technical-scientific nurse' that forewarned of disaster if the threat this image represented was found to be insuperable. While studies have yet to ascertain the full extent to which negative media representations of nursing have affected public opinion, a systematic review by Girvin, *et al.* (2016) found that a gendered discourse was still being employed in contemporary problematisations of nursing across the media. They contend that the influence of newspapers and social media on public opinion could account for the continuing constitution of nursing as a less

educated, less challenging and less responsible occupation that has often been compared to other female-gendered, practical occupations, such as hairdressing.

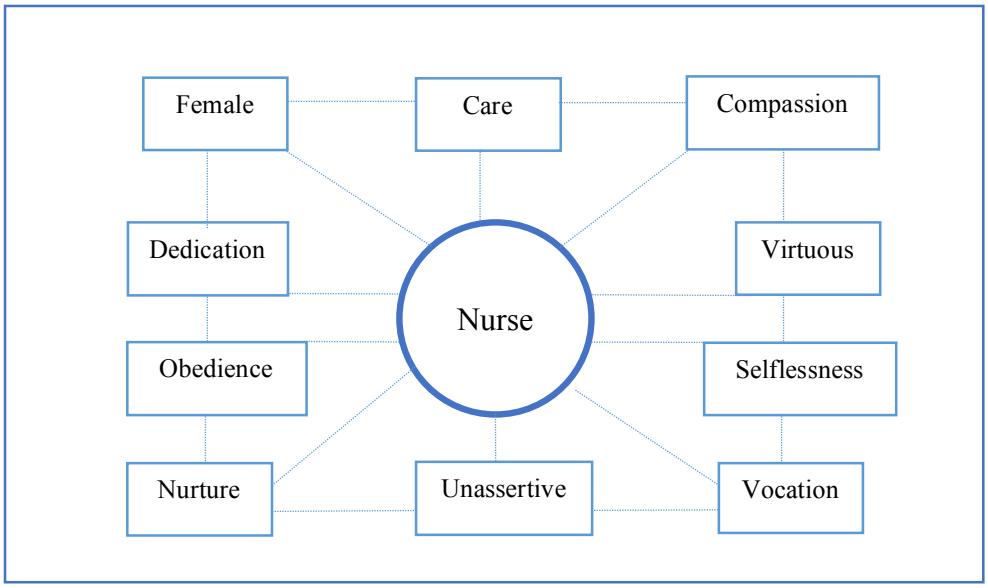


Figure 17: Nurse as a nodal point of identity within UK media discourse pre-1990

Figure 17 illustrates the chains of equivalence that served to construct the nurse identity within media discourse pre-1990. Media articulations could be seen to reflect a sedimented vocational nurse identity but although actors may have had an unquestioning belief in this normalised 'truth', moments of dislocation can expose the contingency of that identity. Such revelations subsequently result in actors questioning the veracity of their own assumptions, but they also function to confirm the orthodoxy being identified as breaches in 'the norm'. Stories of patient neglect and nurses' uncaring behaviours revealed the lack in the nurse identity, hence it then became possible to imagine what was previously unimaginable – that some nurses might indeed be uncaring and non-compassionate. According to Laclau and Mouffe (2001) the creation of an 'us' identity is always accompanied by the creation of an opposite 'other', and just by the acknowledgement of this 'other', our personal sense

of being is threatened as our own identity is also found to be lacking (Glynos and Howarth, 2007). In that case it was not only the nurse identity that was found to be contingent but also actors' sedimented understanding of the patient identity, and consequently their belief in the authenticity of nursing's discursive construction as 'the caring profession' was disrupted and subsequently rearticulated as illustrated in Figure 18.

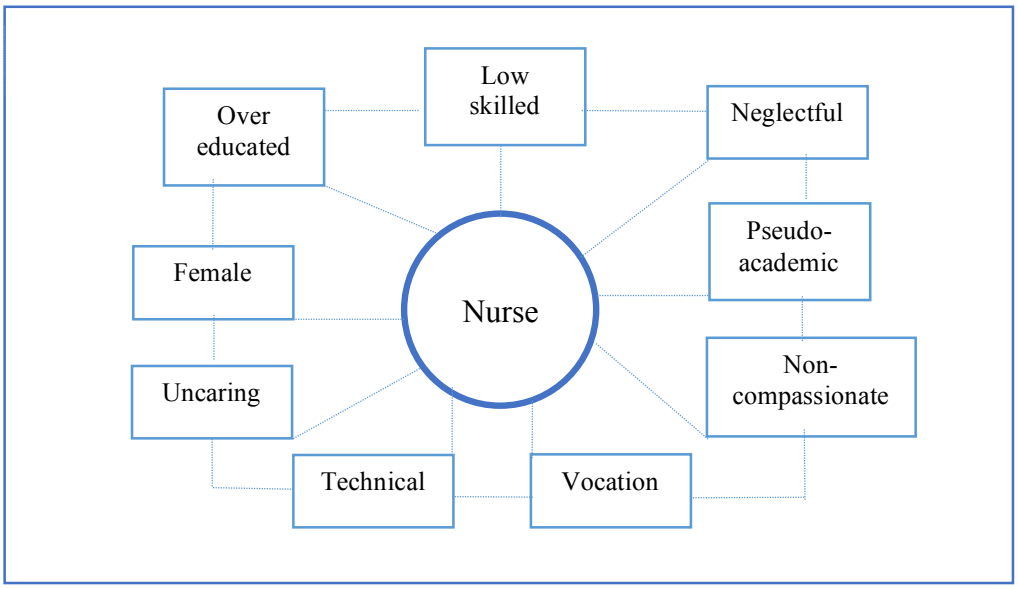


Figure 18: Nurse as a nodal point of identity as constituted within UK media discourse post-Mid Staffordshire

Indeed, Darbyshire and McKenna (2013:305) describe the plethora of critical reports on the standards of nursing in the NHS as 'fire starters' that heralded a resurgence of media criticism against technical-scientific nurse education (Lawson, 1996; Delingpole, 2009; Adams and Smith, 2012; Chapman and Martin, 2013; Donnelly, 2014; Hawken, 2015). As I have already illustrated in chapter 6 such storylines joined to form a discourse coalition that created significant socio-political resonance that was enough to result in a political response. With various actors turning their attention towards the professional ethics of nurses, this offered an opportunity for the government to deflect attention away from having to account for poor policy

decisions, reductions in NHS spending, and lack of resources onto a subordinated profession that had less politically power and influence than medicine and therefore less likely to resist. It provided the government with an opportunity to allow the scapegoating of nurses and the presentation of a 'Hoggenheimer' type image of technical-scientific nurses to underscore a horrific fantasmatic narrative against the academicisation of nursing that was presented as a reason for substandard patient care. Grindle and Dallat (2000) contends that nurses' position as a subordinated, gendered profession has consistently resulted in governments' scapegoating nurses and introducing educational reforms as a strategy to deflect criticism away from health policies that have failed to improve health services. Moreover, Shields *et al.* (2011) suggest that nurses have become more vulnerable due to an increasing blame culture. They argue that

> 'nursing is always the first to get kicked when something is wrong in the NHS. We are simultaneously praised as 'angels' and demonised as 'too posh to wash'; and we really fear another upheaval at the point in the nursing system where all the blame seems to lie – nurse education' (Shields *et al.,* 2011:2096).

In Chapter 6 I have considered how and why policy actors have struggled to present a true problem / true solution hegemonic normative frame as an empty signifier to give meaning to contemporary debates on HEI nurse education and standards of patient care. This chapter moves this forward by analysing whether this normative frame does indeed represent the particularities of study participants, and whether the introduction of patient involvement in practice assessment provided them with a sense of fullness or totality. I will examine how both the 'problem' and 'solution' have been constructed as the truth of the matter by those involved (despite evidence to the contrary) and I will argue that this offers an overly simplistic picture that fails to consider other important configurations. Here my analysis focuses on the degree to which participants accept or resist the hegemonic normative frame and

suggests varying degrees of positional and/or dimensional drift as participants consider the different contexts of patient involvement, thus revealing the contingency of political and policy actors' problem/ solution truth claims.

Dimensional positioning of patients, students, mentors and lecturers

I return now to the four-quadrant problem/solution intellectual framework discussed previously in chapter 6. In terms of analysis, I first considered frame analysis, which would have been appropriate if I was exploring participants' political contributions to the development of national or local nurse education or patient involvement policy, but this was not the focus of this thesis. Instead, I wanted to explore how each participant discursively engaged with both 'true' discourses. Therefore, rather than distinct binary opposites where the problem or solution can only be defined as true *or* false, a dual continuum dimensional matrix (Figure 19) allowed for an analysis of individual participant's discursive position in relation to the problem and solution as separate rather than synonymous constructs, as well as the degree to which participants accepted or resisted political and policy actors' true problem /true solution hegemonic normative frame.

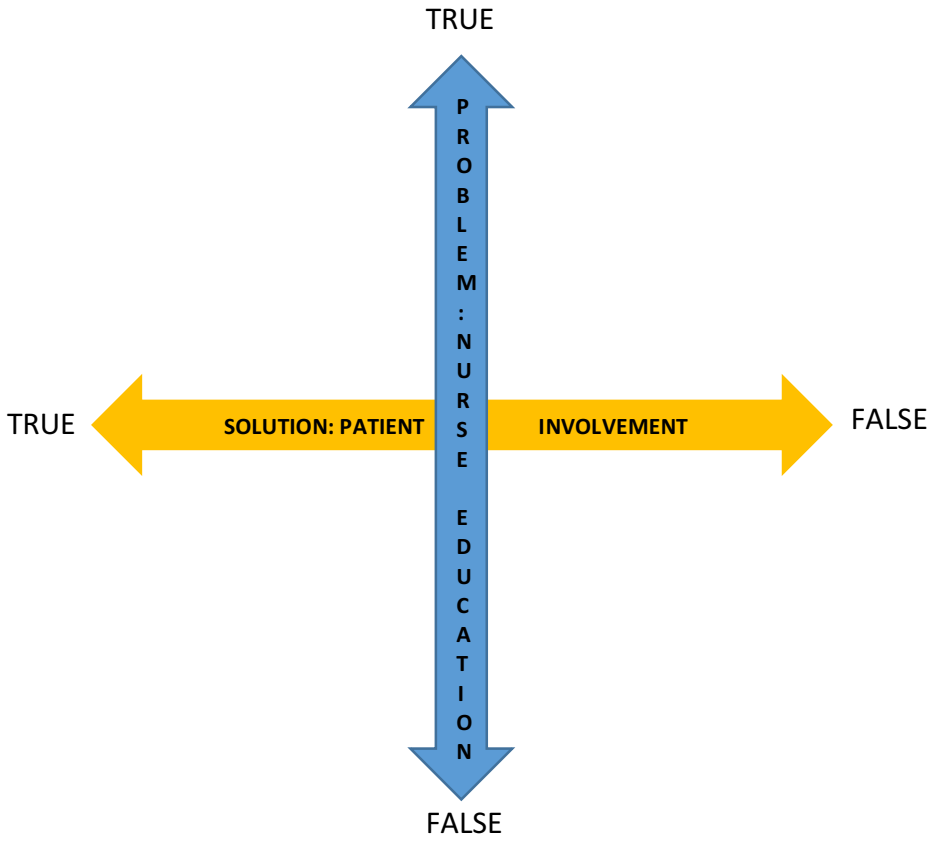


Figure 19: Dual continuum dimensional matrix

The process of dimensional mapping

Unlike positional mapping, a process attributed to situational analysis and grounded theory (Clarke, 2015), which produces a visual representation of participants' discourses set against analytical axes, the purpose of my analysis was to present a pictorial map of each participant's position against the dual continuum dimensional matrix. As discussed previously in chapter 2, discourse analysis is an iterative, reflexive approach, therefore my analysis of participants' matrix positions involved reading and rereading interview transcripts in order to identity where participants had adopted the same storylines as those outlined in chapter 6, well as any contradictory narratives that suggested resistance against or contestation of the hegemonic normative frame. I started by focusing on participants' position against the truth

claim that technical-scientific nurse education was the primary problem and patient involvement in practice assessment was the primary solution. In each interview transcript I highlighted areas of text where participants' narratives reproduced the same problem/solution assertions represented by quadrant A and where participants had offered alternative articulations that reflected quadrants B, C, D. I did not aim to produce a quantitative frequency or perceptual analysis; instead the resultant dimensional mapping (Figure 20) and my subsequent analysis enriches the thesis by providing an interpretative account of participants' positions against the hegemonic normative frame regardless of their subject positioning within the practice assessment process.

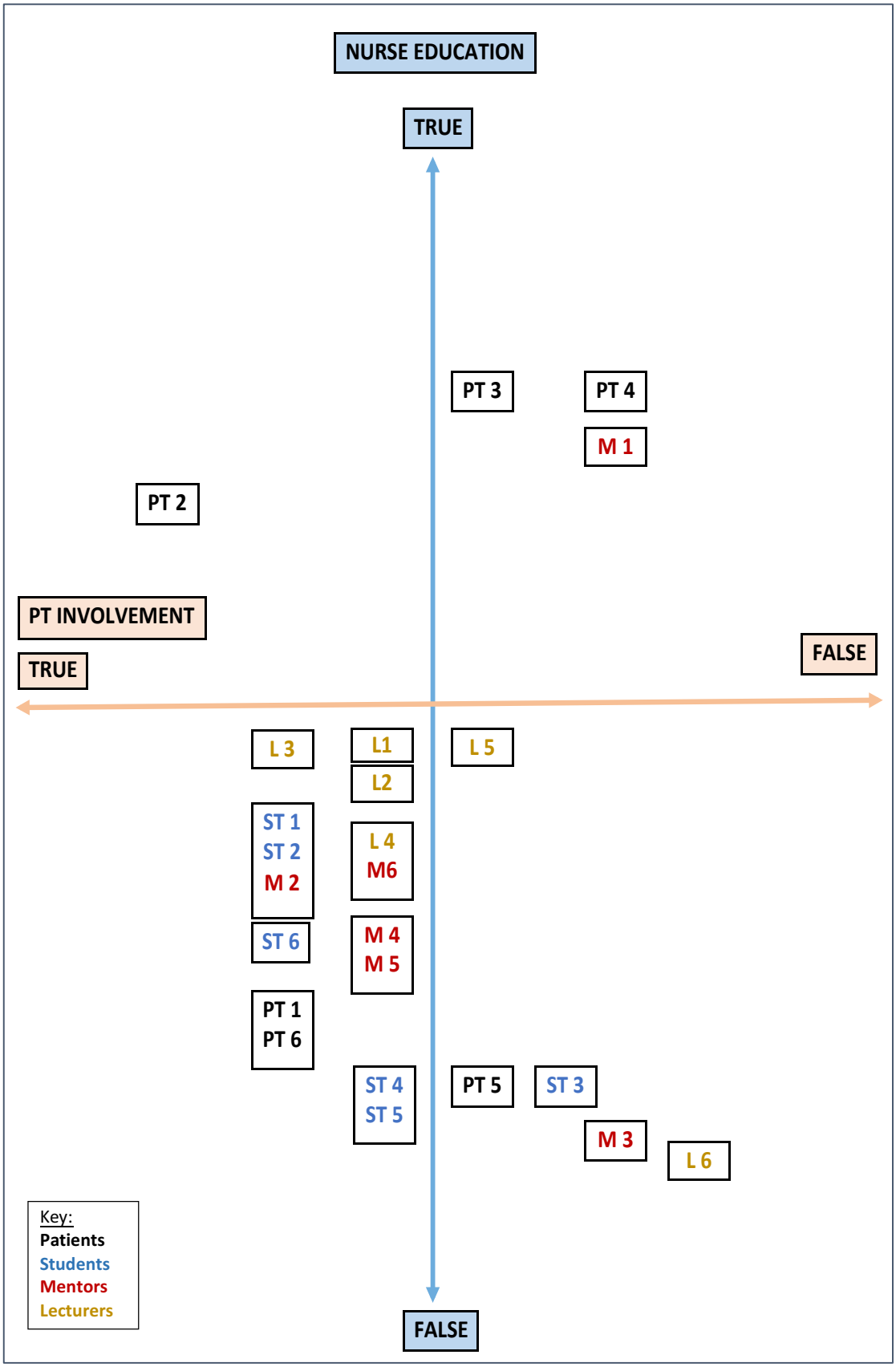


Figure 20: Participants dual continuum positions

The failure of the hegemonic normative frame: Degrees of separation

The dimensional mapping suggests the true/true hegemonic normative frame failed to 'grip' the participants that took part in this study. Only Patient 2 was discursively positioned within quadrant A, although even they did not fully accept the hegemony of the true/true configuration. Vocationalism as a political logic of equivalence is evidenced in Extract 45, where a beatific fantasy of the vocational nurse is evoked as Patient 2 draws from newspaper narratives to problematise technical-scientific nurse education.

Extract 45
P2: Well I only really know what one reads in the newspaper, what it says in the newspapers that it's over academic and I know it's very popular to say now that the nurses don't spend nearly as much time on the wards and that they learn sort of like, they don't, well they don't spend enough, they don't learn on the job and that erm certainly a lot of people say, I really don't know if it's true or not but I sort of suspect that it might be, that the old fashioned way of training was more about hands-on nursing and that nurses are expected to do a lot but having said that obviously in war time you know, people read all about the war time nurses and how wonderful they were but there wasn't so much they could do then because they, you know the technology wasn't there and the doctors did a lot of the stuff the nurses do now so I do see that actually you can't have people who've just learnt you know to turn people and wash them and things, and administrating complicated drugs. So erm it's a catch 22 the government wants to get more technical out of nurses so they can spend less on doctors and then, and yet erm they also want them to be entirely sort of hands on and erm. I think it's a shame that they don't still have enrolled nurses, that seemed to me a really good idea was that some people are naturally academic and want to go on learning about I don't know the public sewers and things and how to administer things and the people who really want to just to be helpful and friendly and look after people because they're a caring kind of person, so I think it's rather a shame that those sort of people perhaps you know, if you can't pass A levels you're not allowed to be a nurse now (Lines 967-986)

Extract 46 also evidenced the political logic of vocationalism by mirroring the sentiments made at the Mid Staffordshire Public Inquiry, constructing 'natural empathy' as an essential personal characteristic for nurses.

Extract 46
P2: I do actually think that's very vital [patient involvement] erm and, and erm so that if a nurse can show that it's obviously very important and if they can't then maybe they're suited you know to another medical job but perhaps not being a nurse ... I mean it's not … some people have a natural empathy and some don't but if someone just doesn't have empathy then perhaps they should be diverted to some other kind of job away from patients but equally useful (Lines 1590-1595)

Within both extracts the horrific fantasmatic image of technical-scientific nurses, is partially reflected in the way that Patient 2 equates those who are '*naturally academic'* with wanting to learn about public health over and above caring for patients. Extract 45 infers a yearning for the past, lamenting the loss of the enrolled nurse, and an acceptance of political and media rhetoric that nurse education has become too theoretical at the expense of teaching practical skills. In Extract 46, nursing is constituted as more than '*just a job'*, with the suggestion that patient involvement in assessment would allow for those students who patients felt were empathically lacking to be '*diverted to some other kind of job away from patients'*. This extract also indicates an engagement with a social logic of experientialisation in the acceptance of patient involvement as a pertinent strategy to ensure students have a natural empathic, caring attitude. Patient involvement policy rhetoric is also reflected in Extract 46, where the government's constitution of patient involvement as a way to ensure a positive patient experience and improved patient outcomes is reiterated.

Both extracts allude to the social logic of experientialisation where academic study is disassociated from care. A political logic of vocationalism, as a political

logic of equivalence, is drawn upon to position HEI nurse education as a barrier to those individuals '*who really want to just be helpful and friendly and look after people because they're a caring kind of person'*. The conflict this posed for the professionalisation of nursing is highlighted, where on the one hand nursing has moved to graduate level entry, while on the other the government continues to adopt a vocational discourse to construct nursing as a practical 'hands-on' occupation. Consequently, nursing risks becoming constituted as a practical-skilled workforce rather than a technical-scientific profession, indicative of a position of vocational hegemony, potentially reinforced by government policy that promised nurses career advancement by offering them the opportunity to develop additional technical skills traditionally associated with medicine in order to 'fill in gaps in the medical workforce' (Imison *et al.*, 2016:44).

Positional differences between patients with and without HEI nurse education experience

Unlike the other groups of actors who participated in this study, looking at the positional spread of patient participants, patients were discursively positioned across each of the four quadrants (Figure 20). However, Figure 20 also indicates a degree of positional separation in relation to where patients' discourses were positioned along the nurse education continuum. Patients who have had no direct engagement with HEI nurse education were positioned either with the True/True dimension – quadrant A indicating an acceptance of the hegemonic normative frame or the True/False dimension – quadrant B where participants' discourses reflected the claim that technical-scientific nursing was a problem but evidenced some resistance against patient involvement as a possible solution. In comparison, patients who have or have had some engagement with HEI nurse education were discursively positioned within

the dimensions of False/True – quadrant C or False/False – quadrant D. What this positional split illustrates is the extent to which patient participants' discourses did not reflect policy actors' true/true hegemonic normative frame. The political truth claims and the horrific fantasy of 'too posh to wash, too clever to care' can be seen to have gained a partial grip. While the solution – patient involvement in practice assessment – had also gained a partial grip; the contingency of the claim that patient involvement will create caring and compassionate nurses is perhaps best illustrated by the widely dispersed discursive positions of patients. Extracts 47 and 48 illustrate the grip and influence those true claims had on the way those patients who have not had direct involvement with HEI nurse education construct technical-scientific nurse education as a threat, thus accenting the horrific fantasy:

Extract 47
P3: I know that mostly they seem to do a lot written stuff and they don't spend a huge amount of time with the patients until they become nurses I think. I think that it would be better if they spent more time with the people to know whether you're actually capable of being a nurse kind of thing cos erm, you know, you could study as far as you know, you could continue studying but it doesn't mean you're any good at what, like erm, being good with people or having a nice bedside manner, you'd have more, more practice on patients, more time spent with them so they, you know that's definitely what you want to do I think. Interviewer: So where did you get kind of, erm, where did you get that knowledge from? Where did you get to understand or hear about nurse training? P3: It's just what people have said to me, I don't really know, I haven't, I don't really read the newspapers that much so, I don't know, but I've just heard that they study for a long time and that it's more about studying until they, sort of at the end of it come into contact with patients, where it should be side by side really. (Lines 595-609)

Extract 48
P4: … I mean I'm one of these people that believes that nurses should be trained on the job and not going for degrees and things like that because I think it's too posh to push and all that business and I'm not going to dirty my hands by taking a bedpan to that patient, that sort of thing you know, because people who were nurses when I was younger they definitely went into it because they wanted to look after people not because there was any money in it Interviewer: Mmm. Do you think that's where nursing has gone? That, that .. P4: It appears to have done. I'm not saying it has done but it certainly appears to, it has all the signs, people talk about it as if yes it has gone that way and I think that's possibly being a bit unfair, erm I think there are still people in the profession who care deeply about what they do erm, but there's an element of people who are in there thinking 'well I've got a degree so I'm not going to do that' you know, well sorry that's what's nursing's all about. (Lines 112-125)

These extracts constitute a nurse as '*being good with people'*, '*having a nice bedside manner'*, and '*wanting to look after people'* something that is construed as only achievable through a practice-based, vocational pre-registration programme. Here the increasing socio-political resonance and power of political and policy actors' discourse coalitions sustains the claim that the academicisation of nursing is the problem. Extracts 47 and 48 draw on a political logic of vocationalism to constitute technical-scientific nurse education as the antagonist other, or 'common enemy', responsible for thwarting patients' 'enjoyment' of nursing care, and accept policy actors' horrific truth claims.

The possibility that technical-scientific, graduate nurses could enhance standards of care and patient outcomes is not considered. This may be indicative of the power of the political alliance between the government, service managers, patient groups, media and some within nursing post-Mid Staffordshire, but it could also indicate a deliberate strategy from government to deflect blame (Cooke, 2012; Hutchison, 2016). The hierarchical positioning of key political and policy actors and

the power of the socio-political resonance created by recurrent horrific fantasy narratives effectively overrode the profession's attempts to reconstruct nursing as an academic science as well as a caring profession. In contrast, policy actors' constructions of a beatific fantasmatic narrative of practical-caring vocational nursing and the horrific fantasmatic narrative of 'too posh to wash' was not evident in the interviews of patient participants who had had some engagement with HEI nurse education:

Extract 49
P5: ... but I just, so yeah I think there's, I think there's, I think there's a lot to be said in terms of the respect that you'll then get, I mean the psychologists started with a degree, that's where they all started so actually I'm kind of hoping that the knowledge and expertise that, that a degree gives a student would hopefully be appreciated. Like teachers they're degrees and things like that. (Lines 807-811)

Extract 49 shows how the attainment of a degree qualification was constructed as a means for nursing to gain respect and appreciation for nurses' increased underpinning knowledge and expertise. Constituted through a political logic of professionalism, as a logic of difference, technical-scientific nurse education is presented as a conduit to increase nurses' professional status and credibility as has occurred with other more established graduate public sector professions. This could imply that policy actor and media narratives drawn from the fantasies of vocation and the technical-scientific profession have failed to grip those patient participants who have been involved with HEI nurse education within the academic setting, as opposed to those who may have been unaware of their educational role during their hospital admissions. The contingency of both the 'golden era' myth and horrific fantasies became visible as patients gained first-hand experience of contemporary pre-registration nursing curriculum, engaged directly with course teams and become involved in student selection interviews and classroom teaching.

This positional separation between patient participants may also be reflective of a fundamental shift in patient identity. Throughout the respective interviews patients tended to adopt a passive-dependent subject position when discussing standards of care and pre-registration nurse education. Only very occasionally did patients assume an involved-partner identity, but only in response to questions about standards of hospital nursing care. In contrast, although patients with HEI experience also adopted a passive-dependent position when reflecting on hospital care, they assumed an educational partner position when discussing patient involvement in HEI nurse education rather than the position of patient-consumer or associate consumers of nurse education. The close association some patients had with HEI health professional education may well account for why the position of these patients' discourses on the dual dimensional continuum were so closely associated to that of the majority of students, mentors and lecturers.

Positional difference between apprenticeship trained mentors, HEI students, HEI educated mentors and HEI-based nurse lecturers

Despite the possible failure of the hegemonic normative frame, the discursive positioning of Mentor 1 within the True/False dimension would suggest some degree of professional acceptance of the true claim that technical-scientific nurse education was a problem, as indicated in Extract 50:

Extract 50
M1: The structure, the fact that the tutors and people actually were working in the hospital that they were really in touch and nursing then wasn't an academic subject, it wasn't the degree although they perceived that the SRN [State Registered Nurse] qualification could be on par to degree level and I think we got a much better basic grounding than a lot of the nurses today (Lines 66-70)

Similar to extracts 46 - 48, extract 50 is constituted through a political logic of vocationalism, where a discourse of nostalgia is employed to discern the faults with HEI-based nurse education. Here the same beatific fantasy is presented as that articulated by politicians, service managers, some patient groups and the media that hospital-trained, vocational apprenticeship students '*experienced everything'* and '*got a much better basic grounding'* compared to HEI-educated, technical-scientific students. Indeed, hospital nurse training was predominantly practice-based with students spending the majority of their training in practice (Cockayne, 2008), in comparison to HEI-based nursing students who spend half of the course (2,300 hours) in practice (NMC, 2010b). The threat of academicisation is not a new phenomenon, and its construction as an obstacle to the profession enjoying the historic public's reverence towards nursing has been a recurrent theme within some quarters of nursing (Mackay 1989; Vousden, 1998; Aiken, 2012). This is often presented alongside the beatific fantasy of nursing as an intrinsic vocation rather than a deliberate career choice, which commentators have used to constitute nursing as a hands-on, customary occupation (Bradshaw, 2001). The continuing use of nostalgia underlying the political logic of vocationalism illustrates the grip of the beatific fantasy by eclipsing contradictory research findings that suggested that newly qualified apprenticeship-trained nurses also lacked experience and competence in some fundamental nursing skills (Cox *et al.*, 1983; Gott, 1984).

Extract 50 illustrates how hyperbole was used to defend the quality of the apprenticeship model, where the State Registered Nurse (SRN) qualification is constituted as *'on par'* with an academic undergraduate degree, despite apprenticeship training having no academic credits attributed to it. Even after the introduction of Project 2000 in 1989 the majority of nursing students completed a

Higher Education Diploma, therefore it is interesting that, within this extract, SRN training is constructed as academically equivalent to today's undergraduate programmes. This could suggest a degree of defensiveness where attempts are made to assure professional credibility, but it could also suggest a degree of resistance and frustration against HEI-educated, technical-scientific nurses who could potentially cause a shift in hierarchical position within the hospital. By likening the professional certificate to today's academic degree qualification there appears to be an attempt to negate the threat posed by newly-qualified Band 5 graduate nurses, by asserting a position of professional and academic equal.

In comparison, HEI students, HEI-educated mentors and HEI nurse lecturers were all discursively positioned within the False dimensions of the matrix; however, the wide distribution of these discursive positions perhaps illustrates how nursing as an academic discipline continues to be internally contested. It could also be a sign of participants' reluctance to be seen to be disapproving of NMC pre-registration curricula changes or their aversion to be seen to be criticising the local HEI. The following extract (Extract 51) draws from a political logic of professionalism, as a logic of difference to reconstruct the nurse identity. Here, the nostalgic yearning for the past is acknowledged, however the employment of this logic served to constitute research and knowledge as essential to contemporary nursing practice to ensure nurses develop the skills to adapt to the rapid advances in treatment and care delivery. Thus this extract provides an example of the tensions between different actors' construction of nursing as either a practical-caring vocation *or* a technical-scientific profession. Here there appears to be a struggle with the 'golden era' myth of vocational 'on the job' training where the expectation of today's nurses is to 'keep up' with the advancements in healthcare not only in updating their practical skills,

but also in their underpinning knowledge. In contrast to the articulation of nurses as less academically able and practical, the professionalism logic is drawn upon to resist the hegemonic normative frame to posit that contemporary healthcare requires nurses to be well educated, knowledgeable as well as technically skilled.

Extract 51
S6: I think people look back on the old days don't they, and think those days were the best, where nurses were actually trained in the hospital, on the job and, but I mean, you know, nurses do need to have the theory behind them, the qual ... the ove... the very well qualified to do it, you'll always do the job Interviewer: Why do you need theory now? You were saying it's like people look back on the old days and … S6: Because healthcare's changing and we need to be able to know how to keep up with the changes I think. I think you need to know the research behind it so that you can keep up to date with the changes. Keep knowledge and skills updated (Lines 689-699)

Similarly, the nostalgic narratives and problematisations of nursing represented in Quadrant A are dismissed in Extract 52. A differential logic of professionalism can be seen in a counter-argument against '*hands-on training'*. Here apprenticeship-style training is constructed as a generational approach to learning, but deemed as '*poor practice'* and nonsensical '*you wouldn't go and walk off a cliff because that's what everyone in front of you always done*'. Nurse education has traditionally involved observational learning and role modelling, nevertheless Toney *et al*. (2015) argue that following the 'herd' can significantly reduce personal autonomy as actors may choose to adopt group behaviours and practices even when they know an alternative approach would be better. Therefore, role modelling can become normalised within practice, which could habitualise students into accepting unsafe practice.

Extract 52
M3: … nurse training always was a very hands-on training and it you know, it was very much you were taught what the people before you were taught and it was handed down in that way, but also in that way you get handed down incorrect ways and poor practice and non-theory based, you know, ways of doing things because that's how we've always done it, and you think well yeah but you wouldn't go and walk off a cliff because that's what everybody in front of you always done (smiles) you know, it's, it's, and I think sometimes people lose that and they don't always see that you know, yes it might be slightly different, it might be slightly more challenging to do it that way but actually the outcomes of doing it that way are a hundred times better than doing it the way you were doing it. (Lines 993-1002)

Extract 53 draws from a social logic of protectionism to resist the expansion of patient involvement into practice assessment. In this context the patient is constituted as a new surveillance device introduced to monitor students' affective behaviours and practices against patients' sedimented beliefs surrounding the role of the nurse and nursing care. Education is presented as being constrained by the NMC, as the profession's regulator, exerting its sovereign power in response to critical inquiry reports. The NMC is presented as an unfair judge of nurses' professional practices, the regulator who had chosen to punish rather than defend nurses and nurse educators in order to be seen to be taking decisive action following the scandals of Mid Staffordshire and Winterbourne View. Extract 53 alludes to a sense of professional powerlessness, where medicine is positioned as having greater political and public credibility. The nurse is constituted as politically weak and professionally acquiescent, with a sense of frustration that the profession and nurse academics appear to have had *'no choice'* other than act on political demands for change:

Extract 53
L4: it's political and the General Medical Council pretends it's not political … erm, and it's hugely political, it's hugely self-serving … erm, and don't get me wrong I recognise the value in that, but as a nurse the NMC, it feels to me that all the NMC does is self-flagellation, we punish ourselves, the NMC punishes us, they ask us to do this and more.

And if criticism is created the NMC kind of roll along with it, but the General Medical Council has autonomy and a power of itself and so ... and I'm a big believer in, in, in kind of, having self-respect and not prostituting yourself to the demands of an outside body, but actually we've got no choice as nurses. Whereas the General Medical Council hold all the cards … (Lines 707-734)

Extract 54 evidences a sense of frustration that the fundamental construct of nursing as a caring, compassionate profession was being publicly and politically contested. While compassion is constituted as part of *'the basics'* of nursing, there is a sense of disbelief at the NMC's and Chief Nursing Officer for England's demands for care and compassion to be made more explicit within the pre-registration nursing curricula:

Extract 54

L6: I think partly, I think the NMC reacts to the pressures from outside, I think universities do, this whole thing about compassion for example, the new curriculum which has just started we've written a, we had to write an assessment about compassion, about being compassionate or something, it has to be part of the assessment now, and

Interviewer: Was that driven by the NMC?

L6: I can't remember, but it's in the curriculum discussion, I wasn't party to the curriculum discussions but they were very keen to get compassion in there and one of these assessments. I think in the curriculum debates there was something about having to have something about compassion because it's obviously a very hot topic at the moment, and that's fine, excuse my language but fuck me you want to be a nurse and you're not compassionate, what the fuck are you doing here! I mean, you can quote that, it's just ridiculous, you're not compassionate, of course you have to be compassionate it's just like the basics and do we really have to say that in black and white that you have to think about being compassionate, is that lost? Why are you even here if you're not compassionate? If somebody's in pain how can you not feel compassion towards that, it's just like ridiculous, I find it so stupefying, it's like putting on an assessment can you use your feet? You know, do you know how to walk because that's part of being a nurse too, shall we assess that? Because it's just like what are you going to be assessing next, it's like I don't know I feel like they're just going backwards in time or something I don't know, we need to broaden the debate not just about compassion but about other things as well, understand the politics of healthcare is really important I think, let's look at that, understanding about the finances and that managerialism and that's a debate worth having let's be really critical about what you're going into if you can understand it and fight for it as opposed to let's worry about being compassionate I mean Jesus, is that really what it is? Three years on that? That just worries me a little bit that that's the kind of where we at (Lines 1494-1513)

Professional resistance against policy actors' construction of technical-scientific nurses as 'too posh to wash' is shown in the above extract with the assertion that it was '*ridiculous*' to assume nursing students lack compassion. Extract 54 draws on a political logic of professionalism, as a logic of difference to position HEI nurse education as an alternative, more effective solution to declining standards of care, through the construction of a politically astute graduate nurse identity that could empower the profession to be more critical about government health policy and more engaged in the politics of care as well as its delivery.

Patient involvement as a contested solution

In contrast to the clear dimensional split seen between participants with and without HEI experience positions along the nurse education continuum, Figure 20 shows there are no clear demarcations between the participant positions along the patient involvement continuum. The gathering of participants at the centre of the matrix suggests varying degrees of ambivalence about policy actors' claims that patient involvement in practice assessment will assist in the resolution of the technical-scientific nursing problem. The discourses of participants positioned within the true solution dimensions may be indicative of a sedimented acceptance of the Government's on-going neo-liberal consumerist discourse and rhetoric of a patient-centred NHS. This belief in patient-centred practices is evident within patient, student, mentor and lecturer discourses where the patient is positioned as the core learning resource in practice. A social logic of experientialisation is alluded to in the acknowledgement of the normalising effects patient assessment could have on students' affective behaviours. Patients were positioned as experiential reviewers of students' practice, however rather than being constituted as equal partners in the assessment process the patient role was constructed as providing feedback on

students' affective behaviours and the quality of care received rather than determining a pass or refer grade.

Rees *et al.* (2007) argues that despite government policy attempts to reconstitute patients as active involved-partners in healthcare and healthcare education, historically patient involvement has constituted a passive-dependent position with patients articulated as 'teaching material', especially within the clinical setting. Extracts 55 and 56 show that patient involvement can transform the patients' historic position from patients having no meaningful involvement other than as '*bodies to practice on almost'* to a position of reciprocal participant in student development and progression.

Extract 55
P6: I think basically erm I think it's a good thing to get the patients involved because after all it's them that's on the receiving end of what the nurses are erm doing [smiles] isn't it, so yes I think it's, it's a very good idea (Lines 922-924)

Extract 56
S1: I think they should be involved in that side of it less than the academic side erm because like I said before they're the ones receiving that care aren't they, they're the ones that we're like, using their bodies to practice almost. Yeah I suppose that is how I think of it, like that's, you know we're 'oh can you go and take that cannula out?' I'm effectively practising my skills of taking that cannula out on that person erm as well as treating them with all that, dignity and everything, you have to think like, they're our means of where we want to be, like I want to be a nurse so I need you to help me to be a nurse erm, so I think, I think the value, the, what they say would be really valuable to the mentors, erm (Lines 1597-1605)

Extract 56 refers to the social logic of experientialisation and the reciprocal exchange the patient assessor role creates between students and patients. There appeared to be a greater awareness and recognition of the subjectivity and agency of patients, as well as the need to demonstrate a patient-centred approach to care, as this student constituted patients as gatekeepers to professional registration. Mentor and lecturer

discourses also engaged with this logic where patient involvement provided mentors with feedback on the patients' lived experience as recipients of students' nursing care. Interestingly, extract 57 referred to the assessment of student attitudes and patients' emotive response to care, a reflection of the true discourse within the hegemonic normative frame, while extract 58 only referred to the physical experience of care delivery.

Extract 57
M2: I think patient evaluation is good as well, so we know what they think about the student er because the students are actually involving with the patient and the attitude of the student and er the care given, actually we can get from the patient, so that would be a good feedback to the student as well (Lines 749-752)

Extract 58
L1: there's definitely a place for it erm, it again it is about their experience, well we think may be that somebody has reached a level or has done something appropriately but we only know that if, one we're observing it and secondly if that person at the end of the day having it done, says that's it (Lines 717-720)

Rejection of the true solution discourse

As stated earlier several participants were discursively positioned within the False/True dimension (Quadrant C), although their positioning towards the matrix apex gives some indication of how the true/true normative frame has gained a partial grip of participants. The hegemonic normative frame presents patient assessment of students as a strategy to judge students' affective competence, something that is apparent within these participants' discourse. Few rejected the idea of patient involvement in practice assessment outright, however a discourse of capability was employed to raise questions over the legitimacy of patients as assessors and their ability to provide an objective assessment of students' professional and clinical

competence as well as providing feedback on students' affective practice. This is illustrated in the following extract:

Extract 59
P4: Again to be fair to the nurse if I had had sufficient contact with that nurse then probably yes but it would only be in general terms about their attitude, their caring skills and so on. But their actual ability as a professional nurse I think not (Lines 1287-1289)

Within this extract there appears to be initial agreement with policy actors' endorsement of a 'true discourse' that patients could provide feedback on students' affective skills, but cast doubt on patients' capabilities and understanding of professional nursing practice to judge students' overall competence. Extract 59 shows a direct contradiction to earlier examples where the quality of care was associated with the attitudes of staff rather than clinical competence. Patient involvement in quality monitoring has been a consistent trend within government health policy since the 1980s therefore it is perhaps unsurprising that a consumerist discourse underpins participants' narratives.

Patient participants in this study were and expected to be involved in patient satisfaction surveys readily assuming a patient-consumer identity. Patient involvement in nurse education on the other hand may be visible to mentors and lecturers via NMC standards, but it remained hidden for some patients. Even when discussing involvement in nurse education, patient participants' positioned themselves as healthcare consumers rather than consumers of nurse education. Patient participants associated the quality of care with staff attitudes and affective competence as this affects patients directly, however those without HEI experience appeared unaware of nurse education and student learning whilst in hospital other

than receiving care from nursing students. This may be due to the way different social actors' understanding of education is constructed.

It is likely that patients become socialised into associating education with school or university; classroom-based learning within designated educational institutions, whereas hospitals are generally associated with ill-health, diagnosis, treatment, patient care and health professionals. As few patients have had any direct exposure to HEI nurse education it is perhaps unsurprising that the patients in this study did not contest the true discourse that nursing students spend too much time in the classroom. For health professionals, their understanding of professional education is only reconstructed following their own experiences as pre-registration students; therefore students, mentors and lecturers constituted nurse education as a mix between theory and practice. For patients, the construct of practice education was more likely to be constituted through other mediums such as television, film or media, thus practice education might be perceived as a clinical tutor formally teaching a group of students at the bedside. This rarely occurs in nursing therefore patients may remain oblivious hence they might not assume a patient-educator or patient-assessor subject position.

Extracts 60 and 61 illustrate a degree of resistance against the hegemony of policy actors' true discourse through a discourse of capability. Both extracts present a hierarchy of power within the practice assessment process where the mentor is positioned as the knowledgeable, accountable assessor while the patient is positioned as an un-informed commentator. The following extracts suggest that despite mentors' and lecturers' apparent acceptance of patient involvement in principle, when it comes to assessing the competence of nursing students in practice some remained reluctant to share their assessment authority with patients. Here summative assessment was

constructed as a professional activity with mentors taking up the position of gatekeeper, which was constituted through a discourse of safety. Rather than patient involvement being seen as a beatific solution that would help produce an affective *and* clinical competent nurse, these extracts construct an horrific alternative, by constituting patient involvement as a threat to patient safety and a risk to the profession.

Extract 60
M3: the patient's not going to know whether or not they did the manual handling procedure right or whether or not their injection technique was correct or whether or not their suture removal was done in the, you know, in text book manner, they're not going to know that, they're not going to …'yes they did it lovely' they took them out, they were you know, they were jolly good at taking them out, but they cut them in all the wrong places and pulled you know, whatever all the way through you know, that sort of stuff, it's, I think it's just a very difficult area (Lines 1416-1422)

Extract 61
L6: I think patient views are important in nurse training and they should be used but I'm not sure summatively assessing a student, say pass or refer, they don't understand, like I said earlier the full understanding of what a nursing role is, I don't think they have that picture so how can they truly assess somebody (Lines 2008-2011)

Dimensional drift

So far, I have presented an analysis of participants' overall dimensional positions, but what was particularly interesting, and something that became increasingly apparent during my analysis of empirical data, was the degree of positional fluctuation that occurred throughout the interviews as participants accepted, resisted or contested different elements of the hegemonic normative frame. Consequently, an analysis of this dimensional drift offers an augmented analysis of participant discursive positions against the true/true hegemonic normative frame as it reveals the on-going tensions between the practical-caring vocation and technical-scientific profession meta-logics

of nursing and how those tensions reveal the contingency of patient involvement as a social practice.

For this second phase of dimensional analysis I returned to the empirical data to analyse the degree of positional drift in participants' discursive positions as each interview progressed. To maintain a consistent approach I followed the same analytical process as before, but this time my analysis focused on showing the discursive movement as participants moved away from or towards 'true' on the dual continuum (Figure 21). Thus, figure 21 provides an illustrative map of the positional drift for each group of actors as they contested those 'true' discourses. It makes visible the degrees of uncertainty surrounding the construction of technical-scientific nurse education as the antagonistic other and the presentation of patient involvement as a beatific solution. In the final part of the chapter I will examine that drift as the interviews moved from discussing their views on patient involvement within HEI nurse education to involving patients in the summative assessment of students' practice.

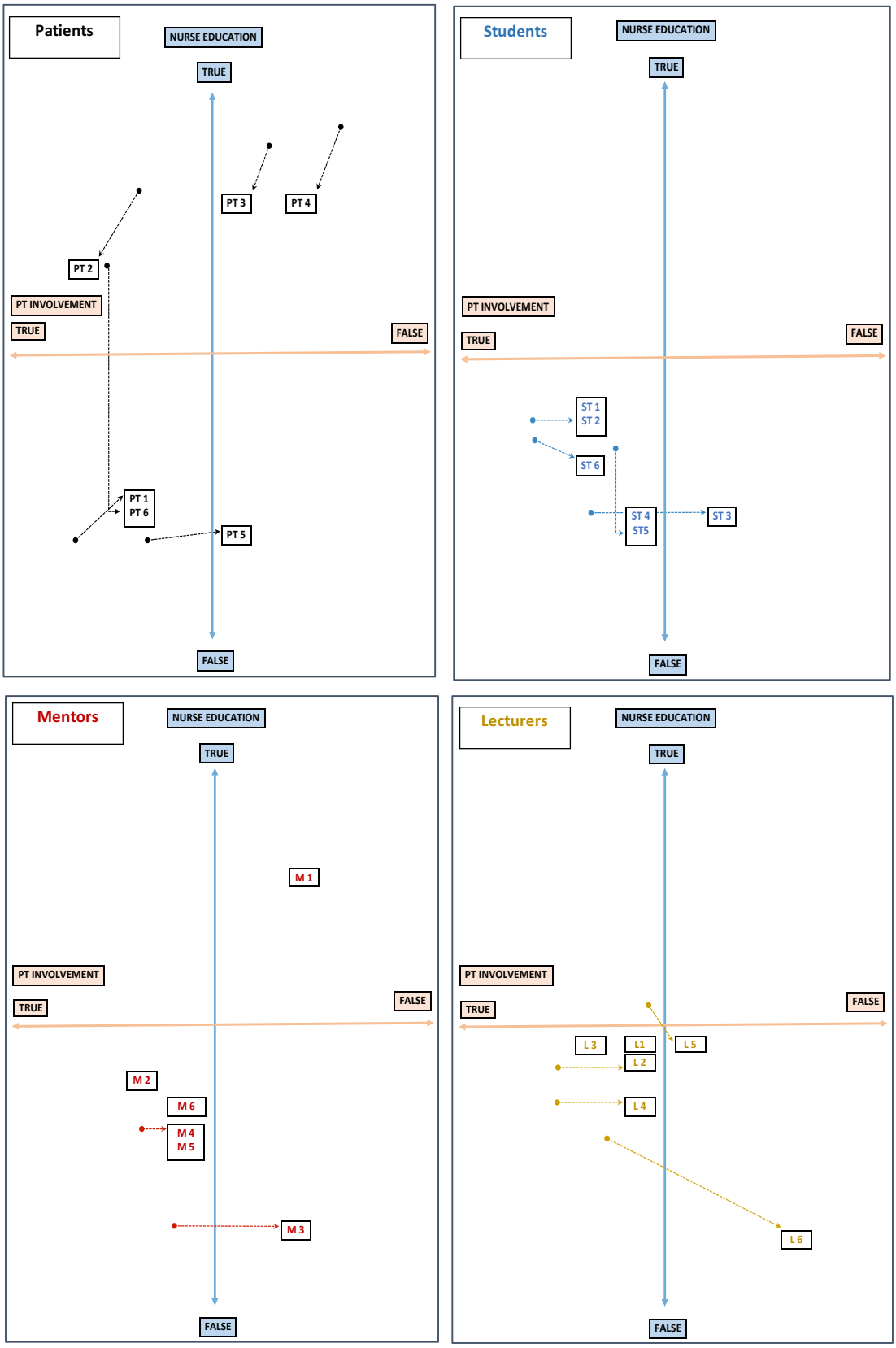


Figure 21: Participant dimensional drift

Patients

Figure 21 shows an oppositional drift pattern between the discourses of patients with HEI experience and those without. During the research interviews the discourses of patients who had had no formal engagement with nurse education showed a marginal drift in relation to reflecting policy actors' problematisation of nurse education and a strengthening belief in the value of patient involvement in reminding students that patients had moved from being passive dependents to involved partners. Extract 62 perhaps exposes the power that discourse coalitions can generate as their collective storylines create significant socio-political resonance with the public causing them to increasingly believe policy actors' truth claims.

Extract 62	Positional movement: Patient Involvement
Patient 2	*Involvement in Nurse Education*
	Well obviously I think nurses should practice on patients if you see what I mean, should look after patients as part of their training erm. Yes I mean I think it would be good if, if, if perhaps er you know maybe if nurses ...if patients or nurses that weren't as you were saying earlier were independent and were asked if they would talk to a student about their experiences but knowing that the experiences wouldn't go back to erm the nurses themselves because I think they would need to feel that. Yes I think that would probably be very useful (Lines 1312-1318)
	Involvement in Practice Assessment
	it's human nature to want to do what your boss tells you and get good marks for it but in some ways the patients are more important. So I suppose if you're being assessed by the patients as well you do realise that, that what might seem like the important thing which is impressing your superiors is not as important as making people comfortable (Lines 1845-1848)

In terms of patient involvement, Extract 62 demonstrates a different deployment of the political logic of consumerism. Initially the patient is positioned as

a learning resource, an object for students to practice on, where such objectification renders the patient invisible during student-centric activities. This may be indicative of institutional and professional hierarchies where patients offer 'the body they *have* rather than the body they *are*' and are situated almost outside the learning experience (Elsey *et al.*, 2016:142). The influence of hierarchical power relations within the mentor/student relationship is revealed as the discursive position of Patient 2 along the patient involvement continuum, suggests a gathering acceptance of the normative beatific solution discourse. A consumerist discourse constitutes the mentor's hierarchical power over the student as a potential obstacle to patients' enjoyment of patient-centred nursing care. There is a belief that patient involvement, as a beatific solution, could help rebalance the power relations between patients, students and mentors. Students' focus on assessment is constituted as '*human nature'* yet patient involvement is drawn from a social logic of experientialisation, redefining patients as patient-assessors that show substantial movement in the balance of power towards the patient. The student now becomes increasingly dependent on the patient to pass practice and that shift in patient position and power has the potential to reinforce the patients' involved partner position in practice. Interestingly the position of patients with HEI experience moved in the opposite direction during their interviews and, as shown in Extract 63, there appeared to be a partial acceptance that patient involvement in HEI nurse education could help to ensure that pre-registration nurse education would produce students that better appreciated the patient perspective.

Extract 63	Dimensional drift: False True → False/False
Patient 5	*Patient Involvement in Nurse Education*
	I think it would be really helpful for them to be involved in the actual training sessions within the classroom. I think there could be something really helpful there in terms of offering a patient perspective... (Lines 880-882)
	Patient Involvement in Practice Assessment
	I think that might really put the willies up some patients and they'd think, they'd be quite worried about that, they'd be quite anxious because actually they don't know what the standards are, they don't know what's good and not good practice, it's a very personal thing (Lines 1022-1026)

The contestation surrounding the patient involvement solution appears in this extract to centre on the patient's contextual subject position. Extract 63 is very much couched in political rhetoric with patient involvement situated within the HEI setting, where the patient position was one of an experiential educator, teaching students about the '*patient perspective'*. Hence in the classroom, patient involvement was constructed more as learning *from* rather than learning *to do to* (Hughes, 2017). The patient-educator identity was constructed as an expert-by-experience whose input assists students linking theory to practice. This finding is similar to those of Scammell *et al.* (2016) who concluded the power of patient involvement within the classroom was associated with students learning from authentic, realistic accounts of care, a view corroborated by Hughes (2017). Within an HEI context, the learning environment is predominantly either a classroom or lecture theatre, hence we become socialised into expecting some form of didactic teaching, here students are positioned as learners rather than nurses or care givers. Therefore, the balance of power within the patient-student relationship moves towards the patient-educator.

Patient involvement in nurse education has been constituted as the bridge between theory and practice, with the patient positioned as a visible co-participant in learning whether that is in the classroom or during bedside interactions. Yet as extract 63 moved beyond the political rhetoric, the narrative became far more contingent as the patient drew on a protectionist logic to question the role of patients in summative practice assessment. Predominantly, the primary focus of patients in hospital is on their physical recovery rather than on the education of nursing students and although patients may have been informed that students might deliver their care, many are unable to distinguish students from the rest of the nursing staff (Health Select Committee, 2013). In practice nursing students become part of the nursing establishment and consequently their position as 'nurse' becomes foregrounded, while their role as learner often becomes hidden, as they get absorbed into the delivery of care.

Patients face a similar dilemma, patients in hospital are socialised to adopt a patient identity that promotes them to take either an active or passive role in their care, determined by the nature of their admission, the complexity and seriousness of their health issues, and the approach of healthcare staff (Tabiano *et al.,* 2016). Renedo *et al.* (2015) suggest that the social practice of 'acting' as patients is often juxtaposed to the idea of partnership working, something patients are just not used to. Despite participants repeating the rhetoric surrounding patient involvement in HEI nurse education, Extract 63 suggests the patient's resistance against the hegemonic normative frame centred upon a contested patient-assessor identity directly conflicts with the sedimented patient identity and the historical patient-nurse power relations, creating a sense of increased patient vulnerability.

Students

The dimensional drift of students' discourses was less pronounced than that of patients and lecturers. Initially these discourses were positioned between the centre and apex of the False/True dimension, and this suggests a rejection of the True/True hegemonic normative frame. For some, the contestation surrounding the professionalisation and academicisation of nursing was constituted as a threat to nurse recruitment, rather than a threat to compassionate care. Furthermore, professionalism, as a political logic of difference, characterised students' rejection of policy actors' claims that technical-scientific nurse education was responsible for declining standards of patient care. Figure 21 highlights the degree of dimensional drift as students constituted patient involvement in HEI nurse education as an abstract concept, whilst patient involvement in practice assessment brought that concept to life and made it personal. As with previous extracts, Extract 64 shows how consumerism as a political logic of equivalence was used to redefine the patient-health professional relationship as one of customer-provider. This narrative implies that political consumer rhetoric has become sedimented within students' construction of professional practice. Within this extract, patients are positioned not only as consumers of care, but also as consumer-educators whose role is characterised as an important addition to ensuring the future nursing workforce recognises the essentiality of patient-centred care. However, when the interview moved to involvement in the summative assessment of students' practice, patient involvement was no longer constituted as an external service focused initiative, now patients were seen to directly affect student progression.

Extract 64	Dimensional drift: False/True → False/False
Student 3	*Patient Involvement in Nurse Education*
	I think it's good that the service users, the patients or families have an input into it because they're the people who, who will be your customers so to speak at the end of the day, and they know what they want and if that's overlooked for targets that someone else has decided are important then you're not meeting their needs. (Lines 422-431)
	Patient Involvement in Practice Assessment
	Well they're already involved in the informal assessment of your practice, which they tell you directly in terms of your personal development, and they're involved in being the people who report to the media, the NMC, the people who get the policies changed by the government, so they're involved in that way. Erm would the additional level of having them sign people off summatively as nurses change the standard of care? In any specific way? That they end up receiving from nurses when they qualify? I don't really think so (smiles) but who knows (smiles) (Lines 734-740)

The extract above shows that the patient subject position and educational power relations had fundamentally changed when patients were no longer positioned as educational resources. The NMC changes reiterated the importance of the patient-consumer not only in terms of monitoring the quality of health services but also position the patient as direct consumers of, and key stakeholders in pre-registration nurse education. Within Extract 64 the change from an historical passive-dependent patient position to involved-partner was constituted as a threat and appeared to directly contradict the student's original stance where the patient was placed as centrally important in care delivery and evaluation. Subsequently, a political logic of professionalism is drawn upon to contest the 'truth' of the hegemonic normative frame (Quadrant A) and question the value of patient involvement in the summative assessment of students' practice within the hospital setting. The patient is positioned as an informal experiential reviewer of students' practice, which the student

articulates as non-threatening and positive; yet the formalised patient-assessor position is rejected by the assertion that patients already have access to other more peripheral, formal evaluative mechanisms, such as the media and NMC and that these are enough to instigate change. This could suggest some resistance against consumerism at a micro level that threatens to shift the balance of power within the student-patient relationship. Yet it also suggests a degree of reticence over how much influence patient-assessors would have over mentors where health professionals remain in a dominant position within organisational cultures and institutional hierarchies of power.

Mentors

The least dimensional drift of all the participant groups' discourses was seen with mentors. Extract 65 provides an example where the patient is constituted as '*the expert patient*' in relation to their specific health condition, rather than their expertise as a recipient of health services. The expert patient role is discursively constituted as a useful addition to students' classroom-based learning where their educational contribution could be characterised as helping to bridge the theory-practice gap, by supporting students' contextualisation of 'textbook' theory. Nevertheless, patient involvement is constructed as occurring within the educational setting and does not appear to be associate the role of the expert patient with student learning in practice. The patient is objectified through a medical discourse where their involvement is reduced to describing '*signs and symptoms'* of their '*ailment*' and '*condition*' so that students better understand disease processes and the impact of disease on daily function.

Extract 65	Dimensional drift: False/True → False/False
Mentor 3	*Patient Involvement in Nurse Education*
	I think there is a, there is a time and a place for the expert patient, I think you know, clinically they know their stuff, they've been dealing with something for a lot of years and they are probably you know, the person to describe the signs and symptoms of a certain condition, a certain you know, ailment as it were, and you know you can read, you can read the text book, condition, symptoms and whatnot but actually if someone tells you how crippling the pain of arthritis is and how it affects them on a day to day basis you'll probably have more understanding about it (Lines 1068-1074)
	Patient Involvement in Practice Assessment
	I think it's a very, it's going to be very judgemental, even more judgemental, I don't think it's going to be a sound base, I think it will be literally face value, 'have you been nice to me, yes tick', have you not been nice to me, were you friendly to me, yes' you know, it's, it's going to be very … very short and sharp, they don't see them for long periods of time, patients you know can come and go within a 24 hour periods is that enough time to, to know whether a nurse is competent? (Lines 1304-1310)

Within the context of an acute hospital many institutional practices remain profession-centred despite the political rhetoric promising a consumer-led NHS. There is an acknowledgement in mentor and student discourses of the value of patient involvement in terms of teaching and learning, yet there appears to be an emerging theory-practice gap where students and mentors query the value of their contributions within practice assessment. For students, patient involvement in practice assessment was construed as a potential threat to their educational progression and to their hierarchical position in practice. Similarly, extract 65 evidences a social logic of protectionism as the mentor increasingly contests the True/True normative frame, by questioning the validity and reliability of patient-assessor feedback and suggesting that patients' assessment of students' practice would be substantially more subjective than mentors who have been professionally prepared for the assessor role.

Lecturers

Out of all the participant groups the dimensional positioning of lecturers suggests a level of professional uncertainty and defensiveness, but also a possible reluctance to be seen to be against the principles of patient involvement and a consumer-led health service. Government consumerist health policy has had a direct influence on HEI nurse education and nurse lecturers since 1996 when the ENB adopted a consumer-led ideology in nurse education policy (ENB, 1996). For over twenty years, nurse lecturers have not only been required to evidence the involvement of patients in the development, delivery and evaluation of pre-registration educational programmes, but have had to deliver a patient-centred curriculum drawn from consumerist government policy whose demands for change have steered NMC pre-registration nursing education standards (NMC, 2004; 2010b).

Extracts 66 and 67 highlight the impact of the socio-political resonance created from the diverse storylines presented by political and policy actors and the significant fallout following the government's summation of the Francis report, which have been used to perpetuate the horrific fantasy that technical-scientific nurses lack care and compassion. The positioning of these two discourses against the dual continuum dimensional matrix both drifted across into the False/False dimension, yet the dimensional drift highlighted in extract 66 was relatively small suggesting an on-going acceptance of policy actors' hegemonic discourse. Nevertheless, despite both extracts attaching significant value to patient involvement within curriculum development and nurse education generally, a social logic of protectionism is evidenced as the appropriateness of patients' formal involvement within the summative assessment process was contested.

Extract 66	Dimensional drift: True/True → False/False
Lecturer 5	*Involvement in Nurse Education*
	I think they would be really good to advise erm what they would like to see student nurses doing erm, maybe the approach that students nurses can have (Lines 805-806)
	Involvement in Practice Assessment
	I find that a little bit challenging, I wouldn't say I disagree, I wouldn't say I agree either. Erm I'd have to see the, I suppose I'd have to have an understanding of what it was they're actually assessing and when they're assessing and what type of patients. Erm if a mentor, for example, was going to go up to a patient who the student had known for quite a few weeks erm and they were at a reasonable standard, and again how can you measure that? erm of their recovery for example, and asked them about, was the student caring and compassionate to you? or whilst they were looking after you did they wash you well? or something and ask specific questions then that could be quite a positive experience if they're getting some positive erm, but I'm not sure summative is necessarily, because do patients understand what assessment is? What the rationale for it is? what the implications for that student are if they say well actually she was awful, even though they were just perhaps in a bad mood that day, that can actually have such significance impact on that student, whereas I think formative yes, I would definitely say I think it has its place with boundaries or a framework around it, but summative I think erm, would provide lots of challenges (Lines 942-956) I think it's come from places like the Francis report, erm and the sort of care and compassion that nurses are not showing supposedly in their work environments, and all the CQC reports that erm, government documents really, government papers I think there's a real government drive for patients to be involved more. Erm which I agree, I totally agree but I don't know it's necessarily appropriate within the summative assessment of students (Lines 1090-1095)

Extract 67	Dimensional drift: False/True → False/False
Lecturer 6	*Patient Involvement in Nurse Education*
	I think they are already because obviously the students go out and nurse them so they are involved in that respect and they can say what they want to the students in essence, but if you mean by do you think we should formalise service user involvement erm as in service user groups and

	(laughs) and service users coming into classrooms to teach students, that's so false (Lines 1651-1655)
	Patient Involvement in Practice Assessment
	I think patient views are important in nurse training and they should be used but I'm not sure summatively assessing a student say pass or refer they don't understand like I said earlier the full understanding of what a nursing role is, I don't think they have that picture so how can they truly assess somebody (Lines 2003-2011)

Consequently the beatific fantasy of patient involvement was contested, but extract 67 indicates a much stronger contestation of political and policy actors' true discourse. Patient involvement is constituted as an intrinsic part of nursing care delivery, which renders it almost invisible to students, mentors and patients resulting in them not recognising this type of patient interaction as professionalised or therapy involvement.

Patients' subject positioning as uninformed assessors is reflective of the views of mental health lecturers in a study by Felton and Stickley (2004b: 94). Lecturers' resistance to involving patients in practice assessment was characterised through a political logic of professionalism that reinforced professionals' dominance and hierarchical position where patients were positioned as outsiders of professional academic practices as people who 'don't speak our language'. This is not just confined to nursing, Chambers and Hickey (2012), in a Health Care Professions Council-commissioned study, explored service user involvement across all allied health professional pre-registration programmes in the UK and found lecturers cited service users' lack of technical and professional expertise to marginalise their involvement in practice assessment. Despite government and NMC attempts to position patients as essential contributors to student learning and competency

development, it appears that political rhetoric has been absorbed into academic discourse within HEI faculties. But the level and type of patient involvement at ward/placement level continues to be dominated by profession-centric behaviours; in contrast to the value placed on the experiential expertise of the patient-teacher, this does not appear to translate across to assessment. There is no expectation for patient-teachers to have the same level of knowledge and professional knowhow as mentors or lecturers; yet extracts 66 and 67 suggest that in terms of assessing students in practice this becomes a pre-requisite in order for patient assessors' feedback to be seen as comparable to feedback received from mentors. The assumption that patients need to have the same levels of academic and professional expertise as the mentor reveals the continuation of unequal power relations between those with traditional assessor responsibilities and unprepared, non-professional patients.

Conclusion

This final findings chapter considered the extent to which the true problem / true solution hegemonic normative frame had been accepted, contested or resisted by the patients, students, mentors and lecturers in this study. In this chapter I have provided an explanation of how and why the true problem /true solution hegemonic frame as an empty signifier failed to gain credibility with study participants in terms of representing 'the embodiment of fullness' (Laclau, 1990:66). My analysis has illustrated the ways in which the hegemony of policy actors true/true normative frame was contested, and revealed significant positional differences between participants who had no previous exposure to HEI nurse education compared to HEI experienced participants. My analysis supports Madden and Speed's (2017) assertion that patient involvement is an empty signifier, it also suggests that the true /true hegemonic normative frame lost credibility as the notion of technical-scientific nurse education

being responsible for poor care and the potential impact of patient involvement on practice assessment remains contingent.

PART FOUR: CONCLUSION AND IMPLICATIONS

Chapter 8: Drawing conclusions

Introduction

This final chapter draws together the findings presented in chapters 5,6 and 7. The chapter focuses on three key findings; first, the lack of resolution in the vocation-profession split, second, the effects of situational context and third, how boundary protectionism promotes tokenistic involvement. Following on from this the chapter considers the parallels and differences between nursing and other health and social care professions, and the implications for patient involvement in practice assessment within nurse education, before reflecting on the use of LCE in nursing research. Finally, I outline the limitations of the study, highlight areas for future research and reflect on my personal development as a researcher.

New perspectives

The aim of this research was to critically explore the contributions and interactions associated with patients and their involvement in the summative assessment of pre-registration adult nursing students during hospital placements. As discussed in Chapter 1, to date studies have predominantly focused on patients, students, mentors or lecturers perceptions or experiences of involving patients in practice assessment, but few considered the patterns of relations between those key players, the patient subject positions or the influence that different actors' constructions of the patient and nurse identity may have had on patient involvement or the assessment process itself. By employing Glynos and Howarth's logics approach (2007) this thesis has offered a new perspective and a critical explanation of how and why patient involvement in practice assessment emerged as a social practice, the politics that surrounded this

emergence and the ideologies that attempted to sustain and maintain it. In that sense the adoption of a political science discursive approach allowed for an in-depth exploration of patient involvement as an emerging social *and* political practice. The main focus of the thesis was the struggle between competing discourses that constituted technical-scientific nursing as a problem and patient involvement in practice assessment as a solution. The strengths of a logics approach are that it enabled me to look past actors' self-interpretations of patient involvement to examine the discursive constitution of patient involvement as a practice to analyse the rules that lie beneath it. Unlike other methodologies LCE involved the analysis of the politics surrounding patient involvement, therefore this research offers new insight as it explored the political processes, including actors' use of storylines and the formation of discourse coalitions that illustrated the ways in which nursing and nurse education had been contested and patient involvement in assessment instituted.

At the start of my PhD I knew I wanted to explore the NMC's introduction of patient involvement in the summative assessment of nursing students' practice during practice placements. As a lecturer I realised that patient involvement had become a sedimented practice within the NHS and HEIs at an institutional level with the establishment of service user networks and forums; however the formal involvement of patients within practice-based nurse education appeared to be a new and emerging practice in response to care scandals in the NHS and the ensuing political and media demands for qualifying nurses to be more caring and compassionate. In writing this thesis I had to be aware of my own potential bias as a HEI lecturer, however I was not attempting to offer an objective study to determine the rights or wrongs of patient involvement. Instead I was intrigued to find out why the NMC had introduced patient involvement at that particular moment and whether patients had demanded formal

involvement in the practice assessment process. I also wanted to explore how patient involvement in practice assessment was characterised as a social practice by those most immediately involved. Therefore this thesis was not simply an evaluation of NMC policy; instead it has sought to explain the emergence of patient involvement in practice assessment as a social practice within a regime of nursing.

Lack of resolution in the vocation-profession split

In conducting this research it became evident that patient involvement in practice assessment emerged at a time when there had been considerable debate over nursing's move to graduate level entry status sustained by a recurrent fantasmatic narrative that constituted nursing students and newly qualified nurses as 'too posh to wash, too clever to care'. Throughout this thesis I have shown that the tensions between nursing as a practical-caring vocation and nursing as a technical-scientific profession that underpinned the introduction of patient involvement in practice assessment in 2010 were not new to nursing. Rather, various problematisations of nursing have shown that attempts to separate nursing into a practical-caring vocation or a technical-scientific profession have been recurrent tropes since the birth of contemporary models of nursing in the mid 1800s. In Chapter 3 I drew from Foucault's concept of problematisation (1997) to produce a genealogy of nursing and nurse education that illustrated how different actors employed discourses of gender, care, compassion and vocation to constitute nursing as a feminised, practical, caring, vocational and subordinated occupation to locate nursing as a social and political practice, and in their resistance against the professionalisation and academicisation of nursing. I subsequently demonstrated in chapter 6 how various actors recurrently 'entered into a play of true and false' (Foucault, 1988: 257) in their attempts to constitute technical-scientific nurse education as a problem. I have also shown how

these problematisations influenced actors' demands for educational change, where patient involvement in practice assessment was advocated as one of a number of solutions to 'fix' the nursing problem.

My examination of the social logics in chapter 5 showed participants drew from a logic of experientialisation to characterise patient involvement in practice assessment as a strategy to enhance the assessment of nursing students' affective behaviours and instil vocational values. The grip of the fantasmatic logic of nursing as a practical-caring vocation was evident as the majority of patients constituted nursing and care through a female gendered discourse. Consequently, participant discourses reflected three of Tronto's (1993) phases of care where patients, students, mentors and lecturers drew on a logic of experientialisation to constitute the patient-assessor role as making judgements on students' vocation attributes i.e. Phase 1 − levels of attentiveness (caring about), Phase 2 − willingness (taking care of) and Phase 4 − responsiveness (care receiving). The third phase of care - care giving (assessing competence in the skills required to provide quality care) was constituted as a role for the professional mentor assessor. Thus, the tensions between vocation and professionisation appeared to translate across into practice assessment drawing a line of difference between the roles of the patient constituted as a subjective, experiential assessor of students' vocational intent and affective competence, and the mentor constituted as an objective, professional assessor of technical competence.

This thesis has shown that nurse education and patient involvement as political practices are dominated by political logics of vocationalism and consumerism. These political logics linked equivalential storylines into a universal demand for nurse education to concentrate more on teaching vocational values and practical skills than academic-scientific knowledge. I have shown that while actors'

storylines may have differed, the political effect of the socio-political resonance generated from their discourse coalitions drew an antagonistic frontier between a sedimented norm of nursing as a practical-caring, vocation and nursing as a technical-scientific profession. In chapter 6 I demonstrated how this boundary between vocation and profession resulted in political and policy actors presenting a new hegemonic normative frame that constituted technical-scientific HEI-based nurse education as the 'true' problem and patient involvement in practice assessment as a 'true' solution. The irresolution of the vocation – profession debate was evident in Chapter 7 as my analysis of participants' discursive positioning against the hegemonic normative frame suggested the true problem/true solution normative frame had failed to grip the majority of those most involved in the practice assessment process. Only those participants who had had limited or no HEI nurse education experience appeared to accept the normative frame's construction of nursing as overly academic. In comparison, although professional participants seemed unable or unwilling to contest the forceful grip of the fantasmatic logic of practical-caring vocation, they did attempt to reduce its power by employing a compatiblistic logic to reconstitute nursing as a profession that combined of vocation with technical ability and scientific knowledge.

The effect of situational context

While previous studies recognised patient-assessors increased vulnerability during acute hospital admissions (Haycock-Stuart, *et al.,* 2016; McMahon-Parkes *et al.,* 2016; Haycock-Stuart, *et al.,* 2014*;* Duygulu and Abaan, 2013; Dearnley, *et al.,* 2011), none considered the discursive constitution of the patient or the patients' subject position within the practice assessment process. I have shown that while governments have employed a health-consumer discourse to constitute patient

involvement as an amalgamation of consumer choice and citizen voice, nurse education policies tended to be predicated on the adoption of a public citizenship involvement model at an institutional level rather than at a practice level. This is not unique to nursing and can be seen in other pre-registration education policies across health and social care professionals (Askheim *et al.,* 2016; Regan de Bere and Nunn, 2016).

Patient involvement in health professional education is a regulatory required practice, yet while models for patient involvement within HEIs have been developed (for example Tew *et al.,* 2004) these citizenship / public engagement models are not easily transferable into the healthcare setting. According to Tew *et al*. (2004) and Beresford, (2013) meaningful patient involvement should be based upon the establishment of a positive institutional culture that considers patient feedback as equal to that of professionals and academics, including a clear strategy for recruitment, support and training, and remuneration for patients' time and input. But while this is considered best practice for institutional involvement, there has been little attention given to developing a specific model for patient involvement in the education of pre-registration health and social care students within practice.

While the hegemony of patient involvement at an HEI level appeared to be accepted by participants, the application of consumerist ideology in nurse education is more complex because of the range of contexts that nurse education is situated, for example, HEIs, acute hospitals, community, primary care, the independent and voluntary sectors. Chapter 4 illustrated that despite health policy consumer rhetoric constituting the patient as an involved partner, the systematisation of NHS practices, especially in acute hospitals, has favoured the continuation of paternalistic task-orientated or process driven approach to patient care. If, as Griscti, *et al.* (2017)

suggests nurses feel threatened by patient consumerism in terms of shared decision-making about patient care, patient involvement in practice assessment could present an additional threat to nurses' authority to determine the professional suitability and competence of nursing students.

As I have illustrated in chapters 5 and 7, participants employed a citizen-consumer discourse to constitute patient involvement in HEI-based nurse education as a social right. This thesis has shown patients constituted as experiential educators and vocational assessors whose expertise-by-experience was seen as important in enhancing students' affective competence and vocational values, yet interestingly the majority of participants talked from an abstract rather than personal perspective. In chapter 3, I have shown that even though government and NMC policies positioned the patient as consumers of health professional education, in terms of involvement in practice-based nurse education within the hospital the patient's position changed and patients were constituted as uninformed, associate-consumers. In hospital, the situational effects of the ward environment, paternalistic institutional practices and sedimented professional and patient identities appeared more likely to cause individuals to adopt a passive-dependent position at least during acute phases of illness. While patients may 'consume' care delivered by nursing students, this research has suggested that patients are more likely to assume an acquiescent position until they are directly approached to provide feedback on student performance and vocational attributes.

Boundary protectionism risking tokenistic involvement

This thesis also demonstrated that as interview questions moved away from discussing patient involvement in nurse education to patient involvement in practice assessment participants' responses became personal reflections rather than abstract

considerations. This was note-worthy, and links back to the situational context discussed above where HEI-based involvement tended to be predicated on a public or consumer-citizen model, whereas practice-based involvement promoted individualised associate-consumer engagement. The majority of patient and mentor participants reported experiencing little or no direct involvement in pre-registration nurse education within the HEI (other than some mentors completing HEI-based nurse training and attending annual mentor updates), therefore their primary involvement with HEI nurse education was as an individual patient receiving care from nursing students in the hospital. As a consequence, patient narratives became personal reflections on that care; students reflected on their interactions with patients and mentors focused on their experiences of student assessment.

Students, mentors and lecturers drew from a social logic of protectionism to place greater emphasis on mentors' professional assessment of students' technical-scientific competence rather than patients' assessment of students' vocational values and affective behaviours. There was evidence of conflict between the constructions of the patient-assessor, as an experiential expert best placed to assess students' attitudes and professional demeanour, and the mentor as the professional assessor accountable for the assessment of students against pre-determined NMC competencies. I have illustrated throughout this thesis that the patient-assessor position was marked by on-going tensions between the discourses of nursing as a practical-caring vocation and a technical-scientific profession. Students, mentors and lecturers seemed to engage in boundary setting practices that attempted to maintain sedimented institutional hierarchies of power and legitimise the mentors' position of authority over the assessment process and outcome. Consequently, professional participants tended to adopt a technical-scientific nursing discourse to constitute patient involvement in

practice assessment as a threat to mentors' autonomy and professional authority to act as gatekeepers to professional registration. Interestingly, patient participant discourses also reflected institutional hierarchies as patients positioned themselves as subordinate to mentors professional expertise.

In chapters 5 and 7 participants' discourses evidenced the subordination of the patient-assessor to patient-reviewer that could account for participants advocating a tokenistic, consultative participation approach to patient involvement. Prieto-Martin (2014) argues that such an approach is often employed by decision makers who see themselves as guarantors of the interests and rights of minority groups. In this study it seemed that while participants believed the nurse's role was to protect the rights of patients to be involved in practice assessment, in practice both students and patients were constituted as the minority group, therefore the mentor's role was constructed as one of a professional guardian to both.

While NMC educational standards advocate a collaborative approach to involving patients in practice assessment (NMC, 2010b; 2011), this requires mentors to engage in what Prieto-Martin (2014) describes as 'honest co-operation' where patients feedback has equal value to that of the mentor, although the final decision would still rest with the mentor. The findings outlined in this thesis suggest a lack of transparency in patient involvement and mentors' decision-making processes that could be indicative of the mentors' authoritative subject positioning. Consequently, participant narratives did not make reference to the need to prepare patients for their assessor role or provide them with information such as the competencies or criteria the students were being assessed against. Hence this lack of information could result in patients adopting a generalist assessor position where they might only able to provide generalised feedback on students' behaviour, rather than a specific

assessment of students' affective competence. Therefore, while mentors might seek patient feedback during practice assessment, this research has suggested that mentors were more likely to adopt a tokenistic '*first you give me your opinion and I will decide afterwards'* approach (Prieto-Martin, 2014:6, original italics). And as a result, this research infers that the degrees to which patients influence the assessment process and mentors' final assessment decision remained dependent on the will of the mentor.

Patient involvement in the assessment of adult nursing students practice since 2013

This thesis has provided valuable insight into the play of politics and fantasy that surrounded the reintroduction of patient involvement as an assessment practice within the field of adult nursing at one UK University in 2013. While this offers a comprehensive critical explanation of patient involvement as an emerging assessment practice, it is important to consider the degree to which this practice has evolved over the last five years.

As already highlighted within the thesis there remains a paucity of published papers exploring patient involvement in adult nursing students' practice assessment, as noted in literature reviews by Scammell *et al.,* (2016) and Suikkala *et al.* (2018). Despite the NMC mandating patient involvement in summative practice assessments in 2010, Suikkala *et al.* (2018) contend that the inherent power imbalances between patients, mentors and students has limited patients' active participation within practice-based nurse education, including the assessment of students' practice. They argue that contemporary patient involvement practices, as illustrated in Chapters 1, 3, 5 and 7 of this thesis, still constitute patients as informal reviewers of students' practice due to their situational, predominantly passive subject position within the

acute care environment. Yet despite Suikkala *et al.* highlighting HEIs perpetual under-utilisation of patients' experiential expertise in practice-based nurse education, rather than calling for nursing facilities to develop more robust and effective practice assessment tools that could reconstitute patients as collaborative, experiential partners in the practice assessment process, they continue to question the desirability and feasibility of active patient involvement in practice-based nurse education.

In 2016 Haycock-Stuart *et al.* undertook an interpretative, multicentre qualitative study to examine lecturers and pre-registration nursing students perspectives of service user and carer involvement in summative practice assessments. This study revealed that while lecturers and students expressed commitment to involving service users in recruitment, curriculum development, research and the development of students' skills in practice, participants sought to maintain professional control over practice assessment by dismissing patient involvement by constituting of patients as incognisant as well as physically and psychologically vulnerable. Similarly, in an exploratory study evaluating the use of a patient assessment feedback tool in adult nursing, McMahon-Parkes *et al.* (2016) found that while patients asserted that their experiential expertise meant they were able to assess students' competence in terms of care delivery, a sedimented passive patient identity resulted in mentors positioning themselves as maternal guardians and professional gatekeepers in order to maintain their hierarchical position and control over the practice assessment process.

An online search for contemporary HEI practice assessment tools found a preference for formative patient involvement and found a notable variation in approaches across UK HEIs (Appendix 13). Involvement ranged from the simplest; where mentors sign to verify that patient feedback helped to inform their assessment

decision, to open text boxes where patients' comments formed the basis of a mentor-student reflective discussion and more structured approaches such as likert scale questionnaires. The wide variation in levels of active patient involvement across these HEIs, coupled with the lack of validiated and reliable patient practice assessment tools, suggests that professional contestation and resistance against the hegemony of patient involvement in the assessment of students' practice within the clinical setting continues.

Parallels and differences between nursing and other health and social care professions

The effect of situational context and boundary protectionism on patients' ability or willingness to actively engage in student assessments within the clinical setting has been observed in a number of other pre-registration health and social care professions. Askheim *et al.* (2016) explored service user involvement in practice assessments within social work education and posit that while contextual gaps will always exist between policy, service, HEI, educators and service users, a co-production approach could reconstitute practice as an active and equal partnership between service user and professional. Similarly, others contend that such gaps are not insurmountable (Edwards, 2002; Bailey, 2005), yet the patients' position within practice-based assessment is made more complex by the continuing lack of evidence that patient involvement in the assessment of students' practice results in measureable behavioural change (Haycock-Stuart *et al.,* 2106).

The ambiguity of the 2010 NMC educational policy could account for why some nursing academics advocate formative rather than summative involvement (Stickley *et al.,* 2010, 2011*;* Haycock-Stuart *et al.,* 2016), an approach that has been favoured within social work (Bailey, 2005); occupational therapy (Cleminson and

Moseby, 2013) radiography (Naylor *et al.,* 2015), radiotherapy (Bridge *et al.,* 2016), as well as medicine (Braend *et al.,* 2010; Muir and Laxton, 2012; Engerer *et al.,* 2016). Formative involvement may be considered less daunting for patients and students, but while this can provide a global perception of care as experienced by patients, it could result in nursing, health and social care faculties shying away from developing reliable practice assessment strategies that promote the same level of patient involvement as seen in HEI-based practice assessments. Consequently, rather than addressing the positional issues outlined in this thesis, formative involvement may help to maintain the subordination of patients by sustaining rather than closing the situational and contextual divides.

That is not to suggest that the subordination of patients within practice-based assessments is unique to nursing. Indeed other health and social care professions' preference for trained actors, volunteers or members of HEI patient and service user groups to act as simulated or standardised patients in HEI-based OSCE assessments illustrates a continuing professional paternalistic discourse that constitutes such profession-led approaches as necessary to address the inconsistencies of real patient encounters, professionals' ethical and safety concerns including the reliability and validity of patient assessments within the clinical setting (Wilkinson and Fountaine, 2002; Bokken, *et al.,* 2009; Dearnley, *et al.,* 2011; Bridge *et al.,* 2014; Naylor *et al.,* 2015; Regan de Bere and Nunn, 2016). As a consequence, practice assessment remains situated within the sphere of professional practice, and as a result patient involvement strategies continue to objectify patients by positioning them as passive learning resources, which has not been helped by what Regan de Bere and Nunn (2016) describe as the 'ontological muddling' that continues to surround professionals' and educationalists' constructions of the patient identity and their role

in pre-registration education. Others contend that this type of professional boundary protectionism is a challenge across all health and social care professions (Dearnley *et al.,* 2011; Thomson and Hilton, 2013; Pal *et al.,* 2014*;* Askheim *et al.,* 2016).

In contrast to a formative patient-reviewer approach, where patients provide a global assessment of students' professional attributes and behaviours, some medical schools have adapted existing validated patient satisfaction or evaluation of care questionnaires in order to provide students with patient feedback on specific areas of their practice, for example communication and consultations skills (Haffling and Håkansson, 2008; Braend *et al.,* 2010; Reinders *et al.,* 2010). HEI-based practice assessments, such as OSCEs, incorporate pre-determined, homogeneous assessment rubrics that may include standardised or simulated patients rating aspects of student performance, yet it is the profession that remains in control of those determinations. As discussed in Chapters 1 and 4 the dominance of a professional discourse appears to subsume a discourse of consumerism within practice assessment, which could account for why nursing faculties appear not to have considered adapting and testing similar validated patient assessment rubrics in the practice setting. Consequently, despite patient involvement being constituted as an essential part of all pre-registration health and social care professionals' education, the literature continues to be:

> '…dominated by descriptive reports and disparate snapshots of PPI initiatives, based on perceptions of patients or students involved at various levels in various specialities or curriculum topics. There remains little evidence of connection between theory, practice and outcomes … ' (Regan de Bere and Nunn, 2016:80).

Implications

This thesis has provided a critical explanation of the emergence of patient involvement in practice assessment as a solution to the representations of problems in

nursing care and the tensions surrounding the discourses of nursing as a practical-caring vocation versus nursing as a technical-scientific profession. The aim was not to offer a generalisable account but to offer an in-depth analysis of the logics that characterised it, the underlying politics and ideologies that helped sustain the tensions surrounding the vocation-profession debates in nursing and nurse education. Nevertheless, the findings do have implications for nursing and nurse education both within the HEI and healthcare settings.

The reconstitution of nursing as a caring technical-scientific profession

Most importantly nursing needs to acknowledge the political and professional rhetoric surrounding technical-scientific nursing and patient involvement. This study has suggested successive governments have exploited a contingent nurse identity to deflect attention away from failing health policies (see chapters 3 and 6). Chapter 3 also illustrated how nursing might be politically weakened by its constitution as a female-gendered, practical and vocational occupation. The problematisations and debates illustrated throughout the thesis have inferred that nursing can either be considered a practical-caring vocation *or* technical-scientific profession, showing the strength of the fantasmatic logic of vocation that have meant that it has been almost impossible for nursing to be seen to be abandoning its vocational heritage. This research has shown that nursing, care and vocation are inherently linked as evidenced in recent definitions of nursing that continue to be constituted through a discourse of care (WHO, 2017b; International Council of Nurses, 2017; RCN, 2014). As with all identities, the nursing identity can only ever be partially fixed and hence any attempts to conceal that contingency will only ever be temporary. Nevertheless, nursing needs to turn its attention to determining what constitutes *nursing* care in particular contexts and at particular points in time. This could provide a professional distinction between

caring and nursing care where the need for technical-scientific proficiency is recognised as being equal to the need for care and compassion. This combination is possibly the uniqueness of the profession and if nursing is able to redefine care in this way the profession may be able to more clearly articulate its own unique sphere of practice.

As has been illustrated throughout this thesis, nursing and nurse education has become a recurrent focus for public and political debate, especially following NHS scandals and nurse education reforms. I have shown how different groups of actors, at different times, tend to adopt the same tropes in their attempt to constitute the professionalisation and academicisation of nursing as a problem. Consequently, by revealing the underlying political and ideological tensions that continues to exist between the constitution of nursing as a practical-caring vocation versus technical-scientific profession, this study's findings contribute to understandings about the current and future challenges facing the profession, including nursing degree apprenticeships and the introduction of the nursing associate (see Chapter 3).

Development of valid and reliable patient practice assessment tools

By defining the uniqueness of the profession, nurses will then be able to determine who is best placed to set the direction of nurse education. Nursing is constituted as a patient-centred profession, based upon an emotional-connectedness with patients (Griffiths *et al.,* 2012), therefore patient involvement in practice-based nurse education is constituted as essential for students to learn the art to compliment the science of nursing. However, the intrinsic value of patient involvement and their contributions to practice assessment in adult nursing remains under-researched. In order to gain an understanding of the patient experience it is important that nursing students not only hear but also listen to and act on patient and service user feedback.

In May 2018, the NMC published a series of revised nursing standards, including programme standards for pre-registration nursing education and proficiencies for registered nurses (NMC, 2018a; 2018b, 2018c, 2018d). While previous NMC standards and circulars (NMC, 2010; 2011) emphasised the importance of patient involvement in practice assessment, this emphasis is no longer apparent within the 2018 standards. Although the NMC continues to employ a consumerist discourse to position service users as equal stakeholders, co-producers and partners of pre-registration nursing and midwifery programmes (NMC, 2018a: 6 – Standard 1.12; Standard 2.7), this is not reflected within Standard 5: Curricula and Assessment that only requires patients to 'contribute' to student assessment (NMC, 2018a: 12). Thus, in contrast to the construction of a patient co-producer / partner identity within curriculum development, the patient, as assessor, becomes constituted as a non-professional 'outsider' that could help to perpetuate an historically constructed passive patient position. Such subordinate positioning also appears to be reflected in the new *Standards for student supervision and assessment* (NMC, 2018b) where the patient is constituted as a learning resource and learning opportunity. In addition, the previously advocated patient-reviewer role in formative assessments is not articulated, instead the assessment of students' practice is constructed as a professional activity, where the practice assessor's summative decisions need only be informed by feedback from practice supervisors (NMC, 2018b: 9). While practice assessors continue to be responsible for ensuring that 'there are sufficient opportunities to gather and coordinate feedback from practice supervisors, any other practice assessors, and relevant people, in order to be assured about their decisions for assessment and progress' (NMC, 2018: 9), the NMC does not clarify who these 'relevant people' are. Therefore, while HEIs and practice assessors might envisage

this group to include patients, carers and relatives, by subsuming patients into a heterogeneous group, their position and role within the practice assessment process becomes imperceptible. Subsequently, current (tokenistic) consultative levels of patient involvement in practice assessment is likely to be reduced to non-participatory manipulation that gives patients the impression of being heard, but without the requirement for patient feedback to be taken into account other than as an assurance mechanism.

Collaborative patient involvement in practice assessment can however, elicit informed, honest and reflective dialogue between patients, students and mentors that has been found to provide direct and indirect benefits to patients and students (Webster, *et al.,* 2012; Speers and Lathlean, 2015; Ward and Benbow, 2016). Nonetheless, as this thesis has illustrated, the normalisation of formative or informal approaches to patient involvement in assessing nursing students' practice would suggest an increasing hegemonic acceptance of maternalist assessment practices. Consequently, tokenistic patient involvement in practice-based nurse education risks becoming sedimented with HEI practice assessment approaches.

If nursing is to continue to be constituted through a discourse of patient-centredness then the profession, including nursing faculties, should move beyond the simple rhetoric of involvement and move to develop robust strategies to address the contextual divide. Moreover, nursing could to do more to recognise and address the constraining effects of professional maternalism on patient involvement in practice-based nurse education. As highlighted earlier in this chapter, research has shown that the validity and reliability of lay observer assessments of students' practice are comparable to lecturer and professional assessments, when using a structured assessment tool related to a specific clinical skill (Haffling and Håkansson, 2008;

Braend *et al.,* 2010; Reinders *et al.,* 2010). In nursing, research has principally focused on patients providing a global assessment of students' professional attributes, but there remains a paucity of literature that specifically explores the transferability of validated, structured HEI-based patient-assessor assessment tools into pre-registration nursing practice assessment. The skills focus of the new NMC standards (2018d: 27) provides an ideal opportunity for nursing faculties to reconsider patient involvement in practice assessment, especially in the assessment of nursing students' communication and relationship management skills. The adaptation of practice assessment tools to incorporate structured patient and mentor Likert scale ratings for specific skills and professional attributes could promote a collaborative approach that acknowledges the patient's experiential expertise. In this way patients would be given a voice and choice to formally participate in practice assessment so that their position as 'assessor by experience' is professionally and academically valued.

Use of LCE in nursing research

Poststructuralist discourse theory and Glynos and Howarth's Logics of Critical Explanation (2007) are more commonly associated with the fields of political and social science. In nursing, it appears that few nurse researchers have utilised PDT although my literature search revealed a study from Oute *et al.*, (2015) who adopted Laclau and Mouffe's approach to explore relatives' involvement in Danish psychiatry. It appears that while nursing research does incorporate discourse analysis, researchers have tended to lean more towards social science DA approaches (Traynor, 2006; Holmes and Gaynon, 2017), and as a consequence PDT and LCE remain under-utilised. For this research, the strength of the LCE approach was that it enabled me to examine key actors subject positions and power relations within the practice assessment process *and* explore the influence of politics and fantasy on the

way patient involvement had been constructed as an essential component of practice assessment. Another strength of LCE is that researchers are able to interrogate the meaning from a wide variety of texts including political speeches, newspaper reports, online materials as well as interviews. This added richness to the data but it also challenged me to acknowledge and look beyond my own sedimented beliefs as a nurse and nurse lecturer. For me, the power of LCE was that I was able to analyse nursing and patient involvement discourses over time and in different social, cultural and political contexts.

Limitations of the research

It is important to recognise that all research studies have limitations, however it is important to acknowledge them and consider how these limitations were or could be addressed in future research. I consider three limitations related to the methodology, participant recruitment and data collection.

This thesis was concerned with offering a critical explanation of the emergence of patient involvement in practice assessment rather than measuring whether patient involvement had resulted in any change in mentors' assessment decision-making, nursing students' vocational values or affective behaviour or patients' perceptions of nursing care. The strength of adoption a LCE approach was that it enabled me to consider patient involvement as a social *and* political practice, however while this allowed for a detailed explanation of patient involvement, a limitation of using an interpretative approach is that the findings remain open to negotiation and alternative interpretations. In addition, LCE does not have a clear analytical framework, which makes it less accessible to novice researchers like myself. Although LCE's five-stage framework does address some of the criticisms of PDT, the continuing lack of clarity on the analytical stages made it difficult for me

identity the political logics from the empirical data (Marttila, 2016). Fortunately, I found Hajer's ten analytical steps (2006) and his work on discourse coalitions particularly helpful in this regard, something I would adopt for future research where the political movement behind an emerging social practice are difficult to discern.

A second limitation concerns participant recruitment. The fact that patient involvement in practice assessment was not an established social practice at the University at the point of data collection was not a significant limitation as LCE does allow for the examination of projected characteristics of an emerging practice (Glynos, *et al.,* 2015b). However, the study would have benefited from recruiting patients at point of discharge from hospital, as they were more likely to have received care from adult nursing students. Although I had discussed approaching ward managers to help recruit patients with the hospital's research and development lead and the deputy chief nurse in advance of applying for ethical approval, it was felt that recruiting patients directly from the hospital wards presented too many ethical and logistical challenges. Therefore, permission for the study was granted on condition that patients were only recruited through Clinical Nurse Specialists (CNS) or via the hospital Patient panel (see appendix 3). My preference was to recruit via CNS however while two CNS did agree to help only one patient was recruited and the rest were recruited via the hospital patient panel and HEI service user forum. It is therefore possible that patient participants recruited from the panel and forum identified themselves primarily as quasi-professionals that may have impacted on the way they responded to interview questions and the final research findings.

The third limitation also relates in part to participant recruitment but concerns data collection. Discourse analysis enables the researcher to analysis '*any* type of data' (Glynos and Howarth, 2007:62 original italics), therefore I analysed a number

of parlimentary speeches, official documents, policies, newspaper articles, inquiry reports as well as semi-structured interviews with those immediately involved in the practice assessment process. This research was focused on patient involvement at an operational or micro level (acute hospital placements), however if I was to undertake the study again I would conduct a series of 'helicopter' interviews as advocated by Hajer (2006) with actors who had a more strategic overview of patient involvement as this could have complimented my analysis of the political logics, for example, representatives from the NMC, RCN, Council of Deans or Department of Health.

Areas for future research

This research has contributed to the field of patient involvement in practice assessment by offering a critical explanation of how this emerged as a social practice, yet this remains a under investigated practice in relation to adult nursing. This study has specifically focused on patient involvement within an acute hospital setting, therefore further research is needed into patients' contributions to practice assessment, their subject positions and social actors power relations within the community, primary and the independent/voluntary care settings. Considering the limitations of this study outlined previously, there is a need for more research exploring the politics surrounding the practical-caring vocation versus technical-scientific profession debate and influence politics had had on setting the direction of pre-registration nurse education.

Finally, as I have already alluded to consumer-citizen models of service user involvement are predominately focused on involving individuals in curriculum development, teaching or assessment within the HEI setting. This study has shown that a change in situational context means that rather than adopting a patient-citizen position that focuses on the greater good, patients involved in practice assessment are

more likely to be focused on the direct and indirect benefits to themselves. As this thesis has demonstrated patients may initially adopt a passive-dependent 'patient' position, therefore further research is needed to develop a placement-based patient involvement model that takes into account variability in the patient identity, subject positions and power relations across different healthcare settings.

Personal reflections

Many have described a PhD as a journey of discovery and transformation (Taylor, 2007; Watts, 2009; Rayner *et al.,* 2015), one that involves perseverance and motivation to overcome the challenges of doctoral research. This reminded me of Laing's poem 'There is something I don't know' (see Appendix 14), which I feel reflects the first months of my own transition from an experienced nurse and lecturer to an inexperienced PhD student and novice researcher representing the 'confusing nowhere of in-betweenness' (Bridges, 1980:5) that I initially found myself in. This involved juggling multiple identities while I relearned how to be a student in an academic environment where I could also be considered a peer. The transformation from practitioner to researcher has been described as a linear process of acculturation (social and psychological adaption to a new culture), assimilation (taking on and understanding new ideas) and actualisation (making it real and fulfilling one's potential) (Rhodes, 2013:5). For me this thesis represents both an external and internal transformation that has been both exhilarating and thought provoking.

Appendices

Appendix 1: Nurse Education TimeLine (1860-2017)

YEAR	
1860s	• 1860s Nightingale School @ St Thomas' London. Taught moral behaviour and discipline similar to St Benedictine and Ascelepioion religious orders (Cockayne, 2008). Lectures given by Drs twice a week, nurses had to attend in their own time.
1892	• Drs starting to call for standardised training and the need for nurses to have theoretical and technical knowledge. Nurses continued to emphasise vocational and moral qualities (Bradshaw, 2001)
1897	• Bready and Elizabeth Fry pushed for skilled, knowledgeable nurses Bready linked the ignorance of nurses with dangerousness (Cockayne, 2008). • Doctors resisted 'the theoretical side has been overdone; the style, method of training being on the same lines as those of the medical student, have not proved equally suitable to the sick nurse, whose work is essentially practical' (Anon, 1897 BMJ p1646). • No national nurse education curriculum each hospital set its own curricula based on meeting service need not the needs of the students or nursing. Nurse apprenticeships = cheap labour. Employers were against nurse registration as hospital specific training meant it was difficult for nurses to change employer (Hatchett, 2005) • Several private members' bills that set out legislation for nurse registration failed to gain support and ran out of time (White, 1985)
1919	• Nurse Registration Act. Nurse title protected and only applicable to trained nurses. • General Nursing Council [GNC] established. Advised on nurse training that followed the Nightingale apprenticeship approach; determined the core attributes and skills required of the nurse based on Nightingale ideals. Set educational entry requirements for the first time but this resulted in nursing shortages so that the state had to step in to ensure there were enough nurses to support doctors (Hull and Jones, 2012) • GNC Register requirements 1 year training or 19 years in service
Interwar	• Most nurses were either un or under trained or stayed unregistered. By 1928 only 28,000 of the 120,000 registered nurses met the standard requirements of the GNC. In 1937 only 28,000 girls were educated to secondary level therefore hospitals relied on nurses who had no or less than three years training (Hull and Jones, 2012)
1923	• First nurse education syllabus issued by General Nursing Council including two exams – one within the first year and a final exam – 'finals' • Practical focus with lectures and demonstrations provided by medical consultants, matrons, sister tutors and ward sisters (Bradshaw, 2002)
1930	• Private members bill by Labour MP Fenner Brockway attempted to establish a 44-hour maximum week and improved wages especially probationary nurses (student nurses). RCN rejected this bill as unprofessional but this may be due to the fact the MP had not involved the RCN in developing the bill (Hatchett, 2005)
1932	• Lancet commission set up to examine the nursing shortage. Commission reinforced nursing as a vocation rather than increasing pay or educational resources (Cockayne, 2008). Called for a reduction in technical theory. Doctors continued to directly influence nurse recruitment and education policy (Davies, 1980)
1938	• Minister of Health suspended the GNC minimum educational requirements for nurse training in 1938 in an attempt to attract more young women into nursing - Suspension lasted until 1962 (White, 1985)

YEAR	
1939	• Interim Athlone report: Recommended student status should result in an equal balance between practice and theory. • Introduction of Enrolled Nurses. • Final report was never published in full due to the start of the 2nd World War recommendations were not actioned for 3 years
1943	• Nurses Act legislation that allowed for a 'lower stratum of nursing labour that would free the student nurse to pursue an educationally orientated form of training'
1947	• Ministry of Health (Wood) Nurse Recruitment and Training working party. Wood Report (1947) • Saw problem with apprenticeship style of training – students doing non nursing tasks. Called for 'student' status to enable students to focus on their education rather than meeting service need (Cockayne, 2008; Hull and Jones, 2012) • Report wanted to remove GNC control of nurse education and make it purely an examining board. • Wood recommended Regional Nurse Training Councils set up independent training schools but matrons, who dominated the GNC and RCN were hostile and rejected this move towards an educational foundation. Service need overrode educational needs of students and the profession (Hull and Jones, 2012)
1948	• Enrolled nurse training commenced in attempt to address registered nurse shortages • Change in NHS structure saw the decline of Hospital Matrons who had been in charge of nurse education. Matrons no longer members of hospital boards.
1950	• Senior Nurse Tutor role, following the American model in charge of nursing education • Start of division between 'moral-vocational' training and 'educational-professional' education (Hull and Jones, 2012)
1961	• *The Duties and Position of the Nurse* (RCN and BMA) recognised scope of nursing would have to change as a result on advances in healthcare and new technologies.
1962	• GNC minimum education entry criteria introduced – 2 O levels or entry exam (White, 1985)
1964	• Platt Report commissioned by RCN • Reiterated call for full 'student status' and for students to be taught in Higher Education, professional education advocated. • Principles / theory to be taught in HEIs, Practice to be taught in the hospital setting.
1965	• Platt report criticised by the GNC and by nurses who felt academic nursing would affect recruitment (MacGuire, 1966 cited in Bradshaw, 2002)
1970-1977	• Barbara Fawkes (GNC Education Officer) and Eve Bendall (ENB Chief Executive Officer) wrote several papers calling for educational reform. Their view was that the vocational image of nursing and nurse education did not fit the reality (Bradshaw, 2002:13)
1972	• Briggs Report • Students poorly prepared for registered role due to lack of teaching and supervision in practice. Only 11% of time spent with a registered nurse. • Recommendations: Establishment of Royal College of Nursing and Royal College of Midwifery; United Kingdom Central Council for Nursing, Midwifery and Health Visiting [UKCC]; National Boards in charge of setting educational standards. • Called for nurse education to move to Higher Education and abolish apprenticeship training (Cockayne, 2008) •

YEAR	
1973	• Manchester University offering nursing degrees
1977	• *The Extended Role of the Nurse – legal implications and training requirements* (DHSS) published • Made explicit the difference between the nurses' role to 'care' and the role of the doctor to diagnose and 'cure'
1978	• RCN proposes nurses should be allowed to prescribe dressings and topical ointments(Jones, 1999)
1985	• RCN commissioned report: *The Education of Nurses: A New Dispensation* [Judge report] • HEI based nurse education has potential to make nursing more attractive to young women as their career options had been expanded by access to Higher Education • Hospital nurse education criticised for being too heavily focused on service need, and perpetuating the 'theory-practice gap' • Students used as cheap labour to cover staff shortages and left unsupervised, which went against the principles of apprenticeships, therefore the report called for supernumerary status for nursing students in practice • Concerns raised that this would lead to nurses losing their ability to care. Some feared a loss of vocation or that if nursing became an 'educated' or academic profession it would attract the wrong type of people who were too focused on gaining a career than joining a caring vocation (Cockayne, 2008) • *Professional Education/Training Courses: Consultation Paper* (ENB) – in response to a perceived 'crisis' caused by students' status as employees and falls in recruitment. Proposed curricula focused on disease prevention and health promotion. Criticised for focusing on the needs of the nurse and note the needs of the patient (Bradshaw, 2002)
1986	• *Project 2000: A new preparation for practice* (UKCC) = transition for hospital based Schools of Nursing to Higher Education based nurse education (move fully completed by 1997) • Government agreed on condition that a new role the 'Healthcare Assistant' or HCA was introduced. Had promised to replace all students with HCAs, but reneged on this and only replaced 50% of the student workforce (Allen, 2001) • UKCC Entry Criteria for Diploma programmes: 5 GCE O levels (A-C) or five CSEs (Grade 1). National Vocational Qualifications at level 3 and Access courses were accepted as alternatives. Degree Entry: as diploma plus 3 A levels • *Project 2000: The project and the Professions: Results of the UKCC Consultation on Project 2000. Project Paper 7.* (UKCC) – showed nurses and students did not support the proposal. Fears of creating an 'academic' nurse • ENB introduces practice education standards *Teaching and assessing in clinical practice (998)*
1986	• Cumberledge report (DHSS) - *Neighbour Nursing: A report for the Community Nursing Review in England* • Recommended qualified District Nurses and Health Visitors be allowed to prescribe from a limited formulary
1989	• *UKCC requirement for the content of Project 2000 programmes* (UKCC) published
1994	• Greenhalgh report • Recommended some basic junior doctor technical tasks should be part of the role of registered nurses (Salter, 1998)

YEAR	
1996	• English National Board claimed nurses were learning too much theory and not enough on disease management. • Criticised practice placements for continuing to be task focused and not supporting students in transferring theory into practice
1999	• Peach report *'Fitness for Practice: The UKCC Commission for Nursing and Midwifery Education* • *Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare* (DH) • Suggestion that newly qualified nurses lacked practical skills • Called for nurse education to be more practically focused
2003	• Duffy report '*Failure to Fail'* PhD commissioned by UKCC • Some lecturers and mentors felt Universities had a 'bums on seats' mentality and were reluctant to withdraw students from courses • Registered nurses failing to fail under-achieving students • Lack of practice supervision
2005	• *Report from the Standing Nursing and Midwifery Advisory Committee: How to ensure that nurse and midwifery education keeps pace with new models of care - April 2005* (DH) • *Supporting people with long term conditions. Liberating the talents of nurses who care for people with long term conditions*. (DH) • Nurse Practitioner role introduced
2006	• *Modernising Nursing Careers* (DH) • Introduction of Nurse, Midwife and Health Visitor Consultant roles • Calls for graduate level pre-registration programmes • NMC publishes new education standards – *Standards to support learning and assessment in practice* • Introduction of new role of 'Sign off Mentor' to address concerns raised by Duffy report • Introduction of 'triennial review' to monitor the quality of mentorship
2007	• *Trust, assurance and safety: The regulation of health professionals* (DH) – published in response to the Shipman Inquiry • Insisted that all health professional regulatory frameworks must maintain public confidence in practitioners' competence • Lay people to make up 50% of panels for all Fitness to Practice hearings • Changes in hearings burden of proof to civil law (in all probability) rather than criminal law (beyond reasonable doubt) • Professionals required to evidence continuing fitness to practice through appraisals linked to the Knowledge and Skills Framework • *Nursing Towards 2015* (NMC) • Suggests sharing regulatory role between regulatory bodies and employers • Calls for greater flexibility in nurse education due to blurring of professional boundaries. • Presented three scenarios A) minimal change B) fewer generalist nursing posts, interprofessional specialist roles, fewer trained nurses C) Specialisation by all registered nurses to become either specialist or advanced practitioners. HCAs to fill the gap. • Need for nursing to become a graduate entry profession following the introduction of the European Credit Transfer System under the Bologna Process

YEAR	
2008	• *High Quality Care for All* (DH - Darzi report) • Called for nurse education reforms • Recommended for mandatory period of preceptorship for newly qualified nurses and midwives • Called for increased investment into apprenticeships • *High Quality Workforce* (Darzi) • Established Council for Healthcare Regulatory Excellence (now the Professional Standards Authority) • Made explicit that service users should be involved in the design, delivery and evaluation of all health professionals' education programmes
2009	• *Investigation into Mid Staffordshire NHS Foundation Trust* (Healthcare Commission) published
2010	• Independent Inquiry into Mid Staffordshire NHS Foundation Trust published (Francis, 2010) • *Frontline Care: Report by the Prime Minister's Commission on the Future of Nursing and Midwifery in England* published • Supports move to graduate entry for nursing • NMC publishes new pre-registration standards • Introduces service user and carer involvement in assessing students' competence in practice – formal involvement
2011	• NMC Circular provides details of strategies to involve service users and carers in practice assessment during placements
2012	• *Quality with Compassion: the future of nurse education* (Lord Willis) – an RCN commissioned report in response to the first Francis report • Found no major shortcomings with HEI based nurse education that could be responsible for declining standards of care • No evidence that degree level registration was damaging to patient care • Called for health service providers to be full partners in nurse education and demonstrate that they pay full attention to educational issues especially poor standards of mentorship and supervision of students on placement • Recommended regulation of HCAs / Support roles • *Compassion in Practice: Nursing, Midwifery and Care Staff Our Vision and Strategy* (DH) • Introduction of the 6Cs (Care, compassion, commitment, competence, courage, communication) • Calls for 6Cs to be embedded into practice and nurse education recruitment strategies, and pre-registration programmes
2013	• Mid Staffordshire NHS Foundation Trust public inquiry report published (Francis, 2013) • *A promise to learn – a commitment to act: Improving the Safety of Patients in England* (Berwick report) • *Quality of Care and Treatment provided by 14 Hospital Trusts in England* (Keogh report – commissioned post Staffordshire to investigate higher than expected hospital mortality rates • NMC and other health profession regulators publish response papers
2014	• *Winterbourne View – Time for Change* published • Department of Business, Innovation and skills and Department of Health announce introduction of Degree Apprenticeships for nursing

YEAR	
2015	• NMC announces introduction of new revalidation process for nurses, midwives and Health Visitors in response to Francis (2013) recommendations • Health Education England establishes a Patient Advisory Forum and Patient and Public Voice Partners to help shape education strategy • NMC sets up Education Advisory Group to include patient representatives and a Patient and Engagement Forum made up of over 100 patient representatives from patient groups, patient advocates and health charities • *Raising the Bar: Shaping of Care – A review of the Future Education and Training of Registered Nurses and Care Assistants* (Lord Willis) – commissioned by Health Education England. • Recommended expansion of fields of practice to include community • Recommendation that pre-registration programmes be two years of generic training (all fields together) with the final year specialising • Called for flexible routes into nursing such as work-based pathways • Changes in mentorship to adopt a coaching approach • Introduction of an additional tier of unqualified staff between HCA and Registered nurse • NMC publishes new Code of Conduct – again another response to Francis (2013)
2016	• Announcement that NHS bursaries for health professionals' pre-registration programmes to be scrapped • Health Education England announces consultation on new 'Nursing Associate' role. Will complete a two year apprenticeship while completing a Foundation Degree
2017	• NMC launches consultation on new draft pre-registration and education standards • Removal of mentor role and the requirement for nursing, midwifery and health visiting educators to complete training to a national level • Removal of specific final placement mentor role and triennial review • Patient involvement in practice assessment rearticulated as a strategy to 'aid reflective learning' by students

Appendix 2: Letter of Permission from the University's Head of School

[redacted]

Phone:

Email:

Our Ref:

School of Nursing and Midwifery

Nicola Rooke

[redacted]

24 July 2012

Dear Nickey

Re: PhD Research Proposal; Service User Contributions to the Assessment of Pre-registration Adult Nurses' Practice

Following our recent discussion, I am pleased to confirm in principle access to [redacted] students and the Service User Forum as part of your PhD studies at the [redacted] subject to ethical approval. I am happy that your study is conducted on [redacted] premises at [redacted] and [redacted] taking account of availability and the constraints of your study.

Yours Sincerely

[redacted]

Head of School
Nursing and Midwifery

University [redacted]
T 01[redacted]000
F 01[redacted]900
E info@[redacted]
W www.[redacted]

Appendix 3: Letter of Permission from Deputy Chief Nurse

[redacted] NHS
NHS Foundation Trust

30th July 2012

Mrs Nicola Rooke

[redacted]

Directorate of Nursing and Governance

[redacted]

Dear Nickey,

Re: PhD Research Proposal; Service User Contributions to the Assessment of Pre-registration Adult Nurses' Practice

Following our conversation yesterday, I am writing to confirm, subject to relevant university and NHS ethical and research development approvals, approval for access to service users via the Hospital Patient panel and/or Clinical Nurse Specialists and to adult nursing mentors and sign off mentors.

Yours sincerely,

[redacted]

Deputy Chief Nurse

Putting you first

NHS

(DEPARTMENT)

Nicola Rooke

Dear Nicola,

Letter of access for research for the following study:
Title: Service User Contributions to the Assessment of Pre-registration Adult Nurses' Practice

We are satisfied that the research activities that you will undertake in this NHS organisation are commensurate with the activities you undertake for your employer. Your employer is responsible for ensuring such checks as are necessary have been carried out. This letter confirms your right of access to conduct research through **Trust** for the purpose and on the terms and conditions set out in this letter. This right of access is valid for the duration of the above study unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

You are considered to be a legal visitor to **Trust** premises. You are not entitled to any form of payment or access to other benefits provided by this organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through **Trust**, you will remain accountable to your employer but you are required to follow the reasonable instructions of your nominated manager, (R&D Manager), in this NHS organisation or those given on his behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with **Trust** policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with **Trust** in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others

Putting you first

while on **Trust** premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

You are required to ensure that all information regarding patients or staff remains secure and strictly confidential at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

Trust will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

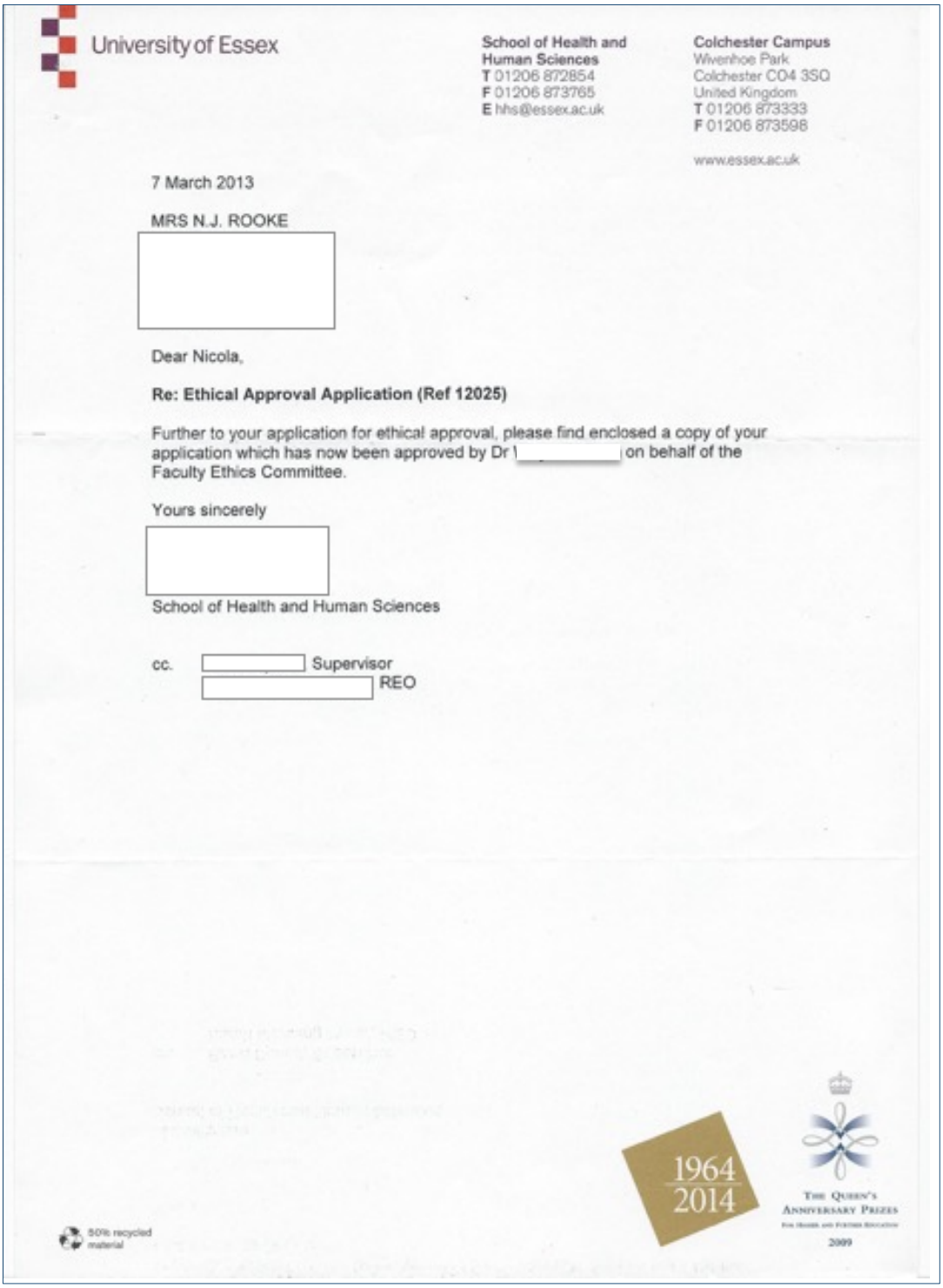
If your circumstances change in relation to your health, criminal record, professional registration or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the NHS organisation that employs you through its normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely

HR Manager
Hospital

cc:

Appendix 4: University of Essex Ethical Approval



University of Essex

School of Health and Human Sciences
T 01206 872854
F 01206 873765
E hhs@essex.ac.uk

Colchester Campus
Wivenhoe Park
Colchester CO4 3SQ
United Kingdom
T 01206 873333
F 01206 873598

www.essex.ac.uk

7 March 2013

MRS N.J. ROOKE

[redacted]

Dear Nicola,

Re: Ethical Approval Application (Ref 12025)

Further to your application for ethical approval, please find enclosed a copy of your application which has now been approved by Dr [redacted] on behalf of the Faculty Ethics Committee.

Yours sincerely

[redacted]

School of Health and Human Sciences

cc. [redacted] Supervisor
[redacted] REO

1964 2014

The Queen's Anniversary Prizes
2009

50% recycled material

Appendix 5: NHS ethics approval

NHS
Health Research Authority

National Research Ethics Service

NRES Committee North West - Liverpool East

19 November 2012

Mrs Nicola Rooke

Dear Mrs Rooke

Study title:	**Service user contributions to the assessment of pre-registration adult nurses' practice**
IRAS Project Number:	**95765**
REC reference:	**12/NW/0823**
Protocol number:	**N/A**

The Proportionate Review Sub-committee of the NRES Committee North West - Liverpool East reviewed the above application on 19 November 2012.

Ethical opinion

On behalf of the Committee, the sub-committee gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

The Committee also specified the following additional conditions:

- Please state in all Participant Information Sheets that there would be no direct benefits to taking part.
- The Committee noted the mention of the £10 voucher in the invitation letters. Please remove this from the invitation letter but detail in the Participant Information Sheet.
- Please confirm that if a reminder letter would be sent it would only be sent once. The Committee noted that this had not been submitted for review. If you would be using a reminder letter please submit for review prior to use.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

You must notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Approved documents

The documents reviewed and approved were:

Document	Version	Date
Covering Letter: from Mrs Nickey Rooke		02 November 2012
REC application: 95765/379742/1/35		05 November 2012
Protocol	3.4	02 November 2012
Investigator CV: Nicola Rooke		02 November 2012
Investigator CV:		02 November 2012
Participant Information Sheet: Patient	3.4	02 November 2012
Participant Consent Form: Patient	3.4	02 November 2012
Participant Information Sheet: Student	3.4	02 November 2012
Participant Consent Form: Student	3.4	02 November 2012
Letter of invitation to participant: Nursing Student	3.4	02 November 2012
Participant Information Sheet: Mentor	3.4	02 November 2012
Participant Consent Form: Nurse Mentor	3.4	02 November 2012
Letter of invitation to participant: Nurse Mentor	3.4	02 November 2012
Participant Information Sheet: Nursing	3.4	02 November 2012

Participant Consent Form: Nursing Lecturer	3.4	02 November 2012
Letter of invitation to participant: Lecturer	3.4	02 November 2012
Letter of invitation to participant: Service User	3.4	02 November 2012
Letter from Sponsor: from		01 November 2012
Evidence of insurance or indemnity:		30 July 2012
Interview Guide	3.4	02 November 2012
Independent Review: signed		15 October 2012
Preliminary Manager Permission Letter: Trust	3.4	30 July 2012
Preliminary Manager Permission Letter	3.4	24 July 2012

Membership of the Proportionate Review Sub-Committee

The members of the Sub-Committee who took part in the review are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

12/NW/0823 **Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

On behalf of

Chair

Email: nrescommittee.northwest-liverpooleast@nhs.net

Enclosures: List of names and professions of members who took part in the review

"After ethical review – guidance for researchers"

Copy to:

NHS
Health Research Authority

National Research Ethics Service

NRES Committee North West - Liverpool East

07 December 2012

Mrs Nicola Rooke

Dear Mrs Rooke

Study title:	**Service user contributions to the assessment of pre-registration adult nurses' practice**
REC reference:	**12/NW/0823**
Protocol number:	**N/A**
IRAS project ID:	**95765**

Thank you for your letter of 26 November 2012. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 19 November 2012

Documents received

The documents received were as follows:

Document	*Version*	*Date*
Covering Letter from Mrs Nickey Rooke		26 November 2012
Letter of invitation to participant: Service User	3.4	26 November 2012
Participant Information Sheet: Student	3.4	26 November 2012
Participant Information Sheet: Nursing Lecturer	3.4	26 November 2012
Participant Information Sheet: Service User	3.4	26 November 2012
Participant Information Sheet: Mentor	3.4	26 November 2012

Approved documents

The final list of approved documentation for the study is therefore as follows:

Document	*Version*	*Date*
Covering Letter from Mrs Nickey Rooke		02 November 2012
Covering Letter from Mrs Nickey Rooke		26 November 2012
REC application: 95765/379742/1/35		05 November 2012
Protocol	3.4	02 November 2012
Investigator CV: Nicola Rooke		02 November 2012
Investigator CV:		02 November 2012
Participant Information Sheet: Service User	3.4	26 November 2012
Participant Consent Form: Service User	3.4	02 November 2012
Participant Information Sheet: Student	3.4	26 November 2012
Participant Consent Form: Student	3.4	02 November 2012
Participant Information Sheet: Nursing Lecturer	3.4	26 November 2012
Participant Consent Form: Nursing Lecturer	3.4	02 November 2012
Participant Information Sheet: Nurse Mentor	3.4	26 November 2012
Participant Consent Form: Nurse Mentor	3.4	02 November 2012
Letter of invitation to participant: Nurse Mentor	3.4	02 November 2012
Letter of invitation to participant: Lecturer	3.4	02 November 2012
Letter of invitation to participant: Nursing Student	3.4	02 November 2012
Letter of invitation to participant: Service User	3.4	26 November 2012
Preliminary Manager Permission Letter: University	3.4	24 July 2012
Preliminary Manager Permission Letter: NHS Foundation Trust	3.4	30 July 2012
Interview Guide	3.4	02 November 2012
Letter from Sponsor: from		01 November 2012
Evidence of insurance or indemnity		30 July 2012
Referees or other scientific critique report signed		15 October 2012

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

12/NW/0823	Please quote this number on all correspondence

Yours sincerely

Committee Co-ordinator

E-mail: nrescommittee.northwest-liverpooleast@nhs.net

Copy to:

Appendix 6: Hospital research and development committee approval

NHS Foundation Trust

5th February 2013

Mrs Nicola Rooke

Dear Mrs Rooke

Service User contributions to the assessment of pre-registration adult nurses' practice

R&D Ref: 2012STU005 **MREC Ref:** 12/NW/0823

I am writing to confirm that the above project was reviewed by Hospital NHS Trust Research Operational Committee on 14th December 2012 and has Trust Approval to proceed. Documents reviewed were those listed below:

–	NHS R&D Form	95765/392016/14/186	
–	SSI Form	95765/392018/6/34/136706/260439	
–	Protocol	V3.4	2nd November 2012
–	PIS – Mentor	V3.4	26th November 2012
–	PIS – Lecturer	V3.4	26th November 2012
–	PIS – Student	V3.4	26th November 2012
–	PIS – Patient/Service User	V3.4	26th November 2012
–	Consent Form – Mentor	V3.4	26th November 2012
–	Consent Form – Lecturer	V3.4	26th November 2012
–	Consent Form – Student	V3.4	26th November 2012
–	Consent Form – Patient/Service User	V3.4	26th November 2012
–	Interview Guide	V3.4	2nd November 2012
–	Letter of Invitation – Mentor	V3.4	2nd November 2012
–	Letter of Invitation – Lecturer	V3.4	2nd November 2012
–	Letter of Invitation – Student	V3.4	2nd November 2012
–	Letter of Invitation – Patient/Service User	V3.4	26 November 2012
–	Reminder Letter – Mentor	V2	15th December 2012
–	Reminder Letter – Lecturer	V2	15th December 2012
–	Reminder Letter – Student	V2	15th December 2012
–	Reminder Letter - Patient/Service User	V2	15th December 2012
–	Ethics Approval Letters	19th November 2012, 7th December 2012, 10th December 2012, 4th January 2013	

You are reminded that the study must follow the approved protocol and that any proposed amendments must be submitted for review via the [ ] Hospital R&D Office for subsequent trust approval.

Approval is subject to compliance with the attached standard terms and conditions for research. You are required to comply in a timely manner with the project monitoring and auditing requirements of the Trust and may be asked to provide non-confidential information on the outputs and impact of the research.

We require that you **sign, date and return** the duplicate copy of this letter to the [ ] Hospital R&D Office to confirm your compliance with the Trust Policy and Procedures on Research Governance.

Yours sincerely

Research & Development Manager

Appendix 7: Example participant invitation letter

University of Essex

Dear Sir/Madam,

I am a Registered Nurse, Senior Lecturer at University ********** and a researcher undertaking a PhD in Nursing Studies at the University of Essex. I am very interested in how patients contribute to the assessment of student nurses' practice and I am contacting you to invite you to take part in a research study called 'Service User Contributions to the Assessment of Pre-registration Adult Nursing Students' Practice'.

The study aims to explore how patients contribute to the assessment of student nurses' practice within the hospital environment and I hope that this study will give student nurses, nurse mentors and nurse lecturers a greater appreciation of patients' contributions to nurse education in practice so that practical and effective methods can be developed to enable patients to give honest feedback to students to help them develop their nursing skills.

You are a very important person to the study as your recent hospital experiences which may or may not have included being cared for by student nurses are invaluable. I am inviting six patients who have been inpatients in hospital over the last year to take part, as well as pre-registration nursing students, nurse mentors who assess students' skills in practice and university nurse lecturers. You have been invited through either the Chair of the Hospital Patient Panel Group, Hospital Specialist Nurses or the facilitating lecturer of the *** Service User Forum within the School of Nursing and Midwifery who are acting as gatekeepers to this study; therefore your personal details are confidential as I do not hold any personal information about you.

If you do wish to be involved in the study please contact me either by letter, telephone or email and I will contact you. The study only involves taking part in one individual interview with the researcher, which will take no longer than one hour, either with me visiting you at home, or we can arrange to hold the interview at the Education Centre at ********** Hospital.

I have included a detailed information sheet about the study with this letter which includes my contact details and those of my research supervisor from Essex University, and I would be very happy to discuss the study further if you have any questions.

Thank you.

Yours sincerely,

Mrs Nickey Rooke
(Researcher)
Senior Lecturer
****
****
****
****
****
*** ****
0*** ******
n.rooke@****.ac.uk

Appendix 8: Example participant information sheet

Patient Participant Information Sheet

Study Title: Service User Contributions to the Assessment of Pre-registration Adult Nurses' Practice.

My name is Nickey Rooke and I am a Registered Nurse and university lecturer who is completing a PhD in Nursing Studies at the University of Essex. My specific area of interest is around how patients are involved in student nurse education. I would like to invite you to take part in a research study which will be looking at the contribution patients (service users) make to student nurses' practice assessment whilst students are working on the wards.

Before you decide whether or not you wish to take part, it is important for you to understand why this research is being done and what it will involve. Please take time to read this information carefully and discuss it with friends and family if you wish. Ask me if there is anything that is unclear or if you would like more information.

Background to the study: Student nurses are tested in both theory and practice to make sure they are safe and to make sure they meet the professional standards required to become Registered Nurses. In 2010 the Nursing and Midwifery Council, the professional regulatory body which sets the standards for nursing and midwifery education, published new standards for pre-registration nursing courses which called for patients (service users) to be more involved in the assessment of student nurses' practice.

The aim of the research: Is to explore patients' contributions within the process of assessing student nurses in practice.

Who will be taking part? This study will be asking six patients; six student nurses; six nurse mentors (registered nurses who teach, supervise and assess nursing students during clinical placements); and six nursing lecturers to take part.

Why have I been chosen? You are being approached to take part as you have had experience of being a patient in hospital.

Do I have to take part? No, taking part is voluntary, you are free to decide whether you wish to take part or not. If you do not wish to take part, you do not have to give a reason and no pressure will be put on you to try and change your mind. If you do decide to take part you will be asked to sign two forms giving your consent to be included in the study, one form is for you to keep and the other is for my records. You are free to leave the study at any time, without giving reasons and without consequence.

What will happen if I take part? If you are interested in taking part in this study please would you contact me directly via letter, telephone or email. I will then contact you to answer any questions or queries you may have, to give you the two consent forms to sign if you are happy to take part and to arrange the research interview.

If I take part, what do I have to do? If you agree to take part, I will ask you to answer some questions during an interview at a time and place which is best for you. There are not any right or wrong answers. The discussion should take no more than one hour and will be recorded on a digital dictaphone. The places where interviews could take place are either at your home, the Education Centre at ********* Hospital; or at the ********* Building, University **********.

I am very aware of and appreciate the commitment you will be giving and as a thank you for taking part in the study I would like to give you a £10 gift voucher. If you wish to attend either ******** Hospital or ********* for the research interview I will pay travel expenses at public transport rate (19p a mile) and car parking fees to attend the research interview.

What are the benefits (if any) of taking part? This study offers you the opportunity to express your own thoughts, feelings and experiences. Although there are no direct benefits to you personally in taking part your involvement in the study will give student nurses, registered nurses, universities and training hospitals a greater appreciation of patient/ service user contributions in the

assessment of nursing students on the wards so that practical and effective methods can be developed to enable patients to give honest feedback to students to help them develop their nursing skills.

What are the risks (if any) of taking part? There are no anticipated risks in taking part. However if you are upset at any point of the study and need help dealing with your feelings, it is very important that you talk to someone straight away. The Patient Advocacy and Liaison service (PALS) at the hospital are available for support. Tel: 01*** ******, pals@***.nhs.uk.

What if there is a problem? If you have a concern about any aspect of this study, you may wish to speak to me and I will do my best to answer your questions. You should contact me, Mrs Nickey Rooke, on 01*** ****** or via email *****@*****.ac.uk. If you remain unhappy you can contact my research supervisor Dr Ewen Speed (contact details below).

Who will have access to information about me and how will information about me be used?

- The interview will be recorded using a digital dictaphone and then downloaded onto a password protected computer.

- All the information you give **will be confidential** and only used in this study. All information will be collected and stored in accordance with the Data Protection Act 1998. The information will be used in such a way that you will not be able to be identified individually.

- Parts of the audio recordings and written records from your interview will be shared with my research supervisor. Extracts from written interview records will be presented in the final report/thesis, journal publications and conference presentations, however all those who take part will be anonymised and you will not be identified individually.

- Your contact details will be held by me but I will destroy this immediately after I have finished the study.

- All information will be stored in accordance with the Data Protection Act 1998 and in line with the University of Essex guidelines. Data will be kept by me, the principal researcher for five years and then destroyed.

Who is funding and organising the research? This study is being funded and organised by the researcher as part of a PhD in Nursing Studies at the University of Essex.

What do I do now? Think about the information on this sheet and ask me if you are unsure of anything. If you agree to take part please contact the researcher directly using the contact details below.

Contact for further information:

Mrs Nickey Rooke	Dr Ewen Speed
(Researcher)	(Research Supervisor)
Senior Lecturer	Senior Lecturer
**********	**********
**********	University of Essex
**********	**********
**********	**********
********	**********
**** ****	*** ***
01*** ******	01*** ******
******@****.ac.uk	******@******.ac.uk

Thank you for taking time to consider participating in this study.

Appendix 9: Example participant consent form

PATIENT/SERVICE USER CONSENT FORM

Title of Project: Service User Contributions to the Assessment of Pre-registration Adult Nurses' Practice

Name of Principal Investigator: Mrs Nickey Rooke

Please initial box

1	I confirm that I have read and understand the information sheet dated 26th November 2012 (IRAS Version 3.4) for the above study and 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, without my medical care or legal rights being affected.	☐
3	I agree to the interview being audio-recorded.	☐
4	I understand that data collected during the study may be reviewed by the research supervisor from the University of Essex. I give permission for this individual to have access to my data.	☐
5	I understand that data collected about me during this study will be anonymised before it is submitted for publication.	☐
6	I agree for any quotes to be used within the final publication and any subsequent publications and conference presentations.	☐
7	I agree to allow the data collected to be used for future research projects.	☐
8	I agree to take part in this study.	☐

Name of participant: Date: Signature:

Researcher: Date: Signature:

1 copy for participant: 1 copy for researcher

Appendix 10: Interview Topic Guide

Interview Guide

This interviews for the study will be semi-structured. The initial question is presented in the guide with subsequent topics the researcher will explore with each participant.

Briefing

Outline the purpose of the interview
Explain that the interview will be audio-recorded using a dictaphone
Do you have any questions before we start?
Are you happy for the interview to go ahead?
Clarify participant can stop the interview at any time.

Topic Guide

Service Users

•What does the term 'service user' mean to you?

•How would you rate the quality of your last visit to hospital?

•Do you think patients should be involved in rating quality of hospitals?

•What do you think quality is; how should it be measured?

•What do you think about the training that student nurses receive?

•Do you think patients should be involved in student nurse training?

•In relation to nurse training, describe to me your understanding of the term 'assessment'

•Again in relation to nurse training, describe to me your understanding of the term 'competent'

•Tell me your personal views about being involved in assessing student nurses' clinical practice i.e. how they provide care to patients

Nursing Students

•What does the term 'service user' mean to you?

•Do you think patients should be involved in rating quality of hospitals?

•What do you think quality is; how should it be measured?

•What do you think about the training that student nurses receive?

•Do you think patients should be involved in student nurse training?

•In relation to nurse training, describe to me your understanding of the term 'assessment'

•Again in relation to nurse training, describe to me your understanding of the term 'competent'

•Tell me your personal views about patients being involved in assessing student nurses' clinical practice i.e. how they provide care to patients

Appendix 11: Documentary Archive (Condensed example)

Government and Regulatory Documents (Extract)	
Working for Patients (DH, 1989)	Frontline Care (DH, 2010)
Local Voices (DH, 1992)	Equity and excellence: Liberating the NHS (DH, 2010)
A vision for the future: The nursing, midwifery and health visiting contribution to health and health care (DH, 1993)	Standards for pre-registration nursing education (NMC, 2010)
Learning from each other: The involvement of People who use services and their carers in education and Training (ENB, 1996)	Advice and supporting information for implementing the standards for pre-registration nursing education (NMC, 2011)
Patient and Public Involvement in the New NHS (DH, 1999)	Education and Training: A report from the NHS Future Forum (DH, 2011)
Making a Difference (DH, 1999)	Liberating the NHS (DH, 2012)
NHS Plan: A Plan for Investment, A Plan for Reform (DH, 2000)	NHS Constitution (DH, 2012)
A Health Service for All the Talents (DH, 2000)	Compassionate in Practice (DH, 2012)
Shifting the Balance of Power (DH, 2000)	Patients Frist and Foremost (DH, 2013)
Working together, learning together (2001)	Treating patients and service users with respect, care and compassion (DH, 2013)
Educating and Training the future health professional workforce (England Audit Office, 2001)	Healthcare Commission Investigation into Mid Staffordshire NHS Foundation Trust (2009)
Standards for pre-registration nursing education (NMC, 2004)	Mid Staffordshire NHS Foundation Trust Independent Inquiry (Francis, 2010)
Commissioning a patient led NHS (DH, 2005)	Report from Forward Look Seminars (Harvey, 2011)
Modernising Nursing Careers: setting the direction (DH, 2006)	Francis Public Inquiry Witness Statements (2010-2013)
Our health, our care, our say (DH, 2006)	Quality with compassion: the future of nursing education. Report of the Willis Commission (RCN, 2012)
Duty to Involve Patients (DH, 2007)	NMC response to the Francis report (NMC, 2013)

Health Select Committee Inquiry into Public and patient involvement in the NHS (2007)	HCPC response to the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. (HCPC, 2013)
Pre-registration Nurse Education. The NMC review and the issues (RCN, 2007)	NHS England - Chief Nursing Officer response (DH, 2013)
Real Involvement: working with people to improve health services (DH, 2008)	Delivering high quality, effective, compassionate care: Developing the right people with the right skills and the right values (DH, 2013)
High Quality Care for All (DH, 2008)	Treating patients and service users with respect, care and compassion (DH, 2013)
Role of the patient in medical education (BMA, 2008)	Transforming participation in healthcare: The NHS belongs to all of us (NHS England, 2013)

Patient / Service User Group Documents (Extract)	
Hungry to be heard: The Scandal of Malnourished Older People in Hospital (Age Concern England, 2006)	We have been listening, have you been listening (Patient Association, 2011)
Patient not numbers, patients not statistics (Patient Association, 2009)	Stories from the present, lessons for the future (Patient Association, 2012)
Listen to Patients, Speak up for Change (Patient Association, 2010)	Patient stories 2013: Time to Change (Patient Association, 2013)

Political Speeches / Media Reports (Extract)	
Nurses cannot be too posh to wash (BBC News, 2004)	Nurses told ‘You’re not too posh to wash a patient’ (Daily Mail, 2013)
Nurses: if a degree means that much to your self-esteem why not become a doctor? (The Telegraph, 2009)	National Health Service Commons Debate (Frank Dobson, 1999)
Reforms in the 1990s were supposed to make nursing care better. (The Independent, 2012)	Nursing Quality and Commission: The Future of Nursing Education (House of Lords Debate, 2012)

Appendix 12: Organisations response to the Health and Social Care Bill 2011

Professional / Managerial Organisation	Position on the Bill
Association of Chief Executives of Voluntary Organisations	Did not support nor oppose
British Association of Occupational Therapists and College of Occupational Therapists	Opposed
British Medical Association	Opposed
British Orthodontic Society	Opposed
British Dental Association	Opposed
British Geriatrics Society	Opposed
British Psychological Society	Opposed
Centre for Mental Health	Opposed
Chartered Society of Physiotherapy	Opposed
Community Practitioners and Health Visitors Association	Opposed
Foundation Trust Network	Supported Bill
General Medical Board	Opposed
Institute for Healthcare management	Opposed
Managers in Partnership	Opposed
Mind	Opposed
National Association of Primary Care	Supported Bill
NHS Alliance	Supported Bill
Patient Association	Opposed
Rethink	Opposed
Royal College of GPs	Opposed
Royal College of Midwives	Opposed
Royal College of Nursing	Opposed
Royal College of Obstetricians and Gynecologists	Did not support nor oppose

Professional / Managerial Organisation	Position on the Bill
Royal College of Paediatrics and Child Health	Opposed
Royal College of Physicians	Did not support nor oppose
Royal College of Physicians of Edinburgh	Opposed
Royal College of Psychiatrists	Opposed
Royal College of Radiologists	Opposed
Society of Chiropodists and Podiatrists	Opposed
Society of Radiographers	Opposed
The Allied Health Professionals Federations	Opposed
The Kings Fund	Opposed
The Mental Health Foundation	Opposed
UK Faculty of Public Health	Opposed
Unison	Opposed
Unite	Opposed

Charities who have expressed concerns in relation to patient engagement in GP consortia and the ability of HealthWatch to be an advocate for patients:

Charity	Charity
Action Against Allergy	Mind
Age UK	Macmillan Cancer Support
Alzheimer's Society	Muscular Dystrophy Campaign
The Anaphylaxis Campaign	The National Autistic Society
Arthritis Care	National Forum of People with Learning Disabilities
Asthma UK	National Rheumatoid Arthritis Society
Breakthrough Breast Cancer	National Voices

Charity	Charity
British Association for Adoption and Fostering	Organisation for the Understanding of Cluster Headache
British Heart Foundation	Ostomy Lifestyle
The British Liver Trust	The Patients Association
British Red Cross	Parkinson's UK
The College of Optometrists	Pelvic Pain Support Network
Crohn's and Colitis UK	Primary Immunodeficiency Association
Diabetes UK	Royal National Institute for the Blind
Every Disabled Child Matters	Royal National Institute for the Deaf
Friends, Families and Travellers	The Neurological Alliance
Guide Dogs	Royal College of General Practitioners (Learning Disabilities Group)
The Linsey Leg Club Foundation	Scope
Learning Disability Coalition	SeeAbility
Lupus UK	Specialist Healthcare Alliance
Macular Disease Society	Stoke Association
Mencap	Thyroid UK
The Meningitis Trust	United Response
The Mental Health Foundation	WellChild
The Migraine Trust	

Appendix 13: Examples of some UK HEIs patient involvement in practice assessment approaches 2013-2018

HEI	Level of involvement	Mentor or Student Led	Feedback Approach
London: South Bank; Kingston; Greenwich; King's College; South Bank; Middlesex; Hertfordshire; Bucks, West London	Formative	Mentor	Structured questionnaire designed by HEI service user groups. 5-item Likert scale: Very happy – very happy with smiley faces Happy with the way the student nurse: Cared for you Listened to your needs Understood the way you felt Talked to you Showed you respect Open text boxes: What did the student nurse do well? What could the student nurse have done differently?
Scotland: Glasgow; Glasgow Caledonian; Stirling; Queen Margaret; Abertay; Edinburgh; Edinburgh Napier; Dundee; West Scotland; Robert Gordon; Open University	To help inform the mentor's summative assessment	Mentor	Open question feedback form – mentors complete Feedback aim and participation information provided. Questions on: Feeling welcome; listened to; ability to ask questions or raise concerns about what the student was saying or doing; feeling respected, being shown care and consideration; areas for improvement
West Yorkshire: Leeds Beckett; Leeds; Huddersfield; Bradford; Hull	Formative	Mentor	Adopted PAN London feedback form
North-West: Liverpool John Moore; Liverpool; Cumbria; Edge Hill; Chester	To help inform the mentor's summative assessment	Mentor	Mentors record service user and carer comments for each placement in open text box. No prompt questions provided.
The West of England - Bristol	Formative	Mentor	Structured questionnaire Six item Likert scale - Poor to Exceptional Patients, carers or relatives asked to rate the

			care provided, levels of compassion; respect; listened to; clear communication. Open text box for additional patient comments including ways the students could have cared for them better
Lincoln	Formative	Mentor	Adapted PAN London feedback form. 5-item Likert scale: Very Happy to Very Unhappy with smiley faces. 6 questions including privacy and dignity; respect; undertook care assessment and delivery – removed 'Understood the way you felt' question
Suffolk	To help inform the mentor's summative assessment	Mentor	Structured form – Open questions Opinion of 2 service users for placements over 4 weeks duration Opinion of 3 service users in final placement Mentor to record discussion on open text form. Aspects for comment: Maintaining privacy and dignity Polite, courteous, respectful Provides adequate information Listens attentively Made them feel welcome
University of East Anglia	To help inform the mentor's summative assessment	Mentor	No specific patient feedback / assessment tool Mentors marks Yes or No as to whether the views of service users and carers have contributed to and informed the outcome of the student's summative assessment
Anglia Ruskin	Formative	Mentor led	Structure questionnaire 2 service users' feedback per placement 5-item Likert scale: Poor – Excellent Patient ratings on dignity; communication & respect; compassionate care delivery; meeting basic needs. Confirmation of students' requesting consent to provide care. Open text box for any additional comments. Students are also required to complete a reflection on each service user's assessment to discuss with the mentor their formative and summative interviews.
Essex	Summative	Student	No requirement to collect testimonials or feedback sheets Collaborating with Service Users is a summative assessed practice skill at each progress point (Years 1& 2) and at completion (Year 3).

			Required to have signed off by the mentor that the student: Year 1: 'uses feedback from clients, carers and colleagues to improve the client's experience of care (1 of 4 assessed elements) Year 2: 'seeks constructive feedback from clients and carers on their performance as a developing health professional (1 of 4 assessed elements) Year 3: 'uses client feedback to enhance their clinical performance, and, where possible, improve the care environment. (1 of 5 assessment elements)
Southampton	Formative	Student led but mentor must be present	Discussion between the patient, the student and mentor. Mentor to record discussion on form within the practice assessment document. Patients are asked to comment on: What the student has done well; what the student could do to enhance their nursing care and any additional information they think would be helpful
Canterbury Christ Church	To help inform the mentor's summative assessment	Mentor Student	Adopted PAN London documentation for cohorts from September 2017 Prior to this mentors were required to document patient feedback in relation to the NMC domains of practice. No prompt questions given.
Plymouth	Formative	Student	Students obtain written reports from service users / patients / carers. Year 1: at least 1 report Year 2: at least 2 reports Year 3: at least 2 reports, one must be in final placement Structured questionnaire – closed questions with space for written comments: Did the student identify themselves and their role? Did they communicate in an appropriate and relevant manner? Did you feel treated with dignity and respect at all times? Did they involve you in decisions about your care and treatment? Did they provide you with information about your care? Were your family members, carers acknowledged and included in your care and care decisions?

			Then asked to provide a global rating using a Likert scale from Outstanding to Unsatisfactory
Portsmouth	Formative	Mentor	Discussion with mentor prior to mid point interview. Feedback to be discussed with student at mi-point formative interview.
Wolverhampton	To help inform the mentor's summative assessment	Mentor	Mentors record that patient / carer experiences have been taken into account in assessing students at each summative assessment point.
Birmingham City	To help inform the mentor's summative assessment	Mentor	Mentors seek patient feedback in relation to specific NMC domains. Mentors record patient comments concerning student nurse's ability to: Provide explanations Listen attentively Make them feel welcome Show kindness and compassion Be gentle
Bolton	Formative	Mentor	Form completed by a service user, carer or relative for each placement. Open questions: State what they have done well What could they do to improve their communication skills, professional manner, participation in care etc plus any other information that might be helpful to the student for their future practice?
Sheffield Hallam		Student	Service user / carer testimonial sheet – a blank comment box Mentor countersigns each entry. No guidance provided for service users, carers, students or mentors.
Open University	To help inform the mentor's summative assessment	Mentor	Structured questionnaire. 4 open questions: What did [ ] do well? What could they do to improve their communication with you? What could they do to demonstrate a more compassionate approach to you? Is there anything else you would like to share that would help [ ] to develop their practice?
Derby	Formative	Mentor / supervisor	Service user experience incorporated into recorded simulated practice sessions. Can collect service user testimonials in exceptional circumstances but only

		Student	testimonial form provided is designed for mentors to complete
Northumbria	To help inform the mentor's summative assessment	Student – but forms to be returned to the staff nurse, sister or charge nurse	Structured questionnaire. 4-item Likert scale: Poor-Excellent How was the student at: Being friendly; listening to you; explaining things; caring for you; involving you in decisions; showing care and compassion. Open text box for any additional comments

Appendix 14: There is something I don't know

There is something I don't know
that I am supposed to know.
I don't know what it is I don't know,
and yet am supposed to know,
and I feel I look stupid
If I seem both not to know it
and not to know what it is
I don't know.

Therefore I pretend to know it.

This is nerve-wracking
since I don't know what I must pretend
to know.

Therefore I pretend to know everything.

I feel you know what I am supposed to know
but you can't tell me what it is
because you don't know that
I don't know what it is.

You may know what I don't know,
but not that I don't know it.
And I can't tell you.

So you will have
To tell me everything.

In R.D Laing (1970) *Knots*. London: Tavistock Publications

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[i] The research aim and objectives were refined at the point of analysis