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SCOPING THE REALITY OF NURSE HYSTEROSCOPISTS: A CASE STUDY

JULIA PANSINI-MURRELL

**A thesis submitted to the University of Huddersfield in partial
fulfilment of the requirements for
the degree of Doctor of Education**

The University of Huddersfield

1st September 2010

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Abstract

This study involves a unique cohort of training and qualified nurse hysteroscopists educated with the same provider. The aim of the research study was to explore the experiences of nurse hysteroscopists undertaking 'see and treat' outpatient hysteroscopy services. There is plenty of literature of advanced practice and activities of an advanced practitioner but with limited contextualisation of socio-cultural implications of taking on a specialised clinical role and what it means for the nurse. The wider sociological issues of organisations, feminisation of the health service and gendered occupational boundaries were considered.

The research takes a case study approach. In phase one, nine nurses participated in creating mind maps with storytelling narratives providing an in-depth understanding of their working lives. The maps illustrated organisational relationships with each nurse who then developed the story behind the map which was digitally recorded. The interviews lasted an average 45 minutes. Each of the nurses had their map and summaries of the analysis returned to them for comment.

The second phase of the study used an on-line survey based on issues raised in phase one. This enabled more of the study group to participate and established a degree of commonality between the two groups. Twenty-six nurses participated. A descriptive analysis of the data and qualitative comments are compared with those of the interviewees.

Key findings are set into context of the health service in the 21st century. It is proposed that there is a culture of organisational closure. Frustration due to poor organisational culture requires nurses to use significant effort in negotiation with and for services in order to achieve their full potential. Inconsistent planning, no sustained sense of purpose from senior staff and professional jealousy required nurses to use skills associated with emotional intelligence to sustain themselves and maintain the hysteroscopy service.

Recommendations include developing the nurses' interpersonal and social skills. A model is proposed for developing services and a recommendation made that a more strategic approach is taken by organisations.

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List of Abbreviations

BSGE	British Society of Gynaecology Endoscopy
CHRE	Commission for Health Regulation
CPD	Continuing Professional Development
DoH	Department of Health
ENB	English National Board of Nursing and Midwifery and Health Visiting
ESGE	European Society of Gynaecology Endoscopy
NMC	Nursing and Midwifery Council
KSF	Key Skills Framework
NH	Nurse Hysteroscopist
NHi	Nurse Hysteroscopist interviewed as part of the study
NHs	Nurse Hysteroscopist that participated in the online survey only
NHS	National Health Services
NHCS	National Health Cancer Services
NICE	National Institute of Clinical Excellence
UKCC	United Kingdom Central Council Nursing and Midwifery and Health Visiting
RCN	Royal College of Nursing
RCOG	Royal College of Obstetrics and Gynaecology

Dedications and Acknowledgments

This thesis is dedicated to my mother and the memory of my husband Chris, both of whom have always believed in me.

I would like to thank my manager Dr Gwendolen Bradshaw firstly for cajoling me into completing this thesis after Chris's death and secondly for organising the time for writing up. Whilst writing up, my departmental colleagues who have ungrudgingly supported my timeout by covering both my teaching and link tutoring commitments. Likewise, I would particularly like to thank Steve Milner for stepping back into the Associate Dean role.

My son for just being himself and keeping me focused on what is really important.

I made many new friends such as Cathy during the thesis and I would like to thank them for their interest. In particular Ann Stokes a sailing mum, and Dave Hutton who have applied their teacher's skills to proof reading this for me. Their common sense questions kept me grounded.

Without the nurse hysteroscopists there would be no study. Thanks to those who participated for their time, and the nurses' forum who are eagerly awaiting the results! Without Miss Jones there would be no nurse hysteroscopists. Over the last eleven years, we have been joined by Helen, Ann and Mary on an exciting journey that is not over yet.

Last but by no means least Dr Ruth Deery, later joined by Dr Sharon Wray, for easing me through the ethics processes and as my supervisors, making positive suggestions throughout whilst getting to grips and seeing round my dyslexia.

Chapter 1

Introduction

Nurses with a special view

Gynaecology – is a world that receives scant public recognition due to its association with the private domain of women's reproductive health. (Bolton 2005:169)

The role of the nurse hysteroscopist¹ did not exist pre-2000 and the environment of outpatient settings for hysteroscopy was limited. The specificity of the work and the gendered challenges as described above by Bolton (2005) make it important that I should investigate the private world of the nurse hysteroscopists. Over the last 10 years, I have been privileged to be part of the professional journey of this very specific group of gynaecology nurses who have taken the opportunity to apply skill and creativeness during an interesting expansion of nursing roles. The presence of men is, 'limited in gynaecology' (Bolton 2005:169) and currently there are no male nurses in training or working as qualified outpatient nurse hysteroscopists, therefore throughout this study nurses will be referred to in the feminine as 'she'.

The need for the Study

A search of the internet in 2009 using the term 'Nurse Hysteroscopy' indicates just how this service is evolving in many NHS Trusts, and how diverse services are across the UK. This internet evidence shows the public face of service development but does not tell the reality for individuals. Yet e-mails from students tell an anecdotal story that suggests there are certain challenges and pitfalls. It is clear that nurse hysteroscopists provide a unique service to women (Jones 2005). As a group of professional women, the nurse hysteroscopists are on a parallel journey to the NHS by responding to governmental demands to change the direction of their practice (Darzi 2008). This move is toward a neoliberal health service in which control is reduced and a free market expands (Lipsky 1980), but at what personal cost? There emerge several questions. Firstly, what is the impact, if any, of this specific area of clinical skill and practice development on the individual? Secondly, do social networks and environments change and therefore impact on the nurses as the new services evolve? It is important to understand these questions both ethically and educationally in order to prepare nurses of the future

¹ A hysteroscopist is a person trained to and uses one of two types of specialist endoscope to view the uterine lining (endometrium). Visualisation along with interpreting ultrasound results and clinical history of symptoms allows the individual to diagnose gynaecological pathological conditions associated with abnormal uterine bleeding. A nurse hysteroscopist can provide a one-stop service particularly when additional training is completed, after which she can perform therapeutic treatments through the scope. After the procedure/s the nurse refers the women back to the General Practitioner or onto other services. She maintains records and audits the service.

to undertake roles that transgress normal, professional boundaries. Thirdly, traditional educational audit tools are not designed for evaluating these intrinsic outcomes². Finally, there is a current debate on what an advanced practitioner is and who can use this title. I suggest that an advanced practitioner is someone who has gained one area of professional recognition but who has undertaken further study and is not practising within another professional's domain of practice. However, it is currently unclear whether this should apply to nurse hysteroscopists. Gradually I unpicked the issues to develop the following aims and research questions.

The aim of the study is to:

Critically analyse the professional and social impact of the new advancing practice roles for outpatient nurse hysteroscopist.

The research questions are:

1. Has there been a personal and or professional impact becoming a nurse hysteroscopist?
2. How do hysteroscopy nurses relate to other staff in their departments or the organisation as whole?
3. Were there factors that facilitated or hindered training and subsequent work as a nurse hysteroscopist?
4. Are nurse hysteroscopists functioning at the level of an advanced practitioner³?

Whilst I have created a series of questions, they are my questions, and they may not be the 'real' issues for the nurses themselves. My feminist background means that I have selected a feminist approach to the study. In the methodologies chapter I will examine feminist research methodologies and explain the rationale for taking this stance.

Rationale for the study

The rationale for this study emerged from the time I have spent with nurses facilitating their training programme⁴; responding to e-mails, listening to their issues

² The local educational audit tool looks at resources for clinical experience training and appropriateness of placement and mentors.

³ Advanced practice: There is currently a significant debate on what this actually means in terms of clinical activities. The nurse hysteroscopists have just entered into the national discussion with the Royal College of Nurses (RCN). A representative from the RCN attended the nurses' annual conference on 28.01.10.

⁴ I am joint course leader for the only provision in Europe of training for nurses and new for 2009 a course for General Practitioners. There has been one European National nurse on the course to date.

and helping to facilitate them as they handle problems in their home Trusts⁵. This study is important, as an educationalist and practitioner. Working in higher education, I am expected to diversify by developing new courses to meet the changing needs of a modernising NHS. The nurse hysteroscopy provision is one such example. The public dimension is that courses provided by the university sector should be of benefit to the health service. The potential benefit of 'advancing practice' to the health service and, in this instance, women's gynaecological health service is not in question (Mills 2004). However what is not clear is the impact on the nurse who has taken on the responsibility and challenge of meeting health needs in using new skills, particularly those not previously associated with nursing. It is this aspect that requires examination.

Personal perspectives

In any study, the reader should understand the researcher's perspective. Perspectives start and finish with philosophy. Philosophy is a way of understanding and explaining problems that are, 'ultimate, abstract, and very general'; the nature of truth and how the world is interpreted (Teichman and Evans 1999:1). There are differing schools of philosophy and, the structure of a philosophy that an individual chooses influences their personal paradigm. For the last eighteen years, my understanding of the world has increasingly derived from a feminist perspective. I came to 'Women's Studies' through a post graduate degree at the tail end of its popularity as a discrete academic discipline. Recent years have seen a decline in Women's Studies only courses, there being only two specific Women's Studies courses left in the UK (Whatuni 2010). Walby (2008), when being interviewed by Kalekin-Fishman (2008), suggests this is because it (women's studies) is now;

established sufficiently that it is appropriate to move on to mainstreaming gender perspectives.
(Kalekin-Fishman, 2008:698).

Likewise, the discourses have moved on from the nature-nurture debate to the 'Social construction of gender discrimination' (Doyle 1994:142). Feminist researchers, searched for, and participated in, examining institutionalised 'patriarchal' power dynamics that were impacting on and defining women's world (Stanley and Wise 1993, Davis-Floyd and Sargent 1997). Walby (2008) went on to propose that the role of women is still creating a restructuring of the social fabric by the arguments that emerge from research and academic discourse.

⁵Since a change in governance, hospitals are now managed as a hospital Trust. Throughout the thesis, I will refer to the nurses' place of work as a Trust denoting the hospital unit that employs them.

As a nurse hysteroscopist lecturer, I can have some influence on how the nurses learn, within the confines of the professional imperative, to ensure that they become safe practitioners (CHRE, 2009). Mooney and Nolan (2006) reflect that the nurse lecturer is never truly free as the:

Curriculum content is influenced by organisations and institutions that influence the broad content of the curriculum.
(Mooney and Nolan 2006:242)

Unlike them, I would argue that there is some freedom in how its content is delivered. I use Problem Based Learning (PBL) to facilitate access to the educational programme for hysteroscopy nurses (Pansini-Murrell, 1996). Whilst there are learning outcomes to be achieved, the power of learning has been moved to the student. This philosophical approach and strategy to teaching resonates with feminism and has been an influencing factor in my academic career. The work of libertarian educationalist Freire (1994) was particularly influential in my understanding of pedagogy. He recalls being influenced by North American feminists, believing that:

Liberation should take place for both men and women and not just for men or women along colour or ethnic lines.
(Freire, 1994:172)

Here Freire recognises the negativity of oppression and that it is not restricted to gender. Through understanding this, his thoughts on 'social transformation' through education developed (Freire, 1994:172). He was arguing for reform during a political revolution and, at the time, he observed that the 'oppressed become the oppressors'. His route to revolution was through education (Freire, 1976). He believed that by changing how and what is taught, this cycle could be changed. If the teacher keeps the power through didactic, 'banking' methods of teaching the student only learns what they are told. Freire believed the development of critical thinking skills was essential. This concept was picked up by nurse lecturers in Mooney and Nolan's (2006) study.

The teacher who imparts knowledge without fostering challenge and critical thinking, is in fact serving the interests of oppressive education.
(2006:242)

It is not possible to claim that in 2010 nurses are denied educational opportunities for developing critical thinking skills. Initial and continuing professional education (CPD) for NMC registrants is, in higher education settings, at a minimum of non honour degree (NMC 2009a). However, this does not account for the onsite

training⁶ nor does it guarantee that teaching methods are transformative. Nurses coming to the hysteroscopy course have had a range of academic experiences⁷. However, they will have been working in a hierarchical organisation. The NHS, whilst protesting it wants critical thinkers, also wants compliance (Halford, Savage and Witz 1997). Whilst Problem Based Learning (PBL) has not been promoted as a feminist educational tool, it does resonate with Freire's ideas of an educational strategy that enables transformation and removes oppression for its participants.

Instead of banking education which domesticates students,
problem posing offers a search for knowledge.
(Shor 1996:26)

The whole philosophy of PBL is to move away from the principles of didactic teaching, shifting the power dynamic and control to the student, and develops the activation of prior knowledge (Schmidt 1990); Appendix 1 illustrates how and why the power is shifted to the student. This is important when the course aim is to extend the knowledge of the nurse and give the nurse the confidence to challenge current practice and argue for services.

The activation of prior knowledge is done by posing 'Problems' for the nurses; exploration is the key. This enables the students to learn actively rather than passively absorbing what is presented to them (Pansini-Murrell 1996). Miers (2000:165) also suggests that feminist content and principles may help nurses, 'to recognise a woman's shared concerns'. The realities of the length of the hysteroscopy course limits the extent to which this additional perspective can be incorporated into the programme, but that is not to say that at the next curriculum review it should remain the case. Fig 1 illustrates how the Maastricht seven Jump process⁸ is used to activate the nurses' prior knowledge.

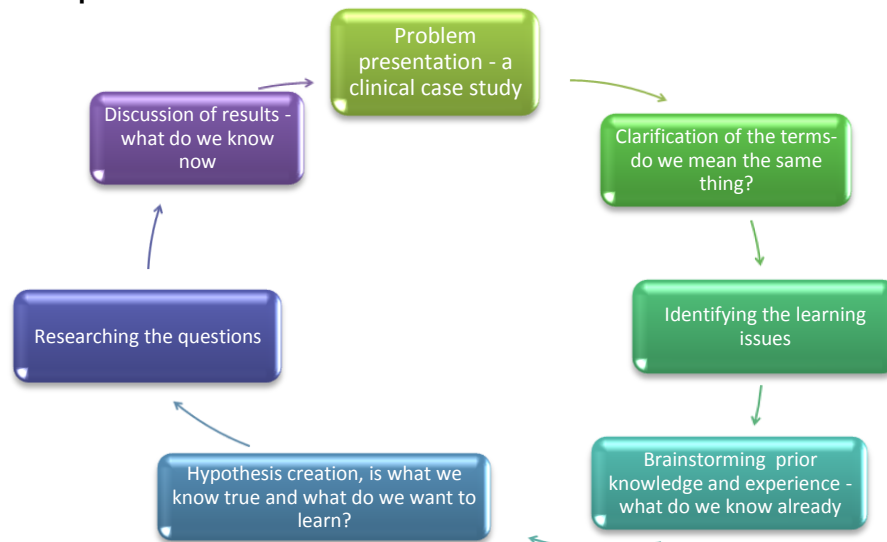
Over the latter part of the 20th century, feminism has endeavoured to explain the culture of organisations through gender. This is particularly relevant to this study for two reasons. Firstly nurses in the study group are all women and, secondly, nurses have been recorded as being part of an oppressed group by virtue of their gender and education (Walby 1986, Davies 1992). It seems pertinent to look at the frameworks that have articulated that notion. Witz, a feminist sociologist, (1990, and 1994) used Max Weber's, a mid 20th century sociologist theories, to explain professional boundaries and the power dynamics in health services.

⁶ Training provided solely by hospitals for their staff is not credit rated, unless they have a partnership arrangement.

⁷ Admission to the course is currently with a minimum of a diploma, but must have evidence of study at level three.

⁸ The Maastricht seven jump processes for PBL are problem presentation, clarification of terms, brainstorming, analysis, hypothesis creation, researching, and discussion of results.

Figure 1 Maastricht Seven Jump cycle used in PBL with nurse hysteroscopists



(Created by the author 2010)

Given that the implied current NHS objective is to challenge those boundaries and the organisational complexity that arises out of them, it appears timely to examine occupational precincts using Witz's model of 'Occupational Closure' within the current health service, using hysteroscopy nurses who could be said to be representative group of nurses adapting to the modernisation of the health service.

'Working on the basis that knowledge and truth only describes the reality for 50% of the population' (Stanley and Wise 1993:30), and that inequalities exist in all aspects of life and that those who are 'oppressed' need to be given a voice (Reinharz 1992), nurse hysteroscopists, as much as any another group, have a right to be given the opportunity to express their experiences.

Sociologists writings from this approach have identified ways in which men and women have been treated differently noting the way in which socialization and sex roles expectations diminished women's opportunities within education and employment...
(Miers 2000:21)

This is not to suggest the nurses of my study are browbeaten, but they may be exploited unwittingly. Using Miers' (2000) interpretation of oppression, nurses fit into this category at multiple levels; through the organisation that employs them,

through what they know, and what they are 'allowed' to know, plus the expectations of how they will use what they know. Debates on these matters have developed through feminist theoretical perspectives on professions and organisations (Witz 1992; Savage and Witz 1992; Miers 2000). I will be expanding on nursing in the context of organisational bureaucracy and occupational closure in chapter 2.

The notion that there is something to investigate through feminist perspectives comes from three key aspects that have emerged whilst managing the course. These were:

Firstly, nurses are being mentored and assessed by gynaecologists into whose historical territorial boundaries they are stepping; are there consequences for this?

Secondly, in hysteroscopy there is an assumption that the evolving practitioner should have advanced skills that are both theoretical and dexterous and to a level commensurate with that of, at least, a medical registrar⁹. Are they gaining recognition for these skills? Advanced practice is being promoted politically.

Thirdly, those coming into hysteroscopy are qualified nurses. The question is, do they have the (necessary) qualities and organisational support not only to take on the new skills but also to lead and develop the services?

Chart 1 (on the next page) gives an overview of the progress of the study.

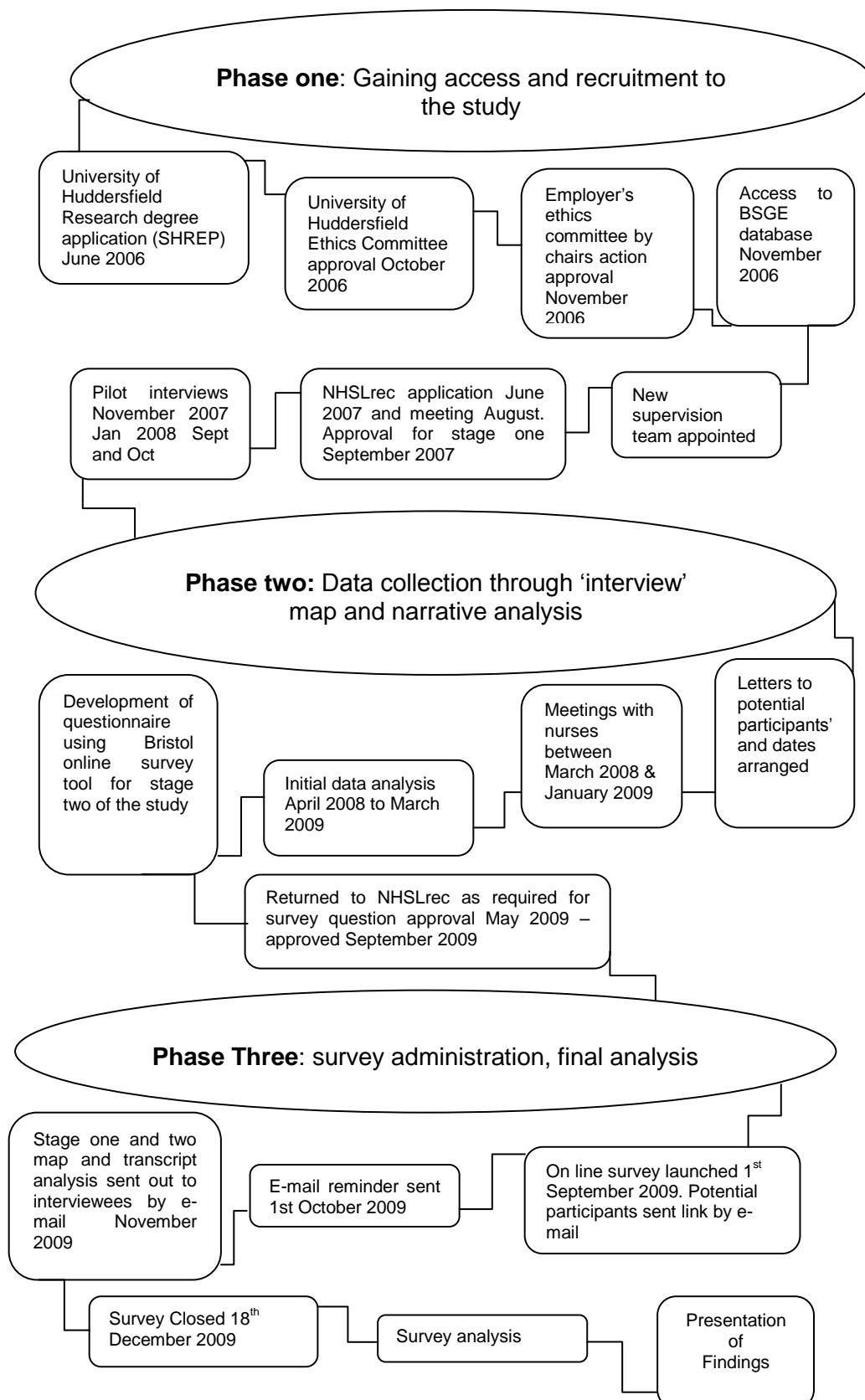
Nurse hysteroscopists as a case study group?

The NHS of the future needs to get smart. That means changing how patient care is delivered and how people are employed.
(Milburn 1998)

The National Health Service (NHS) is challenging the perceived roles and professional boundaries of the nurse. In an atmosphere where no one has determined how new roles should fit into the NHS structure, there are emerging issues. Firstly, the public are not aware of what new roles and titles mean and

⁹ The nurses are taking on an activity that is currently being performed by registrar grade staff in outpatient settings and Senior House Officers in theatres. A medical register will have two years post qualification experience before entering a chosen training programme that could last a further seven years, if they pass the examination at the first attempt. The British Society of Gynaecology Endoscopy standard is that the nurses must pass the same Objective Structures Clinical Examination. Shortly the course team will be running multi-professional OSCE's.

Chart 1 Flow Chart signposting study phases and progression.



secondly, there are assumptions and expectations that individuals are able and will take on the new advanced roles for the evolving services (CHERE 2009). Arguably, any pre-existing organisational and gender tensions (Walby 1986; Witz 1992 and 1994; Halford and Leonard 2001) mean there may be hidden problems accompanying these innovations in practice. To facilitate the changes in workforce patterns of professional behaviour, the Department of Health (DoH 1999, 2001a) proposed that 'Advanced Practitioners' were to lead and become clinical experts and facilitate these overall changes. Thus, questions arise as to which of the plethora of terms within the rhetoric associated with 'advanced practice', best describes the emerging roles and practice and whether a new definition of roles and occupational boundaries are required (Rolfe, 2000).

The aim of introducing nurse led hysteroscopy services was to make a reality of that political intent (Milburn 1998 DoH 2001a). Through working together, my higher education institution and the local National Health Service Trust (NHST) would develop the skills and knowledge required for such a significant role change, (Jones 2005). As a trailblazer, the Trust wanted to have the first nurse led hysteroscopy services in the UK. The host NHST¹⁰ already had an advanced practice group that supported and monitored the creative service delivery with the attendant staff development. This group would oversee the scope and development of nurse led outpatient hysteroscopy clinics.

Prior to 2000, nurses in hysteroscopy clinics were supporting the women patients, helping to manage the equipment; ensuring equipment was sterile and stored appropriately. The actual practice of hysteroscopy was the sole remit of senior gynaecologists. It involved history taking, undertaking invasive investigation of the uterine cavity with a hysteroscope, diagnosing pathologies, debriefing women, offering a diagnosis and suggesting treatment options, including drug therapy or in-patient treatment. The aim was to educate nurses to undertake these activities within a nurse led outpatient service. Subsequently, as new techniques have been available, nurses have continued to extend their practice. The activities include the surgical removal of small amounts of tissue from polyps, and ablation of uterine tissue, within outpatient settings. NHS Trusts were in a position to facilitate the new guidance on waiting times for cancer referrals (DoH 2000a), known as 2 week wait¹¹.

this investment will need to be accompanied by reform: through

¹⁰The NHS manages the services through organisational frameworks known as Trusts. Each Trust differs from secondary health service provision at an individual hospital or small group of hospital units to the primary sector which may manage all primary care facilities. For the purposes of the study, the generic understanding of Trust will be used to refer to secondary care facilities.

¹¹ Post-menopausal women who have unexplained genital bleeding have to be seen within 2 weeks, as there is a high probability of endometrial cancer amongst this group of women.

new ways of working to streamline cancer services around the needs of the patient; through extending the roles of radiographers, nurses and other staff.
(DoH 2000b:6)

For example by moving the practice of hysteroscopy to a 'see and treat' outpatient service, the scope of practice for nurses, amongst others, has been changed. To complete an integrated one-stop service nurses would: refer women for surgical intervention or therapeutic treatments, and prescribe drug therapy under patient group directives (PGDs)¹² (National Prescribing Centre (NPC) 2004), finally liaising with the originator of the referral i.e. General Practitioner (GP) or consultant. Further contextualization with regard to the political motivations and its potential consequences for enabling nurse movement into medical domains of practice will be examined in Chapter 3.

Nurse Hysteroscopists were to be part of this new generation of practitioner. They needed to achieve the three domains associated with clinical competence; psychomotor, cognitive and affective. The principles of this have been captured over a period of time, starting with Benner in 1984 and being redefined along the same principles by a range of subsequent authors (Schön 1991; Stengelhofen 1993; Nicol, Nicol, Fox-Hiley, Bevin and Sheng 1996; Milligan 1998). The argument about the achievement of these qualities as attributes of advanced/specialist or enhanced level will continue throughout the thesis.

Design of the educational programme

During the late 1990s, a local consultant initiated a survey of consultants to establish the interest in having nurse led hysteroscopy services (Ludkin, Quinn, Jones, and Wilkinson 2003). She had seen the potential for nurses to lead the hysteroscopy diagnostic role in outpatient settings, having observed the emergence of the nurse led colposcopy 'see and treat'¹³ clinics. Smith¹⁴ (Ludkin and Quinn 2002) was about to facilitate a change in nurses' clinical activity (to include increased responsibility and accountability for clinical diagnosis and treatments that had traditionally been deemed medical and was negotiating with the board of the British Society of Gynaecology Endoscopy (BSGE) a sub group of the Royal College of Obstetricians and Gynaecologists.

The British Society for Gynaecological Endoscopy exists to:

¹²Nurses may also be known as a supplementary prescriber. The nurse may prescribe a drug directly to the patient with "an identified clinical condition".

¹³This is a colloquial term for one-stop outpatient services where someone is assessed, diagnosed and can be treated all at the same time.

¹⁴Pseudonym for anonymity purposes

improve standards, promote training and encourage the exchange of information in minimal access surgery techniques. (BSGE Website 10.02.10)

The BSGE was important, as its members would be required to maintain clinical standards as they supported nurses in their training. After several years of negotiation at the annual general meeting of the BSGE (2000) agreement was reached that they would support the development as a project. The BSGE would open up their register to provide the nurses with the same rights as the doctors, including professional indemnity, election rights¹⁵, the peer reviewed society journal (Gynaecological Surgery), and they also provide bursaries for training costs and reduced conference fees. The proviso was that each nurse undertook the recognised course of study, demonstrating that they could attain an appropriate level of knowledge, meet a pre-defined set of clinical competencies and work to the national standards. The BSGE confirmed ongoing support for the training of nurse hysteroscopists following the successful completion by the first cohort of nurses in 2002. A member of the BSGE acts as an external expert for subsequent academic approval events. This level of agreement seems unique; but there is a feminist discourse arising out of this development that resonates with theories of gender, patriarchal power and professional boundaries Hugman (1991) and Witz (1994:24) who would see this as a continuance of medical control by monitoring the nurses' academic credentials.

In planning the emerging course, the team was concerned that the nurses should be able to have a progressive program of study that developed technical skill, research interpretation, and through which they could take responsibility for the development of the service in their home trusts. Reflecting on the development of work-based learning modules from the educational perspective, cognisance was taken of some of the issues in the module design and recruitment of nurses for the course.

These have subsequently been discussed at length with the original NHST and the BSGE. Anecdotally, it has become apparent that these issues had been less well thought through by organisations employing the nurses. The subsequent anxiety emerged that the students (nurses), their managers and trainers may not have worked through the idealism and implications of the advanced practitioner role. In particular, the managers and clinical trainers were not considering aspects of organisational governance, arguably placing 'their' nurse in a potentially vulnerable professional position. It is timely, therefore, to consider the interplay of the concepts of advanced practice within organisations and the impact on individuals.

¹⁵There is now a nurse hysteroscopist on the BSGE Board.

The first course started with nine students. At the point of submitting this thesis, there are 45 qualified nurse hysteroscopists¹⁶ and 10 in training. The empirical evidence supporting this new service is limited to date but Mills (2004) records the following details that are taken from an audit published online on her hospital's internet site.

So many patients are pleased with the reduction in numbers of visits and reduced time to diagnosis. Prefer female practitioner. Patients diagnosed with cancer already known to me therefore better support mechanism already in place. Need to look at increasing service to meet the demand and continue to improve times to diagnosis.
(Mills 2004: Accessed 13.08.2010)

Meanwhile, Bode, Duffy and Binney's (2008) small empirical study done in 2005 compares patient satisfaction pre and post commencement of a nurse led service. The results were positive with patient satisfaction remaining high. Other articles provide an overview of the service (Ludkin, et al 2003, and Jones 2005). There is also emerging evidence that having qualified inter-professional teams can provide a comprehensive service outside traditional NHS settings (Connolly 2007).

The rationale for my being "With nurse"

I had been a midwife for eighteen years when I became involved with the nurses. There were two reasons. Firstly, my interest in women's health, having recently completed an MA in Women's Studies, and a range of recognised¹⁷ sexual health modules in order to lead the school's continuing professional development provision. Additionally, during this time I was seconded and sponsored by a local Health Authority to return into practice settings. I chose gynaecology for three months. Not knowing of the future benefits at the time, I had the opportunity to observe outpatient colposcopy¹⁸ and hysteroscopy provision. At that time, the role of the nurses in both services was as an assistant only. My credibility was increased as, co-incidental to this, I was involved with improving the regional standards for cervical screening training. My own work with the regional co-ordinator of cervical screening services gave an understanding of some of the potential threats of poor and inconsistent training standards (NHSCS 1995). Secondly, I was selected because of my curriculum development skills and interest

¹⁶ Three have retired and one has returned to ward work.

¹⁷ The English National Board preceded the NMC in statutory regulation of education and post qualification education. They monitored many more courses than is currently the case.

¹⁸ Colposcopy is the viewing of the cervix by the use of a scope and the taking of surface samples, and treatment.

in innovative teaching methods and had considered some of the political issues of continuing professional developments (CPD) (Pansini-Murrell 1994, 1996).

By working in partnership with the local National Health Service (NHS) Trust, a course was approved with the partner Higher Education institution where I work. The host Trust was already supporting other creative staff developments and as part of clinical governance processes, had an Advanced Practice Group. This group would oversee the scope and development of the new service as the Trust was redefining its service provision, whilst meeting the national safety standards and not opening itself up to potential litigation (Ludkin and Quinn 2002).

Following a series of meetings with the course development team, which included two of the nurses who applied to be on the new course, a set of documents emerged (Ludkin et al 2003). These included papers required for approval by the Trusts Advanced Practice Group, some initial practice protocols, and the documents for approval through the university processes. The course module was approved at Level 3 and Masters¹⁹ and has now been running for nine years. The core teaching strategy remains problem based learning with a pre-course workbook; the assessment is a logbook of activities, a series of case studies and an Objective Structured Clinical Examination (OSCE) as used for the medical staff progressing to registrar status. In 2007, the credit volume of the module was increased and an audit of hysteroscopy services was added.

Understanding models of learning, the work environment, and safe practice

I have already discussed the educational philosophy in preparing the nurses. The other part of the educational framework was the use of work-based learning, which was identified as a tool by which to deliver this module. Work-based learning increasingly articulates well with the current demand from Strategic Health Authorities for practice development and Continuing Professional Development (CPD) provision to be WBL.

All new modules, courses and programmes should increase the focus of work based learning and incorporate assessment of skills and competencies, as defined by Skills for Health National Occupational Standards.
(YHSHA 2006:32)

¹⁹Level 3 and Masters: These refer to the QAAHE standard for academic attainment. The levels were set to reflect the relatively few graduate nurses in 2000 so that the course would not be exclusive and exclusionary.

WBL in higher education was originally designed with the intent that the participant would negotiate their own learning contact to develop specific skills (Boud, Cohen and Walker 1993, Boud and Garrick 1999, Boud and Solomon 2001). However, other models were being developed in industrial settings. Often they were associated with vocational study in industrial settings and were not associated with a licence to practise. A definition of the aim of WBL by the Confederation of British Industry (CBI) is:

The possession by an individual of the qualities and competences required to meet the changing needs of employers and customers and thereby help to realise his or her aspirations and potential in workplace.
(CBI 1998 cited in Glass et al 2002).

Whilst this is an industrial analogy, the principles of competences and adaptability to change are fundamental to any organisation that wants to sustain an operational vitality at the highest level. During an extensive survey by Glass, Higgins and McGregor (2002) on behalf of the Scottish Executive, the principle values of WBL were identified:

Employers tended to cite competitiveness reasons for supporting work based learning, including:
improving quality of service or product
making the company more competitive
improving competence in the job
keeping up with technological developments
increasing the flexibility of employees
increasing productivity
(Glass et al 2002:3)

These are consistent with a business model to which the NHS is being driven. However, models of WBL do differ. There are some examples where local trusts have courses that facilitate some expansion of roles and are delivered 'in house' and are frequently part of 'mandatory training' i.e. IV drug administration. An example can be found on NHS Glasgow and Clyde's CPD education site. These are half-day courses and may not have any competency assessments (www.knowledge.uhl-tr.nhs.uk). The courses are very prescriptive and do not follow many of the original principles of self-directed WBL as espoused by (Boud, et al, 1993). The more prescriptive of the tenets seen in health based courses using (WBL) were described by Boud and Solomon (2001) as having six key features; they are described and reviewed in the context of the development for nurse hysteroscopy. These are set out in appendix 2.

A further accepted principle of WBL (particularly the industrial model) is that the activity undertaken by the student should be transferable. This is achieved because the course outcomes have been predetermined professionally, through a

consensus of senior nurses and nurse educationalists, and endorsed by the 'dominant' profession, with significant learning occurring in the workplace. I have toyed with the feminist arguments about power and relationships and the arrangements of having the national and international recognition from the BSGE, and European Society for Gynaecological Endoscopy (ESGE). However, on reflection, the nurses are starting to set the benchmarks of good practice for service improvement.

Always at the back of a course tutor's mind is that any nurse, who takes on an extended role, increases the potential for litigation if they make a clinical error. In health care there is a requirement for standards and consistency (The National Health Service Litigation Authority) and the government tells patients that they are entitled to expect a similar standard of service wherever they are seen (DoH 2006). These standards can be controlled by training standards, Trusts' clinical governance mechanisms, and the nurses' diligence. However, the potential for removal from the nursing register by the nursing and midwifery council (NMC) under fitness to practise rules should not be ignored (NMC 2009). Whilst the nurse hysteroscopy module outcomes are specialised, the principles for safe practise are commensurate with those for nurse practitioner where the nurse sees and treats patients in a General Practice setting. Reassuringly, to date there is no current evidence to suggest that any of the 1.65% of cases referred to the NMC under the criteria of poor clinical competence were involved in advanced practice (NMC 2009).

The trouble with words

My spelling is wobbly. It's good spelling, but it wobbles, and the letters get in the wrong places.
(AA Milne 1926).

The final personal perspective to this study comes from the acknowledgement that I have dyslexia. I have the above quote with a cartoon of Winnie the Pooh in my office as it reflects the frustrations I have in marshalling my thoughts into the written word. This has occurred throughout my education. In primary school my reports said I was very articulate and my mother recalls that the head teacher could not understand my inability to write with my level of verbal comprehension. At the age of thirteen I was tested²⁰ for dyslexia but nothing came of it. I struggled on, eventually gaining 6 'O levels' after three sittings and an 'A' level. My nursing and midwifery course were fine. I loved what I was learning and had fun at the same time. Likewise, my Advanced Diploma in Midwifery went well, with good marks in

²⁰ This was the about 1970 when dyslexia was still not really understood or accepted

each assignment. It was during my first degree in 1990-1992 that dyslexia was hinted at again but it was not until I was to apply for a PhD that real concerns were raised²¹. When I was finally diagnosed in my late thirties, I learned also that I was not 'thick'. I had learnt to cope with a lot over the years but stress in whatever form foils those coping strategies. During the Education doctorate, a change in the law finally meant I was entitled to help. This in itself has been a challenge as it has been hard to let go and use some of the technology. As a result of this, I have developed for use two strategies in data collection and analysis purely for pragmatic reasons. I believe they add interesting perspectives to the study in that I have adapted a strategy for data collection and applied a dyslexia tool to aid data analysis.

Outline of thesis

In this introduction, I have presented an overview of the key issues that have a relevance to the emerging experiences of nurse hysteroscopists. From the inception of their training and the move into another's professional and occupational space, it has also been done during a time of significant organisational redesign, driven by the government. I will expand on this in more detail in chapter 2.

Chapter two is the first of two in the literature review. I start by examining the political drivers for the organisational structures, hierarchy and bureaucracy in which nurses' work. I will discuss the social constructs of occupational closure, gender and education that impact on the working environments of nurses. The use of policy documents and sociological debates will provide the context, whereas the empirical evidence on emotions will examine how the use of self is important in working relationships, either as a manager or as a subordinate. This will inform a potential understanding of the issues for nurses taking on new roles in public sector organisations.

Chapter three forms the second part of the literature review. Here I will examine professionalism and current debates on advanced practice. This is done in the context of challenging occupational monopolies. Finally, by accepting the view of Stanley and Wise (1993: 47) that there is, 'no mono causation', and anticipating there is no 'mono explanation' for this, I will revisit feminist perspectives of knowing in the methodologies chapter.

²¹ I wanted to explore dreams in pregnancy and the psychologist who read the proposal immediately suggested I was tested. Moving jobs put an end to that idea.

The methods are presented in chapter four. Here I explain the rationale for taking a feminist approach to selecting the methods chosen and what the potential for their application in the study is. The various gate-keeping stages will be considered up to the point of data collection; this includes how I recruited the nurses to the study and the challenges that were presented to me. I argue why I believe I have a quality study.

In the fifth chapter I explain the processes of data analysis in detail, as part of the audit trail associated with qualitative research. This chapter also contains brief reflections on the aspects of learning for the future as a result of my experiences.

In chapter six I present the mind maps so that the reader can familiarise themselves with how the nurses came to be working as hysteroscopists and the types of activities and working relationships the nurse hysteroscopists have within their organisations. Using these maps and some quotations I begin to examine some of the facets and factors that influence these relationships, in particular the relationships and factors surrounding their training and overall support. From this emerged evidence of hierarchies and relationships. I conclude the chapter by presenting a model of how nurses' opportunities are controlled by organisational mediators.

In chapter seven I will expand the discussion using data from the nurses to look at the impact that moving into another's occupational space has had on them during their search for professionalism. I continue to use quotations from the stories and start to introduce more support evidenced using charts and quotations from the survey group. I consider the concept of sovereignty and develop a model to examine how there is control over them from the bureaucracies that impinge on practice developments. Using a model, I will take the reader through the theories that may offer explanations.

Chapter eight takes a look at the personal consequences of the nurses in becoming a hysteroscopists. Using more examples from the data I explore how the nurses are using emotion on a daily basis to manage situations that they find themselves in. This is then considered in the context of the advanced practice. Drawing on the data I have created two tables by using nurse's experiences to demonstrate facets that correlate with the notions of emotional intelligence and risks of becoming advanced practitioner. The chapter concludes by bringing the discussion into the current year, the implications of the new government proposals for the health service, and proposing a framework to support new developments.

Chapter nine includes a review of the findings drawing some final conclusions, a reflection on the study processes, and concludes with a list of recommendations.

Summary

In this chapter I have set the scene for the thesis, with the research questions and outlines for the study based on my work with nurse hysteroscopists as their educational facilitator. I have explained how the nurses can achieve their clinical objectives by outlining the course philosophy. I have also given a personal account of factors that have challenged my development. Finally, I have concluded by outlining the structure of the thesis.

Using literature, in the next chapter I explore the health service and provide a context for the changing directions of nursing work.

Chapter 2

Social Dimensions of the Health Service

The pace of change has grown exponentially as we have rolled into the new millennium and perhaps one of the big failings in nurse education has been to ignore this – not insignificant – factor. (*Hart 2004: 282*)

Setting the Scene

Hart (2004) challenges the educator to recognise the socio-political constructs that impact on nurses and their role in providing vitality to the nation's health. As the research questions crystallised, possible constructs emerged that could potentially impact on the nurses' experience as they contribute to the refashioning of the health service in the 21st century. The literature review is divided into two chapters. This chapter focuses on understanding the sociological context of working in the health service, so as to lend an understanding to the changes which are occurring for nurse hysteroscopists referred to in chapter one. I discuss Weber's model of occupational closure, Lipsky's work on bureaucracy and sociological feminist explanations of power dynamics for women and in health services. I consider how they are relevant to the nurse hysteroscopists.

Chapter three examines in more detail the current literature relevant to becoming an advanced practitioner. The nurse hysteroscopists are one of a number of groups that are central to government objectives, by their taking on an advanced practice role. As Hart, quoted above, states the context is all important. Before defining advanced nursing practice and exploring the facets that accompany that concept, I have considered the characteristics of nursing and of advanced practice nursing, and discussed some of the implications of challenging the occupational monopolies traditionally found in the health service.

Whilst writing the literature review, I used library searches for textbooks and the Metalib facility for searching for electronic sources of information and web based resources. Throughout the duration of the study, searches were performed in numerous health and sociological databases enabling access to electronic journals; for example, Science Direct and Sage Publications. Words and conceptual phrases searched for were 'occupation', 'professionalism', 'work based learning', 'advanced practice', 'advanced nursing practice', 'emotional labour', 'nurses' roles', 'changing roles' and 'organisational culture'. There are many articles that explore emotional labour and work in nursing practice but I have

limited my work to emotion in the context of employment and working relationships. Out of my readings and interpretations of the above, the search was extended to include 'emotional intelligence', 'bureaucracy and professional knowledge'. Policy documents were accessed from professional organisations and the Department of Health (DoH). Many of the studies and papers I refer to were conducted in the latter part of the 20th century or at the commencement of the 21st century. Whilst I can critique them, I have also to bear in mind that the context of British health care has evolved significantly since many of the papers were published. Therefore, inferences may only be drawn with caution. Likewise, for those studies undertaken outside the United Kingdom (UK), whilst there has been some alignment in the structure of health care systems in recent years, I have used caution when considering contextual analogies.

Hierarchies in publically owned organisations.

Hierarchies are the organisational means whereby the day-to-day actions of the members of these occupations are controlled.
(Hugman 1991:66)

Nurses working in the National Health Service are working in a hierarchical system (Hugman 1991). Within this national organisation there are clearly delineated lines of responsibility and boundaries, both from inside the organisation's structure and within professional groups. Hugman (1991:67) goes on to argue that by creating routine tasks at work 'the subordinate is brought directly under the 'superordinate''. A medical example is the student, house officer, senior house officer, various registrar grades and finally consultant. Nursing examples are student, staff nurse, sister and matron. With each stage the 'power' and management of the superordinate increases as does their control of what is done by whom. However, he also argues that a hierarchical relationship:

Emphasises the particular differences, those of organisational position, while at the same time obscuring professional similarities.
(Hugman 1991:67).

This suggests that there is a negative effect in the provision of service. It was not always so, past reviews of the NHS tried to increase efficiency by inserting managerial roles and responsibilities. These occurred as a result of a series of reports: Salmon 1967; Griffiths 1983; Kelleher, Gabe, Williams 1994. Hunter argues that despite the political agendas of the late 1980s and early 1990s there has been little change:

The authority of doctors may have been bruised as a consequence of general management; tier power and status both within the NHS and society more generally have remained intact.
(Hunter 1994:5)

The work of Hunter perhaps gives an insight into the complexities of the NHS as an organisation prior to the change of government in 1997. On reflection, it would appear that the strategy was to change the power dynamics by changing from administrators to managers. Halford et al (1997:128) see a counter argument to this in that:

There was a male 'takeover' of the new nursing hierarchy. The 1990's 'linear hierarchy' required nurses to step through each progression gate, any career breaks²² stalled a women's progression, allowing men greater access.

A consequence of the last labour government's move towards equality through comparability of roles and reward, is defined in the Modernisation Agenda and the Key Skills Framework [KSF] (DoH 2003 and 2004); this may go some way to redress this imbalance. The recent government policies to restructure how services are delivered have challenged the current homogeneity of clinicians into shifting their focus to the most cost effective and efficient way to deliver services. Whilst the overall frameworks are preset through the Darzi report of 2008, individual organisations have the potential, through vision and leadership to reconfigure effective services. Simultaneously, these policies challenge the current homogeneity of clinicians into shifting their focus to the most cost effective and efficient way to deliver services. Nurse Hysteroscopists form a case group that encapsulates a new way of working and are poised to step in. However, life is never that simple and there has to be a collective will within an organisation to do this. The nurse who steps into that new world steps into a potential maelstrom of constructs that need understanding. I will now consider the work of a group of feminist writers in order to build a theoretical framework before contextualising it through Max Weber's theories of society.

Analysing the various paradigms and their consequences are important when exploring the current and historical context of health practice and education. Witz (1990) has been writing about power and gender relations within organisations in particular for some time. More recently, she wrote that 'organisational structures have traditionally been conceived as having nothing to do with gender', (Witz 1998: 56). Doyle (1994) typifies the relevance of feminism to health care by saying that:

²² Family reasons: pregnancy or other family commitments expected with being a mother wife daughter.

Women lack power in formal health care systems. This disadvantages those women who work in the health care sector, but also has a profound effect on the women using its services (Doyle 1994:143)

What we 'know' about disease and care management in the health sector has evolved through positivism. The logical positivists focus on the deduction of facts. Rolfe (2000:16) outlines Karl Popper's criteria which use a scientific framework to understand the metaphysical world of abstract thinking using underlying principles.

The law of knowledge is each of our principle conceptions, each branch of our knowledge passes successively through three theoretical states.... the theological or fictitious, the metaphysical or abstract, the scientific or positivist. (Adreski 1974: 20)

Within the framework research was 'done to' objects or subjects, either as large groups or individuals, or through groups to explain individual responses. It was Foucault (1973) who illustrated this dominance in the phrase 'ontology of medicine'. The current ontology about health has been derived from the objectivity of positivist 'knowledge' (Rolfe 2000). The person has become both the 'object' and the 'subject' of knowledge. The individual was lost. The personal has only recently been brought back into the equation when the 'ontology' of the social scientists with the feminist among them challenged how we all understand health and illness and its delivery of health care. The term 'lay beliefs' is used to describe subjective understandings emerged out of sociological studies (Williams and Popay 1994:118). Other examples which challenge medical perspectives are; Gabe Keller and Williams (1994) who decry medical dominance, Doyle (1994) the dominance of medicine over women as users of the health service, and Rolfe (2000) the whole concept of evidence based practice. Despite these challenges, the positivistic approach to 'knowing' is still the most influential clinical form of knowledge and from it has emerged the political demand for evidence based practice (NICE 2000). The criticism being that in health, however sophisticated and sociologically illuminating, the knowledge expressed in lay beliefs remains disorganised and ad hoc, posing little if any direct challenge to the power of the medical profession (Williams and Popay 1994).

Medicine continues with the scientific deductive randomised controlled trials (RCT's) as 'the' standard, whilst the 'lay beliefs model', in which much nursing empirical research sits, is classed as lower level evidence (NICE 2000). A senior nurse describes this medical focus as a 'technical rationality' in which the individual is excluded (Rolfe 1998:674). He argues that:

No matter how much a statistical model of research is refined, it will never provide findings of use in individual and unique clinical situations.
Rolfe (1998:674)

Rolfe is not denying that there are no therapeutic benefits of the scientific approach to medical developments, just that the alternative 'lay beliefs' need to be included in searching for efficacy; hysteroscopy being a case in point. The argument is that there is more to know than just the 'pure' science of how the world works, and that knowledge should be constructed in parallel with understanding the impact on and for the individual as advocated through social science studies.

The conduct and construction of research has become a feminist's issue. Having considered the dichotomies presented above about how ontology has been skewed towards the pure science, I have studied the arguments by Reinharz (1992) and Stanley and Wise (1993), concluding that there is an alternative way. The ontological perspective and methodological principles that have been chosen for this study are based in feminism. This will be returned to in chapter four.

Occupational Closure: inflexible boundaries.

Max Weber, a neo liberal sociologist writing in the last century, saw that class and status played a significant part in power struggles. His framework derives from a belief that there were different opportunities to dominate.

He was less interested in how people resisted or overthrew the power structures and focussed more on how they were maintained.
(Allen 2004:97)

I came across the work of Max Weber in my first teaching post when undertaking some team teaching, as the sociologist I was working with was exploring professional boundaries. I then came across the work again during my women's studies degree. Whilst exploring the changing roles of nurses and midwives, I have observed how some go with the flow easing themselves like amoebic cells enveloping the challenge and changing shape into the new space, whereas others are obstinate, rigid and erect barriers. I returned to Weber to explore potential explanations for inconsistent attitudes towards role changes.

Nature of power and bureaucracy

Weber in his polemic writings in 'Economy and Society' created a framework that can still help us to understand the nature of power and bureaucracy. Weber (1978)

was interested in how individuals maintained power even when it is under threat. His work is significant to this study as it was this that informed writers of feminist critiques of occupations and professionalism, Walby (1986), Witz (1990), Savage and Witz (1992) and others who refer to Weber's work in their exploration of bureaucracies, Lipsky (1980) and Larkin (1983). Weber's (1978) theories of closure explained how individuals form themselves into status groups with others to protect their privileges. Looking around any social group or society, we can see how status is conferred and protected; this may be through occupational and educational standards, registration and authority.

I pause for a moment; if knowledge is truth and a source of power what is meant by it and how is gender implicated? Truths of the world derive from ontology; the study and understanding of the nature of being, the "what is" of the world (Crotty 2000). How any one individual achieves a personal understanding of those notional phrases of 'what is' differs. Before "isms" (constructivism, subjectivism, objectivism) of the 20th century truth was defined by beliefs in the metaphysical (nature, God and fate). Beliefs such as religions and power Capitalism, Marxism still create frameworks around which individuals live and the 'politics' of the world revolve (Teichman and Evans 1999), but which dominates will depend on generation and cultural influences. For example, despite many societies having the same God and/or similar constructs through the prophets around forgiveness, charity, and peace, differences are demonstrated through interpretation by the leaders. Thus, power is achieved through one or more of the following; religious interpretations, acquisition of wealth, and more recently a combination of the former with technological advances. Feminism has tried to challenge these interpretations and to describe the 'oppression of women'. The arguments develop through a range of political perspectives such as radical, social, liberal, and, less common, conservative (Reinharz 1992, Stanley and Wise 1993). More recent perspectives constructed over the latter part of the 20th century focused on 'mono-causation' through theory (Stanley and Wise 1993: 47). The key premise is that it is the 'masculinisation' of the world that impacts on the life of women.

The 1960s revival of the women's movement was concerned with feminist consciousness. Stanley and Wise (1993: 117) proposed that the 1960s revival of the women's movement was concerned with feminist consciousness and proposed that feminist consciousness is 'one expression of women's unique view of social reality'. There were differing political views to that consciousness. The women's movement started by asking:

Masculinity and Femininity: what are the implications of these

terms? How are they defined? How are the behaviours learned? Are they universally the same?
(Tobias, 1978:78)

These intellectualised questions were being asked about the role of gender when trying to understand why women's experiences of the world were different and to determine whether changes could be made. At this time groups of women were mobilising themselves to challenge the politics of women through the perspective of personal issues that they believed were constraining them. The women's movement 'brought the personal issues into politics' and it is where feminism started to see the breaking of 'demarcations and challenge male-defined exclusions' (Tobias 1978, and Rowbotham 1992:275). This was done through academic discourse and the trade union movements (Rowbotham 1992). Rowbotham (1992) goes on to say that this was 'not without problems' as the economic power of men was being simultaneously challenged. The overall advantage is that feminism became mainstream, moving the beneficiaries from being solely women to oppressed groups in general. Rowbotham continued to say that 'The social protest action frequently relates also to men' (1992: 299).

Walby, (1994) is a feminist writer who theorized how medical occupational closure impacts on nursing and its relationship with medicine and she explains this as:

A set of practices whereby an occupation creates a monopoly over its skills and prevents others from practising that trade who do not have recognized membership to the profession.
(Walby 1994: 63)

Equally Parkin (1979) gave examples of how teachers, as a status group, could erect barriers using closure, through their access to knowledge and qualifications which gave them 'rights' over others. Occupational closure theory continues to be used to consider the facets of power used by professional groups to maintain dominance over specific areas of knowledge, and knowing associated privilege. In the health services there are very clear boundaries written into policies that delineate who can do what. A more recent social theorist, Allan (2004, 87) explains there are two further forms of closure:

One is exclusion where one group erects barriers to maintain its privileges against lower status competitors. Another is usurpation whereby a lower group seeks to move upward by undermining these barriers.
(Allan, 2004:87)

Nurses working in hysteroscopy or theatres can be used as an example. In the past they would have looked after the women, made sure the equipment was

working and cleaned up. The control of the boundaries was with the bureaucracy of the NHS promoted by the medical domain through 'specialist knowledge'. Feminist authors' suggestions that there is an underlying current of domination through exclusion is closely associated with gender and patriarchy. Women accept the status quo without realising that the degree of masculinised control impacts on their earning potential as well as social status, keeping them suppressed and voiceless (Witz 1992). However, there has been some movement by individuals, and the government rather than professional bodies have challenged these positions of power and status. Typically, those that try usurpation recognise that there is something for them to gain; it is arguable whether nurses are undertaking usurpation.

Patriarchy and closure

"Under patriarchal domination the legitimacy of the masters' orders are guaranteed by personal subjugation"
(Weber et al 1978:1006)

Weber (1978) starts by suggesting that this phenomenon has emerged from the authoritative role men have traditionally taken in the home. In his writings in *Society and Economy*, Weber (1978) documents how over history the principles of patriarchy have stayed the same. In general, the male retained power over all those living within his household, whether through birth, marriage, co-habitation, or slavery. These principles were then transferred from the private (home) to the public (industrial) sphere. Allen (2004: 99) describes the three types of authority that frame domination. 'Traditional Authority', which is about the sanctity of custom, 'Charismatic Authority', which relies on devotion to a hero or warrior and finally the 'Legal Rationale Authority' based on properly enacted rules; the authority is given to a post rather than an individual. This explanation of hierarchy is something that is seen in many organisations, the health service being a particularly good example. There are a series of 'legal' structures that still support this route of hierarchy. The hospitals have a legal basis of power through their status as public organisations. Personnel have varying degrees of legal statute authority through their professional bodies (General Medical Council (GMC), Nursing and Midwifery Council (NMC) and Health Professions Council (HPC)); each defines the parameters of roles through which a license to practice can be granted.

Understanding Closure: A time to renegotiate the boundaries?

In 1986, the feminist writer Sylvia Walby (1986) was re-examining the earlier work of Weber and his theories of closure. Weber (1978) had proposed that social relationships were either open or closed. He suggested that within a closed group there should be 'mutually responsible members' (1978:46). By keeping relationships closed he anticipated that it would guarantee 'monopolised advantage for its parties' by:

- a) ... a competitive struggle within the group,
 - b) ... regulated or rationed in amount or kind,
 - c) They may be appropriated by individuals or subgroups on a permanent basis and become more or less inalienable
- (Weber 1978:44)

Weber was clear that it could be relevant to those inside as well as outside the boundary. A group will be only become opened if the current participant believes there will be:

An improvement in their situation, an improvement in degree, in kind, in the security or value of the situation, their interest will be in keeping the relationship open

(Weber 1978:43)

Whilst Weber was initially exploring these propositions in the personal, private sphere, he then went on to examine what happens in the public sphere. He starts by describing how, in the Middle Ages, groups would expand or restrict who was within the group dependent upon the advantages or threats that were perceived. This amoebic boundary was then applied to capitalist market situations. However, whatever the context, the principles remain the same. Larkin suggests that,

Para-medical occupations have had to negotiate boundaries with each other as well as doctors when establishing spheres of competency and responsibility.

(Larkin 1983:2)

Larkin too refers to Weber amongst other theorists, suggesting that a key aspect of being a professional is to have subordinates, be they co-workers from other occupations or their clients. In his examination of occupational monopoly, Larkin (1983) examined a cluster of other 'para'²³ medical staff that were part of the emerging groups at that time and who were seeking professional status. Whilst Larkin's groups were expanding their body of knowledge and seeking state registration, they were also seeking to claim power from the dominant group

²³ Para is used to describe those who are not doctors but have a recognised status for their specific area of practice, such as radiographers and podiatrists.

(medicine), an example of usurpation. Perhaps though, Larkin is less aware of constructs of occupational monopoly, as it was not expanded through a patriarchal paradigm using that phrase.

Walby (1986) abstracted the notions of patriarchy in professions to explore how Weber's theories were relevant to women working in the health sector. Closure has since been pursued further by Witz (1990, 1992), who initiated a debate using the construct of occupational closure, endeavouring to explain gender and work relationships in health care settings. The two writers were not alone in the feminist debates on women and the health service, or 'industry', see also (Oakley 1993 and Foster 1994). Foster, (1994) uses 'Industry' as the title of her book; it refers to the industrialisation of health as an employer and as a vehicle for consumption of its 'products'²⁴. The analogy relates, in particular, to care provision and attitudes, with nurses, by their very gender, also being significant consumers of that care and the attendant attitudes to women. Meanwhile as Witz's (1992) interpretations of occupational closure developed, she gives examples of how the professional group medicine dominates others too; in this case radiography. Eighteen years on from these theoretical constructs being formed and applied to the health service, it is worth examining if there is any basis for them still.

During the 1990s Witz (1990, 1992, 1998) was arguing that patriarchy and resultant power dynamics were still significant in the ability of certain professions to maintain supremacy over a specific field of practice. Medicine and doctors are a case in point. They could choose to close out one group, or facilitate controlled access to certain areas on knowledge and roles. Witz argued in 1990 that this could be done through gendered roles demarcation and inclusion or resisted by exclusion See Table 1.

Table 1 adapted from Witz's Explanation of Occupational Closure

Demarcation	or role segregation associated with gender patriarchy and occupational status (Witz 1992)
Inclusionary	when a group is segregated it tries to counteract with upward movement endeavouring to access all or part of it.
Subversion	is about rebelling or over throwing by insurrection. In the case of nurse hysteroscopist they are studying to a greater depth the knowledge and sciences, to become associate members of a new group
Usurpation	is to seize something without the right to do so in the theoretical construct of closure those that are endeavouring to gain inclusion are then seen by the existing group as the usurpers.

(Created by the author 2010)

Meanwhile, there are others trying to break through exclusion by either subversion this creates a dynamic flexible potential with the one professional group (or some

²⁴ This may be the drugs that are prescribed, or the development in non therapeutic treatments such as plastic surgery, as well an environment that employs women.

of its members) endeavouring to sustain and defend the demarcated boundaries of privilege situation associated with one professional group. Whereas the aim of usurpation, is to gain access to aspects of knowledge and privilege associated with that group. An example of how nurses can apply two of these strategies is given by Witz (1992 and 1997) who proposed that occupational closure is not all one-way, that when referring to 'Dual Closure' nurses have sought to:

Challenge medical definitions and control over what nurses know and do (usurpation) and create a dimension of occupational closure that will clearly distinguish between those that who can and cannot practice as a nurse (exclusionary).
(Witz 1997:23)

Much of the drive for this comes from the quest for professional autonomy, and not to have other (professionals) define what this is. Fundamental to this is how nurses and nursing projects 'their view of nursing to policy makers' (Witz 1997:24). Whilst this particular notion refers to what was happening during some of the structural reorganisation of the 1990's. Arguably, nurse hysteroscopists have created a situation of dual closure:

An upward countervailing exercise of power by the subordinate occupational group to the demarcationary strategies of dominant groups... they consolidate their own position of labour by employing exclusionary strategies themselves.
(Witz 1992:48)

As nurse hysteroscopist roles develop, they have an opportunity for subordination of medical authority by evolving a new area of practise. However, whether they then protect their new position by shutting this off to other nurses/practitioners creating a situation of dual closure is yet to be determined.

Similarly, a phenomenological study by Staden (1998) indicated that, whilst participants were positive about their therapeutic contributions to care, they did not feel that what they had invested was valued. The literature suggests there are two ways of examining this. Emotion at work remains a universal issue. An alternative analysis is given by Wellington and Bryson (2001). They define emotional labour, in image consultancy, as the management of personal feelings during social interactions; in their context, staff bought into a specific culture in order to manage in the workplace. This includes verbal and non-verbal strategies to understand the emotions of others.

Mann (1997), in examining the advertising sector, also discusses how emotional labour in organisations can have either constructive or destructive impacts on that organisation and that both are equally infectious. The paper explores the wider

aspect of working relationships. That where there are intra and inter- group conflicts, which 'escalate into 'polarized' camps' (1997:4); this can impact on performance by either generating cohesiveness or divisions. Indeed, Mann (2004) goes on to suggest that the organisation's 'emotional' culture, generated from the top, will be replicated throughout by its employees. However, there is an argument that what has been described in these papers is in fact emotional intelligence. This will be examined further in the following section.

Emotion in the public sphere

Emotional labour, work and intelligence have become popular frameworks to examine how nurses manage themselves in the work environment (Staden 1998, Franzway 2000, Theodosius 2008). The initial work on emotional labour arose out of Hochschild's (1983) work, the key theorist on emotional labour and the use of emotion and self in the work place. The key premise is that there are certain public roles that demands a person has emotional management skills. However, there is an unfair exchange between the use of and the reward for emotion and this is exploited to the detriment of that person. Hochschild (1983) identifies the physical responses and the cognitive elements of emotion management. For nurse hysteroscopists, just as for other women in female caring roles, there is an expectation that they will manage 'expressions' and 'feelings' or emotions 'better than men' (Hochschild 1983:164).

Theodosius (2008) examines the significance of the physical as part of the post-doctoral study on relationships between nurses and another staff, calling it 'collegial' emotional labour. The nurses, having undertaken a communication event with different members of the multidisciplinary team then reflected on it and the social context of that communication was analysed. Three purposes of the communications appeared to be; to aid communications between groups, to assert status with colleagues and to acknowledge status of others with colleagues. She determined it was all about maintaining a social hierarchy, where interpersonal skills have been used to sustain the boundaries, rather than challenge them. What she discusses is the use of emotional labour and cognition. Another way to consider these attributes is through the concept of emotional intelligence.

The processes involved in recognition, use, understanding and management of one's own and others emotional state to solve emotion laden problems and regulate behaviour.
(Salovey, Beckett and Mayer 2004:i)

This explanation of emotional intelligence refers to an ability to manage situations

through an individual's ability to interpret self with an emotional sensitivity in a variety of inter-personal and intra-personal environments. Over the years Salovey and Beckett in particular have developed a psychological framework resulting in an assessment tool. '*An awareness based intelligence*' (Dann, 2008 p xii), Dann is writing a practitioners' guide for teachers in order to develop their classroom skills in which she identifies how the individual can maximize their use of interpersonal and intrapersonal competencies. Firstly, by stopping and thinking; secondly, controlling impulses; thirdly, to use innate intuition; finally, be true to one's self and others, by managing personal fears when in the role of leadership. McQueen (2003:102) makes a slightly different suggestion:

organize groups, negotiate solutions, make connections and
analysis of social interactions

Whilst McQueen's paper focuses on the nurse-patient relationship, my interpretation of these skills is that they are key in professional interactions and need to pervade all levels of communication, and practice is compromised without their application. High levels of emotional intelligence enable the practitioner to use differing strategies to negotiate their way through life and work. A case study by Woods (1998) reported a longitudinal study on how significant working relationships with peers and medical staff were to those taking on the new roles and factors that facilitated and inhibited advanced practice developments. The participants' ability to be successful was attributed as much to their ability to negotiate through the atmosphere of work, as to the skills acquired on the course. No sociological or theoretical contextual analysis is provided in this early study. The context of this study is similar to my own research, in terms of the structure and analysis. However, there are differences: the nurses were taken out of their normal working environment for a full year only returning as the 'advanced practitioner' once their course was completed. Arguably, their ability to use emotional intelligence may have played a significant role in their integration (Woods 1998).

In an attempt to raise the value of nursing McClure and Murphy (2007) challenge the emerging social constructions of these concepts, where the focus has been to emphasise caring in the constructs of emotion and labour. Through the critical synthesis, McClure and Murphy suggest that there has been a corruption of the concept as it was originally proposed by Hochschild (1983). McClure and Murphy (2007) conclude the terms emotional labour, work and intelligence offer some explanation but they are critical that these terms are not robust in examining the complex nature of nursing work with regard to the challenges presented by the context of modern practice. It is not just about the 'giving', but the responses

nurses make within specific environments. There is an argument that this is emotional work, rather than labour. The key perspectives were generated from the propositions from Strazdins' 2002 thesis. During a conference abstract, Strazdins and Broom (2003) present an outline of Strazdins' findings which emerged from an analysis of nurses' work and home lives. The argument is that where there is dissonance between the amount of work requiring emotion then there will be an impact on the 'individuals' wellbeing' and external relationships (Strazdins and Broom 2003:4). Likewise, emotional workloads associated with nurturing the family that extended from home to patients to work colleagues (Miers 2000).

Care and emotional intelligence

Each of the above authors is picking up on the essence of Goleman's earlier work as a proponent of emotional intelligence. He proposed that there is a dichotomy in intelligence: the 'rationality of knowing and emotion' (1996:42). Within this there are five features, see Table 2. Goleman's (1996) work covers a number of public service areas from the air industry to health, giving examples of where emotional intelligence is weak.

**Table 2 Adapted from Goleman by the author 2010 from
Can Emotions be Intelligent? (1996:43-44)**

Element	Attributes
Self Awareness	Being able to recognise how one's self is feeling. This helps the individual manage interactions with others.
Emotional Management	Being able to handle feeling down, finding a way through towards a positive outcome - 'bouncing back from upsets' - without the distress increasing.
Motivation	Controlling impulses to prevent peaks and troughs of activity, being thoughtful and considered.
Empathy	This requires being in tune with others, reading the signs of others' emotions and responding.
Managing relationship	Relates to a social competence that encourages followers and co-operation. A person's skills make others feel better about themselves.

My study considers the impact of nurses taking on a new role and therefore there are potential similarities. Goleman (1996:164) gives a personal anecdote. Although correctly diagnosed within a consultation, the lack of personal interaction left Goleman feeling 'empty'. This failure to consider his emotions negated any notion of 'care' that might have been part of the consultation. Moreover, care for the individual does not occur in a vacuum but reflects the 'organisational savvy' (Goleman 1996:159). His conclusion was that the interaction he had with the professional reflected on broader symptoms within the organisation that was providing his care.

This seems to resonate with a recent paper by Morrison (2008) working with the Salovey, Becket and Mayer model. Morrison (2008) concluded that nurses' productivity is affected by stress from clinical care and conflicts from professional relationships. She concludes that both nurses and managers need to handle conflict appropriately. There appears to be a close link between the emotional labour employed by individuals to provide a service, and an emotional fragility that can lead to a breakdown when emotional intelligence is not used. Goleman suggests:

The trend is towards a professional universe in which institutional imperatives can leave medical staff oblivious to the vulnerabilities of patients or feeling too pressed to do anything about them. With the hard realities of a medical system increasingly timed by accountants, things seem to be getting worse.
(Goleman 1996:165).

This description of the disruptive nature of organisational frameworks focuses our attention on emotional intelligence being vital for the commercial success of an organisation at the end of this first decade. One of the potential causes of conflicting ideologies between science and care is the medical influence of deconstructionism, based on logical positivism (Hunter 2004). For the nurse hysteroscopist, the conflicts are potentially three fold between organisational imperatives, taking on a medical role and sustaining a nursing role. The UK health service is driven by two factors: financial imperatives and customer services to meet key health policy targets (Commission for Health Improvement [CHI] 2003). This is illustrated with nurse hysteroscopy having timed appointments of (30 minutes), and the expansion of their roles due to reduction in doctors' hours. Within this context, nurses not only need to maintain attention to the emotional reality of their client group, but learn how to apply the core skills of emotional intelligence into the development of their services. However, caution is required when applying Goleman's construct, as accepting emotional labour is also a critical element of power and gender dynamics and potentially significant. Each example given is about a more senior person using their emotional intelligence to enable 'junior' staff to function effectively, the airline pilot with his cabin crew and the doctor with his patient. (Goleman, 1996)

Goleman (1996) frequently uses the term 'star', referring to those who can work effectively in teams; that some individuals have the ability to create a 'social harmony'. This adds to the abilities of a team, capitalising on the rational intelligence to increase outcomes (Goleman 1996:160). I would suggest that for

nurses working in a new multi-professional team it is clear there is a need for all members of that team to use emotional intelligence. In Goleman's words:

To thrive, organizations need to develop their collective staffs' emotional intelligence.
(Goleman 1996:16)

The psychotherapist and feminist Suzie Orbach prefers to use the term 'emotional literacy' but what she is describing is similar. She comments that we spend so much time at work that organisations are hungry for what we can offer. In health, it is the rationality and the emotion that staff offer as a service. She observes that colleagues:

Are seeing the value of emotional literacy and emotional intelligence as adjuncts to achieving their goals.
(Orbach 2008:17)

Orbach argues that respectful care needs to be shown to the employee, 'If work matters then relationships matter' (Orbach 2008:15). To this end, she concludes that we need self awareness as part of self preservation. This is important because we spend so much time at work and there is a temptation to feel there is no space for replenishing the 'emotional energy' (Orbach 2008:17) that is used.

A note of caution is required in the enthusiasm of considering emotional intelligence. Critics of Emotional Intelligence suggest Goleman's claims are fanciful and erroneous; arguments presented by Murphy and Sideman (2006) imply that this is a result of two academic camps coming from different perspective. One camp is made up of the inductionists who want empirical reproducible evidence. Salovey resides here, opposed to the practice orientated proponents such as Goleman who are trying to understand 'real world problems' Murphy and Sideman (2006: 43). It is not the intention of this study to measure nurse emotional intelligence, rather to be aware of the characteristics that may be relevant to how nurses cope. A more recent discursive paper by Jackson, Firtko and Edenborough (2007:6) suggests that to cope, the nurse needs personal resilience. They identify five personal qualities including one of emotional insight, plus; nurturing positive professional relationships and networks; maintain positivity; spirituality; increasing reflection. Emotional insight is reported as an aspect of emotional intelligence and is achieved through enhancing positivity. The crux appears to be that resilience is in the hands of the nurse.

Thriving or surviving: towards new practice.

Just before the turn of the new century, came a study which examined the struggling dynamics in changing a whole community mental health care unit. The study included nurses taking on advanced roles in mental health, and two interactive discussion groups including a national reference group, and local clinicians, service managers and academics. In the findings, Norman and Peck (1999) identified that a manager's credibility was undermined when they did not address issues of reward, credit and education. This work also concluded that between professions there was a strong adherence to their uni-professional cultures:

In seeking an identity, a sense of self-worth... will seek to distinguish their roles. These roles and responsibilities are reinforced by professional ideologies, models of working, professional training, status and reward.
(Norman and Peck 1999:228)

However if participants were threatened they disengaged themselves. As an organisation shifts in the way a service is provided it does not mean that the personal dynamics will change. Whilst there is no reference to a particular sociological theory such as occupational closure my interpretation of the paper certainly hints at it.

Davies (1992) cites the work of Strong and Robinson (1990) who argued that nurses within the NHS bureaucracy will actively work against organisational objectives because they themselves feel powerless.

Doctors observe, act individually, they bypass hierarchies... they show a strong group loyalty... Nurses, by contrast work in a quasi-military hierarchy. They are rigid and passive, protective, sectarian and isolationist
(Davies 1992:233)

Lipsky (1980:172) similarly identifies that authority is commensurate with positive behaviours. This sense of powerlessness is not conducive to an organisation's ability to thrive through change. The current shifting environment in the NHS requires employees to adjust to clinical and organisational difference. To support changes to the organisation of care a plan should be in place, the absence of which potentially increases the risk of role uncertainty having an impact, not just on the nurses, but also on those who support the development.

More recently, in 2004, an organisational framework was published by Bryant-Lukosius, DiCebso, Browne and Pinelli (2004) (see Table 3 page 36). This Canadian paper proposes a structure to use when considering the need for initiating and implementing an advanced practice service. The framework is called Participatory Evidence based Patient-focused Process (PEPPA) for Advanced Nursing Practice (ANP). It sets out nine contributory elements that may well be still current.

Meanwhile, another paper examines the organisational infrastructures and its significance to the development of a service as the individual taking on advanced practice roles. A meta-synthesis by Lloyd-Jones (2004) of specialist and advanced nursing courses (See Table 4 page 36). The conclusions of this synthesis are that the both 'relationships with others' and 'role ambiguity' will have an impact on successful development. Despite the positive characteristics of the nurse, this shows that organisations must avoid ambiguities and ensure there is a sound structure for the nurse to practise (Lloyd -Jones 2005:207).

Table 3 PEPPA Framework from Bryant-Lukosius et al (2004)

Participatory Evidence based Patient focused Process for Advanced Nursing Practice	
1	Define patient population and describe current model of care,
2	Identify stakeholders and recruit participants (service users),
3	Determine need for new model of care,
4	Identify priority problems and goals,
5	Define the new model of care and ANP,
6	Plan implementation strategies (which includes the education needs of the proposed ANP, guiding policies, and administration),
7	Initiate the plan,
8	Evaluate the new model and the ANP and finally,
9	Long term monitoring of both

(Created by the author 2010)

**Table 4 Confounding Factors Impacting On Advanced/Specialist Nurses
Adapted from Lloyd Jones (2004)**

Characteristics	Evidence
The practitioners' characteristics	The most common terms were confidence, adaptability, assertiveness, flexibility and negotiating skills
Practitioners' experience	Being familiar with the organisation, its structures and its service, 'substantive' experience in the specialty,
Professional	The ambivalence of regulatory bodies at that time and lack of articulated career pathways
Educational	The UK studies identified lack of relevant courses, mentors, regulation and standardisation
managerial and organisational issues	Role ambiguity and workload
Relationships with other health care professionals.	Resistance to change from medical and nursing staff
Resources	Confidence and managerial concern associated with being new in post and not prepared.

(Created by the author 2010)

It would appear to be appropriate to use Lloyd-Jones's criteria as a risk assessment tool as service development continues. However, this was developed from studies undertaken between 1995 and 2001, and so should be used with caution as it is not clear if any of these factors still hold currency in 2010.

Nurse hysteroscopists as street level bureaucrats

The objective basis of bureaucratic power is its technical indispensability founded on professional knowledge
(Weber et al: 1007)

Whilst looking at the selected group of nurses it is not possible to abstract them from the environment in which they work. Weber (1978) refers frequently to bureaucratic power. The above quote suggests that nurses should be among those who are seen to hold power; in particular, nurse hysteroscopists, as they have gained an unusual technical ability for a nurse and apply both nursing and medical knowledge. Lipsky (1980) suggests that local councils, health and education are all organisations where the scope of public sector bureaucracy has increased in scale from their inception. Lipsky (1980) undertook a detailed sociological exploration of how the individual co-operates or subverts the structures in which they work. He calls them, 'street level bureaucrats'. These are individuals who, 'interact directly with citizens" (1980:3), and the NHS is a typical, 'street level bureaucracy' because it has high numbers of 'bureaucrats' in its workforce. Arguably, on this basis, the nurse can then take advantage of the title as she has, 'discretion in determining the nature, amount, and quality benefits provided by the

organisation' (Lipsky1980:13).

Nurses may have discretion but there are a number of caveats: from within the organisation, through guidelines, from their professional responsibilities in their accountability and responsibility code of practice (NMC 2008a), and in their contract of employment. I found three conflicting notions: firstly, 'Professionals are expected to exercise discretionary judgment' (p14) and yet, secondly, discretion is relative. The hospital is expected to have policies and guidelines and, certainly, this is the case for nurse hysteroscopists. They are expected to apply the national standard for care set by the RCOG, National Institute for Clinical Evidence (NICE) or the NMC, into the particular unit. Equally, recent government policies are updating the powers given to organisations in determining how the health service is managed and responds to care received (DoH 2006). This change of dynamics will have an impact on the continued use of Lipsky's interpretation on the NHS. Thirdly, Lipsky (1980:190) suggests that the street level workers have, 'significant say over the rules by which they are employed'. Witz (1994:24) puts this differently using the 'occupational control and practitioner autonomy' which are vital to the way a nurse (bureaucrats) can function'. It is not yet clear if, or by how much, each nurse hysteroscopist has control over her work situation as a street level bureaucrat. Perhaps the recent suggestions that the health service has become a neo-bureaucracy will be more significant (Hurley and Linsley 2007). Hurley and Linsley (2007) argue that the current NHS bureaucracy expects a level of transformation and entrepreneurship that nurses and their leaders can no longer ignore. This change has occurred in the context of bureaucratic rules 'enforced by regulatory agencies rather than by hierarchical management' Harrison and Smith (2003:243); they argue that these stifle developments and without consideration development will be constrained.

Summary

In this chapter I have used Weber's theory with Witz's feminist application of occupational closure to explore occupational boundaries in the health service. Through this, I have identified areas that may elicit conflicts and have suggested some of the challenges for nurse hysteroscopy roles. Through the use of feminist discourse, examples of empirical work, and Lipsky's work on bureaucracy I have examined some of the social and psychological impacts this may have on nurses working in the 'subordinate' role as nurses. I have examined some of the empirical evidence from nurses who have taken on new roles, whose experiences may bring some insight into the lives of the nurse hysteroscopists. Finally, I have come back to the potential issues and confines of working in a large, changing organization as a professional.

In the next chapter, I will continue the literature review by defining and exploring the concepts of professions and professionalism and how they are relevant to nurse hysteroscopy in the context of 21st century political objectives.

Chapter 3

Breaking the Mould of Occupational Monopolies

Professionalism

I have frequently used the term professional and professionalism in the previous chapter. As nurse hysteroscopists are in a position of crossing professional boundaries there is a question as to whether nurses taking on the skills of doctors are becoming mini doctors themselves. It is important to establish the basis by which nursing refers to itself as a profession.

Professionalism is a stage in the development of an occupation which is marked by extensive practitioner control of clients.
(Larkin 1983:180)

Larkin is arguing that when status is granted through formal registration and subsequent recognition this member claims 'professionalism' and claims a state of 'occupational monopoly' over a client group. Whilst this phrase is less commonly used in the literature, it appears to be a feature that is recognisable between pre existing groups and the focus of intent amongst newly emerging groups.

In the previous chapter, I identified that a profession is a social construct and is associated with education, knowledge, power, authority and subsequent privilege. Typically, in nursing literature profession is defined as having a 'specific domain of knowledge and understanding of its application' (Rutty1998). She concludes her paper by saying that the knowledge framework is to:

Ensure that knowledge for nursing is advanced from not only the scientific paradigms, but aesthetics and personal and ethical knowledge.
(Rutty 1998:249)

Whereas Liaschenko and Peter (2004) argue that, for nursing, it is the ethics, the morals and professional codes that supersede the other precedents associated with professionalization. In their view, nursing has:

a unique body of knowledge, altruistic service to society, a code of ethics, significant education and socialisation, and autonomy in practice.
(Liaschenko and Peter, 2004:489)

Whilst the ethical code is the basis of how nursing practice is done, it cannot be done effectively without substantive knowledge in the area of practice. For the nurse hysteroscopist, working in a new field, their professionalism comes from their original licence to practice, plus their newly acquired scientific and empirical understanding related to gynaecological practice.

The Nursing and Midwifery Council (NMC) requires its registrants to behave with professionalism, and work within codes of practice, including knowledge and competence. Interestingly, there is no description or definition of professionalism on the NMC web site, yet all documents refer to professional behaviours of a nurse. There is an implication that 'nursing and nurses' have agreed what this is.

Significantly, the interpretation of profession is not homogeneous across the world. There are two models of professionalism within a global construction: one which identifies that Europeans are more focused on 'skilling their workforce through higher education' for a 'knowledgeable workforce', whereas the Anglo-American model 'skills a workforce for elitism and the status' (Evetts, 2003:396). Both Rutt, (1998) and Evetts, (2003), in particular, propose that the key to professionalism is belonging to a 'professional association' to which all in the group belong. This group controls access to a register and has the ability to debar individuals who have broken the social codes, through incompetence or poor ethical judgement. However, a further common agreement appears to be the concept of autonomy, and the associated accountability and responsibility (Liaschenko and Peter, 2004:489). This is perhaps reflected in the recently re-published NMC Code of Conduct (NMC 2008a):

As a professional, you are personally accountable for actions and omissions in your practice and must always be able to justify your decisions.
(NMC 2008a:1)

The NMC, like the General Medical Council (GMC), do not conform fully to the medical definition of a professional organisation. Whilst the NMC has the power to admit or debar groups who do not meet the ethical and educational standards, it does not expand the ontology or epistemology of its members. This is left in part to the Royal College of Nursing (RCN) and Royal College of Midwifery (RCM). These organisations

are more like the medical and legal associations, in that they hold conferences where empirical and work based knowledge / evidence is shared and support members through employment and professional conduct tribunals.

Noordegraaf (2007) agrees that professionals are closely related with professional organisations. He proposed that changes in the public sector are creating fresh struggles with professionalism, that the new dynamics are challenging previously held beliefs of professions and where power should reside. Perhaps this is a postmodern view of professionalism that we should consider in order to move the debate onwards.

Professionalism is used not so much to improve organizational contexts but to improve the idea of professionalism in changing organizational contexts.
(Noordegraaf 2007:775)

Noordegraaf's proposition is that there are two strands of professionalism making a new or hybrid professional; the traditional or 'pure' as described above works through 'occupational control', and the 'situated' professional operates through organisational control 'establishing socio-symbolic legitimacy in changing times' (Noordegraaf 2007:780) . Arguably, this combination creates a reflexive professional who does not just operate control at the 'street level' but can make things happen within the organisation. This appears to develop the ideas of Lipsky as seen in the previous chapter but is not attributed as such in this paper. The nurse hysteroscopists are working in a health service that is moving to a more neo-liberal environment, where market forces predominate and a light touch of government is the objective (Lipsky 1980). It is in this environment of the changing dynamics of the health service and the expectations of service redesign that the nurse becomes or experiences the impact of the hybrid professional.

Do nurses know who they are?

Nurses are under pressure (Evetts 2003). A whole body of nursing literature has become focused on defining the concept of what nursing is, rather than what is needed to take on and keep a professional mantle (Rutty 1998; Rolfe 2000). The government through NICE and the NMC regulation expects nurses and other professionals to use a recognised body of knowledge, with that body of knowledge comes authority. Arguably, since the mid 1970s, there has been a proliferation of empirical research that has developed philosophies and explored the activities and impacts of nurses and

nursing. However that is about what nursing is, not necessarily furthering nursing knowledge to enhance what makes a nurse the autonomous, accountable practitioner. I would argue that the challenge for nurses taking on advanced roles is to move from defining and redefining a profession to examining why professionalism is attractive to them, when it has also been described as occupational 'monopoly' (Larkin, 1983) or 'change' (Evetts, 2003).

Evetts (2003) refers to the work of Weber, among others, as she examines 'occupational change' and professionalism. The argument is that 'dynamic changes in health care driven by the state are changing power dynamics and the professions are losing their dominance' (Evetts 2003:403); the result is that NHS hierarchies are no longer exclusively medical. This is, arguably, positive for nurses. However, there is a need for the professional training that prepares individuals with the tacit knowledge and also the ability to balance personal and collective interests in their occupational capacity, with those of the 'occupational community' (2003:406). Ruddy (1998) argues that the person in the occupational role takes 'risks' which is a recognised facet of professionalism and includes acting autonomously, using problem solving, making risk assessments, and providing information to the client. If the public perceive the risk has been managed well, then it is the public who accord the status of professional (Evetts, 2003, 2005).

The public and private spheres of occupational work are increasingly complex. Any preconceived autonomy is no longer being associated with independence. For nursing, in particular, it is controlled by 'multiple relationships'. A lack of agreement on what constitutes 'expert knowledge' results in a diffusion of relationships and their recognised hierarchies (Liaschenko and Peter 2004:489). There is increasing interdependency, as each occupation relies, to differing degrees, on one another and on how the voice demands changes (Porter, 1992). Therefore, the parameters of occupational professionalism are laid in statute and also occur within situations defined by the employer. It was Larkin that captured this when he said that the para-medics are:

excluded from central tasks of diagnosis, are subject to routine supervision in their work and have little effective control over their own knowledge base.
(Larkin 1983:8)

Certainly, the gate keepers of knowledge for the nurse hysteroscopist, at the moment,

are the membership of the BSGE. However part of the mould is broken by government expecting a freeing up of roles enabling nurses in hysteroscopy settings to undertake diagnosis.

For the individual, more important than occupational control are the terms of employment that require they act professionally. So for example, whilst there may still be discrepancies in the social framework of professional constructs between the medical and nursing staff, the reality of employment in the NHS means that the differences in activities are increasingly more likely to be constructed by political objectives and an organisation's terms of employment (Larkin 1983; Evetts, 2005).

Challenging hierarchies

An Australian study examined the impact of change amongst a number of occupational groups, based upon hierarchy and their roles (Martin, Jones and Callan 2006). The relevance of this study at this time relates to two factors: one is the significance of the role of the manager in facilitating the change; the other is the importance of having a clearly defined professional group. Arguably, the implication of this study is that hysteroscopy nurses are setting themselves apart from their normal allies²⁵ and therefore are either professionally or socially vulnerable.

During academic discourses and debates about nursing and its power relations, the health and health management policy have been redefined for evolution. Changes in government rhetoric (DoH 1998, 2000a) have opened up a number of opportunities for groups to undertake roles normally associated with doctors and medical roles in particular. With that potential comes a sense of responsibility to understand the professional and social constructs of what, in this case, is nursing/ midwifery (Halford et al., 1997; Walsh, 2000). The NMC has a proposed knowledge framework which identifies the key strategies, not only on optimising care as an advanced practitioner but also providing a matrix on what the professional interactions should be (NMC, 2005). More recently, the RCN published a set of clinical domains that propose a framework of clinical skills that represent advanced nurse practice (RCN 2008 republished 2010). These areas will inform the basis of ongoing considerations.

²⁵ Other nursing peers.

Working towards advanced practice

Proposals for a regulated standard have, in part, been in response to the concerns of both the public and the profession of the rapid growth in the number of titles that suggest an advanced level of knowledge and competence.
(ANNPE 2005)

The notion that nurses and other care professionals should expand their field of practice has been gathering momentum over the last twenty years. The political initiatives widening the role of health professionals started in the early 1990s influenced from specialist and advanced roles being taken on by nurses in the USA. The statutory and professional recognition of these role adaptations was recognised in the UK by United Kingdom Central Council (UKCC). In 1992 the UKCC began to define the nurses' responsibilities in The Scope of Professional Practice (1992) which;

Allows nurses, midwives and health visitors to undertake tasks previously the remit of doctors... However, nurses must also acknowledge any limitations in knowledge and skills and should not perform tasks they do not feel skilled or competent to perform.
(UKCC 1992)

The interesting terminology used here is that nurses are 'allowed' to develop their role. This suggests that there were clearly defined boundaries. In 1995, the UKCC then used the phrases 'advanced practice' and 'specialist practice' in the Post-Registration Education and Practice (UKCC 1995). They articulated the difference as advanced practice being about 'pioneering and developing roles', perhaps 'breaking boundaries', whilst specialist practice was about 'exercising a higher level of judgement and clinical decision-making'. Finally, the concepts were reviewed in a revised Scope of Professional Practice and exemplars were described of how this changing practice might look. The following statement is found in the introduction:

No profession is an island and the impact of Scope on practice over the four years must be viewed in the context of other forces, including the reduction in junior doctors' hours, the Health of the Nation initiative, the Patients Charter, GP fund holding, disease management programmes and the drive for greater cost effectiveness in health care provision.
(UKCC 1997:4)

Whilst nurses and nursing cautiously explored ways to implement developments identified as advanced practice (Manley 1997; Barton, Thome and Hoptroff 1999). It was not until the 1997 change of government that the momentum for liberal reform

increased. It was the politicians yet again, and not the profession, who radicalised the potential to change as an essential part of health service reform. The new government developed a framework of health policies that would modernise current services (DoH, 1997). There are two possible routes to understanding their objectives. The manifesto for new Labour used phrases such as:

We have liberated these values from outdated dogma or doctrine.

and

How we care for and enhance our environment and quality of life; how we develop modern education and health services; to spend money on the right things - frontline care.

and

We will rebuild the NHS, reducing spending on administration and increasing spending on patient care.
(Labour Party Manifesto, 1997)

Here we see that the government recognised an overall need to challenge dogma, and nowhere is it explicit that changes would begin to emerge so soon after the election. There was evidence in other areas of the document that they intended to challenge assumed roles and the power dynamics in the health service. There has been a consistent stream of modernisation proposals since 1997; arguably the effect has been to destabilise the status quo thus making change easier. The manifesto planned to create a more dynamic and responsive service. This was recently illustrated in the publication of the Darzi Report on the Health Service (Darzi 2008). These documents identified how and why it is important to adjust the skills mix and move the focus of health provision closer to the populations through satellite 'poly' clinics, shifting the focus from secondary care to the primary sector.

In the introduction, I argued that nurse led outpatient hysteroscopy services are one strategy at the forefront of this change to outpatient services with the potential to move into community hospital settings (Connolly and Jones 2008). Further development may be limited due to financial incentives and constraints, and professional elitism. Moving nurses, and now general practitioners, between hospital and community settings presents a whole host of challenges to roles and relationships between organisations.

Nurses becoming Consultants

There is the potential for some of the nurse hysteroscopists to be consultant nurses. The nurse consultant status was only introduced into the United Kingdom in 2002, (DoH 2001b). Berragan (1998:140) describes a traditional view of a consultant as having 'specialised knowledge' who can 'prescribe specialised solutions to a problem'. She argues that it is a sub role of advanced practice. However the government has determined that it is the icing on the cake, in terms of financial reward, (NHS 2006, 2008a and b).

Manley (1997) used an action research approach to establish a conceptual framework of advanced / consultant nurse roles. The aim was to analyse the post holders' role descriptors, against the reality of the post. Two key findings that were leading to enhanced patient outcomes were the 'transformational culture' and the 'empowerment of staff' (Manley 1997:186). The resultant model is made up from the characteristics of a 'strong nursing foundation' and associated with 'transformational leadership' together creating the advanced practitioner / consultant nurse who had 'developed and empowered staff', developed 'nursing practice' and had a 'transformational culture' leading to 'quality patient services' (Manley:183). The last conclusion here should be read with caution, as it is not set against any clinical outcome evidence.

The concept of consultancy embeds the notion of a search for help with expert knowledge. Yet Manley, using Caplan's model of consultancy, argued that is more than this, and proposes two potential models that the advanced practitioner uses. Firstly, the internal consultants who are also change agents and innovators, arguably functioning within the organisation. Secondly, the external consultants who practise independently have an eye on entrepreneurship. Arguably then, nurse hysteroscopists might be following the model of internal consultancy. However, with the challenges to Foundation Trusts, there may be pressure to take on aspects of the external consultant. Recent searches for Caplan's model revealed articles that return us to McClure and McQueen's critique concepts of emotional intelligence and labour (McClure and McQueen 2007).

Leadership qualities

Goleman (1996) has observed that intelligence can only get so far, and then personal qualities become more significant. His proposition is that people who have characteristics associated with conventional intelligence are emotionally

underdeveloped. Without this additional quality, there is a negative impact on leadership and empathy, with consequences for the organisation. Goleman, Boyatzis and McKee (2002:176) identify that groups can display collective emotional intelligence and this will be more significant than that of the lone person, providing the leader of the group has the skills required to manage the group. It was identified that whenever issues or problems are not confronted and tackled by the leader at source, they will emerge as problems later. The implication being that failure to confront means that productivity / efficiency decreases. For the health service and the individual nurse, this is a significant notion.

Consequences of Feminisation

Feminisation was recently used by Bolton and Muzio (2008) to explain how increasing the role of women changes the dynamics, and how it has consequences for professionalism. In the previous chapter, relationships were shown to be critical to gate keeping and boundaries; with the changing dynamics of the health service, hysteroscopy nurses will have to participate in the transition to an advanced practitioner. The earlier arguments suggested gender plays a significant part in how occupational roles are controlled (Chapter 2). At the start, I highlighted how gynaecology nursing was dominated by women (Chapter 1). Likewise, recent evidence indicates that the gender balance in gynaecology is evolving too.

The gender breakdown of the workforce shows a continuing feminisation, such that, in 2009, 32% of all consultants are now female.
(RCOG 2009:7)

Indeed this does not tell the whole story. Examining the RCOG data further reveals that the percentage of women at the two specialist registrar levels is 67 and 61% respectively. With this difference, there may of course be the presumption that because an individual is female, gender stereotypes associated with the professional role are no longer relevant.

During Bolton's (2005) qualitative analysis of a discrete group of gynaecology nurses, they (the nurses) defined their work as 'dirty' yet 'women's work'. As Bolton notes:

Whilst wanting recognition for their technical skills and unique knowledge, nurses continue to identify with, and willingly

regenerate, the stereotypical image of the 'angel of mercy'.
(Bolton 2005:172)

There was evidence of a subordinate occupational environment, yet they could see themselves as 'feminine professionals' (Bolton, 2005:72). The nurses in Bolton's study were critical of the female medics who displayed male gender traits making them no different from their male counterparts as they were not seen as playing by the 'feminine' rules:

Women doctors who are not seen to draw upon
the cultural resource of the 'feminine' are also ostracised.
(Bolton 2005:181)

In using the term ostracised, the nursing staff were exerting a 'parental control' over the women and junior medics. One of Bolton's conclusions is that by using these negative feminine attributes nurses who have skills for a specialized area of practice are implementing their own form of occupational closure.

Furthermore, Rothstein and Hannum's (2007) qualitative questionnaire provides useful data. From their study it appears there was little difference between the gender of the physician and their working relationship with the nurse. Overall, more importance to the quality of working relationships was given to the traditional professional boundaries. Whilst not conclusive, by using age as a variable it was found that inter-professional relations improved as the age of the female doctors reduced. This may suggest that female doctors were not so reliant on gender and professional alliances but learnt behaviours with their generational peers; so reflective of a broader change in society. However, whilst the literature review in this paper reviews the gender and power dynamics between doctors and nurses, it fails to provide an analysis in the light of those sociological arguments.

Barton (1999, 2006a, and 2006b) has a history of examining nurses and their professional boundaries. The work covers the issues already identified that relate to advanced practice. An early paper endeavoured to explain social constructs of advanced practice through 'Occupational Boundaries', Barton et al. (1999). Later in 2006 he published an ethnographic study of nurses taking a two year advanced practice course to become nurse practitioners (Barton 2006a). In a second paper, Barton (2006b) specifically examined the relationship of the medical trainers to the registered nurse in training. Results indicated that the advanced clinical roles result in

a need for a cultural and social transition during the period of training. In addition to the changing professional role of the nurse, both papers suggest tensions in both nomenclature and status for the nurse, despite validation by the NMC.

Taking a step back to look at the experience of others, Muzio and Bolton (2006) see a paradox in women working in male domains. They suggest that two things happen when a profession becomes feminised through a change in gender balance. Using data from legal and managerial professions they proposed that: the 'vertical stratification' structure becomes elongated, with numbers of women clustering at the lower end, and 'horizontal segmentation' with women dominating the areas of work associated with women's roles, horizontal at the bottom and at one side. They witnessed that:

A marked segmentation is occurring between largely female, individually orientated and relatively underpaid specialism on one side and male-dominated, corporate orientated and remunerative practice areas on the other.
(Bolton and Muzio, 2008:288).

This seems to indicate that occupational closure in health is not unique and that masculine culture of an organisation will not change. The result is, 'inter-professional subordination, exclusion and exploitation whilst the professions attempt to re-organize', (Muzio and Bolton 2005:82). Whilst the nurse hysteroscopist has not changed her profession and become a doctor, she has arguably changed what nursing is. It will be interesting to consider this and what consequences this may have in relation to organisational stratification.

Game playing

Barton et al's paper (1999) proposed that both nursing and medicine were uncomfortable with the uncertainties being created by changes in professional identities, as skills and knowledge were continually relinquished and adopted:

Defensive attitudes that can prevail where there is a perceived breach of professional identity, professional interest.
(Barton et 1999:60)

This was certainly part of the discussions in the early days of the development of the nurse hysteroscopy training programme. Indeed, this was and remains a significant

driver in sustaining a close relationship with the BSGE. Results from Barton's (2006a) study suggested that there remains discomfort as nurses 'transgressed' into more of a medical role; that as the new paradigm of knowledge was adopted there was an abandonment of nursing as they understood it.

The concept of occupational boundary had earlier appeared in a qualitative Swedish study by Svansson (1996). This examined the changing dynamics between nurses and doctors, through a change in training that encourages questioning, and the acknowledgement that the patient perspective should remain important. Nurses in the study were becoming partners in determining patients' care. Svansson described the doctor nurse relationship as 'more direct and mutual', (Svansson 1996:365). Early in the paper he proposes that this successful change in dynamics appeared more egalitarian. However, because of rules this is not sustained throughout the paper as later he says:

The majority, however, describe a rule system which seems to be very permissive about presenting opinions and questioning, even in the medical area.
(Svansson 1996: 389)

It could be argued that by using a set of rules nurses were manipulating the situation to gain the outcome they wanted. They knew there were ways to get the doctor to agree to their ideas and they were happy with how they did it, and accepted it as the norm:

The nurses exert influence primarily by manipulating the doctors, without really challenging the fundamental asymmetry of the power relationship.
(Svansson 1996:395)

In other words, the nurses were conforming to gender rules of patriarchy. The paper concludes that a new transaction or set of rules in communication away from this previously deferential 'doctor – nurse game' is required.

'Game' has also been used by Miers (2000) and Davies (2005) to explain ritualistic practices, where deference and passivity are used by nurses. The nurse indirectly makes suggestions to gain changes to clinical decisions, whilst not being seen to openly challenge the social status of the doctor. This recognizes the lack of women's power and deference in the public sphere. The nurse avoids disagreement whilst

'communicating a recommendation without appearing to', (Miers 2000:134). The ideas become the doctor's, hence the nurse is using characteristics associated with her gender roles of, 'communication, organisation and support', (Muzio and Bolton 2008:88). Davies's view of the game is from a more organisational perspective. The organisation and competitiveness of the professional groups in the health service are gendered, so the normal rules of socialisation mean that the nurse will adopt the most pragmatic role.

Advanced, Advancing and Practice - a title or construct?

A registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A Master's degree is recommended for entry level.

(International Council of Nurses, 2000 cited by the Association of Advanced Nursing Practice Education (AANPE) 2005)

As seen earlier in this chapter nurses were being 'allowed', by those with power and authority, to develop their practice. As this thesis was being written, the political influences have been in flux. However, the potential for conflict due to occupational professional closure should not be ignored. To contextualize the evolution of the hysteroscopy course, local clinicians in 2000 were starting to explore new opportunities. However, this was in the absence of clear definition, characteristics or academic level of advanced practice from the then ENB, the soon to be NMC. Whilst the government and policy makers were grappling with the concepts of new roles and enhanced and advanced practice, the international definition was published (see above).

The activities that were to be expected of the nurse hysteroscopist were certainly consistent with the first part of the quotation above. Without having this guidance, the course team had taken the decision early on that the entry level needed to be at the level of a final year graduate (Jones 2005). Well in advance of the above guidance and the Key Skills framework, the module was simultaneously written at level three and Masters, the latter to facilitate those already graduates and any medical staff wanting to undertake the programme too. The rationale for this was that at the time of writing, in 2000, nurse education had moved relatively recently into higher education, with

students exiting with the equivalent of a non-honours degree.

The philosophical debate about what nursing and midwifery are needs to be continued and developed. It becomes increasingly difficult to continue to differentiate between what the advancing practitioner, the specialist nurse, the advanced nurse / midwife practitioner and finally the consultant nurse / midwife roles are from the doctors (Manley 1997; Rolfe 2000; Jones 2005; Bryant-Lukosius et al. 2004). These roles:

Although retaining nursing values are associated with taking on what were previously considered medical roles.
(Manley 1997:179)

Indeed Woods (1998) warned of the confusion in terms, and the profession is no closer to a definition. At the end of the first decade, there are now some boundaries that describe a nurse practitioner (NMC 2007; RCN 2010). The delay in definition highlights general problems in the unification between other evolving frameworks for nurses, for example the role of 'practice educator' (NMC 2006 and 2008).

Defining advanced practice

Ingersoll, McIntosh and Williams (2000) undertook a Delphi survey in the US to determine the outcomes of advanced practice. The findings predominantly report satisfaction in care and the perceived benefits of the nurses' relationships to the patients' clinical outcomes. More importantly, the discussion also refers to the nurses' ability to collaborate with other care providers. However, lack of detail on who the collaborations were with does not let me establish any significant relationship to my own study or the theories of professional relationships.

More recently, an Australian group conducted a qualitative study in which eight advanced practice nurses were interviewed. Their responses were tested against four models of advanced nursing practice (Gardner, Chang, and Duffield 2007). They selected the model produced by Ackerman, Norsen, Martin, Wiedrich and Kitzman in 2000 that included direct comprehensive care, support of systems, education, research, publication and professional leadership. There is potential for me to use this framework to consider the activities of the nurse hysteroscopists.

Simultaneously, through a meta-synthesis of literature on advanced nursing practice, Mantzoukas and Watkinson (2006) endeavoured to establish the generic features of a modern nursing role. Key features were the cognitive, thinking in action, and praxis. The 'new' nurse was using new areas of knowledge within their practice, but whilst making the claim the paper does not fully explain how this knowledge is used differently within the practice setting. However, the additional dimension that differentiates the advanced nurse was the 'reasoning in transition'. This new person is also a leader, coach and facilitator of practice. There is an expectation of transformation, whilst maintaining practice autonomy and integrity.

It is clear from the literature on advanced practice that there is an emerging set of features to advanced practice. The key determinants appear at this stage to be the volume of leadership and practice development in which the individual is engaged (Mantzoukas and Watkinson 2006; Gardner et al 2007). This appears to require professional momentum to be sustained or arguably the nurse must revert to general nurse or specialist practitioner, with accompanying loss of status.

The profession's collective indecision in defining the emerging nursing profession could be seen as debilitating and limiting (ANNPE 2005). So, whilst we may in fact be better off with a set of guiding principles, it becomes incumbent on the individual to maintain the autonomous practice gained through additional work-based study and practice (Raelin 1998). Hysteroscopic developments are proof that health trusts are already setting staff on a course of enhancing / advancing their roles. Additionally, advancing nursing practice needs to have this fluidity of professional direction and not be too constrained by criteria (CHRE 2009).

When we were developing the hysteroscopy course, there was significant debate among the team in the absence of any 'professional' publication, not only about how the course would look, but also about how we would enable the participants to achieve their goal. The infrastructure for supporting the advancement of nursing roles was, and still is, limited. Several government or professional body initiatives have emerged over the last six to eight years, including the introduction of nurse consultants and community matrons (DoH, 2001a). Finally, the public has been asked what these roles mean to them. A qualitative study as part of the government review of advanced

practice was undertaken with the public. The report found that the public:

Assumed that it (ANP) meant more qualified or experienced in some way, but people were unsure in what way and what being 'advanced' actually said about the professional. However, some people found it inspired confidence where they had personal experience of advanced staff.
(CHRE 2009:4).

Despite national concerns about patient safety, as clinical roles were expanding based on government policies, the commission identified there is a cross profession issue with the terminology, and initially appeared to suggest at one point that regulation was not so important:

That much of what is often called 'advanced practice' across many of the health professions does not make additional statutory regulation necessary.
(CHRE 2009:1)

However, the resultant conclusions are that regulatory bodies should focus on competence and fitness to practice and commissioners should work with employees to determine what roles should look like. This report also highlights that the specialist register that the NMC holds provides no meaningful consistency for its own prescribed requirements and does not reflect the volume and opportunities that there are for nurses to undertake additional qualifications (CHRE 2009).

Regulating the indefinable

Having established that there is no clear consistency on what to call the nurses who take on additional roles or what they do, the NMC continue to review the situation with other professional groups. The inertia is historical. At its inception in 2002, the NMC adopted the continuing professional development framework (CPD) (NMC, 2010) from its predecessor organisation, the ENB. This previous organisation had had a wide range of prescribed competency based courses with opportunities to record additional qualifications within the register. However, there was no statutory requirement for the NMC to continue with volume of standardised courses. The role is limited to monitoring an individual's eligibility to remain on the register through self declaration of CPD and the recording of the specific extended roles of teaching and prescribing.

The gap left between the roles of the ENB and NMC has been filled in part by the

Royal College of Nursing (RCN) and the AANPE, and has arguably been a disservice to the profession at a time when expansion was required. As this thesis is being written, the NMC has started to re-engage in the debate, publishing the following definition of an advance nurse practitioner:

Advanced nurse practitioners are highly experienced and educated members of the care team who are able to diagnose and treat your healthcare needs or refer you to an appropriate specialist if needed.
(NMC 2006a)

This definition could relate to numerous areas of evolving nursing, not just the individuals working in primary care alongside general practitioners. The 'Nurse Practitioner' has a recorded qualification with the NMC and provides an alternative route for patients who are not able or wanting to access their General Practitioner at the time they require. They do not call themselves 'Advanced'.

Interestingly, it is the RCN that has provided a framework for practice competencies for all other advancing skills of nurses, along with a set of guidance for educationalists (RCN 2002). Whilst this document defines the areas of activity and competence, it still does not provide a phrase or description to help with public understanding.

More recently the RCN produced a competency framework for accreditation (RCN 2008 republished 2010). Nurses working in advancing enhanced, specialist roles, or as a nurse practitioner, all follow similar criteria of diagnosis and management of complex care needs. This includes referral and prescription or treatment. There is no statutory basis but it is similar to the activities set out in the Key Skills Framework (KSF) and closely associated with pay bands (NHS 2006, 2008a and b). In 2006 the NMC working with the four Chief Nurses²⁶ 2006 saw the publication of the Advanced Practice Tool Kit (NHS Scotland 2006). This is a set of work streams but the title is misleading as only one element will potentially inform / define what the characteristics of an advanced nurse are; at the time of completion of this thesis no results are available. What is more common is an emerging consensus that education should be at a minimum of graduate level. As this study comes to a conclusion there is renewed vigour to end the ambiguities. Following the 2005/6 consultation, the NMC were granted permission in 2008 to move some proposals to the Privy Council in a government white paper (DoH 2007). The conclusion from the review of pre-

²⁶Chief Nurses for England, Scotland, Wales and Northern Ireland.

registration is that from September 2011 education for registered nurses will be at a minimum of graduate level. Whilst there is ongoing debate about nursing careers within a professional and political context (DoH 2009a; NMC 2009), a return to recent empirical papers illustrates some of the debates for nursing within the new political dynamism. Finally 2009 saw the publication of the Advanced Practice review (CHRE 2009). This reviewed all professions using the term advanced and determined 8 key points. The essence of the report being that the fitness to practice at an advanced level by any employee is for the employer / commissioner to take responsibility for, ensuring patient safety through appropriate governance arrangements.

Advanced Practice and Work Based Learning.

During the introductory chapter, I presented the case for the use of WBL. In 2006 Nixon, Smith, Stafford and Camm undertook a scoping exercise for the Higher Education Academy. This indicated that work based learning is an increasingly popular feature of Higher Education provision for initial and continuing professional development (CPD) and advanced practice. What cannot be ignored is the continued dialogue between the nursing hierarchies about the additional concepts of higher levels of practice as previously discussed (NMC 2009; RCN 2009). Arguably, it is important to maintain and engage with the philosophical language used to define CPD debates in education beyond initial registration. Along with the multi-professional agendas, it appears appropriate to continue to investigate the WBL concept within health professions. To this end, there is significant potential through analysis of the participants' experience to establish the right language to define the evolving and emerging workforce.

There is an emerging proximity of work based learning in the development of Advancing Nursing Practice. WBL is clearly evident in some of the papers reviewed later in this chapter; it is also clear that others have chosen to take practitioners out of the practice environment to study their advanced practice, the focus being on the medical theory. This does not feel congruent, given that clinical practice is a significant part of conceptualising the acquisition of the new knowledge. The proposition is that learning should occur as much in practice as it should in the classroom.

Raelin (1998) proposed that 'tacit forms of knowledge' are fundamental to the success of work-based learning. There should be an integration of the collective knowledge of 'applied sciences' and the individual's knowledge from 'reflection and practical experience' (Raelin 198:281). There is also an implication that there should be

opportunities for sharing with others. Taking the formative principles of work based learning, it is evident that there needs to be consideration of the educational content and organisational support for the tacit experiences. Raelin (1998) begins to articulate that the variables to success include student motivation, and the response by the student to the 'emotional reactions of others'. From anecdotal stories, prior to the thesis I was beginning to see that these variables may be considerable, may be transient, and whilst not due to their knowledge per se, may be significant in their successful progression as hysteroscopists.

Utilitarianism of advanced practitioners:

The change in political will referred to in chapter 1 promoted and encouraged career prospects for nurses within health care settings. Simultaneously the Department of Health set out new pay initiatives as part of government's modernisation agenda for addressing pay inequalities (DoH, 2001a). Changing the parameters of who can and should provide care services has the potential to motivate individuals and maximise career opportunities for, in this case, nurses through advanced practice. In shifting from the traditional altruistic and possibly exploited position, women in health care should be able to increase their standard of living (Miers 2000 and AANPE 2006). From one of the earliest Nurse Hysteroscopy conferences, it became evident that several were struggling to gain rewards for the advanced praxis they were undertaking. This issue was referred to briefly by Ludkin et al (2003).

However in a utilitarian or market driven model it is more probable that the end justifies the means. Rather than improving things for the nurse, the focus was to increase the potential benefits for the population, whilst keeping costs to a minimum. Hence, the purpose of expanding the scope of practice for nurses and other health professionals into those normally regarded as medical responsibilities is based purely on a consumerist paradigm. Emerging evidence from Bode et al (2008), and Connolly and Jones (2008) shows that Trusts are able to report that they are meeting the latest government targets, and a recent influx of applications for our course indicates that Trusts want to expand their services by having a second nurse hysteroscopist.

2003 saw the introduction of a Skills for Health competencies framework that is now managed through the Skills for Health Agency (DoH 2003; Skills for Health 2010), which has been used in parallel with the Modernisation Agenda pay guidance. This

document provides role descriptors, for which the nurse is required to provide evidence of how she meets the criteria, to move through occupational 'gates' and to gain the financial reward commensurate with that role.

The Skills for Health document records that: Advanced Practitioners - Level 7 (pay scale denominator) are:

Experienced clinical professionals who have developed their skills and theoretical knowledge to a very high standard. They are empowered to make high-level clinical decisions and will often have their own caseload.
(Skills for Health DoH, 2004c)

Despite government drivers and skills profiling for salaries (DoH, 2004c), take up of, and the range of potential opportunities for, expanding practice, has been slow. Hence the activity of Darzi to stimulate service redesign (DoH 2009). However, referring back to Lipsky (1980), perhaps some of the reluctance to participate is because the ability of the street level worker is to negotiate what they do and are reluctant to do it without reward. Equally, lack of financial incentive increases whenever there is 're-gendering' of work away from traditional male roles to the more technical area thereby making it worth less for remuneration purposes (Muzio and Bolton 2006). Arguably, this continues to contribute to occupational monopolies and closures, as defined in the masculine paradigm of professional elitism, as discussed in the previous chapter (Witz 1992). However, it may not be all down to the organisation.

Letting go of past roles

If a nurse is taking on a new role then something has to go. Daykin and Clarke (2000), using occupational closure as a framework, identified that nurses themselves have difficulties in letting go of what they determine to be their own praxis in the new skill mix / inter-professional environment. This study was about the nurses giving up what they previously had determined as the 'nursing role' to what Lipsky would call a, 'lower level worker'. It 'weakened their control' (Daykin and Clarke 2000:351) and there was 'strong opposition to skill mix' (Daykin and Clarke 2000:353). These findings perhaps alert us to what the medical staff may experience as the nurse hysteroscopists take on the 'medical role'. Evidence existed from a case study by Woods (1988) which included intensive care nurses as a specialised area of practice. The research participants identified that the support of staff from within the organisation was as

important to success in patient care and personal satisfaction. Nurses themselves are not immune from being protective of their spheres of practice and knowledge.

Summary

This chapter has clarified the concepts associated with professionalism in nursing and advanced nursing practice that are required to break through the occupational monopolies. In this I have considered the potential relevance to nurse hysteroscopists.

The research evidence suggests that advanced practice nurses have to use various communication strategies previously outlined in feminist debates on gender health and bureaucracies in chapter two in order to practice their newly acquired skills. I identified that whilst the political intent of reform was to create a change in services delivery and equalize pay, there has been inconsistent understanding of what that means in reality for the nurse. I have established that there is limited evidence about the specific social impact on nurses who have taken on the advanced practice type of role when training particularly within the social constructs of specific health settings.

Over the last decade there has been an extended period of national consultations, to determine whether the NMC should return its attention to post registration activity in nursing and midwifery. The latest consensus from the CHRE 2009 report is that only nurses who are taking on roles where they are reclassified as Advanced Nurse Practitioners, or who have taken a specialist practice course, are recorded anywhere. Others taking on advanced roles, such as the hysteroscopy nurses, have fallen outside this requirement. However, the professional concerns for patient safety and professional autonomy are still present.

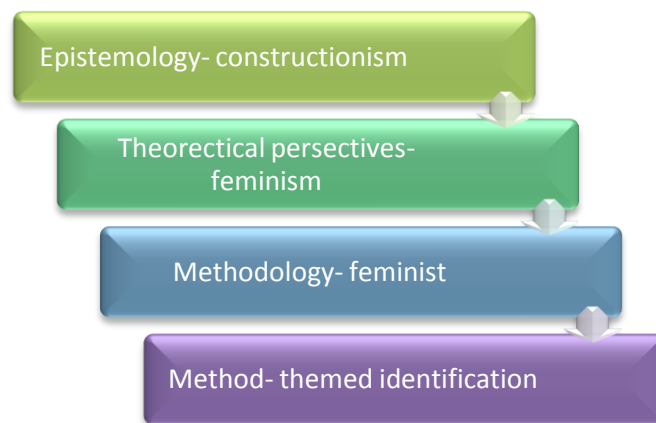
In the next chapter, I describe the reasons for selecting the methodologies used in the study and explain the research processes followed.

Chapter 4

Methodology

In Chapter one I introduced some philosophical constructs of epistemologies through feminism that explained my personal perspectives I presented the basis for my personal paradigm that emerges from feminism. As a nurse and midwife I have developed my critique of the world from challenging the western medical perspective through feminism. . In this chapter, I will develop the rationale for using and applying feminist principles throughout the thesis. Fig 2 illustrates how these fit together and how I will progress the study.

Figure 2 Application of research elements adapted from Crotty 1998



(Created by the author 2010)

Why take a feminist research stance?

Contentiously, it has been declared that 'feminist research is such because the researcher says it is' (Reinharz 1992:8). This statement reflects the concern there is in determining what feminist research is. She articulates the concern feminists had that previous logical positivist research processes and analysis sterilised the individual participants' view thus silencing them. Whereas for others, feminist research is about giving the oppressed, usually women, a voice and by giving the women a voice it keeps them at the centre of the study (Holloway and Wheeler 2010). To do this the researcher has to recognise the power of personal paradigms and how they could distort the reality that women were explaining (Rowbotham 1992). Stanley and Wise (1993) progressed the debate to identify the significance of the researcher / researched relationships proposing that there needs to be as much an acknowledgement of the power dynamics as of the data

that is collected and analysed. This has emerged as a pre-eminent feature in feminist research whilst any one of a group of acknowledged research methods can be used as part of creating a feminist standpoint. This approach requires the researcher to acknowledge privilege and power whilst sharing the research 'foundations' of sociological research approaches (Stanley and Wise 1993:189). Furthermore, there can be a dialogue with the participants so that they can 'get something back' from the process (Holloway and Wheeler 2010).

Methodological influences

As illustrated in the previous chapter, nurses as street level bureaucrats are faced with hierarchies that dominate their working life (Lipsky 1980). This is mirrored through research that informs a hierarchy of evidence based knowledge for practice that nurses are expected to use on a daily basis. The policy documents that Trusts usually create are based on the classifications used in systematic reviews published by NICE. The systematic reviews that also inform health policy guidance are determined using critiques, structured hierarchically with the logical positivist deconstructionists' method of multi-centred randomised controlled trials (RCT) at the top and the qualitative constructionists' near the lower end. Thus, RCT is therefore seen as the highest quality research being deemed to be free of values, objective and therefore pure (Flick 2009). However, there is an argument that even social science research can be:

Rotten with patriarchy values because those who conduct it
endeavour to achieve high ranking on scales of purity to
establish their credibility.
(Stanley and Wise 1993:26)

Whilst the hierarchy minimizes the significance and value of the human experience, Stanley and Wise (1993) argue that whatever the research method the process is as important as the product.

What makes research feminist

Feminist research is closely associated with qualitative methods; the view being that quantitative research silences the research participants' voice and dis-empowers them. It is legitimate however for the researcher to use mixed methodologies where both qualitative and quantitative types of data are collected. There is the potential that even in a mixed methods approach the voice of the individual can still be heard (Rowbotham 1992).

Leatherby (2003:3) describes this as the 'knowing and the doing' and it is defined by Stanley (1990) as the procedure and outcome. Both these constructs are, in essence, about the praxis of the research process. Stanley (1990) went on to argue that the notion of non-feminist research is an artificial construct, that it is how each of the parts of research from epistemology to method are argued for and applied. Through reflection, I have engaged in a reflexive process. This requires me to think critically of the process as well as the assumptions that I would undoubtedly make. Leatherby (2003) describes this as the difficult aspect of research, although she warns against becoming so narcissistic or introspective that the findings of the study are lost. Losing the research participants' voices would indeed appear to defeat the feminist paradigm. Equally the claims of 'truth' have to be carefully resisted because that truth is 'socially constituted and so unstable' (Ramazanoglu and Holland 2003:208), because what happens to us is constantly changing. There are two elements here then: how the researcher behaves and how she makes claims of truth.

The question for me will be; is my study a feminist one when the aim is to get a higher degree. Stanley and Wise (1993) suggest that academia increases the potential for mystification of the research process. By claiming to use feminist principles, I needed to be conscious of using a cloak of authoritative knowledge to disguise what is and has been done.

Gaining an understanding of the nurse hysteroscopist

Feminist research is pluralistic, meaning that there are multiple explanations of reality depending on from where one is looking at it (Reinharz 1992; Crotty 1998). More challenging is that there are no specific methods or principles that denote feminist research (Hesse-Biber and Leckenby 2003). However, the formulaic principles associated with positivist research processes are rejected.

It is the intent, purpose and the interpretations put onto that data
that makes it feminist.
(Ramazanoglu and Holland 2003:154)

In feminism, there is more of the need to identify methods that will facilitate the research purpose to remain congruent with the previously espoused ideologies. As a result, I find that I have come more in line with the principles associated with qualitative descriptive studies.

Qualitative descriptive studies are arguably the least
"theoretical" of the spectrum of qualitative approaches, in that
researchers conducting such studies are the least encumbered

by pre-existing theoretical and philosophical commitments.
(Sandelowski 2000:337)

Sandelowski argues against the highly stylised frameworks associated with the many qualitative studies that create their own limitations, particularly when it comes to data analysis. When analysing voices there has to be a limit on how far the data is abstracted from the research participants' descriptions of their realities; to abstract too much loses the intent.

Disputes against feminist qualitative research that rely solely on constructionism and subjectivity rejecting objectivity as sterile have been criticised by Stanley and Wise (1993). They suggest that objectivity is achievable, however the impact of the processes associated with deduction needs to be acknowledged (Stanley and Wise 1993:150-163). Even in the most scientific paper there are discussions on how the epistemology of the researcher will impact on the direction of that discourse (Hesse-Biber and Leckenby 2004). There are some methods of positivistic research that are less ritualistic than the quasi experimental, for example surveys are used on sociological research to facilitate an understanding of 'what is going on' (De Vaus 2002:173). Arguably, this is in line with the feminist analysis principles as, 'in-depth interview, observations, content analysis and so forth can also be used in survey research' (De Vaus 2002:172).

Grounded understanding

I had previous experiences of using grounded theory in my Master's research. The originators of the principles of grounded theory were Glaser and Strauss (1999) and there have been several co-authors over the years as the methodology has evolved. As a result, there is much debate as to the current genius of that methodological theory. However, the core significant concept is that the 'theory' should emerge from the data, rather than the data set to test a theory (Holloway 2005). The principles of a grounded theory approach have resonated with nursing studies. As Keddy, Sims and Stern pointed out:

It is interesting to note that nursing is in large part a social science, and nurses have sought to hear the voices of those with whom they work. In league with the current feminist research approach, grounded theory allows for the voices of the participants to be heard as they tell their stories.
(Keddy, Sims and Stern 1996:450)

This illustrates there is close association between constructionist epistemology, feminists' perspectives, and grounded theory. Whilst exploring a range of methodologies, I have concluded that each style, method and tools used have their own constraints. I also conclude that data collected from the field through some

form of interaction with my research participants, mixed with survey data as an additional source, would confirm what I was finding and this would complement rather than detract from the results. To maintain the resonance with feminism, I should be transparent with my perspective/s as the researcher and with the nurse hysteroscopists as the participants (Brewer and Hunter 2006; Bluff 2005).

Nurse hysteroscopists as a case study

Case studies in a medical context are often the reporting of a clinical incident. Only when similar cases are drawn together is there any potential to identify phenomena. The methodological understanding of a case study is much broader; they can be used for 'exploratory, descriptive, or explanatory research' (Rowley 2002:16). When a social change is occurring, it is important that there is an understanding of what is happening. Ramazanoglu and Holland (2003) capture the current context that the nurse hysteroscopists find themselves in:

Effective political strategies for social transformation of gender relations require knowledge of what is to be transformed.
(Ramazanoglu and Holland 2003: 207)

Political in the context of this quote is about the desire to examine and alter the power relationships. It would be presumptuous to assume a transformation could be orchestrated through any results. However, without gaining an understanding of what is happening through the nurses' eyes, it will not be possible to stimulate discussions on the potential work environment and dynamics with new students. It was time to step back and consider how to create a narrative approach for this clearly defined specialist group of nurses.

The aim and questions (see introductory chapter) of the study appeared to lend themselves to a case study approach. Case studies are a recognised method for feminist orientated research and can be used to study individuals or groups (Reinharz, 1992). The case study allows individuals from within a defined group to describe their world at a point in time.

The power of the case study to convey vividly the dimensions of a social phenomenon or individual life is the power that feminist researchers want to utilise.
(Reinharz 1992:174)

However, a consequence of this type of study is that it can never be generalisable, and such an understanding throws in challenges to accepted norms of assessing research quality, those of reliability and validity (Reinharz, 1992).

Case studies allow for a mixture of sources of data to be used collectively (Reinharz 1992; Robson 2002) which, in this instance, will generate new insights and give understandings into phenomena associated with the emerging role of those particular group of gynaecology nurses. Using this method gives an opportunity for the nurse hysteroscopists to articulate the impact of changing social interactions and roles from their perspective, within what is ostensibly a politically imposed agenda on the health service, and for others from the same group to confirm the observations.

Further rationale comes from the fact that case studies may be conducted on singular or multiple objects and by using one or more sources of data, there being no definitive right or wrong number. Flick (2009) suggests that the important factor is to use a 'case' that will enable reconstruction. I have taken this to mean that, in the selection of the case group, I will be able to examine how each of them reports the issues as they see them and then construct an understanding from their views. McDonnell, Jones and Read (2000:387) talked about an 'amalgam' of perspectives, providing a multi-dimensional picture, arguing that each perspective interconnects with another. It was this thought that made me look further into what methods to use.

Selecting Mixed Methods

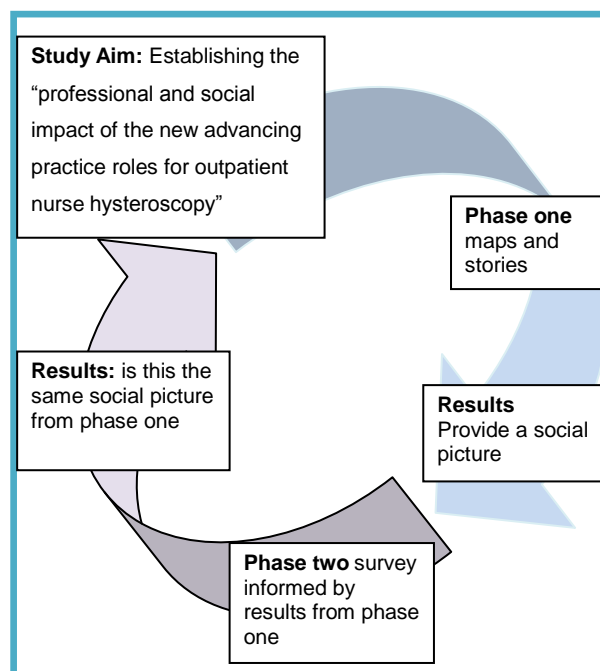
I looked for approaches in which the research questions could be tested without directly asking nurses the questions I had phrased that might directly influence their responses. Having made the argument for a case study approach on the previous page I also alluded to, but not fully argued for, a particular type of multi-method approach. Case studies are made up of more than one source of data and may also use more than one method to collect that data. As a result, I decided on mixed methods or 'multimethods' as phrased by Brewer and Hunter, the aim being to:

Seek a set of measures (two or more) whose indicators point to the same societal phenomenon, whose quite different data-collection techniques minimise the risk of overlapping the methodological biases.
(Brewer and Hunter 2006:106)

There are two perspectives from which to examine mixed methods. One is that collecting data in two different ways provides the opportunity for 'between method triangulation' (Flick 2009:44), where one method test the results collected by another method (Hunter and Brewer 2006). Secondly, it provides a record of any

changes in a longitudinal study. The argument for this is presented by Reinharz (1992), who gives an example of a study that started with a survey and offered the opportunity for interview (Reinharz 1992:200). Likewise, Flick (2009:444) suggests that this type of triangulation is used less for validating data and more for 'enriching and completing knowledge'. I planned to use two methods in the study, in two phases which are detailed below, that create an opportunity for triangulation which might be more accurately classed as bi-angulation, see Fig 3. The features of this are in the two phases of the study. Phase one: a qualitative method of mind mapping as described by Sutherland and Katz (2005) with narrative (story telling) as defined by Reinharz (1992) and Holloway and Wheeler (2010). Phase two: an online survey (Fink and Kosecoff 1998; de Vaus 2002).

Figure 3 Model to illustrate how the findings of both phases will bi-angulate



(Model created by author 2010)

Phase one - Changing the power dynamics: giving a voice

I wanted to find an alternative way of conducting the traditional interview. As the nurses' lecturer, I had a power status that could limit or influence the direction of the conversation. Equally, even by conducting a loosely semi-structured interview, I would be asking the questions I wanted answering. This has the potential to prevent the nurses from articulating what is important to them. Equally I could have used the narrative only; however starting straight into the narrative without time to think about what was important for them means time may have been spent on acclimatisation I felt there could be another way. I needed a method that would

minimize my power and reduce the potential for any bias my presence might have on the direction of the narratives, yet keep the nurses focused on what was happening in their own work environments. I considered 'Mind Mapping'.

Mapping out

I know about mind mapping (spider graphs) as I have used it as a note taking technique for managing my dyslexia and it comes from cognitive learning theories (Sutherland and Katz 2005), and forms the basis of one of the electronic tools I have. I have also used it with students who are having problems visualising what they are trying to express. It helps capture thoughts in class situations or construct ideas when creating assignments. I was not aware of its use in a research context.

When I put mind mapping into the search engine I found Trochim (2006) who is one of a few that has identified concept mapping as a research tool. In a recent book, he says:

Concept mapping is a generic term that describes any process for representing ideas in pictures and maps.
(Kane and Trochim 2007:1)

In this latest text he discusses the use of maps as a source of quantitative data collection. He notes that the data collected is qualitative; his focus is about the measurable, thus losing the individual perspective. In earlier online material, Trochim describes six stages and identifies how each individual verbalises ideas, generating a map of thoughts. Trochim goes on to describe how he used concept mapping to derive conclusions from group views. In both of these he has deviated from what I was looking for (Trochim 2002 and 2007). More frequently concept / mind mapping seems to be used for analysing, or, when used for collecting data, to assist groups to come to a common understanding from statements set by the researcher (Kitchen and Streatfield 2010). When I was planning the study, a paper by Sutherland and Katz (2005) explained the use of concept mapping in a health research project. They used a concept mapping activity to provide a visual representation of participants' relationships within their organisation prior to, and during, their training.

The association with organisations and locating the self within that environment resonated with my own study and I decided that I should use a similar technique in this study. The created map would provide a visual representation for participants to facilitate their descriptive journey from training to qualification as described by Sutherland and Katz (2005). To appreciate the overall circumstances I needed to

be familiar with the background of the journey in order to capture that, rather than just a collective understanding of the organisational environment. I knew that I would not be able to prepare a map that linked 'relating concepts and presenting an interrelationship diagram' (Holloway and Wheeler 2010:338); that each map would need to tell its own story because each nurse was working in a different organisational context.

My research design for mind mapping was to have three elements of feminist research: Firstly, nurses would have silence whilst they created a visual representation of their social interactions as they placed their reference points on a board. Secondly, my power would be reduced to observer whilst they did this. Thirdly, the map would direct their story and I would only ask for clarifications, minimising my influence on the direction of what was said. However, it would be naive to think that I had removed all aspects of power and control associated with asking direct questions. By using this method, I was planning to minimise my influence whilst still being able to observe how the nurses went about this exercise.

Creating a social story through narrative

Stories are reflections on people's experiences and the meaning that this experience has for them.
(Holloway and Wheeler 2010:193)

This resonates with the feminist perspective. Holloway and Wheeler (2010:199) later use the term 'cultural stories', referring to the demonstration of meaning in a particular context. As the research questions identified, the intention was to enable the nurses to explore the social context of their working environment and the impact it had on them. The rationale for the use of narrative storytelling emerged from feminist literature; there is evidence is that it has been adopted by non feminist researchers too (Sparkles 2005; Flick 2009). Indeed Brewer and Hunter (2006) captured it as a post modern concept by presenting an argument that it is not possible to have any scientific development without concatenate narrative; the linking together of a series of factors forming a sequence:

The narrative conception of explanation seems to challenge the positivists' scientific assumption of generalizable laws. But the multi method perspective acknowledges that the very meaning or idea of what constitutes an explanation is itself method specific.
(Brewer and Hunter 2006: 155)

This post modern perspective appears to reduce the conflict between social and scientific ways of knowing and validates the use of the narrative in the context of

this study. Furthermore, the intended research participants, as health professionals, will already have many informal experiences of using and interpreting narrative as it forms a key part of oral reflections in and out of professional practice (Gaydos 2005). These will have aided the individuals' social locating within their working groups and or organisations. Furthermore:

Scholars have begun to treat seriously the view that people structure experience through stories, and that a person is essentially a storytelling animal.
(Sparkes 2005:191)

Sparkes (2005:193) also suggests that in narrative there is potential for, 'linking identity with culture'. Whilst Sparks pursues the use of narratives using examples of critical illness, it is clear that the principles can generate insights from whomever and why ever they are telling their story; 'Story telling gives shape to life experience' (Gaydos 2005:255). It is important to recognise that the storyteller has 'selected the components of the story to convey a meaning' (Bailey and Tilley 2002:575) that represents what it is they wanted to say.

Quantitative research and feminism - Choices for phase two

There is a tension with proponents of feminist researchers when it comes to discussing quantitative methods. As previously discussed in chapter 2 the relationship with logical positivism and scientific enquiry dominated by masculine design and objective interpretation is viewed suspiciously (Stanley and Wise 1993; Reinharz 1992). However, there is a history of survey research to establish social problems or change through feminist research (Reinharz 1992) and there is a valid argument for feminists to include 'quantitative strategies' (Holloway and Wheeler 2010:29). Once again, it is about the researcher being aware of where they are situated in the collection and interpretation of the data.

A survey is a method of collecting information directly from people about their beliefs, feelings social background.
(Fink and Kosecoff 1998:1)

It allows the systematic collection of a series of measures that require explanation; these are: who? what? where? how many? and how much? (Rowley 2002), however the degree to which all those elements are achieved will depend on the construct of the survey.

There are limits to surveys as the research participant can only answer the questions that the researcher asks. They can 'provide descriptions' (Fink and Kosecoff 1998:3) to portray phenomena and 'explanations' (De Vaus 2002: 173) to account for something that is happening. Whilst it is possible to investigate variables, they will only be ones that are expected by the person who writes the questions. Additionally, there are multiple ways of asking questions in a survey from closed to open, allowing free text responses. Questions are usually formulated around the research question/s. In my design, the questions that were used evolved from the narrative data. This 'data validation' is a triangulation process associated with a 'plurality of methods' Sharkey and Larsen (2005:178). It can be used in two ways; either to test the data to see if similar conclusions are drawn or as Flick (2009) describes it is a particular component of case studies, the aim being to test the findings from another source of data.

The gate keepers and gaining access

Before any study can be undertaken, a series of approvals have to be gained. The volume and intensity of that approval will vary depending on the hosting organisations, sites of data collection and personnel / age of potential research participants. Each element of this gate keeping process can be seen as an important part in demanding academic rigour and of ensuring the safety of the public.

I needed three levels of 'approval'. This section describes the series of approval processes that were completed, concluding with a short reflection on the process itself. Before I could even consider undertaking the study, I had to meet the requirements of the School of Education where my course is hosted. The university approval for study is contained within the fourth unit of the course and requires a written philosophical research proposal. The panel reviewed the proposal in terms of appropriateness and methodology. Having successfully completed this final taught unit, I could move on to the next stages of approval.

The next phase of the ethics process was to seek approval from the internal quality assurance ethics panel of the School Research and Ethics Panel (SREP). The documents were paper based and prepared for an academic audience who reviewed my objectives and ensured that supervision was in place. When they were satisfied, I could prepare to submit to the third gate keeper, the local NHS Research Ethics Panel (REC).

In the meantime, because I was conducting a study with current and alumni students of the institution, I had to advise my own school of what I was doing. The chair of the ethics panel required assurance that 'due regard' to ethical issues had been undertaken. I duly submitted a paper document with evidence of approval from my place of study.

Accessing the nurses

This was the most time consuming element of the process. Although my research participants were all members of the BSGE, either alumni or current students of the university, they were also employed by the NHS, and the course is run in partnership with a local NHS provider. The process of accessing NHS staff is through the National Research committee, whose approval processes are devolved to local national research committees. The purpose of local REC is to:

Facilitate ethical research which is of potential benefit to participants, science and society. And in turn protects the rights, safety, dignity and well-being of research participants that are part of clinical trials and other research within the NHS.
(www.nres.npsa.nhs.uk/ accessed 2009)

The key objective in preparing documents for consideration is that patient safety can be assured. The content has to be understandable to the public and the panels' lay membership. I was now onto my third set of paperwork; the first had demonstrated academic credibility, the second for the research process and ethical credibility amongst academics and finally the third, a document for a mixed audience of professionals and lay personnel that maintained the ideologies of the study yet was usable and understandable.

Addressing ethical principles

The ethics committees required assurance that the following elements were in place for those I would recruit. (Samples in Appendix 3, 3a and 3b)

- The introductory letter: this explained who I was and that this was a request for their participation.
- An information leaflet: this included details on the nature, purpose and methods of the study and what it would entail for them if they were to agree.
- The consent forms: these had to draw out the key aspect of the study and included all the principles that they would be consenting for.
- A disclaimer: I had already ensured there was one; by choosing to participate there would be no impact on their programme/s of study.
- A statement that ethical approval was gained and including details about confidentiality and anonymity, the ability to withdraw at any time.

- Finally, information about storage, access to and subsequent usage of data.

Both panels (SREP and REC) were equally concerned that the research participants, who may be my students at some point during the study, should not feel coerced into participation. This was particularly important given my relationship to their course. It is not uncommon when the researcher is known to the participant and involved in their training / education; however it is not dissimilar to the issues faced by the participant observer. Issues of 'Contamination by intimacy' have been discussed earlier in this chapter. In order to reduce any sense of coercion the letters providing information about the research and requesting participation were administered by post through the course secretary. Once the person had accepted, they were revealed to me so that I could contact them about timing and locations.

The second part of the study would not require face to face contact and could be conducted anonymously with research participants being able to choose whether to participate or not anonymously. The original plan for contacting the second phase participants should have been through notices and alerts on the BSGE web site but as this was being upgraded at the time of data collection, block e-mail notification from the BSGE database was used instead. All potential research participants were free to ignore the request or engage with the study without my knowledge of who had or had not responded. In both phases of the study, I could only contact the nurses through their personal details held by the university and the BSGE. On several occasions I had to ensure that communication did not occur through the NHS. This was a challenge as research participants would sometimes write to me on a professional/academic matter with a 'by-the-way' question relating to their participation. To resolve this I would explain the situation to them by responding to their academic question.

Of further interest to the SREP was my status as registered practitioner. In that role, I have a 'duty of care' to the public. When the study approval process commenced in 2005 the guiding NMC document was the 2004 Reporting Fitness to Practice document, which clearly states that most incidences can be managed at a local level.

Every day employers, managers and supervisors of midwives deal with situations concerning the misconduct, lack of competence or poor health of registrants. Most of these incidents are managed at a local level and do not give rise to wider concerns about public protection.

(NMC 2004a:2)

Given the nature of the study, there was potential that poor practice could have been disclosed by the nurses. Further reading of the document would indicate that I would have to act if there was evidence of lack of competence on the part of the nurse. My responsibilities in relation to this matter were identified on the consent form and I reminded participants at the start of each interview that if such information is disclosed the individual's trainer or line manager may well be advised of the matter so that issues might be dealt with appropriately.

Research Integrity

Case studies as a research method or strategy have traditionally been viewed as lacking rigour and objectivity when compared with other social research methods.
(Rowley 2002:16)

Constructs on the quality and trustworthiness of research were developed from the basis of positivism; that scientific research was objective, logical and deductive. The clear steps in processes for data collection and mathematical analysis enabled the concepts of reliability and validity. Studies using statistical tools and measurements were, and still are, seen as high quality studies. From such data then emerges the ability to reproduce studies and generalisable results. What should be achieved is the following set of criteria as described by Holloway and Wheeler (2010), these are dependability, credibility, transferability, and confirmability.

In searching for trustworthiness, Trochim (2006) used Lincoln and Guba's criteria, which advised that credibility can only be confirmed by the participants who have contributed to the study. Credibility requires that the nurses recognise the meanings and that they give a truth to their social context; and the findings should be 'at least compatible with the people under study' (Holloway and Wheeler 2010: 303). The first question on the survey will let me identify those who participated in phase one. By abstracting their data I have an opportunity to check for credibility.

Transferability means that the findings of, 'one context can be transferred to a similar' (Holloway and Wheeler 2010 303), an example being that the findings from nurse hysteroscopists will be transferable to other groups, also moving across professional boundaries. To do this there has to be sufficient information on the context to enable a transfer of the findings into a new context. Hence there will be description of the case group and some ethnographic data. Rather than reliability, the research needs to be dependable. Dependability is checking that the results are consistent and accurate (Holloway and Wheeler 2010). To demonstrate this,

the researcher should describe the changes occurring during the period of data collection and/or to the contexts within. By understanding how the researcher has proceeded through the process, someone else can audit the process (Holloway and Wheeler 2010). I describe how I have applied these principles in the next chapter on data analysis. This will enable someone else to replicate the process whilst the study itself can never be repeated. Finally, confirmability; perhaps this is the area that resonates most clearly with feminist research principles. The study process needs to be corroborated by another who establishes in what way the findings have achieved the study aims. Rather than examining the results, the external reviewer is looking for integrity; for this the perspectives of the researcher need to be transparent as well as the processes used.

Trustworthiness can also be enhanced by using several methods of data collection with a triangulation of the results (Polit and Beck 2008). Each of these criteria was fundamental to the principles I was required to demonstrate as part of ethical approval process.

Sample Size

Despite the principle of case studies where sample size is not a requirement, the university and NHS research committees required articulation of a sample size. Based on understanding the sample group, it was anticipated that the sample for the interview stage of the study would be between 5 and 10. Travers (2001:11) suggests that 'there is no benefit from working with a large data set'. This suggests that it is better to work in detail on fewer transcripts to gain qualitative data that possess both depth and colour. Indeed, feminist researchers frequently work with individuals or small groups with the aim of challenging generalisations rather than creating them (Reinharz, 1992). I had identified that there is quite a variety in anticipated sample sizes for online surveys:

Our results suggest that the number of contacts, personalized contacts, and pre-contacts were the factors most associated with higher response rates in the web studies we analyzed.
(Cook, Heath and Thompson 2000:883)

During Cook et al's (2000) analysis of online studies, comparing web and e-mail studies, they identified a response rate between 34% and 39% as the norm. It is clear from the quote that contacting individuals improved response rates.

However, in line with the ethical agreement for my study, it was not appropriate to keep pushing to increase the response rate. A more recent study comparing web

and paper based response rates in 2009 identified that web based surveys could have response rates of as much as 76% (Greenlaw and Brown-Welty 2009). In their own study, the initial response rate for web based research participation was 54%. Arguably, the topic of salaries created an incentive to participate. Additionally, by the researchers' own admission, the group were technically literate. This confirms that a significant compounding factor in any survey is the web literacy of the group being surveyed and their motivation. Knowing the nurses and their use of the virtual learning environment, and the inconsistent volume of e-mail communication between the teaching team, I would hope to reach the response rate of between 34% and 39% as found by Cook et al in 2000.

Confirmation of ethical approval

I was interviewed by the panel in August 2007 and the approval letter was received in October 2007 requiring no amendments but with the following requirements. Firstly, an annual report would be submitted electronically to the REC site, and secondly, I would return to the committee for approval of my second phase which could not be prepared until phase one was completed. Prior to the launch of phase two in September 2009, I complied with the requirements in the original local REC report of October 2007, submitting the survey questionnaire for supplementary ethical approval in April 2009.

Phase one Data collection

In purposefully selecting a discrete group of nurse hysteroscopists in order to develop an understanding of what is happening in their current practice I was using a purposive technique (Robson, 2002).

'With a purposive sample, you are likely to get the opinions of your target population'.
(Trochim 2006a web page²⁷)

Additionally, within the general principle there are sub categories of which the expert is also applicable to this study:

'Expert sampling involves the assembling of a sample of persons with known or demonstrable experience and expertise in some area'.
(Trochim 2006b web page)

²⁷ This material is now published in a paperback, *The Research Methods Knowledge Base*, by Trochim and Donnelly, 2006

The nurses were all past or current students of the university, all gynaecology nurses and members of the BSGE²⁸. Based on these principles the sampling group falls into the 'expert category' described above by Trochim (2006) and the homogeneous 'criterion based', 'group membership' of Holloway and Wheeler (2010:138). The group of participants and researcher because is not heterogeneous as I am not a nurse hysteroscopist although I teach them. Additionally the nurses differ in age, experience and organisation that they work for. However, I am a registered nurse and the nurses have a commonality in the new skills they have acquired. There were no exclusion criteria.

The available sample size at the time of stage one data collection was made up of 30 nurses in training, and 31 nurses practising as nurse hysteroscopists. The pool of potential recruits shifted with new qualifiers and recruitments. Whilst there was an initial pool of 60, it was recognised that many might not agree to participate. As a module leader, I was aware of the students' commitments to working full time and study. For the second phase of the study, the potential pool had risen to 70 but this was limited to 55 by the numbers of inaccuracies in the database (changes to e-mail addresses). I knew I would not be able to produce any statistical evidence because the numbers in the case group are too small (Fink and Kosecoff 1998). However, I would be able to draw inferences to understand more of the context of nurses than would be possible from the small group responding to phase one.

As a dyslexic person I can be quite chaotic and it was important that I had systems in place to help record what and when I had done it. A spreadsheet enabled record keeping and monitoring of postings, responses and arrangements made. The invitations were coded and a return stamped addressed envelope was included in the distribution. I undertook one posting and a subsequent reminder. After six weeks, I had thirteen volunteers but after much negotiation could only arrange to meet with ten. For a homogeneous group this is an appropriate number (Holloway and Wheeler 2010). The timings of the meetings were planned opportunistically as they had to fit with their work commitments and mine. As a result, it took nearly a year to meet with all nine. I noted that I provided all potential research participants with a copy of the information to keep as well as a consent form.

²⁸ For the nurses it is a requirement of acceptance on their programme and a sustained membership is expected once qualified to facilitate their re-accreditation in the role every three years. Re-accreditation requires the person to have attended a national conference annually and submit a three yearly audit of their hysteroscopy practice and each of their therapeutic skills.

Location

Collecting the data from the nurse hysteroscopists happened not only over an opportunistic time scale but also in a number of locations including the British and European Society of Gynaecological Endoscopy conference venues, conference bedrooms, attendance at University, a motorway service area, a hotel lobby and the remainder generously invited me into their homes. In the past, holding interviews in public places created a problem with sound quality. Modern digital recording tools reduce this issue.

Creating the maps

I prepared a rectangular white board by partially coving it with white felt over three quarters leaving the remaining quarter for a key to be recorded alongside (see map images in chapter 6). The nurses were settled in their respective locations. I re-established the purpose and ground rules for the study. I then asked them to undertake the mind map with coloured felt squares to create a diagrammatic representation of where they currently saw themselves within their area of work / organisation. During this process I sat quietly so as not to disturb them.

Before starting their story, the key was written out and audio recorded with each nurse noting who or what roles the coloured squares represented. The images were also recorded on a digital camera. Then each nurse was asked to tell their story behind the map which remained in front of them for the duration of the interview. The narratives varied between 22-45 minutes, not as long as is often the case with this type of study (Taylor 2005). There was a risk in having such a free form technique for data collection but generally the narrative flow was constant as they moved around their maps, talking about their history and how they related to each of the individuals or groups represented in the map. In this way, the nurses had power and direction during data collection.

The board was too large for flight, so that when two of the research participants agreed to meet with me at an international conference, I had to think quickly and I took a white pillowcase instead. Having taken the precautionary habit of asking the research participants to dictate the colours and roles, this also became important in one interview when the image failed to record. I later recalled that I had not checked it before I left the interview location.

During the ethics process I had been required to consider whether there may be potential harm to my research participants by our relationship of tutor / student. My power as interviewer was important, not only in terms of the relationship with the

nurses but that any actions and / or omissions during the research process by myself may cause harm 'through poor planning or execution' (Greenfield, 2002:42). Even with all the processes followed, poor practice by me or any other researcher cannot be omitted completely. Overall, their caution is understandable in relation to clinical trials and the iatrogenic risks of physical interventions.

Phase two Data collection – Credibility through confirmation

Mid way through the study, it was apparent that I should sample the remainder of the case study group, rather than the original intention to explore the issues with the trainers after I presented elements of my literature review at an international conference²⁹ and the response I had from delegates. This reflexive response still fulfilled the triangulation purpose with the added benefit of testing out the theoretical interpretations of experiences amongst more of the cohort. Sampling only one part of a cohort is an accepted part of case study data collection (Flick 2009). However by broadening out the number of participants using a different data collection tool I was in fact able to triangulate the theoretical observations I was making and not just one experience against another (Reinharz 1992; Flick 2009).

Having determined, in discussion with my supervisors, that it was more appropriate to survey the remaining nurses the next stage commenced. There are several things to consider when developing a survey, these being; the questions, target audience, data administration, collection and analysis (de Vaus 2002). The latter will be considered in the next chapter.

Bristol on-line survey

I determined that I would survey using electronic technology; the key was to select the vehicle. De Vaus (2005) recommends the use of specially designed internet survey packages. One such is the 'Bristol On-line Survey' (BOS) which my employer had gained a licence to use since this study had been designed. The data could then be abstracted into Excel spreadsheets for statistical and descriptive analysis. A caution of using such a tool is that the research participants must be IT literate and have access to appropriate technology (Cook et al, 2000).

The BOS tool guides the construction of the survey and once the question type is selected, the framework to word it is automatic. This meant I could focus on the content of the questions (BOS 2005). Previously I introduced the difference between descriptive and explanatory surveys. The questions were developed with

²⁹ The European Society of Gynaecology Endoscopy (ESGE) 2008, where I presented a paper on Nurse Hysteroscopy from an Educationalist's Perspective in the free communications session 9.11.08

some ethnographic detail to provide context and then constructed thematically as the content had emerged from the transcriptions. The survey was to be available to all the nurses including those who had already participated in the study. It was important that the interviewees could participate but their data could be abstracted out. The rationale being that although I was testing the theoretical principles on a wider audience, including the originators would enable credibility, testing the quality of my interpretation (Polit and Beck 2008). The remainder of the questions were those built on the themes that emerged from the stage 1 data the content of which appeared to have a resonance with either some of the socio-cultural factors of working as a nurse hysteroscopist in a large organisation and / or as reported in the literature review chapter.

De Vaus (2002) suggests there are four components to a survey structure called the 'descending ladder of abstraction' (De Vaus 2002:174). These are: 'defining the concept, identifying the different dimensions, identifying the sub dimensions, and developing indicators for the sub dimensions'. The survey would include independent variables in the general data section and two sections of variables, making up a total of 17 questions (Fink and Kosecoff 1998:64). (See table 5)

To contextualise the survey I was able to lead each section by using phrases such as- 'Your peers suggest that...' or 'the literature suggests that...' This was particularly the case the subdivisions at the start of the last series of questions. This section was made up of a series of statements that test whether the behaviours of the nurses responding to the survey were similar to those who had been interviewed and characteristics the literature was suggesting. Some of the questions also tested the context to responses earlier in the survey.

The BOS survey allows for drop down free text boxes. To aide inclusiveness 'other' enables research participants to provide a response even if I had not provided a phrase that was relevant to them and or it did not fit with their experience, or understanding. An alternative in some cases was to say 'please give examples', the nurses were then able to give examples of phenomena as the interviewees had done. This type of data provides textual illustrations not always found in surveys.

To sustain part of my feminist methodology of not 'leading' the nurses, to answer the research questions; how the questions were phrase had to be thought through carefully. One set of responses required careful choices in semantics. From previous activities I am aware of the issues of bullying in the NHS that are also described as horizontal violence by Deery (2008). Given that the term was only used by one person in the narratives I chose to use the term jealousy instead as it

was a term used for situations that were described by other research participants.

Table 5 Illustration of the structure to the on-line survey question formation

Sections within the survey	Purpose
General data section (The Independent variables)	This provides some ethnographic contexts and allows the research participant to get used to using the tool (Bristol online survey accessed 2005) <ul style="list-style-type: none"> • Had they been interviewed by me. • Length of their experience in hysteroscopic nurse led services. • How long their training had taken. • Financial recognition for their role against national pay framework.
Developing towards nurse led outpatient hysteroscopy services. variables	It was designed to examine how well prepared organisations ³⁰ had been for the nurses to work as nurse hysteroscopist and what impact this may have had on them.
Working as a nurse hysteroscopist Variables	How they were regarded by the organisation. Experiences of professional jealousy
Describing your experiences Intervening Variables	Testing elements. If the nurses are using skills associated with emotional labour and intelligence that appeared to be relevant from the interviews. Along with factors the literature suggests inhibits these.

(Compiled by author 2010)

Summary

In this chapter, I have reviewed the relevance of feminist research to the study and the debates on what is credible research. Through an analysis of feminist methodology, I have made the case for using a case study approach using mapping and stories to gain some in-depth understanding. I have then started a research process trail from ethics through to recruitment and data collection processes. In doing this I believe I have started to establish the case for trustworthiness. This includes reflections that required a reflexive response.

In the next chapter, I discuss the response rates, reflect on the success of the methods and explain the processes used for analysing the data.

³⁰ Organisation refers to the research participant's places of work. These varied from newly built under the Publically Funded Initiative (PFI) to Foundation Trusts including University Teaching Hospitals to non foundation District General Trusts. Some of the nurse hysteroscopists are working on more than one site and type of facility. Whilst there are principles to administration each one will vary dependent on groupings and management structures for clinical activities.

Chapter 5

Methods of Data Analysis

In this chapter, I will continue to discuss the procedure for establishing trustworthiness using the same structure I used to describe the stages of the study as seen in chapter 4. I have reflected on important issues and observations that emerged; this is a key part of reflexivity and helps to establish the quality of this study. The more transparent I can be with my thought processes the more likely it is that this study will achieve the criteria of trustworthiness as described in the previous chapter. I will start with how I analysed qualitative data on the maps, the transcripts from the narratives and finally the quantitative data from the survey.

Phase one - Managing the stories

Having collected the evidence, each digital audio file was downloaded to my computer. I was aware that during some conversations nurses had sometimes named individuals or their places of work. I had reassured them that I would remove all these references. This would ensure confidentiality and anonymity, as required by NHSRE. Holloway and Wheeler (2010) suggest that how to name the persons who have volunteered to be part of the study can cause debate; I have determined on the collective general use of research participant. This was impersonal and not in line with my feminist ideologies. I was working with a relatively small community of nurses, who had chosen to invest some of their time in my study. I needed to be careful how I articulated and interpreted the images created by the nurses in the first stage of the study. Each of the nurses had chosen a name to be known by but unfortunately 'Liz' was very popular, and although I asked if they would choose another name I was still left with three. I changed one to Elisabeth and the others were allocated a number for the order they participated in. Where I refer to the research participants of the survey, I refer to them as nurse hysteroscopists (NH) and have allocated them a number that corresponds with when they undertook the survey. Collectively I use the term interviewees.

Reflecting on using the maps as a tool

Two factors emerged during collection: as a result of the way the interviews were set up, one challenge that I had was that the nurse hysteroscopist being interviewed (NH_i) focussed mainly on the image they had created and gave me

little eye contact. Normal feminist research would have expected more of an exchange of ideas. However, there was a positive side to this. One of the concerns the ethics process had raised was the issues of power dynamics between me and the nurses, having been involved in their training. By not looking at me, they did not seek non verbal or verbal cues which meant I was not in a position to take a lead through non verbal messages.

In practice, and as can be seen from the collection of images, (Chapter Six) on two occasions I was not able to use the prepared tool as these data collection events were at an international conference and the board I had constructed was too large for air travel. I am also short of one image because of technical failure with the camera. I know who and what she had in her image because of the notes I made at the time, and we had a follow up conversation for clarification purposes.

Later, at one of the international data collection events, not having the ability to recharge the camera and a lost phone with camera meant that I was dependent on the research participant who took the picture on her camera and sent it on to me at a later date. After the first loss of image I did not want to be completely dependent on her, so I took time to make a diagram of her mind map. The result is that I have a total of eight mind map images and nine accounts of what the relationships in those images mean are presented in Chapter 6.

Interpretation - through colours and location

From the literature, I not could establish whether there was any guidance on how to examine the mapping element. There was a potential analysis through the nurses' use of coloured squares, however as will be seen on the maps 1-8 in chapter six there is no real consistency in colours they select. As the purpose was to facilitate the direction of the nurses' narrative rather than to say anything about their individual situations, I had planned to describe what I saw to give context to the NHi stories. I was of course conscious that models of occupational closure and theories of organisational culture may help to describe where the nurse had located herself (Trochim, 2002). The clearest observable interpretations to be made were from similarities in patterns in how individuals located themselves in their organisation and so emerged the potential to examine interpretations through hierarchies.

Is mapping a feminist method?

The research participants spent approximately five minutes of the interview process mapping their intra- and inter- professional relationships. The map was never intended for psychological analysis but simply to facilitate the interview process. However, I can now see the potential for this as our personalities will play a part in the way we see ourselves in the world and the choices we make. Indeed McPhail (2002) identified that nursing profits from eclectic personality types. Ou, et al (2004) conducted a series of studies examining colour associations with emotions. Their conclusions were that colour:

evokes various emotional feelings such as excitement, energy, and calmness. These feelings, evoked by either colours or colour combinations, are called colour emotions.
(Ou, et al 2004:232)

The choice of colours was limited and there was no commonality in the choices of colours or where they located them on the map, so no substantive conclusions could be made.

Perhaps an unexpected factor was the utter focus the research participants put into the map during the recounting of their story. As already discussed in the previous chapter there had been concern throughout the preparation of the study about the ethical implications of the potential power dynamics, and contamination by association, between the research participants and myself. Whilst implementing a feminist philosophy within the design, it is easy for the power dynamics to slip during the implementation phase through the questions I might put to them that would generate response to my issues and not illuminate the issues that were significant to them (Stanley and Wise 1993; Ramazanoglu and Holland 2003). Even whilst telling their stories, had they looked to me for prompts, (as the researcher and tutor), I believe I could have influenced them.

However, the method was successful as the research participants' focus almost excluded me, so that I became an observer and listener. I observed that on the whole, the research participants tended to look and point at their map throughout the interview, only looking at me when sharing an anecdote. Additionally, several of the research participants found that it was very helpful to keep them on track and focused on the intent of the interview. I have a record of two comments; Lucy was the most articulate in her comments about the research process. She was very structured in the way she talked about the layout she had done and after the interview she commented that:

I'm glad I went with my first instincts... talking through everybody's position around myself and having that visual aid there was very helpful...
(Lucy)

About the actual process she said:

We had some eye contact but rather than just sit cold and look at each other like an interview, it was also a diversion and I felt more at ease doing the interview than I thought I was going to.
(Lucy)

Liz 1 identified how her content had evolved into communications and not just roles and said:

I didn't know what to expect. I thought it was just going to be a discussion.... it was a simple process.
(Liz 1)

Using this tool appeared to provide the research participants with thinking time. As busy professionals, it afforded them the opportunity to clear their thoughts, refocus and think about the significances of relationships before they began to speak to me. It may be why I appear to have very little 'dross data' and that all but one of the interviews was completed within the hour. The conclusion is that it proved a successful device for individuals. I would recommend it as a vehicle for certain types of narrative story telling.

Examining the narrative

Qualitative data has at some point to be subjected to structured analytical processes. A trawl of research text indicates there is no one method that is seen as the ultimate; however, there are different systems and tools that are associated with particular methodologies (Greenfield 2003; Flick 2009; Holloway and Wheeler 2010). The choice of which to use had to be pragmatic. I was looking for one that would fit with my own coping strategies for the dyslexia. I know that I am better when I hear details. When transcribing I can make numerous errors, as with any writing. Yet accuracy in recording what has been said was important.

Having stored the digital data, I listened to the narratives several times before starting to transcribe them verbatim. I then followed the principle of familiarising myself with the nurses' expressions, which is a fundamental principle of qualitative research (Strauss and Corbin 1998; Flick 2009). This included the language the nurses used to express themselves, and the interrelationships with words. As I listened to the tapes, I looked at the pictorial images the research participants had made. Even where the images were poor or did not record, it appeared clear that

apart from one of the candidates this was a useful tool in maintaining a focus on their journeys. I had very little 'dross data' normally associated with unstructured data collection (Holloway and Wheeler 2010:89). As a feminist researcher, I have always had the problem with the term dross; the data may be dross to the researcher but to the individual it is how they can explain their world.

Solutions to manage the data

Originally, I had intended to insert the narrative and qualitative questionnaire transcripts into the software package NUDIST, to facilitate management of the data set. A software package was not appropriate to be used as De Vaus (2002) suggests that (electronic coding) requires 50-100 research participants to create meaningful data for analysis.

I had been provided with a dyslexia tool 'Dragon Speak' to speed up the process of transcription. 'Dragon Speak' is a voice recognition tool that is provided for people with dyslexia. This improved the movement between different file types (audio and word). However, I had real difficulties training the voice recognition tool, and it increased the transcription time significantly and I eventually abandoned it.

Initially the text results were overwhelming. What was clear is that I was making a lot of errors in the first two transcriptions I did. One of the characteristics of my dyslexia is that I can miss sections of text, I realised that it was important to keep using my audio and visual senses during the analysis process. Whilst in discussion about my progress with a friend, she had identified a new tool which enabled her daughter to annotate recordings of her lessons. I signed up for a 30 day trial on Audio Notetaker© 2007-8. This tool keeps the data as an audio file which can be listened to at anytime; the reader only see lines with gaps, these representing the speech and silences. I could split the text, colour code a section and or highlight the actual text that I had abstracted the meaning of, similar to the principle of abstracting whole sentences. Seeing the lines, I had a sense of freedom, of being able to listen and pick out the phrases and words and make observations, without being lost amongst a lot of words and letters. I had found a new method of data processing which could add to the common methods of transcription as described in a number of research texts including those by Flick (2009) and Holloway and Wheeler (2010). I would argue that, as with many academic processes and conventions that have evolved and are described, this should not mean to the exclusion of new tools. Having made the decision to use this tool I uploaded the remaining transcripts into Audio Notetaker©, including the ones that I had already transcribed traditionally. Indeed I used these first as I had already begun to identify the themes and phrases I am about to discuss.

Process for analysis of textual data

After the first interview I set up a table document in word, initially with four boxes. Using the table function meant additional rows and columns could be inserted as required. I was now ready to insert abstract items that I could use. Having a methodical system is useful where interpretation of language and expression form a significant part of the findings. I also downloaded each image into word too and created a biography of the interviewee and the interview. In doing so, I could start an exploration of the multiple meanings of the power relationships that make up components of NH interactions as they described them (Thompson 1996; Sullivan 2002; Robson 2000).

Making sense of the content

There are different processes for the analysis narratives, reconstruction, structural and thematic (Flick 2009; Holloway and Wheeler 2010). Although feminist approaches are about construction, and there may be anxiety about deconstructionism, and its connotations of positivism (as discussed in Chapter 4), it is not possible to undertake any form of content analysis without a degree of deconstruction within that process (Reinharz 1992). The common constructs of developing codes are through in vivo analysis by categorizing the data from transcripts (Bluff and Sparkes, cited in Holloway 2005 and by Flick 2009). These texts provide a critique of models used by the key proponents of grounded theory and qualitative content analysis. I discounted the latter as reductionist as the paraphrasing of the content requires a significant interpretation which loses the original intent, and is not concurrent with my feminist paradigm (Flick 2009).

I selected thematic analysis using the principles of coding and categorising. The objective in the first instance was to identify a 'series of core sentences or ideas' (Holloway and Wheeler 2010:204). Meanwhile Flick (2009) develops an understanding from grounded theory principles used in health care research that supports an inductionists approach to results in creating a set of generalisations. If I had used a grounded theory data collection framework I would look for themes and modify the data collection to test out the emerging themes in an evolving deductive process (Flick 2009); interviews should be continued until saturation. As I had a finite number of research participants, this was not an appropriate technique. The danger of line by line coding is that it becomes difficult to know where to stop. Flick (2009) suggests that:

One consequence is that too many codes and potential comparisons result. One pragmatic solution for this potential infinity is to break, balance what is found, and build a list of priorities.
(Flick 2009:318)

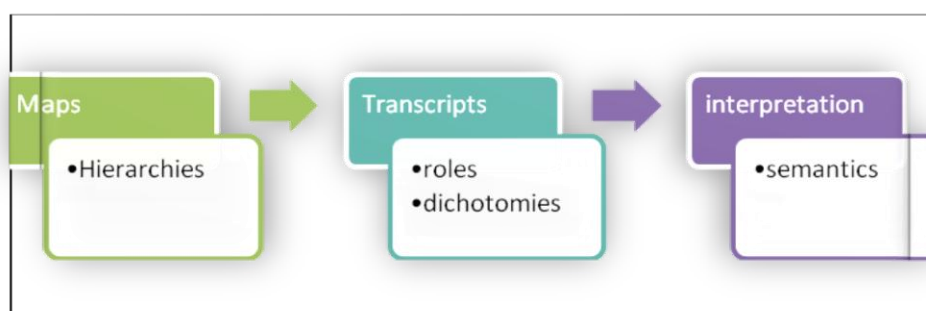
Applying the principles of coding

After listening to my first four recordings three times, I started to recognise that there was a frequency in phrases and words. I found that there were words and/or phrases being used by the research participants that not only resonated with each other's experiences but the theoretical perspectives identified in the literature chapter too. Holloway and Wheeler (2010), caution against drawing conclusions too rapidly, the danger being that anything different will be hidden by the presumptions that have already been made.

The question was how best to capture what was being said. The solution was to use the principles of thematic coding which required a description of each nurse. This was in my notebook and I had the maps. I found that I was instinctively applying a mixture of the thematic and grounded theory simultaneously. By highlighting specific words in the Audio Notetaker®, and by adding explanatory, descriptive notes alongside significant words and phrases, overall themes significant for individuals were identified. This gave me a series of initial categories.

I then considered how best to make sense of what I had found as I distilled the transcripts. I had evidence from the maps of distinct hierarchies and the semantics that emerged from the nurses transcripts eventually fell into dichotomous terms, (positive/negative) which left me with a set of semantic phrases to work with. Fig 5 illustrates the steps of analysis.

Figure 5 Illustration of the steps in coding undertaken



(Developed by the author 2010)

By abstracting key words or short phrases from the transcripts into the word tables (See Table 6 and Appendix 4), I could establish the common threads from which I eventually emerged with six columns. As can be seen these focused on three key

types of staff. On reflection, I could speculate that this particular pattern emerged because of the maps. The nurses randomly talked round the interactions / relationships they had with specific role holders, or groups of role holders, they had placed in their maps. This was giving me a new view of the consequences of taking on a nurse led hysteroscopy role. Finally, I looked at semantics that would provide a language to help describe these roles.

The NHi identification of whom they were talking about facilitated my identification of roles and where people would be in the NHS hierarchies based on pay bandings. It was at this point I undertook 'member checking' with the individual nurses. Holloway and Wheeler (2010:305) describe this process as checking if what has been distilled reflects the reality, checks for errors, presumptions, and to challenge ideas.

Table 6 Illustration of the 'organising' and in vivo coding table that emerged

NH	Nursing / Admin staff	Medical staff	Organisation/ Management	Personal	Other observations
	Work most closely with these staff.	Medical staff are their trainers and it is the occupational group they are challenging.	The type of service was quite eclectic but the managers are operationalising the Trust policies.	Recording features that the nurses attributed to themselves.	My comments on what I observed: emotions, frustrations, power.

I sent the individuals a sample of the coded data with their map and an audio file of their interview with me. I was able to make contact with eight and received six replies³¹. No one asked for changes, the only comments were 'Wow', and 'When are you publishing?'

The final stage was to make some sense of the phrases I had picked out; however, I was cautious that the research participants' (nurses') reality should not just be explained as 'other' to men (Stanley and Wise 1993:204). However, I was conscious that I too am part of a health system that functions through a patriarchal society. The research respondents' explanations of their working lives and my own understandings are framed by those experiences and were influential when generating meanings that would have relevance to the nurses. I put all the individual tables into one document, and looked at them together. What was clear to me was that the comments were dichotomies that fell into either the positive or negative in terms of the impact on themselves and / or their organisations. I formatted a new table (See table 7)

³¹ One person had taken the opportunity to retire and was no longer contactable.

Table 7 Illustration of the revised table layout for the open coding stage of analysis

Name	Positive	Negative
Nursing / Admin staff		
Medical staff		
Organisation/ Management		
Personal/ self		
Recognition		

(Compiled by the author 2010)

The content in tables 6 and 7 gave me the focus for the questionnaire design as described in the previous chapter.

Analysing the survey data from phase two

The intention was to undertake a descriptive analysis of the survey data. It was never the intention to gain a statistically significant response rate, because even with a 100% response rate, the numbers would not be sufficiently large to provide statistically significant results (De Vaus 2002). The purpose was to triangulate the initial research participant experiences with a wider number from the case study group and so be in a position to move further towards being able to make generalisations about the reality of being a NH (De Vaus 2005). With the data that was collected, I could create descriptive statistics based on the following items; frequencies, counting, proportions, percentages (Fink 1998).

The response rate

When the study closed, I had a response rate of 47.3% made up of 26 research participants, with seven of the eight who had been interviewed by me responding. This group made up 26.9% of the responses leaving a remainder of 73.1%. By the time I came to launch the survey, one of the interviewees had retired. Based on the evidence presented in Chapter 4 this was an acceptable level of response for this type of data collection. (Cooke et al 2000). The number of responses and the balance between types of research participants meant it was not appropriate to run tests such as the Chi-Squared or the Mann-Whitney *U* Test to explore for statistical correlations (Fink and Kosecoff 1998).

Abstracting the data for source

Once the survey had closed, I viewed the results within the study; this included numbers and percentages against each response and free text comments, also

available as 'word clouds'³². I also had access to frequency counts and ranking results for questions that had asked for ranked responses. The advantage of using the Bristol online tool was that the data could be transferred into an excel spreadsheet using a '.dat file'³³ facility within the tool. Using this method the potential for human error during the inputting of data was eliminated (Fink and Kosecoff 1998). The potential for human error started after I exported the data into a spreadsheet and created a work page for each question.

Through the abstraction of numbers, the responses to the questions could be examined in three ways. Firstly, I could simply look at the responses for each question giving an over view of their experiences. Secondly, I could look for similarities with the seven interviewees, now known as NHi³⁴ against the nineteen nurses who did the survey only, who will now be known as NHs. Thirdly, I could abstract out the responses from the NHi group from the total to examine for research credibility with the original narratives. If they were providing similar comments then I might assume I had created appropriate questions. I allocated the NH a number from 1-26 in the sequence that they completed the survey. This would allow me or a reader to follow through any one person.

Setting out the data – creating charts and pies

In each work page I set out the data. I copied the question from the survey into the worksheet to create a title. With this numerical data and, using the tools in Excel, I was able to create a series of graphs and pie charts illustrating my categorical data. In selecting which to use (pie or chart), I was careful to resist conflating any of the material to misrepresent, as warned against by Fink and Kosecoff (1998). This is particularly so in the Pie charts. The Pie diagrams illustrate the proportions of responses to a question. To facilitate representation I 'cut' the pie so that, in the case of very small percentages, the number became more obvious. Bar graphs were created to present the data that had been split to show differences or commonalities between the NHi and the NHs groups. The Excel software enabled the appropriate labelling of horizontal and vertical rows. These charts are presented in chapter seven.

³² Word clouds is a function that demonstrates the frequency of words used within a particular set of responses with the font size increasing with frequency.

³³ A .dat file is a generic data file that contains numerical and text data. It can be converted for use in more than one software application.

³⁴ Whilst I know there were seven nurses who had been interviewed it is not possible to identify who out of the nine they were.

Reflecting on the Survey Construction and Application

Through the BOS tool, I was able to establish that there was no incomplete data. However, I did find an anomaly with one of the questions that gave a response of 29 rather than 26. I can only conclude that I must have set that particular question to allow for more than one response. When reviewing the questionnaire, I had several people look at the questions and offer advice. Unfortunately, a paper copy does not indicate whether the question is set with the single or multiple response option. In the instance of question 10 identification of this would have meant I would have edited it to ensure that only one response was possible. I have examined the raw data and will comment in the findings chapter, as it is relevant to the veracity of the research participants' feelings. I must conclude though that the phrases I used were either too similar and one particular research participant could either not discriminate what was meant or that all the phrases were relevant to her experience. The remainder of the survey preparation was straightforward with built in ethical prompts, and instructions that could be developed to guide the research participants.

Summary

In this chapter I have explained the use of tools used during data analysis and preparation of the findings. I have identified the steps I took to manage mapped data for which there are no pre-existing protocols. Furthermore I have explained why I identified and used Audio Notetaker®, a tool for dyslexia, to help me process and analyse the data focusing on my auditory skills. In the next chapter I explain how the findings from the maps are presented and how they create a picture of the nurse hysteroscopists' experiences.

Chapter 6

Nurse Hysteroscopists Locating Self with Colleagues

Introduction

I have taken a step by step approach with which to present the data using the research questions as presented in chapter 1.

- 1) Where do the nurses see themselves in their departments? See chapter 6.
- 2) What has been the personal impact of becoming a nurse hysteroscopist? See chapter 6 and 7.
- 3) What factors are hindering or enabling them? See chapter 7, 8.
- 4) Are the nurse hysteroscopists functioning at the level of advanced practitioner? See chapter 8.

In this chapter, I have taken some time to present the relationships that are presented within each of the maps using some quotes from the research participants. As a consequence, there will be limited analysis in the early part of this chapter.

The maps: locating self within departments and the organisation

I start by focussing on the first research question, 'Where do nurses locate themselves?' Initially this requires me to explain each map from the information that emerged at each meeting and provide some contextualising explanations.

The maps are presented in no particular order. At the top of each map is a key to who the coloured squares represent for each NHi. Where appropriate I have included some quotes to help describe not only their relationships with work colleagues but to add clarity to the differing and complex types of clinical services they are responsible for. As each of the NHi was setting out their maps I was not conscious of any particular patterns. However when I put the images together on one piece of paper, and I understood what roles were represented where, I was surprised to see how clearly hierarchical patterns emerge. I have illustrated these by inserting a black line to expose the demarcations.

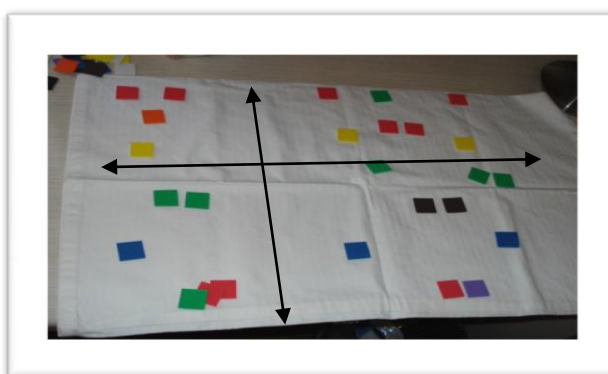
Sam

Map 1 represents a complex set of service provision. Sam had been a nurse hysteroscopist for four years at the time of the interview. She provides three

hysteroscopy services within two Trust sites; the vertical line separates the two Trusts. The horizontal line indicates that Sam locates herself at a similar level in each of the hierarchies. Outpatient 'see and treat' services are provided in the two trusts.

Map 1 – Sam

Key: Yellow – Sam, Pink – consultants, Orange – registrars, Green – nurses, Blue – secretarial, Black – ultra sound scan USS, Purple – GPs, Red – other consultants and the MDT team



One of the two sessions she undertakes is in an operating theatre rather than in an outpatient setting. In all settings, she sees the patients before and after the hysteroscopy. In each of the three hierarchies, she has placed herself (Yellow) close to the top of the image with the junior doctors in close proximity to her. As will be seen, her general relationships were cordial in the Trust with two services. Sam has had one experience of an anaesthetist who *“refused to work with me, in the early days”* with her as a nurse hysteroscopist in theatre. However, she put this down to a *“bad day, when he was running late”*.

Her mixed operating theatre and outpatient role has enabled the achievement of overall clinical demand. In Sam's case, her role emerged at a time when the government was pushing for a change in skill mix. It was paid for out of monies to drive forward the government's plans to change service delivery (DoH 2001b). She comments:

“I was employed into helping the gynae oncologists... from part of pilot study by the modernization agency. To be surgical care practitioners... at first the idea was to provide specialist assistance to the surgeons...”
(Sam)

What finally emerged from the project was a nurse led hysteroscopy service with the sessions to the right of the vertical line (see map 1) conducted in two different

outpatient settings and a theatre for the same Trust. In some clinic sessions there was no additional nursing staff (Map 1 - single isolated green square) to assist apart from a similarly qualified colleague with whom she worked. This meant they could only “*see women alternately*”, rather than “*several women consecutively*”³⁵ thus reducing the number of women seen at a clinical session “*making it less efficient*”.

The unit on the left of the map operated differently and started the ‘see and treat’ service later. The transcription revealed a set of different challenges to be overcome. Relationships appear quite distant on the map and in the transcript. Initially one of the consultants would not “*allow*” Sam to book additional tests as was the practice in the other well established hysteroscopy clinic she ran. Rather than listening and taking advice on what worked from her experience, she was required to wait until the system was not working for the recommendation to be followed. The only ‘close’ working relationships appeared where the squares overlap at the bottom of the map; here she is involved with the multi disciplinary team (MDT)³⁶ at meetings. The transcript revealed frequent contact with secretarial staff who handled the referral letters. Finally, whilst there is now a consultant nurse in post overseeing her activities, being a recent appointment Sam had not established a working relationship and so had excluded it from the image. There is no nurse / hospital management included in this map, perhaps because her role emerged from the project rather than as a strategic plan proposed by her line manager.

What emerges from Sam is someone who has gained the ‘credentials’ (Halford et al 1997:72) to undertake a high skill procedure requiring complex clinical decision making whilst also ensuring that the unglamorous yet essential work to ensure patient safety is undertaken. When Sam described how in one clinic there were only two people present in the room rather than three, the question arises as to whether there would be the same expectations of the medical staff? Here we start to see a gender role difference that was described by Halford et al (1997) in a discussion on restructuring and gender. The expectation is that the nurse will perform a complex task associated with medicine, yet as in this case, is not afforded the same support of a care assistant and is expected to handle equipment that is seen as ‘home’ or feminine work, ergo for women (Bolton 2005). This is not

³⁵ With no nurse or health care assistant in the clinic they would also have to take on preparation of the clinical area (refreshing equipment) for each of the patients as well as making sure the patient had her results and that her recovery continued well.

³⁶ The MDT meetings are deemed as good practice and a key part of clinical governance for post menopausal bleeding (PMB) in improving the outcomes for women with confirmed endometrial cancers. Best practice would include the person who has taken the original diagnostic sample.

simply about a general reorganisation though, as in her other location this is not the expectation and she is afforded the same clinical support as her medical peers. A further explanation then may be connected to the organisational structure of this particular Trust. However without Sam's inclusion of her relationships with nursing or organizational management in the map further analysis would be speculation.

Alisha

At the time of interview, Alisha was doing two days of hysteroscopic diagnosis and one day of treatments, such as endometrial ablation³⁷. A clear hierarchy is present for Alisha (see map 2) within the organisation and between nursing and managerial and medical staff. Her map is simple but yet again Alisha described some complex relationships due not only to roles and responsibilities, but also to the loss of her hysteroscopic trainer and the Matron. This disrupted her training and subsequent ability to practise. According to Alisha, it had been the Matron whose vision it was to set up the outpatient service, with support from the consultant trainer.

"My practical training was very easy, but unfortunately the doctor mainly linked to me during my training, she unfortunately died so I lost my continuity of care, and my main lead trainer um he um even though he was there for me his work load is high and because none of the other consultants wanted to take on the role of trainer I didn't have a lot of support through him."

(Alisha)

For her these disruptions were compounded by her finding the academic side of the programme hard.

"I found the academic side extremely stressful and it affected the whole family..."

(Alisha)

Additionally she was practicing in more than one clinical area, spending some time on the ward and then in the clinic. The other nurses on her map were identified as on the same pay band (6), but whose functions, responsibilities and clinical decision-making were different³⁸.

³⁷ Endometrial ablation is a treatment to resolve heavy menstrual bleeding by destroying the endometrial tissue.

³⁸ One is a nurse colposcopist, the other was the junior ward manager.

Map 2 - Alisha

Key: Pink – Alisha, Purple – nurse colposcopist, Yellow – junior sister, Orange – staff nurse team, Black – senior sister, Brown – Matron, Green – hospital management, Blue – medical lead, White – her training consultant



As can be seen map 2, she has put herself (pink) to the left of the map. The junior sister in yellow opposite becomes important later when there were cutbacks with the loss of a more senior nurse (black). This individual instigated significant questioning of Alisha's role that impacted on her wellbeing as described by Strazdins and Broom (2003). There is a clear distance between the hospital management (green), the medical lead (blue) and training consultant (white) with the two senior nurses including matron in close proximity to each other. I placed the line between low these two as with the exception of the yellow sister Alisha was continually supported. This may have arisen because of what happened to Alisha. See quote on (page 118) where I discuss further her "*feeling extremely let down*".

Lucy

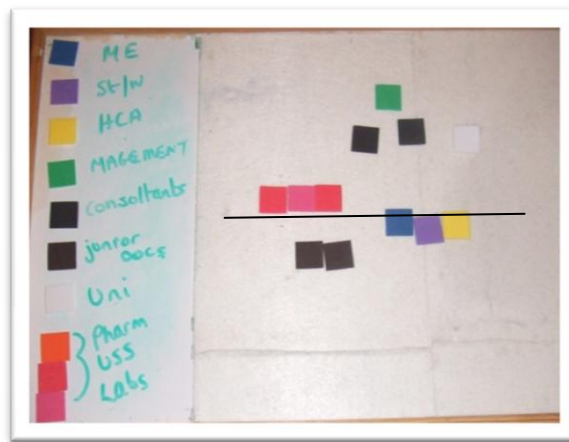
Lucy works solely in 'see and treat' hysteroscopy clinic running several a week; this may be significant to her experiences. In Map 3 there is also evidence of a hierarchy in this image and whilst Lucy is close to the centre, there are still very discrete groupings. She describes herself as a "*co-coordinator*" and that in the environment, "*there is as much a ladder as a network*". The two junior doctors³⁹ (brown) started in the mapping above her but as detailed in the transcript she decided to put them lower down as she says, "*This pattern has probably moved over the years*". This may result from her being in one of the early cohorts. Later,

Map 3 - Lucy

Key: Blue – Lucy, Purple – nurse, Yellow – health care assistant, Brown – junior doctors,

³⁹ Junior doctors refers to senior house officers up to pre consultant grades

Orange – USS, Pink – pharmacy, Red – pathology labs, Black – consultants, Green – management, White – university.



she describes how she “*inducts, teaches and manages the junior doctors’ performance*”. Lucy, like Alisha (map 2), Rose (map 5) and Holly (map 8) has placed ‘senior management’ at the top of her image over the medical staff too. Arguably this reflects the changes in hospital administration over the last 20 years, introduced as a way of limiting the professional power of the Medics (Walby et al, 1994, Halford et al 1997), when there were the first structural attempts to limit the power of doctors in managing health service provision.

Liz 1 and Liz2

I have placed map 4 for Liz 1 and map 5 for Liz 2 side by side as they present two mind maps that place themselves as the nurse hysteroscopist in the centre of what appeared to be a circular map. In both the medical and senior management were lower and nursing colleagues above them. On closer inspection, I recognized that the nursing and allied professionals were presented as a curve, whilst the medical and management staff in a line. I have placed the lines to denote this.

Map 5 - Liz 1

Key: Yellow – Liz 1, Orange – theatre, Red – DCM, Green – ward, Blue – endoscopy, Black – outpatients, Purple – management, White – administration, Brown – medical staff



Map 5 - Liz 2

Key: Green – Liz 2, Yellow – nurses, Orange – administration, Purple – consultants, White – senior management



Whilst their maps are similar, their stories of their relationships were quite different.

Liz 1 (map 4) has an eclectic role not being allied to any one department.

“Right in the centre as you can see. (Um) well because I don’t actually work in any of those areas but I link on a daily basis to all of those areas so that is why I have put myself in the middle.”

(Liz 1)

She appears to set herself apart and her transcript reveals that she has a closer working relationship with departments and administrative staff rather than particular individuals. Liz 1 had just been advised of a promotion to nurse consultant (KSF band 8). Her role had evolved to being involved in a number of specialist areas where surgical investigations are now performed by her, not just hysteroscopy. She believes that her first nurse specialist role was for the wrong reasons for nursing at the time.

“to fill a gap in the medical workforce... has not turned out as expected, but they (nurse specialists) are valuable as a constant experienced member of staff in the unit.”

(Liz 1)

She recounts that the specialist nurses have been able to drive forward service developments throughout her Trust. As part of maintaining consistency in practice, Liz 1 like Lucy is also undertaking “a lot of teaching” of junior medical staff in “all those areas” (She pointed generally to the map). It appears then that Liz 1 has been in control as her role evolved.

Whereas Liz 2 said,

“I very first went in the unit in 2003 as a trainee hysteroscopist which I

qualified for in 2004.”
(Liz 2)

Having been seconded into the position with training she has subsequently taken on the colposcopy ‘see and treat’ service too. Liz 2 talked a lot about her relationships with several grades of nursing and administration staff (see p123). For Liz 2, administration activity was imperative to the smooth running of the nurse led service but the inconsistencies between the consultants’ and line managers’ understandings of her role were frustrating. On the day we spoke, there was, “*no consultant clinical lead for hysteroscopy*” in place, and she described herself as being in a “*dark place*”, although she was optimistic that things would improve.

Rose

Rose, Map 6, worked part-time and solely as a lead nurse hysteroscopist in outpatients. In her map, the Chief Nurse with an Advance Practice Group tops the image, cascading down past the consultant with the university and her direct nursing management in close proximity above the line. She used the most colours to represent a wide range of colleagues that she saw she had important working relationships with.

Map 6 – Rose

Key: Purple over Yellow – Rose, Purple – peer, Green – registered nurses, Yellow – health care assistant, Orange – registrars and SHO’s in training, White below the line – other NH nationally, Red and Pink – other departments, Blue – labs, Black – chief nurse, red – consultant (trainer), Brown – other consultant, Pink over Red – university, White above the line – nursing management



She said:

“I will start with me in the middle and next to me X⁴⁰, we were a job share and were in equal position and supported each other and above us is the consultant. This one is the main one because she had more input into our training and supporting and teaching. The other consultant, who is a little bit below, still supported using the same way but was not quite as involved with everything. Next to us there are the doctors – Registrars and SHO's in equal position to where we are on the board.”
(Rose)

She does talk in hierarchical terms and no one was placed below her on the map. The nursing staff and the other allied staff (ultra-sonographers and pathologist) that she works closely with are to one side. Although she appears deferential to the others in her placing of the medical staff, that is not the impression that comes across in her narrative. Rose is the only one who also places her national peers on the map although others mentioned them in narratives or in the survey (NHs20, NHs 25 see tables in Appendix 5 and 6).

“The other nurse hysteroscopists that we did not have much contact without but we saw at meetings or contacted through e-mail because always we knew they were there and they had the same experiences as us.”
(Rose)

Later Rose was not clear how her status changed, just that it did.

“Afterwards once we qualified they⁴¹ seemed to know automatically with us telling what our position was so someone must have told them what our position was and they seemed to understand that if the consultant was not there then we would be training them and – I cannot remember ever having to explain, you know...”
(Rose)

Elizabeth

Elizabeth, Map 7, started by telling me her role as a nurse practitioner. From her map and story there initially appeared to be an inverse hierarchy. The medical staff are the bottom of the image and she explained that she was taking the lead in the development of services. *“My role is to assist the consultants in their clinics⁴² and my remit was to introduce nurse led clinics.”* There are four hysteroscopy clinics a week in the Trust with Elizabeth running three of them.

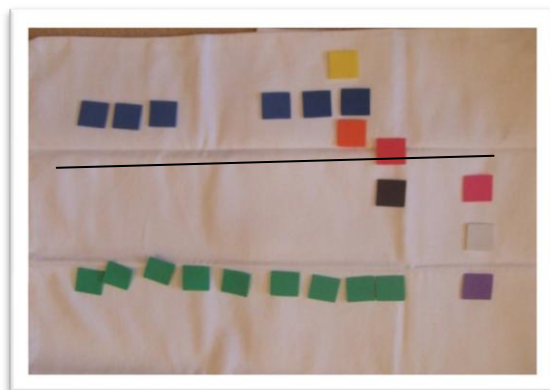
⁴⁰ Name removed for anonymity.

⁴¹ The doctors, SHO up to registrar.

⁴² Gynaecology clinics for a range of services, endometriosis to Post Menopausal (PMB) and pelvic floor weaknesses.

Map 7 – Elizabeth

Key: Red – Elizabeth, Yellow – HCA⁴³, Blue – staff nurses, Orange – junior doctors, Pink – line manager, Black – medical registrar, White – lead nurse, Purple – directorate manager, Green – consultants



In addition, she manages all gynaecology outpatients' activity working alongside doctors of all grades. Elizabeth has her own caseload of women not just when undertaking hysteroscopy. The two nursing teams (blue) she leads are working closely to support the nine consultants, one of whom is a new appointee whose focus is hysteroscopy. Elizabeth recounts that she is "*teaching nurses gynaecology support skills*" so that she can be freed up for more hysteroscopy as it expands. She also had two line managers above her, the pink representing the new 'Modern Matron' (DoH 2000a) "who was very proactive in setting up the outpatient nurse led hysteroscopy". Despite this level of responsibility, she has placed herself below the medical registrar, whereas others such as Rose and Holly (map 8) placed themselves alongside them. From the volume of green on her image, it is clear that Elizabeth has to negotiate with many senior clinical staff individuals. At first, she seems to be working a progressive unit however she comments that "*It's quite traditional at my hospital*". This is returned to on page 131.

Holly

Holly, Map 8⁴⁴, had been a consultant nurse for some time, she also uniquely describes how her Trust has a mechanism *clinical supervision* that supports staff leading services. As can be seen in Map 8 she has located everyone in close proximity to herself. Indeed, she is the third nurse to locate herself in the centre.

⁴³ HCA = Health Care Assistant

⁴⁴ Map 5 is on its side as this is the direction she worked from on the map.

Map 8 – Holly

Key: Pink – Holly, Yellow Nurses, Green medical colleagues, Black specialist nurse, White Trust directorate, Orange academy, Blue directorate management, Purple medical supervisor an clinical directorate lead



"I have put myself in the middle with the relationships around me as I don't as I do not see a hierarchical structure as I think very part of it is very important to how I'm going to develop."
(Holly)

I have placed the line to delineate clinical staff from managerial staff. She was clear about the close networks that are required to make the service provision work. She describes how the medical clinical lead in purple is quite a powerful individual in her own development and in hysteroscopy and ongoing service development in gynaecology provision in general. This is important as she talks about the medical staff (black squares) being a disparate group and the impact this has on developing nursing roles. The Director of Nursing on the other side of her (white) lead nurse provides a safe area for discussing clinical issues.

"her support in developing the role is very important to me and also in a mentor type role in that I can discuss issues with her."
(Holly)

This was clear in her transcription as she highlights how the clinical lead is significant to her current and ongoing development. Overall, the impression is that

Holly aligns herself more with the directorate and the academy than the clinical staff with whom she provides the service. However, page 131 will demonstrate that she too has complex issues to manage.

Lisaden

This is the participant I failed to store the image successfully for⁴⁵. Lisaden is also a theatre sister and was already undertaking hysteroscopies as part of her theatre activities before training for 'see and treat' services. Like Sam she realised that she needed formal training to support the practical skills used in the theatres and to challenge some practices.

"I needed the background knowledge, of saying to a doctor I don't agree with what you're doing, and its only because of experience of what I'd seen that I thought that what they were doing was right by the patient which.. it sometimes I done like saying that because it sounds a bit bad but I was there for the patient and if I thought they were doing something that I did not think was right I had a right to voice that. So in order to give me the background knowledge and prove to them that I knew what I was saying, mainly for the knowledge side of things... I didn't realise it would lead me onto other things. They now see me as a fountain of knowledge and they always ask are they doing the right thing..."
(Lisaden)

No one realised, until starting, what the potential opportunities were for service development.

"They (consultants) gave me their backing but I don't think they realised what it entailed and where it would go... Now they say (to the other medical staff) go and see me (for training)."
(Lisaden)

She went on to describe how at the time of interview there were still debates whether her time should be "*bought out of theatres*" to help support the 'see and treat' hysteroscopy service in the other unit. Her unit is part of three hospitals in a Trust and, although she had managerial support for the course, "*I've actually fought to be part of things*". The nurse led services have since been located into another unit. To ensure she stays competent she has now become a "*freelance*" nurse hysteroscopist, working additional hours through the bank system⁴⁶. As consolation, within her own unit she identified that she has developed more contact with other Trust professionals, whereas when working solely in theatre she was "*isolated despite being a team leader*". The new skill set of nurse hysteroscopy has set her apart, "*I know I'm a practitioner and can do things in my own right*". For

⁴⁵ The colours she used were: Brown for self, Orange – secretaries, Green – consultants, Purple - theatre staff, Red - hysteroscopy colleagues, Yellow - other hospitals, Blue - other hospitals, Black - management, Pink - patients.

⁴⁶ The 'bank' is a pool of staff that can be called upon to cover services in times of shortage. The service may also be called temporary nurse register (TNR)

Lisaden, the power dynamics of planning service delivery reach beyond her own unit.

Personal and professional impact of being a nurse hysteroscopist

Eclectic roles but arriving at the same point

As seen above, each of the nurses came into hysteroscopy services slightly differently. Some such as Liz 2 and Alisha were selected by interview, others because they were in the location of hysteroscopy, such as Holly, Rose, Lucy, in addition to becoming part of a project, Sam. It was a case of being in the right place at the right time. There was a clear mixture of senior nurses involved in decision making such as Matrons (Elizabeth and Alisha), and medical consultants (Rose, Lucy, and Sam), their own role (Holly, Liz 1) to propose changes. This had not equated with support throughout training. There were those, Rose, Holly, and Lucy, whose words suggest they felt fully supported and Alisha who became very isolated during her training.

In Chapter One, I identified that a requirement for accessing the NH course is that a manager and trainer agreed to support the nurse in her training and including the service development. Ideally, nurses were to be supported as part of their units' need to meet the then new cancer targets (DoH 2000b:48). Without a support network for the work based learning element of the programme, completion of the program is difficult to achieve. Alisha was not alone; there are other examples in Appendix 4 made by survey respondents NHs5, NHs11, NHs12 and NHs22.

In spite of the course requirement, two NHi found themselves coming to the formal training through less structured and supported routes. Firstly, Sam for whom the development of hysteroscopic services had not been part of the Trust's project plan. There was evidence of a budget set aside for Sam and a peer to have training. However, the money was only available after their contracts were formalised and there was no notion of what this training should be. Even then, there was no requirement by their Trust to access training as defined as the BSGE or recommended by criteria in the NMC's Code of Practice (NMC 2008b), which has subsumed the 2004 Scope of Professional Practice. These documents outline the responsibility that the nurse must 'recognise and work within the limits of your competence' and 'you must take part in appropriate learning and practice activities that maintain and develop your competence and performance'. It was only when

Sam and her peer were setting up the service at the additional Trust where they were expected to work independently that they:

“thought it would be a good idea to get formal training so (pause) and (I) found out about the course and did the teaching (Um) basically that was all through our own bat... We were not being supervised⁴⁷ in the clinic at that time.”

(Sam)

Sam had already acquired the skills related to performing the hysteroscopy on women asleep in theatres, but not with the underpinning knowledge of pathologies, decision making and counselling. These elements are seen as crucial for the safe provision of a comprehensive ‘see and treat’ service by the BSGE as described on p11), and commensurate with the concepts of advanced nursing practice as discussed earlier and defined by the ANNPE (2005). The expectation of the project Sam was involved in was that the technical skill could be transferred directly into the outpatient setting.

Secondly, Lisaden as we have already seen determined to undertake the hysteroscopy training because, like Sam, she identified a gap in her knowledge which meant she could not act as the “*patients’ advocate*”. Both nurses demonstrated that they took responsibility for dealing with the gap rather than leaving themselves vulnerable in the context and scope of safe practice (NMC 2004b and 2008). It can also be seen as an aspect of professionalism, where Lipksy (1980:72) has argued that even having taken this course of action the nurse can only have a degree of control.

This is perhaps evident when later on in the interview Lisaden identified that, in theatres, hysteroscopy is seen by others as a procedural ‘task’, not requiring cognitive understanding. Lisaden sees clear positives as a result of the actions she took.

“They now see me as quite a fountain of knowledge, (pause) they ask if I agree.”

(Lisaden).

This quote says much about Lisaden’s working relationships in that her colleagues rely on and recognise her expertise. However, the fact is that rather than the organisation embracing her expertise she has to work as a “*freelance*” nurse to maintain her outpatient skills illustrating that her expertise is not recognised by the organisation as a whole.

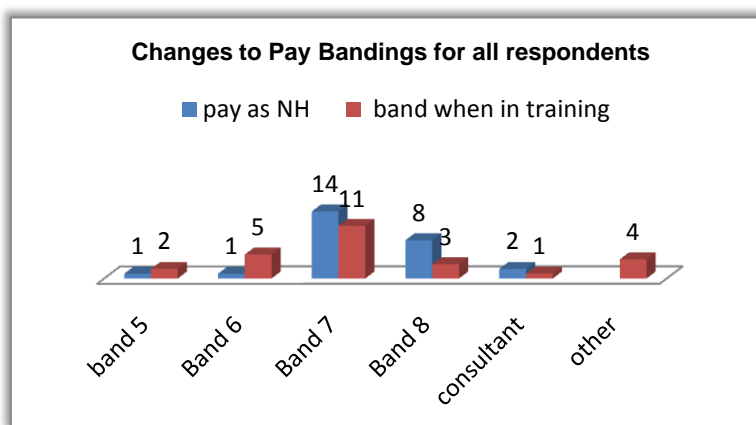
⁴⁷ The consultant was next door.

Rewarding labour

The second set of general data concerns the pay banding. In the chapter 2 of the literature review, the work of Hochschild (2003) identified that the failure to reward women for the opaque female attributes was associated with emotional labour. Several of the NHi had commented that recognition through financial rewards they received was important to them. Additionally the literature review identified how there is a model of pay that means nurses should be paid for the level of responsibilities they have. The pay gates are determined using a nationally defined set of descriptors in the Key Skills Framework (KSF) (NHS 2008a and b). Recording pay banding would give an indication of the level of general expertise the nurses have and also the financial recognition they have for their practice. I wanted to see if becoming a NH translated into a financial position. Fig 5 illustrates that 14 of the nurses were already at band 7⁴⁸ or above when in training indicating that they already had recognition for the skills and responsibilities commensurate with their overall role.

Fig 5 also illustrates there are still two being paid below a band 7, (5 and 6). This suggests that, unlike the others, they are not being financially recognised or rewarded for their work as a NH for the time they are fulfilling that role⁴⁹.

Figure 3: Comparison of Pay Bandings in and After Training



Either their organisations do not recognize what they are doing as advanced practice or the nurse has not been able to articulate a substantive case for change as required by the process (Fig 6, NHS 2006). Yet NHs4 has moved from band 5 to 6 but is still in her training for other activities whereas NHs18 is still on a band 5

⁴⁸ Band 7 is associated with advanced nurse, www.nhscareers.nhs.uk/details/Default.aspx?id=4. Drilling down there are different levels within this band. Likewise, Band 8 is a nurse consultant, but there are 3 sub groups in Band 8 depending on the type of responsibility that the nurse has.

⁴⁹ A nurse can be paid on different pay bands for the different roles she may have.

and, whilst I do not know if the band 6 response is from Alisha, her interview gives an indication of the complex politics that are at play for her. At the time of interview [March 2008], Alisha believed she had entered into a contract that would see a financial reward once she qualified.

“I was interviewed by the matron at the time and my senior sister who is still my sister and I was led believe that I was going for a band 7 post. Unfortunately, this was not contracted down so when I did actually qualify I still kept the same grade as I am now... I felt let down once I had qualified because I felt they had gone back on their word. I'm told that I did not have a leg to stand on because it was not in writing... but I am still fighting for my banding (as are others I believe).”
(Alisha)

Whilst recounting this she punctuates it philosophically, “I wanted to improve my career” and I have already mentioned she found the academic work hard, “but on the academic side of things it was an achievement for me anyway so I was pleased with that.” Whilst putting on a brave face, her disappointment was evident. Nursing prepares the individual to have and use transferable skills (NMC 2004c:31). To suggest that a nurse is undertaking an advanced practice role in one clinical situation, and not another, undermines this key attribute and pay is still being used to exclude women (Rowbotham 1992). In the survey, I asked:

How did the re-grading occur to reflect your qualified nurse
hysteroscopists status?

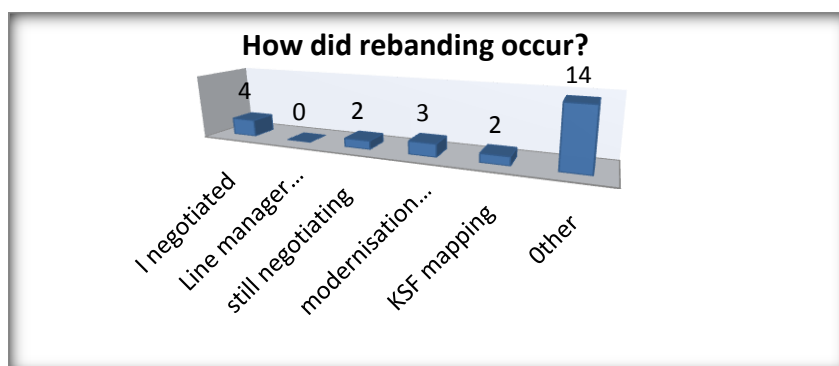
The number of nurses at band seven and eight gives evidence that, within the structured KSF pay bands, (NHS 2008) nurse hysteroscopists' pay is reflecting not only their clinical skill levels but the advanced level attributes required for the higher recognition. This does not mean that pay has been equalised and that they or any other advanced practice nurse is receiving a comparative reward with their medical peers.

Through debates at the BSGE Annual Scientific Conference London (Pansini-Murrell 2009), guidance was given on how to make an application to step through the pay bands on qualification. Overall, what we can see is that most of those who have participated in the study are on an appropriate pay band for specialist practice, as defined in the current key skills framework (NHS 2008).

More clarity emerges from the next question I asked about how the re-banding

occurred. The phrases I offered the nurses reflected the differences in processes used by Trusts.

Figure 4: Range of Ways Re-banding Occurred



In Fig 6, fourteen NH made use of the free text option with this question too. Initially NHi1 who is on a band seven wrote about changes in pay,

“Nothing has changed. Nurse Hysteroscopy role is secondary to my main role”
(NHi1)

Whilst this response did not seem positive, her answer to the next question on how re-banding occurred was more so,

“My banding changed following a mapping of my work using the Key Skills Framework (KSF)”
(NHi1)

She had therefore completed the process required and moved a gateway to achieve a new banding due to her collective role. Likewise, NHs26 and NHi5 appear to suggest that they should be paid at a higher band. In the fourteen written responses, there was limited evidence of passivity as described by Savage and Witz (1997) and six have or are currently actively re-negotiating their pay from bands six or seven. However:

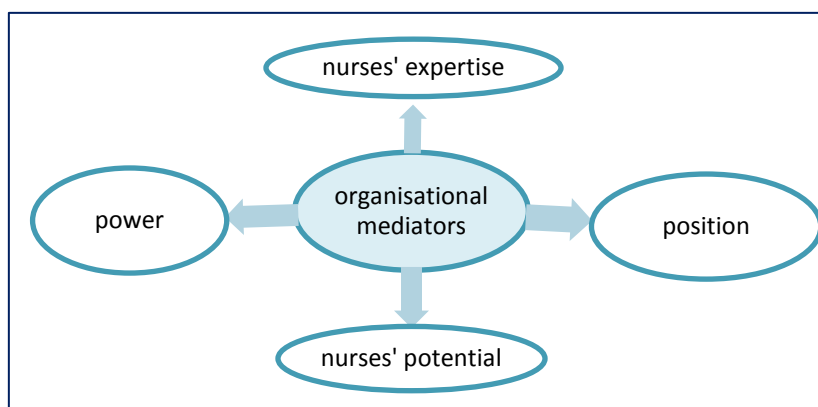
“There was never any question that I would get a higher grade for this role. I was informed it would never happen (Band 7).”
(NHs 26)

“I was not given any further increase in pay or change in grading. I remain on band 7 as I did in my role of nurse colposcopist”.
(NHi5)

NHi22 who has not seen a change from a band 6 and is not being paid at the advanced nurse level said, “paid at band 6 for both roles” (NHi22). Whereas NHs7, rather than fight for recognition, “*Moved to another hospital to work*” for appropriate remuneration. Finally the one nurse (NHs9) out of fourteen using free text, explained that she was, “*re-graded just before starting the hysteroscopy training because of my overall role*”, and two were reviewed automatically during changes from the old pay system to Agenda for Change. One increased, the other stayed the same. Halford and Leonard (2001:56) suggest that the Weberian theory of authority in organisations means that women, in this case nurses, ‘struggle to move through pay boundaries’. My data does not consider how long it may have taken the nurses to negotiate their pay rewards. However, for those that responded, it seems there is a degree of recognition.

Nurses are now more frequently graduates, due to investment in continuing professional development, and career opportunities for nurses that have developed due to political rhetoric (DoH 2000a) but this does not mean this change has translated into remuneration packages. Salaries of nurse hysteroscopists will be anywhere from £24831 at the lower end of band 6 up to £65627 at the top of the nurse consultant band. This upper figure is well above the national average for pay in the UK⁵⁰.

Figure 5 Model of control of nurses’ by organisational mediators



(Created by the author 2010)

In the previous chapter I considered a gendered model proposed by Bolton and Muzio (2008) where vertical expertise in the care of women by women results in a clustering of power in the horizontal. Using the nurses’ descriptions and taking

⁵⁰ 2009 median gross annual earnings for full-time employees was £25,800. The median gross annual earnings for men were £28,300, up 2.7 per cent from 2008 and for full-time women was £22,200. www.statistics.gov.uk/pdffdir/ashe1109.pdf

cognizance of Halford and Leonard's (2001) explanation of how female doctors are controlled by their gender within an organisation. I propose a development to that stratification model (see Fig 7). Here I have placed organisational mediators in the centre.

In this instance, this is the pay policy and those who gate keep it on behalf of the organisation, determining who does what and who gains the rewards. The rewards are determined at a national level but who is in a position to access them is mediated much earlier on at the point of potential. The nurse with potential will rise through the vertical with their expertise, but as we have seen from the NH their power and reward is capped. A mediator will determine what else can be included in their role to allow them access to more status. Holly the nurse consultant is fulfilling a significant role. This exemplifies that opportunities are still stifled by the limitations of structural hierarchies in nursing and the organisation.

For the moment then, taking into consideration all the factors presented to date, the case study group has a high level of expertise in nurse hysteroscopy but are subjected to control. Each of their Trusts, with the exception of two, has determined that the clinical and organisational responsibilities associated with the service are commensurate with advance nursing practice as determined in the Key Skills Framework (NHS 2006).

Training and mentoring

Isolation, whilst not common, is a feature for some. Alisha found herself particularly isolated because both her manager (the matron) and her trainer were no longer in the organisation; she recalls initially that she:

“was approached by one of the consultants who then went on to be my trainer who suggested that I would be good as a nurse hysteroscopist and the matron at the time promoted these new posts and got agreement for them to go ahead and I was interview by the matron at the time and my senior sister who is still my sister.”
(Alisha)

However this did not continue:

“I found my practical training very easy umm but unfortunately the doctor that was linked to me... unfortunately died⁵¹ half way through my training so I lost the continuity of care and my (named the new trainer) umm he umm.... even though he was there for me because he is also an oncologist his workload is extremely high and because none of the other consultants wanted to take on the role as trainer umm I did not really have the support through him but it wasn't his fault and nobody was

⁵¹ Other NH have lost their trainers through retirement, ill health or death.

there to step into the shoes once unfortunately I lost the lady doctor who was mainly training me.”
(Alisha)

Hysteroscopy is not the sole work for many of the consultants and, in situations where someone leaves, the level of interest was not be the same as the primary trainer. Rose identified that one of the consultants, (not the lead trainer), was not always present when she was at the independent practice stage⁵².

“He wasn’t usually there; if we had a problem he often wasn’t there....
Julia: (prompt) He should have been there?
It’s probably because of the way he is – he has a lot on he has got so many things going on he was often in different place and also he wasn’t so involved with the nurse hysteroscopy training...”
(Rose)

A ‘laissez faire’ attitude to training support for the nurses has been an ongoing issue for the course team. There is an argument that this lack of attention is not malicious. One argument is that it is a reflection of mutual trust that has developed where the nurse and doctor work in harmony. Conversely, it reflects the theory that there are two levels of trust. One is associated with patriarchal dominance, where ‘I trust you’ so I will ‘allow’ you do this (Miers 2000) is mixed with a ‘filling the gap’ (Walby and Greenwell 1994) as described by Liz 1. The second, an acceptance of professionalism that facilitates inclusion through a process of usurpation as described by Witz (1990), is recognition of a co-professional praxis. It could be argued that through the nurses’ skill and knowledge development they shift the occupational boundary associated with a skill. Lucy, Holly and Rose provide clear examples of this co-praxis that appears to require positive professional relationships. For Holly her trainer was acting as a ‘funnel’ or mediator with the remainder of the consultant body; she placed him between herself and the rest of the consultant body on the map, describing the remainder of the medical staff as “*disparate*”. She explains how her role is to develop ‘robust’ services,

“To try and reassure them it’s not about threatening the medical body”
(Holly)

Lucy has a good working relationship with the senior nursing staff; she can discuss service issues and request support for equipment essential for keeping the service running.

“I have always been senior, but what is lovely is because a lot of the

⁵²When the consultant and student agree a minimum of 50 hysteroscopy’s are undertaken with the consultant on standby in the unit.

nursing staff have been there for a long time they have been instrumental in my development and encouraging me along the way, so, although I'm perhaps a step more senior than I was my position before, my ranking in the team hasn't actually changed".
(Lucy)

The next two quotes from Lucy capture the significance of a supportive environment. She explained how the advanced practice groups oversee all new expansions of clinical skills, be they by medical or other clinical staff, and have been 'core' to hysteroscopy development.

"I've been very supported since day one, I know it's not the same for others, and I am very fortunate that they have supported everything that we have done. Obviously there are some financial restrictions and um that does restrict what we are doing in ways of study time, taking on extra staff, but from management up to high trust level um have always been very supported and we regularly go to the advanced practice group, and any changes in practice will go to their group (mentions presenting audits). From a supportive point of view no restrictions, very very supportive of the role that I am doing."
(Lucy)

Lucy also includes the other departments from which their service requires support. Whilst they are to one side in her (map 3) she talks about how, when setting up the service, she took time out to go and meet with the Heads of each department. She describes why she has put them above herself because she "*respects their knowledge*", but also that they too have been very supportive to the point where she can say:

"I've gone to the Head of the Department and said 'you found that I found that where do we go from here'" and you know I feel that they appreciate what I do – I appreciate what they do and we can work side by side."
(Lucy)

Rose too argued:

"I think that because of our training we were able to do what we did and we dealt with the head of pharmacy (err) somebody we hadn't dealt with before and developed the patient group directives with him."
(Rose)

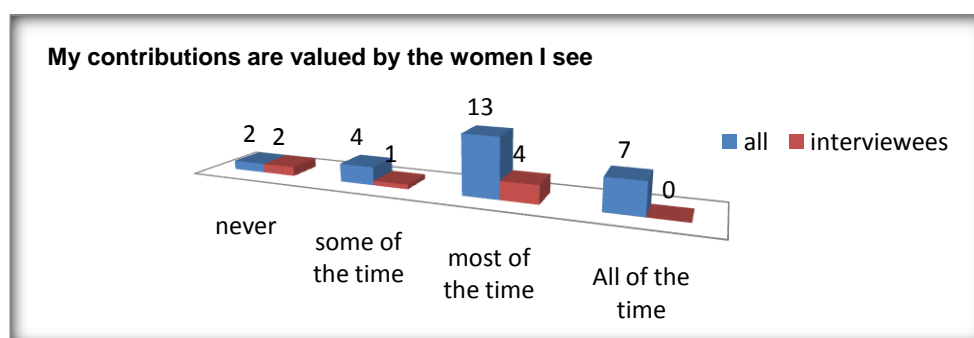
Nurses were important to Alisha too; she suggests her nursing team relationships are the strongest, and were again built on her clinical praxis.

"Very very closely (um) I have worked with them for oooh nearly 7 years and have a very close relationship (um) they actually prefer working with the nurse hysteroscopist rather than a doctor doing hysteroscopy basically because... I don't know whether it is because nurses work better together. A nurse running a clinic seems to work far better, we

have a far better relationship with the patient and (um) the clinic just runs far more smoothly. If a doctor's doing a clinic they're far more slower. Because I do it all the time (um) I know exactly what's what patient what treatments I can offer them and because I do it on a very regular basis I am a lot quicker (um) and I have a very low failure rate because of it because it's my job and it's something that I solely do. (um) and I the ladies will initially say oh you're a nurse and I'm so glad that you're a lady doing this procedure on me I have never had a complaint from any of my patients at all and the majority of the ladies will go out of my room and say I thought this was going to be awful but you have made it as pleasant as possible and thank you very much.”
(Alisha)

The supportive validation by the women is significant to this particular person, as it was to the other participants (Fig 8).

Figure 6 Nurses Believe Women Appreciate Their Care



When the co-professional praxis that had been established with her trainer and nurse colleagues was broken up on the departure of her consultant and Matron, all other avenues of support from senior staff disappeared. Here usurpation had been transitory or illusionary and the subsequent vacuum had significant consequences.

“After I qualified umm because I was doing so well and everyone felt that umm yeah Alisha she is fantastic she can do it we don't need to know check up on her you know we just let her get on with it... um I think um in my head consultants um I thinking just felt well she's got it now we'll just let her get on with it um was then ascertained um that consultants were sending me through patients and expecting me to do things um which the hospital then suddenly decided that was out of my remit um I didn't have admin support I had to do all my own protocols, my own guidelines um and so therefore theoretically I had done them all myself my trainer and consultants had agreed to them but then it was found out that the medical lead Gynae um was then told um is what I was doing then it was reported to the hospital management err to cut a long story short they felt that legally I wasn't covered to do the job I was employed to do um so um, basically um I felt extremely let down I was put through a hell of a time um a lot of stress because of it.”
(Alisha)

There are several issues to unpick. Firstly, although another consultant picked up her training and saw it through, the new clinical lead for gynaecology presented a challenge by not supporting the development of nurses. This, along with the departure of the matron with no one taking up her vision for the service, left Alisha vulnerable to accusations of inappropriate practice with no one to sustain the vision after the loss of the consultant and matron. Secondly, whilst Alisha was seen as a useful resource by the other consultants, once she qualified they arguably took advantage, *"sending me through patients and expecting me to do things."* There was no written documentation other than the plans and protocols done by Alisha herself. There does not appear to have been the mechanisms to approve them on behalf of the organization. Thirdly, there was no collective understanding of what a nurse hysteroscopist was capable of and could be responsible for. Finally, she appeared 'cross' with herself:

"I just assumed that anything that I had been doing in my training...
should just continue."
(Alisha)

Arguably, these quotes provide signs of reactions associated role ambiguity connected with street level bureaucrats. Lipksy (1980:48) suggests that role ambiguity and resource inadequacy are two of the three features causing stress, 'by impairing personal action and reduce workers effectiveness'. The third is workload; Alisha does not suggest that her workload is too great but Liz 2 does. The workload is not around clinical procedures but in managing staff. Liz 2 has no line management responsibility for the secretarial staff but did have for organising their day to day activities. This included having to resolve their arguments. I will return to this in Chapter 7.

The organisations have some culpability in these situations particularly that of Alisha. As an organisation, there will have been significant investment (cost of the course and time of trainers, purchase of equipment). It appears that the rules of the organisation were more than the overall objective, and is perhaps an example of Harrison and Smith's (2003) concerns that the structures of rules and hierarchies are counterintuitive to service development. Here, no one stood back to look at what she was doing in terms of outcomes. For Alisha, she said there had been no evidence of clinical errors and no mention by her of the income for the Trust and there was no recognition that there were two other nurse hysteroscopists working in the same Trust network that did not have the same experience. The above observations are examples that continuing medical dominance as described in the literature review by Allen (2004) and drawn from Weber is still present.

Evidence of changing dynamics

What we see from the maps and quotations is evidence of a group of nurses who have acquired the common objective as change agent in the delivery of hysteroscopy from inpatient to outpatient 'see and treat' hysteroscopic services. For each nurse hysteroscopist interviewed, there are factors that impinge on who and how they relate to staff in their respective Trusts. The nurses are on a journey of occupational change, whilst still registered nurses. Evetts (2003:403) used the phrase 'occupational change' with professionalism. The argument presented by Evetts is that 'radical' governments now have control over professions. From the data I did not see evidence of control; rather it could be argued that nursing opportunities have been created which have resulted in redefining some of the hierarchies making them no longer exclusively medical.

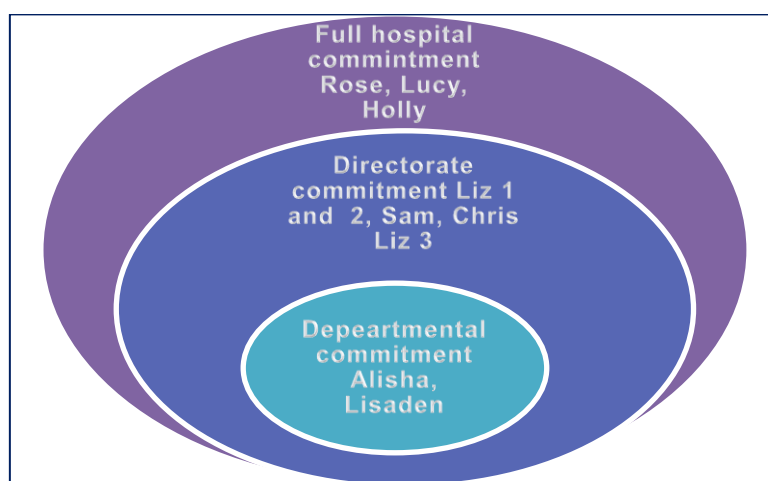
Walby et al (1994) outlined the objective of placing senior Trust executives above the consultant medical staff in order to create a dynamic shift in the power base in hospitals. This was potentially positive for nurses as Liz 1 articulated earlier (see page 99). However, changes in power do not always appear to change the inter-professional dynamics. Alisha, Liz 2, and Lisaden all describe issues related to role expectations but not having the power to control what happens. From the evidence of the mind map images and aligning them with Walby and Greenwell's (1994) model, there remain vertical hierarchies of accountability to the organisation and between professions. The argument remains that whilst ever these exist then horizontal inter-professional teams are not in a position to flourish. Whilst not as extreme as Freire's (1979) example of the oppressed becoming the oppressors, elements of this are still exemplified in the actions of Alisha and Liz 2's nursing managers. Perhaps Hugman's description (1991) is more representative of the demarcations that nurses described as evidence of professional differences being maintained thus enabling suppression to continue. In accepting notions of organisations' power base being gendered then there is no evidence of it having changed at this time. There is evidence from the data that the structural subordination through hierarchies has just relocated the power base.

Liaschenko and Peter (2004:489) explored the concept of 'multiple relationships' in the context of diffusing relationships. However, what is seen from the maps is that the nurses, where they are enabled, have the skills and ability to redefine the relationships (Sam, Lucy, Liz 1 and Elizabeth). Yet there are also clear examples of deference to others, particularly senior medical and managerial staff by most of the NHi. Clearly, the public and private spheres of occupational work are

increasingly complex. Both Liz 2 and Alisha made some reference to the impact on their personal lives during the interviews. The references in maps and transcripts to other nurse hysteroscopists allude to the importance of the 'occupational communities', indeed it was Evetts (2003) who describes the importance of support mechanisms for the nurses taking on new roles. There is evidence in this study from Holly, Rose, Lucy, Liz 1 and Elizabeth to confirm the significance of such communities to the nurses. However, the disparate location and functions of the hysteroscopy nurses compared with other nurses means caution should be taken in transferring the findings from this case study group to specialist nurses working within single locations.

From the nurses' descriptions, I identified the level at which support or commitment seems to be available, not only in the actual development of them as nurse hysteroscopist but also the point in the organisational hierarchy it emanates from. Even now there is a commitment through the Department of Health for improving services through the latest, 'Enhancing the Healing Environment', one of the ongoing objectives being that Trusts develop new skill mixes (DoH 2010). For the nurses in phase one of the study, I have identified in Fig 9 the levels at which the support emanated from within their organisation.

Figure 7 Levels of Organisational Support for Nurse Led Hysteroscopy Provision.



(Created by the author 2010)

This model is built up from the nurses' images and descriptions and does not imply this is the actual level they were supported from. It fits with an aspect of Lloyd-Jones (2004) analysis that one part of the commitment must come from the nurse's manager. As has been seen in the maps, with the exception of Sam, the nurses relate to their managers as agents for the organisations. From the analysis of transcripts, I identified dichotomies that indicated the managers were either

empowering or, more frequently, blockading. It may not have started this way but is supported by the nurses' view that there was a lack of organisation particularly when key staff left. There is an issue here for the replacement managers which Peck and Norman (1999) identified, that not recognising the skills of others was overall detrimental.

Summary

In this chapter I have presented data from the nurses that I interviewed and with their maps they have provided examples that illustrate the complexity of their working lives. Not because of the clinical cases they manage but because of the interactions with personnel within organisational frameworks. By exploring the relationships that were discussed I have been able to illustrate the networks that the nurses are working in and how the hierarchical relationships are constraining or empowering them. The evidence presented in this chapter suggests that whilst individual consultants do not practise and power, the collective still appear to do so. This is compounded or alleviated by the support that comes from the nursing peers and managers.

I have started to refer back to the theories of gender and power between gendered professions with some initial reference to occupational closure and there is evidence of tensions, which have arisen out of some the nurses' experiences. This will be developed further in the next chapter as I draw in more of the survey.

Chapter 7

The Impact of Moving Boundaries

Here I continue to draw on evidence from the nurses but begin to incorporate more literature to underpin the analysis and start to draw together the implications of the emerging themes. In the previous chapter, I commented on the evidence of nurses usurping occupational activities from medical staff. Here the evidence starts to emerge that whilst there are personal strategies a nurse can adopt as she develops her clinical skills, the organisation and its players can impact significantly on that journey. The chapter concludes by considering whether there is evidence that the nurses are actually working at an advanced level as defined in the recent literature.

Moving Boundaries

When I examined the abstract terms as part of the in vivo coding, as described in Chapter 5 and presented in Appendix 4, I identified that the nursing staff either 'Respected' or 'Resisted' what the nurse hysteroscopist was doing. Several of the research participants have had examples of positive support from their nursing colleagues but this was not always the case. In the previous chapter, I described how Holly was able to negotiate the changes in services with her clinical trainer mediating the processes. Alisha and Liz 1 describe a different set of challenges to themselves giving insight into how a lack of understanding of a role or activity can escalate into a jealous / bullying type situation. Alisha used the term bullying, and Liz 1 jealousy. I will explore this further in this chapter.

I have already illustrated (see page 110) how Alisha understood that, on completion of the course, her trainer consultant was confident of her abilities and the evolving service, but she chokingly recalled that;

'so.. um basically I felt extremely let down and um....and I was put through a hell of a lot of stress because of it and then I personally felt I was being bullied by my senior nursing team on my ward... and basically they were going to report me and take disciplinary action against me".
(Alisha)

Alisha is still clearly affected by the emotional ordeal. Looking back at her map (2), it appears there were two levels of jealousy; not only was she being challenged about her practice by a senior medical colleague but her nursing peers allied against her. This is reminiscent of a pack mentality which is triggered by ambition,

fear and the need to survive (Vega and Corner 2005:190). They suggest that this type of bullying is associated with organisations that reinforce hierarchies from top down and separation of tiers of staff. Whilst Alisha's experience was the most dramatic example with a specific reference to bullying, nine other examples were provided by the surveyed nurses (See Appendix 5). These illustrate reactions to change by nursing peers and doctors that are indicative of jealousy, and anxiety arising out of change, both cross professional and between professional groups. Alisha describes how senior medical staff were threatened by other peers who were taking the initiative for service improvements, too.

In the previous chapter, I identified that Liz 2 was having problems with administration staff. Another example from Liz 2 was not in relation to her hysteroscopy role or skills, but as she was about to add colposcopy into her repertoire of skills, the other colposcopist nurse was feeling threatened.

"With the nurses it's reasonably ok... we sometimes have our ups and downs so does everybody. My relationship with the lead colposcopist (nurse) I feel didn't start off very well. Not because of any one thing but she saw me as a threat because I was a hysteroscopist... "
(Liz 2)

The context was during a potential reconfiguration of staff; having only a single qualification, the individual felt insecure. This was not initially about the personal relationships but the roles became confused with the person and so became personalised.

"We've had a few tears and tantrums not from me, her, but I think we've got over that now. I've just carried on doing what I've done... it wasn't of my making."
(Liz 2)

Hochschild (1983:170) gives a way of understanding this relationship. As a result of nurses' powerlessness, the nurse appears to have 'become assertive about certain secondary decisions' over which she no longer has influence. In behaving like this she is challenging Liz 2 to use greater degrees of emotional management. These experiences were not unique to the nursing staff. The in vivo coding (Appendix 4) led me to identify the following dichotomies displayed by the medical staffs, which were either authoritative or antagonistic.

The term authoritative could be seen negatively but the word in this context is used more positively as that use of authority was seen to support and develop the relevant nurse led services. By the language and tone used by the nurses in their accounts, I gained the sense that there was a close alliance between themselves

and their lead trainers. For example Lucy says that her lead consultant when talking to junior doctors, “*She will say to them Lucy is here to do that job.*” That job includes teaching⁵³, advising and ensuring that the protocols approved by the advance practice groups are used. This resonates with others. Liz 1, Elizabeth, Lisaden, Lucy and Holly for example are all teaching medical staff and all talked about it during their interviews as recognition of their expertise.

The term antagonistic encapsulates a dichotomy with authoritative (see Appendix 4). Whilst the term antagonism was never articulated specifically, the identification of this word is that it that best captured the behaviours of and between clinical and managerial staff who created environments in which the nurse bore the brunt of the consequences of no plan being in place.

Holly articulates the antagonism most clearly. Despite being a nurse consultant for 10 years, Holly still needs her training consultant to mediate for her. Holly said:

“I don’t think it’s unique to this course. Right throughout my career as a nurse consultant I’ve had to do a bit of fighting to keep on board the rest of the consultant body um they’ve got lots of issues and they will try and put some hurdles in place. You know they feel that we’re actually encroaching on their professional roles. They’re concerned about teaching and training of junior doctors and usually you can win them round by just explaining – well I’m not actually going to take the job over... I’m going to teach junior Drs on route. My view is they’re really happy to use nurses when the odds are down... because of rotation, I’m the one person probably that gives continuity to that team... they settle down but when a new innovation comes along they get rattled. Between me and my supervisor we can usually... you know... they come round and they’re absolutely fine.”
(Holly).

These tensions between doctors and nurses are reminiscent of features associated with feelings of threat and link with theories of occupational closure as described by Witz (1990). I considered whether there is evidence to accept the findings of Rothstein and Hannum (2007) whose study rejected the feminist argument of female deference as part of the doctor nurse relationship in favour of professionalism. However, neither Holly, Liz 1 nor Alisha has used terms that might support that aspect of the argument, although there is evidence to support nurses’ dissatisfaction which was one of the observations reported in the study;

‘Nurses were less satisfied with physicians’ recognition of their other responsibilities... Physicians have little cognizance of the extent and time demands...’
(Rothstein and Hannum 2007:239)

⁵³ All those not in training are teaching all grade of doctors and some nurses.

The term 'extent' in the quote refers to the clinical skills used and the 'time' the organisational / managerial responsibilities that come with applying that skill. This is perhaps reflective of Hugman's (1991) view that hierarchical structure obscures the skilled similarities. It is Witz and Savage (1992) who have talked about power and resistance and I was reminded of a law of physics: 'to every action there is an equal and opposite reaction'. Where there is a force in one direction there is always something to counteract it. In the literature review, it was Mann (2004) who described '*polarised camps*' between professional relationships. In this study's case Weber's examples of professional boundaries, particularly between medics and nurses, resonate. Applying the rules of physics creates a structure that has amoebic qualities; the health service has tensions that flux and flow depending on political and fiscal demands (DoH 2000), changing shape like a cell's walls. In Chapter 6, Liz 1 considered whether the development of nursing roles was detrimental to nursing using a lower professional to fill the gap in medical vacancies. Equally, taking the macroscopic view of developing skill mixes, it was considered if in fact the fluxing boundaries happen at multiple levels. Using the theories of Weber 1979 and Witz 1992, I have prepared a model (fig 10) to illustrate boundary flex without takeover.

Figure 10 Demonstrates how Occupations Respond to Forces by Easing Boundaries.

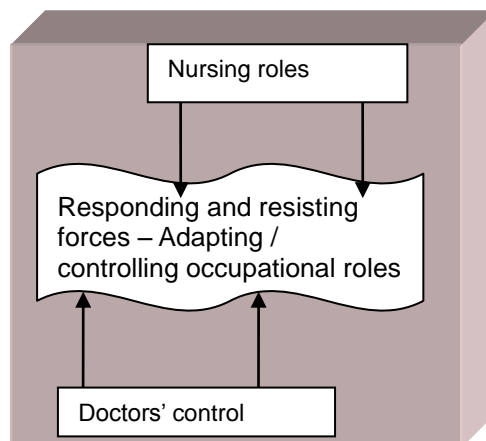
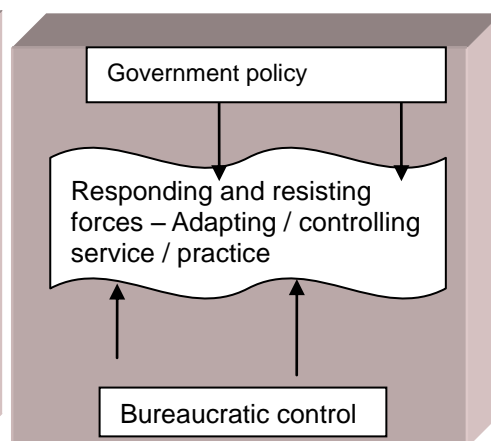


Figure 11 Demonstrates how Bureaucracies Respond to External Pressures



Where pressure is relaxed in one direction a new pressure applied elsewhere. In Fig 11 I have illustrated how this model can be repeated into an organisation too. This is in part because there are struggles at all levels for professionalisation and the power that comes with it Noordegraaf (2007). For example, replacing the responders i.e. nursing roles with government policy, and the resisters i.e. doctors with bureaucracies. Holly, a nurse consultant for ten years, is describing aspects of

occupation closure. As a band 8, she has vertical expertise as a nurse consultant yet she has exploited a career opportunity through usurpation, to acquire a unique set of skills. Both Holly and her training consultant have worked on the principles of inclusion and subversion to change the current status quo. She, as are others, was clearly seen by the other consultants as a usurper, as they retaliate and challenge her newfound expertise. Holly used the phrase, *“when the odds are down nurses come into their own”*. This was also a feature referred to specifically by Lisaden, Liz 1 and Liz 2. Considering this, and content from the previous chapter, there is a picture developing of tensions between ‘practitioner autonomy and occupational control’ (Witz 1994:24). Based on Weber’s model of occupational closure Witz is postulating a theory for the struggle for nurse’s professionalisation.

Liz 1 provides an example of how she has been striving to develop her own professionalism, to prove her worth. She explained how her relationships with medical staff had grown over the seven years she has been practising as a nurse hysteroscopist. She believes this is down to her demonstrating clinical credibility and supporting this with educational credibility. In occupational closure terms, she has been subverting for some time but not necessarily in the sense of gaining an occupational monopoly that Larkin (1981) wrote about.

“Everything I have done I have backed up with official training courses... I’ve got that underpinning knowledge and I think this has gone a long way to building those relationships... now they all get a piece of me but they all want more.”

(Liz 1)

There are two features here; one is about knowledge and the other about relationships. This felt like she was justifying herself and because of her intonation I wondered if there it was something more complex at play and I asked her to explore it further. The pride shown in announcing her promotion at the beginning of the interview hid the battle she has had to get it. She had become aware of resistance by the medical staff to her promotion to consultant nurse.

“Because of what the title said in it, because it said the word consultant, the fact that I’ve been doing the job I am doing the job for the last 18 months to two years, but they are not happy, but actually giving me the title with the word consultant has caused a lot of animosity... um and I’m sure the basis of that has been professional jealousy.”

(Liz 1)

The solution sat with information: *“once they had the information of what is actually involved with that role it changed”*. Arguably, this is an example of the competence

use of game playing. From her earlier quote, *"Everything I have done"* illustrates there has been a long-term strategic plan. Svansson (1996) observed its use as an interpersonal skills strategy to create a more egalitarian working relationship. Similarly, Miers (2000) and Davies (2005) have talked about the game, where nurses apply their feminine traits to manipulate a situation. For Rose and Lucy this is potentially the case, they show a respectful deference to their peers. Debatably using the attributes of gender has been successful for them in establishing their status in the organisation.

The interference by medical staff in Liz 1's career progression is of concern. Nursing consultant posts have been part of government policy to change the career dynamics since 1999 (Woodward, Webb and Prowse 2005). In this paper, it was identified that unless the nurse consultants have both clinical expertise and leadership skills they will struggle to make a difference to the role. However, they do not consider the predatory reluctance of one professional group to allow another group to use a term associated with them, in Weber's (1978) word, 'exclusionary.' The bases for professional tensions were explored in chapter 2. With the current hierarchies in the health service, doctors and nurses have different lines of management. Whilst there may be a collective aim in the achievement of clinical outcomes, the progression of staff is still through role profiles (NHS 2006).

Whilst clinical performance is required, promotion rests with line managers. The fact that another professional group can influence the career progression of a nurse is intriguing. It may be surmised that this is because professional boundaries have been imposed by government policy and are threatening. One would expect street level power to be controlled by managers (Lipsky 1980:19) and to some extent this is correct. Lipsky was writing at a time when, as now, consultants are also managers (of clinical services) and therefore wish to exercise control. However, what has changed is that they should not have the power of veto over nursing roles, the power being exercised against the usurper Liz 1 who for a time took a financial consequence for resistance. This is an example of rational legal authority as described by Weber (1978) as discussed in chapter 3.

This example supports the proposition modelled in Fig 11 that helps our understanding of how a government policy may impact on the bureaucratic organisation. Lipsky (1980:187) suggests that turmoil comes with 'rationalized change'; projects that aim to reconfigure services within public agencies are affected by the street level bureaucrats' ability to exert a level influence and discretion. One of the issues about using Lipsky's work is that there are street

level bureaucrats at multiple levels in the public sector and it can become confusing, where does one level (street level bureaucrats) stop and the other begin. In my study, there are two levels of bureaucrats, the 'lower street level bureaucrats' who it is suggested are the nurses at band 7 and below, whereas the doctors, line managers and possibly, the consultant nurses have become the 'street level bureaucrats'. For example, in Lucy's image (See map 4), the management for her includes the senior medical and nursing directors of the Trust. The latter are located together at the top, above the consultants she works with, as they too have to answer to the hospital management. Her description explains that there has been a collegiate approach to nurse led hysteroscopy.

Another example of game playing is given by Lucy where she included the other departments from which their service requires support. Whilst they are to one side in her map (5), she talks about how, when setting up the service she took time out to go and meet with the Heads of each department. She describes why she has put them above her because she respects their knowledge, but also that they too have been supportive to the point where she can say,

"I've gone to the Head of the Department and said "you found that I found that, saying where do we go from here?" and you know I feel that they appreciate what I do – I appreciate what they do and we can work side by side".

(Lucy)

Lisaden works as part of a group of team leaders, her need to undertake the hysteroscopy has, "*set (me) apart*". Despite that she says she is "*more confident*" in her role. "*I know I'm a practitioner that can do things in my own right.*" However, like others, she is not involved with, nor does she have a voice in, the organisation as a whole.

Enabling the vision for change

In the paragraph above, we see that Lucy has had a supportive experience. From other interviews, there appeared to have been a degree of frustration amongst the nurses: Alisha, Liz 2 and Elizabeth who felt 'out on a limb', and Sam in relation to their Trusts' responsiveness to change. Whilst the Trust may have initiated services, they have taken time to evolve. Liz 2 talks about her (new) manager;

"He keeps sending me e-mails to say this person is breeching or that person is breaching⁵⁴ or that lady has breached, especially if she is to

⁵⁴This is to do with not meeting the governments 18 week targets from appointment to treatment.

breech in 3-4 days time, what do I do now because you then have to get appointments into your clinic's targets. Targets, targets all the time which again is something that I have never had to deal with..."
(Liz 2)

As we have seen, the lack of a plan held significant implications for Alisha; the consequences have impacted on her wellbeing at work and home requiring some time off work, she is still tearful. This potential consequence of advanced practice on a person's wellbeing was identified by Stradzins and Broom (2003). Lisaden reported the benefit to patients but she was still not functioning in a 'see and treat' capacity at her own unit. The three units in her Trust are being reconfigured. As a result, she has to keep her expertise in outpatient work by doing additional hours in another Trust, on the bank and fight to be able to maintain her accreditation with the BSGE whilst organisational decisions are made. She commented that:

"Where I work, management has changed over the last three years. Everybody that originally signed me up to go has gone - there's not one of those managers left and each one of them just passes the parcel on hysteroscopy and I don't think they appreciate truly what it is about so I keep saying I'm just hanging on by my fingernails and just keep pushing and pushing and pushing without them getting fed up of hearing what I want to do and need to do um... No business plan was done - not properly, even though they all signed it and I've got all the documents... they pass the buck now. They can't agree because they weren't the managers in place at the time."
(Lisaden)

Here game playing is not working, this is about the relationship she has with the managers where the nurse doctor games will not work. It appears that frequent changes in personnel have not allowed a working relationship to develop. There is not enough here to indicate that the issues relate to Barton et al's (1999) observations that threats to professional identities are an issue, it appears a lack of co-ordination at an organisational level. For her, not only is there no outpatient service yet in place because it keeps being put off, there is no understanding that, to be able to run the service once it is ready, Lisaden needs to keep her accreditation⁵⁵ with the BSGE. This is further evidence of a lack of bureaucratic organisational intelligence and as a result opportunities proposed by the government are being missed (Lipsky1980).

Lisaden was one of the NHi who talked about service and business plans. A search of the internet indicates that business planning is important to the

⁵⁵ For reaccréditation, nurses complete an audit and must attend an annual conference where clinical cases and developments are discussed.

functioning of NHS trusts. The Department of Health (2006) until recently had guidance on its web pages for Foundation Trusts. From the stories, it is not just enough to plan a service, but there needs to be ownership of it is also. There were several illustrations of the nurses' lack of control of the direction of the service and professional opinion not being sought. This particular issue was significant for Elizabeth, my last research participant, working as a band 7 nurse and running three clinics for different purposes. Whilst she had significant clinical decision making discretion in direct care this was not mirrored in service organisation. She gave the example that when there was a discussion on the relocation of post menopausal hysteroscopy into outpatient services no advice was sought from her.

"There was discussion at consultant directorate level as the oncologist felt it was not safe for us to be doing it in outpatients, because they always thought that these ladies should have um a... rigorous curettage which is not something we would do. It's an ablation that we do in outpatients; I think her fear was that we would miss cancers so there was a lot of discussion... at a higher level than I was involved at."
(Elizabeth)

During the interview, I asked her to clarify this;

"It's quite traditional at my hospital I would say, when you look back over the years they have not actually spoken to the people on the ground... things could have run more smoothly if they had spoken to people who do the job... the matron will bridge that gap."
(Elizabeth)

For others, there appeared to be a clear business plan for Sam. She was the only one who mentioned it specifically; however there was evidence from the other interviews of clear planning. For example, Rose⁵⁶ commented:

"Oh that's the nurse manager who again gave us support during our training, a huge amount of support, was always there with any problems."
(Rose)

and

"Initially she paid for the training (laughs) and agreed to us doing it and appeared pleased – and we knew she was there if we had any problems. I cannot think of any."
(Rose)

Having been proposed for the course that would change their roles, (Rose, Lucy, Liz 2) the need for ongoing support is seen by the course team as important. The nurses had very different experiences of support. As I transcribed, the emerging

⁵⁶ Rose was pointing at the map at the time.

dichotomy I drew from the nurses' transcripts, through the 'in vivo' coding (See Appendix 4), was sovereignty and suppression.

*Sovereign agents overcome the wishes and resistance of others
in order to achieve their will.
(Halford and Leonard 2001:27)*

Sovereignty here is expressed by Halford and Leonard (2001) as the potential for autonomy, independence and power. The transcript data reveals evidence of a liberal approach to attaining power within an organisation, despite the obstacles and attempts to suppress them. The nurses can rightly claim that they were sovereign agents (Halford and Leonard 2001:27) where their work is episodic, acting as agents to overcome opposition. Further evidence emerges from the survey data which describes service developments as they were initiated (Appendix 6).

Lack of Trust support, lack of funding, lack of understanding of role and level of training
(NHs25)

I felt a great sense of achievement, more so than any other course I have completed. Recognition from other doctors that I had a skill they were yet to achieve.
(NHs26)

I have advanced through the hysteroscopy role into a nurse specialist giving me a larger profile within the organisation. Have referrals direct to myself from consultant colleagues. Can now offer a wider choice of clinics to patients and clinicians to access. Reduced waiting times.
(NHi22)

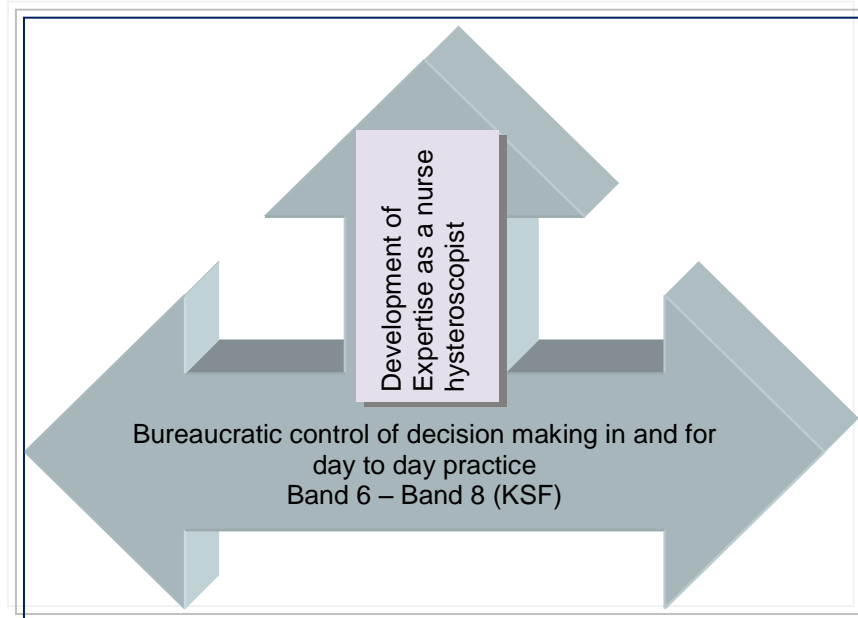
However, a caution is needed as the power element of sovereignty still appears to be in the gift of others.

Yet another perspective to consider is whether nurses are exhibiting the middle class power relations that Savage examined (1992). The proposition is that, through professionalisation, women were gaining access to expertise, but there was no commensurate gain in power or authority. A more recent argument is to refer again to use the vertical and horizontal segregation discussed by (Bolton and Muzio 2008). For the nurse hysteroscopists, the vertical power comes from the evolving expertise and knowledge that comes from the hysteroscopy modules, set against the lack of opportunity for organisational decision making through bureaucratic authority, as demonstrated in the horizontal plan. See Fig (12).

The question arises that with the expansion of nurse led services can organisations sustain an increase in the numbers desiring or requiring some organisational

authority to facilitate those roles?

Figure 12 Vertical Expertise and Horizontal Power: adapted from, Muzio and Bolton (2008)



(Created by the author 2010)

Evidence of bureaucratic control comes from Liz 1, Lisaden, and Elizabeth. Liz 1 having recently been made a nurse consultant talks about, "fire fighting." She suggested that there had been a lack of strategy for nursing in contrast with the direction of medically oriented services based on meeting targets. This is reflective of tensions between the medical systems approach to care that is driven by targets rather than that of providing a personalised service for an intimate procedure. However, on a more positive note Liz 1 is part of a "*new senior nurse group looking at plans for nurse led services within the directorate*", particularly in gynaecology. Holly had described her close relationship with the director of nursing; there was no indication that as a long standing nurse consultant she had different authority to the other research participants so suggests that the model of higher level skill does not equate with more strategic decision making powers and have not shifted the location of power. The fact that we have examples of nurses being ignored when it comes to decision making on structural change, means that nurses remain subordinate and that the 'superordinates' have maintained their power (Larkin 1980:13).

Summary

In this chapter, I have explored in more detail the implications of becoming a nurse hysteroscopist. There is evidence that the occupational anxieties and shift in lines of authority all still conspire to impact on the nurses', medics' and managers' ability to adapt to changes in roles. This can have an impact on the development of the services. I have developed two models based on the work of Weber, and Witz and Savage to explain the tensions. The consequences of not recognising or addressing some of the factors have been discussed. There is also evidence that nurses have to use some of the skills associated with game playing.

In the next chapter, I examine the data for the personal social consequences of becoming a nurse hysteroscopist.

Chapter 8

The Personal Consequences of Becoming a Nurse Hysteroscopist

In the literature review, I explored the literature around 'labour' 'emotion' and 'work'. In the previous chapter, I hinted at the level of jealousy that appeared to present during storytelling and survey responses. In this chapter, I return to the theories and re-examine them in the light of the nurse hysteroscopists' experiences, using quotations from transcripts and charts created from the ordinal data to illustrate the findings.

Work and emotion

The presence of characteristics associated with using emotion, or the cost of it, threaded throughout the interviews. One aspect is the additional time nurses put into their roles. For example, Liz 2 is putting in additional unpaid hours,

"I only work part time but in the last 2 weeks instead of working 30 hours I have put in 40 hours and some of that at home too. But I feel that is because the management side of it has deteriorated so much there is a lot of catching up to do."

(Liz 2)

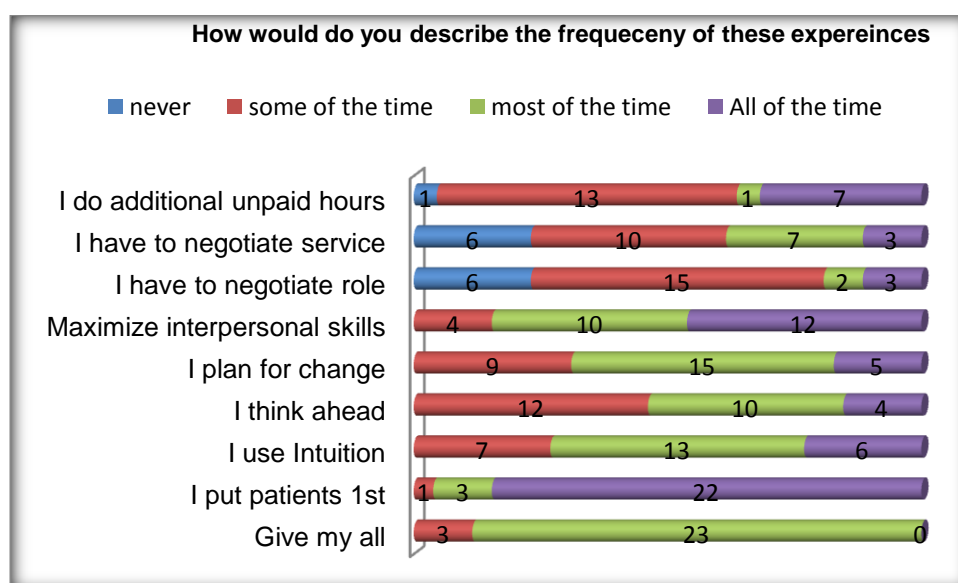
There is no contractual requirement to do this and this reflects a sense of responsibility at a time when she has had to manage more than one conflict situation at the expense of taking work home. Completing the additional clinical activity for no guarantee of remuneration has been proposed as a consequence of gendered work and gendered organisations (Lipsky 1980; Davies 2005; Bolton and Muzio, 2008).

Undertaking work without appropriate reward has been associated with an aspect of emotional work. There is more evidence that Liz 2 was not on her own. Fig 13 illustrates that for other participants this was a case too. The first three questions are about roles and service provision. Seven of the nurses are undertaking some additional hours all of the time. Using Liz 2 as an example, she feels a personal responsibility that she must do these hours to ensure the totality of the service is not affected. Twenty two of the nurses put the patient first with 23 putting the service first most of the time but can be seen in the context of Bolton and Muzio (2008) proposition of horizontal segmentation where women are doing women's work whether that is new or redefined as with the nurse hysteroscopy role.

Additionally it can be seen that eleven nurses continually have to negotiate aspects

of service provision, whilst twenty are planning ahead to ensure that the service will operate. Collectively these results provide us with an image that suggests that their roles are not just about the clinical decision making during the patients visit, but about providing a comprehensive service that requires continual attention to details.

Figure 8 Attributes Associated with Emotional Work and Emotional Intelligence



An observation from Fig 13 is that the nurses recognise that they are using their intuition and interpersonal skills, with twenty-two again recording that they frequently maximise their interpersonal skills in their role. With the exception of three, the nurses' response to 'give my all' alludes there is a composite view of giving 100% to the role which resonates with Hochschild (2003:164) who recognised women as *'emotional managers'*.

Managing emotion

In Chapter 2, I referred to a review paper by Jackson et al (2007) in which they identified how nurses might need to develop resilience using skills that included emotional insight and nurturing professional relationships. In the previous chapter, I suggested that there was evidence of game playing as part of the working relationships. There is an argument that these are also skills that can be attributed to emotional insight if not intelligence. For nurses emotional work is not just about caring, it is about interpersonal situations and managing conflicts (Hunter 2004, Morrison 2008). To do this effectively it is not just about how nurses use skills of communication as demonstrated previously through quotes, but also managing the

whole environment, for example Elizabeth and Lucy. There is also evidence from the stories that the nurses are working their way through a maze of challenges, for example Alisha, Lisaden and Liz 2, and that to do this they were using the associated skills of adaptation and flexibility. Whilst not identified as bullying or jealousy, Liz 2 was challenged by some of the staff members, one of whom she describes as confrontational. However, this was not linked specifically to changes in role but has still impacted on Liz 2's ability to perform:

"One of the nurses in particular is very confrontational; she always has been and always will be. And no matter what you do it will not be right and she'll try and confront you about issues that you know are going to take a while to sort out. But she does it all the same."
(Liz 2)

Of other staff with which she ran her specialist services she said:

"One of which is absolutely fine and one of which again is an issue because she was previously a senior nurse and cannot accept that now she is only a band five and she cannot accept that. She tries to interfere..."
(Liz 2)

She clarifies that this individual had made a choice to have some time out and since her return is having problems "*letting go*". The two examples seem to epitomise a response arising from someone who is ill at ease with a bureaucratic organisation. In the literature review, I considered the problem of letting go as one that would affect the medical staff or the nurse hysteroscopist, not their peers. It was Daykin and Clarke (2000:351) who identified problems when 'control is weakened'. For Liz 2, this situation was creating the need for the management of complex inter and intra personal issues (Dann 2008) and was clearly impacting on Liz 2 to the point where she had to manage her own frustrations not just those of others. Lipsky (1980:181) suggests that a street level bureaucrat's response to dissatisfaction causes stress, arising out of the organisational culture. This theory of stress reaction is that the coping mechanism is to be troublesome; this can manifest itself in a number of forms: alienation and disruption being two. Whatever the causes of this personal interplay, as part of her role Liz 2 had to deal with the consequences by using her emotional intelligence. She did not react, rather waited and role modelled appropriate behaviour.

Both Hunter (2004:267) and Morrison (2008:981) examine the implications on and for the 'caring' professional, of conflict between professional ideologies and personnel respectively. However, there are differences in their work. In this study, nurse hysteroscopists were stepping out of one occupational boundary working

within a new medical role that changed the relationship dynamics with nurses, doctors and their managers. Liz 1 and Liz 2, Alisha and several of the NHs have experienced emotional work, not in terms of patient care but in conflict resolution with work colleagues. This was characterised by Mann (1997:4) as inter and intra group conflict. In Hochschild's work (1983) the management of emotions is very much about suppressing personal emotions when interacting as a public servant with the customer. The argument for emotional work appeared evident in fig 13 There are high intensity responses to prioritising women and personnel effort for service delivery. The indication is that no matter how hard 'pushed' the nurses are, they are managing their emotions with women, as 76.9% (20) are appreciated by the women all or most of the time, and their clinical peers. Were they not using emotional work they would be reflecting Lipsky's (1989) model of reaction to pressure, which is to block and only do what is required of the role.

Professional jealousy

In Chapter 7, Holly and Alisha specifically identified problems that they had with relationships. These gave an insight into how a lack of understanding can escalate into a jealous / bullying type situation. Liz 2 was equivocal yet the comments were in contrast to those of Rose and Lucy. I have already suggested that these two were adept at game playing, however it might also suggest that they had high level of emotional intelligence that facilitated their avoidance of conflict from the start.

Earlier I talked about the impact of business plans, and I need to return to this again. Halford et al (1997) talked of the significance of strategies or plans; this may be for the organisation or the individual. The NHS is currently full of plans. In this rational approach to organisation two features are at play. One that the organisation recognises and identifies key "actors" that are going to expedite its plans, and secondly, that there are "actors" who are prepared to gain visibility that comes from doing something different. It was Barton (2006a) who noted that 'successful' advanced practice nurses had made successful social adaptations. Some of the nurses had applied for the role, and for others it was a natural progression from what they were doing. Placing oneself or accepting a position that leads to a perceived area of power can cause unexpected reactions from co-workers. As reported by Rothstein and Hannum (2007) making oneself visible through a lead role is not commensurate with femininity; and is a gendered issue.

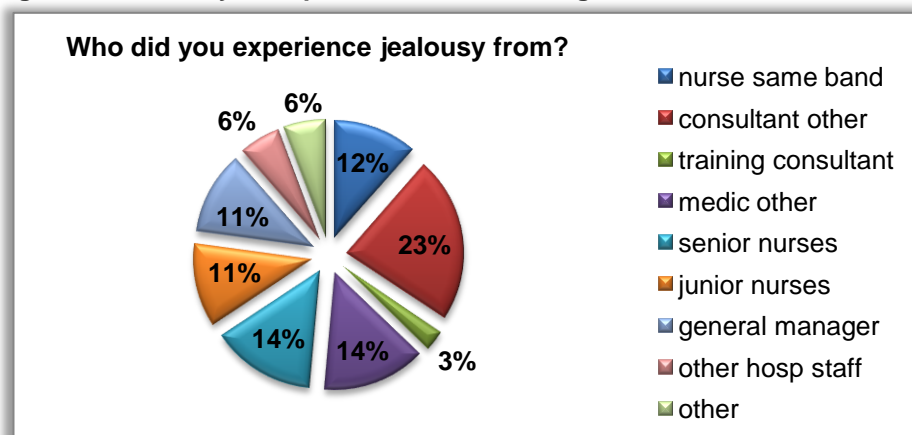
In Chapter 6 I referred to Alisha as having had a particularly challenging time with her organisation and particular staff that she worked with. Whilst it had been the

consultants' idea to set up the hysteroscopy service, the Matron had operationalised it. Alisha and other nurses "as actors" were quite open in that they had found the cognitive element of the program a challenge. On completion, Alisha's new trainer was confident with her abilities and the service was starting to evolve, but she chokingly recalls that,

"It was ascertained that um consultants were sending me through patients and expecting me to do things which the hospital then decided it was out of my remit, I didn't have any support um. I had to do all my own protocols all my own guidelines... the head consultant had agreed to them but then it was found out that the medical lead for Gynae was then told this is what I was doing and then it was reported to the hospital management... er... to cut a long story short they felt that legally I wasn't covered to do the job that I was employed to do... so... um basically I felt extremely let down and um... and I was put through a hell of a lot of stress because of it and then I personally felt I was being bullied by my senior nursing team on my ward... and basically they were going to report me and take disciplinary action against me."
(Alisha)

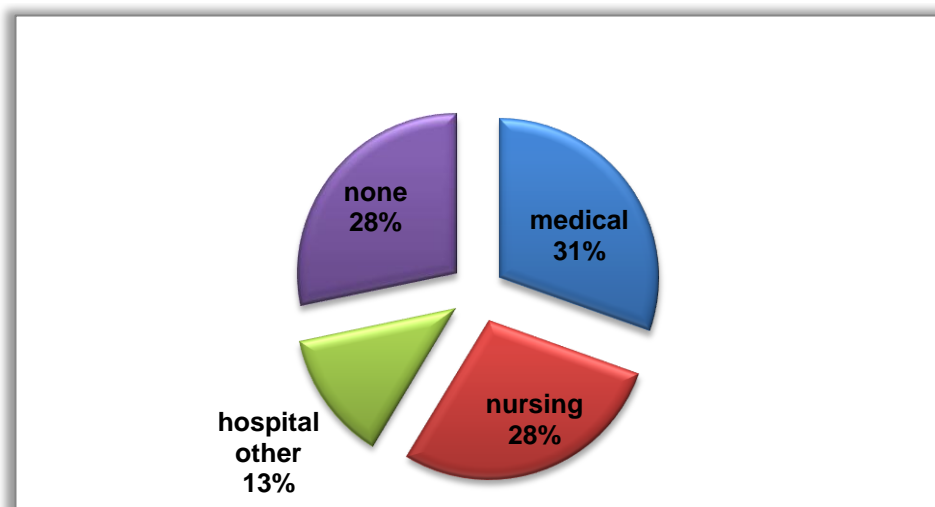
I have already illustrated that Alisha is still clearly affected by the circumstance she found herself in. As an observer it appears there were two levels of jealousy; one at a ward level, the other medical as she went on to describe how the new lead consultant did not like how his peers were "*taking the initiative for service improvements*". This appears to be an example of what Mann (1997:4) described as 'intra and inter group conflict'. Whilst this is the most dramatic example that included a specific reference to bullying, other nurses also commented on actions by nursing peers and doctors that are indicative of jealousy, both across professional and between professional groups. It was because of this and comments in the second interview that I explored the expression of jealousy further in the survey group. 13 (50%) said they experienced it, 2 (7.7%) were not sure, the remainder had not. Fig 14 provides an indication of how frequent experiencing jealousy was.

Figure 9 Jealousy is Experienced from a Range of Staff



On deeper interrogation of the data of the 13 replying positively, two only experienced it from an individual, 6 from 2 people but most seriously 4 experienced jealousy from 4 or more groups of professionals, making a total number of sources of jealousy from 35 people for those 13 individuals. A breakdown of the data indicates that nurses are almost as likely as doctors to be culprits. Fig 15 illustrates this.

Figure 10 Jealousy by professional groupings



The “other” were from staff in departments the nurses worked with such as ultra sound and theatres (Appendix 6). NHs20 specifically refers to staff in ultra sound and theatres. The table in Appendix 5 provides examples of how jealousy was manifest for each of them. Collectively, the details indicate how differently jealousy was recognised depending on where the person or groups were in the organisation.

We know from descriptions and maps in Chapter 6 for Lucy, Rose and Elizabeth support from their nursing peers was very supportive, but the evidence in fig 15 tells another story. In the introduction, I had identified that the BSGE was supportive of nurses taking on the new role of nurse hysteroscopist. Perhaps as Walby and Greenwell (1994:62) had identified, medical staff proposing change were willing to support nurses' development. Whilst for those not party to the proposed change in occupational activity pre-empted by a service redesign it is threatening. The realisation that praxis can mean a change, however small, can impact on power dynamics and is disconcerting for those it will impact on, as was seen by Holly, Liz 1 and the qualitative comments from survey participants

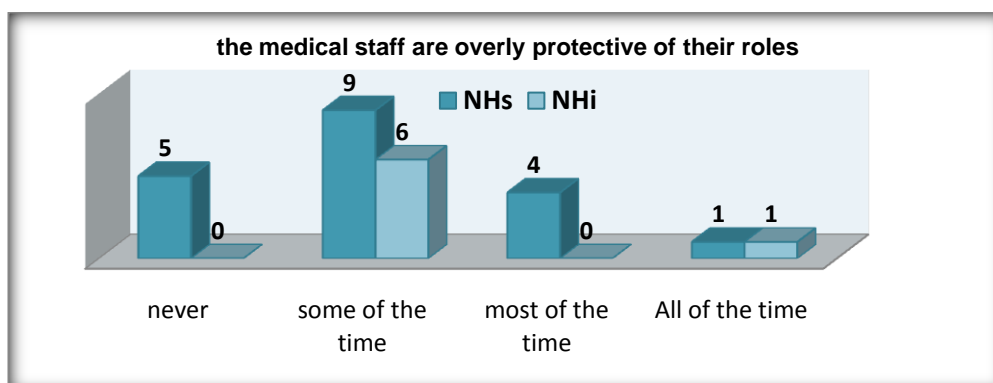
(Appendix 7). Earlier Lucy described how she sought out advice from the paramedical staff as the service was set up. As in Wood's (1998) study, being able to negotiate their way through work situations contributed to successful development of advanced practice roles.

Offering explanations

Whilst Hochschild (1983) examines how gender impacts on emotional management, she only talks about jealousy briefly (1979:74) in association with private personal relations. However, if we transpose those feelings into a professional context, there appears to be evidence that staff are acting out of hurt, betrayal and fear (see Appendix 6). Hochschild (2003) suggests that when 'roles change' so do the rules (2003:74), and that 'punishments' are meted out, Hunter (2004) (Appendix 6). Ferrara-Love (1998:301) relates female jealousy to 'someone's success or their own insecurities'. In the literature review, I referred to playing 'the game'. This was about interpersonal interactions and the use of femininity / masculinity to manage situations. Ferrara-Love also uses the term 'games' and suggests that both genders revert to the games children play. For women being 'nice' is a corner stone of success; to ensure that women are portrayed in the best light they will reform alliances. For Hochschild (2003) and Miers (2000) 'nice' and modest and avoiding confrontations are features of being a good woman. Ferrara-Love suggests that nurses will change their alliances to sabotage the person they are not happy with. Whilst she lists ten characteristics, only some are identifiable from what the nurses have articulated. These are: a threat through reorganisation (Alisha, and NHi25 in Appendix 5), role changes (Liz 2 and Elizabeth), authority bypassed (Liz 1 and 2), and information bypassed (Alisha, NHi22 in Appendix 5).

Without talking to their peers, I cannot confirm the strategies the NH experienced. However, here is evidence that the nurses were performing the 'collegial' interactions as described by Theodosius (2008). The nurses were working to maintain the social fabric within their units rather than challenge it. An explanation is that the manifestations of jealousy across the professional groups is reflected by being protective, particularly doctors and nurses and is reminiscent of features associated with occupational closure that I identified in the literature review. Fig 16 illustrates that only 5 NHs felt that it was never an issue for them or the medical staff.

Figure 11 NH ratings of medical staff as being protective of their roles.



In the previous chapter, I included a quote from Holly when she was reflecting that, "*other consultants needed reassurance*" and that she and her trainer had to offer reassurances to those concerned. It seems that there is evidence that other nurses are finding that medical staff projected their anxieties about role erosion to the nurses. However, on cross-referencing the data between survey questions on business planning and jealousy there was no evidence to suggest that the presence of a business plan stopped the experience of jealousy.

Using self to manage situations of jealousy

The NMC have put the 'use of self' as a key skill attribute for one of the few CPD programmes they prescribe standards for (NMC 2006, 2008a and 2008c). But what does this mean? Two theoretical areas were considered in the literature review; emotional work and intelligence. There is yet further evidence that the nurses were frustrated at times, yet at no point do they appear to have been angry interactions or to have used anger. Whilst there is evidence that some with the appropriate status have been able to propose development, Holly and Lisaden, the power associated with this has not been sustained into dealing with conflict. However, equally interesting are the responses given below on how to manage these difficult situations which are indicative of managing emotions:

'Leading from the front, always polite, totally professional, let my 'work' do the talking.'
(NHs21)

'getting them involved.'
(NHs15)

'Approached person(s) concerned on one to one basis & identified what the actual issue was. Discussed my role and training programme, stated I was not a threat to them. I was keen to learn and develop working partnership with them. I listened to what they had to say, their fears,

made sure I was approachable and answered their queries and concerns honestly. Suggested they may wish to undertake further study.'
(NHs20)

'Nearly had a nervous breakdown, Support of friends and colleges and (names organisation) decided to fight and show them I was right! I am now a stronger person and I have had my success in the long run. I was told to believe in the fact that I was a good hysteroscopist and had acted according to my training.'
(NHi21)

'Tried to maintain a calm atmosphere and just get on with my job.'
(NHs24)

And for the medical staff:

'By getting them on board, constantly discussing the benefits for the patient.'
(NHi1)

'Understood difficult position to be a new consultant able to discuss openly and develop mutual respect.'
(NHs6)

Three took their responses further and recognised the association with the whole organisation, for example:

'I have just carried on doing my job. In my opinion, they are the ones with the problem, not me. I have a job of work to do that my organisation has deemed necessary.'
(NHs18)

NHs9 was concerned that the operational decisions by her Trust would have an impact on her. She appears to see what is happening as corporate jealousy by the two other hospitals in the Trust who she believes are jealous of the service that she and her peers provide. This has led her to respond in the following way:

'I am currently gathering data to support my practice, to add weight to my position. I have many achievements which should not go unnoticed - but do they have to acknowledge these when designing a job plan to 'suit' the Trust? How much of the job plan has to tie with the organisation and how much with the nurse (maintaining current skills, external commitments, special interests). The Trust is considering losing one aspect of my role that I am highly placed nationally and have had a major input into locally. Can they remove that skill from me?'
(NHs9)

This activity is a response to try and influence what is happening. Where some have confronted the individual or used their practices to speak out, she has taken a systematic approach using 'rational-legal authoritarian' that a Weberian organisation would recognise (Halford and Leonard 2001). Finally, Liz 1 had this to

say in her interview:

“Lots of skills interpersonal, you’ve got to be a good listener. You also have to vocalise on a level for people in these different areas (*points at her map 3*) and who you are talking to... You use a totally different language. You uses the same words... for example the medical staff don’t want waffle, they want the facts, precise. When you go to the admin staff they want it chatty, take more time and flower up the same things, not just social chit chat.”
(Liz 1)

Liz 1 describes how she is adapting what and how she communicates on a daily basis. We had a discussion about any gendered associations with roles and how she adapted herself. Liz 1 identified that she talked to male secretarial staff as well as female medical staff. In the literature review, I talked of emotional intelligence and its association with advanced clinical practice (Salovey et al 2004). I conclude that the nurse hysteroscopists are using emotional intelligence to manage the emotional work associated with advanced practice, and have established their own forms of resilience that do not correlate directly with those proposed by Jackson et al (2007). What I have been done is return to Table 2 in the literature review on Goleman’s attributes of emotional intelligence and have collated the evidence from the data into table 8 below.

Table 8 Nurse Hysteroscopist are displaying emotional intelligence?

Element	Emotional Intelligence Attributes from Goleman 1998.	Evidence from the Nurse Hysteroscopists
Self -Awareness	Being able to recognise how one's-self is feeling. This helps the individual manage interactions with others.	The nurses were frustrated about lack of recognition and have negotiated, however they are negotiating their way through the pay bands as well as the development of services.
Emotional Management	Being able to handle feeling down, finding a way through towards a positive outcome - 'bouncing back from upsets' - without the distress increasing.	With the exception on Alisha and two survey research participants, there are no comments that they have been overwhelmed or unwell.
Motivation	Controlling impulses to prevent peaks and troughs of activity. Being thoughtful and considerate.	The nurses have had to keep going through adversity. They are concerned about their posts (Appendix 6, 7) but continue with optimism (Appendix 10).
Empathy	This requires being in tune with others, reading the signs of others' emotions and responding.	Holly and Liz 1 particularly articulated this and how they have used it to improve situations between staff.
Managing relationships	Relates to a social competence that encourages followers and co-operation. A person's skills make others feel better about themselves.	From the comments on managing jealousy, the nurses believe this is case (Appendix 5). Additionally nurses see that their practice has improved the situation for women and staff in their departments (Appendix 8, 9, 10).

(Compiled by the author 2010)

Facilitating and hindering nurse hysteroscopists

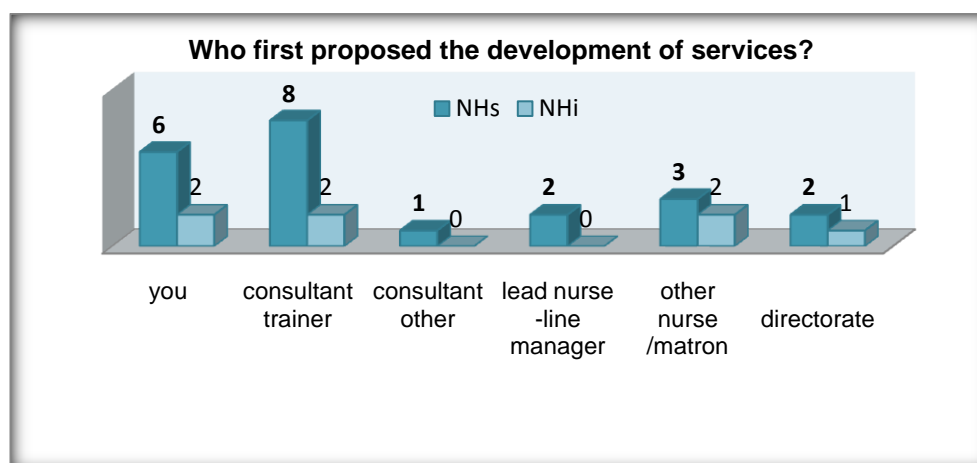
One of the research questions was to assess the factors that may have impacted on the nurses' development. It was clear from the stories that there was either a lack of planning or a clear sense of direction. For some this appears to have added a layer of complication to their developmental journeys. There is an expectation in most organisations that business planning should be clearly articulated so that continuity can be maintained. As already seen previously, when key staff leave, even if they are not directly involved with care, service development and commensurate training can be affected. Working on feminists' notions that knowledge is power, it appears important that nurses should have some knowledge about systems within their trusts (Halford et al 1997; Doyle 1994; Allan 2004). This formed an area of questions to be discussed next.

Evidence of organisational effectiveness: Responding to demand

On page 39 I explored the PEPPA model of Bryant-Lukosius et al (2004) and in Chapter 6 the nurses described how they had come into hysteroscopy via different routes, and the frustration that plans were not always followed through. There is little evidence to suggest that the nurses' experiences were the results of the application of an advanced practice framework.

Fig 17 illustrates that more of the survey group were key in the initiative to develop hysteroscopy services; perhaps a reflection of their relatively senior roles. Two of the three free text responses indicated that they were the second person in their unit to take on nurse led hysteroscopy.

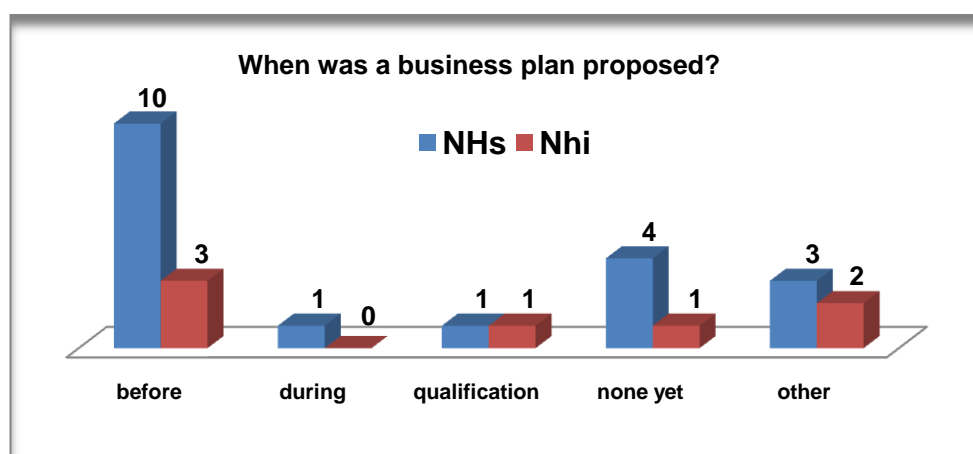
Figure 12 Who Proposed Developing a Nurse Led Service: Similarities between Participant Groups



In part, those having been proposers should arguably have been using a model such as PEPPA. Nurses accessing the NH course require a manager and trainer to agree to support the work based learning element of the programme through appropriate clinical experience, support and opportunities. In order to thrive as an organisation not only does it need to use the intelligence of its staff but also have a plan (Bryant-Lukosius et al 2004). Table 18 suggests that there was variation in the timing / existence of planning.

Some, for example Sam and Liz 2, were clear that this was to meet the new cancer targets (DoH 2000). In chapter 6, I identified how Sam and Lisaden had been party to defining their own service / career development whilst in other stories, plans had been put in place but if an individual manager or consultant left there was no record of a plan, or other managers were not prepared to continue the support (Alisha).

Figure 13 A Business Plan was Proposed Before Training



The first free text comment was made by one of those who met me:

'It was all a bit sketchy as no one really understood the hysteroscopist role within nursing and how it could be developed to improve patient experience and service. Also vast management changes over this period of time (these are still continuing today) meant the momentum was lost time and again and no one really took ownership to progress the service.'
(NHi1)

There appears to be a lot of indecision here also:

'There is not a set plan although verbally the plan is to develop the nurse hysteroscopy service to help achieve government targets.'
(NHs6)

Others had a clear sense of direction:

'My role will develop to extend the current clinics from 2 to 3 per week.'
(NHs7)

And:

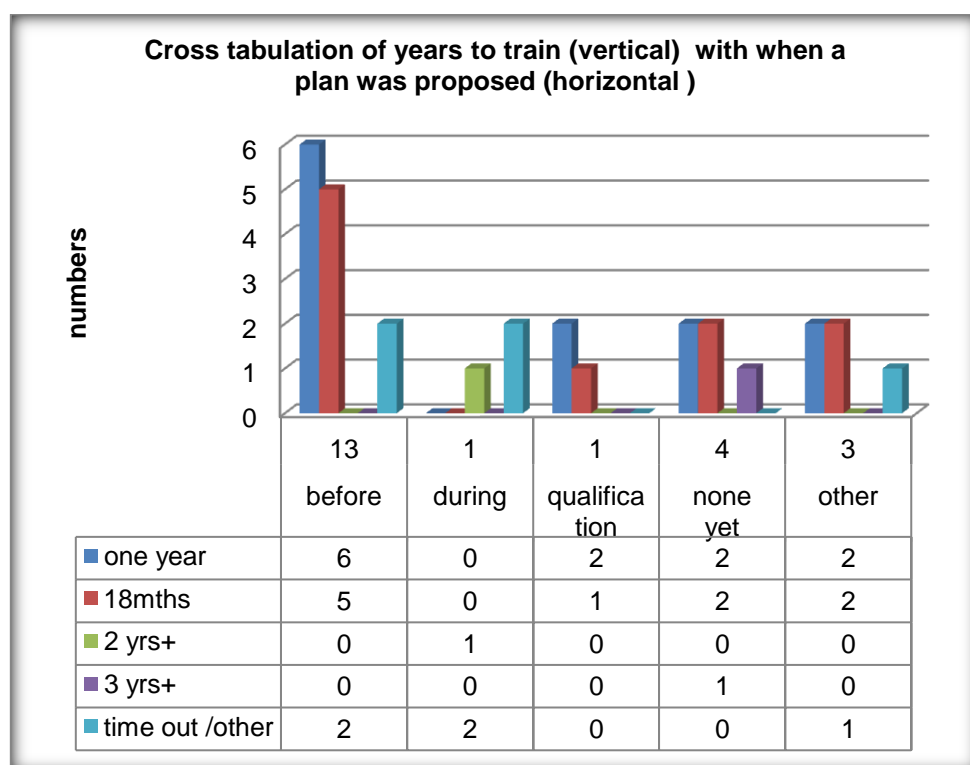
'Recent change of workload, probable business plan for this though I was not involved in the process.'
(NH12)

On reflection, it might have been useful to explore with whom and at what level in the organisation the plans existed. There were significant reforms to the NHS in the 1980s with career restructuring and the introduction of grades of staff and specialist practice. The intent was to shift the balance of power from any one professional group to professional managers. This occurred as part of a whole set of 'restructuring paradigms' in the 1980s. Halford et al (1997:65) provide the context of economic restructuring, and whilst that was initiated over twenty years ago, arguably there is an ongoing progression of economic frugality dressed up as improved service delivery, using nurses in medical roles such as the nurse hysteroscopist (Milburn 1998). Whilst the development of clinical roles has liberated female nurses to reach new clinical potential, the removal of managerial nursing posts has removed the higher levels of power from nurses (male) that previously held those positions (Meirs 2000). Changes that disempowered nursing managers by the removal of tiers of nursing management in the 1980s have been detrimental, as a void was created between the operational and the organisational power bases. It appears that there may be evidence from what the nurses are saying that the 'void' Savage (1997:130) warned about during career restructuring is still there and that it is detrimental not only to the service but to personal relationships within an organisation. Liz 1 and Holly are evidence of the new nursing careers but only they appear to have any operational power. Equally, NHs9 has articulated the problem of stasis due to a restructuring void.

Developing the argument further, the current bureaucratisation of business, including the NHS, still requires a masculinised business framework (Halford and Leonard 2001). In such a world, a business case for new developments should be made. Whilst there are connotations for gender attributes to be able to do this, these are not for discussion here, but the potential consequences of not completing a business plan are. I was able to cross-examine the data. I wondered if there was any correlation between those who took more than two years to complete the programme with having a business plan in place.

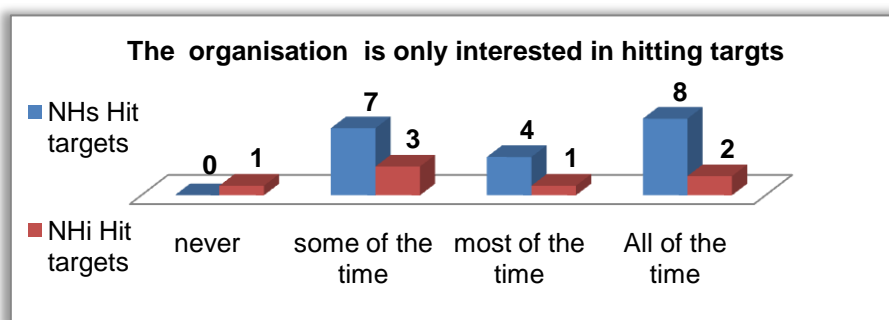
There is no evidence that this is the case, see Fig 19. The stories created awareness that when no one takes ownership of the plans (Alisha, NHs9) there are consequences. It is not just planning to have a service, but may impact on the nurse training. Additionally in the Appendix 6 some of the survey respondents talk about the problems of consistent trainers to oversee their development. Previously, Elizabeth gave one of several illustrations of the nurses' frustration with the lack of their own control and that of others in the direction of the service. As a course team, we will never be in a position to dictate on business planning. We do currently offer guidance and support for protocol development to nurses who come for training and we also offer assistance to managers and trainers about the course. Perhaps there is scope for a question and answer section on what to do if organisational changes occur.

Figure 14 A Business Plan Shortens Training Time



What we have seen already is that business planning alone can translate into a coordinated approach to staff development. There may of course be other imperatives associated with the economic imperatives of business cases, targets being a case in point. Simultaneous to the development of nurse led hysteroscopy services meeting Government's agenda for changing services' delivery by using new skill mixes, has been the development of commissioning services by the primary care sector and monitoring by the Quality Care Commission (DoH 2009c). The latter's role is to measure against targets; this has a significant impact on Trust income. Target measured performances of specific relevance to hysteroscopy are the cancer targets for post menopausal bleeding (PMB) (DoH 2000b). Sam had mentioned breaching and Liz 2 specifically mentioned breaching the latest targets as an issue (see p124).

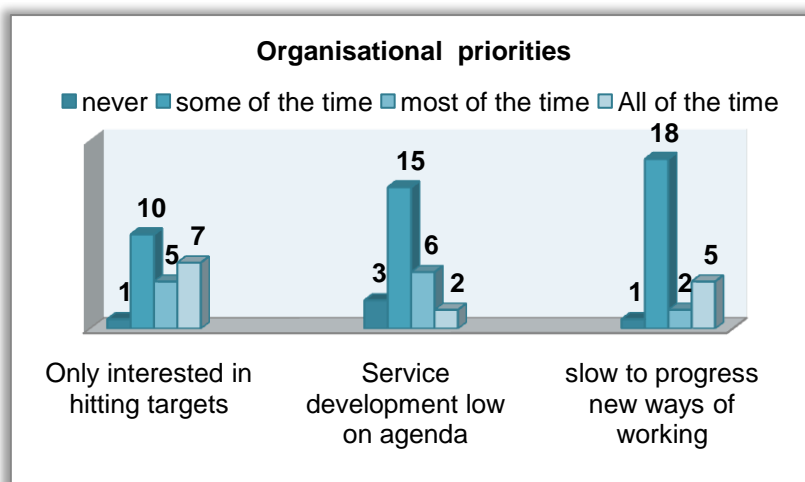
Figure 15 Targets are Important to the Organisation



The survey group rated their organisations in relation to the importance of meeting targets (Fig 20). The nurses' perceptions of their organisations seem split with 2 of them believing the focus is on targets all the time or some of the time. In order to meet government targets the organisation may need to initiate change and set organisational priorities.

Fig 21 is quite complex but provides results for three of the key agendas. This shows that, for each category I asked, 'some of the time' was the main response.

Figure 16 NH ratings of their organisations' attitude to government targets.



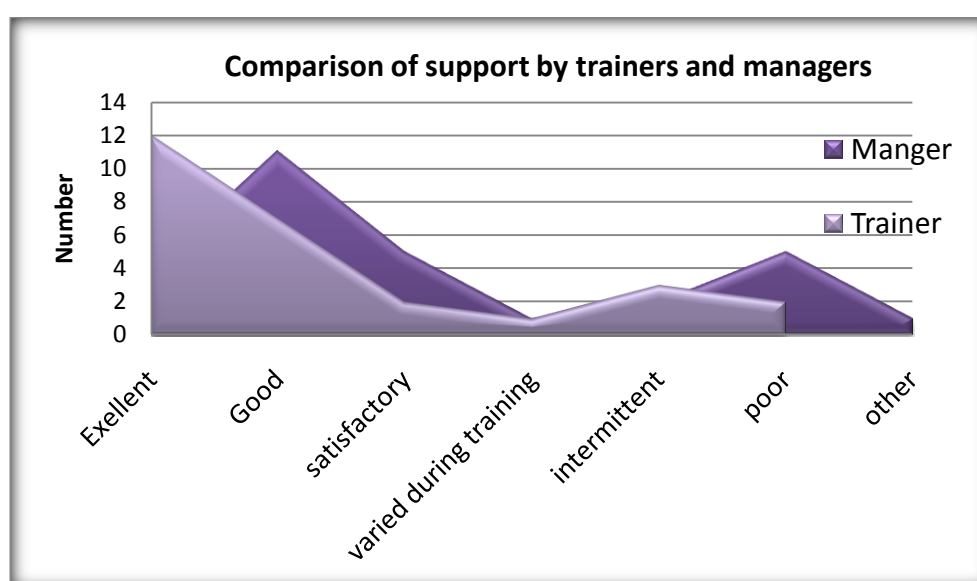
As a grade seven, nurse hysteroscopists will be responsible at an operational level for meeting the targets. However, frustration exists; they are powerless. Their organisations show a lack of matching sense of urgency, with 15 respondents saying that service development is low on the agenda some of the time, 18 whose Trusts are slow at finding new ways of working 'some of the time', and 5 'all of the time'. This reflected the experience of those interviewed and is counterintuitive to the government's policy identified in the literature review, which says service redesign should be high on the agenda. This suggests that Trusts are sluggish in

finding new ways of working.

Vision and support

Through the nine stories, examples of support and or lack of it were given; with the sense that trainers were supportive and managers less so which led to the conclusion in chapter 6 that support was important. On further examination of the survey data (Fig 22), the NHi responses indicated an even spread across the range of options, with less at the extremes, which is why I gained a greater sense of ambivalence about aspects of their support.

Figure 17 Trainers provided better support than managers



In Fig 22, twelve of the nurses rated their trainer's support as excellent and whilst a similar number, eleven, of the managers were rated as good, the distribution for the managers was more equivocal overall with ten recording the support as intermittent, satisfactory or poor. Appendix 6 presents the textual comments and compares the positive and negative responses to the question: 'In your practice settings were there specific issues or people that impacted on your training?' In Appendix 6, I highlight the number of times the phrase 'support' is used. As can be seen, the term 'support from the clinical staff' was present in a number of responses although NHs21, NHs24 and NHs25 illustrate that not having support was not unique to the NHi group. The positive responses also provide insight into what the key areas were. Unfortunately, NH16, NH17 and NH20 whilst having positive experiences, offer no additional suggestions. Norman and Peck's (1998) study identified that managerial credibility in leadership was important element for advanced practice to develop.

Next in Appendix 7, three nurses have made comments identifying what would have helped in their development. NHs9 uses the term 'nurturing' in her response. Her use of the term 'nurturing environment' is reminiscent of the emotional contexts discussed in the literature review, both as a construct of gendered roles (Hochschild (2003) and based on the evidence from previous studies Strazdins and Broom (2003). Other NHs make specific references to study time and educational support for themselves from their managers and the university. This latter point has been noted. From the university perspective there is academic support by phone or e-mail throughout the course but it is one of the challenges associated with a remote provision. This illustrates why there is a feeling of isolation that some of the nurses felt. Having recorded some positive comments there were also negatives in NHs9's overall survey responses. She had praised her original trainer but of the one that took over she says,

'Does not support therapeutic training. Does not seem to have vision and plan for the short, med and long term. Puts the training of the consultants first and consider the nurses as GAP filling.'
(NHs9)

The 'gap filling' phrase resonates with the fear that Liz 1 had (Chapter 6) and descriptions found in Walby and Greenwell (1994). This appears to support the notion that the nurse is there for the task rather than as a professional with complementary skills (Halford et al (1997). This is at odds with the intent for nurses to take more of a lead through advanced practice.

What can be concluded from the evidence is that the nurses' experiences are dependent on the reactions of specific individuals within their network of professional relationships. The organisational responses to the governments' objectives for change are inconsistent, and there is little evidence of state power controlling professional expansion at lower levels (Savage and Witz 1992).

Advanced Practitioners

The last research question was whether nurses were functioning at the level of an advanced practitioner. The characteristics defined in the Council for Health Care Regulatory Excellence [CHRE] (2009) report require evidence of; direct complex care, leadership, developing support systems, transforming clinical service, education, research and publication, ethical practice of autonomy and integrity. These terms emerged after the survey was prepared and so there is no direct evidence to confirm the nurse hysteroscopist activities against all these criteria.

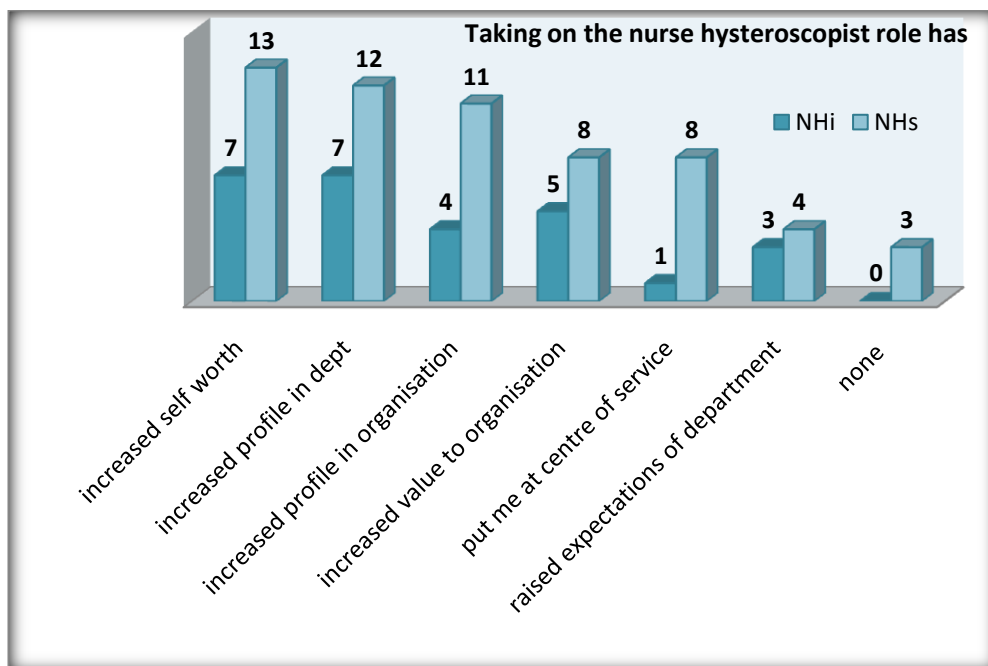
However, there is implied evidence which follows.

Pay banding using the KSF provides one crude indicator which includes most of the above listed attributes. Using that as a basis on which to make an assessment, 14 nurses are classed by their role profiles as advanced practitioner, the remainder as specialist role criteria.

Recognition

The nurses identified that they had less regard from their line managers. Norman and Peck (1999:288) made an association with '*manager credibility*' and advanced practice. Arguably, there is evidence that hysteroscopy nurses have sought self-worth and want to be held in positive regard not only for themselves but also for their colleagues (see fig 23). Positive regard is an ethical principle that health professionals are expected to have for the patients (NMC 2008), adopting this belief that this is important to the development of inter-professional relationships, particularly when fiscal reward may not be easily forthcoming. In Chapter 3 it was questioned whether the potential to take up an advanced nurse practice role was an altruistic one, that nurses would do it for the benefit of women as part of their contribution to the organisation and the well being of women's health (Doyle 1994).

Figure 18 Benefits of Becoming a Nurse Hysteroscopist



I was aware from the stories that, whilst there had been frustrations, no NH would have taken a different path as new horizons had been opened up to them. In response to the question 'Taking on the nurse hysteroscopist role has:' I enabled them to answer more than once so as not to make them choose just one facet (see Fig 23).

Appendix 8 provides the textual commentary on how the nurses believed they are making a difference through the scope of clinical decision making and / or services that the NH are managing. Despite some of the interpersonal challenges highlighted, there was no particular evidence that the nurses believe they were exploited. For the moment, as Lipsky (1982:25) suggests, there appears to be reciprocity between managers having organisational objectives achieved whilst the worker is taking an opportunity to maximise their own autonomy to improve client outcome. The evidence for this emerges in Appendix 8, where two participants focused specifically on professional relationships; identifying specifically that the opinion of the medical staff and peers was important to role recognition. This has changed the dynamics of their interactions. In the literature review, I considered the power dynamics between professional groups (Hugman 1991 and Davies 1992). The survey supports the stories that peer recognition and role profiles are important.

Some responses from the others were different (see Appendix 10) as there is evidence of tensions and frustration. NHs4 alludes to pressures that she has not expressed anywhere else in the survey despite the free text opportunities. However, this comment made me stop and review her overall responses; she is one of four NH still in training. NHs4 is one of the individuals who identified experiences of jealousy from five different staff groups. Furthermore, she does not think that her manager / organisation or trainer rate her skills or knowledge very highly. I then examined the others in training. Two reported no jealousy and the other refers to the 'fears' of medical staff (NHs6). This frustration at not being recognised and valued is reminiscent of Staden's (1998) findings for nurses taking on advanced practice roles discussed in Chapter 2.

Meanwhile, in Appendix 10 NHs9 provided us with further detail about how the nurse managers appeared torn between their responsibilities to the organisation and to their profession (Martin et al; 2006). This has created an irresolvable dichotomous tension. What was not immediately clear was whether this was about the managers' concerns about their nursing careers or the service. This greater understanding about what is going on within her award-winning organisation is more poignant as it helps us to understand the impact of organisation culture.

'Instead of running with a tried and tested model (such as ours) there have been meetings about meetings to decide on a suitable service model. The jury is still out. They even marginalised the "expert consultant" rather than ask him to implement any changes... This means a degree of marginalisation for myself and perhaps loss of grade?' (NHs9)

Here NHs9 is letting us know something of her own relationship within her organisation and reflects the significance of tiers that Hunter described (1994). Lipsky (1982:19) would suggest that this is an example of the street level bureaucrat's concern with maintaining authority. There is a dichotomy between being compliant with her managers and retaining her professional status. (Halford et al 1997) consider individuals reflect the organisational cultures by their responses. Throughout the findings glimpses of frustration surface; there emerges a sense of wanting to, but not being able to, 'belong'. NHs9 has clearly reported a threat to herself with the anxiety that there will be a status (and fiscal) implication to any decisions. At this time she is powerless, everything happening around her not with her. Without a resolution there is the potential to impact on her wellbeing (Stazdins and Broom 2003).

Conversely we have optimism from NHs20, (see Appendix 6 Table 16) describing who she has established relationships with using characteristics of leadership, yet feels isolated as the sole NH. The very nature of an advanced practice role means that the nurse is likely to be on her own but, as we have seen from the stories, Liz 1 was part of a nursing group looking at developing key roles, Holly had support from clinical supervision rarely used in nursing, and Lucy had an advanced practice group. As a collective case group only 10 (38.5%) of the nurses knew there was an advanced practice group, a similar number, 9 (34.6%) thought there was not, and 7 (26.9%) were not sure. Again, in the question about being involved in Trust decision making about outpatient services, nine of the nurses had been involved throughout their nurse hysteroscopy careers, eight from before their training and 9 since. However, there were four where there had been no involvement or only informal involvement in discussions. NHs9 again provides the most detail about what was happening at her Trust:

'Currently, since my Consultant mentor retired in Feb 09, there is a review of my job role. There is some confusion regarding my independent practice (nurse led) services. The NHS commissioning documents mention 'consultant led' and I think this is being interpreted as working with a Consultant rather than a "named lead". Also, there is confusion regarding seeing target waits; some nurse hysteroscopists only do PMB clinics. It would be useful to have BSGE recommendations for nurses' services.'

(NHs9)

This plea seems to play against the ability to participate in leadership and operate at the advanced practice level. As the study progressed, it became clear that the organisation, whether it be at a departmental, directorate, or Trust level played a significant part in what was happening as the nurses trained and practised.

From NHs9 there is evidence of confusion in roles. Chapter 3 considered the use of Ackerman et al (2000) model to establish evidence of advanced practise as supported by Gardner et al (2007). The direction of the stories and subsequent survey questions did not lend themselves to a full analysis against the criteria; however with the exception of research publications there is some evidence against the criteria that nurses are working as advanced practitioners (see Table 9).

Table 9 Assessment of Advanced Practice against the Ackermann (2000) model as cited by Gardner et al (2007)

Categories and Features	Evidence
Direct comprehensive care procedures, assessment, interpretation of data, patient counselling	This is the role of the 'see and treat' nurse led hysteroscopist
Support of systems professional contribution to optimal functioning of the institutional nursing service	Those at nurse consultant level are able to do this, Holly and Liz 1.
Education enhancement of caregiver, student, and public learning related to health and illness	Not assessed in this context. However there is evidence from the stories that nurses are teaching others: Rose, Lisaden, Liz 1 and Elizabeth
Research supports a culture of practice that challenges the status quo and seeks better patient care through scientific inquiry	Not assessed in terms of research output, and none found on an internet search
Publication Professional leadership promote dissemination of nursing and health care knowledge beyond the individuals practice setting	Ludkin and Quinn (2002) Mills (2006), Martin (2010) ⁵⁷ , however these are not about clinical outcomes, only skills development NHs3 <i>"Developing a nurse led hysteroscopy service on 3 sites within the Trust has become a huge personal and professional achievement, to the degree that I have been asked to present in BADS meetings in the UK and Australia."</i> NHs10 <i>"Before I commenced training, outpatient hysteroscopy was one session a week with the majority undertaken in theatre. The service now has 6 sessions a week and the majority are performed in outpatients. The service ties in with the menstrual disorders miscarriage and oncology pathways this has highlighted the service throughout the trust."</i>

(Created by the author 2010)

There is also evidence to suggest that risk assessment model developed from the

⁵⁷ These references were found from internet searches and the author cannot identify whether or not they participated as research participants in the study.

Lloyd-Jones (2004) meta-synthesis should be used too. I drew together the evidence and transposed the activities that have impacted on nurse hysteroscopists to create a new profile (see Table 10, next page). In the risk model there appear to be tensions that are reminiscent of the occupational closure as described by Witz (1990). I was beginning to see a relationship with the elements that made up closure; I started to call this organisational closure.

Table 10 Risk Assessment of NH Working in Nurse Led Services (Adapted from Lloyd Jones meta-synthesis 2003)

Aspect	Meta synthesis results	Evidence from NH
The practitioners' characteristics	The most common terms were Confidence, adaptability, assertiveness flexibility and negotiating skills	Sovereignty, autonomy, and independence, emotionally intelligent Evidence of power suppressed
Practitioners' experience	Being familiar with the organisation and its structures, and service, 'substantive' experience in the specialty,	Experienced clinicians leading a service but reliant on the organisational structures to be enabled to work with the many gate keepers to service development
Professional	The ambivalence of regulatory bodies at that time and lack of articulated career pathways	Still evident however the new head of the NMC is preparing to revisit, in the light of the CHRE (2009)
Educational	The UK studies identified lack of relevant courses, mentors, regulation and standardisation	Recognition of the need for theoretical understanding. However lack of support during training. Level M creates challenges (CHRE 2009) is positive but could be seen as a threat.
Managerial and organisational issues	Role ambiguity and workload	Nurses are clear about their roles but others around them were not, leading to conflict or non attainment of clinical objectives.
Relationships with other health care professionals.	Resistance to change from medical and nursing staff	Evidence of jealousy for a third at all levels of the organisation, with resistance from nurses and antagonism from medical staff
Resources	Mostly associated with being new in post and not prepared.	Poor business planning, lack of clinics, excluded from clinical and organisational meetings

(Compiled by Author 2010)

The phrase organisational closure reflects a series of observations that I have made from the evidence collected. On page 131 I described how there appeared to be tensions not just between professions as were expected, but between structures (departments or directorates) too. Here I developed a model of forces on the need for change (see Fig 11). It could be argued that Weber's model of closure could be applied to various levels within organisation. Bureaucracies, in particular the NHS, are gendered not by the mix of personnel but by the styles of management (Halford and Leonard 2001). Whilst examining the work of Lipsky (1980), explanations are proffered through management and professionals in the absence of gender. During the interviews I was struck, in particular, by what the

nurses were describing which appeared to be evidence for occupational closure as described by Witz (1992) and Walby and Greenwell (1997:63). However, rather than this occurring by a professional group it was being done by organisations through their bureaucratic structures.

Table 91 Model for developing nurse led advanced practice see and treat services.

Characteristics	Routes to Success	Rationale
Educational ability	Have achieved a higher level of study above that of initial registration ideally.	Nurses will be expected to work on a par with medical colleagues, must be able to integrate and apply nursing and medical knowledge and clinical evidence. CHRE (2009) Minimum is postgraduate.
Appointment to role	Open invitation. The nurse to be appointed to the position, or redeployed into the role, using a profile and specification that includes educational needs.	Nurses in the study came to the role in an eclectic route. Opportunities may not have been available to others. Role profile and specification provides something that achievements are measurable against during and after training completed.
Service planning	Service development plan approved at Trust Board level, or through service development group working on behalf of chief nurse and the executive. To include budget for staff development and clinical facilities	Nurses that had higher levels of organisational infrastructure (see fig 10) whilst not problem free had an appropriate network of support.
Apply change management tool	The implementation of goals that include monitoring of work based learning competencies, income generation / savings. Increase understanding between other staff of organisational objectives.	The nurses were frustrated by the loss of staff and changes in direction, which they believe impacted on their ability to function appropriately.
Measures of success	Use the neo-liberal framework proposed by new government (DoH 2010) to respond to changes service delivery and technological development	Women requesting the service as part of patient choice. Increase numbers of women in 'see and treat' services = reduction in costs. Nurses proposing new opportunities.
Maximise staff potential	Chief nurse to create a forum for staff at Grade 7 and 8 to discuss and advise senior managerial colleagues on operational objectives	The nurses in this study were frequently frustrated and undermined by the lack of recognition in their understanding of service needs that are associated with their grade 8 skill set.

Created by the Author (2010)

This is reminiscent of occupational closure yet not about gender per se but the hierarchies that make up organisations which are being controlled by the state. As a consequence, as a result I propose that the model above, and propose it should be used when developing a nurse led service.

Summary

In this chapter, there is evidence that there are inconsistencies in planning an outpatient 'see and treat' hysteroscopy service, and how this in turn impacts on how others react to the nurses' new role and configuration of the service. I have presented examples of jealousy from inter professional colleagues and illustrated how Alisha was the exception where the bullying was organisational too. I explored how the nurses have demonstrated the use of emotional intelligence to manage areas of conflict. Using the literature and evidence, it is suggested here that theories of occupational closure and bureaucracy are still appropriate to explain the tensions created by power dynamics within the NHS. Despite the changes in policy direction and shifts in personal power structures from the 1990s, it appears that power still rests with individual roles previously associated with gendered controllers. Reference back to other empirical studies has helped in understanding the current context. Emotional work and emotional intelligence has appeared to be a significant factor in the nurses' ability to understand and mediate their working experiences.

Finally, I have looked at two models that I identified in Chapters 2 and 3 of the literature reviews that relate to advanced practice. I have given consideration against the criteria proposed in those models against the data that has emerged from this study. In conclusion, I have proposed my own model to be used when organisations are planning to develop nurse led services.

In the next and last chapter, I will review the key findings, draw final conclusions and present some recommendations.

Chapter 9

Concluding observations

In this final chapter, I summarise the key findings and draw conclusions. This study has examined the development and implementation of a course that prepares this unique group of nurses in their journey leading the development of new clinical services for their organisations. At the start of the study, I wanted to investigate four aspects of becoming a nurse hysteroscopist. Firstly to examine the professional and social impact on nurses taking on the role, secondly to explore the significance of inter-professional relationships on the nurses and what skills they deployed to manage them; thirdly I planned to explore the factors that may have hindered and facilitated their training and work and finally, to assess whether they were functioning at an advanced practice level.

In the literature review, I considered the political opportunities presented for change, along with a consideration that the role of nurses and women in the health service has continued to change and evolve since theoretical feminist authors wrote about gender and health at the end of the previous century. I have explored the health services in the light of theories on occupational closure, professional hierarchies, feminisation of the health service, and emotional labour and intelligence.

Following the analysis, I developed several models and used existing theories to test out the evidence from this study. I shall refer back to these as I develop my concluding thoughts. However there were two key findings that confirm a social impact on the nurses; Firstly that each individual organisation and its staff, acting as its agents, have a significant impact on the nurses ability to perform. Secondly this is reflected through the how the nurses have to manage the overall relationships through emotional labour / intelligence in order to achieve the outcomes of a 'see and treat' service.

Duality of Occupational Closure

In Chapter 2, I described the dual nature of boundaries as explained by Walby and Greenwell (1994) and I concluded that professional boundaries have not changed significantly from Weber's propositions in the 1960s (Weber 1979). In chapter 7, I prepared Figure 10 to explain how professions are under constant pressure to change or regain control creating a constant set of tensions.

The influences on occupational closure, professionalism and modernisation which are reinforced by the political will have developed during the period of the study (Darzi 2008 DoH 2010). This dual pressure has challenged both professions and organisations to modernise workloads and occupational activity. This has emphasised a dichotomy between those individuals and organisations that see the potential to take on the challenge of change, and those who are concerned or anxious and feel threatened about the changes to their status / power (DoH 1997, Darzi 2009). Liz 1 suggested that there is evidence that social and professional boundaries are not rigid, that there have been opportunities. In the past where the controlling group have changed the lines of demarcation, nurses have been 'allowed' to take up a new area of praxis. This means the controlling group has redefined the boundary and not allowed in the subordinate into their profession. There is evidence that the nurses and their trainers are creating a situation of usurpation where pressure is being resisted by other professionals. This seems to exemplify Witz's (1992) proposition of the duality of exclusion through power and exclusion through occupation. From the data analysed it is clear that the nurses and their trainers have started to create a shift in exclusion by occupation but there is little evidence that it has had any impacting on the source of power. Whilst the nurses can impact positively on the service provision, they are restricted from organisational decision making,

Organisational closure

There is a distinct lack of 'organisational savvy' (Goleman 1996). In Chapter 7, I proposed that I had observed something that I have called occupational closure. I prepared Figure 10 to illustrate how organisations are under similar and constant pressures to change. This was derived from my understanding of Witz's model of occupational closure discussed in Chapter 2.

The NHS is in the public's mind since the new government published its white paper (DoH 2010). The overall hierarchical structures of roles are common to the health service bureaucracies since the general restructuring in the 1980s (Halford et al 1997). In Chapter 7 I also identified that nurses were ignored when it comes to decisions relating to structural change, and this represented no change in the power relations (Larkin 1980). I developed Halford and Leonard's (2001:42) argument that Weber's world of bureaucracies, with the standardization of rules and processes, for example those evident in the DoH policies and evidence based practice, has not diluted the impact of personalities as Weber (1979) had expected.

In the literature review I identified that despite new managerial approaches

masculine qualities are still prevalent so that competitive expectations of targets as achievable are part of the target driven health service (Halford and Leonard 2007). The reality is that despite the targets culture the quote by NHs9 illustrates a sense of stagnation or incapacity for some organisations to act in a timely way. The suggestion is those organisations have become too bureaucratic, too unwieldy to respond to clinical / service imperatives. This has been picked up in the new White Paper (DoH 2010) which will extend the neo-liberal requirements of the NHS. The nurse hysteroscopists are an example of facilitating change through practice development to maximize productivity. However, trusts having invested in the development of a service, the 'superordinates' are concerned about the consequences of relinquishing control Hugman (1991). There is an argument that increasing the numbers of nurses has feminised this one area of practice and so despite the rhetoric of the last government there has been no universal change in organisation behaviour (Bolton and Muzio 2008).

The feminine is in conflict with the masculinised organisation which continues the neo-liberal thread. Nurse hysteroscopists identified that they were working in a target driven culture. This is evidence for the proposition made by Hurley and Linsley (2007) that the NHS is a neo-bureaucracy. This concept of fiscal incentive becomes the power, pushing for change with the organisation taking over the role of professions as seen in the model on page 131 (see Fig 11). Through usurpation the political will was to change the old practices (Labour party manifesto 1997) and this was sustained through to Darzi (2009). Whilst it is still unclear how the propositions the new white paper 'Liberating the NHS' I appears that neo-bureaucracy will persist and indeed grow (DoH 2010). The objective is still to increase challenges to the hierarchical bureaucracy of the NHS by empowering, liberating clinicians to innovate and to focus on improving healthcare services (DoH 2010). There continues to be the presumption that such drivers will continue and will challenge the demarcations. Yet examination of the details suggests the old powers are to be sustained with the 'choice of consultant-led team'. This sustains the notion of medical superiority. Experiences from the nurses to date are that the potentially liberating modernisation agenda and KSF of the first decade has only redrawn the lines of power. Ambiguities of control around the 'professionals' role serves to constrain service development (Noordegraaf 2007).

Game playing - or using intelligence

In the presence of organisational closure, I suggest that there was some evidence of emotional intelligence being used. My rationale for this comes from the reactions the nurses said they employed. (Table 8) used phrases from Goleman's

criteria for emotional intelligence. From this, I drew a dichotomy of abilities firstly from the nurses' 'in vivo' transcript analysis and secondly the textual survey responses. Looked at collectively, I had arrived at the terms sovereignty and suppression. As discussed in chapter 8, sovereignty is associated with control. I drew on Foucault (1986) whose 'concept' relates to autonomy, independence and power. The line of argument was picked up using a notion of Halford and Leonard (2001), that in fact we are all players in power and the practice of power. Another perspective considered was that of game playing. It was possible to see the nurses were managing themselves. Particularly useful were the descriptions used by Mann (1997) and Dann (2008), who both consider the use of inter and intra groups or the person. Despite obstacles placed in the nurses' way in attempts to suppress them, it could be argued that they have certainly used some of the emotional skills to achieve a degree of sovereignty over their work (Jackson et al 2007). However to suggest that they could ever have absolute control would deny the premise of nurses' code of conduct which requires the recognition of limits to their skills and inter-professional working (NMC 2008). Sovereignty would also deny the patient's right to choose care options. However, within the limits of their working practice there is evidence that this is an appropriate choice of word, as there is evidence not only from the transcripts but also from the content in the appended tables that nurses have initiated the development of services and that at the time of participation they are continuing to expand.

From the data, the proposition emerges that sovereignty is closely associated with emotional intelligence. The nurses have provided details where the significance of working relationships to their achievement are revealed. This is reminiscent of Wood's (1998) longitudinal study. We have seen that the nurses experience a variety of situations that require sophisticated emotional responses. McQueen's (2003) paper focused on the nurse-patient relationship; based on evidence presented in Chapter 8, the interpretation is that these skills are the key to professional interactions and need to pervade all levels of communication, without which practice can be compromised. Nurses are able to achieve this with differing degrees of success; perhaps there is a role for the course team to develop recognition of personal attributes. First is the planning and organising groups the nurse hysteroscopists are supporting a complex range of staff in clinics, this requires intuitive adaptation of communication skills; the second is by problem solving clinically and organisationally; third is working with 'new' professionals and finally in both the survey and stories nurses have examined the reasons for certain interactions, and explained how they have resolved them. Use of emotional intelligence enabled the practitioner to apply differing strategies to negotiate their way through life and work (Goleman et al 2002, Jackson et al 2007).

Surprising were the areas from where jealousy arose. It was not confined to the professional group being challenged, but from across the spectrum of staff. The experience of jealousy of the nurses meant that they had to exert energy in their emotions whilst managing the emotions of their colleagues. Alisha had to contend with significant pressure resulting from jealousy and Liz 2 in managing others, this equates with emotional work as defined by McClure and Murphy (2007). Equally, there is some evidence of labour exploitation. There is no compunction to limit the hours worked of those who will help meet the needs of the organisation. This seems at odds with the NHS drive to reduce medical hours under the working times directives (Milburn 1998), that it should increase the labour of nurses (Davies 1995) and maintain the original balance of power.

Rewarding Practise

There is no correlation between pay and respect. In Chapter 3, I developed the argument that just because society has changed, and there is increasing feminisation of clinical roles, remuneration for the work actually undertaken has been positively impacted (Bolton and Muzio 2008). This was reflected in the evidence presented in Chapter 7 where the data suggests that whilst there were tensions in gaining appropriate reward for the roles performed these have been overcome within the limits of nursing pay structures. There was a suggestion that nurses as women are not valued by Doyle 1994, Miers 2000, there is some evidence to support this with the additional unpaid hours nurses are undertaking. These feminist arguments will continue to require re-contextualisation (Halford and Leonard 2001; Walby 2008) as the health service modernises.

Even with equity of pay through the KSF there is still evidence that power dynamics within and between gender can still inhibit the nurse. At bands seven and eight clinical and managerial strands of work appear with comparative remuneration (NHS 2008a, and b). As I discussed earlier in Chapter 6, nurse hysteroscopists are, on the whole, now in a receipt of remuneration that equates with advanced practice. However, it is still questionable whether the exchange includes the effort associated with emotional intelligence and work given that what is missing is the authority and relative power to make things better for the organisation.

In Chapter 3, I identified that pay for nurses had been a feminist area of concern. The model created previously in Fig 12 endeavours to illustrate the strictures and

conflicts of gendered roles outlined in the literature review. The dynamics that balance the concept of horizontal expertise verses vertical power relations as explored by Muzio and Bolton (2008) hold currency in this study too. Organisations are ultimately in a state of conflict; the conclusion that can be drawn is that NHS bureaucracy continues to stifle the potential of individuals in specific professions. Each nurse hysteroscopist in the study reflects differing experiences, yet despite this, they are emerging as a confident group of women, who see yet more potential for their roles. The question remains on how to make their voices heard. Several of the nurses talked about the need for support through direction from the BSGE and communication with each other.

What has become clear from this study is that the social structures of nursing are changing, but the experience of each nurse has to be understood within the context of organisational change that is happening around her. As an organisation is made up of individual players, the organisation is dependent on individual interactions as part of overall 'organisational savvy' as expressed by Goleman (1996:159).

Advanced Practice

When starting the study in 2005, the literature clearly reported the inconsistencies and lack of agreement in defining the advanced practitioner. The Council of Health Regulation Excellence CHRE (2009) report highlighted that this is not a unique issue for nursing. At the start of the thesis I wanted to establish some resolution to the notion of advanced practice.

In Chapters 7 and 8, the data suggested that there needs to be a greater recognition from within some of the Trusts that nurses can and do have the potential to make a significant contribution to the development of clinical services. Renewed activity to gain a consensus on what advanced practice is and should be required a participation in ongoing national debates (CHRE 2009, RCN 2009 NMC 2009). Whilst this study has focused on the personal perspectives for the research participants, the content has begun to eliminate the non clinical issues surrounding becoming an advanced practitioner in this case study group. I have used the model from Gardner (2007) to assess whether the nurse hysteroscopists have the traits of advanced practitioners as suggested in that model. Using data from the participants, I have adapted the risk assessment tool developed by Lloyd-Jones (2004) which assesses the potential levels of risk to the nurse hysteroscopists abilities to perform as advanced practitioners (See Table 10).

For the nurses they felt that they were, on the whole, working as advanced practitioners but that there was frustration at a lack of recognition of their professional abilities. Using Evetts' (2003) conclusions it could be argued that the dichotomies that were revealed from this study's transcripts and the in vivo analysis suggests that nurses are struggling to achieve professional credibility with all but the supporters of their development, who were frequently their trainers / medical clinicians.

It was Manley (1997) who suggested that there is a close association with nurses' consultancy and advanced practice, the characteristics being developing and empowering staff, development of nursing practice, and transformational leadership. The two participants working as consultants certainly appear to be achieving this, and there was evidence that nurses are training other nurses.

There is the potential that any regulation of advanced practitioners will become prescriptive and unresponsive. In the past with the English National Board (ENB) there were courses with detailed guidance; rather what is needed is a specific set of competencies focusing on the generic skills. The NMC Code of Practice requires the nurse to perform safely using theory and research evidence to support the praxis. The CHRE (2009) recommended that advanced practitioners should be whatever the Trust says that they are. However this creates a concern that this will have negative consequence on the professionalisation of nurses (in this instance) and keep the public mystified as to what comprises an advanced practitioner. It is clear from the responses that nurses have experienced jealousy potentially as a result of other clinicians not being clear about the rationale and the implications of changes in levels of responsibility. With or without a national strategy for advanced practice, for any organisation wishing to maximize its staff potential there is a need to have an overall framework. One of the traits appeared to be that other staff were unsure of what was planned or what the nurse led clinical developments would mean for them.

Educational consequences

The results show that nurses who undertake the hysteroscopy course take anywhere from one year to five years to complete the programme. Complimentary evidence suggests that this appears to occur for several reasons related to organisations and their personnel. This still resonates with the work of Lipsky (1980), who was conscious that personnel reflect the organisation and I propose that they are either organisational facilitators or resisters.

Evidence in the maps and the survey indicates that the NHS in general and Trusts specifically remain vertically hierarchical organisations. On page 131, I proposed a model that reflects this. Whilst individual nurses are able to exercise emotional intelligence to mitigate escalating situations there can be no expectation that nurses should challenge the whole social structure of their institution individually.

Whilst no concerns about patient safety have arisen during this study, there is evidence that employers need to consider the attributes of those they recruit to posts and the support mechanisms that are in place. There is evidence from the study that clinical skills are not sufficient to develop practice. Nurses need to be resilient and persistent too. Part of the tool kit for advancing practice is the nurses' awareness of the need for the ability to adapt to situations and interpersonal interactions.

In the absence of specific competencies from the CHRE report (2009) and continued indecision by the NMC to develop advanced practitioner requirements, course teams need to be clear what is required for the praxis they are to develop. As has been seen from the evidence, the nurses have a collective understanding of their roles and scope of objectives to work towards. Even within this case group, experiences of how they practice are eclectic. Without a common understanding that has evolved from joint nursing and medical perspectives of hysteroscopy with common educational objectives, practice would be even more disparate (Ludkin and Quinn 2002; Jones 2005). In recognition of the current government's intentions to expand the neo-liberal objectives of income generation and professional autonomy, all the elements of this study's findings have been brought together to create a model that might facilitate an organisations expansion of nurse led services using advanced skills (see table 11).

Personal reflections

Listening to what nurses say tells us more than just what nurses are doing and how they feel; it can also reveal something about the complex process of change and resistance to change currently going on within NHS organisations
(Halford et al 1997:92)

Halford et al (1997) examined the impact of gender and careers in organisations. In this study, I have endeavoured to follow feminist principles throughout the methodology. I have provided an opportunity for a small group of nurse

hysteroscopists to have the freedom to identify key factors that were impacting on them as they participate in a role emerging from recent NHS reforms. I followed this through by enabling those interviewed the opportunity to comment on my interpretations and respond in the survey. Furthermore I have used the 'voice' of the survey nurses wherever possible. As a result of this strategy, the nurses have provided an insight into their world and I hope that I have done justice in reporting what I have found. I am reminded of travellers' ponies; tied to a stake at the side to the road, their freedom depends on the length of rope. The analogy is that each nurse is controlled by the bureaucracy and the vision of the organisation is the length by which the nurse can achieve her part in change. It is hoped that the outcomes from this research will highlight the factors that limit an individual nurse's potential and compromise service development.

Managing dyslexia

Throughout this academic journey I have struggled with the "wobbly words". However it has led me to creating and adapting tools that are used to support people with dyslexia in their studies.

Firstly the mind maps, as described in chapter 4 and in chapter 5. Here I reflected on the application of this tool for data collection. I would propose that this could be a useful tool for anyone wanting to conduct a narrative type study. For the research participants it appeared to focus their attention and let them have control over how they wanted their stories to develop. For me this was a key element to facilitate a participant focused data collection tool.

Secondly, it was a fortuitous conversation that I had with my friend that let me to **Audio Notetaker®**; this tool was critical in aiding my ability to manage the transcript data. Throughout the writing up stage I have been able to open up the file and quickly locate the areas of speech I wanted to listen to again.

I hope that I will give inspiration to others who believe that they are not good enough to complete the doctoral challenge.

Recommendations

Recommendations for Educational Programme Content

1. Developing an understanding of the social relationships

It is clear that as educationalists not only ought we to facilitate learning to support clinical praxis, but assist the nurse in understanding the social complexities that they may encounter. I recommend that early in the programme each nurse should complete a map of her social network. Recording the map as a digital image and articulating the issues the nurse will be able to understand who are the enablers or the exclusionists within the organisation or professional group. With a digital recording it can be stored electronically. The students would share this with the course team in the first instance. This will enable the student to recognise personal and organisational barriers and help her to develop management strategies.

2. Using electronic portfolios

There is increasing use of electronic portfolios to support reflection and these are useful in distance learning. Having mapped their organisational and occupational relationships the nurse can use this as an embedded template to reflect on how their relationships change. Using an electronic portfolio the student will have constant access to this and can choose to share the map with peers and tutors or persons of her choice (managers), each of whom may offer resolutions. The benefit of this is that whenever an issue arises the nurse can refer back to her map to source the problem. As a distance learning student, she can share this with whoever she feels appropriate.

3. Publications

The Council of Health Regulation Excellence has suggested that part of being an advanced practitioner is to undertake research and publish. Equally, models of advanced practice suggest that nurses should be engaging in research. As seen in the literature review there are limited publications let alone research undertaken by the nurse hysteroscopists. None of the nurses referred to publications in their responses. However by re-writing the modular assessments to include the preparation of articles for publication based on audit reports or case studies, it will give the nurses confidence not only to be consumers of critical literature but start to be producers of it too.

Recommendations for Developing Nurse Led Services

1. Advanced practice groups

This study set out to examine the social impact of nurses taking on a nurse lead role. As with other studies, there is clear evidence that nurses are likely to experience some form of jealousy from a range of staff. There are two potential solutions. First, an ethical approach to management would ensure that there is an effective business planning cycle that is embedded at the heart of an organisation, and does not reside with one or two individuals. Second, based on the evidence the establishment of a multi-professional 'advance practice group' is one model that could be adopted. This group would include band seven roles or above to participate in the consultation about changes in day to day operations.

2. Establishing the Evidence of Clinical Effectiveness

This study did not set out to explore clinical effectiveness; however the lack of empirical evidence limits arguments in relation to benefits an organisation may gain by having a nurse led 'see and treat' service. In this particular instance of the case study group the BSGE has a greater role to play. The trainer and the manager are key individuals in the preparation of a nurse hysteroscopist. This recommendation is to the trainers. Whilst individuals might want to reject the idea of occupational closure, the evidence is that when present it is debilitating.

3. Reconfiguring services

Reconfiguration of services through nurse led clinics requires investment, even when the objective is to save money or reallocate roles. Staff development as part of the change process needs to be part of the business plan. The investment may be one of the following: explanations to the staff, course fees, appropriate settings and time to acquire the clinical expertise, finally cost to cover existing roles before the change is completed. There need to be clear lines of responsibility to ensure the nurse is presented with and able to maximise the clinical opportunities. To complete work based course requirements in a timely fashion will require managers and trainers to have performance indicators both in terms of value for money and personnel management.

It may be prudent to use a model such as PEPPA.

To measure advanced practice against the Ackermann model

To assess organisational risks using the Lloyd Davis model

Finally implemented via the development model proposed by the author in Table 11.

4. Contributing to the advanced practice debate

During the compilation of this thesis, the discussions on advanced practice re-emerged. Nurses themselves have various titles, at the time of completion of the survey most of them were being paid at an advanced practice grade. Furthermore, the CHRE report recommends that employers and statutory bodies like the NMC focus on protection of the public. Currently the NMC and HEI's are not reactive enough to meet the changing clinical needs of the NHS. To have very specific courses competencies for highly specialised areas of practice means that they are not viable for the HIE to provide. It is proposed that if HIE institutions already achieved approved institution status to NMC course they should be no compulsion of have a whole range of courses each individually approved. Courses would be approved through their institution as suggested by the CHRE outcomes and quality audited using a risk assessment model as in other annual inspections. This is similar to the QAAHE model. Using these as generic competencies that are not too prescriptive but can guide educational establishments would be appropriate.

Furthermore it would be the nurse who makes an application for the recognition as advanced practice nurse using a set of benchmark criteria similar to an APL claim. These should be based on the core competencies outlined by the ANNPE and the CHRE and agreed with the NMC. This would facilitate educational and clinical autonomy to meet the needs of a rapidly changing service. The savings made by changing the approval process in step one above would be used here.

Finally, the DoH should agree the set of core competencies with all parties. Only when these have been achieved and a claim has been approved can the nurse (or other professional) be entitled to be known as an Advanced Practitioner.

Recommendations for further research

1. The personal impact of advanced practice on individuals from other professional groups requires ongoing exploration with an analysis against the role descriptions that describe advanced and consultant led roles.
2. Further research to establish the impact of jealousy on the functioning of nurse led services.

3. Research should be done within organisations to examine where bureaucracy stifles the development of new developments, using evidence from all grades of staff.
4. Research by nurse hysteroscopists needs to be undertaken to establish key characteristics of their clinical effectiveness.
5. To use the questions posed in the survey on emotional intelligence / work with a greater range of nursing undertaking advanced roles to establish if I have identified a feature unique to NH or common amongst nurses at the end of the first decade of a modernising service.
6. Design a further research study to test out the use of mind mapping as a data collection aid where participant control is the focus.

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Appendix 1

Table 10 *Developing critical consciousness: Alignment of Problem Based Learning with Freire's Pedagogy of Hope Adapted from Sho (1994) and (Freire 1999) (Table Compiled by the author 2010)*

Values of Freire's pedagogy	Principles of PBL
Participatory	Asked to participate by brainstorming a woman's case.
Situated	Relates to clinical situations and pathologies women will have presented with.
Critical	Reflect on what they know and how relevant that is.
Democratic	Students have equal rights to speak and share what they know. They can also comment on the effectiveness of the situation they have been presented with. They also determine what they need to learn before the next session in hypothesising.
Dialogic: "they are doing the education not it being done to them"	Working with the enigmas, students are guided to discuss in increasing depth. They work out how to explain phenomena.
De-socialisation	'sabotages silence' (Shor 1996:33) students have to participate and teachers have to give up control. Creating them as problem posers – set their own questions for investigation.
Multicultural	During discussions recognising when and where discrimination may occur. We have some ethnically sensitive scenarios.
Research orientated	Students go out and find empirical sources of information to develop their understanding for the next meeting. Using, in the main, medically based journals ⁵⁸ , there is an expectation that they bring in nursing knowledge as a matter of course.
Activist	The class room is a place of activity, participation and co-operation are key to success. Changes the dynamics of what is known and who knows it.
Affective	During the discourse there will be a range of emotions expressed. (surprise at what others are doing and humour are common)

⁵⁸ Students have not always been familiar or confident in accessing medical journals to read the evidence form source preferring to use systematic reviews.

Appendix 2:

Table 11 Model of Work Based Learning for Nurse Hysteroscopist training Based on Boud and Solomon 2001 (Compiled by the author 2010)

1. There should be a partnership between higher education and the organisation with appropriate frameworks to support learning, and that there is a contractual agreement.	For Hysteroscopy there are several levels of agreement. a) Through the partnership to provide the course and the mutual support. b) As trainees they are seconded from their host Trusts with a line manager and a trainer signing letters of support. In return, they receive documentation of their roles in supporting the student. ⁵⁹
2. Learners are employees; they may self-select or be seconded to a work based learning activity meeting the employers organisational objectives.	All the students enrolling with the preparatory advancing practice course are seconded by their employer. Our experience to date, this does not guarantee the level of involvement of the host employers in the supervision, mentoring, and line management support. Indeed students may be expected to drive the development locally, requirements under the first point.
3. The curriculum content is derived as much from the students' needs and the clinical and decision making skills to be developed as the requirements of a defined professional group. It could be argued that the curriculum construct has strayed from the philosophy of WBL.	Several professional organisations with a vested interest in the overall course outcomes contributed to the early planning: Royal College of Nurses (RCN), British Society of Gynaecology Endoscopy (BSGE) and the Royal College of Obstetricians and Gynaecologists (RCOG). The latter had already set standards and these have since evolved as empirical evidence has become available. Best practice guidance is now available through NICE, BSGE, RCOG and SIGN 2002. One of the driving concerns for the course team was to have the same standards as set by the supervising profession to protect the individual's initial registration as a registered nurse.
4. The principle is that a participant in work based learning does not need to be credited at a certain level. The proposed venture did not include the fourth principle.	The national guidance is that Advanced Practice should be at a minimum level of masters which is commensurate with senior medical staff. There was a need to establish credibility. Given the academic level of most nurses, the minimum level was set at Level three, that of a final year graduate, and has since evolved to post graduate level study and the volume of credit increased. One may argue that this was a form of professional gate keeping, as described above. Conversely, this was a pragmatic approach aligned with a professional "duty of care" to the public to meet their expectations, and to help protect the student from litigation (NMC 2008b).
5. The principle is that learning develops out of a set of learning projects in the work place alone. There is significant class based learning too.	There is a detailed range of clinical activities that students must achieve, as part of the national standards. Clinical contact time varies between students based on the number of clinics and the volume of women coming through each one. The clinical areas of praxis are complimented by case management presentations and audit. Students take advice from experts in their organisation with regard to clinical skills, professional issues of accountability, standard setting, and prescribing and general service provision. However, there is a significant pathological content associated with medical knowing. This requires thirteen off clinical site contact days ⁶⁰ out of a minimum 18-month period.
6. In this final aspect of Boud's model, it is expected that students set their own learning outcomes.	To establish credibility and to facilitate a professional group.

⁵⁹In this case, student refers to the nurse who is to train to become a nurse hysteroscopist.

⁶⁰How this was aspect is delivered is explained in the introduction – see Problem Based Learning. This is now complimented with nurses leading topic seminars, so the knowledge is becoming theirs.

Appendix 3a



Address

Dear Student / Nurse Hysteroscopist,

I would like to invite you to participate in my doctoral research study. Due to my work with the Hysteroscopy course I am interested in exploring your journey into advanced practice and extended roles, with a particular interest into any organisational factors that may have impacted on you and your work. I will also be asking Doctors to participate who have been involved with training and assessment for their perspective

To see what it will mean for you and the consent form please see the attached documents.

If you agree please can your reply be made in 7 working days using the stamped addressed envelope? For further information please ring me on 01274 236435 or e-mail j.pansini-murrell@bradford.ac.uk. I can send this information electronically if you would prefer.

Yours Faithfully

Julia Pansini-Murrell



Queensgate Huddersfield HD1 3DH UK Telephone +44 (0) 1484 422288 Fax +44 (0) 1484 516151

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Appendix 3b



Nurse Hysteroscopists information sheet For Research By Julia Pansini-Murrell

What will it mean for me?

Your part in the research will involve two elements; the first is a short mind mapping exercise, this will involve using magnetic shapes on a board, I would suggest that this will take about ½ an hour, the second is for you to tell me your story referring to the mind map, and this should take about an hour. Depending on what we agree for meetings this will either take place all at the same time or on two different occasions. You can choose the location.

When I have transcribed your information and made some initial interpretation I will return the transcript to you for comment a) to clarify that I have made an accurate representation and b) that I have not misunderstood aspects of your story.

When I have conducted most of the nurses interviews I will be undertaking a questionnaire with trainers. I will not be matching you with your trainer although you may both agree to participate.

To ensure anonymity I would like you to select a name to be known by and I would like your permission to use quotations from the transcript. However you would reserve the right to decline the use of quotes from your contribution

Although I am involved in the module/s you are or may take in the future, I am only one part of the course team and any decision about participation or withdrawal from the study will not affect your academic / professional achievement.

Like you I have a Duty of Care: If I am concerned about aspects of care that you may disclose during the study; I am required to support you and may need to discuss the matter with your trainer / line manager.

Approval for this study has been gained from the University of Huddersfield research and Ethics committees, University of Bradford and Bradford Hospitals Teaching Foundation Trust ethics committees.

At the end of the study a copy of the report will be made available to all participants, and dissemination will be through conferences and journal articles.

If you agree to participate please complete the enclosed form and return in the stamped addressed envelope.

You will retain the right to withdraw from the study at anytime without giving a reason.

Yours Faithfully

Julia Pansini-Murrell

Ref No



Queensgate Huddersfield HD1 3DH UK Telephone +44 (0) 1484 422288 Fax +44 (0) 1484 516151
Vice-Chancellor: Professor Bob Cryan BSc MBA PhD DSc
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Appendix 3c



Consent to research conducted by Julia Pansini-Murrell

Ref No

Research Consent for Study by Julia Pansini-Murrell

I have read the information leaflet and I understand that by participating in this study I will be involved in a mind mapping exercise and telling my story and that I will be able to review the Transcript and make comments.

I am aware that I can withdraw from the study at anytime without giving a reason.

I wish to be known by the name..... and that any quotations used in the final document will be attributed this name.

I also reserve the right to decline the use of quotes from my contribution

I am aware that all data is protected under the Data Protection Act and the guidance on storage of research data by Higher Education Institutions (2005).

I have read and understood all the points in the information sheet and I (print).....agree to participate in the research being conducted by Julia Pansini-Murrell as part of her doctoral studies, under the guidance of academic staff and the University of Huddersfield.

Signed..... Date.....

To make the arrangements you can contact me by telephone 01274 236435

or e-mail j.pansini-Murrell@bradford.ac.uk

or Please provide a contact point

Appendix 4 Results of the invo analysis

Source	Stage two Negatives		Stage two Positive		Stage three Results theme	Concluding concepts: the nurses were
Nursing / admin staff Liz 1 Alisha Liz 2 Sam Rose Lucy Liz 3 Holly Lisaden	Resistance	Embroided	Nurse consult	Appreciated	Supportive Energized Mutual Recognition Team working Jealousy Disruptive Resistance Isolation Tensions	Respected Resisted
	Not "doing" Flowery communications Boundaries Significant jealousy bullying suspension delineation of roles in different units Fragmented	Managing Interfering Personalities Disrupt Avoidance Tensions Set apart Isolated from	over seeing New Matron new broom proactive quotable accepting Supportive Excitement Support Recognised	Reflected glory" supportive a network Teams significant Valued		

Source	Stage two Negatives		Stage two : Positives		Stage three Themes	Conclusions
Medical staff unless otherwise specified means consultant	Jns reluctance to ask One absent Juniors arrogant /challenging Hurdles placed medical staff disparate fall back disparate Jealousy No recognition of the can do Took time for others lead oncologist Told to do Resistance	persuasion Instructed to another working independently Lack of clinical lead No team Conflicts at senior level Defining without knowing To the point resistance animosity time No hysteroscopy Leadership	Planned by Medical directorate Consultant Planned Helpful Knew fountain of knowledge the back up One lead consultant Dawning satisfaction Consultant planned Supportive but distant	Approachable Problem solving Educational and clinical credibility Close working Planned development In demand Consultants supportive facilitated trains has control of juniors	Planned x5 Knowledgeable Supporting Credibility Respect Facilitative Absence Arrogance Leaderless Conflicts insignificance Opposition	Authoritative Antagonised

Source	Stage two Negatives		Stage two : Positives		Stage three Themes	Conclusions
Managers /organizations Some of the nurses are referred to are line managers as well and the issues are included here rather than in nurses or self	Non medical directorate the greatest challenge Fire fighting Not knowing Barriers by non nurse manager No planning No consensus about service Start before education No emergency plan No organisational strategy- No strategic view Staffing arrangements No structure for AP Prevented left Opinion not sort	No emergency support No Access to MDT Felt out on a limb Not talking to the expert Excluded from Decision making Changing leadership Disbanding trained staff Knowledge undervalued No lead. shifting Management structures attending AP group No plan No strategic No recognition Barring	Progressive Freedom specialist practice nurse group trust map Teaches manage own funding Can refer to others planned service Support mechanisms for AP Found status impacts Supportive of AP Systems	Increase recognision safe environment expanded connections Social understanding Supportive AP Committee senior nurse access to MDT Skills valued Approachable directorate AP group	Planned x1 Facilitative Advancing practice recognised Independence system	Determined Blockaded
					Direction less Leader less barrier Excluded Ignored	

Source	Stage two Negatives		Stage two : Positives		Stage three Themes	Conclusions
Personal / Self Here I have used their own terms or have distilled complex phrase into specific words that capture the spirit.	initial struggle managerially dependent Academic Bane of life Isolated Writing protocols personal cost family cost educational struggle	no control over staffing not consulted biding time additional hours picking up Reluctance to use EI	Emulating best practice Clinically Autonomous Protocols negotiation Deference Taking lead Advising Academic qualifications central Coaching Proactive Emotional intelligence Communicator Infectious Education Listener Teacher Adjusts Planning Clinical skills self motivated self directed organised own education clinical autonomy confidence	changing practice leadership opportunities new skills patients family valuable independent compartmentalizing Evolving career. Journey Teaching Managing own maintenance of competency Motivated Adaptive Education key to professionalism Stability Professional maturity Age and maturity Leadership Education Clinical supervision and autonomy Communicator	Communicator Teacher Autonomy Leadership Reflexive Professional	Sovereignty Suppression
					Disempowered Challenged Detrimental	

Appendix 5

Table 12 Qualitative Evidence of Jealousy

NHi1	"One consultant was going to every meeting that took place re hysteroscopy and I was never invited or made aware of any progress that developed. Also some consultants allow me to practice the role others do not".
NHs5	"In Amsterdam: I looked to my peers at the conference (a senior Scandinavian medic disparaged a NH and her paper on nurses leading hysteroscopy services)"
NHs6	"Other consultants appear threatened - sometimes hostile making clinic situation tense"
NHs15	"opposition to change within outpatient dept by junior staff (trained staff)" Survey research participant
NHi18	"jealousy was from other nursing staff who felt that because I was becoming in their eyes 'more valuable' to the organisation."
NHs20	"Occurred mainly in theatres (nurses and junior sisters) and USS dept not OPD. Senior nurses and ultra-sonographers refusing to communicate with me"
NHi21	"Deliberately being unhelpful (junior nurses) ranging to declaring intentions not to be supportive and verbal aggression"
NHi22	"Intimidation, verbal and non verbal bullying. Accusations of incorrect practice leading to disciplinary action!"
NHi25	"Hysteroscopy business cases - re auto-clavable scopes & up grade in equipment management took information from me and then excluded me from the loop and final outcome etc".

Appendix 6

Table 13 Qualitative Comments on Training Experiences

Positive	Negative
NHs2 Trainer had most impact. A positive supportive approach ensured a positive result. The patience amongst assisting staff in the clinic helped.	NHi1 Change of management. Also I do not work within gynaecology so no one would make the decision to "buy" my time out of my own dept in order to follow my nurse hysteroscopy role.
NHs3 No, had good support both medially and financially whilst in training	NHs4 Not enough time to study with work life balance
NHs6 Trainers have been good but... A second trainee starting whilst I am in training meant additional pressure to obtain numbers plus qualified Drs waiting for consultant posts wanting further experience with hysteroscopy's	NHs5 Not initially, however, funding for attending conferences is difficult
NHs9 I was lucky as I did not have the competition of registrars.	NHs11 Training was affected by trainer being on long term sick but is now back. I have been provided with a lot of help and support
NHs10 My main trainer was very supportive ,. but another consultant was quite negative and still is, this had an impact on my confidence at various stages of my training	NHi12 There was no training available so I made arrangements to train at XX
NHs11 Training was affected by trainer being on long term sick but is now back. I have been provided with a lot of help and support	NHs18 worked in a predominately colposcopy led service area. Conflicts arose with other nurses and consultants.
NHi16 My trainer and manager gave me constant support	NHs21 lack of resources (scopes), clinic staff and study time
NHs17 No, I was recruited into a training post. My trainer and manager was a nurse hysteroscopist (consultant nurse)	NHi22 Lack of understanding from manager re training issues hindered my training. What is a nurse hysteroscopist meant to do within the organisation? Who was I?
NHs20 Yes we cover a huge geographical area and receive a high number of referrals from GP's and other medical staff referring women with menstrual problems and PMB. This impact signified a need for another person to train in OP hysteroscopy. Since qualifying I have been approached about further training in endometrial ablation	NHs25 Lack of Trust support, lack of funding, lack of understanding of role and level of training
NHs24 My consultant trainer prioritised the registrar training but the staff grade focused on my training	
NHi26 The total support of all my unit was very encouraging and kept me going	

Appendix 7

Table 14 NH Qualitative Evidence on What Enhanced Development

Were there other factors that would have helped your development?	
NHi1	All of the above (see table) and Managers able to make a decision based on insight and best practice
NHs2	On the whole, the Trust supported me with giving dedicated time to attend clinics for training. Personally I think I may have benefited from having a block period in the hysteroscopy dept. opposed to 1 session per week. (had not worked in hysteroscopy dept. prior to training!)
NHs3	No not really, the only thing which would have been of use would have been protected study time. All I had was the time in XX, the rest had to be done in my own time
NHs4	More input from trainers and support from management
NHs5	recognition from management that my role would have helped service development
NHs6	all consultant trainers and manager to be aware of course content - mandatory that they attend study day before course starts
NHs9	The wholehearted support of my consultant mentor made all the difference. It is difficult to learn a medical craft without this. It is also impossible to have a protected training experience without their dedicated support. Knowledge, clinical practice and experience can only be developed in a nurturing environment - any distractions and added stresses placed upon the trainee by the management are counterproductive. Standards for learning must be enforced by the BSGE
NHs10	Trainers attending some aspects of study days to gain more insight into the course.
NH 11	Other role commitments mean that I only do a half day session once a week
NHi12	There was not much interest in o/p hysteroscopy when I first qualified, I felt stagnant doing only 3 per week for a few years
NHs21	Having a nurse hysteroscopist as a trainer rather than being the first (consultant trainer)
NHi22	A trainer who had time for me. Study support not just through e-mail.
NHs24	protected teaching sessions
NHs25	Network support from other hysteroscopists
NHi26	should have attended any course that would have prepared me for writing at degree level and not assume that I knew how to.

Appendix 8

Table 15 Nurse Hysteroscopist are Enhancing Services

Service Development	
NHs3	Developing a nurse led hysteroscopy service on 3 sites within the Trust has become a huge personal and professional achievement, to the degree that I have been asked to present in BADS meetings in the UK and Australia
NHs7	was able to implement PMB clinic
NHs8	My practice ensures the 2 week wait target for patients with PMB is met
NHs5	Recognition from some of the consultants and the patients that I offer a good service.
NHs10	Before I commenced training, outpatient hysteroscopy was one session a week with the majority undertaken in theatre. The service now has 6 sessions a week and the majority are performed in outpatients. The service ties in with the menstrual disorders miscarriage and oncology pathways this has highlighted the service throughout the trust.
NHs13	Allowed me to develop the job I was employed for within the outpatient setting, and develop other nurses within advanced practice roles.
NHs14	My role has allowed further development of nurse led hysteroscopy clinics.
NHs17	Practicing independently and providing an outpatient service is recognized a valuable to the department by my nursing and medical colleagues
NHi22	I have advanced through the hysteroscopy role into a nurse specialist giving me a larger profile within the organisation. Have referrals direct to myself from consultant colleagues. Can now offer a wider choice of clinics to patients and clinicians to access. Reduced waiting times.
NHi23	Have referrals direct to myself from consultant colleagues. can now offer a wider choice of clinics to patients and clinicians to access. Reduced waiting times.
NHs21	Autonomous practitioner able to provide total patient care from referral to discharge.
NHs24	I lead on most audits and developments
NHi25	I have my own two week wait PMB clinic but only once a week which is frustrating!
NHs11	This is a significant development both personally and the service.

Appendix 9

Table 16 Evidence of Peer Recognition

NHi1	It has raised my knowledge base and some colleagues both medical and peers come to me for assistance which has raised my profile
NHs26	I felt a great sense of achievement, more so than any other course I have completed. Recognition from other doctors that I had a skill they were yet to achieve.

Appendix 10

Table 17 Qualitative Explanations of What Nurses Are Doing at Time of Survey

NHs2	Following qualifying received many congratulations. Put forward for an award (did not win!).
NHi16	The opportunity arose for this position and I wanted to be the person to develop the role.
NHs4	It has been extremely stressful with pressure put upon me to perform and complete the course
NHs9	Although my profile has been raised in the dept, organisation and externally, the Trust does not value its nurse clinicians in the same vein as doctors. They are managed by nurse managers who have one foot in the professional nurse camp and the other very firmly in management. Nurses do not get the support that is required to fight their positions
NHi18	Having taken on the role new areas of training and responsibilities have become available but there is a danger of taking on too much.
NHs20	In my Trust and like many of my NH colleagues I am the only NH. During my training my profile was raised as I was encouraged to attend other departments to introduce myself, define my role and developed professional relationships with others colleagues for example ultra sonographers, theatre staff, oncology nurses and clinicians. I wanted some help writing Performa's for women attending OP hysteroscopy and so made a point of introducing myself to a lecturer in the education dept with a keen interest in gynaecology