Professional Doctorate in Education Thesis

Emerging from the Shadows

Exploring registered nurses' experiences of work-based learning projects from a Habermasian Perspective

Maggie Roberts 4173889

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“And though the stage presents the drama of our powerlessness, the shadows offer the secrets of our power.”

(Solnit, 2005, p.34)

Abstract

Emerging from the Shadows: Exploring registered nurses' experiences of work-based learning projects from a Habermasian Perspective.

Within the context of the United Kingdom National Health Service (UKNHS) in the twenty-first century, there is pressure on the nursing profession to change working practices to suit a competitive market of healthcare. Historically, nurses trained in the UKNHS perceived themselves as working in an environment where public service values guided their activity. The research reported in this thesis used work-based learning (WBL) projects as a site in which to explore the conflicts that arise when these values clash with those of marketisation. The findings revealed that the nurses' lack of political awareness and their restricted power hindered their attempts to bring about change through their projects.

As an educational approach to the professional development of nurses, WBL has been lauded by nurse educators as personally empowering and facilitating nurses to become leaders (Swallow, Hall and English, 2006; Manley, Titchen and Harding, 2009; Stupans and Owen, 2010; Quick, 2010; Williams, 2010; Marshall, 2012). In this thesis Habermas's *Theory of Communicative Action* (1984, 1987) is used as a lens to investigate the healthcare workplace as a learning environment and to assess the contribution of WBL to the professional development of nurses. The Habermasian concepts of the 'life-world', 'systems,' 'colonisation' and 'communicative reason' are used to examine the learning experience.

Interviews with ten experienced nurses who had undertaken work-based projects showed that within the nursing 'life-world' the nurse-participants were motivated by their relationships with patients and wanted to enhance care in a collaborative way, but the political, economic and social 'systems' around them presented challenges that impacted on their learning and the efficacy of workplace projects. Ideological and practical challenges were presented by the conflicts that arose during the implementation of their project work.

In this thesis I show how the nursing 'life-world' was shaped by socio-political influences that constrained the nurses' abilities to improve services. The nurses' reflections on their projects revealed both the hierarchical nature of their existing 'life-world' and the 'colonising' effect of business 'systems.' Not understanding the political and economic forces shaping their work, left these nurses at a disadvantage or 'in the dark' when knowing how to influence service developments.

Habermas's concept of 'communicative reason' was used to analyse the WBL interactions reported and to explore how the educational support offered in WBL contributed to nurses' empowerment. As a vehicle for professional development WBL was found to have strengths and weaknesses: while it encouraged leadership development, it did not prepare the nurse-participants adequately for the challenges of the work setting. It is argued that a focus on socio-political awareness and communicative reasoning would enhance the nurses' power. By increasing self-awareness and self-determination; facilitating a questioning of influences on work environments and promoting collaborative working nurses could emerge from the shadows and become influential in the workplace.

Dedication

I would like to dedicate this work to my late father Charles Frederick Hoptroff.

He was a working class intellectual, whose tireless work for his union and the communist party inspired my interest in Marxism.

It was my early experiences at home, learning to see the bigger picture and to question everything, and my experiences as a young communist league member, debating politics and discussing world events that made me think.

This thesis takes the form of another stage in my intellectual and political journey, which I think my father would have appreciated. I would like to say it completes it, but like him I believe we are continually learning.

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List of Abbreviations

Continuing Professional Development	CPD
Evidence Based Practice	EBP
Higher Education	HE
Higher Education Academy	HEA
Higher Education Funding Council (England)	HEFC
Nursing and Midwifery Council	NMC
Royal College of Nursing	RCN
Theory of Communicative Action	TCA
United Kingdom National Health Service	UKNHS
Work –Based Learning	WBL
Work-Based Supervisor	WBS

Chapter One - Introduction

"Experience alone does not create knowledge"

(Attributed to Kurt Lewin, undated)

The Focus of the Research

In this thesis I explore the relationship between work-based learning, professional development, and empowerment in post-registration nurse education. The exploration is based on the findings of an in–depth interview study of ten experienced nurses after completing a work-based learning (WBL) module. The ten nurses recounted their experiences of undertaking a work-based project and reflected on the challenges they faced. I have used Jürgen Habermas's *Theory of Communicative Action* (TCA, 1984, 1987) to critique their accounts, identifying links between the difficulties students faced and socio-political changes taking place in the United Kingdom National Health Service (UKNHS). Scrutinising the learning environment in this way meant that a range of structural factors were considered alongside personal beliefs and behaviours, to develop an understanding of how the work setting can shape learning.

This introductory chapter sets the scene by outlining the WBL module studied in 'The Work-Based Learning Format' and clarifies its importance to contemporary higher education (HE). I go on to explain my educational role and identify the concerns that triggered the research in the 'Rationale for the Research.' The way in which the research ideas developed is clarified in 'Research Aims and Assumptions.' It is in this section that I consider the social context of the workplace learning environment and begin to connect the research proposal to my theoretical framework. The last section: 'The Structure of the Thesis' expands on the stages of the research investigation and how the detail is presented in subsequent chapters.

In this thesis I have chosen to use a critical theoretical perspective to examine the empirical findings and the reasons for this are outlined in chapter four. I have used the quotation that heads this chapter to highlight this theoretical

emphasis. Lewin states: “Experience alone does not create knowledge” (undated). For me this assertion refers to the role of theory in generating knowledge about lived experience in both research and education. First, theory can contribute to understanding empirical research, by revealing the connections between social change and individual experience. Second I discuss how theory contributes to WBL in a practical way helping students manage the conflicting demands of clinical practice and higher education (HE). Both these theory applications are relevant to this study.

The Work-Based Learning Format

Before considering the concerns about WBL as an educational practice, I will outline the WBL module under discussion here and examine its role in the continuing professional development (CPD) of nurses. I will then identify areas of conflict between aspirational claims and real experiences. The module examined in this study was one of a group of “university programmes that bring together universities and work organisations to create new learning opportunities in workplaces” (Boud and Solomon, 2001, p.4). In the University studied, the ‘Midland’ (pseudonym), the project module evolved out of a need to meet occupational demands for changing clinical content to be included in academic module formats.

Boud and Solomon argued that this kind of WBL was perceived by the HE community as ‘innovative’ and ‘radical’ when it first began, because of the employer’s role in influencing content (2001, p.19). This shift in the control of the learning environment is an important factor in this analysis and is still identified as a concern in recent writing on WBL (Attenborough et al, 2019). WBL developed out of a desire to reverse the pattern of academic-led learning, by encouraging workplaces to take a lead on content and teaching method, raising the profile of experiential learning (Raelin, 2008). Garnett et al (2009, p.3) write: “Work itself becomes the subject discipline”.

This educational approach therefore attempts to satisfy the needs of three parties: the university, the employer and the student, which is perhaps ambitious, but was enthusiastically adopted by a broad range of employing

organisations and academic institutions (Higher Education Funding Council for England, HEFC, 2006). In most universities these relationships are formalised in tripartite agreements between representatives of the universities (lecturers), employers (supervisors) and the students themselves at a local level in relation to individual projects (Flanagan et al, 2000).

Garnett defined WBL as:

> "A learning process which focuses University level critical thinking upon work, (paid or unpaid) in order to facilitate the recognition, acquisition and application of individual and collective knowledge, skills and abilities, to achieve specific outcomes of significance to the learner, their work and their university." (2004, Inaugural Lecture cited in Garnett, Costley and Workman, 2009, p.4)

The WBL 'project' module which is the focus of my research allows students to identify an issue that they want to explore and work through a series of personally designed self-directed activities to develop their knowledge and solve practical problems in the workplace. Raelin (2008) argues that WBL involves a combination of reflection on work practices, problem solving and action planning to bring about change, all of which were expected at the Midland.

In nursing WBL the goals have always been to keep learning as relevant to clinical practice as possible (Williams 2010) and to retain staff in the workplace (Jackson and Thurgate, 2011). Additionally, it is suggested that WBL offers the potential for service improvement (Williams, 2010). A rhetoric grew up around WBL as empowering practitioners by helping them to take on more advanced roles and transform services through leading change (Swallow et al, 2006; Manley et al 2009; Stupans and Owen, 2010; Quick, 2010; Williams, 2010; Marshall, 2012).

This qualitative study focuses on a module that emerged out of this rhetoric in 2007 and aspired to meet these expectations. The sole module aim was: "To facilitate the student's completion of a small change management project" (Module Handbook, 2007-2017). The subjects chosen for WBL had to offer sufficient material to generate academic discussion appropriate to an undergraduate or postgraduate level of achievement and be practically useful,

thus meeting the requirements of both academic assessors and employing authorities. Despite the fact that the overall goal of service improvement was accepted by all, the questioning of current practice and the instigation of change could bring conflict in the workplace.

Research Rationale

As an experienced nurse educator, I was initially excited about this new form of, what at first appeared to be, student-centred learning. I was co-ordinating a set of these WBL modules and believed that WBL could empower individuals and bring about change in the workplace. It was with growing unease that I realised that my initial enthusiasm was being checked by wider concerns associated with UKNHS pressures. Here, I clarify some of the difficulties raised in the WBL literature that began to surface in my own educational environment and explain how this triggered a desire to investigate further.

As an educator, I had been immersed in the practicalities of running the module and focused on fixing problems as they arose in a reactive way. However studying for the Professional Doctorate provided the opportunity to step back and examine WBL as a whole and in more depth. Students described work pressures not only to work more quickly on projects, but also to focus on subjects that were higher on the healthcare trust's agenda rather than topics of their choice. I became increasingly concerned about the loss of student autonomy and their sense of ownership of their learning.

I found myself suggesting they agree to employer demands so they could gain sponsorship for their academic study. For me this presented an ethical dilemma as to how to support the students as individuals without colluding with work pressures that were not being questioned. I realised I needed a greater understanding of these work influences to be able to help students to navigate their way through challenges the WBL created. As a researcher I wanted to learn more about the dynamics of the situation and as an educator I was concerned about setting unrealistic targets for students and doing harm in this process, conforming to influences I did not understand.

During the eight years that the module had been running at the Midland (2007-2015), there had been a growing recognition in the WBL literature of a range of barriers to successful learning, identified in course evaluations (Chalmers et al, 2001; Chapman and Howkins, 2003) and then explored in more depth in a larger research study (Moore and Bridger, 2008). Barriers took the form of a lack of protected time and a lack of support from peers or superiors in the workplace, prompting the question: why were these problems occurring when all partners were enthusiastic about the work?

I had noticed differences in individual student behaviour; some appeared to gain confidence, while others struggled; at the extremes some won awards for bringing about impressive changes in the workplace, while others ended up leaving their posts dissatisfied. I wondered whether these, sometimes dramatic, differences were related to the individuals themselves or their workplaces. I suspected that as the learning environment shifted from the classroom to the workplace, a new range of powerful influences came into effect.

Students were attempting to meet work-based criteria as well as academic requirements and I was concerned about the compatibility of these demands. My experience revealed that right from the beginning of their projects some students' freedom to choose topics was curtailed, because practice topics were allocated rather than negotiated. When reflecting on their experiences at the end of their project work students had talked to me about conflicts between managers, supervisors and working colleagues. I became aware that additional pressures might be coming from forces outside of the organisation when frictions arose about access to information, risk management and accountability.

In order to understand how these tensions in the workplace had developed I needed to look more closely at the projects as a means of learning, and to consider how the project work connected with the nurses' day-to-day work roles and responsibilities. I wanted to know what the obstacles were, how and why they were being overcome by some and not others, and how I could help students manage these situations in a way that would provide them with both professional development and the capacity to bring about successful change in

their workplaces. I therefore needed a very open enquiry that would identify the range of factors involved and could explain the links between them.

Research Aims and Assumptions

The research intention was therefore to investigate a complex web of influences on the learning environment of qualified nurses. In this section I explain how my aims developed and guided me towards critical theory. First, I wanted to examine the detail of the student experience on the existing module so that I could clarify what was happening in terms of influences on the learning environment. A qualitative approach seemed appropriate for gathering accounts for this analysis. Second, I wanted to look more closely at the learning process itself and to identify ways in which WBL could facilitate nurses' professional development and therefore an analytical framework focusing on interaction and learning processes was going to be important.

Traynor (2017) pointed out that the barriers to workplace study often appeared to be organisational (for example, shortages of staff, pressures of time) rather than personal, yet the emphasis in education and research was often on personal characteristics and developing individual resilience (rather than questioning the power relationships involved). By adopting a theory with a wider reach into the impact of socio-political and economic constraints on human interaction I hoped to avoid the trap of assuming individuals have independent agency. Nairn (2009) argues that this kind of broader theoretical structuring of research enquiry is often missing in nursing research, leaving problems to be over-individualised or agency oriented.

The students in this study were employees of the NHS, workers in a public service situated in what I conceptualise as a neo-liberal[1] capitalist society: the

[1]Neoliberal - A capitalist society, supportive of a 'laissez-faire' attitude to the economy. This includes a comprehensive set of beliefs: "In sustained economic growth as the means to achieve human progress, its confidence in free markets as the most-efficient allocation of resources, its emphasis on minimal state intervention in economic and social affairs, and its commitment to the freedom of trade and capital." (Smith, Encyclopaedia Britannica, 2019)

contradictions, advantages and disadvantages of this positioning are embraced in this analysis. Evans et al (2002) argue that it is impossible to study WBL without taking into account this bigger picture of the politics and economics of the workplace and the occupational pressures involved. The economic climate of austerity[2] and debates about the future of healthcare provision provide a backdrop to this study, triggering ethical considerations in the examination of this setting. I was therefore looking for a theoretical stance that embraced moral as well as cognitive considerations. The normative stance advocated by Habermas focuses on working towards 'the public good' (1990, p.200) and his emphasis on a society trying to achieve collective consensus and social justice seemed particularly appropriate to this public service environment.

To summarise there were four background assumptions that led to my choice of theoretical framework. The first was that the occupational environment was affected by socio-political influences; the second that theory could offer a way of exposing those influences. Thirdly I suspected that there would be internal tensions between partnership organisations, supplying educational support; and lastly I believed that altering the educational approach could help students deal with these tensions. To address all four areas of investigation and to untangle the threads I believed to be present, I decided I needed a theoretical framework with the ability to examine these socio-political influences as social forces, but also had the breadth to cover a wide range of other factors. I needed a theoretical lens that examined the social and the individual aspects of this action-oriented educational environment.

My overall aims were thus beginning to coalesce into two areas of investigation: first around the contrast of educational aspirations and learning experiences and the influences that created this difference in the learning environment, and secondly around the impact of educational support in helping students to manage these challenges. After reading around a range of philosophical approaches that would draw out different aspects of the situation

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[2] Societal austerity is defined as "difficult economic conditions created by government measures to reduce public expenditure" (Oxford Dictionary, 2019)

I found Habermas provided a comprehensive analysis of individual and social action. In addition he uses a proactive discussion of reasoning to suggest how communication could be improved, all of which were pertinent to this investigation of learning processes.

The Structure of the Thesis

This first chapter has clarified the reasoning behind integrating theory into the practice enquiry, but the detail of how this is done is revealed in Chapter Four. I have used a critical theoretical approach throughout this thesis to critique health policy and the WBL literature and to interrogate the interview accounts.

In chapter two I focus on the NHS as a research setting because it is the largest healthcare workplace for nurses in the UK. I describe the historical background of the UKNHS, focusing on the relationships between the state, the UKNHS and the nursing profession. This political analysis is used to describe the pressured reality of this occupational environment and to draw attention to ethical contradictions that can leave staff confused or in a moral vacuum. This chapter identifies cultural mores associated with nursing and considers these in terms of public service. I then contrast these with values associated with market forces and changes taking place in the UKNHS and identify potential areas of conflict.

In addition I detail some of the professional issues arising from nurses attempting to advance their professional position within the context of multi-professional teams and discuss the blurring of professional boundaries. I argue that political pressures and the conflicts between different interest groups such as management, medicine and nursing have added to the stress of this WBL environment. I therefore present a picture of a professional group with a contested identity, located in a complicated, fast changing environment, where neither ideology nor organisation, provide stability. This chapter closes with a consideration of how these influences have shaped the CPD of nurses and WBL in particular.

A detailed examination of WBL is provided in chapter three, where original aspirations are discussed with reference to research evidence in the WBL literature about student experience. Inherent contradictions within WBL are examined and I discuss the dual purpose of acquiring both clinical knowledge and academic skills. This chapter critically reviews the early literature on WBL in nursing CPD, identifying weaknesses in curricula design and gaps in the existing research.

This leads into chapter four where I explain the detailed thinking behind the aims and research questions, linking this to the sociological, Marxist and critical theoretical background of Habermas's work. A more detailed exposition of the Theory of Communication (TCA) is provided and the separate concepts of the 'life-world'; 'systems and colonisation'; 'communicative reason' and 'reconstruction' are presented and related to this situation. The term 'life-world' is used to provide an overview of the socio-cultural setting in which nurses find themselves and embraces group assumptions, beliefs and caring values. I discuss the significance of this in terms of traditional values that nurses might hold dear and the impact of hierarchical structures that are embedded in this occupational environment.

In this thesis I use the term 'systems' to refer to the steering influences of money and power and refer to the latest pressure for marketisation of the health service particularly. The way these influences can interfere with previously unmarketised domains of activity is termed 'colonisation.' I use these concepts here to distinguish old and new ideas and consider possible areas of conflict. Having explored how these groupings can differentiate internal and external influences on nursing I go on to look at how the educational response impacts on these factors and could question changes taking place in the workplace. I discuss whether 'communicative reason' could stimulate a more rigorous questioning. This more discursive and collegiate form of reasoning is important to TCA, and it is argued encourages a more democratic decision making. This contrasts with the more strategic 'instrumental' reasoning often used in top-down decision making, side-stepping ethical concerns, by applying pseudo-scientific evidence. Finally I show how the concept of 'reconstruction'

can be used to improve educational support by encompassing communicative reason.

This chapter thus highlights how theory can illuminate what is happening by explaining the dynamic of a learning environment and how education can be used to question events. I have placed the research aims and questions in this outline of the theory because I have used Habermasian terminology to articulate these. I demonstrate how these emerged from my thinking and formed a sequence of ideas. I have placed these before the methodology because I believe that being consistent with the terminology throughout facilitates a depth of discussion and a consistency of approach.

Methodology and research methods are identified in chapter five, where I show how the research aims and questions were refined into a workable study, from the overall design to detailed interview questions. The nurses were full-time workers and part-time students, and for this reason they are referred to as 'nurse-participants' in the rest of the thesis. Access arrangements are identified and a profile of the individual nurses is provided. Interview techniques and stages of the analysis are explained and justified, with illustrations of the processes provided. All these aspects are considered in the light of methodological consistency and ethical appropriateness. In this description of the research process I have tried to examine my own influence on the study and to make reflexive observations transparent as I move through the account of the work.

Chapters six, seven and eight combine findings and interpretation. This framing prevents repetition of material and clarifies how empirical findings were first scrutinised and then meaningfully linked to the TCA concepts. Material is grouped under the conceptual titles of 'The Nursing Work-Based Learning Life-World' (chapter six); 'Market Systems and Colonisation' (chapter seven) and 'Communicative Reason' (chapter eight). These headings are explained in chapter two. Chapter six constructs a picture of the nursing WBL 'life-world' from the interview accounts. I compare the empirical findings to concepts of public service and look at the strengths and weaknesses of the specialist worlds revealed.

Chapter seven identifies some of the more serious conflicts that developed during the project work and the concerns elicited from the nurse-participants about future practice. By separating out 'systemic' influences I consider the evidence of 'colonisation', in terms of the impact of private enterprise business approaches surfacing in one or two of the nurse-participants' accounts, and review indications of resistance to service changes. I discuss whether those who had less knowledge and understanding of socio-political pressures (and appeared to be in the dark with regard to local power relationships), were more vulnerable to pressure and struggled to achieve their goals.

Chapter eight looks at how the WBL experiences affected the nurse-participants. This chapter reveals how the nurse-participants tried to use their reasoning to question and advocate for what they believed would be better for their patients. The interactions described by the nurse-participants were examined for evidence of communicative reason and educational support is discussed.

Finally chapter nine returns to the original aims and questions and broadens the discussion, weighing up the strengths and weaknesses of WBL. I discuss how enriching educational dialogue and socio-political awareness are linked. I look at power relationships in the workplace and how these could be addressed to offer nurses more influence. I close with a reflection on the research as a whole.

Conclusion

This introductory chapter has set the scene by explaining the background to the study, outlined the research rationale, assumptions and overall intentions. The importance of the theoretical framing has been highlighted and details of the study context will be presented in next.

Chapter Two – The National Health Service and Nursing

"Governments decide health policy, nurses enact it"

(Gott, 2000, p.7)

Introduction

This chapter outlines the context of the research study. It provides a historical overview of the changing political and economic situation within the UKNHS and examines the effect of changing policies on nurses employed within that service. I explore the way nursing history is intertwined with the development of the NHS as a public institution, because, I believe, there is something unique about this public service ethos in the socialisation of nurses in the UK. The aim here is to explain the public service history and to show how the changing political situation has brought new challenges in terms of changing value systems and organisational patterns, which impact on the workplace as a learning environment.

Historical description is discussed in the light of political comment, beginning with the origins of the NHS and moving forward in time to recent government changes. The contradictions inherent in policy documents are exposed and the life-world and systems concepts are used to reflect on some of the differences between professional nursing values and the reality of newer occupational demands. The chapter is divided into three sections, beginning with the origins of the NHS and the different moral stances present at its inception in 'Moral Contradictions'. The second section, 'Elements of Privatisation,' focuses on changing political attitudes towards state intervention and the economic constraints this has brought. In the last section, 'Nursing's Professionalisation', I examine nursing's professional development, explaining some of the background debates that have taken place and I argue that in some ways the focus on professionalism has distracted from concerns with the NHS as a whole. The implications for CPD and the nurse-participants in my research study are considered in the light of this occupational background. Nurse

researcher and educationalist Marjorie Gott (2000, p.7) states "Governments decide health policy, nurses enact it" and this phrase prompts a consideration of the relationship between nursing and the service in which they work.

Moral Contradictions

This part of my appraisal of the learning environment begins with an examination of the values underpinning both the service and the profession. The historical ethos of the NHS as an institution is crucial to the background of this research, because the nurse-participants were all trained and employed in this setting. In this section I argue value systems and healthcare priorities have been gradually moving from an altruistic stance of offering a universal service to a more differentiated and individualistic approach. This moral shift is explored in terms of equity of service; conflicts of interest between public and private providers; and professional accountability issues.

Tracing back the development of the service it is evident that an ethical stance was fundamental to the creation of the NHS. The Labour Party, which gained power in 1945, viewed the construction of a welfare state as a reward for all the people who had suffered during the second world-war. The Labour Party manifesto of 1945 stated: "Labour regards their welfare as a sacred trust." One of the key strands of this socialist welfare policy was the creation of a National Health Service, which came into being in 1948 (NHS Act 1946). The sense of hope this Act offered to poor people is captured by Smith (2014) in his personal account of the development of the UKNHS, where he recalls the relief his family felt when they realised that everybody would be able to access healthcare. Todd's, history of working people (2014) similarly records how important the inception of the NHS was to the general public. Seedhouse (1986), a healthcare ethicist, suggests the formation of the welfare state reflected a moral drive to lift people out of poverty and enable individual and social development. Similarly, Wilmot, a health service historian, refers to this ambitious creation as 'a moral project' (2003, p.11).

Altruistic in its inception, the NHS was structured on three tenets: that it meet the needs of everyone; that it be free at the point of delivery; and, that it be

based on clinical need, not on the ability to pay. The original legislation (NHS Act, 1946) guaranteed universal access to provision. Yet, in the negotiations that led to the setting up of the organisation itself, the omission of a clear set of moral guidelines was evident in the uneasy fit of public and private components within the structure. Members of the medical community, who had existing private practices, were not eager to lose their independent status, and therefore private practice was allowed to remain within this nationalised industry (Brown, 2001). Aneurin Bevin, the health minister, who had accepted these amendments resigned when in addition, prescription charges were introduced. He believed the equity of the service was weakened by the removal of the free service to all (Brown, 2001).

Principles have now been established in the UKNHS constitution, but contain a modified view of NHS capability (Gov.UK. 2015). This modified view identifies seven key principles, fundamental to the current UKNHS, these are summarised in Table 1 with critical comment.

Table 1 The NHS constitution

Principle	**Problem with Statement**
I. The NHS provides a comprehensive service, available to all.	This phrasing suggests a breadth of provision, but does not guarantee the same service to all. It promotes anti-discriminatory practice, suggests equal access, attempting to end the postcode lottery. However, the 'choice' agenda and local circumstances will limit provision.
2. Access to NHS services is based on clinical need, not an individual's ability to pay.	The original tenet has been maintained, but there is an addendum that states 'free of charge except in limited circumstances sanctioned by Parliament' allowing charges to be applied.
3. The NHS aspires to the highest standards of excellence and professionalism.	This general statement is difficult to disagree with or to measure, as it is aspirational.
4. The patient will be at the heart of everything the NHS does.	Again an admirable aim, which does include words like: 'involved' and 'consulted' on personal care and encouraged to provide 'feedback', on individual care.
5. The NHS works across organisational boundaries.	This embraces a full range of providers, embedding a plurality of provision.
6. The NHS is committed to providing best value for tax-payers' money.	The words 'effective', 'fair' and 'sustainable' are identified, but the last sentence: "Public funds for healthcare will be devoted solely to the benefit of the people that the NHS serves."(p.4) could be viewed as a safeguard or open to different interpretation, with regard to profit making bodies, providing that service.
7. The NHS is accountable to the public, communities and patients that it serves.	Reminds the public that NHS accountability systems should be transparent within the NHS, but there is no mention as to how this affects related organisations.

The language of the first four principles echoes some of the original altruistic core, with small modifications. The last three principles subtly remind the reader of the range of organisations involved; the need to be cost-conscious; and, suggest that although the NHS is accountable at all levels, this burden of responsibility is not necessarily shared with government. In my opinion, the mood has shifted from one of philanthropy to moderated financial commitment.

This tempering of early ambition can be seen in the downgrading of the overall achievement, in descriptions of the creation of the state run service. *The Five Year Forward View* (NHS England, 2014a, p.2) grudgingly admitted that: "The NHS may be the proudest achievement of our modern society." The sentence ends there, but the word 'may' is worth noting. The reader is guided to expect a 'but' and this comes later in the same foreword where it states "Our values haven't changed, but our world has". The report goes on to describe how the NHS "needs to adapt" and "needs to evolve" (ibid, p. 2), there are mysterious references to "the possible futures on offer and the choices that we face". It talks about "new partnerships" and "critical decisions about investment" as well as "local service charges" (ibid, p.3).

NHS England[3] similarly state: "Our values haven't changed" (2014a, p.2), yet the Health and Social Care Act (2012) removed the Secretary of State for Health's duty to provide a national health service. The justification for the shift from management to guardianship seemed to be based on a need to 'decentre' the state from provision, to remove political influence in favour of market forces (Newman and Clarke, 2009). The shift entails a stepping away from moral responsibility for the NHS. Although NHS England acknowledge: "There's been pride in our Health Service's enduring success, and in the shared social commitment it represents" (2019, p.6), the praise for this collective achievement is phrased in the past tense and the legislation encouraging competition remains unchanged (June 2019). The plan positively encourages

[3] NHS England is the body that 'leads the National Health Service (NHS) in England, it oversees the commissioning and accountability concerns' https://www.england.nhs.uk

increased NHS activity and makes reference to health inequality, but the financial and staffing difficulties remain a problem in turning the rhetoric into reality (King's Fund[4], 2019).

Wilmot (2003, p.13) argues that part of the problem is a perceived 'rigidity of service' and this has contributed to a 'diminishing tolerance of public service'. This criticism is summarised in the *NHS Long Term Plan* where they state: "One-size-fits-all statutory services have often failed to engage with the people most in need, leading to inequalities in access and outcome" (NHS England, 2019, p.12). However, if the solution to inequalities is viewed as one of choice provided by commercial plurality, then it may not be social justice, but individualism that guides future developments. Turner et al, (2014) argue that in Western capitalist philosophy individualism[5] has become a dominant ethic.

This individualistic emphasis has been noted by left wing lobby groups and is analysed in more detail in Whitfield's (2012) paper on *The Mutation of Privatisation.* As Director of The European Services Strategy Unit[6] (ESSU), Whitfield is committed to public management of public services and has been involved in a range of European trade union research in local government services over the years (a UK example being the ESSU report on Commissioning in Barnet, 2012). In his analytical paper (2012) on rights, Whitfield identifies and critiques a series of English legislative changes that promote individual and community rights and discusses the relationships between 'rights', 'choice' and 'contract cultures,' examining the conflicts and contradictions that arise. His conclusions from the linguistic and economic analysis are that the rhetoric of individual freedom and choice supports increased competition and marketisation, with the potential to destabilise public services (Whitfield, 2012, p.6).

[4] The Kings Fund is an independent charity with an interest in health and social care established in 1897. It supports research and improvements in England, with the aim of providing better services for all.
[5] The interpretation of individualism used here refers to the New Right view of individualism as an economic and political freedom provided by a capitalism that "defends the individual against the state" and "forces of collectivism"(Abercrombie, Hill and Turner, 1986,p. 3)
[6] This European Services Strategy Unit states" it is committed to social justice, through the provision of good quality public services by democratically accountable public bodies "(Whitfield, 2012, p.2)

The choice agenda has been stressed in the NHS and is regularly referred to in government publications, and the need to present individuals with options has become a common thread (NHS England, 2019), but this suggests a range of providers need to be available. Some of these providers are profit-making organisations and Wilmot makes the point that privately owned or public companies are by their very nature 'amoral', because their first priority is profit (2003, p.69). The King's Fund policy team has expressed concern about the lack of transparency in newer profit making organisations and the lack of accountability checks established in the new market place (Ham et al., 2016; Collins, 2017).

Left wing journalists Leys and Player (2011) collated evidence from observations of government meetings, political interviews and international news sources identifying ethical concerns about some of the healthcare businesses presenting tenders. They claim some of the organisations offering to provide services in the UK have been involved in court cases or out-of-court settlements in other countries for patient neglect, fraud and unsound financial practices[7]. The specifics of each case can be debated, but the alarm raised here is in terms of our lack of adequate checking mechanisms. If the only requirement is to complete a task and profit is the only driver, the standard setting and enforcement mechanisms need to be strong to prevent abuse. This reminds me of Wilmot's (2003, p.11) concern for the loss of a 'moral compass' within services as a whole.

It is not only the profit motive that is a moral concern, but the business management styles associated with corporations that use new public management techniques. Iles in her capacity as an educator in health care leadership, argues that 'performance management' has become dominant in the NHS (2011, p.7). She claims, from her experience of leadership workshops that management techniques have become 'impoverished' (ibid, p.7). Iles claims that this combined with the constant under-investment in re-

[7] Leys and Player identify instances with United Health, p. 131; Kaiser Permanente, p.133; Netcare (owners of the BMI chain), p.74

organisations has had a destructive effect on "the intrinsic motivation and passion of all concerned" (2011, p.72). My nurse-participants were experienced nurses who had lived through many of the organisational changes and I wanted to know what impact all this change had on them and how that affected their project work.

They would have experienced public service values in their early socialisation in the UKNHS. Pratchett and Wingfield's case studies in local government services captured some of these values, finding a distinct public sector 'ethos', characterised by a sense of 'accountability', 'bureaucratic behaviour', 'public interest', a 'motivation' that was 'altruistic,' and 'loyal' to the service (1996, p.641-642). McDonough's in her research into the effect of municipal restructuring in Toronto discovered an unexpectedly 'fierce loyalty' to public service amongst her interviewees (2006, p.629). McDonough describes being surprised by the responses from front line staff, who listed numerous examples of spontaneous actions and expressions of concern about the 'public good' (2006, p.629). I wondered whether any of these attitudes would be evident in the nurse-participants or whether they would have adopted consumer-oriented mentalities.

Wilmot (2003, p.10) argues that nursing and medicine as professions in the UK "draw heavily on the idea of vocation as a motivation for engaging in their activities" and have "ethically oriented" professional codes. His evidence comes from an examination of professional guidance documents, research articles and professional opinion and he claims that these sources are: "reasonably consistent" (ibid, p.22). The UK NMC provides a list of ethical principles framed as professional standards in the 'The Code' (2018). Austin, a nurse educator and researcher, argues that historically: "To state that one is a nurse is to make not only a professional claim, but a moral one (2011, p.161). This stimulates the question 'are the values of the life-world those of vocation and or public service'?

The problem with having a moral stance of serving others is that it can be exploited. Austin (2011, p.158) argues that the research on compassion fatigue highlights the 'incommensurability' of customer service models with moral

practice. A report on nursing 'character' identified data from an NHS survey carried out in 2016, which identified that over half the nursing staff reported working unpaid overtime each week (Jubilee Centre for Character and Virtues, 2017, p.1). More concerning was the finding that just over half the respondents felt unable to deliver the care they aspired to (ibid, p.1). This suggests their value systems were being challenged by conflicts between aspirations and work conditions.

Hart (2004), a nurse consultant and university lecturer suggests that nurses have been exploited because of their tendency to take responsibility for others and to adopt of a sense of self–sacrifice. He argues that the phrase 'for the good of the service' (ibid, p.82) has been used in the UKNHS particularly. Hart identified nurses desire to be 'heroic' as a weakness, rather than a strength, as he argues it has suppressed rebellion, prevented radical action and "complicates the relationship between nurses, practice and politics" (2004, p.32) .

In a literature review on new public management (NPM) Dutch university lecturers Kolthoff et al. (2007) identify the breadth of debate and the ethical challenge NPM presents, as organisations move from an assumption of human rights entitlement and the bureaucratic supply of services to a more fragmented mix of public and private provision. They suggest that even if professionals are unlikely to be corrupted because of their codes of practice, the loss can be one of 'benevolence', when staff become more cynical or cost driven and moral problems are redefined as management issues (ibid). Firth-Cozens and Cornwall expressed concern in their report on enabling nursing compassion that:

"If finance and productivity are perceived as being the only things that matter, it can have profound negative effects on the way staff feel about the value placed on their work as caregivers."(2009, p.8)

Waring and Bishop (2011) examined transfers between NHS acute hospital trusts and independent treatment centres in comparative case study research. They carried out semi-structured interviews with health professionals in two day-surgery units in the Midlands and looked at how staff adapted to business

ideology. They found ‘widespread reserve’ and some ‘resistance’ from nurses in terms of their willingness to adopt private enterprise values and revealed a range of different professional responses, which they characterised as:- ‘pioneers’, ‘guardians’ or ‘the marooned’ (ibid, p.675). Nurses tended toward the latter two groups. Hebson et al. (2002) similarly looked at nursing secondments and found that concerns were increased when staff transfers were involuntary.

In this section, I have used independent and left wing commentaries to critique government policy statements to expose a changing value system within the UKNHS. In this shift from a universal public service to a more individualistic consumer oriented provision I have identified concerns about the impact on public service values, highlighted the potential for a loss of moral direction and discussed the possible impacts on the professionals involved in the service.

Elements of Privatisation

In this section I examine how business principles were gradually being assimilated into political and economic alterations to service provision. Political and economic reforms are considered together, because the way economic constraint is applied is a political decision (Newman and Clarke, 2009) .I offer a timeline that charts the increasing presence of business influence in UKNHS reforms and discuss the impact of these changes.

Habermas (1984) explains the development of the welfare state in the 20th century as capitalist economies compensating for the damage done by industrialisation and market forces. Successful western economies provided a safety net of welfare as reparation for human suffering and this was illustrated in the Labour Party manifesto (1945) which said of the people: “they deserve and must be assured a happier future than faced so many of them after the first war.” Moran, a political economist, presents a more radical perspective, describing advanced capitalist economies as providing “generous social programmes” to counter “the appeals of fascism and communism” (2000, p. 138). In this interpretation, a safety net of welfare was a defence against rebellion. This political interpretation of post second world war history

suggests social reform was pragmatic and driven by powerful interests using state control to maintain power.

Whichever motive drove the establishment of the UKNHS one could argue that the need for ‘reparation’ or defence has declined. Public health has improved and society has become more politically stable, treatment options have expanded increasing costs. Financial pressures that were triggered by oil and banking crises over the years have prompted a reassessment of state investment. The government is now more likely to present the escalating patient numbers, resulting from an ageing population, as an unmanageable cost, and use this as an argument for supporting an agenda of ‘reform’ (DH, 2014; NHS England, 2014).

If you place these changes in the context of a wider capitalist frame of reference, services, once perceived as ‘protected’ from commercial development, in the sense that they could not be bought, were now being appraised in terms of business value. Scholarly social policy has pointed out that global businesses were beginning to view state investment and contracts as lucrative sources of guaranteed income and profit (Newman and Clarke 2009). In a culture where business is viewed as the ideal model, reaching for this source of investment can appear ‘instrumentally’ reasonable. There is now evidence that in the long term it increases the cost of services, for example in terms of private finance initiatives with their high interest on loans (Welch 2018, p.91). The decision to increase private involvement appears to be based on an assumption that business-oriented thinking is somehow superior to public administration systems in terms of efficiency, although as Kolthoff et al (2007) state this assumption does not appear to be evidence-based. The decisions made were political preferences, although often presented as economic necessity.

Table 2 identifies the encroachment of market forces in a list of government changes that have taken place over the last forty years (Welch, 2018). This cataloguing of changes delineates how the UKNHS has moved from a few private patients in UKNHS hospitals to private enterprise involvement in advising on commissioning and providing services.

Despite the NHS being recognised as the highest performing health organisation out of eleven industrialised countries (Commonwealth Fund, 2010), there is evidence of a systematic dismantling of the service so that private enterprise organisations can profit from its success. The Marxist writer, Mishra (1990) argues in his review of social policy in Europe, North America and Australia that public sector investment was held down, not only because of cost, but also as a deliberate tactic to make public services more attractive to private buyers. Certainly there have been repeated calls for efficiency savings of billions of pounds (NHS England, 2014; The King's Fund, 2015; NHS England 2019). These financial pressures were passed down to local staff, not only in salary cuts through role reorganisation and skill mix, but also in terms of reducing the resources with which people work.

Despite the Government's enthusiasm for the market model, leading figures in health care policy challenged the extreme changes that were unfolding: Iles (2011) drew on discussions taken from a learning set established between leading policy analysts, and concluded that good ideas have been undermined by under investment. Iles requested a reconsideration of the market plans that the group believed would 'seismically refashion' the UKNHS through the Health and Social Care Act 2012 (ibid, p.16). More specific criticisms of these contracting-out policies have been triggered by the dramatic failure in private ownership of the Uniting Care Partnership , and were made by individuals working with the King's Fund, for example Collins' (2016) ,yet the government message had not changed at the time of my study.

Table 2– From Public to Private Organisational Changes in the UKNHS (Adapted from Welch's timeline, 2018)

Date	Change	Impact
1983	General Management introduced into to the NHS, on the advice of Griffiths Report (1983).	Clinical leadership replaced by generic management, managers from private enterprise organisations were also brought into the NHS.
1990's	The internal market and GP fundholding introduced through the NHS Community Care Act 1990.	The commissioner / provider split introduced and GPs encouraged to 'shop around' for services. Pressure was placed on services to look at costs as well as benefits of different treatments.
1991	The Patients Charter identified individual patient's rights.	Individualist focus embedded and targets for waiting times established.
1997	Fundholding was repealed in the 'The New NHS Modern and Dependable' white paper, but the internal market remained and in 1999 Practice Based Commissioning (a universal form of GP fundholding) was brought in.	This change created the illusion that the political direction had changed, but it had not, commissioners and providers were still separated and competition was still encouraged.
1997	Private Finance Initiatives encouraged.	Public service organisations obtain high interest loans resulting in new hospital build debt accumulation.
2003	The Health and Social Care Act introduces: the concept of Foundation Trusts in the NHS (NHS trusts with greater independence), with a new body called Monitor overseeing them APMS, Alternate Provider Medical Services contracts allowing non-NHS providers to be commissioned. Independent Treatment Centres	This opened up public service provision to private enterprise contracting organisations and brought in a plurality of providers.
2004	GP contracts were modified allowing	Private companies tendered

	GPs to opt out of out of hours care.	for these contracts.
2010	Commercially-based business consultants used to advise commissioning groups and trust providers.	The government encouraged business thinking to be adopted in NHS organisations.
2012	The Secretary of State for Health's responsibility for the Nation's Health was delegated down to commissioning groups, his role changed to one of stewardship, having a 'duty to arrange provision' rather than provide it. The 'Any Qualified Provider Scheme' was introduced permitting private companies to tender more widely for contracts. (Health and Social Care Act 2012)	The state steps back from overall responsibility for services, choosing to rely on local bodies to institute governance arrangements to protect the public.
2014	The Five Year Forward Review (NHS England, 2014) promoted a breakdown of barriers to new providers.	Commissioners are encouraged to accept a wider range of providers.
2014	Monitor given responsibility to oversee licensing and standard setting across public and private organisations (Monitor, 2014)	An organisation previously involved in regulating the independent sector is expected to set the standards for all organisations under the NHS umbrella.
2016	Health spending is at its lowest since the second world war, yet the government pushed for seven day working. (Welch, 2018)	This does stimulate questions about how the government imagined this would be resourced.
2015 2016 2017	Integrative Vanguards set up. Vanguards Evaluated (Monitor absorbed into NHS Improvement). (Gov.Uk, 2019) Rolled out. Formation of Accountable Care Organisations (American Phrasing) The legislature still does not now support anti-competitive behaviour.	Kings Fund policy analysts query whether this heralds the end of the competitive market and whether private enterprise initiatives are being reigned in or whether this will pave the way to bigger healthcare companies holding larger and longer contracts. (Collins, 2017)

The Government's response to concerns about the fragmentation of the market system was to propose integrated care networks. As outlined in Table 2 (shaded area) pilot sites were established and then reviewed by Collins, who complained that the vanguards were being developed "within a set of organisational arrangements that are more complex and fragmented than any in the history of the UKNHS, involving multiple commissioners and providers" (2016, p.6). Although these later changes were after the research interviews this comment outlines the complexity of the nurse-participants' situations. Changing organisational structures meant concerns about workloads and terms and conditions of service. In addition Willis refers to the constant demand for organisational change as causing 'change fatigue' (2015, p.1).

The nurse-participants were being encouraged to be innovative for their WBL, yet within the constraints of contracts and budgets. The contradictory message of cuts described in terms of reform and innovation is reflected in some of the introductory paragraphs of WBL articles. Thurgate (2018) uses the cuts being demanded as a rationale for her WBL course for a new level of health care assistant, increasing the skill mix, but reducing the level of overall qualified personnel. To me this raises concerns about the 'colonised' nature of such project aims. By listening to the nurse-participants' accounts of their project work I hoped to learn whether such political and economic 'system' changes were affecting their projects and to explore whether hegemony[8] was occurring or these pressures were being challenged or resisted.

Habermas (1984) states the influence of steering 'systems' can be obscured by the language of supposed reform and the complexity of these mechanisms. Bauman commented on how the word 'reform' is used by political groups to justify change they wish to bring about (Bauman and Lyon, 2013). This is not a new phenomenon. Ball wrote of the 'new vocabulary' of performance, and suggested it forced old ways of thinking to be viewed as redundant (2003, p.218). The language being used by the nurse-participants to describe changes

[8] "Hegemony is the process by which we learn to embrace enthusiastically a system of beliefs and practices that end up harming us" (Brookfield, 2005,p.93)

in their learning environment was an important factor in gauging their adoption of business ideas and their response to changes taking place.

In this section I have identified how the responsibility for running the UKNHS has been gradually shifted away from state bureaucracy towards a plurality of commissioners and providers, with an increasingly private enterprise influence. I have tried to show how this change in provision has been subtle, incremental and not obvious to those working in hospitals across the country. The nurses in this study might therefore be unaware of the alterations taking place in the 'systems' around them or of the impact of these on their 'life-world'. I suspect that an unquestioning acceptance of policy directives could make them vulnerable to 'colonisation by' these business-like ideas.

Nursing's Professionalisation

Nursing in the meantime was pursuing its own agenda of professionalization. Here I show how nursing has tried to establish its own separate identity within the multi-professional team. I consider nursing's attempt to break away from medicine and establish their own identity and discuss whether nurses need to develop autonomy to discover their power. In this section I look at how nursing as a profession has been evolving within this changing healthcare context and consider whether this professionalising project could be distracting attention away from wider concerns with the UKNHS as a whole. I outline how some nurses have tried to take advantage of some of the opportunities provided by policy changes to raise their profile and question whether some of these developments, perceived as professional advances, benefit nurses and their clinical teams or weaken the health service as a whole.

The role of nurse education in increasing socio-political awareness and professional development is discussed here. I argue that without an understanding of their contribution to this political setting, nurses are working and learning in the dark. UKNHS nurses care for both public and private patients in NHS hospital wards under the institutional umbrella of the NHS, but the overall care is viewed as a public service and a team activity. Early images of nurses are very much of them as subordinate to medicine within this

team work. Freidson (1970) classed nurses, like other allied health professions, as inseparable from medicine, in fact paramedical. In sociological terms the nursing profession appears as a 'semi-profession' (Etzioni, 1969), because it is unable to distinguish its body of knowledge and has failed to control occupational boundaries in terms of the number of grades of health care assistants developing.

Cohen argues that nurses need to understand the power relationships within the workplace to progress their professional status, but he argues these are overlooked in "nursing education, theory and research" (1992, p.113). The educational emphasis is on the detail of clinical practice, instead of the politics of service provision. In my experience as a nurse educator, even when Project 2000 (United Kingdom Central Council for Nursing and Midwifery, UKCC, 1986) made student nurses university students (rather than employees) and such subjects as sociology were introduced to the curriculum there was little questioning of political infrastructures in what I observed.

When nursing schools transferred into universities (1980's) they remained on the 'periphery' (Watson, 2006), because nursing students were unable to access the university social life when on shifts for placements and their accommodation was often separate. Miers, in her small study of nurse teachers found that individuals were concerned that nursing would become the 'Cinderella' of HE (2002, p.213). The nurse-participants in my research study may have experienced this isolation from academic scholarship, even if educated in a university building, because there was likely to be little contact with the wider university. In many parts of the country the educational emphasis, remained on maintaining links with practice and clinical skills teaching.

However, having a university base did provide opportunities for nurse educators to develop their ideas around theory and participate in research. Salvage (1992) developed 'primary nursing', emphasising holism and continuity of care. This 'new nursing', began to build a separate body of clinical knowledge and has been viewed as part of a 'professionalisation project,' in which nurses attempted to gain academic recognition for their

intellectual as well as practical work (Wilkinson & Miers, 1999, p.25-26). However, Miers believes that the dual problems of 'anti-intellectualism within nursing' and 'the academic denigration of practice in academia' have dogged the assimilation of nurse education into HE (2002, p.212). She draws on a series of surveys and accounts of new graduate experiences of anti-intellectual attitudes towards them. These were sometimes extremely negative and nurse leader Trevor Clay (1992) commented on the need to address this issue within the profession. In addition Miers builds on the research work of others like Carlisle et al. (1996) who identified nurse educators' concerns about not being accepted as equals in HE.

Miers expresses concern that "nurses might have internalised a view that caring is natural and does not require intellectual and educational development" (Wilkinson and Miers, 1999, p.70). Grealish and Smale (2011) echoed these concerns about anti-intellectualism in their research in Australian nurse education, between 1985 and 1994. They believed that the emphasis on nurses as 'doers' rather than 'thinkers' contributed to undermining critical thinking (ibid). This was not helped in the UK, by the fact that nurses' education was initially at diploma level. All-graduate study wasn't introduced until 2013 (NMC, 2019a) and did finally bring some parity with other health professions, but student status had already reduced nurses' influence in the workplace (Miers, 2002).

The nurse-participants in my research were experienced nurses and were trained before nurses gained graduate status. Their focus on professional development was tied to their occupational roles as specialist nurses, managers or clinical educators, but they were aware of the changing academic status of nurses and debates about nursing's direction as a profession. Nurses have to keep up to date, and the latest guidance on their 'Revalidation' process demands a portfolio of supporting evidence of study (NMC, 2019b). Within the Royal, Midland University WBL modules were viewed as a way of accrediting learning being undertaken in the workplace, a practice recommended by Health Education England (HEE, 2016, p.18) as a useful form of CPD.

Another way in which nurses had attempted to increase their professional independence was by carving out specialist roles and this is pertinent here to WBL. Nurses had been given greater opportunities to develop advanced practice skills when doctors' hours were reduced as a result of the European working time directives (Executive National Health Junior Doctors, 1991; DH, 2003). The shortages of medical staff and the pressure to reduce labour costs presented opportunities for nurses to take on medical tasks and some seized this chance to take on more advanced skills, becoming 'mini-doctors' with a chance to increase status and salary.

Allen and Hughes comment with regard to the blurring of doctor and nurse boundaries: "often it is not clear whether this represents an opportunity for professional advancement or a threat to existent professional norms and working conditions" (2002, p1). The advanced clinical practice role involved taking on medical knowledge and more responsibility, but on a lesser salary. Many of the students' WBL projects over the last few years at the Midland were focused on extending roles and enhancing professional skills in this way, and therefore this debate about nursing's development as a profession is particularly relevant to WBL.

The problem has sometimes been one of recognising when responsibility is passed down, but authority is not. Although able to make some decisions, referral powers and clinical influence in medical teams was restricted. The latest ethnographic research on multi-professional teams suggests doctors are still viewed as team leaders, despite nurses increasingly demonstrating co-ordinating roles (Allen, 2015), perhaps because doctors retain the overall legal responsibility for care. Nurse educators: Cameron et al. (2011), in their editorial on nursing philosophy, raised concerns about nurses' apparent lack of political awareness of their workplaces. Bjornsdot-tir (2009), in her international review of ethnographic studies of home care, identified that nurses perceptions of themselves as powerless and only involved in practical activities made them apolitical in approach. Yet this is problematic, as Allen points out: "there seems to be an assumption that nursing work is infinitely

elastic" and that the "nursing workforce represents an endlessly absorbent sponge" (2001, p. 165).

The Willis Report sponsored by HEE, to identify the future educational training needs of nurses, states that the registered nurse 'is not a finished product' and that further career development is vital (2015, p.50). He argues registered nurses will need to gain a long list of clinically advanced skills including: undertaking diagnostic tests; prescribing; administering intravenous fluids; and, complex pain relief in patient's homes in the future (Willis, 2015, p.22). This report thus confirms the trend towards more advanced skill development and increased workloads, and identifies increased levels of responsibility. The course pathways he suggests do seem to offer a broader framing than simply clinical skills acquisition, embracing leadership, education and research skills, all of which are appropriate to postgraduate education, and I would argue call for a communicative rather than an instrumental reasoning approach.

However, if nurses do not have a clear sense of professional identity or understand the socio-political forces around them, they will absorb work without being able to influence the way they develop as practitioners. They would not be able to protect themselves or their patients from the negative effects of reducing the number of skilled professionals in their teams. Although a nurse may want the advanced skills listed in the Willis Report, what may be happening in practice is that a doctor is no longer employed, reducing the knowledge base and skill mix of the team as a whole. Gott (2000) argues that this constant focus on nursing's own separate or singular professional development in terms of advanced skills detracts from a wider awareness of the larger issues about the structures in which they work. In my experience WBL students rarely reflected on why the new roles they were devising or enacting were required politically, instead they saw them as a personal opportunity to develop.

The lack of formal opposition from nursing professionals to the dramatic changes that have taken place in the NHS over the last few years may seem surprising, but the dual smokescreen of criticism of the NHS and praise for

business (Iles, 2011), combined with the incremental nature of the changes, has meant that alterations occurred with little public notice. The private businesses were secreted under the cover of the NHS and even the staff employed in these sub-contracted facilities were unclear about the way these 'systems' worked (Waring and Bishop, 2011). These organisations appeared to be serving the public good, by offering services 'free' at the point of delivery, although they were costly to the UKNHS in the long term.

Although the largest part of the workforce in the UKNHS, nurses have had little influence on strategic developments, Hart (2004) suggests this could be due to the lack of political awareness identified before or because of a blindness to anything but a practical role (Bjornsdot-tir, 2009). Gott (2000) suggests that when nurses enact policy decisions there can be 'conflicts of interest', because they can be asked to enforce restrictions on services and to implement changes they may not feel comfortable with. This would put pressure on nurses to consider political constraints, but if they have a colonised view of cuts as economic necessities they will not even be aware of alternatives.

Cameron et al. (2011) argue that nurses are unable to engage in a political debate, because they lack the theoretical and intellectual resources to formulate defences against attacks on their profession or services. Maslin-Prothero and Masterson, writers on nursing policy, comment: "There seems to be a fear that becoming political will damage the caring ethic, stability and respectability of nursing" (1990, p.218). This echoes Mier's statements about the anti-intellectualism that can still be present in the workplace. This fear of appearing political could also be due to their sense of public service or vocation limiting their life-world view or could be due to systemic pressures to conform.

Despite ethnographic evidence of a willingness to take on new roles, health professionals have still been: "berated for their tribalism, turf battles and professional self-interest, health and social service staff have been portrayed as an inherently conservative force" (Allen and Hughes 2002, p.100). Yet nursing has 'change and innovation' written into pre- and post-registration standards of education (NMC, 2019a and b). However, when they are unwilling to change

practice, for whatever reason, these criticisms are levelled and I argue their lack of political insight makes them unprepared for such conflicts. The Italian Marxist, Gramsci (1971) pointed out that professionals tend to have an idealistic view of themselves as unaffected by class conflict, but that this elitist attitude can obfuscate the power struggles surrounding them.

This section has focused on nurses as a professional group struggling to establish a powerbase alongside medicine. Nursing as a profession has pursued independent professional status through firstly trying to build a separate knowledge base and gain academic recognition through achieving graduate status and secondly taking on advanced roles alongside doctors. However, nurse educationalists have suggested that nurses' awareness of their political setting remains limited (Maslin-Prothero and Masterson, 1990; Gott, 2000; Hart, 2004; Bjornsdot-tir, 2009; Cameron, et al, 2011). I suggest that nurses often appear to have adopted policy initiatives for UKNHS reforms without question and view themselves as managing and implementing them, rather than initiating changes they think are important.

Conclusion

In this chapter I have identified: changing value systems, shifting political stances, economic pressures and professional debates. I have shown how the development of the UKNHS was driven by the altruism of some, the political machinations of others, and the economic demands of capitalism. I depicted an occupational setting under pressure to change, but beset by contradictions in terms of messages to staff. I have suggested nurses working within this environment might experience moral dilemmas and conflicts of interest between a life-world of public service and system drivers to be more 'business-like'. Economically cuts present difficulties but have been perceived as opportunities by nurses wanting to grasp professional development. I argue here that blindness to the socio-political debates about service development make them vulnerable to manipulation. By identifying the complexity and significance of the political agendas surrounding the nurse-participants, I hope to have identified some of the possible challenges they faced. In the next

chapter on WBL I examine whether current educational provision is sufficient to prepare students for theses political challenges.

Chapter Three - Work-Based Learning Dilemmas

"Even the development of nursing knowledge has a political aspect to it"

(Maslin-Prothero and Masterson 1999, p.209)

Introduction

As outlined in the introduction, WBL in this context was designed to meet the educational needs of qualified nurses for CPD and to respond to clinical demands for specialist content to enhance nursing practice. In this chapter I examine the strengths and weaknesses of this form of learning in terms of the learning process itself; the need for workplace support and WBL's ability to deliver transformative learning.

My critical review of the WBL literature draws on historical and critical comment from generic WBL sources including: HE guidance documents; WBL texts and conference papers, as well as nursing texts and articles. I begin by identifying how experiential learning in the workplace is by its very nature vulnerable to external influence, but go on to explain how it has developed as a learning approach over the years in 'The Evolution of WBL.' Here I use the early nursing literature (1990 - 2006) to demonstrate the unquestioning enthusiasm for WBL and the early focus on innovative curriculum design and course evaluation.

Nurse educators began to use research tools to examine their courses more closely from 2007 onwards, but studies remained small in scale and infused with an eagerness to make programmes work. This second section 'The Conditions for Workplace Support' shows how these studies identified the difficulties in the learning environment and began to link these to the problems of gaining adequate support. By analysing the commercial pressure to customise courses and to meet employer demand I argue that workplace support has been steered by local socio-political pressures to conform to internal agendas, yet despite this willingness to accommodate employer demands, gaps in organisational support remain. I contrast how the generic

WBL writers identify these as real concerns, yet nursing researchers treat these as manageable problems.

The third section 'Transforming Learners and Organisations' proceeds to examine the aspirational claims for transformative learning and considers whether these were and are achievable. I show how the literature recognises that the learning is socially constructed and therefore how collaborative working is essential. Yet, note that there appears to be an assumption that nurses can lead change in isolation.

In this chapter I therefore reveal the continued passion for WBL, identify the obstacles to successful learning, and question the apolitical stance, which prevents nurse education addressing workplace issues. I do refer to my own experience as a module co-ordinator to clarify contextual issues and make reference to educational theory where it illuminates the learning taking place. For reference details of the search strategy for the review are included in Appendix One with a chronological list of the WBL nursing literature.

The Evolution of Work-based Learning

In this explanation of the nature of the WBL process I show how WBL work evolved from customised formats to broader professional development. I argue writings in nursing CPD (1990-2012) illustrate how student work was being shaped by organisational pressures that reflected an instrumental rather than a communicative reasoning approach. The consequent tensions between competence development, capability enhancement and broader professional aspirations are identified.

Historically, in nursing it was assumed that practice learning could be absorbed through observational shadowing, learning almost by osmosis (this was referred to as 'sitting by Nelly' in my own training). The understanding gained could be equated to what Beckett refers to as a kind of 'organic' process bringing together 'thinking, feeling and doing' (1999, p.86). However, this form of learning can be contextually limited, minimally linked to theory and influenced by the individual behaviours of those involved. Potentially WBL

can still take this form if not linked to any critical questioning of the learning environment. Hunt (2000) undertook a scoping exercise looking for examples of WBL amongst British universities and found many examples demonstrated behaviourist approaches of skills training days, where only theory specific to the clinical material was included.

Nursing CPD in taught university courses was similarly focused on specialist knowledge with either a clinical focus for example cardiac or palliative care; or operational management and research skills, again behaviourally oriented. At first these CPD courses did not accredit practice-based assessment, but this changed, when specialist practice competences were standardised as occupational tools and thus became credible evidence for academic portfolios (Timmins, 2008). From a curriculum design perspective, however, it was still difficult for universities to accommodate the constantly changing demand for new clinical knowledge and skills. Chalmers et al. note, from their perspective of training practitioners in emergency care, that there was a "need for a rapid response to wide ranging changes in the health service" (2001, p.597). New modules took time to be designed, constructed, validated and resourced in HE, while healthcare organisations used existing clinical teachers to carry out clinical skills training at short notice, incorporating practical assessment into these short programmes. However, UKNHS employers wanted assurance about the 'rigour' or quality of their training courses and academic recognition of the study involved (Chalmers et al, 2001,). I was party to many meetings where employers sought to strengthen links with the university to gain accreditation of their in-service courses.

WBL, as an educational 'mechanism' (Gray, 2001, p.3), offered a vessel by which a variety of specialist subjects could be tackled in a standard academic framework, forming a bridge between in-service training and HE accreditation. This joint approach was enthusiastically linked to the concept of building 'learning organisations' (Senge, 1990), a concept specifically mentioned by WBL educators Moore and Bridger (2008). The HEFC identified the potential of WBL as a 'prime vehicle for workforce development', because learners could both remain in the workplace enhancing their practical skills, enrich their

knowledge through academic study and improve their professional development by applying their learning to their practice (2006, p.78).

In 2006, the HEA highlighted WBL as a 'prime route' for 'lifelong learning, because of its focus on 'learning to learn' (Nixon et al 2006, p.83). This 'meta-competence' (Raelin 2008, p.13) suited academic demands for independent learners, and the employers' needs for adaptive workers. Learning to learn is often perceived as a graduate attribute, valued in university education (Durrant et al, 2011); and a problem solving, 'getting things done' attitude is appreciated in the workplace (McGill and Beaty, 1995, p.21). Combining these active learning approaches represented a shift from learning based on subject disciplinary knowledge acquisition and its application (Gibbons et al,1994), to learning being more practical, experimental and evaluative (Scott et al, 2004).

Descriptions of WBL courses in nursing began to appear in the UK in the 1990s (Brennan and Little, 1996) and the writings from 2000-2015 echo the enthusiasm expressed in educational policy. The first nursing writings in WBL celebrated the customised nature of WBL and its ability to embrace specialist content for clinical role development. The benefits of successful collaboration in developing new roles for specialist nurses or 'mini-doctors' were highlighted in articles describing new courses (Chalmers et al, 2001; Clarke and Copeland, 2003; Dewar et al, 2003; Swallow et al, 2006). Swallow et al (2006) praise the way WBL keeps learners in the workplace, Chapman (2006) highlights the impact on services and Dewar et al enthuse about how their course improved 'personal effectiveness' in the workplace (2003, p.3).

Stephenson likened WBL modules to 'capability envelopes' bringing together: 'a thoughtful openness to change', 'self-management of learning' and 'problem solving,' all of which are important in developing a professional, who needs to continually update their knowledge and skills (2001, p.87). However, such courses were dependent on the ability to create people who could 'do' and did not necessarily include any questioning of personal or political values. The emphasis was on increasing personal effectiveness, not on questioning structural conditions or workforce direction. There are no explicit statements in discussions of 'capability' development in WBL about

questioning the social context. Capability, in this situation, was about acquiring the knowledge and skills for work and learners 'making a project of themselves' to meet requirements (Garrick and Usher, 2000, p.9).

Yet experiential learning as an educational approach had evolved into more than just a learning to 'do.' Kolb's (1984) reflective cycle encourages both reflection and abstraction. In nursing, Benner (1984) emphasises the role of reflection in the development of nursing expertise and she includes theoretical analysis in her stages of professional development. Eraut (1994, p.20), in his consideration of professional learning raises the concern that context, because of its established routines, needs to be deconstructed for new learning to take place. Manley et al. (2009), in their concept analysis of WBL in nursing, describe how WBL had evolved from simply the observation and reproduction of behaviours to a much more complex questioning and interrogation of the workplace and co-production of learning. However, the questioning appeared to be limited to clinical routines in most of the nursing WBL literature.

In the healthcare context the knowledge being imparted originated from UKNHS policy and had embedded values and biases that were directed towards a specific end. As Maslin-Prothero and Masterson state: "Even the development of nursing knowledge has a political aspect to it" (1999, p.209). The problem was that there seemed to be an assumption that what employers wanted their staff to learn was paramount, worthwhile and in the student's interest. Although the professional debates about nurses continually being expected to take on extra skills and tasks (Allen and Hughes 2002) had been present in scholarly circles for some time, it was not until my students began to focus on cost savings and skill mix that I began to question project choices. Senge (1990, p.4) warns that learning should be 'generative' not just 'adaptive'. Creating new advanced roles can be generative, but not if it involves merely adapting to an existing context and transferring skills from one professional group to another. Promoting this as professional development assumes it is beneficial for the staff concerned and above question.

I began to look in WBL writings for a questioning of the appropriateness of workforce changes, in terms of the impact on workloads, responsibility,

accountability or services in general. Most introductions to articles on WBL courses focused on the need to reduce costs in the NHS or to up-skill the workforce, making reference to the latest government policy. However, this could reflect justifications given to increase the likelihood of article publication and appeal to a wider audience, rather than reflect the original reason for the course development. In the literature I examined, I found very few nursing WBL writers offering any generic questioning of why services needed to change, any challenge to specific skills development or evidence of any questioning of student's topic choice. At this time I was working on a European nursing project where the identity of a nurse was being internationally debated and this heightened my concern for the lack of debate in the UK.

Livesley et al. did express some unease about the lack of organisational 'readiness' for the new advanced practitioner role they were developing (2009, p.592). In defence of the new role in an emergency department they state rather generically: "There has been little published that would indicate any resistance to the notion that changes in health care delivery are still needed" (2009, p.585). Although this states no-one is challenging the need for change, the presence of this statement in the article suggests a concern. In the same article they describe the four hour emergency department target as 'no longer tenable' for complex case management (ibid, p.585), yet their new role was designed to meet this need. Although they accepted there were problems with existing pressures, there was no sense of any power to challenge these circumstances.

A concern about the potential moral implications of this lack of questioning brought me to Habermas's ethical questions:

> "In one direction the question is whether the motives and actions of the agent are in accord with existing norms or deviate from these. In the other direction the question is whether the existing norms themselves embody values that in a particular problem situation give expression to generalizable interests of those affected and they deserve the assent of those to whom they are addressed. (1984, p.89)

Chapman (2006) does apply this questioning in her research on WBL

> "It is important to recognise that the interests of the learner do not necessarily equate with the interests of the employer. And neither may equate with the long term interests of society" (p.75).

Chapman had been involved in a leadership WBL course (Chapman and Howkins, 2003) and this is perhaps why she was one of the few to acknowledge there could be potential for conflict.

Stanley and Simmons (2011) comment on a lack of workplace readiness in their findings from action-learning sets in neo-natal care, but in this case it appears to be less about acceptance of new roles and more about access to specialist knowledge. Their student focus group and interviews with senior staff revealed barriers in the workplace in terms of lack of time to study and a lack of teaching support from colleagues (ibid). Stanley and Simmons (2011, p.23) conclude: "The clinical learning environment for qualified nurses has generally received little attention." One of the problems with assuming in-house education can occur is assuming there are those with that expertise and the time and energy to share their knowledge.

Problems with mentor and colleague support are mentioned in Chalmers et al.'s (2001) and Chapman and Howkins' (2003) course evaluations and in Clarke and Copeland (2003) individual student story. The lack of protected time particularly was a recurrent theme in a series of later qualitative studies (Chapman 2006; Rhodes and Shiel, 2007; Moore and Bridger, 2008; Marshall, 2012). These later studies focused on courses that were broader in appeal embracing a range of different professional groups, not just nurses, and covered different subject areas from health promotion to midwifery care. Their WBL formats followed more of a project format and will be examined in the next section.

Here, I have highlighted how this kind of process learning emerged out of a need to meet occupational demands for academic education in the workplace. I have noted how WBL evolved from a 'customised' WBL focused on specific skills development with in-house training (Chalmers et al. 2001 and Dewar et al., 2003), to a broader capability development in terms of new roles in Chapman and Howkins' (2003) leadership course and Livesley et al (2009)

advanced practitioner preparation. With increased demand for WBL from a wider group of staff, courses began to adopt a change management project focus.

It is important here to summarise by saying that, despite the enthusiasm for this WBL work, weaknesses in practice support were beginning to surface. In addition, although WBL had been viewed as 'instrumental' in terms of a means of achieving specific goals, the increasing emphasis on professional reflection offered an opportunity for a richer form of professional development to take place. A more collaborative learning was possible, but only if there was workplace support, in the next section I look at the problems of using the healthcare environment as a learning resource, where partnership working was essential.

The Conditions for Workplace Support

In this section, I examine how workplace support can be conditional on the usefulness of the projects to the area concerned and I explore how this can impact on individual freedom. Beginning with a brief reminder of original partnership intentions, I look at the tensions between autonomy and control in generic WBL writings. I then look at qualitative research studies carried out in nursing between 2006 and 2016, where concerns about the learning environment bring into question levels of management control.

It was anticipated that WBL would be a process of co-production (Boud and Solomon, 2001). However the balance of power was affected by the need to 'sell' courses. Boud and Solomon (2001) argued that universities would be left behind if they did not explore WBL working with employers. Kettle, on behalf of the HEA (2013) argued that the WBL format offered the type of flexible learning suitable for partnership working and praised universities who prioritised employers' for being 'business-like.' As the government moves towards an even more competitive higher education market in the future (Department of Business Innovation and Skills, 2016) the need to meet customer demand will continue.

Symes, one of the pioneers of WBL in vocational education, agreed with this need to tailor programmes, but warned that 'academic values' could be 'subsumed to commercial values' if universities were not 'vigilant'(2001, p.212). Symes warned that: "Critical perspectives could be obscured in the rush to make learning productive" (2001, p.212). Similar concerns were raised by WBL educator Light (2009, p.158), who agreed that academic study in her management courses was being skewed "to market needs and demands". She adds:

> "This trend supports dominant free market, neo-liberal ideology that considers knowledge in terms of its utility and tradability, but is limiting in both discourse and application" (ibid, p.159).

Her concern was around the work she was doing with individuals from different ethnic minority backgrounds where there was a tension between accommodating employers' wishes, and helping individuals to personally develop. Nevalainen et al. (2018) conclude in their systematic review of international WBL literature:

> "Work-based learning is affected by two opposing issues: the organisations' needs for effectiveness on one hand and the needs related to professional growth and development of staff on the other hand." (p.27)

Jumaa (2008) from a healthcare leadership perspective, asserts that supporting a culture of learning is beneficial to organisations because it provides a competitive edge, increases performance, helps to recruit new staff, raising the profile of the organisation. However, the tendency is to insist that learning be applied. Phillips (2012), an experienced leader of WBL in health and social care, stresses the need for WBL courses to be 'bespoke' and "congruent with the views and plans of the organisation" (p.918). She states: "The work of the organisation becomes the curriculum", although she adds that ideas for coursework should be 'intrinsic', suggesting a local negotiation (ibid, p.918).

In nursing there has long been a close working relationship with service organisations through practice placements and through CPD in the workplace. However, the move from workplace nursing schools to HE raised concerns about a potential distancing from clinical care (Williams, 2010). In her literature review on WBL and its relevance to nursing practice (ibid) she

identifies WBL as supporting employer interests and clinical developments, but she recognises possible conflicts of interest can occur when students question existing practices. To obtain financial support in the UKNHS for CPD, nurses have to gain the agreement of their managers and their education leads, or if funding is short, they apply to charitable bodies linked to healthcare institutions (advised by senior staff in these organisations). Nurses are therefore aware of corporate priorities and know that to obtain funding they must present their ideas in ways that address internal agendas. Boundaries are therefore already imposed on the ideas learners wish to pursue before courses start and it could be argued that as the service is paying this is not unreasonable.

However, Foxhall and Tanner's (2008) phenomenological study of WBL student experience revealed that individuals can sometimes be viewed simply as operatives. One nursing interviewee reported feeling she was becoming a 'more productive employee' (ibid,p.70). Zemblyas (2006), taking a Foucauldian view, recognises the danger of this eagerness to please employers, arguing that the insistent change and increased surveillance in the workplace could make the individual believe it was his or her choice of action and self-directed, when it was not, as organisational views become powerfully embedded. Individual responsibility is being emphasised, but organisational power is still in control:

"WBL is not simply a form of empowerment of the worker as it may seem at first glance, but it is also a form of 'seduction' at work by work as well" (ibid p.293).

This idea that staff can be unaware of how their ideas are being steered exemplifies how colonisation of the life-world can occur.

Employees were being assessed in terms of their productiveness in Stanley and Simmons' (2011) nursing research. They related a scenario described by a focus group member, where a manager asked a student: "what value am I going to get out of the course from you" (ibid, p.23). Capability here seemed to be tied to production, stripping away interest in the individual as a human being. This perception of employees as productive units is echoed in Moore

and Bridger's (2008) three year cohort study where they refer to WBL as creating 'social capital[9]' for organisations. The social indicates a collaborative and community approach, but the capital suggests corporate agendas. A separate article by Moore (2007), examining some of the detail of this three year study of WBL stresses there are ethical concerns here when inner change is being driven externally by organisational ideas, rather than by personal reflection. Garnett (2008) talks about the concept of 'intellectual capital[10]' suggesting a more cognitive and reflective knowledge base being organisationally developed. This claim to increase organisational value could be positive if linked to the specialist knowledge contribution nurses can make, but my concern is that it appears to depersonalise those concerned.

A sense of ownership is identified as key to student motivation and success in Chapman's (2006) research. She interviewed ten of her previous students, and found that despite their expression of an internal drive, there was a shift in learning dependency from academic to practice supervisors. HEFC (2006, p. 80) had predicted that: 'the distributed nature' of WBL would bring a shift in educational roles for academic staff from teachers to facilitators. This creates a more distanced academic relationship and can leave the student more open to workplace pressure.

Foucault (1988) commented that even the demand for reflection can become 'oppressive' when painful emotive experiences are expected to be shared, and exposed to scrutiny. Zemblyas (2006) highlights how there is a constant pressure in WBL to continually adapt oneself to organisational need and suggests educators should 'problematise' the way the terms 'flexibility', 'teamwork' and 'self-enhancement' are used to regulate behaviour. He asks: what can educators do to contest WBL practices that they believe to be unethical?

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[9] Social Capital - a term that embraces the benefit of community established through social networks where trust, social ties and sharing information help to make the whole system function more effectively (Poteya, 2019).

[10] Intellectual Capital is identified as an ability to create knowledge, share it, and apply it generically across organisations. It is seen as important source of organisational wealth and valuable to a 'knowledge economy. (Stewart (1997)

The combination of a distancing of academic support, and the increased pressure on frontline staff, already committed to other work, intensifies the pressure on support mechanisms. Chapman concludes her research by asking whether you can promote adult learning in an environment which is "already stretched" (2006, p.45)? Rounce, a promoter of WBL, identifies another problem, writing the 'greatest risk' to successful partnerships is potentially: "The constant restructuring that is symptomatic of the current public sector climate" (2009, p.170). The inherent problem of WBL's dependence on the quality of service environments is acknowledged by generic WBL writers, but in nursing seems to be viewed as manageable.

Practical suggestions for how WBL can be improved do not appear to have changed over the years, focusing on increasing mentor or supervisor preparation and trying to guarantee protected time for study (Jumaa, 2008; Moore and Bridger, 2008; Livesley et al, 2009; Quick, 2010; Thurgate and Holmes, 2015 and Attenborough et al. 2019). Moore and Bridger (2008) however, do take this further by identifying a way in which this kind of managerial support could be assured. The largest of the research studies, Moore and Bridger's (2008) cohort evaluation, is both comprehensive and thorough in its analysis of WBL in nursing. Their mixed method longitudinal study embraced the views of students, mentors and managers by collating data from focus groups, interviews and documentary analysis of assessed work and course evaluations (ibid). They argue that WBL needs to be embedded more firmly in organisational structure.

This would entail bringing WBL into performance appraisal schemes, having clear structures of identified facilitators and increased management control to embed WBL project work into organisational agendas (ibid). There are nineteen organisational recommendations, but for me they raised concerns about student autonomy. I believe there is a danger of losing the personal and internal motivation they themselves suggest is important to individual student success. This would move WBL away from the student autonomy first envisaged by Dewar, et al (2003), the ethical freedom sought by Moore (2007) and from the self-direction prized by Stanley and Simmons (2011).

Other WBL educators like Helyer (2010) put the responsibility firmly on the individual student. In her textbook guidance to students, she states:

"It is your responsibility to ensure that you do your best to satisfy them all: your employer, colleagues, fellow learners, tutors, mentors, customers, partners, family friends and yourself" (p.33).

There has been some sympathy amongst nurse educators in terms of concerns about the size of the workload (Ramage, 2004). Ramage (2004) in her conference reflections on her own courses accepts that conflicts triggered by the 'dual role' of service provider and WBL learner present difficulties. Whereas Helyer simply concludes a "high level of commitment is demanded" (2010, p. 33).

A further option for support outlined by Stewart (2008) is professional bodies. Stewart (2008) explored the relationship between professional associations and WBL and argues these organisations could take more interest in WBL and encourage a questioning of organisational pressures. He warns that if ideas are not questioned and critical reflection is not incorporated into the learning it will remain instrumental, behavioural and competence oriented (ibid). His research findings indicate that professional commitment "transcends obligations to an employer or organisation" (ibid, p.61) and this could be used to strengthen individual professional stances.

Here, I have identified how the dream of co-production is not only threatened by the unequal influence of employer / employee power, but also by practical constraints in terms of time pressures and staff availability. I questioned whether there is a danger of the level of support being conditional on the acceptability of the project and pragmatic workplace demands. Critiquing the nursing literature highlighted that few in the profession were questioning these pressures, but instead were trying to work around them by either locking the work into organisational agendas (Bridger and Moore, 2008), or placing the burden of responsibility on the students themselves (Helyer, 2010). Although a third option of strengthening professional support was presented by Stewart (2008). Some progress has been made and this is discussed in the final section.

Transforming Learners and Organisations

In this last section, I look at how personal growth and service change has been identified in the nursing WBL literature. WBL educators do remain passionate about this learning style and in all of the nursing research identified there are comments about increasing confidence and success at bringing about change. Here I hope to unpack some of this achievement to clarify what has been constructive and helpful.

The way in which the project work embraces a range of collaborative activities ranging from data collection and local consultation to organisational change means local areas have to be open to new ideas and supportive of experimentation or 'expansive' as Engestrom (2004) describes them. In specialist units this often means having localised team support willing to assist. This does appear to have been the case in the early customised courses focused on specific specialised areas of care and increased confidence was reported in all of the following course evaluations and small scale research studies: Chalmers et al (2001); Chapman and Howkins (2003); Clarke and Copeland (2003); Dewar et al (2003); Chapman (2006); Swallow et al (2006).

When considering why individuals gained confidence both Dewar et al (2003) and Chapman (2006) indicate that gaining ownership of their studies contributed to personal growth. Dewar et al (2003) suggested the staged learning process itself gave students back control of the organisation of their learning. Clarke and Copeland comment that "the use of theory in the context of practice development" was recognised as helpful to the WBL students (2003, p.240). Ramage (2012) suggests, in her grounded theory study, that curiosity was 'sparked' by the dissonance between theory and practice. She interviewed ten experienced nurses and described them as moving from being reactive to proactive during the learning process (ibid). Examining the spark which stimulates learning is important and made me question the nurse-participants about the triggers for their projects.

Clarke and Copeland quote one of their students as saying that they did a good deal of "fairly detailed thinking" (2003, p. 239), suggesting it might be the

depth of knowledge gained through the learning process that increases confidence. Hallet, from an educational research perspective with early years practitioners quoted an interviewee who said: “I seem to walk taller. I know what I am doing and am not afraid to say so” (2008, p.55). Some researchers described this increased knowledge and confidence as bringing about ‘transformation’ (Ramage, 2004; Chapman and Howkins, 2006; Rhodes and Shiel, 2007; Moore 2007; Moore and Bridger, 2008). I wanted to separate out individual change from service change, but most writers wanted to connect the two. Tynjala (2008, p. 131) in his international literature review of WBL states: “The change learning brings about takes place, not only in the learner’s mind, but also in the learner’s environment”.

Marshall (2012) identified how this aspect of public influence takes on further significance when project work is appreciated by others. In her mixed method study of midwives and WBL she comments on how the participants’ increased confidence was combined with an increased credibility with colleagues because of their service improvement work (ibid). It may be that when nurses or midwives become change agents, an increased confidence results from being able to put new knowledge into practice and being recognised for doing so.

As a WBL lead, I regularly read student evaluations describing an increased confidence, but at first I questioned whether this could have been achieved through any form of professional development where there was an academic award. Engestrom in his research in primary care, suggests that it is the way increased knowledge helps individuals to reconstruct their own professional identity that is key to their transformation (2004, p15). This could come from in-depth theoretical study and the personal application of ideas or from something more interactive where mutual support could be strengthening that change. It might be that being recognised as a leader assists this changing image of oneself. In my research I analysed the nurse-participants’ reflections on change and their perceptions of themselves and their role within it, as well as their descriptions of their learning processes to examine the connections between these factors.

Moore and Bridger (2008, p.62) suggest there is a move from a self-sufficient independent learner status to a more collegiate model of working when embarking on WBL projects, as students have to use colleagues to support their learning journeys. Chapman states "the mentor (*work-based supervisor*) was overwhelmingly identified as the most important person in the learning process" (2006, p.44). Managers, professional forums and networks offering support have also been identified as helpful by Moore and Bridger (2008). The discursive mechanisms used in the networks and forums echo the collaborative way of working encouraged by Habermas in his analysis of the concept of communicative reasoning. However, the relationships between nurses, their colleagues, their managers and their supervisors might not be open and equal. These dynamics again suggested a rich bed of enquiry.

This last section has touched on the nature of empowerment and change in WBL. There are bigger questions that I have left untouched here about the language of transformation and links to reform agendas, but these issues will be revisited in the analysis of findings and final discussion. Here I have stuck to what was revealed in the WBL research, where claims to personal empowerment and service transformation were found to be present. The nursing WBL literature emphasised the transformative nature of the learning approach, but it was not always clear whether this was simply because of the changes accomplished or whether this related to professional development. This inspired me to look more deeply into what my nurse-participants experienced, what they thought they had learned, and how this had occurred (chapter eight). I wanted to find out whether it was simply teams or one-to-one support that facilitated personal growth and transformation, or whether frictions or personal challenges needed to be present to trigger deeper learning.

Conclusion

In this chapter I have described the emergence of WBL as a learning format and drawn out the strengths and weaknesses of this learning style. I found that the generic literature, although enthusiastic about this partnership working, was critical of the social pressure to meet employer demand. In contrast there

was a scarcity of questioning of employer pressures in the nursing WBL. Instead these articles reflected an eagerness to accommodate clinical drivers and government directives and to take the opportunity WBL presented to enhance specialist skills. Critiquing these research contributions encouraged me to include more of a background exploration of the nurse–participants' motivations in the interview schedule, so that I could examine assumptions and intentions and examine whether project goals were aligned with organisational agendas.

Local staffing difficulties were acknowledged in the WBL literature, but viewed as manageable by nurse educators who recorded problems in evaluations and research studies, but tended to repeatedly recommend intensive workplace support. By looking at the inherent contradictions in the literature and within this educational process I have identified some of the problems of attempting to control this learning environment. This review established that WBL researchers in nursing have examined the student experience, in terms of overall project activity, but not examined the detail of communication or considered the socio-political structure's impact on student experience. In my research I wanted to find out whether my nurse-participants believed they were enabled or constrained by the social networks around them and to investigate what part they felt social and political conflict or cohesion played in their learning process. In my research I set out to explore this process more fully and in the next chapter I clarify how this was organised.

Chapter Four - The Theoretical Framework

"Theories now made abstract and autonomous objects float like flying saucers above the rest of science, which by contrast becomes 'experimental' or 'empirical'."

(Latour 1987 p.242)

Introduction

In this chapter I trace the development of this particular theoretical perspective through Marxism to Critical Theory. I then elucidate Habermas's position within the Frankfurt School and explain the contribution The Theory of Communicative Action (TCA, 1984, 1987) made to this philosophical tradition. I go on to provide detail about the separate concepts that make up the overarching theory and show how they were used to frame the research aims and questions presented here.

For me the quotation from Latour (1987) above, offers a visual metaphor, articulating the danger of theories or research philosophies becoming isolated from research design and practice. The quotation echoed my experiences of listening to research presentations where the philosophy was stated then forgotten during the explanation of research findings and I hope to provide a more integrated perspective. This chapter, therefore, sets out to embed the theory underpinning the research into the structuring of the thesis, preceding the methodology and detail of the methods. This chapter clarifies the philosophical stance adopted, the intellectual approach taken and justifies the terminology, drawn from critical theory and assumed throughout the work.

I begin with background information about the sociological perspective and Marxism, explaining the reasons for the adoption of this stance in 'The Bigger Picture'. This is followed by an explanation of the work of the Frankfurt School and the emergence of Horkheimer's questioning approach in 'Critical Theory'(Finlayson, 2005). I then introduce Habermas's 'The Theory of Communicative Action' (TCA, 1984,1987) and discuss his analysis of modernity, including his hopes for democracy and enlightenment. In this section I explore the relevance of this philosophical approach to my research

aims. I then give examples of how others have used this theoretical approach in their research in 'Educational Research Applications'. There are then separate sections on 'The Life-World', 'Systems and Colonisation' and 'Communicative Reason', providing more detail about theory and clarifying how they shaped the three research questions.

The Bigger Picture

To understand the connections between the environment of socio-political pressures and individual concerns I required a perspective that could embrace both structure (systems) and individual agency and therefore a sociological perspective was appropriate. Here, I explain the need for a 'bigger picture' in terms of a societal and a sociological analysis; the adopted normative stance and then look at how a dialectical analysis[11] was used to explore the dynamics involved.

I suspected that public service ideologies were changing nationally and wanted to discover how this impacted on nursing and nurse education. Habermas states: "Alone among the disciplines of social science sociology has retained its relation to problems of society as a whole" (1984, p.5). The sociologists Bauman and Lyon (2013) reflect that there has been a fragmentation culturally and philosophically in post-modern research which can mean that major economic and political influences are obscured in an eagerness to focus on localised subjective interpretations of events. I wanted to avoid this narrowing of perspective.

A broad sociological perspective allowed me to consider which socio-political pressures best described the forces at work in healthcare and helped me

[11] The idea of a dialectical approach evolved from classical Greece and Plato's search for the truth through the analysis of contradiction, Kant, Hegel and Marx have all contributed to the discussion of this analytical approach (University of Chicago, 2017). As a research philosophy Marxism offered a dialectical overview, with a historical and rational explanation of political and economic events (Therborn, 2018).

identify elements of capitalist ideology[12], such as the enthusiasm for market forces and certain business approaches that might be influential in this analysis. Examining the changing values that underpinned service development brought into question how this might affect those working in this professional environment. I suspected there were tensions between nursing's identity, as a caring profession and employer demands to keep within cost constraints

In addition, for me, the research approach needed to acknowledge any ethical dilemmas that might arise from these conflicting ideas. Carr (2006) argued that teachers, need to have personal integrity and adopt a professionally ethical approach and for me this principled stance applies to education, healthcare and research. Habermas's concern for the 'public good' (1990, p.200) identifies links between individual ethics and a moral concern for community, in a way that emphasises a collective sense of responsibility, a theme pertinent to healthcare.

A dialectical questioning of the learning environment offered a way of examining possible contradictions between policy demands and occupational constraints. Horkheimer and Adorno, leading figures in the Frankfurt School, a Marxist research institute at the University of Frankfurt, demonstrated a dialectical approach to the study of society. In 'The Dialectic of Enlightenment' (1944) they argue that Western civilization's attempt to understand society and the natural world in a more rational way to produce a better society, had been distorted in ways that control individual freedom.

Building on their personal experiences in both Germany and in America in the twentieth century they argue that the ideal of a civilised democratic society being governed by reason (the concept of the enlightenment) has been exploited by powerful interests who use, supposedly scientific, reasoning to influence individual beliefs about humanity, to justify, at the extreme,

[12] By ideology I mean a set of ideas and values that are accepted often without question but serve to justify and maintain a dominant group in society. This relates more to Brookfield's (2005) critical theoretical perspective than most dictionary definitions.

inhumane practices and racism and genocide. They argue that the freedom of thought provided by the growth of a secular society is thus vulnerable to manipulation, when arguments appear superficially rational. The research work of the School integrated psychological and social influences in the study of human behaviour (Jeffries, 2016), examining how intentions could be skewed by propaganda, indoctrination or more subtly advertising.

In chapter three I highlight the contradictions between government publicity with regard to personalised care and the economic pressures to reduce staff costs, which directly affected my nurse-participants. Similarly in the critique of WBL research I wanted to see how educators described the social pressures on their students and how contradictory messages about money and care were embraced in WBL projects. Like those in the Frankfurt School, I wanted to learn why certain individuals accepted imposed change and why others resisted. Having chosen a sociological and normative frame of reference and identified some of the contradictions I wanted to focus on, the next task was to decide which theoretical perspective within this school of thought could provide a logical set of propositions to work through these issues.

Critical Theory

The term ‘Critical Theory’ was first coined by Max Horkheimer (Finlayson, 2005) and emerged out of the Frankfurt School. In this next section I explain its history, in terms of the move away positivist research approaches to a more holistic and political questioning of social influences.

Horkheimer was outspoken in his criticism of the narrowing of scientific investigations into positivist approaches that focused only on the ‘particular’ (Finlayson, 2005), where studied objects were seen as separate from their context. Finlayson (2005) explained Horkheimer’s concern that this positivist research appeared superficial, hiding the underlying political and economic mechanisms of society, which a more questioning, contextualised approach could reveal. Horkheimer believed that those who limited their approach to what superficially appeared to be objective facts were adopting a veneer of

neutrality that did not exist and were in danger of becoming the unwitting 'lackeys of capitalism' (Horkheimer, 1937 cited in Jeffries, 2016, p.145).

In the 1940s an extreme group, the 'logical positivists', stressed that if a statement could not be verified empirically it was not credible (Corry et al. 2018). This echoed some of my own experiences of the predominance of quantitative research findings over qualitative research. Moves towards evidence-based practice have benefited healthcare, but if the view of evidence is limited to numerical and behavioural measures I believe it devalues the insight that can be gained by examining psycho–social perspectives.

Natural and social science has progressed and post-positivism[13] has embraced qualitative elements in mixed method research, even in medical randomised controlled trials (ibid, 2018), but the concern for me is that learning from reflection on experience can still be undermined. Midland University nursing students were being encouraged, by some academic supervisors, to limit searches for clinical evidence to research papers that rated high on credibility indexes, prioritising randomised controlled trials (RCTs). Yet these types of experimental studies are rare in nursing, because of the limitations on the kinds of questions they can answer. Professional moves towards evidence-based practice (EBP) have benefited healthcare, but if the view is limited to numerical or behavioural studies I believe it devalues the insight that can be gained from qualitative research.

Disputes about the nature of evidence are important to healthcare, because they can result in some professional groups being awarded greater power. Medically-oriented statistical evidence is frequently seen as more credible than nursing clinical knowledge, even when the subject is not measurable in this way. In my research, I wanted to know how the nurse-participants articulated their ideas within multidisciplinary teams, how they used evidence to support

[13] "Post-positivism asserts the primacy of theory arguing that science progresses from the identification of clearly articulated hypotheses that are posed in such a manner that they are amenable to empirical falsification." (Corry et al, 2018, p.6)

their arguments and how the clinical context supported or denied their attempts to make a case for change.

This investigation embraces the context, events and human responses to social factors and critical theory has the breadth to manage this range of influences (Cohen, Manion and Morrison, 2005). In addition, Jeffries (2016, p.21) states:

> "If critical theory means anything it means the kind of radical re-thinking that challenges what it considers to be the official version of history and intellectual endeavour"

This questioning was applied in Chapter Two, where I examined the history of the health service and the 'reform agenda' and its impact on the context of care. Alvesson and Skoldberg (2000, p.111) state it serves to: "Increase our awareness of the political nature of social phenomena". This questioning continued in the examination of WBL in Chapter Three, and will continue in the interview analysis in the findings chapters. Questioning versions of history can be important in individual as well as social histories and, although as I will show the nurse-participants tended not to describe their situations as political, it was important from an education and research perspective to question what might be influencing their accounts, shaping their judgements and impacting on their experiences.

Brookfield (2005), an educational critical theorist, describes critical theory as resting on three key assumptions: the first being that Western democracies are still highly inequitable societies; that a dominant ideology persuades people that this inequality is acceptable, and finally that this needs to be understood and challenged as a precursor to any change. As Murphy (2013, p.14) suggests theory should be used to 'extract meaning' not just 'construct method' and using theory to question interviewee's background assumptions was therefore important for unpacking ideological influences on beliefs in this investigation. Using a theoretical lens throughout the research process thus facilitated a questioning of the predetermined environment (the healthcare context and the learning framework) and the interview accounts of these situations providing an opportunity to 'look twice' (Schratz and Walker, 1995, p.105) at the situation both organisationally and individually.

Schratz and Walker (1995) argue that social research should not only focus on questioning but also consider the possibility of shaping improvement. To achieve this I chose a qualitative, interpretive research approach, within a transformative paradigm (Corry, Porter and Mckenna, 2018). The intention was to make sense of the interactive nature of the elements in the nurse-participants' life-world, in order to advocate for educational change in the future. Early critical theory offered a socio-political questioning, but it was the later philosopher Jurgen Habermas, who added a sense of hope in his perception of opportunities for change.

The Theory of Communicative Action

In this section I explain Habermas's overarching theoretical argument and show how it offers hope through the project of 'modernity'. I explain the thread of communicative reason that forms the backbone of the TCA (1984, 1987) and differentiate between the everyday 'life-world' and 'steering systems' connecting these to my first research aim. I go on to clarify the links between communicative reason, ideal speech situations and communicative action in education and show how these are linked to education development and my second research aim

Habermas accepted Horkheimer and Adorno's (1944) social analysis in terms of the social pathologies of capitalism and the manipulation of individual behaviour. However he believed that privileging 'instrumental reasoning' encouraged such pathologies to develop. He argues that by adopting a different form of rationality 'communicative reason' communication patterns can be altered to empower people and facilitate greater participation in decision-making. This more open dialogue and collegiate working, he believed strengthened democracy and strengthen resistance to manipulation.

Habermas made a stirring speech in 1980, challenging the belief that the endeavour to create a better society was over. He argued 'modernity' was an 'unfinished project', described by Finlayson (2005, p.65) as a "continuing cultural movement". Habermas's thoughts emerged out of the discussions of the Enlightenment and suggested a collective secular reasoning could free man

from authoritarian control to produce a better society (1980). Outhwaite (1996, pi) describes Habermas's view as offering the "promise of autonomy, justice, democracy and solidarity". The Theory of Communicative Action (TCA, Habermas, 1984, 1987) evolved out of his early lectures and essays, developing into a two volume historical analysis of the social world, in which he contrasts 'instrumental' with 'communicative' reasoning. In the next section I clarify how Habermas discusses these forms of reasoning and the relevance of this to this research. This optimistic thinking is encapsulated in the TCA.

The Theory of Communicative Action is described by Baynes (2016, p.47) as "Habermas's model of a critical social science". By focusing on the language and communication underpinning social action, Habermas (1984, 1987) steers the reader away from descriptions of institutions and events toward a deeper analysis of accepted patterns of thinking and behaviour. Drawing on evidence from social psychology, he argues that humans are essentially social beings stating: "Individuality too is a socially produced phenomenon" (1987, p.58). If humans are social beings then it is inevitable that their thinking is socially influenced, by the language that surrounds them. Rasmussen (1990) argues that Habermas's study of reasoning represents a paradigm shift from a philosophy of consciousness, where the focus is on individual cognition to a philosophy of language, where the focus is on social communication. I believe Habermas's work augments traditional Marxist theory by taking arguments about money and power away from simply the ownership of the means of production into an analysis of the communication in society as a whole. By examining different forms of reasoning and looking at how they constrict or expand educational communication I believed I could learn how nurse education could be enhanced.

Habermas (1984, 1987) had observed the language of everyday life and showed how ordinary people negotiate social activity through a communal form of reasoning. He contrasts this more open discursive form of consensus seeking with the language of goal oriented 'instrumental' thinking often used strategically by those in power. He argued that if knowledge and societal

development could be anchored to this everyday reasoning approach, rather than instrumental reasoning it would ensure moral and aesthetic as well as scientific processes would be embraced in decision making (ibid, 1984).

Habermas explains how individuals make claims that are assessed by those listening in a process of discussion. He argues that these take place in the informal life-world and he distinguishes these negotiated discourses from the systemic communication which is directive. He does identify that both types of communication have their place, but if the directive intrudes into the informal communication it 'colonises' it by making it more regimented and inequitable and pathologies develop.

The distinction between these two aspects of the social world: the 'life-world' and 'systems' helped to me to separate out the informal localised communication taking place in healthcare teams from organisational directives coming from political and economic guidance. Examining the reported communications taking place in the project work offered a way into the life-world and insight into the assumptions, values and beliefs traditionally held by the nurse-participants. These could then be contrasted with procedural dictates and outside influences impacting on the progress of the work. The first of my two research aims therefore became:

1. To compare and contrast the rhetoric and the reality of work-based learning and to examine the varied influences on learning activity, in the light of Habermas's concepts of the Life-world, Systems and Colonisation.

Having examined the influences on the learning environment I needed to link this to the learning process itself and Habermas's (1984) overarching concept: 'communicative reason' offered a conceptual tool for this critique. Its collaborative approach seemed particularly relevant to organisations using multi-disciplinary teamwork and to project work involving collective action. The distinction between this kind of negotiated agreement and 'instrumental' reasoning is important, because it moves professionals away from task-oriented approaches and facilitates a more discursive analysis of clinical situations appropriate to CPD.

Habermas (1984, 1987) argues that communicative reasoning empowers those who use it. Power is often viewed as an individual attribute, but a more radical perspective and the one adopted here is that articulated by Lukes, where he states:

> "Social life can only properly be understood as an inter-play of power and structure, a web of possibilities for agents, whose nature is both active and structured, to make choices and pursue strategies within given limits, which in consequence expand and contract over time." (2005, p. 68).

The complex web Lukes describes provides a suitably nuanced view of the shifting power games that can take place in occupational settings. He outlines three dimensions of power: the first obvious from open disagreement; the second identified through structural bias or exclusion and the third more insidious, hidden in culturally embedded behaviours that set less visible limits on action (Lukes, 2005, p. 27). This comprehensive analysis helped me to consider all the different ways in which nurses could be empowered in this WBL situation. I wondered if the first two dimensions might be more obvious in the systems affecting nursing work, but the third would be more likely to appear in the life-world itself.

In this thesis I explore how nurse's empowerment can be dependent on the 'life-world' context of teams and hierarchies, but in addition affected by the structural 'systems' or organisational influences. Finally I wanted to know if educational interventions and learning processes impacted on these opportunities or constraints. Gauging the use of communicative reason in the dialogues taking place would shed light on the power relationships present and could be used to reflect on the nurses' educational experience, professional development and empowerment. The second research aim emerged from this questioning:

> 2.To explore how the concept of communicative reason illuminates existing educational experience and can offer suggestions for reconstructing work-based learning in a way that empowers nurses to work more successfully and collaboratively.

These broad research aims allowed for an assessment of the existing situation and debate about possible future learning interventions or reconstruction. The research questions are identified in the separate sections on the concepts. However before I detail the final research questions it is helpful to review how other researchers used this theoretical framework in their analyses.

Educational Research Applications

Communicatively achieved agreement is the intention in communicative reasoning (Habermas, 1984, p.7), but requires certain conditions to be met for equitable dialogue and constructive negotiation to take place. Researchers have often focused on this aspect of education or healthcare interactions. Pedersen refers to Habermas's 'ideals speech situations', which facilitate "a symmetry between partners in discourse" (2008, p.74). He clarifies how this kind of participation requires everybody to have a chance to pose questions and argue in a 'coercion free' setting (ibid, p.472). Pedersen suggests that the concept of ideal speech situations can be used as a 'critical standard' to judge opportunities for good learning interaction (ibid, p.472).

Scott(2018) used the TCA framework in her research into the CPD of further education teachers and found that CPD could provide a space in which ideal speech conditions could be created. Her focus was on transformative learning and this led her to look at how teachers could be encouraged to develop their communicative reason and be empowered through reflective discussion of work situations. Like Scott (2008) I consider whether nursing CPD could offer similar educational support through WBL.

In nurse education Sandberg (2013) used TCA and ideal speech conditions to examine the process of WBL in the recognition of prior learning in health care assistants (HCAs) being assessed for licensed practical nursing in Australia. This theory helped the researcher to identify the differences between the formal instrumental systematic approach applied in accreditation interviews and the informal processes taking place in the workplace. He highlighted the difficulties the HCAs experienced meeting the different requirements of the two settings and switching between reasoning and language patterns (ibid).

There were echoes here for me of some of the difficulties faced by students on WBL trying to please the two masters of education and practice. Sandberg's research revealed that both organisations can implement instrumental' or 'communicative' approaches in the way they work. The educational environment applies formal systems of assessment in the same way as an employer may require adherence to formal procedures. Therefore it was important for me not to assume what was taking place in either setting, but to look more closely at their actual functioning. In my study the examination of whether ideal speech conditions were present and what reasoning was being used revolved around the project interactions and the nurse-participants reporting of their experience in practice.

It may be that 'ideal speech situations' could be achieved in the nursing workplace, but there are difficulties at each level of dialogue. At a macro level nurses needed to be listened to as a professional group; at a mesa level they needed to be part of strategic management meetings and at a micro level in their specialist teams there needs to be an equitable dialogue taking place. These situations are possible, but not always available, accessible or used to good effect. Nursing CPD provides a context in which such involvement could be discussed. In my research I examined the reports of interactions to gauge whether this kind of open communication was taking place, because to thrive communicative reasoning and communicative action depend on this freedom of speech.

Even when an open communicative environment is achieved, post-modernists state communication can be oppressive if consensus means homogeneity and there is the question of whether this lack of acceptance of diversity is acceptable (Lyotard, 1984; Deetz, 1992). Habermas (1984) argues that it is the striving for consensus that is important and empowers those involved. If reasoning is distorted by the necessity to conform and unequal power relationships are present then 'ideal speech conditions' are not met.

Habermasian theory thus offers a layered analysis. Habermas draws attention to the macro in terms of capitalist societal influences, the mesa in terms of organisational and management agendas and then the micro in terms of local

dialogue, all of which are important for sociological study today (Scambler, 2001). In this thesis the societal influences are addressed in the examination of changes to the NHS, organisational issues are reviewed in the impact on the projects and local communication is addressed in the reports of conversations in the interviews.

This theoretical approach has a further advantage of a sequenced view, in the sense that Habermas's examination of communicative action takes the reader through background assumptions in the context of the 'life-world'; 'system' influences which can 'colonise' that environment and then into a discussion of 'communicative reason' where these forces are questioned. This framing of the study provided a 'conceptual toolbox' (Ball, 2010) which was used to address different elements of the investigation. I will now deal with each concept in turn and identify its relevance to my research questions.

The Life-World

Habermas drew on the work of phenomenologists Edmund Husserl and Alfred Schutz (Schutz and Luckman, 1973) in bringing together ideas of the phenomenon of the life-world, as a place of shared background knowledge, historical cultural influences and established relationships. Habermas (1987) delineated the life-world as an informal group context, or, as Finlayson (2005, p. 51) refers to it an 'unmarketised domain'. Habermas (1987, p.124) described it as a historical and cognitive resource, relying on a shared set of beliefs and understandings, which seem intuitive, as ideas become embedded in a common language. I thought this description could relate to the sense of identity nurses socialised in the UKNHS might have developed. There seemed to me to be commonalities of attitude I could explore. I thought it would be important to explore this more immediate world before looking at outside influences upon it, hence the first research question:

1. What values, beliefs and expectations did WBL students hold about nursing and how do these relate to the concept of a nursing WBL life-world?

It is an educational truism that teaching begins with learning about our students, in terms of their existing ideas, expectations and knowledge base. The importance of the life-world here for WBL is that the nurse-participants' learning environment was centred on this organisational world. Although the hospital is a physical occupational space, the life-world embraces the context of values, social relationships and work activity within that environment.

Habermas (1987, p.137) describes the life-world both as a source of socialisation and solidarity. As WBL promotes change, students draw on shared local knowledge as a resource, but WBL can also stimulate conflict when traditions and customs are questioned. Gadamer (1988) suggested that the way the life-world moves forward in human society is by shifting its horizons through continuous dialogue and changes are illustrated in the shifting language. The life-world sets the scene for WBL, but also provides boundaries. By appreciating the values of the life-world and understanding how change occurs there I was able to explore how WBL could build on this resource. This part of the learning environment is explored in the first empirical chapter 'The Nursing WBL Life-World.'

Colonisation of the Life-World by Systems

Having identified the informal social networks in the life-world Habermas identifies systems or 'steering media' which are mechanisms driven by money and power (1984, 1987).The Habermasian concept of 'colonisation' is helpful for analysing the non-consensual intrusions into local activity, highlighting tensions between traditional ways of working and new ways. Habermas explains how, despite the significant change being enacted, the nature of the change has to be disguised to gain acceptance:

> "The effects of the system on the life-world, which change the contexts of action in socially integrated groups have to remain hidden" (1984, p.187)

An example of this is where the profit making nature of a business introduced into a public service is treated as if it were no different from other public providers. The long term prospect of monies being syphoned off and the

destabilising effects of a loss of a continuity and accountability of a service are underplayed, while efficiency is promoted. The 'false consciousness' (ibid, p.187) created in this case is one of accepting private and public systems as comparable. The presumption that business and market mechanisms are unquestionably more efficient ways of improving services than previously led clinical approaches is an illustration of a dominant, but dubious ideology colonising people's views. As UKNHS employees, the nurse-participants were aware of the constant pressure to bring about change, performance targets and auditing systems, but might be less aware of the influences on these pressures. Clarke and Newman (2009) in their writing on public services, argue that the managerial, and latterly, commercial terminologies adopted in public services indicate the increasing adoption of 'business-like'[14] approaches. Colonisation was thus reviewed in this thesis in terms of the level of acceptance of business-like ideas in the nurse-participants' descriptions of the life-world.

The interview analysis involved a consideration of WBL project goals in relation to origin, justification and links to systemic pressures to reduce costs. How product goals were visualised, depicted, communicated and measured were all a consideration in assessing colonisation. The concept of colonisation thus facilitated the exploration of how systems could affect individual thinking, speaking and acting, without people being aware. The desire to understand how these system influences may have affected the nurse-participants generated the second research question:

> 2. How did the learning around the project process and the overall educational experience appear to be affected by the wider socio-political aspects of healthcare and could these factors be viewed as colonising the nursing WBL life-world?

Chapter seven collates and analyses the empirical findings that relate to these influences. The binary nature of this research approach (Pedersen, 2011) is that it facilitates an examination of the existing situation, but then offers an opportunity to look at how mobilising communicative reason can

[14] 'Business-like' being applied to public services involves a pressure to think like a business, "identifying and improving the product; mapping competitors and collaborators; assessing the market; planning investment; capturing and satisfying customers - becomes a framing device for organisational decision-making" (Newman and Clarke, 2009, p.82)

tackle the problems created. In the next section I outline this second part of reconstructing rationality.

Communicative Reason

The concept of communicative reason provided a way of critiquing the learning taking place and offered an opportunity to consider possible educational solutions to any communication barriers identified. I begin by defining communicative reason before looking at how it is applied here. Communicative reasoning involves a process by which:

> "The actors seek to reach an understanding about the action situation and about their plans of action in order to co-ordinate their actions by way of agreement." (Habermas, 1984, p.86)

In this research the nurse-participants needed to gain agreement to enact their WBL project plans and this concept helped me to question how individuals reached understandings with others about the rationale, purpose and activities undertaken. The concept of communicative reasoning was important here in identifying whether a constructive dialogue had been achieved. Were ideas shared in situations where people could speak openly and were individuals allowed to participate in discussion? Consultation, debate and negotiation were all essential, but how were these handled? Unpacking what had happened during the nurse-participant interactions and how they were helped or hindered in this discursive approach was important. The third research question emerged from this concern:

> 3. What evidence was there of communicative reasoning in the nurse-participant's descriptions of learning and how could this communicative reasoning be supported and enhanced?

Habermas (1984, 1987) argues that everyday dialogue is tested by the listener for inconsistencies. Speakers make 'validity claims' to objective truth, moral authority and sincerity when they assert themselves and as listeners we gauge the presence of these elements, with barely conscious thought (Habermas,

1987, p.121-123). Therefore at the level of one-to one communication if one of these elements is missing we become sceptical or cautious. Yet tradition and hierarchy may make us blind to the contradictions or insincerity of our team colleagues.

Staff groups such as specialist teams can provide examples of situations where communicative reasoning takes place in multi-professional decision making. In the findings chapters I use the concept of validity claims to explore how beliefs were expressed, presumptions made and how some nurse-participants learned the hard way to be cautious of colleagues. At the time of the interviews the nurse-participants had successfully completed their projects and passed the module and therefore had managed any challenges they came across. I wanted to know what they learned and how. Their reflections helped me to review how their self-awareness and self-determination had changed. I tried to reconstruct how their knowledge grew and power changed.

Habermas (1984,1987) emphasises consensus seeking and so the ways nurse-participants co-operated with others was key to this investigation. To be effective in their change management projects they had to influence others and gain support from colleagues to bring about communicative action.

Conclusion

This chapter has outlined the way critical theory is used in this thesis to analyse policy, professional developments and WBL as an educational tool. I have shown how the TCA (Habermas 1984, 1987) helped me to construct a research framework and analyse interview accounts. The framework is used to compare educational aspirations to empowerment with nurse-participants' reported educational experience. I have clarified how the TCA (Habermas, 1984, 1987) was used to facilitate a logical sequence of considerations, identified in the research questions. In the next chapter I demonstrate how this theoretical questioning was translated into a practical research study.

Chapter Five – Methodology and Methods

"The insights of critical theory do not lend themselves easily to use in empirical undertakings"(Alvesson, 2003, p111)

Introduction

In the previous chapters I have set the scene for my research study, by clarifying the healthcare context (Chapter Two), critiquing the existing research on WBL (Chapter Three) and outlining the theoretical framework in Chapter Four. These chapters have identified social and educational concerns, research omissions, and generated two aims and three research questions summarised in Table 7- Research Aims, Questions to Interview Questions (p.94). This chapter describes how my research methodology set out to answer these questions and how appropriate methods were decided.

Alvesson's quotation above became relevant to me, when I tried to construct a suitable design for the study. Abstract Habermasian concepts needed to be anchored to practical research tools and I needed to challenge my presumptions to ensure that theory illuminated rather than narrowed the enquiry. The most difficult part was shaping Habermas's macro-scale 'grand theory' (1984, 1987) into a smaller scale interview study. The funnelling from large to small is echoed in this chapter layout, starting with an ontological, ethical and epistemological explanation of the research stance followed by a more specific justification of my research methods.

The first section therefore clarifies the links between the philosophical stance, my research positioning and the moral principles embedded in this enquiry in 'Ontology and The Ethical Conduct of the Research'. In the next section 'Epistemological Approach' I tackle the nature of the module and the knowledge sought. Here, I have provided an outline of the module and illustrate this with an example of a typical project. This section clarifies the detailed intent and compares and contrasts different research approaches. 'A Qualitative Method' focuses on the choice of an interview method and the learning from 'The Pilot Study' further refines the research approach adopted.

The details of access and selection of nurse-participants is covered in 'The Research Design' and a profile of the nurse-participants is provided here. In 'Data Generation' I explain the detail of the interview arrangements and the links between research aims, questions and interview prompts and outline the supporting documentation contained in Appendix Two.

The methods of analysis are discussed and illustrated in 'Data Analysis and Interpretation.' I discuss tables that explain the stages of analyses and I refer to examples provided in Appendix Two. I end this chapter with a consideration of 'Insider Researcher Issues,' in which I discuss how research supervisions assisted this iterative and reflexive process. This chapter therefore charts the development of the research investigation, clarifying and justifying decisions along the way and concludes with a reflection on the experience as a whole.

Ontology and the Ethical Conduct of the Research

Ontology, as a concept, was derived from Greek and Latin origins and refers to theories of 'being' (Blackburn, 2008). Here I explain my perspective and describe how it determined the theoretical and moral stance adopted. Building on Chapter Four, I demonstrate how theory was integrated into my research approach and strengthened ethical aspects of the research method.

For me, humans develop their identities within their social world and I liken this understanding to Habermas' view of "man" as a socially created individual (1987, p.58). My belief that people's social interactions affect their thoughts, beliefs, behaviours and relationships with others, leads me to a symbolic inter-actionist approach (Blumer, 1969). Punch writes that symbolic interactionism "stresses that people define, interpret and give meaning to situations" and they then behave in ways that fit these "definitions, interpretations and meanings" (2009, p.125). These meanings are shared through language and communication. I accept that, as Punch states, "the actor's definition of the situation" (2009, p.125) is important to understanding how people behave. However this is not a subjective view but an interpersonal one.

This socially created world contains inequality, in terms of access to education and to power in the workplace, both of which have an impact on WBL. My interest in the political stemmed from an ethical concern about how individuals were unfairly treated by social systems and how they managed to overcome these. Attempting to understand how powerful groups influence freedom of speech and equity of experience underpins my research curiosity, as it did with those of the Frankfurt School. As outlined in the last chapter, my interest in social justice thus drives a socio-political questioning of influences on healthcare and education and has led me to a critical theoretical perspective and Habermas in particular. Habermas's (1984,1987).

For me, the social world of WBL is complex and requires careful unpacking, because, as Cohen et al. (2005, p.3) state: "Education, educational research, politics and decision-making are intertwined". They argue that critical theory helps clarify connections, facilitating both an applied and evaluative approach to research (ibid). I wanted my study to go beyond questioning current events toward a discussion of future educational and professional activity and therefore this evaluative element was important. My concerns about WBL being presented as empowering meant I needed to look at what was happening to the students, not just in terms of their academic learning, but also with regard to occupational and professional position. Moreover, the critical theoretical perspective takes both individual experience and socio-political influences into account, ensuring "political and ideological contexts" are not neglected in a way that would make accounts "incomplete" (Cohen et al, 2005, p.28) and this was important for me.

Striving for the 'public good' (Habermas, 1990) was something that was important for me as an educator of healthcare professionals and important in WBL projects where services were being altered, hopefully for the better. The nurse-participants were employees, public servants and students and there could be clashes between corporate and personal agendas. Concern for their well-being is reflected in my ethical approach to the research participants. Marsh et al. (2018, p.178) stress the need for research consistency in their metaphor: 'a skin not a sweater'. Social justice considerations are therefore

embedded in the ethical stance adopted, these were, not simply driven by a need to have the research study approved, I had a wider concern for the impact of unethical behaviour on the individuals involved in the study personally, socially and politically. My understanding of the difficulties that the nurse-participants might face if information was disclosed inappropriately in the workplace meant I was aware of how my behaviour in the research process could intensify the social pressures individuals were already experiencing.

A series of safeguards were therefore developed and outlined in the formal ethics application and used in the study itself, in line with the British Educational Research Association (BERA) Revised Ethical Guidelines (2011). Permission was granted for the proposal by my School of Education Ethics committee in 2014 (Appendix 2.1). How principles were applied at each stage of the investigation is included in Table 1, where Brinkman and Kvale's (2015) seven concerns around an interviewing inquiry are applied to this study. Further detail about each of these aspects is covered in the appropriate section.

Table 3Application of Brinkman and Kvale's Ethical Concerns

Stage	Ethical Concern	How Addressed in My Research
1.Thematising (choice of focus)	The research purpose should be to improve the human condition.	The research aim was to understand previous student experience, so that better educational support could be offered in the future.
2. Designing	The methodological approach should not harm those involved.	The investigation gained formal ethical approval, by adequately addressing issues of informed consent, security of data and, anonymity (Appendix 2.1). In addition I was aware that the opportunity to debrief that the interviews provided could generate further anxieties or questions and therefore details of follow up support were made available.
3.Interview Situation	The interview setting should be constructed with care, to reduce unnecessary stress on the interviewee and to offer support for any personal distress created.	Prior information was supplied and repeated in the interview briefing (Appendix 2.2). Informed consent was obtained before the interview (Form Appendix 2.3). Individuals were told they could stop the interview at any stage if they felt they needed and that they would be able to withdraw with no detriment (interview prompts Appendix 2.4). The nurse-participants were asked if they were happy to be audio recorded and only recorded once consent was obtained. Privacy was secured for the interviews and time made available for longer discussion if this was felt necessary. Nurse-participants were also told what would happen to the data and were happy to proceed.
4.Transcription	The text needs to accurately reflect the content of the interview and the anonymity of the material should be guaranteed.	Recording ensured accuracy and non-verbal communication was recorded in interview notes. Names were changed to protect individuals from identification. Nurse-participants were offered the chance to view transcripts, though all declined. They were informed that they would be able to see a final summary of the findings at the end of the research.
5. Analysis	This aspect of the research is important in terms of interpretation and interviewees should have some say in this commentary.	Material was selected for themed analysis and quotations were used to ensure transparency. Although nurse-participants did not access the thematic analysis their views and stories were checked by the researcher regularly returning to the original interview material.
6. Verification	This concern is around how the interviewer interrogates the information provided by the interviewee and respect for their account.	As perceptions and emotions were sought rather than objective truth, verification took the form of observation of non-verbal behaviour and checking the consistency of accounts during the interview. In listening to the accounts. I constantly questioned the tone used and the manner in which comments were expressed to ensure my understanding of the emotional tenor was accurate and to critique my own influence.
7. Reporting	The issue of confidentiality with regards to private accounts becoming public arises as the final writing is conducted.	This was a small group from one institution and recognisability of the individuals was a concern. Therefore stories have been altered slightly to make identification more difficult. The time lapse between interviewing and dissemination has meant several staff changed jobs and incidents have faded in people's memories.

Epistemological Approach

The aim of the research was to learn about the WBL experience and influences upon it and to understand the dynamics of this learning process. In this section I begin by clarifying the detail of the module reviewed and then explain what I hoped to learn about the learning process and those engaged in it. Epistemology is defined as "issues about the nature of knowledge" (Pryor 2010, p.163) and here I explore what kind of knowledge was sought in this enquiry.

The overall module aim was to design and manage a service change of the individual's choosing and to use this as a vehicle for personal learning. As outlined in Chapter Three, each university had drawn up their own versions of the module format in CPD and so for clarity and consistency one university The Midland (pseudonym) and one module format was chosen as the basis of study. The course template identified below in Table 4, followed a common format.

Table 4- Characteristics of the Work-Based Learning Module

Characteristics of the Work-Based Learning Module	
Course Duration	Six months
Introductory Half Day Briefing	Power-Point
Access to Web Learning Platform provided	Course documents Examples of past assignments Power-Point on change management Self-assessment exercises around project management
Access to Library Resources provided	Literature searching information available
Contact with Academic Supervisor	Choice of supervisor and monthly appointments made by students themselves
Contact with Work-Based Supervisor	Choice of supervisor and monthly appointments made by students themselves
Tri-partite meetings encouraged	Student-arranged

Learning Action Plan (contract)	Student to gain agreement from supervisors re content, rationale for project topic, list of activities to be undertaken and timescale and note as to resource required. To be completed in first six weeks and submitted with final assessment
Series of Project Activities	Literature searching, data collection, consultations and clinical activities
Portfolio Submission	Containing : literature review, project report and professional reflection (total 3,000 - 5,000 words depending on academic level)

The taught elements and distance learning materials on these courses varied across institutions. The Midland did have an introductory briefing, course documents and examples of previous projects on their web learning platform. A Power-Point presentation on the principles of managing change was supplied and the module team were in the process of developing a series of online self-assessment exercises to supplement resources, when the research was being carried out.

The module co-ordinator or convenor would carry out an initial briefing and then encourage students to access the online resources and begin working with their chosen supervisors on project plans Depending on the project focus subject content could vary enormously from clinical information on equipment use and safety protocols to human resource issues in terms of patients or staff. My interest in this learning process was focused on differences in how individuals experienced the learning and what they learnt overall. In order to gain an understanding of these I needed background information on the individuals and their settings, details of their projects, their accounts of their experiences and their reflections on them. Comparing and contrasting empowering rhetoric and reality meant examining their reports to see how the nurse-participants lives were affected and exploring the facilitators or barriers to personal and professional development.

The module could be taken as a 'stand-alone' module for degree or postgraduate credits or could be part of a specialist course. The difference was that some students would have had academic writing and literature searching preparation while others would not. Some would arrive with ideas from previous clinical study, while others would not. An example of a typical student project is set out in Figure 1 below.

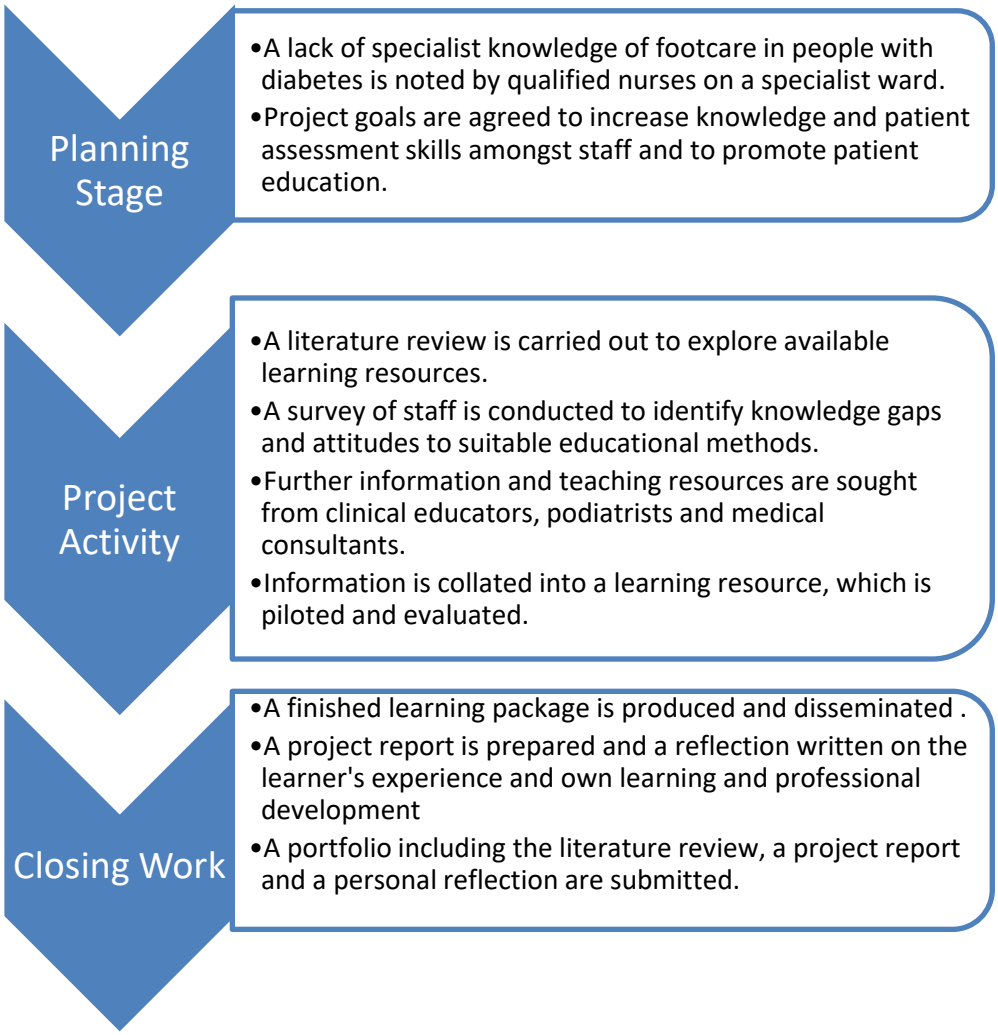

Figure 1 Example of a Student Project

I was studying a phenomenon, but one that involved an interactive process, with shifting tensions between different forces. Phenomenology was important to constructing a picture of this experience from their perspective. My intention was to capture the whole WBL experience from the nurse-participants' recall of events. An ethnographic study would have drawn out cultural patterns of behaviour (Punch, 2009, p.126), but the aim here was to examine the educational dynamics. In this analysis the aim was to carry out a dialectical analysis of the social influences, highlighting contradictions in this experiential learning process.

This was done by using an interpretive[15] approach and therefore the explanations the nurse-participants gave for events, which shed light on their values and beliefs, were further scrutinised through a Habermasian lens. The Habermasian phenomenological concepts of the life-world and systems helped me to group the knowledge obtained about the various influences present and to examine the impact of these different forces on the nurse-participants and their WBL.

This approach mirrored the stages outlined by Habermas (1972, p.230) in his description of a reflective ideological critique, from description and questioning of the influence of existing forces (Life-world, Systems and Colonisation) through to proposals for action, where vested interests are revealed and challenged through an examination of Communicative Reason (Reconstruction). Sandberg (2013, p.103) writes in his explanation of his reconstructive approach to the assessment of prior learning this approach helps the researcher to:

i) Critically appraise processes that do not realise the potential for communicative action,

ii) Reconstruct examples of processes that are more in tandem with the norms of communicative action,

[15] Interpretevism concentrates on the meanings people bring to situations and behaviour and which they use to understand the world (O'Donoghue , 2007,p.16-17)

iii) Highlight the consequences of a lack of mutual understanding and communication and the resentment, confusion and fragmentation that individuals may feel when the conditions for proper communication are scarce,

iv) Look for examples that show the potential for changes in practice.

To summarise, Punch states that epistemology explores the relationship between the knower and what can be known (2009, p.16). As an educational researcher I wanted to know what was happening in educational practice from the source of student experience. I chose the Habermasian lens to scrutinize what could be learnt from the information collated so that the knowledge went beyond a list of barriers to WBL into an examination of the potential for better educational practice.

A Qualitative Method

Having decided on overall intentions it was a question of deciding how best to obtain the appropriate breadth and depth of information for such an analysis. In this section I look briefly at some of the different methods researchers have used in the study of nursing WBL, and then consider what methods researchers have used with Habermasian theory specifically, before explaining my choice of an interview study.

The focus in nursing WBL had initially been on course evaluation and these did become more rigorous over time (Foxhall and Tanner 2008; Thurgate and Holmes, 2015). As outlined in the last chapter, small-scale qualitative studies captured cohort experiences in case studies (Rhodes and Shiel, 2007; Livesley et al, 2009; Stupans and Owen, 2010), however, again the emphasis seemed to be more on evaluation than an open enquiry. There was one individual narrative that was useful in providing insight into the learning journey by more fully exposing the student experience (Clarke and Copeland, 2003) and an interview study by Chapman (2006) provided more detail. Moore and Bridger (2008) provided a comprehensive mixed method longitudinal study which was extremely helpful in generating a large body of information on nursing WBL. However, the detail I was looking for could not be captured in a study of this scale. Looking at the descriptions of methods, findings and discussions in these

research reports I decided that the interview study offered the most detailed account of individual experience and therefore was a more suitable method for my purpose.

Habermas did not refer to any personal empirical study in the exposition of his TCA (1984, 1987), but based his work on a comprehensive analysis of a huge body of literature. However he inspired others to use his theory in their research work. Trede (2012) used a Habermasian approach in action research with physiotherapists to test out an alternative communication style in patient consultations. I did not believe I had sufficient background information about the problems in nursing WBL to initiate solutions and therefore this was not appropriate for my research. I wanted to understand the learning environment before changing it.

Sandberg (2013) had used Habermas to examine the recognition of prior learning in health care assistants in Sweden and the analysis being in healthcare education was more relevant to my own situation. His reconstructive approach described in the last section made sense to me. He used an interview method to gain the detailed perceptions of the interactions that had taken place in appraisals and placement supervisory meetings. The similarity of the WBL environment was helpful to envisaging how an interview study could gather data about learning experiences about both education and workplace settings.

As Brinkman and Kvale suggest, the aim of qualitative research is "to understand the world from the subject's point of view, to unfold the meaning of their experiences, to uncover their lived world" (2015, p.1). Although observation could describe events and behaviours, it could not reveal assumptions, expectations and reactions or 'unfold the meaning' of student experience. An interview study offered the potential for more personal reflections to be gathered. Furthermore interviewing offered two elements for analysis: "thematical development and dynamics re relationships" (ibid, p.124), providing topics for investigation and reflections on social interactions. Direct observation of interactions would have been helpful for examining the 'relationship dynamics', but there were two good reasons why this was not

appropriate. Firstly the clinical setting would have made observation difficult, because of the presence of intimate patient contact. Secondly a researcher presence during the dialogues between supervisors and nurse-participants would have altered the dynamics of those interactions.

Having compared different methods of data collection I decided that individual accounts would elicit background information about the context of WBL projects, supply an overview of the dialogue that took place during the projects, and provide information about any repercussions that occurred.

The Pilot Study

The question that then arose was who could contribute valuable information about student experience. This section describes the organisation and implementation of a pilot study, which helped to shape participant selection and interview prompts. Here, I explain how the pilot study led to over-ambitious plans becoming more realistic in scale and organisation.

I knew that the small numbers of students involved in the course (about ten per cohort) would mean delays in gaining interviewees and could slow the process of data collection. I also thought it would be helpful to gain a more holistic or triangulated view of what was happening by interviewing students and supervisors and this approach was tested in the pilot. I chose a different healthcare trust from the final research and interviewed one WBL student, her work-based supervisor and her academic supervisor to test out this interview framework. The university remained the same to ensure the module format was identical, but the academic supervisor was from a different university site. This pilot was carried out in the academic year prior to the final research study (2014/2015). The learning is summarised in Table 5.

The findings from the pilot were discussed in supervision. I wanted to ascertain what information could be generated from a retrospective interview study with these three perspectives. Table 5 summarises the learning gained and the impact it had on the research design. Most significantly for the research, the responses of the supervisors made me aware of the difficulty of

separating out from their accounts the individual student experience, I would ask them for an individual account and they would speak about the student group as a whole. Their comments tended to be generalised and influenced by corporate agendas. Both the academic and the work-based supervisor were keen to describe their behaviours in organisational terminology, in terms of fulfilling requirements. This reaction may have been due to staffing pressures making them defensive of their roles or their response to me as a module co-ordinator. The overall impression was one of more generic concern about their duties to students and staff in the specialist department than their understanding of the student's experience. The student's account appeared to me to be the most authentic and productive in terms of history. I wondered whether this was because of the emotional investment in the learning or the singularity of the experience. It became clear that focusing on students' accounts, in this student-centred learning approach, would bring the most reliable data.

Table 5- Learning from the Pilot Study

Activity	Learning	Application
Nurse Interview	Behaviour – The nurse was careful to ensure privacy for discussion and spoke emotionally about the experience. Timing – Five years had elapsed because of prolonged work leave and this reduced detailed recall. Question Prompts – The student was cautious in her comments, at first and needed some question phrasing clarified. An example of this was a question about partnership working between the University and the Trust, which left her confused. It became apparent that she did not view the relationship between the university and her employer as relevant, reinforcing my concern that projects were viewed as solely the student's responsibility, despite the fact that the project was about developing an enhanced role qualification that she was not allowed to use because an occupational post was not available when she completed her course.	This reaction to questioning reinforced the need for privacy to be assured. A two year limit (post course) was placed on future volunteers. This made me aware that I needed to emphasise my genuine interest in the student's perspective (due to cynicism re repeated course evaluation) and change some wording on the interview schedule. The partnership question was too strategic in nature and although it was not workable I realised that the local effects of partnership working could be examined through the description of project activity itself
Academic Supervisor	The supervisor had difficulty separating out single student experiences; generalised comment was given about supervisory actions. Discussions tended toward broader protocols and time commitments and the individual's style of supervision.	The value of this feedback was questioned in terms of insight it could provide with regard to detailed interactions. The generic content of the feedback convinced me not to interview supervisors in the study
Work-Based Supervisor	Reference was made to the NHS Trust's training approach, which did reflect a distinctive internal culture, but again general principles of supervisory support were discussed, even when specific examples were requested.	Recognition that each organisation might have a separate educational ethos made me aware of the need to focus on one specific trust in the study.

The Research Design

Having singled out the students for attention I needed to decide on the institutional context and sampling arrangements. This section therefore looks at why the employing organisation was chosen and outlines the population from which the nurse-participants were drawn. I identify how individuals were invited to participate and the information they received.

The healthcare trust chosen as a focus for this study, the Royal (pseudonym) was part of the UKNHS with an organisational size that allowed for a variety of nursing specialities. From a research perspective, the training lead's enthusiasm for WBL established the Royal as an example of a 'best case'. The training lead had been willing to be interviewed prior to the study's commencement, and had fought for funding for the module and could be viewed as a champion of WBL. She had encouraged clinical educators to support the initiative and the partnership relationship was stronger here than with other trusts. This situation of explicit support did produce examples of constructive learning, yet I knew from my professional experience that this was not happening in all clinical areas, and therefore there was an opportunity to learn more.

Purposive sampling (Denzin and Lincoln, 2005) was thus adopted in identifying those who had come from the one institution. The larger numbers of employees coming on to the WBL module from that trust meant more volunteers could be invited to the study. Mental health nursing and learning disability nursing students were educated at the same acute hospital, but were not recruited because there had been no students from these backgrounds on the WBL course since 2013, due to changes in the composition of their CPD courses. However, there were students from both adult and child professional fields. I was able to locate fifteen students that worked at the Royal who had completed the course in the previous two years. I judged that this retrospective was far enough away to see the experience as a whole and close enough for events to be remembered and so did not go further back in tracing students.

A general invitation containing the research aims, a brief description of the study and my contact details (Appendix 2.2) was sent by email to all fifteen students. Twelve students expressed a willingness to be interviewed, dates were arranged to meet for face to face interviews, and consent forms (Appendix 2.3) were sent out. Interviews were carried out during the academic year 2015-2016. There were two respondents who could not attend because of personal circumstances, and a sample of ten students was identified.

As can be seen in the profile (Table 6) there was a commonality of post–registration qualification of over seven years. Occupationally their staff band ranged from Band 5 (staff nurses) to Band 7 (unit managers), and all had clinical as well as managerial responsibilities. Qualified nurses are expected to take on an educational role with junior staff and so four of the staff nurses were undertaking projects that involved producing staff education materials and There was a range of clinical specialities represented and all of the nurse-participants happened to be white British by background (there were very few students of different ethnic backgrounds on the course and none in the cohorts from the Royal in that time period). Similarly they were all women, reflecting the female dominant workforce, but again there were no men who fitted these inclusion criteria. Paula had accessed the same module, but through her first and second degrees, her first project was around staff education, her second related to ward management. Three had taken WBL as a postgraduate module and the six were taking it as part of their first degree study.

Table 6- Nurse-Participant Profiles

Name	Nurse-Participant Profiles
Beryl	Beryl was a senior staff nurse with over twenty years of nursing experience and was working on a health care of the elderly ward when she undertook the WBL module. She noted how drowsy her older, frail patients were in the day and argued that this tiredness was affecting their functioning, making it difficult for them to converse with medical and nursing staff and carry out physiotherapy exercises. Beryl questioned whether their tiredness was due to the pressure area care guidelines that insisted they be encouraged to move two hourly even during the night. She had read the research that connected tiredness with delirium in hospitals and wondered if the trust's procedural guidelines were making patients more vulnerable to this problem. Beryl had attended an evidence-based study day at the university and was encouraged to carry out a practice project, she therefore negotiated to do a pilot study exempting some patients from the nightly two hourly turn, when assessed by a qualified nurse as at a lower risk of a pressure ulcer development. The local training lead suggested she gain academic credit for this work by using it as a basis for a WBL project. This initiative was supported by senior staff in the trust. Beryl had trained when nursing was at certificate level and she anticipated transferring the credits gained into a first degree. The pilot was successful, in that no patients were harmed and there was a noted improvement in the alertness of the older patients during the day. However the support for a continuation of the change did not materialise and the lessons learned were not taken forward into new procedures. Beryl moved to another ward to work and had not managed to continue her degree work, despite expressing continued interest in it.
Carol	Carol was a nurse with over twenty years' experience and had worked her way up to become a manager within the operating department. She had undertaken some degree modules, but the lack of specialist modules in this field meant that she had to look at generic modules. The WBL module was an unknown quantity to her, but offered another way of accruing credits. She thought she could base her work on a project she was already undertaking in the workplace. Carol had attended a leadership / management course run by outside business consultants which emphasised increasing efficiency. She believed there was a need to increase the speed of transfer from recovery back to the wards and decided she could use an initiative she had developed, involving pre warning the wards of a transfer, as a basis for her WBL. This was successful in increasing operating department throughput and improved relations with the wards, but she expressed concern at the way it may have affected team relationships. Carol herself had changed jobs taking a promotion after the project and had not had a chance to take on another module or complete her degree at the time of interview.
Elaine	Elaine was an intensive care nurse with seven years nursing experience and a cardiac care background she expressed shock at her colleague's apparent lack of knowledge about a cardiac catheter being used. She had the idea that further education on the equipment concerned would be useful to the staff. Elaine had already enrolled on a master's programme and found that she could carry out this project for her WBL module. The educational material evaluated well and when interviewed Elaine had followed up her interest in education by taking up a nurse teaching role in the university. She completed her master's course successfully.
Jenny	Jenny was a sister in an intensive care unit with fifteen years of nursing behind her. Jenny believed that her nurses were not confident with a particular ventilator they used infrequently and thought they required some information on it. She was undertaking a master's programme and the WBL module was an essential part of it. Jenny was surprised by her medical colleague's dismissive comments about the project and this led her to examine the research more closely, but still pursue the subject. In the end the educational material was

	incorporated into a departmental competence document on ventilators as a whole. Funding limitations had delayed her next module and she had still not completed the course when interviewed although she did say she would perhaps fund herself so she could complete.
Mandy	Mandy was a staff nurse in Infectious Diseases she was involved in clinics for individuals with specific conditions. She noted that certain groups found attendance difficult at certain times of day and wanted to be more flexible in the service she provided. She had a diploma in nursing and wanted to gain a degree and embraced the WBL module so she could focus on something relevant to her work, as there were few specialist modules in her field. Running a pilot she did show that attendance improved if the times were to client preference, but expressed frustration at her colleagues' unwillingness to change. She left the department soon after the project to work to join a team where she felt were more open to new ideas. She had completed her degree by the time she was interviewed.
Paula	Paula was a senior manager in cancer care with fifteen years of nursing experience. She had qualified as a nurse with only a diploma qualification and had carried out two WBL modules one for her first degree and then one for a postgraduate qualification. The first project focused on staff education around cancer care and the second was on developing the multi-disciplinary ward round. Both were successful in changing practice and she gained her masters qualification. However at the time of interview she had decided to leave her hospital post and take on a cancer educational role in the community.
Ruth	Ruth was a senior manager with over twenty years of experience and worked in an outpatient department specialising in haematology. She focused her project on increasing clinic opening times to manage increasing patient numbers. Ruth was already teaching student nurses in her speciality and had begun a master's course of which this module was a part. Her project brought her into conflict with senior managers, but she did change the service in the way she planned. She was still on the master's course at interview.
Stephanie	Stephanie was a paediatric staff nurse with approximately seven years of work experience behind her and was working in a renal ward when she began the WBL project. She identified an 'educational deficit' in renal knowledge amongst her colleagues and so decided creating an educational resource for new staff to the unit would be useful. She had gained a diploma when she qualified as a nurse and was undertaking the WBL module as part of a 'top up' to her first degree. She was proud of the success she achieved both academically and in practice.
Veronica	Veronica was a staff nurse on paediatric intensive care with over fifteen years of experiences as a nurse. She had found herself struggling with the instructions on a ventilator they had introduced whilst she had been off on maternity leave, but now used regularly and wanted to produce some guidelines that would help staff to use it correctly. Her project was supported by a local educator, but difficulties arose between her and her work-based supervisor. She completed the project successfully, but left the department and entered education after the work was complete. The WBL module was part of her specialist master's course, which she completed.
Yvonne	Yvonne was a paediatric staff nurse working with children with urinary problems. She had begun working part time after marriage and although she had over seven years of experience she described losing her confidence. Yvonne had a diploma qualification and the WBL module was part of her top-up' degree. Her project involved improving bladder screening processes for young people in her care. Her project was successful practically and academically.

Data Generation

Once the nurse-participants were identified and plans were made to meet, the focus switched from planning to operationalizing activities. Here, I look at how the interview conversations were framed and information was gathered.

The political situation locally was one of increasing caution in terms of comments made about employing organisations. Despite public statements about transparency, I was hearing informally of individuals being censored by organisations for their criticism and this fear of retribution was reinforced in several interviews. This understanding combined with concerns about the 'busyness' of service areas led me to offer a choice of venue for the interviews. Two did opt for their place of work, but both were senior staff who had their own offices and could thus guarantee privacy.

Before proceeding with the interview I checked that prior information (Appendix 2.2) had been understood and reminded the nurse-participants that they could stop the interview at any time with no detriment. I asked for permission to record interviews, explaining that pseudonyms would be used for anonymity and all agreed. I described how their accounts would be kept on a password protected computer and in a locked filing cabinet, in a secure location, and reassured them that nothing they said would be verbally shared with any colleagues. They were made aware that the overall findings would be collated and printed in a thesis report and that they might be individually quoted. All agreed to these conditions and signed consent forms.

In addition, as a nurse and an educator, who was known to be the module co-ordinator, I had to recognise my own position of power and the impact I would have on responses. The nurse-participants' image of me as a lead lecturer and my own protectiveness of the nurse-participants, as ex-students, could have prevented open and equal dialogue from taking place, therefore I had to find ways to establish a research distance, yet put nurse-participants at their ease. I emphasised my eagerness to learn from them in an attempt to reduce power differentials during the interview and to convince them of the genuineness of my interest, the first few minutes of the interview were used to build a good

rapport (Brinkman and Kvale,2015). The concern for me was that the nurse-participants might not feel able to criticise the existing module because I was involved with it, although they did in fact do so.

All the interviews lasted over an hour and the semi-structured framework allowed for an open discussion rather than an interrogative questioning. Interviews grew into conversations (Rubin and Rubin, 2005). I took field notes during the interviews to record key points and to note corresponding non-verbal behaviours, for example signs of anxiety such as blushing or physical discomfort that I noticed when nurse-participants criticised their supervisors. I believe the slight distance provided by taking nurse-participants out of their work environment did help them relax.

The questions were designed to align with the research questions and this structure is identified in Table 7. The semi-structured interview schedule is reproduced in Appendix 2.4, but the separate parts are briefly outlined here. Part One included background information. This was about their nursing experience, current role and why they had decided to take the WBL module, allowing them to set the scene (Brinkman and Kvale, 2015). Part Two involved an exploration of the project experience. I asked them to tell their story in terms of where the idea for the project originated and how the work progressed. Their experiences of supervisory relationships, social factors and wider networking were all uncovered by a more open questioning about these factors. I had altered some of the terminology around barriers after the pilot to embrace positive as well as negative experiences to help them connect with their memories of events and particular issues that had affected them.

The last part of the interview focused on the effects the WBL project had on learning and I asked how they thought their ‘thinking’ had been affected by this learning process. The word ‘thinking’ was introduced after the pilot and supervisory discussions, because the open question on learning drew out a response about content, not thought processes. The schedule then went on to ask whether they felt they had changed as nurses and what they had learned. This part of the interview crystallised how the WBL experience had contributed to their professional development.

Closing the interview I welcomed any suggestions for curriculum changes or types of support. Brinkman and Kvale (2015) suggest a debriefing is always important at the end of the interview because it allows interviewees time to reflect on how they felt about the process which may have stirred up painful or disturbing memories. Once the recorder was switched off this ‘breathing space’ was provided. The nurse-participants commented that they had gained some insight into their experiences through the reflection and nobody required any support after the interviews, despite expressing a range of emotions during the interviews.

Table 7- Research Aims, Questions to Interview Questions

Research Questions	Interview Questions
First Aim: To compare and contrast the rhetoric and the reality of work-based learning and to examine the varied influences on learning activity, in the light of Habermas's concepts of the Life-world, Systems and Colonisation	
R.Q.1) What values, beliefs and expectations did students hold about nursing and how do these relate to the concept of a 'life-world' in terms of work-based learning in the UKNHS?	1) I would like to begin with a little background in terms of your nursing history and your current role. Please tell me about yourself. 2) What was it about WBL that attracted you? 3) Why did you want to do this particular project?
R.Q.2) How did the learning around the project process and the overall educational experience appear to be affected by the wider socio-political aspects of healthcare, and could these factors be viewed as 'colonising' the nurses' existing 'life-world'?	4) Please tell me about the project itself 5) Please can you list some of the factors that you think influenced the development and progress of the work?
Second Research Aim: To explore how the concept of communicative reason illuminates existing educational experience and can offer suggestions for reconstructing work-based learning in a way that empowers nurses to work more successfully and collaboratively.	
R.Q.3) What evidence was there of communicative reasoning in the nurses' descriptions of learning and how could this communicative reasoning be supported and enhanced?	6) How did the work on your project shape or reshape your thinking? 7) What do you think you learnt from the process? 8) Do you think you have changed as a person through this work and if so in what way? 9) Are there any suggestions you would make to future students to help them through this learning process? 10) Is there anything else you would like to add?

Each interview was a learning experience in terms of refining interview technique. As the research work progressed it became evident that research technique is a craft. In their attempt to redefine rigour Anderson and Herr (2010) argue that for practitioners carrying out research in their own environments validity can be viewed as relating to outcomes and processes. The outcomes relate to whether research questions were answered and process issues relate to how the data was gathered. I found that the more adept I became at picking up leads and encouraging further discussion, the better the outcome in terms of the detail that emerged and therefore these two quality measures are undoubtedly connected.

This section has clarified how the nurse-participants were interviewed and how interview technique was refined to encourage detailed disclosure. These lengthy in-depth discussions produced a rich seam of data and the next section describes how this was mined for meaning.

Data Analysis and Interpretation

In this section I explain the process of data analysis that was undertaken, with a step by step description of thought processes and activity. The data set formed 10 transcripts ranging from 2,550 to 5,859 words, over 43,000 words in total. The interviews were spaced out over the autumn and spring of the academic year 2015-2016 and this meant that I could note down reflections on the interviews soon after, usually the same evening (an example of a piece of reflection is presented in Appendix 2.5). I transcribed the tapes verbatim the same week, adding in the associated non-verbal behaviours recorded in the field notes, so that these could be drawn upon in the later analysis.

When I set about the first reading of the transcripts I recalled Guest et al.'s comment that:

> "Transcribed conversations are full of oblique references, incomplete statements, hemming and hawing, incoherent mumblings, and cognitive leaps from one idea to a seemingly unrelated other." (2012, p.65)

My first impression of the nurse-participants was that they were enthusiastic about expressing their views on the learning process, but they had not come

prepared to make a statement, in the sense that their thoughts tumbled out in chaotic bursts of instant question responses, followed by a slightly more detailed account and then snippets of deeper reflection completed the story. Subjects that appeared to worry them were frequently returned to and this pattern is identified in the findings chapters where I refer to the frequency of a word or phrase used and the amount of time that was spent on a subject in the interview as a whole.

I read each of the transcripts first for general understanding and to grasp key concerns. Although I had my own agenda in terms of guiding the interviews through a series of questions I think it is important to recognise that as volunteers the nurse-participants too have reasons for agreeing to be interviewed. Silverman (2010) points out that it is worth looking at the discussion as a whole, to learn what interviewees are 'doing' in the way they present activity, and this was done on the second reading. For my nurse-participants it was a mixture of sharing enthusiasm for the learning process and their successes, then raising issues they believed needed addressing and debriefing over unanswered questions they had.

My task was to set about "locating meaning in the data" (Guest et al, 2012, p. 49) and to do this I followed Guest et al.'s guidance on applied thematic analysis. I already had a structured coding frame (ibid, p.56) set out in the interview schedule that linked to the stages of WBL project work and related to the three research questions: beginning with background motivations, then moving on to influences on the learning journey, and finally the learning that was gained from the experience. However, these were large categories that needed themes and codes identifying under these headings. Table 8 below sets out the stages of analysis that for me commenced with the third read of the transcripts. The process outlined here ensured that a precise and rigorous approach was adopted and was transparent to the outsider.

It does not indicate how many times the text needed to be read for the themes and codes to be collated, and for me this was a laborious process of repeated reading, as it involved a constant checking back to original material to ensure that all possible issues were covered and there were no gaps. As a researcher I

did feel as though I had immersed myself in the data. I found drawing up separate tables of transcript analyses for each nurse-participant with reorganised text material grouped under themed headings helped me to pull together references that recurred through the text.

Table 8- Stages of Applied Thematic Analysis

Read the text and propose themes.
Refine themes into codes with well-developed definitions.
Have two or more analysts read a sample to discuss coding.
Compare the way each analyst coded the sample.
If the results are the same, continue coding with periodic rechecks or if not identify why there are differences and adjust code definitions and recheck and repeat if necessary.

(Adapted from Guest et al 2012, p.70)

To cross reference material across transcripts I did experiment with different methods of selecting sections of text. Miles and Huberman (1994) suggest playing with the data in terms of looking at frequencies of terms used, making comparisons across interviewees and considering patterns. However, Guest et al. warn that the segmenting of text into themes and codes leads to further and further abstraction (2012, p.52).The nurse-participants seemed to me to be very individual in their accounts and in my findings I have tried to keep large parts of individual accounts together to contextualise remarks and to help understanding of the project activity discussed. This is a thematic analysis, but I have tried to gather sections where nurse participants have gone back to a topic, and this I think has the advantage of elucidating comments and strengthening the data by showing the consistency of the individual's stance. This is illustrated, very briefly, in the example of coding discussion in Appendix 2.5.

In Table 8 I have combined the last three of Guest et al.'s (2012) stages into one, because the process could be short or prolonged discussion depending on the transcripts. For instance, when asking: 'what does a particular sentence reveal about someone's beliefs,' there are going to be differences of opinion and debating these different perspectives was important to deciding the most

accurate interpretation. I found referring back to the audio recordings, checking the emotional tenor of particular phrasings and the context in which statements occurred helped to clarify stances. The accounts the nurse-participants told were their interpretations of what had happened and needed to be deconstructed, identifying the thoughts, feelings and actions reported.

Habermas refers to a 'double hermeneutic' (1984, p.109-110) meaning that there is a striving to interpret a world that is already an interpretation and not objective fact and therefore great care needed to be taken with this level of abstraction. Once common socio-political or educational themes were identified they were compared to the Habermasian concepts identified earlier (Life-World, Systems and Colonisation and Communicative Reason). Alvesson argues: "Without a theoretical understanding, any use of interview material risks being naive" (2003, p.14). By questioning the terminology used by the nurse-participants and querying how these linked to health service mantras, acceptance or rejection of these influences could be explored. Scambler (2001) suggests it is about identifying which language has become the 'norm' in 'life-world' discourse.

The question for me was what constituted and differentiated evidence of the different concepts. Table 9 highlights the kinds of evidence I sought in the transcripts. However this was not a precise list, but took the form of an initial consideration of what could be elements of these different phenomena and each was refined more carefully into a codebook of definitions (Guest et al. 2012).

Table 9 - Elements Sought for Interpretation

Concept	Possible Examples
Life-world	Public service values: Altruistic stance Prioritising patients Loyalty to public Teamwork Caring values: Close working relationships with patients Sense of professional identity Professional networking Hierarchical structures Openness to gradual change
Colonisation by Systems	Unquestioning acceptance of the following: Emphasis on the competitive market Emphasis on performance measurement and efficiency Cost cutting Customer orientation Blurring of professional boundaries Increased skill mix in nursing Economic cuts to educational development Reduced respect for clinical management view Contradictions between innovation and risk aversion Isolated / alienated working Emphasis on individual responsibility - blame culture Narrow scientific view of evidence-based practice as sole source of knowledge
Communicative Reason	Ability to question: Moral intentions Service approach Socio-political context Power relationships And use: Different forms of evidence Discourse and processes of argumentation Social networks

In order to demonstrate how the larger category of influences on the learning journey was broken down into different aspects of the learning environment I

present a short example here in Table 10 of a breakdown of a theme[16] into a code[17] definition that relates to research question two.

Table 10 - Structure and Thematic Coding

R.Q. 2. How did the learning around the project process and the overall educational experience appear to be affected by the wider socio political aspects of healthcare and could these factors be viewed as 'colonising' the nurses' existing 'life-world'?	
Theme	Potential Colonising Influence
Coding definition	
Economic Driver	Textual reference to the importance of financial considerations without reference to patient clinical benefit.
Transcript Illustration	Beryl: "Because of the end of the day it is all down to beds isn't it?"

Habermas (1984, p.114) emphasises that accounts should be seen as rational claims not subjective statements and to me this was important in respecting individual views of a situation. Appendix 2.7 contains an illustration of a piece of transcript analysis. The detailed findings are presented in chapters six, seven and eight. Data analysis and interpretation are integrated under the headings of 'The WBL Life-World of Nurses', 'UKNHS Market Systems and Colonisation' and 'Communicative Reason'.

In this section I have explained how the analysis was approached: first individually, then comparatively, and I have gone on to indicate how interpretive themes were drawn out. This process was complex, because it involved getting underneath the language of health service reform, unravelling deeper concerns and dealing with unexpected findings. In the next section I acknowledge how as an insider researcher I had a unique opportunity to illuminate 'new forms of micro-politics' (Anderson and Herr, 2010, p.18), but needed to be aware of my own influence upon this process of exposure.

[16] "Theme: A unit of meaning that is observed (noticed) in the data by a reader of the text." (Guest et al. 2012, p.50)
[17] "Code: A textual description of the semantic boundaries of a theme or a component of a theme." (Guest et al. 2012, p.50)

Insider Researcher Challenges

My research position both aided and challenged the inquiry at different points in the research. As a doctoral student, literature reviewing and theory debate was welcome personal development. It was only at the interviewing stage that conflicts between educator and researcher roles began to emerge and these are outlined here in a discussion of the importance of reflexivity.

I recognised that I was an 'inside researcher' (Hellawell, 2006) in terms of my educational role as a module co-ordinator, although I had not studied WBL myself. The nurse-participants had finished their modules over a year before and had progressed on their courses, they had moved on academically. Yet for me my interest was still in WBL development as I was responsible for the course. This sense of responsibility did make me, at times, defensive of criticisms of educational support, but I realised that I needed to document the problems in order to suggest curriculum improvement. I was surprised how open the nurse-participants were in providing this feedback and in one of my post interview reflections I noted how the interviews provided a depth of course feedback that most evaluation exercises could not.

Educational facilitation was harder to dismiss and it was hard not to rush in with advice when the nurse-participants raised issues. My educational style had always been nurturing and that side of my nature was hard to switch off because doing so felt uncaring. This did make me consider wearing a different 'uniform', a white coat perhaps, for the interviews to make the role change explicit. I didn't, but I did have to visualise adopting an independent research persona for the interviews. In addition I found at the end of the data collection I had a strong drive to generate suggestions for course improvement and found myself jumping to solutions rather than exploring the complexity of what had been learned.

I was also an insider in terms of my experience as a nurse, although again I was distanced by my move away from clinical practice into education. Inside knowledge was an issue in terms of the nurse-participants assuming understanding of their situations. The nurse-participants knew I had a nursing

background and would use abbreviations and references that I knew, making some of the interview transcription familiar to me, but inaccessible to outsiders. This presented problems in supervisions and when peers tried to review my interpretations of the accounts. As a result I became more careful to ask for clarification during the interviews.

Hellawell defines an inside researcher as one who carries an intimate knowledge of 'the community and its members' (2006, p.483). I was aware of my loyalty to nurses and it was through supervisions that I became aware of the impact my protectiveness towards them might have, in assuming their good intentions, and on occasion failing to question comments made in the interviews. However, in the findings chapters I have tried to highlight these instances and analyse them more thoroughly because of this potential weakness.

As I learned the skills of interviewing in this context, I was beginning to see myself in a mirror, learning about my weaknesses through the way the nurse-participants responded. Although I knew it was impossible to be completely neutral or objective as a researcher (Habermas 1984, p.123), but some of the values and attitudes being described were close to my own and I knew there was a danger of me showing these individuals more approval and encouragement. Those who challenged my value system might be able to sense my possible disapproval and close down and I had to be sensitive to that. I did not want the nurse participants to feel they could not expand on their ideas, whatever they might be. In this study I was as Blaikie describes 'consciously partial' and attempted to act as a 'reflective partner' (2010, p.52) in my commitment to a critical interpretation of their situations.

Reflexivity was important throughout this research process, in terms of regular reviews of interviewing conduct, and reflection on analytical material. Fenge (2010) argues that this is central to anti-oppressive practice and thus important to critical theory, because it acts as a moral benchmark and encourages respect for the authenticity of the material collected.

Conclusion

This chapter has clarified how the theory was worked up into a research action plan. I have shown how the experience and findings from the pilot study helped me to refine the focus of the inquiry and I have discussed how experience helped me to craft my interviewing technique. Wrestling with analytical approaches and trying to make them explicit and reflecting on the researcher's role were all part of this research learning journey for me. The next three chapters reveal the results of this work.

Chapter Six - The Work-Based Learning 'Life-World' of Nurses

"You don't know what you have got, till it's gone"

Joni Mitchell (1970)

Introduction

This is the first of the three chapters that draw together, present, and interpret the findings from the interviews. This one focuses on the Life-World, the next on UKNHS Market Systems and Colonisation (chapter seven) and the last on Communicative Reason (chapter eight). By grouping interview material in this way I wanted to first identify what was happening to the nurses during their experience of WBL, then examine the system challenges they faced, and finally discuss the impact on their learning.

This chapter is the largest, because it sets the scene in terms of establishing what was discovered about key elements of the nursing life-world. I wanted to be as open as possible to whatever information the nurse-participants could provide. This conceptualisation of the life-world flows from the aspects the nurse-participants appeared to think were important during their learning journey, prompted by questions about the motivation for the projects and their experience of them.

The accounts presented here reflect the nurse-participants' understandings of their situations, their expressed values and beliefs, their attitudes to nursing activity and address the first research question:

1) What values, beliefs and expectations did work-based learning students hold about nursing and how do these relate to the concept of a nursing 'life-world'?

The strongest theme that emerged was the centrality of relationships with patients, and this acted as an important trigger for project work. This is captured in the first section: 'Background Convictions'. This is an important section because it reveals the values and beliefs, which acted as a driving force

for the projects and provided a principled approach to the work. Joni Mitchell wrote in her lyrics for Big Yellow Taxi: “You don’t know what you have got till it’s gone”; the ‘what’ here are valuable aspects of this UKNHS environment that appeared important to the nurse-participants and for the service. I suggest that there are positive attitudes to care found in this life-world that should be recognised, if we are not to lose them.

The next three sections are framed by the way Habermas (1987, p.142) describes change taking place in the life-world through three routes, the first of which is socialisation and embraces identity formation; the second is cultural reproduction and the third social interaction. ‘Nurses as Change Agents: Issues of Socialisation’ explores the nurse-participants’ transition from givers and organisers of care to change agents within healthcare teams. This is followed by a consideration of change in the light of hierarchical pressures in ‘The Experience of Hierarchy: Cultural Reproduction’. This section captures the difficulties of navigating the cultural expectations around authority and who has the power to lead change. The final section entitled ‘Team Communication: Social Interaction’ reflects on how nurse-participants built alliances within their specialist teams through more consensual patterns of interaction.

Background Convictions

The first impression I gained from the nurse-participants were that they were all keen to articulate how their projects were relevant to their work and not just academic exercises. They expressed an eagerness to ‘make a difference’ to care (a term used by three different nurse-participants on more than one occasion during the interviews). The nurse-participants’ aims are examined here and considered in the light of Habermas’s concept of ‘background convictions’, beliefs that provide ‘a reservoir of taken-for-granteds’, ‘mutual understandings’ and form a continuous background to the life-world (1987, p.124) .

I have divided this section up into three to identify the separate importance of firstly relationships with patients in ‘Starting With Patients’; then their

perception of their professional roles in ‘Caring and Empathy’, and then I examine how this sits in a broader concern for equity and social justice in ‘Public Service’. Habermas describes society, culture and personality as domains of the life-world (1987, p.142) that work together to maintain it. Here I take this framing in reverse, by starting with the most intimate and working out towards wider concerns.

Starting with Patients

Nine of the ten nurse-participants articulated a desire to improve services for patients with an intensity of feeling which surprised me. I look at the values and beliefs expressed and explore what these claims suggest about their relationships with their patients. I then examine this emotional response more closely by looking at the way the nurse-participants’ ideas for their projects developed from contacts with patients.

Beryl asserted in her interview: “*You do what is best for your patients don’t you*?” Beryl’s sentence ended with a rhetorical ‘*don’t you’* expressed in a forceful tone that assumed agreement would be given, but also indicated a slight defensiveness or concern that not everybody acted in the way they should. Beryl had stated something she believed was a key principle: putting the patient first, assuming it was an accepted stance within the profession, which it is (NMC, 2018).

Beryl’s project focused on reducing sleep deprivation for older people, in order to improve their mental health by decreasing the number of pressure area interventions at night from two hourly to four hourly. Although superficially a small change to procedure it presented a radical change to accepted protocol. She was articulating her frustration with an intervention that she believed was causing more harm than good: “*We were wearing them* (frail elderly patients) *out*”.

Habermas describes one of the constituents of the life-world as assumptions that are ‘intuitively familiar’ (1987, p.124). Thinking of the patient’s best interest appeared to be intuitively familiar to Beryl. She was reminding me of a principle she believed nurses should be following, as she leant forward to say

rather fiercely: "*You have to protect them really, you know*." She went on to generalise by saying: "*Patient-centred care is providing effective care and keeping the patient safe*." Habermas argues that within the life-world there are 'collective world views' which offer a 'scaffolding' (1984, p.70) of traditions and beliefs that are formalised, as in this nursing context with codes of practice that protect patients from harm (NMC, 2018). Although Beryl's phrasing echoed the wording of professional guidance it was delivered with a passion all her own.

Elaine similarly described her project as motivated by a need to protect her patients, by educating staff about monitoring equipment in critical care. She said: "*It seemed that we were putting this thing into someone's heart and we did not have any training in it which seemed crazy. They didn't realise the risks."* Jenny had similar concerns about her staff's level of knowledge of a ventilator they were using for respiratory patients, but talked more formally about how an "*educational deficit*" had been discovered. In addition, Paula described her first WBL project on education for staff on cancer care as improving "*the quality of nursing of those patients and improving their quality of life*"; by '*arming*' nurses with information they could give their patients. All three of these projects were therefore focused on educating colleagues to protect patients from harm.

Mandy's project was more directly focused on patient care in terms of adjusting clinic times for her patients. In this project she demonstrated a practical concern for clinic attendance, but her words went further in expressing an eagerness to meet the needs of different client groups, including young mothers, who were anxious that they could not make early morning appointments because of child care. Mandy stated: "*Putting the patient at the centre was a big thing for me*". She asks: "*Why wouldn't you put them right in the middle and move mountains to become a really good team*?" The way that Mandy states this suggests she cannot understand why this wouldn't be the case, suggesting a sincerity of approach. In both Beryl and Mandy's interviews the forcefulness of their verbal expressions convinced me of the strength of their accompanying emotion. An important part of the life-world appeared to

be this sense of "a shared understanding" (Habermas, 1987, p.124) of prioritising patients.

The drive to bring about change was echoed in Stephanie's claim to want to "*make a difference*" to patient care, which she mentions three times. This could have been a reform slogan, although I am not aware of this language being used in this way in the UKNHS. Stephanie convinced me of her personal sincerity in enthusiastically describing how her project brought about change. Her project was concerned with providing renal education to staff and was stimulated by a survey she had carried out which had revealed gaps in staff knowledge. Stephanie reported: "*They did say it was the hardest part, the lack of education.*" She reported how not having specialist knowledge had made it uncomfortable for staff trying to advise parents in the care of their children.

Stephanie emphasised that the difference she wanted to make was "*within nursing and to other people*," embracing parents, children and staff colleagues in her improvement drive. During the interview she explained how she felt about her clinical area: "*I love it. I love the speciality, I love the children and I love my ward*" she went on to say: "*Even when other posts come up like a job in the Children's Hospital I always think about it, but I think, could I really leave the children that I have and go?*" I did not expect her to have such a strong bond to her patients I had thought motivation would be defined simply in practical concerns.

Two other nurse-participants explained how the impetus for their work came from concerns that had arisen from difficult patient situations and these situations are examined in more depth here. Habermas suggests that the "knowns" (1987, p.124) or beliefs accepted in a life-world are only questioned when a problem arises or a situation is "problematised" (ibid,p.133), by a challenge presented and this arose when the nurse participants considered subjects for their projects.

The local triggers that stimulated projects were sometimes quite dramatic. Paula, in her second WBL project on ward communication, identified a situation where a patient had died earlier than expected, as a result of being

discharged too soon because of poor communication between team members. She described the family as understandably "*traumatised*" by the event, going on to explain: "*There was all sorts of psychological damage, it was terrible and it all stemmed from no documentation in the medical notes"*. The painful process of debriefing the relatives about the death was a key prompt for her to look at ways of improving team dialogue. Paula expressed her belief that "*if there had been a nurse within the ward round then that would not have happened, as they would have known what was happening*." It appeared that the frustration and distress created prompted her to take on a WBL project to improve communication in her department. Davies refers to emotional triggers "kick-starting the learning process" and describes how a traumatic incident can "jolt us out of our coasting behaviour" (2008, p. 43) and this seemed to be the case here.

Yvonne illustrated this emotional trigger when she described how her project idea came to her when she recalled a previous patient situation:

"*It did bring up the story of the girl in X ray who had to stand up and wee in a pot between her legs. A teenage girl under pressure it was going down her legs and all over the floor, but that must have been absolutely devastating for a teenager, even now I feel upset about that it must have been awful for her*."

To avoid this happening again she wanted to bring her patients back to their own department so they could manage a test that could be more sensitively handled.

The way information was shared between members of the professional team in Paula's scenario had, in Habermas's (1987, p.133) terms, been 'taken for granted', but it was now in question. Similarly Yvonne had recalled what happened to one of her patients had triggered concern for their welfare and her screening system had become "problematised" (ibid, p.133). Disturbing patient experiences, a fear for patient safety (staff education projects) were key stimuli for changing everyday practices in these WBL projects. The close working relationships with patients thus provided vital background information, but more importantly guilt, shame or even anger, emotional triggers for new learning to take place.

I began this section with Beryl's comments on how she prioritised patients and I end it with a further comment from her on the intimate way she perceived her relationships with patients. Beryl described how she liked to treat patients "*as if they were a member of my family or a friend*". She acknowledged that this was a 'cliché', in that nurses frequently talk about care in this way and this echoes my own observation of nurses speaking in clinical practice. The echo made me aware of the danger of over-empathising with the nurse-participants. I have my own beliefs about what nurses relationships with patients should look like and I had to ensure I could examine that and put it to one side during the interview process. Focusing on Beryl, her comments suggested to me that she felt an emotional bond with her patients, but in addition it revealed a sense of responsibility. This statement explained her behaviour, not as a 'customer service' orientation, but (likening a patient to a family member) suggested a more personal involvement. In the next section I examine how the nurse-participants' relationships with patients connected to a sense of personal responsibility and standard setting in professional behaviour.

Caring and Empathy

In eight of the ten WBL projects, the nurse-participant's awareness of patient experience helped them to identify problems that needed addressing. I look at how their knowledge of and loyalty to their patient groups impacted on the project work and was translated into skilled caring and empathy. In addition I now look at the role professional pride played in promoting good care.

In both Yvonne and Paula's scenarios concerns about poor standards drove their project ideas, in Yvonne's case in the handling of a local screening procedure, and for Paula in local ward communication. For these nurse-participants it appeared their pride in giving good care was challenged by these incidents. Ruth described her clinic patients as "*fantastic*", and mentioned "*I just have to have that*". She had identified a strong connection between her nursing identity and her service. This made me wonder whether or not the need to be close to patients was essential to this nursing life-world.

Paula's account offers insight into how close working relationships with patients, for her, was linked to her sense of professional identity. She reflected on her own career development in the following way, she stated:

"*I feel I have gone into a different phase in my nursing, so I am ready to release having to be so attached to patients physically, in terms of that one-to-one contact. You know I came into nursing to be a caring, loving nurse that would help and deal with situations with people and make them feel better. Then to step out of that, through well, being a ward sister you're slightly stepped out anyway, as clinically you are not working quite as much and it is more of a managerial thing, yes you are caring and nurturing your staff , but it is a different shift*."

Paula continued to describe yet another role change into a specialist nurse commenting: "*the nurturing and caring is still very prominent, but the issues are slightly different and they are not quite as ill so often, again the shift*."

She referred to a colleague who, when asked how she felt about moving away from direct patient care said she had found it difficult. She described the other nurse as "*not ready for it*", but went on to say "*I am now ready for it*". There is here a sense of acceptance of loss in this '*shifting*' away from caring duties. Paula concluded that she was now "*comfortable*" even though "*I won't necessarily be with patients*". The move away from being with patients appeared to require some adjustment or change of self-image, certainly for Paula.

One nurse writing her memoirs (Watson, 2018) compared the relationship between nurses and their patients to an umbilical cord with the blood flowing back to the nurse (as if they were the baby). She described how she had undergone several births in different specialist fields of nursing through being intimately involved in the dramatic 'joys' and 'tragedies' of human lives and growing through these experiences. Oermann (1997), a nurse educator, when theorising models of nursing socialisation described how changes of influence occur as newly qualified nurses move into workplaces and she stressed that the client group served remained important to a nurse's identity. This is one opinion, but is perhaps reflected in the way some nurse-participants described their attachment to their specialist areas, for example when Stephanie had

commented on not wanting to leave the children she nursed for better job opportunities.

That the motivation to carry out projects had been so tied to the emotions of 'caring' had surprised me, because I imagined the project drive would be more practical and organisational. Concern is repeatedly expressed in lay and professional writings that nurses could be losing the tender 'caring' trait, perceived by lay and professional writers as essential to the nursing role (Huston, 2017). My findings suggest caring was still strong in this group of experienced practitioners. Gaze (1991) expressed an opinion that lay images of nursing are inextricably linked to women's position in society. Historically, as a profession, nurses have moved from the image of nuns (convent origins of care), to obedient servants (Florence Nightingale's disciplined approaches), to more recently nurturing mothers (Jolley, 1995). Certainly, it appeared to be a 'motherly caring' that was motivating Beryl's approach (illustrated in her use of the word 'family').

How the nursing profession perceives its therapeutic relationships has been shifting and is reflected in differing attitudes to empathy within the profession, and is discussed here because I believe it is pertinent to the nurse-participant's project work. Empathy was explicitly advocated in training courses in the past, hailed as an essential skill in nursing communication and previously seen as "at the heart of a therapeutic nurse/patient relationship" (Williams and Stickley, 2010, p.753). There are many and varied definitions of empathy, but my conception of practising it follows that of Carl Rogers (1967) embracing: a non-judgemental openness to another's perception, the ability to extract information through verbal and non-verbal communication, an emotional imagination that enables understanding of situations and feelings and a willingness to consider new options in response to this learning. The use of this term in healthcare has been challenged, on the grounds of over-familiarisation and paternalistic behaviour (Pike, 1990) and UKNHS Policy documents and formal professional guidance seem to have moved away from the term 'empathy' towards the idea of 'compassion' (NHS England, 2012).

I suspect that if you want to increase the number of untrained staff, it is helpful to reduce the skill level of this activity. I argue almost everyone is capable of 'compassion', which emphasises sympathy and kindness, but this can also carry connotations of pity (Oxford Dictionary, 2019). By simply stressing sympathy and kindness the focus moves away from a depth of understanding to a superficial recognition of a client's anxiety or pain.

In attempting to understand a patient's situation from their perspective a nurse has to listen, use their imagination and reflect on their patient's position, and then find ways of accommodating that perspective. Yvonne could have shown compassion in her management of her teenage patient in x ray by warning the girl about the procedure and in being sympathetic after the event. However, empathy led her to feel appalled at the girl's experience and stimulated her to search for a better screening method, so that none of the patients would have to go through such an experience again.

In a less dramatic way both Ruth and Mandy used empathy in considering their patients in terms of suitable clinic times. Ruth acknowledged "*We have a lot of elderly patients who don't want to be there late at night, at 9.30 on a cold winter's night*." Mandy empathised with her mothers with young babies who found it difficult to attend clinics early in the morning: "*Having now had a baby I realise*" accepting the problems of getting organised and juggling family commitments.

As Bazalgette (2017) suggests, the greater understanding that comes with empathy can make individuals more tolerant of others and willing to adapt to their needs. Veronica, developing educational materials for staff, concluded that the course had enabled her to "*give better patient care*" through her teaching work. Two points emerge as key here, as Knowles et al. (2014) suggest, as adult learners, these nurse-participants valued learning that was related to their daily work, but in addition they wanted their learning to benefit their patients.

In this nursing life-world the nurse-participants demonstrated in their projects, how observing, listening and trying to make sense of the problems that

surfaced for their patients they could set out to make services better. Beryl, Paula, Ruth and Stephanie articulated their therapeutic relationships, but like Yvonne others demonstrated their approach more subtly in the way they worked through their projects. I argue here that in this WBL life-world emotional attachments guided the nurse-participants towards a respectful and caring approach to the task.

Public Service

I now explore whether the background convictions my nurse-participants held went further than just valuing their immediate patients. Paula's first project on nurse education was inspired by a concern for fairness. I look for further evidence amongst the nurse-participant accounts of a wider socio-political awareness and compare the values identified to those of public service.

The prioritisation of patients described earlier suggests a public interest reminiscent of the altruistic interest and loyalty to the public, identified in the Pratchett and Wingfield (1996) research accounts of public service. However, I suggest that Paula's concern for fairness illustrated in her account of her first WBL project takes this closer to a social justice perspective. She had focused on staff education for cancer care, she stated: "*Often those patients didn't get the same level of support and education as the outpatient ones*". She had observed that the low number of people with specialist expertise in the ward area meant that generically trained nurses were forced to give specialist advice, when they did not have the underpinning knowledge. Talking about the ward environment, she stated: "*There was definitely a lack of knowledge and information."* Addressing this inequality through increasing staff education was Paula's goal. Paula was not under any formal pressure to standardise the service, but had noted a weakness in educational support.

Although Paula's project was driven by a desire to improve service, it did not however, address the bigger concern of a lack of specialist nurses or carers. She did not question the socio-political context in which the work was set and staffing levels, but sought to manage the situation and this is reminiscent of Gott's words about nurses 'enacting' policy rather 'deciding' it (2000,p.7).

Either Paula sought to work within the political context rather than challenge it, or did not realise she could challenge it. Close contact with her patients had brought an awareness of social inequities and it appeared to be a sense of justice that drove her moral purpose in wanting to prevent this unfairness. Having become aware that the information she assumed would be given was not, she came to question her service.

Paula had been looking for a focus for a project and observed a local need and thus narrowed her view to immediate problem solving. As Henderson (1980) writes, nurses can feel satisfied with making a small change in one area, but remain in a 'rut' by failing to see the bigger picture, or the causes of the problems they are dealing with: in this case staff shortages and broader questions of staff development overall. This behaviour echoes that of the nurses described in Bjornsdot-tir's (2009) ethnographic studies where they viewed themselves as apolitical, powerless to change larger issues and thus concentrated their efforts on practical problems they could manage. In Paula's situation local problems were the brief for the project undertaken and therefore her educational goal was appropriate for the scale of the project, but an acknowledgement of these wider concerns would have demonstrated a political awareness of changes taking place in the UKNHS. This was not articulated in our discussion, her framing of the 'problem' was limited to the local context, which might have been due to the WBL framing or her personal perspective.

Stephanie had looked more widely at the UKNHS in her research, but from within her speciality, for her project stating:

"I looked at recruitment and retention within renal nursing (pause) and why do we struggle to retain nurses. Then I wanted to produce something at the end of it that would / might help to keep nurses. The evidence showed a lot of it is lack of education. It is a very specialised or complex area of nursing, especially within paediatrics and you don't get any real help, especially with the work pressures here. It is not like you get an extended course on renal. You sort of get chucked in and learn along the way."

She had anticipated that her project work on staff education could increase recruitment and retention in her department and thus demonstrated a broader professional view. She had seen beyond her immediate goal, of producing a renal guide for staff locally. However, her motivation to change local

circumstances did not emerge from a socio-political goal of improving the UKNHS; but rather, as her words suggest, by a more personal drive to help her speciality. I believe that this determination reflects McDonough's (2006) 'sense of commitment' (described in chapter three) that public service workers can sometimes feel to their staff and service, but perceptions of the individual's range of influence can be limited to, in Stephanie's case, a smaller specialist world.

Ruth expressed a similar loyalty to her specialist department, but in addition identified a personal ethical stance when faced with organisational changes of which she did not approve. Her project was focused on altering clinic times to meet increased patient numbers, however senior staff had imposed a change that took her patients away from the specialist care she felt they needed. Ruth stated: "*I couldn't just go along with everything. I have to feel it is the right thing to do*". This echoed McDonough's (2006, p.643) public service research findings where she described her interviewee's experiencing 'disquietude' and 'anguish' when unable to provide the quality of public service they wished.

I have not mentioned Carol, the only one of the ten nurse-participants who did not directly associate her motivation for choosing her project with enhancing patient experience. I describe her comments here because they do relate to how nurses behave in the NHS. Carol too displayed convictions in the form of what she believed should be the role of the nurse in patient care. She asserted: "*Being a nurse....is about sitting down and talking to the patients giving them time, which we don't have the luxury of anymore*." Carol's description of the role of the nurse referred to the one-to-one relationship with patients and an attentiveness to their care. As an operating theatre manager her more distant relationship with patients meant that her perspective was more strategic, yet she had confirmed (in these words) that the relationship with patients was vital to the nursing role, however she had also identified that this belief could no longer be realised.

Habermas refers to a 'naïve trust' that can be present in the life-world, an assumption that things will continue the same (1987, p132) and nine nurse-participants arguably demonstrated an eagerness to simply 'do good' through

their projects by improving the quality of patient care. However, Beryl's defensiveness about the patient's best interests, Mandy's questioning of why staff wouldn't want to put patients at the centre, and Carol's comments suggest an awareness of differing mores existing in their life-world. Habermas (1987, p.131) portrays those living in the life-world as sometimes being unable to see over their horizon, unable to imagine things as fundamentally different, so although there may be a suspicion of outside influences seeping in or of changing attitudes, the force of change is not always recognised. Here these three acknowledged that attitudes were changing.

The elements of the life world that have been identified here are a collective value system that prioritises patients and an appreciation of the importance of close working relationships with patients to giving good care. The analysis revealed that the nurse-participants' attachment to patients went deeper than a public service commitment into a more emotional relationship. The moral and emotional aspects of care motivated their desire to fight for improvement and this appeared to be associated with their sense of identity and responsibility as nurses. My analysis revealed that the nurse-participants were working hard to achieve small changes that would enhance their service locally, but only three drew attention to any change in this relationship between nurse and patient. The others seemed to reflect a certain naivety toward change which left them in the dark until conflicts arose.

Nurses as Change Agents: Issues of Socialisation

In WBL, the nurse-participants were shifting from doers, givers or organisers of care, to initiators of change in a more proactive way and this had to be accepted in their nursing life-world. In this section, I look at the initial reactions to this transition in 'Being a Change Agent' and then how it was accommodated or rejected in 'New Frictions' and explore what this reveals about nursing life-world and change. Habermas (1987) identifies this socialisation as one of the first ways change is embedded in the life-world, but the difficulty can be that historic expectations can become blocks to further change.

All the nurse-participants were enthusiastic about the opportunity to effect change (there was no dissent on that), yet all but two (Carol and Stephanie) experienced problems in achieving their service goals. In this section I examine both why this process was difficult and how it became a chief source of learning. The WBL project assessment required proposals to be shared and approved by supervisors and managers, therefore seeking agreement and gaining acceptance of their ideas was crucial to success. I identify references to work-based supervisor (WBS) contact specifically in this agreement process.

Being a Change Agent

I begin this analysis by identifying the nurse-participants' views of their changing role. Also I draw out the problem with nursing socialisation in terms of a lack of preparation for less senior staff in leading change and the way this was overcome.

The nurse-participants accepted that the UKNHS was always changing and were resigned to a constant turnover of clinical developments and this is expressed by Elaine: "*You know everything in medicine and nursing goes in fashions*". However, it was those in management positions Jenny, Ruth, Paula and Carol who articulated the pressure service change could impose. Jenny commented on her role in implementing new changes: "*In my role as a sister I have to do change constantly, changes in practice and supporting change is part of my role*". Ruth alluded to the increasing cancer population in explaining the rising demands on her clinic services: "*It has been a constant battle of demand and capacity*". She went on to say: "*I am doing a lot of workforce change and service improvement initiatives, which is a big part of my role.*" Paula stated: "*So as a ward sister, the pressure and the focus that the trust want you to have, you can't deviate from, you have to be quite clone like.*" Carol was already conducting the change she was using for her project and commented that the project "*seemed to fit in with my management role*". These accounts suggest that implementing and managing change, although not initiating it, were seen as a manager's responsibility. This top down system caused difficulty for those approaching it from less senior positions or who

wanted to do something different from what was identified by those above them.

Veronica, a staff nurse, explained that "*change management was something I had never really thought about*." When Veronica began suggesting a change to some educational materials in her clinical area she described it increasing her visibility, "*it sort of brought me more into the light*," and into conflict with a senior colleague. She as a Band 5 (staff nurse) was expected to be involved in planning ward level healthcare activity, but was not invited to service planning meetings, she stated: "*It is the Band 6s and 7s that make the decisions*."

The individual enthusiasm for their projects drove the nurse-participants' ideas for change, but their fervour did not seem to be supported by a knowledge of how to manage the socio-political issues that arose as a result. Nursing education in the past did not encourage leadership in the way it does now (Willis, 2015) and these staff were not educated to take on a higher level leadership role. The irony was that the nurse-participants were being encouraged to initiate change and supported by the Trust on a WBL module to bring about change, but locally their leadership was not always recognised or respected.

New Frictions

The first step in their project work involved the nurse-participants gaining the agreement of a WBS to their learning action plan and this presented some with their first challenge. Six of the ten experienced good support from their WB supervisors, but Elaine, Veronica, Mandy and Jenny expressed shock at the hostility they received from some of the senior educators who they approached during their projects. By focusing on these four I hope to highlight what can go wrong.

Elaine's conflict situation seemed the simplest, but still caused upset, because her first WBS, who had initially been involved in her project, was omitted from the planning whilst on sick leave and Elaine believed she returned disgruntlement at the plans that had been agreed in her absence. "*The old one*

was very negative about what I wanted to do and what I had produced". Veronica found herself torn between two different educators' views of how she should proceed, which she described as feeling like "*piggy in the middle*" (a phrase used three times during the interview).

Mandy met resistance to her ideas from a more experienced colleague and her WBS. She explained:

"It was a lovely team, but the two other specialist nurses had been there for twenty years and I just felt like nothing really changed much. We did things because we had always done them that way"

She had assumed an openness to change that did not materialise when she suggested altering clinic times to suit different patient groups. With a sigh she said: "*We always ran a clinic at the hospital and we never ran it anywhere else and we always ran it in the mornings, and it was never an option to run it in the afternoon.*" The change might have involved the staff working different hours or travelling to different sites, but suitable arrangements could have been discussed. It was the refusal to countenance change that had brought Mandy frustration. Mandy commented that there was she believed "*a huge need for change but nobody ever wanted to do it, they weren't keen on change.*" She reflected: "*I don't think I really looked into the dynamics of the team before, when you are keen to change and actually somebody else isn't, but they are more the powers that be and you aren't.*"

Mandy articulated the social isolation that this brought: "*There was just me*". Mandy and Veronica both described contemplating leaving their posts during the projects and left soon after they finished their course work. Both Mandy and Veronica's descriptions of their later employment situations suggested that it was the atmosphere on the previous units rather than their change management styles that had caused the problems, as Mandy described the new environment as "*refreshing*" in welcoming her ideas. She recalled: "*Currently my boss, you know, you can say to her let's do it this way and she will say right let's have a try then*." Talking of where she was based during the project experience she added: "*It just wasn't like that in that team*". Veronica felt her

move into a full time education role provided more freedom to carry out the teaching role she enjoyed.

These setbacks could indicate a lack of willingness to allow less senior colleagues to lead change. In addition it suggested a lack of power and influence among these nurse-participants and this presented them with practical blocks to project development. Jenny's situation was slightly different in that she was criticised by medical colleagues for working on educational material for equipment that they thought was not a priority: "*They were: "Why have you done that*". These conflicts affected personal confidence and motivation, Jenny stated: "*It did make me wonder if I had just wasted six months of my life [nervous laugh]*". By coming out into the light and suggesting new ideas, she reflected: "*You are opening yourself up for criticism and belittling*".

However, the difficulty here seemed to be less about the changes themselves and the quality of their work, as at the end of the projects products were appreciated by local staff (evidenced in chapter eight), but it appeared to be more about the threat to existing authority. I suggest that in all four situations conflict was associated with challenging hierarchical power relationships. Veronica's suggestion for further educational material had inadvertently identified a weakness that her supervisor had not noticed and thus reflected badly on her; in Elaine's case the supervisor lost her influential position by being side stepped; Mandy was blocked by her colleagues' seniority and because Jenny chose to prioritise the nurses' requests for information she challenged the doctor's perceptions. In a medically dominated setting this had a powerful influence on the amount of support she received. In the next section I look at these hierarchical concerns in more detail.

The Experience of Hierarchy: Cultural Reproduction

Habermas states that the 'language' and 'culture' are 'constitutive for the life world itself" (1987, p.125) and the culture in this UKNHS setting was 'hierarchical'. He refers to the "regulated interpersonal relations" present in a life-world (ibid, p133) and in this situation some of the nurse-participants were

challenging these relations. In this section I consider how the hierarchical aspects of this setting impacted on staff by firstly noting the concerns about speaking up in 'The Fear of Reprisal' and then secondly how communication obstacles were overcome in 'Getting your Voice Heard.'

The Fear of Reprisal

This section outlines three very different ways hierarchy can constrain project work. Firstly I examine Veronica's situation in depth because it revealed how conflict arose between a student and a supervisor, colleagues only one grade apart, yet because of the power differentials and close working relationships it had a strong impact on those concerned. I also look at Beryl and Paula's situations as they reveal the difficulties of making change happen when less senior staff won't support an initiative because of the perceived risks involved. Finally I touch on the hierarchical aspects of Ruth's conflict with senior staff, although this will be examined in more depth in Chapter Seven, as it went beyond immediate staff issues.

Veronica described her setting as particularly "*competitive*". She had described the Band 5s as not feeling they had a "*voice*", commenting: "*They would often say they are just plebs*." I identified earlier how Veronica commented: "*It is the Band 6s and 7s that make the decisions*." She summarised the situation as "*you just kept your head down and let them sort it out*." When it came to the project she said: "*I knew what I wanted to do but to try and get it so everybody else was happy and on board with it and knew what I was doing, that was a bit tricky*". She used '*tricky*' to describe this situation four times during the interview.

Veronica appeared surprised that what she seemed to think was an innocuous suggestion had been perceived as threat by her supervisor. The proposal to produce a further education resource to explain a device which her WBS had installed was not appreciated apparently. However, her staff colleagues and the local practice development matron recognised the need for further guidance on the device. When the practice development matron offered practical assistance Veronica began to work with her and found this placed her in a difficult

position between the two senior educators who held different views. During the interview Veronica spent twenty minutes going back over how her WBS had approached her and reflecting on why this arrangement had turned out to be a mistake. She appeared to be trying to understand what had gone wrong in their relationship.

She described her WBS's initial enthusiasm to take her on: "*She said I will be your supervisor, I will help you out and I said: 'Oh thank you'*." WBSs gained kudos from their role, and depending on their local status could view controlling developments as a way of sustaining their own senior or influential position in this narrow political world. Educational responsibility like management authority appeared to offer status within the nursing team either through expert or informational power (Raven, 1992) and therefore a challenge to this expertise could be viewed as a threat. Additional concern and even insult might arise when the questioning was coming from someone less senior.

Veronica commented that she had now realised she must have given '*offence*', by not following her supervisor's direction and finding another colleague who was more supportive to work with. She reflected: "*I don't know whether she got umbrage. I don't know if it [working with another colleague] made it worse*." She explained: "*Me, being a Band 5, if I had really thought about it I would have gone with the one who wanted me to do the package, rather than the one that was not so keen, but I went with the wrong mentor.*" She concluded: "*If I had my way I would have changed supervisors.*" I was surprised by this last comment, because students could change supervisors, but she obviously believed this was not possible for her in this situation and this had accentuated her sense of powerlessness.

Veronica gave examples of what could be seen as obstructive behaviour in terms of the WBS not using the resource Veronica had produced in any of her teaching sessions. She stated:

"*What would have been nice would have been, if my supervisor had been more supportive of the project, when acting as a clinical educator when teaching people she could have directed them to it, the resource was there, but she didn't."*

Veronica described her WBS auditing her work more closely and pointing out weaknesses in her CPD portfolio, which threatened to undermine a departmental promotion, she had been awarded. Veronica had not covered the exact number of reflections required to meet a target, even though her part-time hours made this difficult to achieve.

Not deferring to authority appeared to bring repercussions, Veronica stated that she believed: "*The way she had done it was completely wrong, completely wrong (slapping her hand) it was not supportive it was bullying*." This is a serious occupational concern, but Veronica had not articulated this feeling to her colleagues at the time or taken out any formal grievance, this remark appeared to surface during this later reflection. As she had left the department she was unlikely to take this issue further, although at the end of the interview I did suggest further counselling could be accessed. This is of course Veronica's account and her interpretation of events, but the full account of the project process during the interview did seem to suggest that this reported hostility emerged after the nurse-participant went on to work closely with someone who could be perceived as a rival.

In Beryl's situation, where she wanted colleagues to change routine practice, she thought it was the fear of repercussions that made her colleagues negative toward the changes suggested. This again links back to hierarchical concerns in terms of responsibility and authority. Beryl carried out an internal survey amongst her staff in relation to her proposed change in waking patterns and it revealed that staff colleagues agreed with the change, but were reluctant to take a risk. She summarised their responses as "*Yes, it needs to be changed, but I am not prepared to do it*." She seemed to imply that she believed her ideas were too radical, because it involved staff using their own clinical judgement to override standard trust-wide protocols. Paula was similarly trying to encourage nurses to take personal responsibility for their clinical opinion when joining doctors on a multi-disciplinary ward round. Some were described as wary of this additional work, but it was unclear whether this was simply about workload or more about the additional responsibility. She described one of her colleague's responses: "*Well, it's the doctors' ward round isn't it*?"

These superficially small-scale personal conflicts made me aware of the significance of power differentials in relationships in the workplace that were not obvious to academic staff outside these departments. They made me aware of the need for both educators and students to be sensitive to the dynamics of these when initiating change. The number of these conflicts surfacing during the interviews made me shift from thinking they were simply one-off personal frictions to considering that there might be more of a pattern forming in terms of the use of power.

One of the most hostile situations arose when Ruth came into conflict with senior management. She questioned service changes that were being introduced from above and suggested an alternative plan that she was working on for her project. Her idea had been to rearrange clinic times to embrace the greater patient demand within her speciality and this clashed with decisions that had been made at a senior level. Ruth reported the repercussions that followed her challenge to this plan stating that the project manager "*was very critical of me personally and he did it in a public domain through emails and meetings and he made me feel quite devalued.*" Although I was not shown the emails, and the actual words used by the manager were not repeated, Ruth's sense of injury seemed real. It could have been that this kind of '*belittling*' was used to reinforce authority or pre-empt dissension. There were further repercussions when she still wouldn't agree to the plan for her departmental change. She commented: "*I have been in trouble, but I have been spoken to about speaking out and being reactive.*" The fear of reprisal did not stop Ruth in the long run, but it did make her consider leaving her job. Veronica, Beryl, Paula and Ruth all described this challenging part of their learning journey, but three found ways of working around the obstacles they faced.

Getting Heard

In this section, I look at how communication was used to manoeuvre around the blocks presented. The nurse-participants' attempts to bring issues to attention had brought a transparency to the workings of their life-world, highlighting the conservative climate in terms of hierarchical constraints. Beryl commented in her interview: "*I don't think people are aware that things can*

be done differently." Here I look at how some of the nurse-participants gained access to the dialogue about their services that were taking place at a higher level in order to influence them. Rather than directly challenging senior staff some of the nurse-participants found other allies who helped them to communicate more effectively through these hierarchical channels.

Ruth resorted to using a medical consultant to act as her '*champion*' to advocate for her plan, and thus used the hierarchical communication pattern in the UKNHS, adopting existing cultural practices to bring about change. Ruth recalled the difference her consultant made: "*As soon as a consultant said what I had said everybody listened, when I was saying it I wasn't listened to. So I had to speak through him.*" She went on to stress that she believed this was about "*status*" she compared it to when nurses saw her in a sister's uniform and changed their behaviour. She did not suggest there was any gender issue here, although the consultant was male, she may have thought it would not have made a difference, as she emphasised occupational status. Mandy, Stephanie, Elaine and Paula provided examples of how they gained medical support, rather than nursing support to secure authority.

The consultants in these three cases appeared to value their colleagues' work and encouraged them to present their work. Mandy explained how this recognition impacted on team support: "*She [the consultant] did a presentation on the screening, we all got involved in that and they [the other nurses] were quite supportive of that, because she was senior.*" Stephanie had encountered fewer barriers to her ideas, but also commented "*even the consultants were on board*," the '*even*' indicating her surprise at this support. Elaine reported working with the equipment manufacturers and the consultants to make sure the educational materials were right, but concluded: "*there was recognition from them (the consultants) that you were doing something better*."

Paula was trying to get the doctors to see the benefits for them in the new multi-disciplinary ward round she was developing as part of her project and alluded to the game-playing this sometimes entailed: "*I wanted it not to be 'nursey', [pause] so it wasn't the nurses telling the doctors what to do. I didn't go down the handmaiden bit, but nearly, played those games a bit.*" This

finding adds to the debate on the continued existence of the communication games, first identified by Stein[18] (1967) that have been played out by doctors and nurses in the workplace to the present day.

In nine of the ten projects nurse-participants explicitly identified medical support being drawn upon at different stages of the projects. Even Beryl, who did not directly involve medical staff in her project, found local doctors indirectly pushing for the same result in terms of reducing night time interventions to facilitate better sleep patterns. However she used the nursing hierarchy to support her initial pilot: "*I did have the support of the Director (of nursing) at the time.*". The political power games and the way change was controlled in this WBL nursing life-world still seemed to be determined by hierarchical patterns. Veronica talking of the competitive atmosphere in her department commented: "*I think you need to be aware of that politics*."

Team Communication: Social Interaction

This section examines how the nurse-participants used more open forms of dialogue within their own teams to develop their projects. Communicative action is 'complementary' to the life-world (Habermas, 1987, p.144) in that it guides social progress, while maintaining existing value systems. This colleague and peer level dialogue is examined here in the light of Habermas's statement:

"Participants (in the life-world) cannot attain their goals if they cannot meet the need for mutual understanding called for by the possibilities of acting in the situation" (1987, p.127).

Here I examine examples of the nurse-participants trying to create opportunities for equitable dialogue or 'ideal speech conditions' (Habermas 1987) inside their specialist teams.

[18] Stein (1967) first described the way that nurses subtly modified medical behaviour, without directly confronting them. This original publication generated further research and discussions about whether these distorted communication patterns still exist, the latest being Svenson in Scandinavia (1996) and Olin in America (2012) who have argued that although some progress has been made in moving toward more open and equal communication patterns game-playing is still in evidence.

The nurse participants first learned the skills of equitable dialogue in their own helpful supervision situations. Beryl recounted how, once a joint approach had been agreed, her WBS, a manager, told her: "*You do what you have got to do and we will support you*." Beryl confirmed this was publicly stated, "*she told staff that she supported me*." This affirmation contributed to her being able to run a pilot study. Jenny found her second supervisor, (the peer of her first), more supportive of her ideas: "*really positive and really helpful*".

Ruth found coaching support from her WBS, an experienced senior nurse, invaluable, recalling that she: "*just gave me individual advice about how to manage what was quite a difficult situation.*" Similarly Veronica drew on the help of the practice development matron, who was her supervisor's peer. In each of these cases the nurse-participants were able to draw on supervisory support to have their ideas acknowledged discussed in a practical way and then agreed with supervisors. These WBSs had influence through their more senior roles, but in addition appeared to provide a safe space for conversations with the nurse-participants, so that 'ideal speech conditions' (Habermas, 1987), could be achieved in the intimacy of these meetings.

Ruth and Paula had access to a group form of support - an RCN leadership programme and an action learning set which both described as helpful:

"*Everyone was doing a project, so everybody was going through the project process. They were coming up against brick walls and how they managed those brick walls was interesting….It is just the sense of solidarity and the contact we would see each other monthly*."

Here Paula draws attention to an additional concept of '*solidarity*' an important element if resistance to pressures from above is countenanced. Ruth identified how important that support network was to her emotionally: "*I think without doing the action learning and having the leadership course I think I probably would have left my job at that point*."

Ruth was taking this supportive approach forward for her staff by being involved in a trust-wide initiative: "W*e are just implementing shared governance, so I always try to do it as a team approach*." Unlike the action set

this new more formal and public forum, seemed to offer a range of staff an opportunity to contribute ideas to service improvement.

Gaining the thoughts of their staff colleagues was crucial to the project work. The nurse-participants needed to collect information and data to support their case for change. As most changes involved teams of staff, collaboration was an essential part of that process. The nurse participants followed course guidance in surveying opinion, focusing on their staff, because the changes would more immediately affect them. Stephanie commented on the positive responses: "*I did a questionnaire with my work colleagues, I interviewed some of our educators, but everybody was lovely and supportive. I got a lot back, I was shocked I was lucky, I think.*" Stephanie explained that she believed it was because staff felt the work would benefit them in the long run and she used the word "*lovely*" to describe her pleasure at the level of response, suggesting emotional gratification as well as practical relief at gaining this kind of response from her colleagues. Veronica found that the staff she was preparing a learning resource for seemed to appreciate her work: "*The evaluations were: "great package, liked it, really useful*."

Habermas states: "The core of collective consciousness is a normative consensus established and regenerated in the ritual practices of a community of believers" (1987, p.60). Teamwork is usually centred on joint goals and agreed methods and ward rounds are one of those opportunities for consensus seeking. By establishing a standard operating procedure for her multi-professional ward round Paula sought to facilitate this kind of open communication. In this case Paula was attempting to gain commitment from those concerned in terms of their participation in a joint decision-making process. Yet she found some of her own nursing staff reluctant to take on this work: "*Some of the nurses were a bit obstructive – a bit like – 'oh it has been tried before, we haven't got time to do it*." However, by listening to the concerns expressed by her staff and acknowledging their worries she found ways of supporting this extra work. She appreciated the constructive criticism they presented, saying: "*Actually those who go 'how brilliant 'you get less from them.*"

This approach illustrates Habermas' comments about how we test the 'validity claims' (1987, p.121) that people make in the life-world. If views are articulated honestly about situations that occur, with beliefs that are sincerely held and appear to be morally right, they are more likely to be accepted by their peers in the life-world. Paula felt that she knew her staff shared her principled stance in relation to wanting to give better patient care and that their comments were sincere and objections were truthful in terms of concrete problems that might be presented by the change. Therefore, she was able to respect their contribution and modify her plans to accommodate their concerns.

Good relationships with professional colleagues were explicitly highlighted, as important to project success in nine of the ten interviews. Some clinical specialist teams appeared to be more democratically organised allowing everyone a chance to speak and thus empowering the nurse participants. Yvonne enthused about the advantages of being in a specialist team: "*I do feel comfortable talking to everybody, dieticians, play therapists etc. We all respect and value what we do*." She stressed "*mutual respect*" and "*regular contact*" as important factors. Yvonne's project progressed smoothly and was extremely successful in terms of acquiring new screening equipment for her department. Elaine described her team in similar terms: "*We all work as a team and people are treated as equals*." Elaine's conflict had only been with one individual, her first WBS. She added that her team was so large "y*ou can hide in there if you want to*", which prompted me to think about this space not only being safe for speaking, but also providing a cocoon against the outside world. This might be appropriate when growing expertise, but in the long term could discourage the nurse from taking any separate leadership responsibility.

The need to preserve team relationships and strengthen peer support could be crucial not only to maintaining morale and making projects achievable, but also maintaining the nursing life-world as a stable social structure flexible enough to adapt to change. Habermas stresses the significance of these social bonds and solidarity to the stability of the life-world (1987, p.137). However, I have shown that working collaboratively to gain consensus was not a simple matter for the nurse-participants. In seven of the ten interviews teamwork was

a positive influence on WBL, but the three that had experienced negativity in their immediate teams (Veronica, Mandy and Jenny) had to find wider support from multi-professional networks.

In this way they stayed within their specialist fields, overlapping life-worlds. Veronica recalled:

"*I emailed out to critical care areas and paediatric intensive care units around the country and asked whether they had any teaching packages. I found that two or three replied and one was really helpful*"

Mandy described how she networked:

"*I contacted quite a few other services by email and telephone. I actually went to London in the end because they have a team and spent some time working with their team."*

Going further afield professionally Jenny like Elaine contacted equipment manufacturers to discuss product guidance and educational resources. Jenny stated: "*I spoke to the rep (medical) and he helped me a good deal*". In order to manage social pressures nine of the ten explicitly identified networking to achieve success.

Conclusion

In this chapter I have constructed a picture of the WBL life-world of nurses illuminated by the nurse-participants' accounts. Within this world there appeared to be a strong drive to improve care, stimulated by close working relationships with patients. This seemed to be a life-world that contained an ethos of caring, an enthusiasm for change for the better, but it was focused on local instrumental achievement of service goals.

I have shown how the nurse-participant's developing roles as change agents triggered conflict, because they challenged the traditional pattern of top-down leadership. Overcoming the hierarchical barriers entailed finding ways around existing systems, and for some this involved reproducing cultural patterns such as talking through doctors or using senior colleagues as champions. The controlling power of hierarchical systems and the powerlessness of the nurses'

positions remained unchallenged. The need to be more socially aware of the micro-politics and power dynamics of each clinical setting in terms of hierarchical constraints was highlighted.

There was some evidence of open and equitable discussion in specialist teams and some nurse-participants found solidarity in their professional forums while others used wider networks of support. There were references to academic supervisors in the accounts, but these are discussed in chapter eight and linked to discussions of the role of education and the use of Communicative Reason. I argue that the weaknesses of a lack of knowledge of wider influences and the lack of academic and professional support left the nurse-participants vulnerable to powerful outside pressures, some of which will be examined in the next chapter.

Chapter Seven – NHS Market Systems and Colonisation

"Performance has no room for caring"

(Ball, 2003, p.224)

Introduction

In the previous chapter an image of the nursing life-world was constructed, portraying a clinically specialist world with established hierarchies, which presented barriers to project work. In this chapter I consider if these barriers were intensified by changes occurring within the NHS with regard to marketisation. I provide evidence of the impact of the 'steering media,' systems of money and power (Habermas, 1987), in explicit organisational challenges and examine subtler shifts in terms of a hardening of approach towards performance management and increased pressure on staff at different levels.

I explore whether the impact of these confrontations of ideas can be conceived as the pathologies of colonisation (Habermas, 1987). The material here attempts to answer the research question:

2) How did the learning around the project process and the overall educational experience appear to be affected by the wider socio-political aspects of healthcare, and could these factors be viewed as 'colonising' the nurses' existing 'life-world'?

In this consideration I look at the immediate impact of some of these forces and end by discussing the longer term impact on the nursing psyche. I examine how, as Ball suggests in the quotation: "Performance has no room for caring" (2003, p.244), the shift of emphasis could damage the caring ethos identified in the life-world.

Only four individuals explicitly referred to business like values: Carol and Ruth in terms of the influence of external consultants on the work of their departments and Beryl and Paula in terms of commercial concerns about risk.

The references to subtler changes of emphasis in management style are drawn out from other nurse-participants' accounts, but it is important to note that four of the nurse participants (Elaine, Jenny, Stephanie and Yvonne) seemed unaware of any socio-political changes around marketisation of the UKNHS and were able to make progress in their specialist clinical environments without this being a concern for them. Therefore, I have not used the same thematic approach as the last chapter, because there is less commonality of experience and individual accounts appear to reflect the changes more clearly. The mechanisms, imposed from above, are viewed as colonising when associated with pathological effects (Habermas, 1987).

The first section focuses on system changes that were impacting on these WBL projects and shifting concern from the clinical to the economic: 'Steering Systems: Shifting Patient Care to Cost Care'. In this I concentrate on two particular accounts (Ruth and Carol) to illustrate the changes taking place and the nurse-participants' contrasting reactions to them. This is followed by a section on 'The Problems with Working Instrumentally' where I look at the pathologies caused by routine practices being colonised by commercially oriented concerns, in a hardening of performance management approaches and auditing measures. The final section focuses on the further impact of changes on professional status and influence in 'Professional Pathologies'.

Steering Systems: Shifting Patient Care to Cost Care

Habermas outlines 'systems' as processes enacted through the formal structures of legislation, political guidance and economic power (1987, p.183) and these are examined here in terms of the application of market ideologies in this local organisational context. The strategic influences are viewed as colonising when the drive for 'purposive rationality' focused on 'calculable value' "bypasses processes of consensus oriented communication" (ibid, p.183). I apply Habermas's concepts to this NHS setting by interpreting this as the system's demands for tasks to be completed within set time limits and to a particular cost dominating any discussions of the quality of care being given.

In these two accounts I refer back to Habermasian theory to provide a critical commentary on the events described.

I have chosen to examine Carol's account first because it illustrates the impact of a shift in contracting mechanisms and Carol is able to detail what attitudes were expected to manage this different emphasis in care. Her personal reactions to these changes are explored in a debate as to whether her views had been colonised. A similar account of organisational changes is given by Ruth, but the way changes were introduced was managed differently and Ruth's account details events and her reactions to them. Her account is explored in a discussion of potential resistance. These two scenarios start from a similar frame of reference, but diverge.

These are not two extremes, but generate material, which facilitate the discussion of two different responses to system changes. I felt both individuals demonstrated a dedication to their services and a wish to improve them, but they found different paths through change. I hope therefore to draw out the difficulties both faced, their distinctive reasoning patterns, and to show how they chose different ways to protect their staff and services. Waring and Bishop found in their research that nurses sometimes adopted 'pioneer' roles or acted as 'guardians' in the face of marketisation changes (2011, p.675). There are echoes here, but I would argue both Carol and Ruth appear to illustrate both role behaviours in their reported actions.

Carol's Account

Carol explained how she had attended an in-house course, run by external business advisers at the Royal, describing it as including the following content:

"*I think it was more about gathering evidence and putting steps in place and measurement and audit. That is how I saw it, they might have called it leadership (laugh), but it seemed more management*."

Carol did not appear to have been involved in any previous dialogue about the way services were changing, but was invited to develop her leadership skills. Carol outlined the insight she had gained from this course as "*a realisation*

about how the health service has changed." The change she referred to was the introduction of the internal market. Habermas talks about the 'steering forces' as less transparent, removed from the co-ordination determined through consensus groups and sometimes hidden in organisational changes (1987, p183).

She recalled how those on the course were encouraged to review their overall purpose, using a "*money making model*". She explained: "*It was different from management and business models I had used.*" Carol continued:

"What they wanted us to do - was to aim our business towards our customers. That was the primary aim of the project. We all went in there thinking customers are patients, and came out of it thinking no our customers are actually the people who are buying our services if you like e.g.:- the surgical specialities, which was a bit of a light bulb moment."

The shock of this is emphasised here in the use of the phrase '*light bulb moment*.' This prompt to reflect on purposes was already embedded in information provided about the internal market that had been created.

Carol describes the next realisation was that of becoming aware of the need to be competitive:

"*Then we thought actually orthopaedics could put their work through us or they could go to the (named) centre, or (names other places) or lots of different places, they could go and buy from there. So how do we make our services the most efficient and effective and the most economic. So that was a challenge, like taking your brain out and swilling it round and putting it back in again.*"

By introducing this fear the course had shifted Carol's focus from the patients immediately in her care to promoting her service as a commodity. Carol stated her departments' new focus: "*We look at our surgical specialities (a mix of public and private providers) as our customers*." The use of '*we*' here suggests an acceptance of this corporate approach.

Habermas outlines how 'an internal colonisation' can involve a growth of 'sub-systems of the economy', which are 'complex' and "penetrate even deeper into the symbolic representation of the life-world" (1984, p.366/367). In this case the sub system is the presence or threat of more market providers

offering a similar range of services in their own specialist field of healthcare. Habermas describes how a 'false consciousness' (1984, p.187) can be created by shifting individual perceptions and encouraging people to believe that priorities have changed. Care of the patient was still paramount in the UKNHS as a whole, but the fear of competition could skew perception to suggest cost considerations are going to be more important than anything else. In Carol's case she had not forgotten her responsibility for safe practice and this is revisited later in the discussion.

Carol described her reason for her project as being triggered by an exploration of these new ideas, stating: "*I felt quite strongly that I was trying to show how I was learning to think in a different way and not a traditional nursing way*." She admitted that when she started WBL she did not have a specific project in mind, but was already involved in trying to put her new learning from the management course into practice. She stated: "*I went back over the work I had done and slotted this work with (company name removed) into the work-based learning. Then I was able to run on with it.*"

Carol's project focused on patient flow through theatres, so the emphasis was on increasing numbers of operations taking place daily. This management challenge seemed concrete and practical, simply an organisational task. However, the increased demand was being driven by the need to appear competitive. Increasing throughput of patients was therefore no longer simply a management task, but now a corporate task aimed at providing a competitive edge over other providers offering similar operating facilities.

Carol stressed how radical this change appeared to her by using the word '*fundamental*'. She expressed this as a shift to a different "*paradigm*". Carol draws attention to this subtle shift in the influence of different stakeholders:

"From being a nurse who had always thought she was supposed to be there purely for the patient, to make the patient's experience as good as it could be, now, I had got this: - actually in the big scheme of things the patient isn't key anymore, it is the people who buy your services. They will be influenced by what patients think, so if your patients give really bad feedback to the commissioning groups you will perhaps not get that business, but if we can't provide an efficient, effective, safe service it doesn't matter what the patients think then we still won't get that business."

Carol acknowledged that it had changed her view of the health service, "*not good or bad*". She said "*it just made me more aware of how the health service works now*." Going on to explain the detail of her project she stated:

"I wanted to see if we could improve our efficiency, if I could smooth our transfer to wards that were waiting for our patients, we were a bottleneck. I thought if I could get the patients out quicker and that would improve the whole flow."

Carol described trying to share her new ideas by bringing in the trainers to speak to her staff, but reported the staff resisted this influence. Carol believed this was because the trainers had come from outside and their phrasing alienated them, "*if I had done it with my staff myself and changed the language, it might not have been as challenging for them. I would not have had to go through all that rigmarole of I'm not doing this.*" This breakdown in consensus working could have been brought about by "systematic restrictions on communication and distortion" (Habermas, 1984, p 188). It is not clear whether the opposition was due to the overall changed value system being imposed, the communication method or concerns about increased workload.

In terms of language Carol commented on this being "*very off-putting*." She described the phrasing the business advocates used as "*jargonistic*" and "*Americanised*". This was not just about types of English phrasing, but unfamiliar business terminology. The language examples given: - "*Wildly Important Goals*" were those associated with private entrepreneurship, rather than public service. This phrasing was meant to stimulate creativity and imaginative forward planning and could potentially have benefited the service, but when the overall direction is unclear or there is a suspicion of a hidden agenda of privatisation wariness can be generated.

Her aim to improve the numbers of patients treated was laudable but her staff had not been enthusiastic. Although Carol accepted the need to speed up the lists and had adopted these priorities there was evidence of some disquiet in terms of walking a fine line between cost effectiveness and safe practice:

"When we do patient safety audits and questionnaires the staff in recovery often have difficulty – when asked:- 'do they have to work too quickly' or does the speed of work affect patient safety, they do struggle with that:

99% of the time the answer comes out - no, but they are challenged to do so. If they didn't have me putting pressure on them and were on their own they would spend longer."

Her acknowledgement that the recovery practitioners "*often have difficulty – when asked*" about "*the speed of work*" affecting "*patient safety*" indicated some concern about the new practices. This phrasing indicates the pressure she felt she was putting on her team and highlights some concern about how her staff perceived her. She went on to state that she thought they felt "*challenged*" by her.

Having recognised her forceful role in driving change Carol acknowledged that this changed her relationship with her staff: "*I think my staff now see me as more analytical, focused and target driven, I know they do*". Habermas outlines how 'collective identity' can be unsettled (1987, p.143), when colonisation takes place. It can be a symptom of the process of an uncoupling of system and life-world, which Habermas refers to in his explanation of internal colonisation (ibid, p.183). This situation impacted in two ways: firstly on the unit's relationship with patients in terms of removing them from being first priority and secondly for the staff in terms of a loss of shared values. Carol, in adjusting her view to the new perspective stated: "*It made me think like a business person*." Ball warns that this kind of political and economic change "does not simply change what people do, it changes who they are" (2003, p.215) and it seemed that Carol was experiencing such a change.

Carol's account highlights how a market system already introduced was being refined by the introduction of internal training mechanisms, designed to help staff to adjust to these approaches. The account of the mental shift she had to make in her ideas illustrates the skewing of perspective required to fit the new model of working. Carol had seen an opportunity to develop her own management skills and to improve the service, and she had seized this chance to become more knowledgeable and to make her department more efficient. She was pioneering a new way of thinking about her service. However it brought her into conflict with her staff and the lack of questioning of the larger change gave me cause for concern. She appeared to be in the dark about the political pressures behind the changes she was implementing. We will not

know whether she would have agreed this change to the health service as a whole, because this bigger picture was not discussed. Judging by Carol's comments on her learning the information supplied by the trainers gave the impression that change had already taken place and the internal market was the new reality.

The WBL project had given her the chance to examine the work she was implementing and a comment that I found interesting was that "*If I had not done the course I would not have reflected in such depth I would have dismissed the (named course) and rejected it*." Because she was looking for a focus she had chosen to analyse what she was involved in more closely. Rather than stimulating any questioning of the overall change, WBL had helped her to ensure she had the right tools to apply the new thinking:

"It made me look at it in a more (pause) academic or scientific way, rather than just getting on and doing it. I looked at what data gathering tools were out there and audit tools were out there and thought about which was the best to use and why."

Habermas describes how colonisation links to a kind of alienation in terms of a loss of individual control (psychopathologies) and certainly Carol had gone through a shift in thinking and adopted a new approach, but she had tried to take control of this change and thus did not appear to believe it was negative for her. WBL had in fact contributed to this reshaping of her identity.

Ruth's Account

In Ruth's situation the organisational change was similarly driven by the need to increase departmental throughput, in terms of clinic numbers. Again the Royal had brought in business consultants, but in this scenario to advise more directly on handling the increased demand for outpatient cancer care. Ruth, as the clinic manager, had been looking at the same problem and preparing to make a case for a six day service. She gave a nervous laugh when she recounted how a project manager was sent: "*To implement a change which was different to the change I was working on and we conflicted quite significantly*."

The difference in her own and the project manager's approach was that she argued that they could absorb the increased numbers by opening on a Saturday, whereas the business consultant's suggestion was that large numbers of patients from her speciality should be seen in a different speciality clinic which had the capacity to absorb the numbers during the week. This was a cheaper option, but this latter proposal did not consider the specialist knowledge Ruth believed was needed to care for 'her' patients: "*Their ideas of what would work were completely the opposite, to what I thought were in the patient's best interests.*" Even when this concern was pointed out by the nurses involved it was not accepted as a barrier to change.

Ruth believed this rejection of clinical advice was "*because they were a business team the senior management just went with whatever they said.*" Although general management had been in place for a while, clinical expertise had been heeded in the past. However the pressure to reduce costs seemed to be tipping the balance towards cost only considerations. Ruth identified how she had felt '*crushed*' when her proposal for Saturday opening was rejected without consideration.

The significance of this '*devaluing*' as she referred to it was considerable for her credibility as a clinic leader, for her WBL plan and for her personal confidence. The Royal, through their educational leads was encouraging innovation and supporting leadership projects, but there did not appear to be open channels for these ideas to be communicated through to a strategic level. Poor timing contributed to the problem as Ruth was aware that the Royal had already appointed a business consultancy and accepted their advice to move her patients to another speciality. Ruth stated:

"They had a project manager to implement it. I tried to stand up against it and was never going to be heard, it was going to be very difficult for them to back down after they put a band 8 in post to implement it and do something different. So it was quite a big challenge to get them to change their mind really"

Ruth had been emotionally affected by this rejection of her proposal describing herself as '*demoralised*' and considered leaving, reflecting "*as a ward sister, I was facing challenges from consultants , senior management teams and a*

project manager, who were all a higher banding than me." Ruth described the scale of the challenge:

"It was quite a massive task to unpick their ideas and get them on my side. So I had to put a lot of effort into why and what, present the evidence and get them on board. I had to go to them on an individual basis otherwise in a meeting I would not even been listened to"

The coaching she had received from her WBS helped her to be more patient "*instead of jumping in I would try and understand what is going on before I make assumptions and that is how I dealt with the consultants and senior management team".*

She recounted how she tried to gain "*their perspective and views on the service improvement initiatives going forward and started to understand that actually not all of them were as engaged in what was happening as it seemed in the meetings"*. By working on a one-to-one basis she identified that:

"They were not all on board with the changes and so then I was able to tell them my opinions and ideas. One of the consultants was then chairing one of the meetings and it was as if he spoke my words, through him and that is when the changes happened."

Ruth described her development as "*a real big learning curve*" and went on to talk about herself '*earning*' a place at the table with senior management, by showing them she was "*capable and worth being listened to.*" By showing that the change she advised was workable and achieving the turnover required she recounted:

"I have implemented the change… it is up and running. The patients have got a positive experience. We are able to fit all the consultants' patients in in a timely manner within our capacity and meet demand. So that is how I think I have earned it."

She stated: "*They have got what they wanted at the end of the day,"* similarly she said she had what she wanted "*all our patients are in their own speciality*"

Ruth had found a way to work with senior staff, maintain her integrity and benefit her department she believed.

I argue that Ruth resisted the colonisation of her ideas and values and prevented the system from interfering in her life-world. By coming out of the shadows into the light and arguing her case, initially through the medical consultants, she had protected her patients. It could be argued that she avoided the spotlight by using the hierarchical system. However, there was no evidence of her playing the doctor-nurse game as she seemed to use listening skills and the processes of argumentation to convince her colleagues by showing them evidence of the importance of specialist care to morbidity and mortality: "*I finally got listened to, or heard and was able to present data and information after the consultant had started to turn people's ideas for me.*"

Ruth was being innovative and therefore a pioneer, but acting as a guardian of her speciality in the same way Carol was. Ruth was challenged by her senior colleagues when she tried to do what she said she thought was best for the patients and her staff, and accused of being too protective of her staff: "*Senior management have already said - am I trying to run a service around my team, rather than what the service needs?*" Her loyalty to her service was questioned, but it is not clear whether those challenging her were referring to organisational or patient need when using the term 'service.' Ruth remarked: "*I think if I look after the nurses, then we as a team can provide a good service.*" Carol had similarly been concerned with protecting her staff in managing the pressure for change, by leading her team through it herself: "*I needed to keep us effective and to give them enough time, to give them scope to do their nursing*", but her approach was one of accepting a particular change rather than resisting it.

This section has concentrated on the economic pressures and business strategies used to address monetary concern in two separate areas. The response to financial constraints seen here was not simply to cut services, which the Royal could not ethically or legally do, but to reorganise them in a way that would make them more competitive. Two possible pathologies have been identified as resulting from this business approach: the first being a distancing of service planning from patient influence and, the second a diminishing acknowledgement of clinical expertise and guidance in service

planning. In the next section I examine the impact of tighter controls on clinical work

The Problem with Working Instrumentally

Here, I collate the evidence for concern around systems imposing tighter controls over clinical behaviour and enforcing conformity. Systems are important to the life-world in terms of offering standardisation of good practice and this is highlighted in Paula's ward round project, where she strengthened a communication procedure by creating a formalised structure (Standard Operating Procedure, SOP) for her doctor-nurse communication. In this way a system can constructively support life-world action. Pearce et al (2009) in their research study of 25 practice nursing situations in Australia suggest that nurses often draw systems into their life-world to secure safe practice and quality care, and it seems this is what Paula was attempting to do in trying to standardise communication practices.

However, systems can suppress creativity by imposing conformity and risk aversion. In this section the focus is on managerial systems that appear to rely on short term thinking, reducing cost, controlling risk but also increasing performance efficiency. These 'business-like' mechanisms are examined here in terms of potential pathologies with regard to the impact on WBL project activity in the work setting and in relation to education.

Beryl's account draws attention to issues of conformity and risk aversion. Despite the fact that Beryl's pilot in reducing sleep deprivation had been recognised as successful in her department, she could not get an extension to her trial period. She reported that feedback from multi-professional colleagues indicated patients were "*less tired in the day and seemed more comfortable*" and "*out of 52 patients, nobody (this word was emphasised) received any skin damage*". She explained that she had wanted to carry on to show how her improvement affected patients in the longer term, but also in terms of the costs associated with long stays: "*Because at the end of the day it is all down to beds, isn't it?*". The pressure on beds was and still is enormous in the care of older people in the UKNHS, yet the rhetorical statement had a bitter tone,

highlighting her cynicism about this quantitative rather than qualitative approach to assessing care.

Beryl identified the barrier to her project continuation as being risk aversion which was cost driven in terms of fears about fines being imposed for pressure ulcers that might result from not turning patients in the night. Even though both medical consultants and senior nurses seemed to accept the research findings and knew that a lack of sleep could increase the risk of delirium individuals were being regularly woken during the night because of the threat of financial penalties associated with skin damage, Beryl sighed as she commented: "*It was probably very naïve of me to think it (the change) could go further, you know, with the national figures and financial implications and things*."

Unquestioning rule-following was what exasperated Beryl who claimed "*a lot of the newly qualified nurses are just used to tick boxes they aren't prepared to think any further than the box.*" Nursing has always had routines and ensuring safe practice involves adhering to rules that are evidence based and agreed. However, in this situation Beryl was bemoaning the loss of questioning and thinking around clinical decision making. Her claims suggested that she thought nurses were using 'instrumental reasoning' in this task-orientated behaviour of following the routine rather than questioning whether it was appropriate for that particular patient, who might be at risk of delirium, because of sleep deprivation. Organisational risk avoidance did not allow for a weighing up of options and clinical discussion in the multi-professional team.

Paula described this risk aversion as a growing problem in the UKNHS more broadly, stating:

"I understand why nursing needs to be like that and the pressures in terms of hospitals being sued and complaints and everything has to be done in a rigid way, but we have lost completely the clinical creativity and clinical skills that I felt as though I had as a baby nurse."

She identified the pressure to conform in terms of its impact on creativity: "*I don't think we are creative enough sometimes with our research, it is very safe because we know we won't get the funding so it does stifle it."* She claimed:

"Unfortunately the way you get funding now is to look at what the hospital wants and what they want nationally and I think that is what drives it and if you at all deviate from it or it is a bit out there or wild you are less likely to, which is a shame.

Paula concluded: "*I think it is all about outcomes, unfortunately*."

Outcomes are used in performance management to increase performance and a range of techniques were being used to encourage staff through competition. Carol's business trainers had encouraged her to try some of these techniques in her unit. Competition was seen as a stimulus and Carol tried using comparative methods and scorecard systems to encourage good practice in phoning ahead from the post-operative area to warn the ward about an anticipated discharge and thus speed up discharges. She explained:

"So we had a performance board. We had a sad face say - only phoned 50 % of the time we managed it, whereas this time last week we had managed 90% of the time."

Carol stated: - "*It worked quite well*" She proceeded to say: "*It was not sustainable, but I don't think it would ever have been collating this amount of data."* Carol argued it helped to embed new practice and it was successful in the short term, but limited. Earlier discharge from recovery to the ward area could be good for patients, but we do not know whether this was the case or not as this was not being measured, as far as I am aware. It certainly meant a larger turnover of patients, which would be good for those on the waiting list.

Paula believed this outcome focus affected funding for continuing education as well as everyday work, explaining that if she were applying for a course again: "*My proof and evidence would be much more tangible.*" Eight of those on the degree or masters pathways were fortunate enough not to have to compete for educational funding, but the later applicants for modules, Carol and Stephanie, had to make a case for charitable funding and were then constrained by goals agreed with the Royal. Jenny reflected that this was consistent with the Royal's prioritisation of measurable clinical performance and added with respect to CPD funding: "*The unit is currently focused on getting people doing clinical modules*," a more immediately measurable target.

Veronica felt that this emphasis on clinical skills was more about image than real necessity. In relation to her own study she said:

"*As far as the ward and the unit was concerned, they wanted me to do the course. Then there would be another person who had done the critical care course. I don't think they would have given a monkey's how I got there, as long as I got there (nervous laugh*)."

This derisive phrasing reflected her cynicism about how the superficial acquisition of a '*specialist*' course title for a member of staff was being used as a number crunching exercise to raise the profile of the department, rather than an opportunity for broader educational skills development.

Thinking about this made Veronica reflect on her earlier description of her WBS's behaviour and she wondered whether a similar issue of image was motivating her WB supervisor when she volunteered to take her on: "*I think half of it was because she was new and she was trying to assert herself*". Veronica had already described the competitiveness of her unit and went on to state: "*Pressures on staff work and time – it has got worse, how people treat each other. It is sad.*" Habermas describes a loss of authenticity (1987) as one of the pathologies of colonisation of the life-world when the focus is on performance and being seen to perform.

Measuring ability to perform educationally is gauged by competence achievement in practice education and this affected WBL project development. In Jenny's case there was a pressure to show learning had taken place behaviourally through the use of competences. Jenny described how her educational resource, a guide to ventilator usage, was being steered in this direction:

"My supervisor wanted me to do it more like a trust format, like a competency document. I wasn't planning to do a competency document. I just wanted to do an educational resource, so people could answer the questions, but not be assessed on it."

Jenny's work was incorporated into a larger unit competency package. She did not therefore gain any individual recognition, but at least the work was not wasted.

She commented that if she had not accepted what her WBS wanted, her resource probably would not have been used. Here the conflict was between open-ended educational materials and products that could be used to check and rate performance. Jenny felt that this approach did not make sense in her situation as "*There is nobody competent enough to sign you off [laugh]*." In addition, she pointed out that: "*You can be competent one day and not another*," depending on frequency of equipment use, so this could provide a false sense of security in terms of safe practice. However the organisation could then state if anything went wrong that they had trained the individual to a level of competence and any error after that must be due to human error. Competence frameworks have their place and can be helpful, but colonisation takes the form then of victim blaming, as the organisation has carried out their duty to educate.

In his critique of capitalism Habermas(1987) explains that capitalism sets 'conditions and costs' that have to be met for welfare or public support to be given, for example in welfare provision, applicants for benefit have to attend job interviews, even if they are not relevant to them in order to satisfy eligibility criteria. Students from the Royal were expected to attend one hundred-per cent of any formal component on all continuing education courses supported by public funding, a demand not echoed in university guidance and unrealistic in an UKNHS struggling to cover areas that were understaffed. Indeed, study leave for WBL, could not be formalised in this way and therefore students did not automatically receive time out, yet were severely reprimanded (by letter) for not attending the single class session. Veronica commented that she had been given no study time, but then corrected herself: "*They let me have one day*." Elaine described her situation as similar: "*It was difficult to get time out in a working day to be able to fit meetings in with supervisors*". This lack of protected time in the workplace has been identified frequently in the WBL literature (Clarke and Copeland, 2003; Chapman, 2006; Moore and Bridger,

2008; Stanley and Simmons, 2011) suggesting this was not a new experience but a recurrent problem with WBL in nursing.

This section has shown how the focus on business-like strategies affected WBL student work. Here I have focused on the day-to day stresses of meeting targets set to make the organisation more efficient in terms of patient throughput or to avoid risk. The same measurable approach and cost concern meant an increase in focused education and competence achievement. These are disparate instances of a work culture that moving away from a relationship focus to an outcome one.

Professional Pathologies

In this section I examine the impact of this tighter control on clinicians. I argue that tighter supervision of activity, combined with a lack of voice could result in psycho-social pathologies and these will be explored in the nurse-participants' accounts. I continue to examine Beryl's account of her project work as she discusses the effect of fear on clinical judgement and look at Mandy's conclusions. In both cases they reported that their trial work had shown change to be beneficial, but the work was not continued.

Beryl had provided an example of a fear of censure in her account of trying to move away from the rigid protocol of turning frail older patients every two hours at night. She described her frustration with colleagues: "*not wanting to stick their necks out really*," stating: "*I think people are very insecure and frightened to do anything different.*" Here I focus more on this psycho–social aspect of colonisation. Beryl had found that when she handed over to senior nurses with a recommendation to leave a patient asleep for longer they carried through that action, but she had doubts that lower grade staff would take that responsibility. She argued they were concerned about their individual accountability: "*I have no evidence of that, but I think that is one of the negatives*". She continued: "*There is always the chance that regardless of any assessment, if they had not followed what the trust had laid out…."* This sentence was never finished, but the threat hung in the air as she pursed her lips and shook her head to indicate negative consequences. She added:

"In all fairness, at the end of the day if the patients did develop any pressure damage and they were on the last shift, then I can stand and say well I will support you, but at the end of the day it is them responsible for that patient at night"

Listening to this final acknowledgement of the difficulties of bringing about change made me think she had accepted defeat.

The Royal had responded to the results of Beryl's trial by suggesting a further assessment tool be introduced Beryl commented: "*The trust has not changed their guidelines, but they have introduced the skin tolerance test.*" This was supposed to offer another layer of risk assessment, to provide more evidence to support decision making and standardise practice, rather than delegating clinical judgement. However, there were already validated pressure area risk assessment tools in use in these clinical areas. For some, in this age of litigation, tools bring reassurance, but they could also be viewed as taking professionals further away from exercising clinical judgement.

From Habermas's perspective, making small clinical changes appear simply practical (instrumental and rational) removes these decisions from any values-based (normative) debate (1984, p305). The issue of whether a professional has a right to make a particular decision on skin care (in this case) and whether this is actually of any benefit to the patient is side-stepped, as a standardised approved tool is proudly produced. Habermas alludes to an 'objectifying attitude' that results from such strategic action, this process of 'mediatisation' or interference results in an 'internal colonisation' of the individual practitioner's sense of worth. The result is a further dependency on checklists and a loss of confidence in one's own ability to make such judgements without these tools.

Beryl had rolled her eyes when she mentioned the new tool, suggesting some doubt as to the value of this new procedure. When asked how she felt about this further safety net, her voice went high pitched she said "*yeah*" in a choked gulp, suggesting some frustration with this approach. She went on to comment: "*It would be interesting to see how different things would be if people did put their necks out sometimes.*" She added with a laugh she was not advocating "*anarchy*" just a bit more initiative. However, she did acknowledge that her

pilot had limitations: "*It was only on a small scale it would have been nicer if I could have taken my stuff off and preached a bit further, but it is a big Trust, a big place you know*." Although she appeared disappointed she was prepared to accept that further work needed to be done.

The concern in this situation was that without a supportive procedural document giving permission for clinical judgement to override protocol, nurses would not feel safe enough to go against the standard advice. Beryl felt experienced and confident enough to take that responsibility, but realised it might be unfair to ask for that level of commitment from others, with less experience or a lesser sense of their own power. Beryl said she wondered nowadays if "*nurses use their initiative or do they work solely by tools and assessment charts and things*." Beryl had resigned herself to just taking responsibility for her own actions and not asking others to take on this responsibility: "*At the end of the day I log it, I have a rationale for what I have done, and that is my justification if needed*."

Mandy had similarly shown through her trial that altering clinic times to suit different patient groups worked, but then went on to state that even though she had proven feasibility:- "*I think I would have struggled to change it – on my own as a one man band.*" Mandy's isolation was disempowering, the barrier had been created by colleagues, but the organisation must take some responsibility for allowing that block to go unchallenged, despite medical support and evidence demonstrating service improvement. A consequence of colonisation can be 'restrictions on communication' (Habermas, 1984, p.188) and the hierarchical separation of senior managers from clinical ground staff meant that individuals at a higher level were probably unaware of debates raised at unit level. The lack of a suitable communication channel left Mandy without influence.

Sumner, in her research into nursing, used a Habermasian framework to explore whether nurses could "flourish in an environment that emphasises a managerial, economic efficiency based on technical rationality" (2001, p.23)? Her concern was that if the moral and relational work and dialogue about care

were abandoned for scientific efficiency and technical tasks, the essence of nursing would be lost.

Having explored the concerns that were raised about threats to clinical judgement and questioned how local control can be maintained when such blocks exist I finish by remembering Beryl's stance of deciding just to take responsibility for her own actions, that was her way of coping with the restrictions. Paula commented that one of the reasons she was leaving hospital care was because she did not want to be "*clone like*," she described herself as a "*creative*" person, she continued: "*I am not one to stay safe on the ward and there is nothing wrong with that. I want to use my brain I want to be a little bit challenged or scared at times.*"

Conclusion

This chapter has looked at what could be considered intrusions of the system into the life-world and the pathological impact of these. Colonisation creates a range of challenges from changing organisational goals, limiting opportunities for individual decision making to undermining personal confidence. The interview accounts suggest that there was some evidence of colonisation and these compounded the traditional life-world barriers to change.

Carol had explored the new thinking and is the one whose ideas could be viewed as the most colonised in terms of the adoption of business principles. Yet it could be argued that those who accept the political constraints on investment in public services and accept marketisation are making a political choice to accept business thinking. Most of the nurse-participants were learning about their life-world through their projects and confronting challenges in terms of communication and influences that they had not come across before, but were still in the dark about political activity at higher levels of their organisation. In the next chapter I show what part WBL played in assisting individual nurse-participants to deal with the conflicts they came across, even though they did not become completely socially and politically aware.

Chapter Eight – Emerging from the Shadows, Mobilising Communicative Reason

"Critical thinking without hope is cynicism, but hope without critical thinking is naiveté" (Popova, 2015)

Introduction

The focus of this last findings chapter is on how the nurse-participants' developed through their learning journeys. I begin by presenting their hopes and expectations and then look at how the learning progressed and what was achieved. Habermas states that: "a reconstructive analysis begins with the members' intuitive knowledge" (1987, p.151) and therefore this chapter traces the nurse-participants' reflections on their growing understanding of themselves and their world through their project work. By examining this learning process through the lens of communicative reason I look at how most of the nurse-participants emerged from the dark, in terms of becoming informed and publicly visible, but remained in the shadows politically.

Popova's (2015) quotation above emphasises the need to have both critical thinking and hope present to succeed. I think hope was present in the nurse-participants' ambitions and sustained by the affirmation of supportive colleagues, but critical thinking was the skill that helped them manage the problems they faced. I would argue that both of these elements are embraced in the process of communicative reasoning. Here I look at whether there is evidence of communicative reason being used. Then Iconsider if the learning experience could be enriched further and nurses could be empowered to communicative action. This thematic analysis therefore addresses the third research question:

3) What evidence was there of communicative reasoning in the nurses' descriptions of learning and how could this communicative reasoning be supported and enhanced?

The Habermasian concept of communicative reason was outlined in chapter two as part of the overarching TCA (1984, 1987), but here I use three

overarching headings to take the nurse-participants through their project learning. Habermas embraces self-consciousness, self-determination and self-realisation in his conceptualisation of this term (1985, p.338). In practical terms this involves increasing personal and social awareness, taking responsibility for personal learning, gaining some control over the situation and achieving.

Beginning with the start of their WBL experience the first section presents the nurse-participants' comments on their academic motivations for undertaking WBL in 'Seeking Graduate Skills'. This sheds light on their assumptions about the contribution universities make to health services and nurses' professional development and reveals the ambitions they had for WBL. I then move on to the anxieties triggered by the module brief in 'Finding Their Way in the Dark'. Here I look at both the ideological and practical problems associated with self-directed study. The nurse-participants' gradual increase in self-awareness is discussed and in 'Developing Self-Consciousness through Supervision' I discuss the way the nurse-participants took ownership of their learning and built relationships with their supervisors. I then move from mentoring support to wider networks and consider the evolution of solidarity in team and group support in 'Solidarity and Self-Determination'. The action research part of the nurse-participants' work is embraced in the discussion as to how they developed through the 'Processes of Argumentation.' Finally I examine the concept of transformative learning and its role in 'Self-Realisation'.

Seeking Graduate Skills

Although the nurse-participants spoke of individual motivations with regard to specific projects, four of them explicitly linked this to the nursing profession's move to graduate status. I discuss this then move on to look at the interest in WBL particularly and argue that a powerful driver for the module itself was the need to gather evidence to change practice and how this data gathering and action researching was perceived as an academic skill.

Stephanie identified the importance the degree had for her: "*To sit here with my degree, it is the first time I have ever felt proud.*" She went on to explain: "*I*

am the first one in my family to get a degree." In my experience some nurses who entered diploma study were told at school that they could not achieve a degree. For nurses who had experienced this kind of dismissal at senior school WBL offered access to an academic pathway that they felt had previously been denied to them. Yvonne might have had suitable qualifications for a graduate course, but trained when the course was at diploma level. Her statement: "*It is a graduate profession now, so you feel you need to have it*," made me aware of the pressure that some experienced nurses feel to gain equal status with their peers (although Yvonne denied this was the case for her) a more in depth analysis of this exemplar is available in Appendix 2.7.

Although Yvonne did not believe she had to be at a comparative award level as her work colleagues three of those with management authority did. Carol explained:

"The reason I want the degree is, being at the level I am working at, it would be good to have that, I suppose, that confidence in myself that I have done that. I can speak to colleagues on a professional level about education and the newer nurses coming through are all degree level, so I feel I need to know what they are talking about and be at that level myself."

Carol's reference to "*confidence*" suggests she wanted the sense of achievement such an accomplishment would provide, but in addition she saw the advantage of a degree placing her on a par with multi-professional colleagues. Also, there appeared to be a wish to be included in knowledgeable dialogue about nursing in her phrase "*know what they are talking about"*. This remark thus embraces a complex mix of desires for personal development, professional gain, and intellectual stimulation.

Ruth associated her desire for further academic learning with her clinical teaching work: "*My primary objective was to get a master's qualification, so I could support master's students on my own module.*" Paula like Ruth and Carol felt it made her more "*credible*" as a senior member of staff, she did not mention the academic award as such, but commented on acquiring EBP skills: "*If you have gone through that process, people then go – oh right, she has looked at all the evidence, talked to loads of people, done*."

The emphasis on EBP in seven of the ten accounts surprised me, but it was this information that the nurse-participants needed to have to make a case for change they were focused on. It was not just the university pressure to present evidence that prompted their research, but the Royal's demand for evidence to support any initiation of change, a practice rather than academic driver. I had observed staff at healthcare trust meetings being asked to produce a literature review to support an argument for change. For these nurse-participants WBL provided an opportunity for them to collate evidence to support change and therefore gave them, as change agents, an added authority.

Habermas depicts knowledge development in the life-world as being gradually assimilated, adding to the "interpretive work of preceding generations" (1984, p.70). Experience was still highly valued, but now within organisations there was an expectation that up to date research should support any case for change. Many of the nurse-participants had trained before the concept of EBP became accepted in nurse education and so for some this researching approach was new to them. Paula and Stephanie both identified literature searching as a particular challenge for them. Whereas Mandy commented: "*I quite liked the idea of evidence based practice and changing things and trying new things*."

I believe this interpretation of university learning as simply gathering evidence stresses the pragmatic or instrumental elements of knowledge acquisition rather than the broader dialogue and philosophical development Habermas might have envisioned. He conceives the university as a place where there is a common thread of 'communicative or discursive forms of scientific argumentation' (Habermas and Blazek, 1987, p.21) emphasising the dialogic elements of learning. Some of the nurse-participants did suggest a more critical approach to the evidence was needed. Beryl asserted: "*Research and guidelines are there to extend your knowledge and your level of understanding and awareness I think*." She went on to state: "*But the decision you make has to be your decision,*" reinforcing the idea that this new knowledge should be used in conjunction with what she referred to as your "*clinical judgement*". Veronica stated: "*You start to look at the evidence base, I became more critical. I wasn't taking things quite at face value."*

However this critical thinking appeared to remain an individual process not discussed with colleagues. The nurse-participants were dipping into a professional and clinical dialogue through the literature and networking and therefore using reasoning and drawing on the knowledge of others, but not discussing their decision making. Thus there was still a sense of the individual decision making, rather than collaboration. I suspected that this may have made both their project journeys harder in terms of the local recognition of their ideas.

Specialist knowledge was being sought and obtained as part of the drive for professional development, but there was little comment in the interview accounts of debate about local issues, until conflict arose. It may be that supervisors and students did discuss the ethical and political implications of the work that was proposed, but this was not reported. However, their lack of socio-political awareness about how senior teams considered service developments left them in the dark about how their proposals would fit local political agendas in the Royal and in the UKNHS as a whole. In the next section I look at how this weakness left them without a sense of direction.

Finding Their Way in the Dark

In this section I explore how the openness of the brief the nurse-participants received, in terms of being able to choose their topic and methods was disconcerting for some and anxiety creating for others. Five of the nurse-participants emphasised the stress they experienced deciding on a project, with individual comments ranging from the moderate, "*quite anxious*" Yvonne, to Beryl's state of "*panic*," at the lack of a timetable. The module relied on students identifying their goal and setting their own objectives for learning, but the question for me was, why was this activity was so stressful for them? Here, I examine the sources of the anxiety created, critically examine the module's focus on self-directed learning and consider why others did not experience this distress. I then reflect on how communicative reasoning could have alleviated this situation and explore how increasing socio-political awareness might have helped them navigate their life-worlds.

Educational Vacuum or Educational Space

At the beginning anxiety led to delayed learning for Carol, Yvonne and Jenny. Carol stated: "*I didn't think about it to start with*", she confirmed: "*Well - It was three months in to the course when I got my brain in gear.*" Yvonne described it as "*a step into the unknown*" and for her "*that initial time of not really knowing what was expected was difficult. I suppose*." Jenny reflected: "*It was too easy to leave it for a long time,*" stating that taking responsibility was "*fine*", she was an "*adult learner*", but her voice was high pitched and choked and then trailed off, indicating some reluctance around assuming this accountability. She proposed a prompting email once the course had started saying: "*What have you decided*?" would have helped her to stay on track and offer a sense of support. As Carol pointed out, even though she was "*quite self-reliant and motivated*", she took months to get to grips with it and added: "*If you weren't those things, you would find it extremely difficult.*"

Mandy stated: "*I found it quite odd that you have your first sort of meeting and then you sort of run with it. So that was quite alien, you don't have that in other modules.*" Beryl similarly commented: "*That is the one thing I did find hard: the fact that you were left to get on with it*" For some, anxiety was therefore created by the openness of the project brief, Veronica spoke of an initial "*floundering*" and used this 'fish out of water' analogy to express the strangeness of having the empty space to fill. Some of the nurse-participants appeared to feel abandoned as that support had to be found by them. Carol commented on the "*minimal support*", from the module lead, said she felt the message was: "*Go away and see you in 6 months*".

The educational critical theorist, Brookfield draws attention to the assumption in self-directed learning that individuals can make 'unfettered choices' that are not constrained by the 'culture' in which they exist (2005, p.84). In this WBL setting there was an acceptance that these constraints might be present, because the emphasis was on partnership working (Flanagan et al 2000). The assumption was not that the nurse-participants could make individual, 'separate' or 'private' choices, as might be assumed in self–directed learning

(Brookfield 2005, p. 84), but that collaborative activity in the workplace was supporting the decisions they made.

However it seemed that this work project aspect simply added to the workload, Elaine commented: "*I actually had to produce something at the end of it, as well as an assignment, and I think that was a worry from my point of view."* Elaine emphasised how mammoth the task seemed to her: "*I felt like I was at the bottom of a mountain and I had no means of getting up there."* She compared this to other modules where she felt the work was like a "*hill"*. The uncertainty here was not just about an assignment to be completed after the subject matter had been discussed, but a choice of focus that would steer the next six months of academic and practical work and would have long term repercussions for them in their clinical settings. There was, as with any piece of academic work, the concern expressed by Veronica as "*am I doing it right?"*

There are at least four concerns raised here: the pressure to grasp an idea quickly; the difficulty of finding a topic that was manageable in the time; gaining agreement between managers and supervisors, and carrying out something appropriate for the award. A potential weakness in this educational provision seemed to be that a large piece of work was demanded and yet little formal concrete guidance appeared to them to be available. Such openness can present an exciting opportunity for those who have the freedom to choose and have many ideas, or come prepared, but for others it could appear daunting.

McLean, in applying Habermas to university learning and the development of communicative reasoning argues: "we should not short circuit necessary uncertainty" (2009, p.237), because this space allows students to explore their ideas. Dewar et al (2003) and Moore (2007) both refer to the 'autonomy principle' in relation to WBL and educational space for individuals to find their own path. Veronica stated: "*I learnt that the floundering stage is part of the process.*"

The Role of Critical Dialogue

Academically they were expected to critique their ideas, but in what light? Should they just be focusing on the practical manageability of their proposals and local acceptability of their project ideas or should they be considering what was best for their service in the long term and checking the implications of their changes to nursing professional development and staffing in the UKNHS? Only Paula referred to any discussion about original purposes. Paula stated: *"I ran it past the practice development matron, to say what I was thinking about doing and she said she thought it was a good idea.*" This phrase "ran it past" does suggest a hasty checking mechanism rather than a critical review.

The Royal, like other trusts had impact and risk assessment documentation that could assist such a questioning process, but nurses who were not in senior roles would not necessarily be familiar with these forms or approval processes and it was doubtful that these would question political assumptions embedded in local policy documents. As Brookfield states choices were not 'unfettered', but were made in isolation rather than collaboratively and there seemed to be little discussion about proposals.

Habermas refers to the need to "overcome all self-deceptions and difficulties of comprehension" (1984, p.22) when using communicative reason and learning argumentation processes and I take this to mean the need to question one's own role in colluding with ideological pressure. The nurse-participants saw themselves as embarking on practical service improvements and did not indicate in their accounts that they viewed these as in any way political. I cannot provide a quotation to support this statement because there was no evidence that a connection was made. Concerns were expressed in relation to pressure to conform and reference was made to business consultants and economic issues on a fragmented basis as identified in the chapter on colonisation. However, the nurse participants did not describe these influences in political terms as capitalist, neo-liberal or left or right wing and therefore seemed unaware of the potential political nature of the service changes planned.

Six of the nurse-participants talked about their WBL as both challenging and yet giving them a sense of accomplishment and this is reflected in Veronica's comment: "*So it was really stressful, but I felt like I had achieved.*" The two concepts of struggle and attainment are often linked in lay speech and this seems to be based on an underpinning assumption that learning is more valuable if it has been more difficult. The educational critical theorist Brookfield raises a concern about this philosophical approach, arguing it colludes with myths around everybody being able to succeed 'against the odds' (2005, p.83) and echoes capitalist ideology of the 'self-made man'. It could be that people do feel stronger having struggled, but was that necessary to the learning and was that the key to empowerment or hegemony persuading individuals that suffering would be good for them. Seeing the difficulties as challenges could prevent people from questioning why those obstacles are there.

This may seem a small concern yet the intensity of the conflict that occurred during the project work did bring Ruth to consider leaving her job and three others left their workplaces at the end of their project work (Mandy, Paula and Veronica) because, they appeared frustrated by the limitations they experienced. In at least two of the projects the new knowledge was not applied in the workplace (Beryl and Mandy's work). Five of the ten nurse-participants had experienced considerable difficulty that might not have been possible to avoid, but could have been more critically examined. Being in the dark about their social contexts had meant they walked blindly into what Veronica called '*tricky*' situations.

A more critical discussion of the socio-political context would have helped some to test the viability of their projects. Mandy reflected:

"It would be useful to know, before you do this, before you choose your topic, sort of thing, if you are thinking of something you could potentially implement further down the line, to know if you would be allowed to do that, but then I think, no I still gained from it"

Her final words seem to contradict this proposal: "*I think it did spur me on to then go and develop really, which was great.*" Here Mandy acknowledges how she still learned from the work she did, despite being blocked from

implementing her proposal at the end and leaving the department. Perhaps adversity did help her discover her strengths.

This study has already highlighted how powerless nurses can be in the life-world and so to expect a proactive stance from all the nurse-participants was perhaps unfair The generic WBL briefing did not appear cover any background information about change in the UKNHS or any socio-political discussion of the contexts in which they worked and no debate of these issues was mentioned by the nurse-participants. It could be argued that the university was abdicating responsibility and neglecting the diverse needs of their students by not offering more support in this aspect of preparatory work.

In this section I have discussed the problems associated with the open project brief and the difficulties of establishing a sense of direction in this context of partnership working. In considering how more communicative reasoning with supervisors could have helped the nurse-participants prepare for potential conflicts of interest I began to examine relationships with supervisors. In the next section I look at how the nurse-participants worked with their supervisors to enhance their development.

Developing Self-Consciousness through Supervision

First I look at how the nurse-participants began to enjoy organising themselves and taking ownership of their projects. I then move on to the challenge of building relationships with WBSs and use validity claims to discuss how trust was, or was not established. I look at Mandy's case in particular, because it highlights the difficulties that can occur, but then balance this with the other nurse-participants positive experiences, collating their reflections on the supervisory relationships. Reference is made to the need to create 'ideal speech conditions' (Habermas, 1984) for constructive dialogue to take place. Further on, I reveal how the WBSs were important here in affirming the nurse-participants' strengths, helping the nurse-participants to become more aware of their own skills and influence.

Once the initial shock of not being formally taught had subsided, all the nurse-participants began to take control of their work. Mandy said: "*I liked the idea of being able to sort of, not set your own outcomes, but sort of take it where you needed it to be*." She went on to say: "*I think you get ownership. It becomes a bit more personal than sitting and writing your assignment on a topic. I just felt I owned it a bit more*." Carol echoed this sense of ownership: "*Of all the modules this is the one I am most proud of, because it was all me*." This reference to a sense of ownership echoes findings produced by Dewar et al. (2003) and Chapman (2006). Despite the fact that some of the projects were reactive in nature, responding to health care pressures, they were beginning to be viewed as personal projects, made their own by the nurse-participants controlling the choice of activities involved.

Paula enthused about her methodical planning: "W*ithin the WBL structure, I could evaluate what was going on, what was happening and what was needed."* By creating her own schedule, Paula set herself deadlines and added:

"It compartmentalises things, so you are not stood at the bottom of the ladder looking up and thinking – see how much there is to do and thinking 'oh my god I have so much to do!"

Elaine similarly described how "*breaking it down into smaller chunks*" made it more manageable. Balancing different activities was an essential aspect of this project management. Even when Jenny critiqued her time management, she demonstrated her immersion in the work. She said:

"I didn't appreciate how long it would take…I also got bogged down looking at all the research. I was too focused on the literature review, which wasn't that many words, whereas the thing that took the most time was writing the educational resource and I did not start that early enough, which is my own fault."

Habermas refers to communicative action as being based on a need to seek consensus with others to achieve agreed goals (1984, p.60). The nurse-participants needed to articulate their views so that a "co-operative process of interpretation" of their ideas about their immediate clinical world could be agreed (Habermas, 1984, p.101). Supervisory agreements needed to be

formalised and so the first project interactions focused on supervisory meetings.

WB supervisory relationships emerged as the most important of any of the relationships encountered during the project work, frequently referred to in the interviews, and this is reflected in their mention in each of these three findings chapters. This again echoes Chapman (2006) findings. Breaking this down further the first task appeared to be finding a supervisor you could trust. For some in small teams the choice of supervisor was limited and governed by local etiquette. As described in New Frictions Mandy chose a more experienced specialist nurse colleague as her WBS, but soon realised there was friction she at first described as being on "*different wavelengths*". Here I note her final comment: "*I think she (the WB supervisor) probably just thought I was a silly little girl*". This last phrase doesn't just indicate differences in age and experience, but is suggestive of a power relationship of parent to child (Berne, 1996) that emphasised the supervisor's superiority and reduced the nurse-participant's capacity to liaise with her as an adult colleague, denying ideal speech conditions.

Communicative reasoning entails a criticality in assessing the everyday validity claims of others, Habermas suggests with regard to their truth, sincerity and moral rightness, (1987, p.121). Mandy blushed when she described the WBS's behaviour, appearing embarrassed to admit this was how she had been treated, but I think this distress indicates the shock of being treated in this way and her humiliation. The impact of this unexpected denial of the validity of Mandy's claim was that Mandy's power to negotiate was considerably diminished. It did not appear to be Mandy's sincerity or knowledge that was questioned, because the proposed change had been trialled by her reportedly successfully. However it was her lack of seniority that seemed to be the problem, it meant that she was viewed as not having the right to question their authority and her action might have been seen as morally inappropriate.

Mandy was able to consolidate her knowledge by networking around the country with other similar specialist departments and presenting her findings to

a wider audience. Mandy acknowledged the challenge this presented her "*I was quiet. Personally it was quite a good thing for me really to go through.*" It seemed that because she had to promote her ideas more widely in a more public way it increased her sense of ownership and made her aware of how she was changing as a person. When the relationship was negative it had forced her out of her comfort zone, but in an unsupported way. Veronica had similarly had supervisor difficulties then found a stronger bond with another mentor, stating: "*the other supervisor said to me you want to do this, let us get together, I will teach you.*" This suggests a more equal relationship, with someone she described as becoming "*seriously involved*", by working with her on filming and critiquing the educational resource she was preparing.

It appeared that the nurse-participants had to defer to the WBS's specialist knowledge, trust their personal sincerity and professional willingness to support them. Elaine stressed: "*You have to respect them professionally as well. You have to think about personalities.*" Local culture and etiquette appeared to discourage criticism of experienced colleagues, therefore free and open dialogue was constrained, and 'ideal speech conditions' were not always being met where the supervisory relationships were strained (three situations). The learning entailed realising what was happening and finding ways of overcoming the obstacles presented without offending those concerned.

Seven of the nurse-participants had good experiences with their WBSs found they positively encouraged them to articulate their ideas more widely, providing a channel for communication out into wider professional networks. The more experienced staff knew their colleagues well enough to choose individuals they trusted (Beryl, Carol, Paula and Ruth). Carol confirmed: "*I chose her because I trusted her*." The younger staff (Jenny, Stephanie and Yvonne) chose individuals they had worked with previously and felt comfortable with and as a result did not appear to have had problems communicating. In these cases the 'actors' were able: "to reach an understanding about the action situation and about their place of action in order to co-ordinate their actions by way of agreement" (Habermas, 1981, p.86).

Stephanie commented on her supervision arrangement: "*It worked fantastically; I worked very well with both my supervisors.*" Enthusing about the academic supervisor particularly she said:

"*She saw the potential in me, which I didn't see. It probably takes someone else to say it is going to be hard, but you can do it, I am glad someone was like that with me personally*."

Ruth and Paula had the action learning set and WB supervision as part of that group. Although these comments emphasise moral support rather than critical reflection these relationships had the potential to encourage further critical debate.

Paula summed up what was crucial to finding the right WBS in terms of a person who: "a*) knows a bit about the subject, but also b) will converse with you, in a way that you feel as though is logical.*" Elaine advised that students should choose someone: "*Who can be honest with you and say what they really think, not just be nice to you*." Carol added it would have been helpful to have someone who had undertaken WBL themselves. Even if the WB supervisor was the best person for the job, they could be ignorant of the documentation required and Elaine recommended that the WBSs themselves should perhaps be given more support or that more tripartite discussions with academic supervisors should be used to help consolidate their understanding of course documents. These practical suggestions illustrate the kind of constructive relationship the nurse-participants believed to be helpful; one in which open dialogue could take place, individuals could be trusted, but ideas would be debated.

Solidarity and Self Determination

The WB supervisory relationship was the most important of the support structures, but seeking out other supportive colleagues facilitated a stronger network of support to develop. The nurse-participants gained a sense of solidarity from these. Habermas describes communicative action as a "switching station for the energies of social solidarity" (1984, p.84). This process was to a certain extent visible in the shift that occurred in loyalties as

projects moved on. Here I look at how these contacts were then sources of information and communication skills learning. I touch on academic supervisory roles at the beginning then move on to the action learning sets that some had access to and consider how the educational style moved from coaching and mentoring by individual supervisors to group support through to learning through action research and individual resilience.

Elaine stated: "*I think that pushing you out of your comfort zone was one of the biggest things*". In order to achieve change in the workplace the nurse-participants recognised they could not achieve this by staying either in the library or in the cosy intimacy of one-to one relationships with work colleagues. Academic supervision was one way of reaching out to access university resources. Academic supervisors were rarely mentioned in the interviews without a question prompting a response, yet WBSs were prominent in the accounts. I think this does reflect the differences in accessibility between education and the workplace in WBL. Carol, Paula, Stephanie and Yvonne mentioned the close proximity of their WBSs for regular meetings. Carol said: "*As a practice development matron she doesn't have a clinical commitment and so I knew she would be more accessible to me and would have time as well to meet."* Ruth chuckled, as she commented that her WBS was conveniently "*just next door*."

The distance the nurse-participants experienced from the academic world by not having classroom time made academic supervision even more important. However contact was not always easy to achieve. Beryl stated: "*At one stage it was very hard to get hold of anyone, but then it was fantastic*". Paula commented: "*I did get it, but again I had to wait a long time*." Jenny worried about how little she had seen her academic supervisor: "*my biggest regret would be not asking for help more*". Carol, Ruth and Yvonne did not mention them at all. Only five of the nurse-participants described their academic supervisors as supportive, which is a concern for the university, but not necessarily any one person's fault and the Midland like the service organisation was experiencing increasing commercial constraints. It seemed in Veronica's case where there had been internal conflict, the academic

supervisor tried to intervene, Veronica stated: "*She knew what was happening on the ward and the background politics, but there wasn't a huge amount she could do.*" The focus on the workplace as the basis of learning made it difficult for those not working there to have influence.

Extending contacts professionally or trust-wide seemed more productive in helping the nurse-participants to achieve their goals. Jenny referred to: "*Widening your social circle*". Her choice of the word '*social*' with regard to '*circle*' rather than 'political' is interesting here as it places emphasis on friendly relationships rather than power relationships, constructing the hospital environment as a socially functioning unit, rather than a political entity. Jenny had stressed the need to strengthen wider links to counter the problems she said she faced with internal criticism and described part of her learning as being about: "*Being able to handle that*."

Elaine too highlighted that in this project process she "*had to learn how to take knocks and deal with them*." Her source of support for her educational resources was the equipment manufacturers, she enthused: "*You do have to go and speak to people and use people's strengths and knowledge and draw on it.*" She had acted politically in the way she had sought allies and increased her power by gathering support. This led on to presenting her ideas to medical consultants, which she anticipated would be "r*eally scary,*" adding: *"There were times when I just thought I really can't do that, I really don't want to talk to a group of consultants about why we need this thing.*" Afterwards she said: "*I got a really good sense of achievement, really sort of stretching myself and pushing myself.*" She comments on discovering an inner resilience, describing herself as becoming more "*dogged*". When stating what she had learned from the module she said: "*Well learning about me, rather than the resource – if I really want something I will just keep trying till I get it.*"

Leaving the comfort zone meant more than just breaking out of an immediate circle of workmates to talk to others, it involved stimulating a wider debate amongst colleagues. Paula wanted to capture people's interest and stir up some discussion, commenting: "*I had to create a bit of a buzz about it.*" Having

stimulated the debate Paula identified the need to keep going, stressing the need to be resilient, she described the challenge as:

"Going up to people and talking about the idea and not worrying too much that they might think that the idea is not very good, to be steely enough to keep going. Listening to others, not deviating, but shifting ideas that is fine"

At the end she added: "*I really enjoyed it as well*." Paula spoke of this almost as a revelation, her reflection making her realise that she had the '*steely*' strength of character to carry her ideas through. Mandy similarly appeared to surprise herself in her response to the challenges presented: "*I think it made me keener to fight for evidence based change. I think it made me very driven*." She described herself as becoming "*more vocal*" and "m*ore confident to say: Why aren't we doing it this way, why don't we have a go at this."*

Habermas viewed discursive communication as an essential part of the reasoning process and stimulating discussion is part of that opening of debate. Part of leaving the comfort zone was about becoming aware of how others perceived things. Paula said: "*I had known all the doctors, but I spent a bit more time with them and their concerns and issues*."

Ruth described how her learning was about how to deal with managers and leaders, people she described as "r*esistant powerful people*" within her organisation. It was not as simple as being more articulate and assertive, but rather switching communication technique. Ruth had to learn to change her interpersonal style, read the political environment she found herself in, and adapted her communication:

"Because I was angry and frustrated I became more vocal and as soon as I did, then that would be when people would stop listening to me, so I had to change my own behaviour to counteract that."

Her direct questioning appeared to be viewed as aggressive (she alluded to an informal verbal warning she received); therefore she had to take a step back and absorb information, be more patient. She learned that a philosophy of: "*two ears and one mouth use them in that proportion*" worked for her. She

adopted this motto alongside: "*Seek first to understand then be understood.*" Maintaining the life-world traditions at the same time as resisting external pressure to go against her principles appeared to require a more thoughtful communication style. By canvassing opinion she was able to identify those of similar feeling: "*Instead of jumping in I would try and understand what was going on before I made assumptions and that is how I dealt with the consultants and senior management team*."

The WBL course by its very nature forced the nurse-participants to the forefront of change, but they were not always prepared for the move into a more public political arena. In this section I have identified how the nurse-participants increased their self–determination by seeking out support from academic staff, other professional colleagues and discovering solidarity with colleagues. They gained insight into the dynamics of their work environments and began to adapt to those new perceptions of their settings by becoming unknowingly political.

Learning the Processes of Argumentation

Having decided on their path and their compatriots, the next stage of the project work involved making a case for change. Habermas states: "The rationality inherent in this practice (of seeking consensus) is seen in the fact that a communicatively achieved agreement must be based in the end on reasons" (1984, p.17). The nurse-participants had to increase their own knowledge base and present a logical argument. Habermas refers to these learning processes for argumentation helping us to acquire: "theoretical knowledge and moral insight and extend and renew our evaluative language" (1984, p.22). Gathering evidence, critiquing it and then discussing this information with others are the key activities here. However, it was what was learnt from these action research processes that are considered in this section in terms of personal and professional development.

Many of the nurse participants were familiar with literature searching, but not all. Stephanie had not taken an evidenced based practice module before WBL or carried out any literature searching and stated: "*From my point of view I am*

not the most academic. It was a huge challenge, the first big hurdle. It may come naturally to some, but it didn't come naturally to me." She went on to describe it as her "*biggest achievement*". Jenny had similar concerns with searching the literature and Paula was worried about her lack of familiarity with educational computer systems. She did conclude that completing the module: "*has made me think I could potentially do that and I know the processes a bit more, I know what to access for support and how to ask*". Three of the nurse-participants (Carol, Jenny and Paula) still expressed a desire for further learning in this area. This again suggests the need for more proactive support from the university.

Those who felt they had mastered this activity were eager to share their new knowledge. Yvonne stated: "*We are all literature searching – (laughing) not in such a formal way (laughing). You are looking around more, more aware of how to look around.*" Beryl echoed this in her descriptions of how she started to bring articles into the workplace for discussion, attempting to stimulate professional debate about practice issues. These last two examples relate to attempts to develop learning communities in practice (Wenger, 1998) and extend the vision presented by Habermas of universities encouraging scholarly discourse (Habermas and Blazek, 1987, p.124).

The WBL module seemed to encourage evidence to be critiqued not just as a research entity, but in practical terms, comparing generic findings with local data and opinion to establish whether change was advisable and possible. Beryl highlighted how theory had this practical application: "*not only is it about critiquing your literature as in evidence based practice, but also going back and putting it into practice in your workplace*." Mandy stated that for her the action-research aspect held a strong appeal: "*I was really keen to become part of the evidence and to be in a team that is willing to change*."

A driving force here was the anticipated changes they hoped to bring about. Ruth identified how she had used the WBL course to strengthen her argument: "*I found the theoretical side helped me to reference and evidence base arguments and business cases to put in through the trust."* She added that had she been doing simply a practice project she would not have researched it this

meticulously. For her it brought academic weight and made her more "*thorough*" in her analysis:

"It is having a really robust business case and evidence. You need to show you know what you are talking about…you have to have the knowledge and evidence to back up what you are saying."

She mentioned drawing on professional policy, data, communication and change theory and did demonstrate a generic understanding of service improvement rather than a narrow contextual view.

This section has clarified the way in which the nurse-participants were drawing together different types of evidence to inform their view of their situations. Habermas lists 'theoretical knowledge and moral insight' (1984, p.22) in his conception of a profound consideration of an issue and Paula, Ruth and Veronica all made specific reference to theory in their descriptions of their work.

There was some evidence of knowledge being shared (Beryl and Mandy's examples), which brings us close to a sense of the university as a community learning space (Habermas and Blazek, 1987, p.124). The presentation of their project work to others was discussed in earlier debates about multi-professional teamwork, but is revisited in the last section where overall personal development is considered in more detail.

Self-Realisation

In this section I look at the way the nurse-participants described how they had been changed by the learning process. Nine of the ten nurse-participants described an increase in personal confidence. For some it related to status in their workplace, for others it was about bringing about change, while academic work was for some a particular challenge. I examine how this personal empowerment developed and link this with Habermas's call for learning to emancipate.

I have taken slightly longer quotations from the accounts here to provide different examples of personal growth. I describe the individual nurse-

concerned and varied in nature. I have summarised these in a table at the end of this section. Beginning with those who reported WBL increased their personal confidence and restored their occupational status (Veronica and Yvonne), then moving on to those who articulated feeling bolder and were able to change practice (Elaine, Mandy and Beryl). I then move on to look at what the more detailed accounts (Ruth, Paula and Carol) tell us about the learning process.

Workplace Recognition

Veronica had changed post and this impacted on her professional confidence, because of the difference in roles between departments. Veronica commented on her move to intensive care:

"*As a band 5, (in a specialist unit) you can feel deskilled, but this (the WBL module) gave me the chance and the opportunity to regain some of that and influence things. I could do something to develop staff… people were listening to me, that was – mostly. It was nice I got the little bit of respect, even if I did not get it from the top*."

Veronica realised: "*It prepared me for my Band 6*." She explained:

"This portfolio made me start looking at politics, made me start looking at staff and it made me see things, where I wasn't happy where things should be changed or things worked well, not just negative changes."

The project seemed to help her career progression: "*I wouldn't have come into academia if I had not done this teaching package.*" She clarified: "*It gave me the evidence for what I wanted to do*", by this I believed she meant proof of her educational skills.

For everyone their starting point was slightly different, depending on their previous histories, Yvonne explained:

"I think sometimes you lose your way a bit. I got married and when I came back part time, life was really busy and you do what you need to do. When I worked full time I felt like I had my finger on the button sometimes you need to refocus again. That's what this did for me it tuned me in and made me feel more part of the workforce getting things done, things being achievable."

For Yvonne gaining confidence was the result of engaging more fully in her clinical area.

The 'getting things done' element took the learning from communicative reasoning through into communicative action. This increased her recognition within her department, strengthened the solidarity of the team and brought about social improvement. Yvonne looked surprised when she realised how her view of things had changed, saying:

"I feel very differently about things... actually, I think that sometimes there are problems and it is sort of out of your hands, so it makes you understand how you can deal with them….I learnt that you can look at these things, and do something about them."

Stephanie reported that her renal guide had been published and commented: "*I didn't think I could produce anything like that.*" This noting of personal achievement helped them to identify I would argue an emancipatory change in themselves.

Elaine focused on this more personal aspect of change too. She managed to mention 'c*hallenging*' five times during the interview, in relation to the intellectual demands, supervisory relationship building and the practical activities. She stated:" *People need to know it (WBL) is about challenging yourself and seeing what is possible, not just about the package and I didn't get that at the beginning*." She concluded that the WBL course: "*made me more confident at challenging people*," at the end of the interview she volunteered to support others undertaking WBL to help them develop in the same way.

For Mandy this increased boldness took the form of wanting to work more independently. She stated that she had looked for a new post where she could be more of "*an independent practitioner*" and had moved to a new team for this role. Reflecting on how her project had progressed Mandy commented: "*I thought surely this is feasible and then proved it was feasible and I think it made me more confident.*" She went on to say (laughing): "*Now I am an activist for all sorts."*

Ruth makes the point that a kind of reflexivity develops: practice stimulates questions; research is used to answer them, and when this is applied to the practice setting further learning takes place, and further questioning is generated. She identified that her biggest learning came from testing out the knowledge she had gained from theory in practice when "*negotiating with senior managers, and getting people on board, and getting my point across*." She stated:

"I think I have gained a bigger understanding, a more rounded understanding of the way service improvements and initiatives move forwards, but I think my big personal learning was negotiation skills and change management."

This process of translating the knowledge she had gained from the literature into a case for change, working through that with colleagues in a collaborative way seemed to me to demonstrate communicative reasoning in action. It involved a rational, collegiate, moral approach. Ideal speech conditions had not been present initially and she had to find a way into the dialogue about services, but once there she had established a right to argue her case. Ruth talked about "*having to earn*" recognition: "*I need to know what I am proposing will work*." She said "*People would look at me differently if I did fail*". Having gained knowledge, not just of the clinical situation, but also of the economic and political environment, in terms of the local politics around service improvement, she was able to use her knowledge and communication skills to influence it. Ruth, in addition to being invited on to a range of boards described how she had become bolder in asking for a leadership mentor: "*I have now asked for one of the project managers to be a mentor and this has been arranged for me*."

Ruth credited a good deal of her learning to a process of reflection: "*I was very reactive, now more reflective*." She went on to say: "*It helped me to unpick some of the things*", explaining that it helped her to understand why people reacted the way they did in the organisation. She added: "*I now have an internal pause button!*" This learning was not based on individual soul-searching alone, but working reflectively with her WB supervisor and learning set. This kind of collaborative discussion had helped her to assess the situation

and to look at her personal choices. She was able to define her life-world principle of putting patients first, clarified the business methodology colonising her department and WBL had helped her to find her own power to resist what she felt was wrong in her situation. Beryl echoed this sentiment saying: "*I think it raises awareness that things can be done differently. It certainly has done that for me*." She continued: "*I don't comply as much now*" commenting: "*You know we are not sheep*" I think the professional development identified was not just about confidence, but empowered individuals to emerge from the shadow of conformity and to question.

Academic Achievement

The question for me then was the same empowerment taking place in the educational environment. Influencing the workplace was one aspect of the work, but there was also the submission of a portfolio for the academic award. The three parts involved: a literature review, a project report and a reflective account. All of these required different academic writing styles. Academic writing was a concern for Paula, as she was nervous about writing in a "*Master's stylee*", as she referred to it, dragging out the last syllable. She went on to say:

"*My language is sometimes not as academic as I would like it to be…I read other people's that are very academic I think – it would be nice to write like that*."

Paula's development embraced academic as well as practical skills development, she concluded: "*There was immense personal growth for me*."

Carol too, had been nervous of the academic work and had wanted to present her work in the format suggested by the business consultants. When talking about her academic supervisor she noted:

"She was more concerned about me using the (business name) structure rather than a trust or academic structure I think she found that quite challenging and thought it would be difficult for me to write up correctly. I felt quite strongly that I was trying to show how I was learning to think in a different way and not a traditional nursing way."

I wondered whether this was a case of the nurse-participant wanting to regain control of her writing or just trying to follow through her thinking about the project, either way this had clashed with academic approaches. In the end a compromise was achieved by Carol managing to include enough explicit reflection on the business principles outlined, in a format that was acceptable.

However, this did make me think about how disempowering academic stricture can be and I wondered if the same problem of punishing a lack of conformity was occurring here too. However, as Carol's later comments on her overall result suggest education may use reward more than punishment to gain acquiescence. Carol described her pride in her high mark: "*It gave me much more confidence in myself as a learner. It was good for me, as a professional, to know that I can do that level of work.*" She had now gained admission to a graduate life-world.

The difficulty of handling the dual demands of university and workplace remain as a tension here. It is important here for me to recognise my own academic life-world naivety in seeing only the positive aspects of university study. I have emphasised the empowering elements of evidence gathering, dialogue and reflection, but the same 'instrumental reasoning' can be being applied in the guidance for assignment submission. Communicative reasoning is not reflected in the relationship between university assessor and student as there is a disparity of power and ideal speech conditions cannot be created where there is not equal control, whereas the formative assessment involved in WB supervision encourages partnership working. The challenge therefore for WBL, is how can this inherent contradiction within assessment be overcome?

In summarising the findings discussed in this section it is important to state that little was said about the academic side of the work. Those who did mention the challenge, Carol, Paula and Stephanie seemed pleased with their final achievement. In terms of self-realisation some students like Ruth and Paula demonstrated high levels of understanding of their settings and maintained their principles while carrying out work that was needed for their departments. Carol chose a different path embedding business ideology into her workplace. Others were able to strengthen their contributions to their

specialist areas or explore their own career development. Jenny was the only one who did not describe herself as gaining satisfaction from some form of personal development, but she did say: “It probably makes you a better nurse, it makes you more questioning.” To close this section I have included Table11 on the next page, summarising the transformative effects.

Table 11- Personal Transformations

Name	Self-Consciousness	Self-Determination	Self-Realisation
Beryl	Beryl became more aware of the importance of clinical judgement to her own professional identity and began to question organisational policies.	She decided to practice as independently as possible in terms of taking decisions and defending them, rather than simply conforming to internal procedures.	She recognised that she had become more questioning and less conforming and was able to change her practice.
Carol	Carol became more aware of changes in the NHS as a whole and of her contribution to them.	Although already quite self-reliant, Carol acknowledged the challenge of working alone and was proud that it was, as she said: "all me."	She recognised that she could explore new ideas, test and debate innovative ideas successfully academically as well as in practice.
Elaine	Elaine appreciated being pushed out of her 'comfort zone' and therefore forced to look at the wider context of her work and to network.	She found she learned "how to challenge people."	She discovered she could gain recognition of her ideas.
Jenny	Jenny learned that she does not ask for help enough.	She recognised that she had widened her 'social circle' as she was forced to network to achieve her project goal.	She described herself as a 'better nurse' at the end of the project.
Mandy	Mandy realised she was a person who wanted to be innovative and that conflict actually provoked her into becoming more outspoken to prove her ideas.	Mandy expressed a satisfaction with setting her own outcomes and referred to the 'ownership' of the project she felt.	She learned that she could play a lead role in a team when given the opportunity and authority to bring about change.
Paula	Paula realised how much she enjoyed taking charge of the planning.	She discovered who she could ask for help and decided she wanted	She changed job to acquire the freedom to be more creative.

		more independence.	
Ruth	Ruth became aware of how her method of communication was preventing her from being heard and that she would have to change her style to be heard.	She learned to listen to others more carefully and to find other routes to communicating. She found she could use theory to develop evidence to make a case for change.	She found she could have an impact on organisational changes by finding her voice in senior meetings.
Stephanie	Stephanie was very proud of her academic success and this increased her confidence with her colleagues.	She learned how to improve her academic and professional status.	She found she could educate others and even have her work published.
Veronica	Veronica became aware that she hadn't understood the micro-politics of her unit.	She realised she could carry out a project if appropriate support was available.	She found she was skilled at developing educational materials and could gain respect through teaching others.
Yvonne	Yvonne found she enjoyed the problem solving and looking for evidence to support it.	She recognised that she was taking a lead in sharing information.	She realised she was respected in her team and could bring about change.

Conclusion

This chapter has drawn out, from the interview accounts, comments that suggest personal and intellectual progression took place. Having compared these remarks to the development of 'communicative reasoning,' I discovered that the nurse-participants grew in self-awareness, took ownership of their learning and established some control over their learning journey as they proceeded. Some began from a very powerless position with ideas that were not going to be listened to, yet managed to recruit allies to their cause and strengthen their political positions as the work progressed.

The lack of educational structure and freedom to decide their own goals, timescale and method was at first stressful, but then made the nurse-participants think more carefully about what could be done. The conflicts that arose stimulated an increase in self-knowledge and socio-political awareness. Yet most of the nurse-participants did not appear to articulate that ethical dialogue or socio-political debate had taken place, and still appeared to view change pragmatically. Veronica did use the word political and Ruth and Paula demonstrated high levels of understanding of their settings and maintained their principles while carrying out work that was needed for their departments. While Carol chose a different path embedding business ideology into her workplace.

The personal insights revealed helped me to consider how nurses are affected by WBL learning processes and to consider how they could be further empowered if conditions in the learning environment allowed, and workplace support was adequate. In the final discussion chapter I reflect on the aims and questions originally posed and look at what has been learnt from these nurse-participants about the contribution of WBL.

Chapter Nine - Conclusion

"A slumbering giant who lacks the assertiveness and courage to do what clearly it ought to be doing" (Kuhse, 1997)

Introduction

In this final discussion I revisit the original aims and answer the research questions posed at the beginning of the thesis. I consider what I have learned from working through the evidence presented and the contribution this makes to our knowledge of nursing WBL. I examine the implications for policy and practice, whilst acknowledging limitations of the study and then discuss my personal learning from the thesis as a whole.

Research Aims and Questions

The first research aim was:

1. To compare and contrast the rhetoric and the reality of work-based learning and to examine the varied influences on learning activity, in the light of Habermas's concepts of the Life-world, Systems and Colonisation.

It was my first intention to check whether my impression of the WBL writings promoting the empowerment of nurses was borne out in the literature, and then my second to investigate what was happening in practice. In chapter three I discovered there was an aspiration to empower nurses to lead change. I then found the enthusiasm for WBL projects was present in both the literature and my empirical findings. In answer to the first research question, the empirical findings suggested there was a harmony of values and beliefs around public service and the importance of relationships with patients and this drove the nurses to want to bring about change. The nurse-participants displayed a sense of personal responsibility for care that was tied into their identity as nurses and this inspired them to become change agents. However, the life-world did not always support this role change, making this transition difficult.

Pratchett and Wingfield suggest that the public service ethos is in itself a 'political institution' (1996, p.654) that provides public systems with stability and coherence and this echoes Habermas's comments about the cohesiveness of the life-world. In this nursing WBL context political influences were impacting on the nurse-participants' abilities to manage their project work, but often the nurse-participants remained in the dark about these forces until confronted by them in conflict situations. Chapter two revealed forces impacting on the UKNHS that could be viewed as systems threatening the traditional ways of working and these influences were examined in relation to the second question about systems and colonisation. Some of the inhibiting forces were historical inter-professional hierarchical relationships (doctor-nurse games) and attitudes to authority (the need to conform), yet others reflected a changing ideology in terms of an increasing acceptance of market forces. The nurse-participants seemed to perceive these as social, practical or personal barriers.

Systems were beginning to intrude into the life-world in terms of business consultants and business techniques being drawn into staff education, but these were not noted as different political forces but economic changes. The pathologies of colonisation identified in the empirical findings seemed to originate from senior management pressure to: work at a faster pace (operating department); adhere to strict procedure and not take risks (elder care), and distrust specialist expertise and experience (chronic disease clinic management).These more insidious influences could be quite damaging to professional clinical judgement, in that they undermined it, by enforcing rules and procedures out of the nurses' control.

Despite these difficulties or even because of them (as some of the nurse-participants argued) the claim that WBL increased confidence and enhanced skills development was supported by my empirical findings. The rhetoric of empowerment was therefore borne out in the personal growth the nurse-participants reported. The nurse-participants were empowered by the successful achievement of their academic work even when project changes were not carried out after trials were completed.

In amongst the WBL writings there had been concerns about the lack of organisational support for staff undergoing this kind of education (Chalmers, Swallow and Miller, 2001; Chapman, 2006; Moore and Bridger, 2008; Stanley and Simmons, 2011and Marshall, 2012). My empirical findings confirmed that the nurse-participants experienced problems with a lack of 'protected time' for study, experienced frictions with colleagues and on occasion antagonistic managers. The reports of the learning journeys were considerably more fraught then I first anticipated.

There were a considerable number of communication challenges and emotional stresses along the way and this links to the second research aim which was:

> 2. To explore how a framework of communicative reason illuminates existing educational experience and can offer suggestions for reconstructing the course in a way that empowers nurses to work more successfully collaboratively.

In chapter three I outlined WBL intentions and the project work approach and began to compare it to the use of communicative reason. By looking closely at the interpersonal relations in the project work reported I considered the kinds of reasoning being used in the communications that were described and analysed the difficulties that arose. The third research question asked if communicative reason was visible, it was, within specialist teams and between some nurse-participants and their supervisors, but this kind of consensual agreement was not guaranteed in these relationships.

The empirical findings revealed that the nurse-participants were quite dependent on the on-to-one of WBL supervision and found the move into the more public arena of multi-professional team leadership daunting. I found that the nurses do use communicative reasoning in their conversations, but are not always included in situations where decisions are made. In addition feelings of powerlessness can prevent individuals from embarking on activities that would bring them into conflict with senior staff. By identifying the ways some nurse-participants developed their communication skills and overcame internal problems it was possible to visualise ways in which nurses could improve their articulation and negotiation skills and build on the solidarity of their professional colleagues. How the use of communicative reason could

contribute to WBL is addressed more fully in the implications for policy and practice.

Contribution to Knowledge

Despite my concerns that the rhetoric of WBL being empowering and transformative, with regard to bringing about change, was overplayed, my own nurse-participants demonstrated it was possible to a certain extent. My main contribution to the research into WBL in nursing is thus to highlight that claims should be tempered, because the path for most of the nurse-participants was not an easy one. Here I look at what this research adds to current understanding of nursing WBL.

When I began the research I had imagined a variety of influences contributed to the problems students faced, although I loosely framed them under the two headings life-world and systems. The knowledge I gained was that the life-world or the psycho-social aspects of the learning environment had a much stronger hold on the minds of those involved than I had anticipated. Therefore this area of influence, I believe, should not be underestimated. For WBL, that means giving more attention to the dynamics of this occupational background. The nurse-participants had seemed surprisingly unaware of local opposition before their projects commenced, suggesting a political naivety in terms of the social stresses around them. Again I believe this is new knowledge in the sense that not many WBL researchers have explored the political nature of social influences. Kuhse's (1997) image of nursing as an organised body sleeping through the changes that go on around them, rather than challenging them comes to mind here. I agree with Allen (2001) that nurses' localised focus and willingness to adapt to any situation has made them absorb the expectations of others rather than helping them to set their own. In Marxist terms this means they accept the dominant ideology and suffer the hegemony that results. Without knowledge of their socio-political surroundings nurses cannot question them or defend their professional position.

In contrast, the nurse-participants' experiences have provided insight into how light can be shone on these darker recesses of control, when you have

supervisors with inside knowledge or learning sets and contacts who can help you to make sense of and use political resources. I think my empirical findings illustrate how the resources of the life-world and sources of collegiate solidarity can be mobilised to support nurses embarking on leading change. The socio-political knowledge of organisations in the health service, gained either from classroom or workplace learning, could facilitate a questioning of workplace settings. Nurses could then decide whether they wish to defend the strengths of the life-world or work to change weaknesses they see there.

In the nurse-participant accounts success seemed to come from learning from others by networking and altering personal communication skills. The WBSs appeared extremely important in affirming the nurse-participants power and opening channels of communication, again areas that could be developed. The importance of the WBSs has been identified by previous WBL researchers (Chalmers et al.2001; Chapman and Howkins, 2003; Clarke and Copeland, 2003; Chapman, 2006; Rhodes and Shiel, 2007; Moore and Bridger, 2008 and Marshall 2012), but my research reinforces how they promote or block the student's influence in the organisation as a whole.

Habermas talks about developing 'ego-strength' to create defensive strategies against colonisation and this entails evolving: "Personality systems that have developed such strong identities that they can deal on a realistic basis with the situations that come up in the life-world." (1987, p.141) The nurse-participants all demonstrated achievement academically and nine out of ten talked about increased confidence. Personal growth seems to come through both: working through personal challenges and from working in strong team relationships. I think this suggests that such strength is not wholly dependent on personality, but can be nurtured through collegiate relationship where controlling forces are questioned. I suggest that the drive of the project purposes and the strength discovered along the way acted as a powerful 'self-steer' (Habermas, 1987, p.356).

I summarise the four areas of knowledge, to which I think I have contributed:

1) Our understanding of the importance of background professional and occupational assumptions, structures and relationships to WBL.

2) Our awareness of the socio-political influences on the context of nursing WBL, and how they affect organisational agendas.

3) Our understanding of the importance of student self-awareness and social awareness with regard to values, beliefs and expectations so they can decide on their direction and ethical stance.

4) Our awareness of the need to develop the role WBSs play as mentors and networkers in building student confidence.

Here I have separated structure and agency in identifying knowledge about influences and individual behaviour. What has been learnt is that we should tread carefully when assuming what is happening in any learning environment and look more carefully at the dynamics of that socio-political context, before commencing work on individual plans. Understanding the student's life-worlds could help educationalists offer more customised support.

Helping students to understand their setting and then the wider influences upon it (systems and colonisation) would provide nurses with the means to examine the forces impacting on their workplace and help them to choose whether to accept or resist internal and external pressures. Habermas's conceptual framework itself could be used to help students distinguish influences on their learning, facilitating a greater questioning of their own personal drives and organisational pressures. 'Systems' influences could be analysed through looking at the language used in policy documents and considering the assumptions made in the protocols devised. To facilitate the student's personal development concepts such as 'the public good' could be explored in terms of their own beliefs and compared to professional and organisational goals. Improving their understanding of their own motivation could then help them test out which supervisors would be the most suitable to support their aims.

Learning from the Theoretical Approach Applied

When I reflected on my learning from this research process and the theoretical framing of the study I appreciated how using the TCA (Habermas, 1984, 1987) helped me to anchor the examination of an educational process to a socio-political analysis of a work setting. I did not begin by searching for political causes, but wanted a broad investigative approach. However I believe this theory helped me to analyse the learning environment more thoroughly. Evaluative feedback reveals individual student experience this research approach helped me to look beyond the immediate and the technical to gain a deeper understanding of the dynamics of the situation.

Using the life-world as a theme for analysis allowed me to draw out background assumptions, surprising me with the passion that some nurses expressed about their work. It clarified existing hierarchical structures and relationships and the importance of these positive and negative aspects of these elements. During the research I wondered whether different specialities nurtured different learning environments or sub life-worlds. Veronica's comments about her own area being competitive suggested there might be considerable differences between clinical areas. Future research could be directed at investigating these to learn which circumstances provide the most supportive educational context for WBL.

At first I perceived the life-world as 'good' and the system as 'bad' but then realised it was far more nuanced than that. Society move toward enlightenment is supposed to remove the restrictions imposed by previous traditions and in nursing some traditional values are helpful, but others remain constricting. Some of the nurse-participants were encouraged by entrepreneurial developments and the chance to innovate and this in itself is not negative. However, looking at the language helped me to identify hidden influences on local perceptions and as Clarke and Newman state the 'transformational discourse' (1997,p.52) can in itself prevent debate about social justice by emphasising any change is good.

As a critical theorist I have to acknowledge my own vulnerability to this discourse and the aspirational language of empowerment. This led me to the hope offered by Habermas, but there are other theorists who could have contributed more fully to the examination of power. Yet, testing out the TCA in a research setting gave me a better understanding of this theoretical framework, driving me back to check original texts, encouraging me to question my own analysis.

Critical theory helped me to cross reference a critique of the literature with socio-political debate and empirical findings, for me a powerful combination in this investigation. Tracing back the health service changes made me realise how much policy had changed or drifted (Rafferty, 2018) and how much I had missed politically. Examining the WBL research made me recognises patterns of gaps and concerns. The interview accounts made me realise how students were often sent into difficult situations completely unprepared politically, because it was assumed they knew their areas. Their enthusiasm made me want to see more support offered.

Initially I wanted to write a list of practical suggestions for educational improvement, but then I realised I could fall into the trap of being merely instrumental, rushing to offer solutions. Going back to reflect on 'empowerment' made me realise that more work would need to be done to explore what worked and finding the right educational approach to facilitate socio-political awareness and build self-confident communication.

Implications for Further Research

Building on this research it would be possible to test out different ways of facilitating increased awareness through action research. Initially focus groups could be used to explore suggestions and then materials could be designed and tested. The term 'the public good' could be used as a one trigger for discussion and value exploration exercises could be used to draw out beliefs and attitudes. Educational resources providing more information about UKNHS changes and critical social policy techniques employed in online or classroom exercises

could be evaluated in terms of the increased awareness generated and the ability to stimulate debate.

A further dimension that appeared worthy of further investigation was the supervisory relationships which appeared very powerful in this kind of independent learning. Gaining the views of those who have acted as supervisors and considering the ways in which they carried out their role might also be useful. Widening this research to explore the development of collegiate working, enhanced team relationships and increasing solidarity could be another area of research. This might be of particular interest to professional associations and unions.

Implications for Policy and Practice

In this section I identify what would be needed to enrich current policy and practice to support WBL in nurse education. Firstly like Rafferty (2018) I would exhort nurses to become more politically active in terms of debates around public services and healthcare, because they are affected by outside forces, which at the moment they appear to have little knowledge of, or control over. Nurses are the largest workforce within the UKNHS and as Rafferty (2018) stresses it is this slumbering giant that could be awakened to protect and develop the service.

Although government documents stress the clinical importance of nursing leadership in terms of health promotion or long term condition management (NHS England, 2019) they rarely encourage political questioning of policy. Generic leadership courses for nurses have increased in availability, but without access to decision making bodies the ability to exercise power will remain limited. As Jumaa (2008) suggests as educationalists we need to prepare nurses to view themselves as professionals who can contribute to policy making arenas.

To realise their power nurses need to develop a sense of their selves as political, rather than apolitical. I argue that if WBL were reconstructed around communicative reason it could bring nurses out of the clinical shadows into the

light of political activity. I believe instrumental reasoning has led to 'practicism' (Scheel and Pedersen, 2008), where technical issues are addressed with little questioning of the underpinning principles of care giving and overall healthcare purpose. The tendency of CPD toward competence achievement encourages task oriented working, reducing the opportunity to discuss and debate the ethical or social issues around policy implementation. As Matthew-Maich et al. suggest as we increase research utilisation in nursing, 'critical reflection' and 'discourse' with other clinicians could help to strengthen "shared meanings among groups" (2010, p.31) and thus increase professional solidarity around clinical issues.

Although reflection and dialogue were encouraged in WBL at the midland and the Royal, it lacked a breadth of questioning. A reclaiming of communicative reason would stimulate moral and social questioning of motivations, practices and contextual influences. Brookfield suggests that in adult education "to awaken human agency" (2005, p.31-32) individuals need to move through a series of tasks. First they need to challenge dominant ideologies, by unmasking "the flow of power" and "reveal hegemony" (ibid). They then need to be able to identify and 'connect' with others with whom they can challenge and defend beliefs. In this way they can learn to 'exercise freedom' and 'practice democracy' (ibid).

Developing the role of the academic supervisor further to participate in this encouragement of questioning could help students build their confidence in workplace conflicts. Academic supervisors were rarely mentioned in most of the interviews, this is not to say they were ineffective just less visible. Similarly enhancing work-based supervision arrangements would help, as my findings did show that such support networks were important. One of the r reasons I chose Habermas was for the wider societal perspective, which I think fits with Higher Education goals of providing a broader knowledge than just subject disciplinary information. If nurses restrict their field of learning there is a danger of not achieving the aim of bettering society.

Study Limitations

In pressing for change I do have to recognise that these recommendations are based on a study composed of willing volunteers, self-selected and therefore not necessarily representative of all WBL students. However, the positive remarks of the enthusiasts were balanced by those nurse-participants who had supervisory problems and used the interview as a therapeutic debriefing. The interview method was intense in the sense of a one-to-one situation and this has advantages and disadvantages in terms of the individual's ability to disclose depending on their relationship with the researcher.

I have earlier in the thesis described some of the concerns around my own insider status and we will never know whether the nurse-participants would have given different information to a different interviewer. However, I had critical friends from within the educational doctorate who read material and interpretations were discussed with my supervisors and I have tried to be as transparent as possible in reporting the nurse-participants views. The insight provided here is a snapshot of a group of experienced nurses in a specific location, but the light they shed on nursing in the twenty first century seemed precious to me, because it was rich with passion, caring and provided a thoughtful and timely reflection on events.

Conclusion

In this chapter I have identified the knowledge gained, but also recognised the limitations of the investigation to ensure the research is placed in context. This thesis argues that WBL can empower individuals by shedding light on the influences that normally remain hidden in the structures and the ethos of the workplace. This research has shown that achieving change and gaining success can increase a sense of power and control. WBL can bring nurses out from the shadows to lead change, but I argue to emerge more fully into the spotlight of political activity they need to become more politically aware and discover their professional power. There is still a lot of work to be done to politically to empower nurses in the workplace, but I argue that their loyalty to patients,

caring attitudes and professional moral code make them potentially a force for good.

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Appendices

Appendix One

A Critical Review of the Nursing WBL Literature

Literature Searches

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2.1 Ethical Approval

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Appendix One
A Critical Review of the Nursing WBL Literature

Literature Searches

On-going searches were established through Ovid Auto Alert covering Nursing, Medical and Allied Healthcare Literature databases from 2011 – 2016. This rolling update was able to provide cumulative evidence of research and provided access to expert opinion articles on the subject. I was able to access to the online journal International Journal of Workplace Learning to monitor topics that might be relevant over this period. A request to the Royal College of Nursing to carry out a literature search in 'work-based learning in nursing' in 2017, helped me to verify that I had not missed any articles, or report, which might be relevant.

Nixon et al (2006) identified, in their Higher Education Academy Report, that literature searching for WBL publications has always presented difficulties because of the breadth of terminology used. Workplace learning is the broadest phrase, but in nursing it can cover the initial preparation of nursing students, in-service apprenticeship training, foundation courses, pre-registration degree placements and some writers even include classroom simulation (Kettle, 2013). Internationally language has varied from 'work-integrated' to 'work-based studies' and 'work-related' learning in relation to vocational courses. The term used in my searches was 'work-based learning' as this appeared to be the preferred term for continuing professional development in nursing in the UK, Australia and Scandinavia. In South Africa 'work-integrated' learning was found through hand searching reference lists.

The literature accumulated here is focused on the CPD of nurses, although occasionally I have drawn on other professional groups, where nursing literature is limited and the material is appropriate. Writers on accredited prior learning (RPL or APEL) do look at WBL from a retrospective accreditation perspective and do have valuable comment to make on the differences between higher education and employer attitudes to learning and these writings are touched upon where relevant.

Chronological Table of Nursing WBL Articles

Author	Year	Type of Literature
Chalmers, Swallow and Miller	2001	Description and evaluation of WBL course for Emergency Nurse Practitioners.
Chapman and Howkins	2003	Description and evaluation of WBL modules on leadership, advanced practice and teamwork for community nurses.
Clarke & Copeland	2003	Discussion Paper - example taken from personal experience of WBL in cancer care.
Dewar, Tochar and Watson	2003	Descriptive Report of a customised WBL course.
Ramage	2004	Conference Paper – Learning from leading WBL Courses.
Chapman	2006	Small qualitative study focusing on the impact of WBL on patient care.
Swallow, Hall, English	2006	Course evaluation of WBL designed for Learning Disability Nursing practice in Northumbria.
Rhodes and Shiel	2007	Case Studies - Northumbria
Foxhall and Tanner	2008	Interpretive phenomenological research of student experience of WBL.
Jumaa	2008	Commentary on the development of board level leadership capability through WBL.
Moore and Bridger	2008	Longitudinal evaluation of a WBL cohort over three years.
Stewart	2008	Doctoral thesis on the role of professional associations in WBL.
Tynjala	2008	International thematic review of research on workplace learning.
Christensen	2009	Theoretical paper on models of WBL development.
Livesley,Waters and Tarbuck	2009	A descriptive case study of a WBL course for advanced professional practice.

Manley, Titchen and Harding	2009	A concept analysis of WBL.
Stewart and Morgan	2009	Discussion paper on the role of professional associations to WBL.
Moore	2010	Discussion paper on the management issues generated by data from the Moore and Bridger study (2008).
Quick	2010	Description of a course for specialist advanced professional practice development.
Stupans and Owen	2010	Case study of WBL with clinical educators supporting pre-registration students in South Australia.
Williams	2010.	Literature Review of WBL.s contribution to clinical practice development.
McDonald,Jackson,Wilkes and Vickers	2011	Collective case study of nurses and midwives –WBL course to increase professional confidence and resilience.
Stanley, and Simmons	2011	Interpretive study of WBL using a focus group with 5 Senior Nurses.
Marshall,	2012	Mixed methods study of WBL in a post- registration midwifery degree programme.
Phillips	2012	Course leader opinion paper on difficulties students face in WBL.
Ramage	2012	Conference paper presentation of findings from a grounded theory research study.
Thurgate and Holmes	2015	Pilot course evaluation

Appendix Two – Chapter Five Documentation

2.1. Ethical Approval

2014/9/JG

School of Education – Research Ethics Approval Form

The University of Nottingham

Name Maggie Roberts
Main Supervisor Monica McLean
Course of Study EdD
Title of Research Project: Work-based learning in the continuing education of nurses
Is this a resubmission? No **Date statement of research ethics received by PGR Office:** 08/09/14

Research Ethics Coordinator Comments:

I have seen all the documents accompanying this submission and I am satisfied they meet the requirements for ethics approval as long as the following is observed:

Participant Information Sheet: Please use the generic email address for the School's Ethics Committee, as in the Consent Form.

I consider this research to be above minimum risk ☐

Final responsibility for ethical conduct of your research rests with you and your supervisor. The Codes of Practice setting out these responsibilities have been published by the British Educational Research Association (BERA) and the University Research Ethics Committee.
http://www/educationstudentintranet/researchethics/index.aspx http://www.bera.ac.uk/publications/Ethical%20Guidelines *If you have any concerns during the conduct of your research then you should consult those Codes of Practice and refer again to the School of Education's Research Ethics Committee.*

Independently of the Ethics Committee procedures, supervisors also have responsibilities for the risk assessment of projects as detailed in the safety pages of the University web site. Ethics Committee approval does not alter, replace, or remove those responsibilities, nor does it certify that they have been met.

Outcome:
Approved ☑ Revise and Resubmit ☐

Signed: Name: Dr J. Gimenez (Research Ethics Coordinator) Date: 07.05.2014

2.2 Participant information

The Purpose of the Research

This research forms part of a doctoral study in the School of Education at the University of Nottingham and is focused on partnerships to support work-based learning in nursing. The aim of the research is to identify influences on student and supervisor arrangements and to analyse the impact of these factors on working together for service improvement. This study concentrates on just two organisations: The *Midland* University and the *Royal* Trust and their collaboration, through a set of work-based learning modules. Individual students will be interviewed in order to capture their perceptions and experiences.

Expectations of Participants

You are invited to describe your experience and tell us your ideas in a semi-structured interview approximately an hour in length. This is voluntary and you are free to withdraw at any time, with no negative consequences (non-participation will not affect your organisational or educational standing if you decide not to proceed). I will ask to audio-record the interview so that no comments are lost, but you have the right to refuse this recording. The interview will include questions about your professional background, but then move on to how project ideas were developed and decisions made. There will be some open questions to allow you to express your ideas and any concerns. Data will be stored in a secure place and your name will be changed to ensure anonymity. Only my supervisors and I will have access to the information taken from you. It will be kept in a locked cupboard in a locked room. Comments you make may be quoted, but anonymously. A consent form is provided for you to sign before the interview.

Findings

Once the data is analysed you will be given the chance to read the transcript for accuracy if you wish. The results will be summarised and feedback will be made available at the end of the study. Recommendations will be made to improve future practice.

Contact Details

If you have any queries or concerns about the research you can contact the researcher or her supervisors or the Department of Education.

Researcher: maggie.roberts@nottingham.ac.uk

Lead Supervisor: monica.mclean@nottingham.ac.uk

Second Supervisor: alison.edgley@nottingham .ac.uk

2.3 Participant Consent Form

Project title Partnership Working in the Professional Development of Nurses:- A Case Study

Researcher's name Maggie Roberts

Lead Supervisor's name Professor Monica McLean

Secondary Supervisor's name Dr Stephen Timmons / Alison Edgley

- I have read the Participant Information Sheet and the nature and purpose of the research project has been explained to me. I understand and agree to take part.

- I understand the purpose of the research project and my involvement in it.

- I understand that I may withdraw from the research project at any stage and that this will not affect my status now or in the future.

- I understand that while information gained during the study may be published, I will not be identified and my personal results will remain confidential.

- I understand that I will be audiotaped during the interview, but that I can refuse to be recorded and to have the interview recorded in handwriting.

- I understand that data will be stored in a locked cupboard in a locked room and password protected computer file, with only the researcher and supervisors having access to it. Personal details will be separated from results by the use of coding and pseudonyms to protect confidentiality. Data will be kept for no longer than seven years after publication of any findings.

- I understand that I may contact the researcher or supervisor if I require further information about the research, and that I may contact the Research Ethics Coordinator of the School of Education, University of Nottingham, if I wish to make a complaint relating to my involvement in the research.

Signed ……(research participant)

Print name …… Date ……

Contact details - Researcher: maggie.roberts@nottingham.ac.uk

Lead Supervisor: monica.mclean@nottingham.ac.uk

Second Supervisor : stephen.timmons@nottingham.ac.uk

School of Education Research Ethics Coordinator: educationresearchethics@nottingham.ac.uk

2.4 Interview Prompts

I would like to thank you for agreeing to be interviewed

Reminder of overall purpose:- to understand their experience – 'walk in your shoes' Information re the aims (information) given:- Yes / No

As a researcher I am trying to gain more distance so - please try to imagine I am someone outside the organisation, a colleague asking you about the course, perhaps Consent obtained to interview:- Yes / No Recording permission received:- Yes / No

Background details – Code Name**:-**

Questions

Part One – Background

1) I would like to begin with a little background in terms of your nursing history and your current role. Please tell me about yourself.

2) What was it about WBL that attracted you?

3) Why did you want to do this particular project?

Part Two – The Project Experience

4) Please tell me about the project itself

5) Please can you list some of the factors that you think influenced the development and progress of the work?

Part Three - Impact

6) How did the work on your project shape or reshape your thinking?

7) What do you think you learnt from the process?

8) Do you think you have changed as a person through this work and if so in what way?

9) Are there any suggestions you would make to future students to help them through this learning process?

10) Is there anything else you would like to add?

If difficult to close interview and participant keen to say more, then interviewer will ask:

Would you be prepared to be interviewed again to develop your ideas further? Yes / No

Participant Thanked Would like to review transcript:- Yes / No

Appendix 2.5 –Example of Reflection

Reflection on Elaine's Comments on her Academic Supervisor

Introductory Question & Answer

- Prompt: "Tell me about your supervisor"
- Elaine: "I knew her, probably more as a friend at that stage, so in that respect, also that relationship was *(pause*)it wasn't awkward, it wasn't. Sometimes when if I needed things and she was busy I got perhaps a bit more frustrated with her than if she had been a colleague it wasn't awkward no."

Discussion

- Prompt: "Was that about expectationsthen?"
- Elaine: "I think maybe, (*pause*) she did give me some tutorial support, but maybe it would have been different if we had not been friends. Seeing how she is with other people, from when we have suepervised together. I possibly might have had more support if we had not been friends."

Reflection

- On **interview technqiue** - I regretted the leadign question, but it did draw out more information and reflection.
- On **education**
- This short exchange made me think about how a sense of personal obligation and loyalty to someone who is a friend could prevent a student from speaking openly and challenging their behavour.
- From a sense of power, supervisor and nurse-participant were on a similarl footing, yet there was a pattern of polite respect and perhaps not always complete honesty that was established and restrained open dialogue.
- It reinforced the thought that historical relationships within the life-world, even friendships do not always guarantee 'ideal speech conditions', but can be constrained by loysalties.
- It made me think - As relationships change individuals can need guidance in how to adjust and it cannott be asumed that existing relationships awill be constructive educationally.
- It emphasised the need for care to be taken in arrangingand preparing supervison arrangments.
- Elaine's non-verbals indicated a shrug (which I interpreted as playing down the importance of the concern) some wriggling which could have indicated some discomfort at the possible disloyalty expressed and finally a little sadness and resignation in the tone and body posture at the end of her final statement.

Appendix 2.6 - Discussion of Coding

This is an example of a discussion with a critical reader over coding of Carol's statements about why she chose to focus on a business management approach in her WBL project

Carol's Statements	Critical Reader Comment	My Comments
"Because *ehm* a lot of what we were doing at the time within theatres was about efficiency and performance and with the (*named course*) that we had all been on, that seemed to fit quite well and linked with my management role, rather than my clinical role."	This reflects a socio-political influence of a business-like management approach to WBL.	I suggested this choice was generated by a need to have a plan ready for WBL, timing was a factor, but politically if she had not already been involved in improving efficiency and had not attended the business course she could not have chosen this topic.
"I didn't speak to the manager about this I just looked at what I thought would be important at the time and felt this would fit with this format." "It was a realisation about how the health service has changed".	This revealed an autonomous decision to adopt this strategic approach.	Carol stressed it was her decision and therefore was not directly told to carry out this work. Yet was already expected to improve efficiency in her department and believed the health service had altered. Therefore she could be said to have agency to a certain extent, but what other choices were there?
"I went back over the work I had done and slotted this work into the WBL. Then I was able to run on with it."	This suggested she aligned the two courses.	Again as she was already doing the work she wanted to bring them together.

Theme: adoption of business-like management style.

Coding definition agreed: adoption of business-like management principle of increasing efficiency.

Cross-referencing link: possible colonisation and question of whether Carol would have adopted this strategy if she had not been doing WBL?

Appendix 2.7 - Example of Analysis - Yvonne's Account