

THE UNIVERSITY OF HULL

Continuing Professional Education: The Experiences and
Perceptions of Nurses Working in Perioperative Patient Care

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by

Susan Louise Tame MSc BSc (Hons) PGCE (FE) RN (Adult)

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ABSTRACT

This thesis presents a holistic description of perioperative nurses' experiences and perceptions of continuing professional education (CPE), from their decisions to study and experiences as students, to the outcomes realised from formal post-registration university courses. Some studies have explored CPE holistically; however these did not include perioperative nurses, whose views may differ from colleagues working in other specialities due to the patriarchal nature of the theatre environment.

A descriptive qualitative approach was adopted and 23 unstructured interviews were conducted with 23 perioperative nurses who had recent experience of CPE. Audio-taped interviews were transcribed fully into the Ethnograph, and the data coded and analysed using both Seidel's (1998) and Dey's (1993) models for data analysis. Four themes emerged: 1) 'Background', including managers' attitudes and cultural discourses 2) 'Going In', relating to motivations and deterrents in accessing CPE 3) 'Process', including participants' experiences as students and 4) 'Going Out', describing the personal, professional and practice outcomes which resulted.

Findings relating to motivations, barriers and outcomes reflected those of previous studies. Local cultures within theatres appeared to promote practical skills above academic qualifications, with managers controlling access to CPE, and horizontal violence experienced by nurses who traversed dominant cultural discourses. Participants perceived the possession of student cards as symbolic of a raised social status. Formal study did not impact directly on practice, however the development of increased

confidence appeared to facilitate participants' collaboration with, and questioning of, medical colleagues and was attributed to indirectly enhancing patient care.

The extent to which participants revealed their CPE lay on a continuum from telling all colleagues they were studying (public study) through to telling no one (secret study). Participants indicated the extent to which CPE was revealed, or kept secret, was crucial, based on the prevailing cultural discourse, their own academic confidence, and potential ramifications should they be unsuccessful. This study is the first to attribute significance to the concept of 'secret study'.

This work contributes to the knowledge relating to CPE: It confirms the transferability of existing literature relating to motivations, barriers and outcomes of formal study to the perioperative setting, and advances knowledge with regard to participants' perceptions of their student status, and the development of inter-professional relationships following CPE. Further research is required to explore the concept of secret study, and to indicate whether the findings are transferable to areas outside of the perioperative setting. The findings are of significance to nurses working in practice, and educators involved in designing and delivering post-registration formal courses to perioperative nurses.

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CONTENTS

CHAPTER I: INTRODUCTION	1
Lifelong learning within society	2
Integration of lifelong learning into the NHS	5
Definitions of CPD and CPE	6
Operationalising CPE within the NHS	9
How I developed an interest in CPE	16
How CPE relates my professional work	16
Overall design and theoretical framework	17
Purpose of this study	19
Contribution to existing knowledge	22
Chapter summary	24
CHAPTER II: LITERATURE REVIEW	26
Search strategy	27
Undertaking CPE: motivations and deterrents	29
The outcomes of continuing professional education	42
The impact of CPE on professional practice	42
The impact of CPE on individuals	60
Methodological issues	67
Chapter summary	72
CHAPTER III: METHOD	76
My location within the study	76

Theoretical framework	78
Data collection	87
How participants were recruited	87
Sample size	88
Gathering the data	89
Data management and analysis	102
Data management	104
Data analysis	109
Ethical considerations	115
Establishing rigour	119
The audit trail	119
Trustworthiness	120
Credibility	120
Dependability	122
Confirmability	124
Transferability	124
Chapter summary	125
CHAPTER IV: OVERVIEW OF THE FINDINGS	127
Characteristics of participants	128
Group 1: Participants in CPE	129
Group 2: Non-participants in CPE	130
Conceptualising perioperative nurses' experiences of CPE	133
Chapter summary	138

CHAPTER V: CPE WITHIN PERIOPERATIVE PRACTICE	140
Cultural issues related to CPE	140
Attitudes towards CPE	144
Managerial attitudes	145
Other nurses' attitudes	149
Medical staff attitudes	153
Operating department practitioner attitudes	157
Discussion relating to CPE	158
The nature of nursing as a profession	162
Socialisation into the profession	166
Horizontal violence	168
Chapter summary	174
CHAPTER VI: NEGOTIATING THE CPE JOURNEY	178
Embarking on CPE	178
Motivation to study	179
Barriers preventing access to CPE	186
Intrinsic barriers	186
Extrinsic barriers	190
Travelling through CPE	193
The importance of support during CPE	194
Support from those at home	195
Support provided by work and work colleagues	196
University as a source of support	198
The student experience	202

The impact of CPE	203
Enjoyment of student status	205
Emerging from CPE	208
Professional and practice related outcomes	210
Working in the perioperative team	216
Personal outcomes	219
The effects of failure	222
Continuing to study	223
Chapter summary	226
CHAPTER VII: THE PHENOMENON OF SECRET STUDY	231
The nature of secret study	232
The prevalence of secret study	234
Participants who undertake secret study	236
The motive to study in secret	236
The culture in which the individual works	238
Support and managerial influences	239
Cultural boundaries	242
Individual characteristics of the perioperative nurse	245
Lack of confidence in academic ability	245
Fear of the consequences of failure	246
Interaction of these factors	248
The practicalities of studying in secret	250
Time management	251
Issues relating to support	254

Outcomes following a period of secret study	256
Chapter summary	260
CHAPTER VIII: DISCUSSION	264
Main findings	266
The influence of culture on experiences of CPE	267
The role of support	271
Student status and experiences as students	276
The influence of CPE on the doctor-nurse relationship	279
The concept of secret study	283
Limitations	287
Implications for perioperative nursing practice and higher education	289
Suggestions for practice	291
Dissemination of findings	293
Personal reflections on work to date	295
Further work	296
CHAPTER IX: REFERENCES	299
APPENDICES	323
Appendix I Initial search strategy	324
Appendix II Second literature search strategy	325
Appendix III Information sheets	327
Participants in CPE	328
Non-participants in CPE	330
Appendix IV Original topic guides	332

	Topic guide 1: Participants in CPE	332
	Topic guide 2: Non-participants in CPE ...	332
Appendix V	Local research ethics committee approval	333
Appendix VI	Consent forms	337
	Consent form 1: Participants in CPE	338
	Consent form 2: Non-participants in CPE	339
Appendix VII	Family tree to level four	340
	Explanation of themes and categories	345
Appendix VIII	Excerpt from transcript	357

ILLUSTRATIONS

Box A: Relationship of CPE and CPD to lifelong learning	8
Box B: Variables affecting behaviour change following CPE	50
Box C: Variables related to behavioural change following CPE	51
Box D: Factors influencing the implementation of skills and knowledge	55
Box E: Johari's window approach to identifying learning needs	58
Box F: Potential effects on nurses following CPE	66
Box G: Seidel's (1998) model of qualitative data analysis	103
Box H: Dey's (1993) steps for analysing qualitative data	103
Box I: Key characteristics of participants in CPE	130
Box J: Organisation of themes into 3 abstract conceptual stages	134
Box K: Model of CPE as described by perioperative nurses (Level 2 codes)	135
Box L: Vignettes illustrating horizontal violence	170
Box M: Motivations for undertaking CPE	180
Box N: Sources of support during CPE	194
Box O: Outcomes derived from CPE	209
Box P: Vignettes illustrating secret study	237
Box Q: Factors influencing the openness with which participants studied	249
Box R: Sources of support available to those who study secretly	254
Box S: Relationship of themes to those of Stanley (2003)	266

Chapter I

INTRODUCTION

In recent years Government and professional bodies have placed increasing emphasis on mandatory continuing professional development (CPD) (NMC, 2008a; DH, 2006a; DH, 2006b; DH, 2004a; DH, 2004b; RCN, 2002; Audit Commission, 2001; DH, 2000a; DH, 1999a), as an integral part of clinical governance (Wilkinson and Davies, 2004; DH, 2000a; DH, 1999a; UKCC, 1999). It is associated with enhancing evidence-based patient care (DH, 2008a; NMC, 2003; RCN, 2002; DH, 2001; Girot, 2001; DH, 2000a), strengthening professional self-regulation and public protection (NMC, 2008a; DH, 2006a; DH, 2006b; Wallace, 1999): That which Chiarella (1990) termed the Cinderella of education has now been given a high priority.

Nurses have always been required to demonstrate their competence (Quinn, 1998), however endorsement of mandatory CPD represents significant cultural change within the National Health Service (NHS), mirroring that occurring in the United States (US) during the 1970s (Houle, 1980). This has been driven by an increasingly litigious society, where people are increasingly aware of their rights (DH, 2000a; HMSO, 1998a), and patients are better informed regarding treatment options, and the successes and failures of the NHS (DH, 2006a; DH, 2006b; The Shipman Inquiry, 2004; Kennedy, 2001; PARN, 2000), and it is envisaged CPD will restore lost public confidence in the NHS (DH, 2006a; DH, 2006b; DH, 2004c; NMC, 2004; The Shipman Inquiry, 2004; Kennedy, 2001; DH, 2000a). Emerging nursing roles identified as essential to NHS modernisation (DH, 2001; DH, 2000a; DH, 1999b), and necessitated due to reductions in junior doctor hours (Council of the European Union, 1998; DH, 2001; DH, 1991),

have also driven the need for CPD. Equally, this has been driven by the integration of lifelong learning into the ethos of healthcare staff development (NMC, 2004; DfES, 2004; DH, 2000a; DfEE, 1998; DfEE, 1997a).

Lifelong Learning within Society

The notion of lifelong learning can be traced back to the early 20th century (Tight, 1998), however it has existed as a concept within education only since the 1970s (Gopee, 2001a), embracing formal, non-formal and informal education (Dave, 1976). An understanding that the ability to learn does not peak at adolescence but develops throughout life (Rogers 1983; Knowles, 1980; Maslow, 1943) has resulted in the advocacy of increased public participation in lifelong learning to enable individual development and fulfilment of potential (NIACE, 2004a). The government (DfEE, 1998; DfEE, 1997a; DfEE, 1997b) believe this will create opportunities, benefiting families, neighbourhoods and the nation, supporting Dave (1976), one of the earlier advocates of lifelong education, who defines this as “a process of accomplishing personal, social and professional development throughout the lifespan of individuals in order to enhance the quality of life of both individuals and their collectives” (p36).

Some authors (Friedman and Phillips, 2002; Knapper and Copley, 2000) state lifelong learning is an intentional and deliberate activity undertaken to fulfil specific goals. However, this is refuted due to the multifarious of sources of learning within life, and the recognition learning occurs on an informal basis subconsciously as people interact (Pratt and Nesbit, 2000; Titmus, 1999). Whilst lifelong learning *may* incorporate conscious deliberate activity, a belief is held that this occurs continuously, at times subconsciously and passively, with individuals constantly re-framing their understanding

and knowledge through their experiences. Within the context of this study, lifelong learning is defined as occurring continuously throughout life irrespective of whether full-time education is undertaken or new information is acquired actively or passively from informal learning opportunities arising from vocational and recreational situations.

Houle (1980) claims there is no definitive lifelong learner, as individuals have their own distinctive styles of lifelong learning influenced by their background, character traits and immediate environment; as personalities and circumstances change, so do attitudes to lifelong learning. Despite this Knapper and Cropley (2000) state lifelong learners;

- 1) Can relate learning to real life
- 2) Perceive the need for lifelong learning
- 3) Are highly motivated to learn
- 4) Possess self-concepts favourable to lifelong learning
- 5) Possess the required study skills for participation

Gopee (2001a) was more explicit and identified lifelong learners can be characterised as innovative, flexible, resourceful, working as change agents, sharing good practice, knowledgeable, adaptable, creative, self-reliant, responsible and accountable.

There is a belief learning should be valued for its own sake not merely equality of opportunity (DfEE, 1997b), and all adults should aspire to self-directed learning to endure the constant changes within life (DfEE, 1997a; Knapper and Cropley, 1991; Knowles, 1980). However, not all people value this concept, or possess the characteristics of lifelong learners (Gopee, 2001a; Knapper and Cropley, 1991) and there are social and cultural implications within lifelong learning (Titmus, 1999). Whilst Tight (1998) states the dominant view of lifelong education is that it is now a part of

one's occupation, this is refuted by Titmus (1999) who argues distinctions made between initial education and adult education, rather than viewing education as occurring continuously throughout life and recognising the importance of learning which is innate and experiential, impede active participation in lifelong learning. Indeed Tight (1998) himself acknowledges that envisaging this as a part of work may be removing the enjoyable element and averting people from engaging in lifelong learning.

Nationally, older people and those in lower socio-economic classes are less likely to engage in learning (NIACE, 2004b) as are those who have negative school experiences, or those who lack confidence or self-esteem (McGivney, 1990). The distance from where the education would take place, reluctance to go out at night, and lack of time also account for non-participation in lifelong learning (McGivney, 1990), and compared to non-participants, adult learners tend to be better educated, white, in full-time employment and have higher incomes (Cafferella and Merriam, 2000).

NAICE (2004a) state attitudes to lifelong learning have changed following government initiatives which assume people wish to learn (DfEE, 1998; DfEE, 1997a; DfEE, 1997b). However, the implementation of such initiatives may not change attitudes towards lifelong learning due to the interaction of social and cultural factors on whether learning is undertaken (Titmus, 1999). Of the employed population, attitudes towards lifelong learning appear to have changed with participation increased from 14% in the 1990s to 20% of full-time and 22% of part-time workers (NIACE, 2004b), with 9 out of 10 people believing education beneficial (Aldridge and Tuckett, 2003). However, within society collectively, despite efforts to widen participation and change attitudes, participation in formal, intentional, learning has fallen from 23% of the population in

1996 to 19% in 2004 (NIACE, 2004b), with 1 in 4 people believing learning is not for them (Aldridge and Tuckett, 2003); the majority of those returning to education excelled at school (Parker, 1998). Thus, little seems to have changed with regard to societal attitudes to lifelong learning, and whilst those involved in lifelong learning state they will continue to learn, only 14% of those not undertaking intentional, formal learning intend to do so in the future (Aldridge and Tuckett, 2003).

Although participation within the employed sector of society has risen, the lack of a lifelong learning culture in society identified in the 1990s (DfEE, 1997a) still persists. If lifelong learning is not embraced within society, this suggests it may not be integrated into NHS culture despite government and professional body recommendations.

Integration of Lifelong Learning into the NHS

Concurrent with lifelong learning strategies (DfEE, 1998; DfEE, 1997a; DfEE, 1997b) were recommendations for this within nursing (DH, 1998), leading to *Post-Registration Education for Practice* (PREP) requirements (NMC, 2008a) and integration of nursing into higher education. The importance of maintaining and improving professional competence began to be recognised late in the 19th century (Houle, 1980), and was first referred to within nursing in *The Briggs Report* (Briggs, 1972). Whilst once enabling nurses to practice throughout their careers, the period over which pre-registration education is current is reducing (Wallace, 1999; Parker, 1998).

The pace of change within healthcare, including advances in research and technology, demographic changes and concomitant changing needs of patients necessitates lifelong learning, in the form of CPD, is integrated into NHS culture (DH, 2004a; DH, 2001; DH, 2000a; Reid, 2000; Wallace, 1999; DH, 1998; Parker, 1998). The aim of this is to

maintain nurses' competence and encourage quality, evidence-based, patient care in accordance with professional guidelines (NMC, 2008a), with parity in the requirements of CPD across the different professional bodies (DH, 2006a; DH, 2006b).

Definitions of CPD and CPE

Despite differences between CPD and continuing professional education (CPE), there is a tendency for these terms to be used synonymously, with CPE the preferred term in the US, and CPD that in the UK. The term CPD was first coined by Gardner (1978) who recognised the importance of experiential learning alongside formal learning for professional development. CPD is described as post-basic education (ENB, 1990) and assigned different purposes; updating existing skills (DH, 2001), improving or maintaining the quality of patient care (RCN, 2002; ENB, 1990), retaining currency with practice (Cervero, 2001) and continued effectiveness (Friedman and Phillips, 2002). Using a range of definitions (Geale, Crockett and Rogerson, 1995; Madden and Mitchell, 1993; Hunt, 1992; Construction Industry Council, 1986; Health Education Board Scotland, undated) and their own research, PARN (2000) link lifelong learning to CPD in a definition applicable across professions;

“CPD is any process or activity of a planned nature that provides added value to the capability of the professional through the increase in knowledge, skills and professional qualities necessary for the execution of professional and technical duties, often termed competence. It is a lifelong tool that benefits the professional, client, employer, professional association and society as a whole, and is particularly relevant during periods of rapid technological and occupational change” (PARN, 2000)

Whilst most early definitions within nursing emphasised the impact of CPD on patient care and the NHS (DH, 1998; ENB 1990; American Nurses Association, 1984; Briggs, 1972), with some notable exceptions (eg Construction Industry Council, 1986; Gardner,

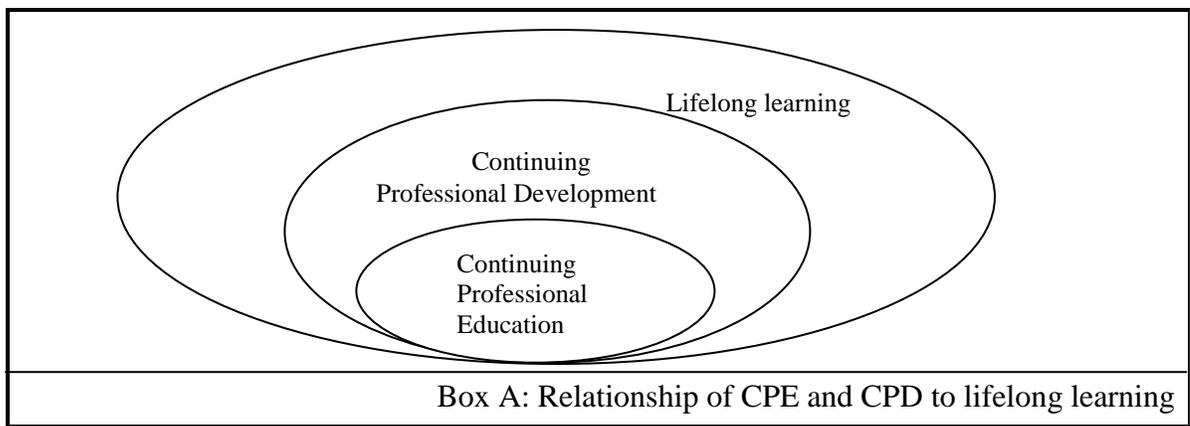
1978), more recently benefits to practitioners have been incorporated (American Nurses Association, 2000). The most commonly accepted definition of CPD within nursing defines this as “the lifelong process of active participation in learning activities that assist in developing and maintaining their continuing competence, enhancing their professional practice, and supporting achievement of their career goals” (American Nurses Association, 2000 p5). As such, CPD encompasses all formal and informal learning within nursing practice, including clinical supervision, in-house learning, professional discussion and reflection with colleagues, mandatory training, and accessing professional literature, and may be undertaken either overtly or covertly.

The term CPE came into general usage in the US in the 1960s when it was recognised informal learning was insufficient to uphold public protection in the face of increasing technologies (Queeney, 2000; Houle, 1980). More recently, Wicker and Strachan (2001) assert clinical expertise cannot be developed in isolation from educational programmes. They state it is not sufficient to learn skills alone, but, as recommended by Houle (1980) to also develop an inquiring mind to challenge accepted practice, which comes from educational programmes or CPE undertaken away from the workplace within academic institutions (Apgar, 2001).

There is an absence of an agreed definition of CPE, although it is viewed as formal education (DeSilets, 2006; Parker, 1998; Jarvis, 1987). Apgar (2001) attributes career maintenance development or enhancement, prevention of professional obsolescence, and broadening of the depth and breadth of information to cope with change and complexity to the function of CPE. It is less prescriptive than pre-registration education, allowing practitioners to pursue identified areas of need (Jarvis, 1987), where necessary enabling

new directions and roles (Knox, 2000; Madden and Mitchell, 1993) or physician substitution (Jordan, 2000), and involves technical or specialist updating of self-directed practitioners (Cervero, 2001; Madden and Mitchell, 1993). This would imply although CPE is planned and structured learning (DeSilets, 2006) it is discontinuous, discrete learning, which is a part of the continuous process of CPD.

Thus differences exist between CPD and CPE, with the former more akin to lifelong learning, embracing all learning whether formal or informal, within or outside the workplace, and CPE to more formal learning, which occurs outside the workplace and is usually associated with gaining academic qualifications. Within this study, CPE is defined as formal learning activities undertaken post-registration, purchased either directly by NHS Trusts or Strategic Health Authorities (SHAs), and which takes place outside the workplace, with the intention of developing both practitioners and their knowledge and skills to maintain or develop professional competence. As such CPE can be conceptualised as a subset of CPD, which also encompasses informal, or experiential, learning that occurs continually within the clinical environment, which in turn is a facet of lifelong learning (Box A).



Whilst Houle (1980) believes neither CPE nor CPD should be regarded as superior as both are essential and complementary in nature, and equally legitimate ways to meet PREP requirements (NMC, 2008a), views of these differ between managers and clinicians (Reid, 2000; Chiarella, 1990). CPD is regarded as more important than CPE by employers (NHSU, 2003; RCN, 2002), perhaps because CPD may be undertaken within the workplace without associated ‘back-fill’ costs (Brown, Belfield and Field, 2002), allowing the continuation of service provision (Scholes and Endacott, 2002). Conversely, CPE is regarded more highly by employees (NATN 2001; UKCC, 1998), due to educational socialisation (Ryan, 2003; Miers, 2002; Maggs, 1998; Eraut, 1994), and the integration of nurse education into higher education institutions.

Operationalising CPE within the NHS

The change required to incorporate lifelong learning into NHS culture has been strengthened by developments for both registered and non-registered staff. Since 2001, as a part of *Working Together, Learning Together* (DH, 2001), SHAs (formerly Workforce Development Confederations (WDCs)) have been central to implementing lifelong learning within the NHS (DH, 2001; Robinson, 2003), commissioning and funding CPE for non-medical healthcare staff. *Skills for Health* was established in 2002 to help improve patient care (Beesley, 2004), and individual learning accounts (ILAs) enable non-registered staff to develop their knowledge and skills, as proposed in the *Learning Age* (DfEE, 1998). In addition, under *Agenda for Change* (DH, 2004b), staff obtained the contractual right to paid time in which to undertake CPE.

Whilst these initiatives demonstrate education is valued, the NHS University which was developed to provide access to education 24 hours a day, 365 days per year (Ion, 2004)

was disbanded in July 2005 (DH, 2007), replaced by the *NHS Institute for Innovation and Improvement* which has no direct educational remit. Thus, although the NHS portrays an image of embracing lifelong education, this may not be sustainable within the current climate, where informal education may be preferred over CPE. Whilst the NHS may not be capable of developing an infrastructure supportive of CPE, from a professional body perspective the need to develop professional competence through CPE and CPD has never been stronger in terms of self-regulation, and maintenance of fitness to practice (DH, 2006a; DH, 2006b).

To uphold its public protection responsibilities, since 1998 the NMC mandates as a requirement of professional self-regulation nurses undertake 35 hours of PREP every 3 years to retain their currency and eligibility for re-registration (NMC, 2008a). At the time of writing, governments were deciding how to implement findings of the Chief Medical Officer (DH, 2006b) and the Foster Review (DH, 2006a), which will affect future regulation of professions, strengthening public protection by ensuring only professionals fit for practice are registered (HMSO, 2007). This will mean changes for the way in which nurses, and other professions, are regulated (Parish, 2007).

Conflict exists between these requirements and government policy, as there is implicit assumption inherent within the *Knowledge and Skills Framework* (DH, 2004a) that staff will not merely remain up-to-date with current practices but continually develop new skills, travelling on the '*Skills Escalator*' (DH, 2004b) with the premise subsequent patient care will be enhanced. However, not all staff wish to develop new skills, preferring to remain up-to-date with current practice (Audit Commission, 2001) and there is no clear correlation between skill acquisition and improved patient care (Ellis

and Nolan, 2005; Cervero, 2001; Jordan, Coleman, Hardy and Hughes, 1999; Barriball, While and Norman, 1992). Indeed, the spatially perceived theory-practice gap, recognised since *The Briggs Report* (Briggs, 1972), is well documented (Gallagher, 2004; Stark, Cooke and Stronach 2000; Hewison and Wildman, 1996) and described as irrefutable (Upton, 1999). Thus, the assumption CPE develops knowledge and skills, retains professional competence and enhances patient care (DH, 2008a; NMC, 2008a; DH, 2006a; DH, 2006b; NMC, 2004; DH, 2001) may not be true: a fact acknowledged by those same bodies advocating CPE (RCN, 2002; Audit Commission, 2001).

With the introduction of *Agenda for Change* (DH, 2004b), an extrinsic form of motivation, the NHS has imposed a mixed benefits and sanctions model for nurses (PARN, 2000; Madden and Mitchell, 1993), where previously only sanctions existed relating to non-compliance with CPD requirements, through ineligibility for re-registration (NMC, 2008a) or removal from the register through incompetence (NMC, 2003). Under *Agenda for Change* (DH, 2004b) if staff demonstrate at their annual appraisal attainments matched against the *Knowledge and Skills Framework* (DH, 2004a) outline for their role and their personal development plan, they benefit from financial reward. However, whilst financial reward can be motivational, some people regard job satisfaction as a greater motivator and rationale for employment (Handy, 1999): In addition, this financial reward is against competencies, that is, what people are capable of doing, which may not correlate with their actions.

Benefits models raise the profile of voluntary CPD and professional standards, and are output orientated, emphasising learning resulting from participation (PARN, 2000). Whilst sanctions models have explicit mandatory requirements for CPD, which are

monitored and offer increased public protection and emphasise the content and process of learning (PARN, 2000), in a benefits model results are implicit, and CPD is a part of the culture, demonstrating commitment to that profession (Wallace, 1999). Although monitoring increases the credibility of CPD, especially when related to public protection (PARN, 2000), there is no evidence this increases motivation or its effects (Hinchliff, 1998). Despite this, many newer professions utilise benefits rather than sanctions models (Madden and Mitchell, 1993), to monitor the CPD of those whom they regulate (PARN, 2000) and these are beginning to be adopted by some older professional bodies.

Whilst CPE can be liberating for practitioners, it benefits the NHS financially as nurses' salaries are lower than doctors'. The success of *The NHS Plan* (DH, 2000a) is dependent upon professional development of staff who perform extended roles (Reid 2000), and imposing such benefits and sanctions may impact on nurses' perceptions of CPE. As such, the increasing drive from Government and professional bodies to undertake education and training to develop skills and further qualifications post-registration may affect nurses' attitudes towards CPE, changing its perceived importance and necessity.

Motivation may be extrinsic, where behaviours are rewarded externally, as described above or intrinsic, where individual behaviour produces satisfaction regardless of external rewards (Wallace, 1999). Theories of motivation can be further divided into process and content theories (Klyczek and Gordon, 1988). From a humanistic perspective, Lawler's process theory relating to motivation states individuals determine their own learning needs (deficits) and solve their own problems based on applicability to real life situations rather than external expectations (Sparling, 2001; Klyczek and Gordon, 1988). O'Kell (1986) asserts truly motivated practitioners learn without

pressures being applied through a desire for knowledge. However this is not always the case, and in relation to continued learning “some professionals catch up, others keep up and some get ahead” (Lowenthal, 1981 p521). Maslow’s (1943) hierarchy of need looks at processes and how behaviour is affected in accordance with both deficit and progression principles; an individual aims to fulfil any needs deficits in order to progress, but only when all former needs have been satisfied.

It is argued current pre-registration education fosters an intrinsic desire to undertake CPE (Ryan, 2003; Maggs, 1998; Houle, 1980), to allow personal growth capitalising on existing knowledge to develop professional competence. However, whilst a perception of nursing as lifelong learning which begins pre-registration and extends into professional careers may encourage recently qualified nurses to study, many nurses qualified prior to the integration of nursing to higher education and this premise. Those taught all that was needed to practice using pedagogical approaches may not find CPD easy to embrace, as they may have been socialised to be passive, not self-directed, learners (Sparling, 2001). Whilst nurses can become lifelong learners even if used to traditional teaching methods, this is a gradual, time-consuming process (Hinchliff, 1998; Fleck and Fyffe, 1997), to which some may not adapt (Scott, 2003). Not being socialised, cultured, and conditioned to lifelong learning can leave nurses feeling daunted (Gopee, 2001a; Platzer, Blake and Ashford, 2000a; Platzer, Blake and Ashford, 2000b), and may contribute to them leaving the NHS (Hewison, 1999). These nurses may hold different perceptions of CPE from those educated using andragogical methods.

Mandatory CPD is contrary to principles of self-directed learning (Hinchliff, 1998; Pearson, 1998; Knowles, 1980; Knowles, 1975) and lifelong learning (Lawton and

Wimpenny, 2003), where adults are self-directed in their learning and learn best when motivation is intrinsic (Hinchliff, 1998) based on perceived need. As Mezirow (1991) believes in his theory of transformative learning this is based on adults reliving their history and identifying needs in a way children cannot, and recognising a need to know. This concurs with the post-modern belief knowledge is deconstructed and reconstructed to build individual discourses and create multiple truths. Thus, enforced CPD may lead to hostility if nurses are required to study in the absence of perceived need. In addition, Furze and Pearcey (1999) assert mandatory CPD may have been introduced to target 'laggards' (Houle, 1980) not those who embrace learning.

Paradoxically, whilst the DH (2001) state nurses are responsible for their own education, as aspired to within society (DfEE, 1998; DfEE, 1997a; Knowles, 1975), this bottom-up approach is not apparent when Government policies adopt top-down approaches to development (DH, 2006a; DH, 2006b; Wilkinson and Davies, 2004) and sanctions exist for non-compliance. Personal development plans aim to allow directed, structured development to benefit individuals, the department, and organisation, where previously this was absent for both professionals and professions (Tobias, 2003; DH, 1999a). Westwood (2001) states professionals do not like being told what to do, which explains why few staff have personal development plans (Berridge, Kelly and Gould, 2007; Audit Commission, 2001) despite the intention for all staff to have these by 2002 (DH, 2000a). Where these exist the quality varies (Berridge et al, 2007; Audit Commission, 2001) questioning their value in practice. Whilst stated to be *personal* development plans, the *Knowledge and Skills Framework* (DH, 2004a) requires staff to develop skills to support their roles, and consequently few personal needs may be incorporated unless they are congruent with those of the department and organisation.

Thus societal changes have impacted on the NHS, and healthcare staff have been catapulted into lifelong learning in the form of mandatory CPD. Views emphasising the importance of individual development and maintenance of knowledge as a part of professional commitment are offset by social, political and economic forces which influence individuals' values and beliefs and which are dynamic, changing over time (Tobias, 2003). Tensions also exist between different stakeholders as to whether the function of CPE is to maintain skills and knowledge and aid public protection, as is the view of the professional bodies (NMC, 2008a), or development of new skills and knowledge to allow modernisation of the NHS (DH, 2000a). These opposing views and the consequent introduction of mandatory lifelong learning within the NHS may have changed nurses' perceptions of CPE. As members of society, nurses will hold individual discourses of CPE, developed from past experiences affecting their perceptions of continued learning within their professional lives.

The researcher is the main tool for data collection in qualitative research (Polit and Beck, 2004; Byrne, 2001; Oakley, 2000; Field and Morse, 1985), and similarly holds temporally and contextually bound truths (Golafshani, 2003; Rosenblatt, 2002; Hughes and Sharrock, 1997). Bracketing of such truths and consequent assumptions is difficult (Polit and Beck, 2004; Denzin and Lincoln, 2003; Horsburgh, 2003; Lincoln and Guba, 1985), and impact on decisions made at each stage of a study (Bird, 2005; Litva and Jacoby, 2002; Rosenblatt, 2002; Warren, 2002; Byrne, 2001; Arksey and Knight, 1999; Rossman and Rallis, 1998). For this reason, whilst the majority of this thesis is written in the third person, the first person is used in reflexive sections, located below and in Chapters III and VIII, to illustrate how underlying assumptions and beliefs may have influenced the study.

How I Developed an Interest in CPE

I developed a critical perspective towards CPE after reading a review by Barriball et al (1992) who identified a lack of robust literature on nurses' perceptions of CPE, and its perceived outcomes. When more recent literature was searched, I found despite increasing importance placed on CPD this situation had not been redressed, and there was a lack of trustworthy, credible and dependable empirical evidence which investigates nurses' post-registration education.

In a superficial literature scoping to determine the need, feasibility and literature base for this study (Streubert and Carpenter, 1995) I located no research exploring perioperative nurses' ideographic emic perceptions of CPE. In a previous review of the literature (Knight, 2004) I identified multifarious barriers to skill implementation within perioperative practice which were dependent upon historically grounded intra- and inter-professional issues. I also believed perioperative nurses' perceptions of CPE may be influenced by the paternalistic and hierarchical nature of perioperative practice (Alvesson, 2002; Carter, 1994), resulting in differences from ward-based colleagues' perceptions of CPE, limiting the transferability of existing studies to this speciality.

How CPE Relates to my Professional Work

As a nurse I adhere to PREP requirements (NMC, 2008a) to retain eligibility for re-registration; as a training advisor within perioperative practice, I have a responsibility for facilitating staff development, and auditing education following staff attendance.

It is recommended education and training specialists are involved in measuring and evaluating the impact of CPE on practice (Audit Commission, 2001; DH, 2000a). The Government currently invests £231 million annually in non-medical CPD for registered

healthcare professionals (Thompson, 2008). As nurses, midwives and health visitors deliver 80% of patient care (Hutton, 2004) it is an appropriate assumption the majority of this money is spent meeting nurses' developmental needs. Despite governmental and professional body requirements for CPD, I believed in an increasingly cost-conscious NHS, there may be a temptation to replace costly external CPE with cheaper internal developmental opportunities if there is no credible evidence to justify its position as part of CPD (Draper and Clark, 2007; Campbell, 2004; Furze and Pearcey, 1999; Calpin-Davis, 1996; Chiarella, 1990), with money reallocated to direct patient care.

Such a move may impact negatively on staff morale (Wicker and Strachan, 2001), which consequently impacts on recruitment and retention (McCormack and Slater, 2002; Montgomery, 2001; Smith and Topping, 2001; Nolan, Owens, Curran and Venables, 2000; Wicker, 1999) and the quality of patient care. Although some are sceptical regarding the link between recruitment and retention and CPE (RCN, 2002; Hewison, 1999), believing mandatory CPE may contribute to professional attrition (Hewison, 1999), this is widely cited as a benefit of CPE (McCormack, 2004; Audit Commission, 2001; DH, 2000a; Nolan et al, 2000; Barriball et al, 1992), through creating work excitement (Wicker and Strachan, 2001), enabling staff to achieve skills and their potential (Beesley, 2004; McCormack, 2004; DH, 2000a). I believe this may be of increased significance in perioperative care where historically recruitment and retention problems exist (Mehigan, 2003; Moore, 2002; Montgomery, 2000; Wicker, 1999).

Overall Design and Theoretical Framework

Epistemologically, the intention to explore and describe the unquantifiable, time and context specific phenomena of perioperative nurses' experiences and perceptions of CPE

is congruent with a qualitative perspective (Punch, 1998; Holloway and Wheeler, 1996; Field and Morse, 1985). This recognises the plurality of meaning of individuals' lived experiences, based on their past interactions, experiences and discussions (Rossman and Rallis, 2003), rather than Truth as a grand narrative. This results in multiple truths which are ideographically experienced, rather than Truth as a grand narrative, and recognises that voluntarism is apparent in human nature. Qualitative research aims to understand phenomena in context-specific settings, extrapolating findings to similar situations (Golafshani, 2003) making this approach appropriate to meet the study goals, and is congruent with underlying personal assumptions.

Specific qualitative approaches which have their assumptions within, for example, philosophy and anthropology were investigated as possible methodologies, but rejected as it was not intended to generate new theories or hypotheses regarding perioperative nurses' experiences as in grounded theory (Glasser and Strauss, 1967; Polit and Beck, 2004); nor was it the aim to become immersed in the culture in order to describe emic views of participants as in ethnographic methodologies (Rossman and Rallis, 1998; Streubert and Carpenter, 1995; Atkinson and Hammersley, 1994). Of the traditional approaches to qualitative research (Silverman, 2005), the philosophies inherent within the Heideggerian interpretative, or hermeneutical, school of phenomenology, which appreciates the enrichment the researcher's experiences affords when intuiting data (Golafshani 2003; Parahoo, 1997) were perhaps most consistent with the overall approach of this study: They were applicable to addressing the research goals, and also with personal assumptions about the plurality of meaning within society, based on previous experiences, and the resultant multiple truths regarding a phenomena rather than Truth as a grand narrative, however, this approach was also rejected.

Sandelowski (2000) explains qualitative research is sufficiently well established to be seen as an approach in itself which does not rely upon a methodology with roots in other disciplines, and methods should be chosen which best address the research goals rather than adhering to one of the more traditional approaches to qualitative research. Thus, instead of utilising an explicitly phenomenological methodology as a theoretical framework a broader interpretive descriptive qualitative approach was adopted. This permitted the use of a pragmatic mix of methods which cut across different approaches to qualitative research to better address the goals of the study. The theoretical framework used is explored in more depth within the methodology chapter.

An underlying assumption made in designing and conducting this study was that gender influences perceptions of CPE, and that perioperative nurses may hold different perceptions from ward based nurses, who participated in existing studies. This assumption arises from the literature which describes perioperative care as patriarchal and hierarchical (Tanner, 2003; Alvesson, 2002; Carter, 1994), and through conducting previous work (Knight, 2004). Whilst this is acknowledged as a supposition, no attempt was made to transcend such beliefs, as a researcher's experiences can enrich data analysis (Etherington, 2004; Golafshani 2003; Parahoo, 1997).

Purpose of this Study

The above discussion describes the NHS in a time of change with regard to CPE as societal changes are reflected in healthcare, with the intention of increasing the quality of patient care. This study intended to address an identified gap in the literature, to create a holistic description of perioperative nurses' emic perceptions and lived

experiences regarding CPE. It was not the intention to describe the effectiveness of different teaching or assessment methods with regard to knowledge development.

The literature reviewed prior to developing this study (Chapter II) identified a paucity of empirical evidence exploring nurses' perceptions of CPE. Most studies investigated isolated aspects of CPE rather than employing holistic approaches to explore the factors influencing the decision to participate in CPE, and its outcomes, creating a fragmented picture of CPE, although there were a few exceptions (Ellis and Nolan, 2005; Stanley, 2003): Few studies included the views of non-participants in CPE. No literature explored CPE within perioperative practice, either directly through questioning perioperative nurses, or indirectly through relating data collected to perioperative care. In addition, the literature is inconclusive as to whether practitioners undertake CPE due to behavioural or existential motivators or both of these. Personal assumptions held prior to, and strengthened through, reviewing the literature are congruent with an existential theory of motivation (Eraut, 1994). That is, the motivation for CPE is not altruistic or related to enhancing patient care (behavioural theory), but primarily to aid an individual nurse's development, although patient care may be affected as an outcome.

It is acknowledged that others' motivations may not be in accordance with this view, and CPE will be subjectively experienced, affected by individuals' personal and professional lives, their past experiences, and future ambitions (Rossman and Rallis, 2003). This creates a plurality of meaning which cannot be captured within an over-arching theory, or proved or disproved through the generation of hypotheses (Oakley, 2000; Streubert, 1995a). Thus, this study was guided by broad goals, due to the emergent nature of themes which arise from the data collected (Holloway and Wheeler, 1996).

These broad goals, derived from the literature and previous work (Knight, 2004; Knight 2003) were to;

- 1) Explore and describe the lived experiences of perioperative nurses who participate in CPE regarding the motivation and deterrents to attending university
- 2) Describe the process of undertaking formal university education from the emic perspectives of perioperative nurses
- 3) Describe the perceived outcomes of formal study and the extent to which these impact on personal and professional development of perioperative nurses
- 4) Describe the perceptions of university study held by perioperative nurses who do not participate in this to explore their reasons for non-attendance
- 5) Relate participant and non-participant perioperative nurses' perceptions and experiences of CPE to the literature to investigate whether distinctions are apparent compared to ward- and community-based nurses

At the time of writing, there was discussion about the possibility of nursing becoming an all-graduate profession, the potential impact of this on recruitment and retention, and whether this would enhance patient care (NMC, 2007). It was not the intention to contribute to this debate, and participants were currently studying, or had studied at, diploma, degree or masters level. Neither was it intended to determine whether degree or higher awards provide better patient care than diploma level study; rather this study explored any post-registration education with regard to the goals set out above.

Wisker (2001) identifies a number of different types or levels of research; using these definitions this study was both descriptive, aiming to capture detail regarding a phenomenon, and explorative asking what happens and why, rather than trying to

explain actions or determine causal links between perioperative nurses and their reasons to undertake CPE or the outcomes of studying. Descriptive and exploratory approaches may be used in conjunction with one another (Wisker, 2001), and are appropriate considering the lack of evidence regarding perioperative nurses' experiences of CPE. They are also congruent with the overall approach and personal beliefs about knowledge development which underpinned this study, as explored further within Chapter III.

Contribution to Existing Knowledge

Some researchers have investigated nurses' perceptions of CPE (Gopee, 2003; Barriball, 2002; Stanley, 2003; Dowswell et al, 1998a; Hogston, 1995); however, recent changes within healthcare, education and society impacting upon CPE may limit the transferability of their findings to the current perceptions of study. The NHS aims to become a learning organisation (DH, 2000a; Reid, 2000; Senge, 1990), where CPD and CPE are equally valued (Robinson, 2003; Senge, 1990). Rather than creating cultural change, as is intended by the government and professional body mandates, change evolves gradually (Handy, 1999), and coupled with uncertainty may lead to feelings of being out of control, anxiety and apprehension (Maggs, 1998). Therefore nurses' views are important as their commitment and desire to benefit from CPE is essential in changing practice (Barriball et al, 1992). In addition, these studies may be not transferable due to perioperative nurses' close inter-professional relationships.

The context and social system in which nurses live and work affects attitudes towards learning and CPE (Ellis and Nolan, 2005; Beatty, 2001; Francke Garssen and Huijer Abu-Saad, 1995; Cervero, 1985): A search of published and unpublished literature located no studies relating to perioperative nurses' perceptions and interpretations of

CPE. Work undertaken previously (Knight, 2004; Knight 2003) indicated issues within perioperative environments not experienced by ward-based colleagues, associated with the paternalistic nature of perioperative care (Alvesson, 2002; Carter, 1994) and close working relationships with traditionally male-dominated disciplines of medicine, anaesthesia and operating department practice, and the different backgrounds and hierarchies of these professions (Hamlin, 2005; Leathard, 1994). It is asserted through CPE nurses gain acknowledgement from other professions (Johnson and Copnall, 2002), and as such nurses, traditionally part of a vocational occupation, are attempting to assert their professional status and gain credibility with male colleagues.

Stein (1978; 1967) described the doctor-nurse game, whereby traditional hierarchies within healthcare resulted in female nurses being subordinate to male medical staff. Although as a result they never openly questioned doctors' authority or decisions, nurses covertly commented on patient care, influencing medical decisions. Both nurses and doctors were aware of this 'game' and complicit in its conduct. Although Stein, Watts and Howell (1990) believe the doctor-nurse game has changed others believe medical dominance is still evident (Tanner, 2003; Mason, 2002; Scholes and Vaughan, 2002). This is apparent within the theatre environment, with the nature and pace of work dictated by surgical and anaesthetic staff (Hamlin, 2005; Carter, 1994) and confusion whether perioperative nurses' roles are dependent or independent of doctors' (McGarvey, Chambers and Boore, 2000). Thus, the inter-relationship between gender, professions and status may be of increased significance within theatres due to inter-professional relationships, which may affect perioperative nurses' perceptions of CPE.

This study is a relevant and original area of investigation, which addresses an identified gap in the literature and contributes to knowledge regarding perioperative nurses' emic perceptions of CPE. The methodology (Chapter III) adopted a holistic approach to exploring nurses' perceptions of such courses, and their effects upon practitioners, the practice setting and on the patient. The findings (Chapters VI to VII), provide insight into perioperative nurses' ideographic perceptions of CPE, the wider implications of which are discussed in Chapter VIII. These are of relevance to professional bodies, policy makers, purchasers of perioperative CPE, managers in perioperative care, and lecturers in higher education designing and delivering post-registration education, as well as perioperative nurses. The findings have direct application to the workplace, and suggestions for practice are made in Chapter VIII, along with further work which could confirm and expand these findings.

Chapter Summary

This chapter has provided the background to this study from a political and professional perspective, and acts to contextualise it as a contemporary piece of work. By providing specific goals, the study is focused on providing perioperative nurses' descriptions as they traverse the journey which is continuing professional education, and relates this to the current literature base.

This study makes a unique contribution to knowledge as the experiences and perceptions of perioperative nurses as they undertake CPE have not previously been explored within the literature. It is envisaged that the findings (Chapters IV to VII), discussion relating to these, and the resulting suggestions for practice (Chapter VIII), will be of relevance to

all stake holders from both practice and academic fields involved in continuing professional education.

The following chapter reviews the literature surrounding CPE for nursing staff in terms of the motivations and barriers to attending CPE, and the outcomes of this for the practitioners involved and the patients for whom the nurses care which was available prior to the commencement of data collection and on which the methodology was based. It also outlines the methodological approaches taken in previous studies and how these influenced the study design, a theme which extends into the methodology chapter.

Chapter II

LITERATURE REVIEW

There is debate within qualitative methodologies as to the timing and role of the literature review. Some researchers advocate a full review of relevant literature prior to data collection, to allow verification of areas for investigation (Freshwater, 2004; Polit and Beck, 2004; Hart, 1998), and enhance interviewing by allowing a more comprehensive, considered approach to data collection based on an understanding of the phenomenon. However, purists argue this belongs to the positivist paradigm; arguing that literature should be reviewed only following data collection (Streubert, 1995b) based on the unfolding nature of the emergent themes to reduce the researcher's preconceptions when interpreting participants' ideographic experiences (Murrell, 1998; Layder, 1993; Field and Morse, 1985). Others advocate superficial literature 'scoping' prior to data collection (Streubert and Carpenter, 1985) to gather an insight, but not in-depth knowledge, about the phenomenon to enhance data collection and analysis (Poland, 2003; Arksey and Knight, 1999; Kvale, 1996).

Closeness to the field of inquiry made 'bracketing' or transcending of *a priori* beliefs and assumptions regarding perioperative nurses' perceptions of continuing professional education (CPE) impossible. Within a descriptive qualitative framework (Chapter III) reflexivity by researchers regarding their location and the impact of this, and their knowledge relating to a topic under investigation can enhance understanding of participants' experiences (Etherington, 2004; Wilberg, 2002; Holloway and Wheeler, 1996), allowing greater trustworthiness in data interpretation. As such, a critical literature review was undertaken prior to data collection to explore previous work in this

area, which focused on the motivations and deterrents for entering education, and its associated outcomes. Whilst the literature identified strategies to aid the effectiveness of CPE, including mentoring schemes (Friedman and Phillips, 2002; Sneddon, 1992), goal attainment scales (Fleck and Fyffe, 1997) and developing cultures which appreciate and recognise the need for formal study (Cervero, 1988), these were outside the scope of this initial literature review. Similarly, studies relating to the effectiveness of teaching and assessment methods (Cervero, 2001; Sparling, 2001; Wolfe, 1999; Waddell, 1992; Waddell, 1991) were also beyond the parameters of this study.

Search Strategy

Search terms and synonyms (Appendix I) were delineated from the research goals, previous work (Knight, 2004; Knight 2003) and reading around the area, getting a ‘feel’ for the literature (Streubert and Carpenter, 1995). This created a search strategy with high sensitivity and low specificity, which allowed many relevant articles to be located (Dempster, 2003), improving the quality of the results (CRD, 2001).

A comprehensive electronic search of databases, journals, and web-sites was conducted from 1998 when *Post-Registration Education for Practice* (PREP) (NMC, 2008a) was instigated to 2006 when data collection began. In addition, pertinent journals were hand-searched, as electronic databases may only find 50% of articles relating to a subject area (Mageray, 2001) due to the use of synonyms and not all articles being indexed. Considering much of the research conducted does not reach publication (Dickson, 1999), this search covered published and unpublished literature, and completed and ongoing studies. An absence of literature relating to perioperative nursing necessitated widening the search to studies including nurses from other specialities.

Additional studies were located using the reference lists of articles, and the web of science (via the web of knowledge – www.wok.mimas.ac.uk) was used to ‘forward search’. In order to remain current, the search terms were used to activate the alert features on the Zetoc (<http://zetoc.mimas.ac.uk>), Regard (www.regard.ac.uk) and National Research Register (www.update-software.com/National) databases, to provide links to relevant articles and research generated following the initial search. Subscription was also made to the JISCMail (NURSE-UK) discussion list and the Professional Associations Research Network (PARN) website (www.parn.org) to remain up-to-date with research in the field.

Magaray (2001) states to avoid bias, foreign language studies should not be ignored, however, whilst the literature was searched without language restrictions only studies written in English were located. This study was culturally grounded both within the perioperative environment and geographically, and whilst studies conducted outside the United Kingdom (UK) were reviewed to gain a better understanding, their transferability to the UK was made with caution due to differences in international perceptions of CPE (Adami and Kiger, 2004; Cervero, 2001).

The literature in this chapter was reviewed prior to data collection and identified significant issues relating to CPE, which have been confirmed by findings published after 2006 (such as Cooley, 2008; Bahn, 2007a; Gould, Drey and Berridge, 2007). The knowledge gained from this literature review provided the basis on which the study was designed and data collected. As expected in qualitative studies (Holloway and Wheeler, 1996), literature is included and reviewed within the findings and discussion, and emergent themes were subject to a literature search, to determine their relationship to

existing literature (Streubert, 1995b). Participants placed importance on aspects of CPE which did not appear as significant in this initial literature review, which necessitated a second literature review. As such, the search terms (Appendix I) represent those used during this initial literature review, with additional terms (Appendix II) used to place the discussion within the context of the literature based on emergent themes.

Undertaking CPE: Motivations and Deterrents

In considering lifelong learning, Knapper and Cropley (1991) state individuals must take the initiative to continue learning to cope with life's demands, but this does not appear to be the perception within nursing, although it occurs in other professions (PARN, 2000). Prior to initiatives to increase lifelong learning in society (DfEE, 1998), Nolan, Grant, Melhuish, and Maguire (1993) reported demand for formal study outstripped supply within nursing. However, nearly a decade later, despite efforts to increase learning within society (DfEE, 1997a; DfEE, 1997b), where there was once insufficient CPE provision a surfeit existed, with one in 5 National Health Service (NHS) Trusts using 75% or less of allocated university places (Audit Commission, 2001).

It is claimed that education transforms lives (Heaney, 2000), and CPE is enjoyable, stimulating, and to be recommended (Sheperd, 1995). However, as previously recognised (Gopee, 2003; Furze and Pearcey, 1999), not all nurses feel this way, and the extent of an individual's desire to learn determines the amount and kind of education undertaken (Gopee, 2003; Houle, 1980). In one of the earliest works investigating CPE across professions, Houle (1980) used the work of Rogers and Shoemaker (1971) to describe 4 categories of practitioners;

- 1) innovators - constantly seek to improve practice, try new ideas, enjoy education, study independently
- 2) pace-setters - not usually first to act, but strongly committed to education and professional ideals
- 3) middle majority - the bulk of practitioners whose attitudes towards education vary from enthusiasm to apathy
- 4) laggards - do the minimum necessary, resisting learning and new ideas

He also identified 'facilitators'; those no longer actively practicing who fall into any of these categories. Rogers (1995) re-classified 'pace-setters' as 'early adopters' and identified two subdivisions within the 'middle majority'; the 'early majority', who adopt new practices once these are widely accepted, and the 'late majority', who eventually adopt new practices, but with scepticism. Whilst individuals move between categories depending on their situation (Houle, 1980), Carpenito (1991) estimated 25%-35% of any profession are laggards, with some actively resisting formal education (Gopee, 2002). Houle (1980) noted speaking of its virtues did not necessarily equate with individuals undertaking CPE, whilst other professionals study without paying this special heed.

In an unpublished PhD study, Gopee (2003) aimed to determine nurses' perceptions of being propelled into lifelong learning. He conducted 26 semi-structured interviews and 2 focus groups with 11 registered nurses, representing all grades, who had all completed at least one module at diploma level. It was not apparent whether participants who were interviewed also took part in focus groups. Participants were recruited from both primary care and acute NHS Trusts, although sampling procedures are not described. Supported by documentary analysis, his findings revealed the motivations and deterrents to lifelong learning related to organisational, personal and socio-political factors,

including funding, attitudes of managers and colleagues, individual motivation levels, and whether nurses had previously studied at university. He also described how nurses perceived mandatory CPD as ineffective, and if forced to study, nurses would pay only lip-service to their development. This study appeared to make an assumption lifelong learning is a positive notion which should be embraced, which may have biased findings. Whilst his thesis makes no indication as to whether saturation was achieved in the 26 interviews, which was a number pre-determined at the start of the study, other studies also suggest that access to university education is influenced by individuals themselves, or the profession and culture in which they are situated.

Stanley (2003) also identified the importance of culture on CPE. Using a phenomenological approach to investigate CPE, she interviewed 9 professionals from 2 cohorts (n=22) of nurses, midwives and health visitors who had recently completed part-time degrees. The emergent themes from *verbatim* transcripts and field notes revealed the motivation to study, and its impact, is a complex web influenced by individuals, their workplace, managers, colleagues and personal tutors. Stanley (2003) describes students as 'travellers' motivated to study through a desire to develop increased confidence, cognitive skills and because this is becoming more common as a primary qualification: 'Guides' within travellers' journeys were family, friends, managers, and tutors who were pivotal to coping with the undulating highs and lows of study and to success.

Rather than the culture, Cafferella and Merriam (2000) found learning was related to experiences and opportunities, and is dependant upon individuals' circumstances, and differences have been identified between volunteers and non-volunteers who access university education. If learning is sought, practitioners view its burdens as light and

rewards as great; if dreaded or viewed with indifference, even in the presence of external encouragement or threats, participation will be grudging and minimal (Houle, 1980).

Houle (1980) described individual motivation can be affected by;

- 1) The settings in which professionals work; their autonomy, responsibility and authority, whether their role is adjunct to other professions
- 2) Career changes
- 3) The quality of formal and informal work life
- 4) The age of the individual

These motivations have been reported in more recent literature (Ellis and Nolan, 2005; Stanley, 2003; Alejandro, 2001; Calpin-Davis, 1996). Gopee (2002) documented that nurses who perceived nursing as a career in which they wished to do the best they could, were more likely to study than those who viewed nursing as a job to provide an income and were not bothered about developing. In addition, nurses who are currently, or have previously been, involved in CPE or other professional advancement are more likely to study, as are those whose immediate family is well-educated and supportive (Ellis and Nolan, 2005; Gopee, 2003; Stanley, 2003; Alejandro, 2001; Beatty, 2001).

In an unpublished study, Wagner (1989) adopted a grounded theory approach and conducted interviews with snowball sample of 23 nurses. Constant comparative analysis found 6 factors affected nurses' CPE; intrapersonal, socialization/development, socialization/professional, enrichments, restraints, and empowerment. Positive attitudes towards learning were attributed to individuals, their parents and family, and Wagner (1989) concluded lifelong learning begins to be valued at school and is strengthened through professional education and socialisation. More recently, Gopee (2003) also

reported the influence of formative and professional education on whether university study will be undertaken.

In contrast, Houle (1980) found little evidence of the effect of schooling on the desire to learn, however he made connections between the length of formal education in youth and adult participation, but whether this was a causal relationship was inconclusive. Paradoxically, extensive education may *reduce* nurses' motivation to study (Francke Garssen and Huijer Abu-Saad, 1995), and those overqualified for their role may have little motivation to study. Other work has demonstrated if experiences of education are negative or create an impression learning is about passing or failing, not professional development, this may also prevent further education (Ryan, 2003; Phillips and Friedman, 2001; Nolan, Owens, Curran and Venables, 2000, Platzer, Blake and Ashford, 2000a; Schuller, 2000; Calpin-Davis, 1996; McGivney, 1990). More recently, Gopee (2003) found nurses are deterred from formal study because as a concept it is new; he also described its 'continuing' nature as daunting, overwhelming some professionals.

Whilst not a barrier in other professions (PARN, undated) age may prevent older nurses accessing CPE (Gopee, 2003; Furze and Pearcey, 1999; Barriball and While, 1996; Francke et al, 1995; Houle, 1980): Nurses educated in the 1950s and 1960s, when streaming was commonplace in schools, may perceive themselves as ineligible to undertake CPE following its integration into higher education institutions (Gopee, 2002). Whilst Gopee (2002) asserts attitudes towards academic and practical skills are changing, and Furze and Pearcey (1999) describe a shift in nurses' attitudes from apathy to favour mandatory study, Hinchliff (1998) questions whether nursing culture values CPE and Miers (2002) describes anti-intellectualism within nursing. Indeed Hardwick

and Jordan (2002) discovered that some nurses do not disclose their academic achievements to peers and colleagues due to predicted negative reactions. The nature of pre-registration education has been shown to be statistically significant in deterring attendance at CPE (Barriball, 2002; Beatty, 2001), and nurses with diplomas or who were second level registered were less likely to participate in higher education than those with degrees or those with first level registration.

The literature identifies nurses study for personal reasons, including increased confidence, having friends and peers who are studying (Gopee, 2003; Gopee, 2002; Schuller, 2000), or when demotivated with their work as it increases motivation, morale and job satisfaction (Barriball, 2002; Dowswell, Hewison and Hinds, 1998a; Barriball, While and Norman, 1992), and improves career prospects (Gopee, 2003; Stanley, 2003; Barriball, 2002; Hardwick and Jordan, 2002; Eraut, 1994; Barriball et al, 1992). Other studies report that nurses study primarily to maintain and develop their competence, knowledge, and skills (Ryan, 2003; Hardwick and Jordan, 2002; Apgar, 2001; Beatty, 2001; Smith and Topping, 2001), with no significant difference in motivation to study between levels of registration or based on shift pattern (Barriball, 2002).

Following a pilot study, Ryan (2003) assumed behavioural reasons motivate staff to attend CPE, and distributed an extensive questionnaire containing Likert scales to assess the influence of extrinsic and intrinsic motivators to a sample of nurses (n=150) and 150 professions allied to medicine (PAMS)(occupational therapists and physiotherapists) from one NHS Trust. Analysis of returned questionnaires (n=182, 60.8%) using SPSS and content analysis, revealed nurses completed the most CPE: Their largest motivation was increased professional knowledge (mean score 4.62), and the least important

additional qualifications (mean score 2.51); intrinsic factors were higher than extrinsic, with no significant differences between professions (Anova $F=0.203$ $df=2$ $p>0.05$). Ryan's (2003) sample represented ranges of ages, years of qualification, part-time and full-time staff, however, she does not state either her selection criteria or the reasons for disparity in numbers. Whilst the Cronbach's α co-efficient test score of 0.7613 demonstrates internal consistency and homogeneity within her questionnaire, she does not explain from where Likert scales were derived, or why these relate only to individual practitioners or the profession, rather than patient care.

Apgar (2001) used qualitative and quantitative methodology to determine reasons which influence trauma nurses uptake of CPE. Her phenomenological study included 27 participants from 1 trauma centre in America and utilised semi-structured telephone interviews with 26 managers and 2 directors, and 3 focus group interviews with 18 nurses. In addition 1675 questionnaires completed by nurses provided quantitative data, although the response rate this represents is not stated. Her results indicated nurses study to enhance their knowledge, skills and abilities which enhance patient care.

Other studies indicate nurses study for both personal and professional reasons (Gopee, 2003; Barriball, 2002; Hardwick and Jordan, 2002; Dowswell et al, 1998a). Hardwick and Jordan (2002) found 86% of the 43 nurses and midwives responding to their questionnaire studied to improve their knowledge, 58% to increase their academic qualifications, 51% to enhance promotion prospects and 40% to gain research skills, suggesting CPE addresses personal and professional development needs. As part of a larger Economic and Social Research Council (ESRC)-funded study, Dowswell et al (1998a) found participation was dependent upon both personal and professional reasons.

Interview transcripts from semi-structured interviews with a convenience sample of 29 nurses, midwives and allied health professionals undertaking part-time degrees, to determine their motivations to participate in CPE revealed many participants studied due to negative feelings about themselves or their professional status, or negative changes to home situations; most faced additional financial burdens. At both professional and personal levels, nurses were ‘pushed’ or ‘pulled’ into study. At the personal level knowledge gaps pushed students to study, and 8 stated the pull of one course led to another, preventing staff going stale, allowing progression and increased confidence. At the professional level pushes related to the job or the profession; those linked to the profession related to improving its status, whilst those related to the job were personal to the individual, and similar to others (Gopee, 2003; Stanley, 2003) participants studied if they were falling behind colleagues academically. Professional ‘pulls’ related to individuals current job situations and future aspirations including promotion, and promotion itself acted as a motive to study for some participants. The professional domain was most frequently mentioned, and pushes were greater than pull motivators.

In addition to beliefs relating to CPE, the literature identifies colleagues’ attitudes towards university education also influence the study undertaken. A negative reaction from senior professionals reframes nurses’ views and reduces their motivation to study (Ellis and Nolan, 2005; Gopee, 2003; Ryan, 2003; Nolan et al, 2000; Nolan, Owens and Nolan, 1995), and causes resentment (Dowswell et al, 1998a). If senior staff are committed to staff development, other grades of staff were also similarly committed (Schuller, 2000). Gopee (2003) also identified nurses were more likely to study if others within the workplace were studying, and described the motivation to learn as “infectious” (p183), with participants continuing to study successive courses.

Some studies report nurses wish to undertake CPE but are prevented by factors beyond their control (Scholes and Endacott; 2003; Barriball, 2002; Furze and Pearcey, 1999; Nolan et al, 1995). Gibson (1998) employed Delphi technique to survey 28 nurses from 2 acute medical and 2 acute surgical wards, representing a range of grades and shift patterns, and a purposive sample of 6 strategists. The 3 rounds of data collection utilised questionnaires with open and closed questions and Likert scales to elicit opinions of formal education, current and future needs. A small pilot study determined the validity and reliability of the questionnaire used in the second and third rounds, which was based on answers received in the first round. The findings revealed nurses wanted to study, but were dissuaded through low pay, lack of time and funding, but most influentially by lack of support and recognition, which was rated as important as the availability of resources for personal development.

Sheperd (1995) took a proportionate sample of 627 nurses selected from 6300 employees, across 5 specialties and 3 health authorities. He conducted 206 interviews, and distributed 421 semi-structured questionnaires to nurse managers and nurses (response rate 64.6%). All 54 nurse managers were interviewed, but how other interviewees were selected was not stated. Despite 79.2% describing CPE as beneficial, 97 participants had not studied in the last twelve months. Reasons included staff shortages (35% of respondents), inadequate notification (34%), family reasons (24%) insufficient study leave (14%), and unequal access for part-time staff (14%).

More recently, Johnson and Copnall (2002) found comparable barriers preventing access to CPE; reduction in hours and loss of salary (90%), course costs (89%), lack of remuneration (70%) inability to retain position held prior to the course (36%), lack of

opportunities for career advancement (25%) travelling to classes (18%), distance from university (14%), family commitments (2%) and course workload (1%). Similar findings were also obtained by Barriball (2002), where work commitments (87%), poor publicity (17%), budget constraints (16%) and lack of managerial support (7%) prevented nurses enrolling on educational programmes. In an extensive survey of NHS staff the Audit Commission (2001) identified that different factors prevailed in different Trusts, indicating local cultures influence the ability to access university education.

In an unpublished American doctoral thesis Beatty (2001) adopted a positivist approach, distributing questionnaires to a random sample of 620 nurses across 7 Pennsylvanian counties designated as 75% rural to determine attitudes towards CPE and reasons for participation. Of the 253 returned (41% response rate) only those relating to practicing nurses (n=199) were retained, of whom 60% had attended 3 or more episodes of CPE within the last 2 years. These indicated rural nurses experienced different challenges from those in urban areas and held different perceptions, with the former having very positive attitudes towards university study. The primary reason for attending was to enable better patient care provision; personal benefit was not described as a motivator. Age, gender, race, place of employment, speciality and family commitments did not deter participation, although family/spouse/partner support was an important influencing factor. Instead lack of financial support, time constraints, distance to the CPE, and inflexible work schedules prevented participation.

The literature suggests a 'high proportion' of staff self-fund CPE (Alejandro, 2001; Audit Commission, 2001; Dowswell et al, 1998a), however as most education is now funded by Strategic Health Authorities (SHAs) this should no longer prohibit study

(Hutton, 2004; DH, 2000a), and significantly fewer nurses are currently self-funding post-registration education (Davey and Robinson, 2002). Whether this funding has increased nurses' motivations to study is not explored within the literature, however, if this was previously a significant barrier (Johnson and Copnall, 2002; Audit Commission, 2001; Beatty, 2001; Sheperd, 1995) the implication is that more nurses would be able to study. However, the introduction of regional funding may have altered this barrier: Where previously staff were unable or unwilling to finance CPE, managers are now unable to finance 'back-fill' making release from work difficult (Gopee, 2003; Scholes and Endacott, 2003; Audit Commission, 2001), especially if short-staffed. This may explain why CPE places remain unfilled (Audit Commission, 2001), and rather than individuals not wishing to study, they are restricted by organisational constraints.

Time constraints (Ryan, 2003; Alejandro, 2001; Nolan et al, 1995; Francke et al, 1995; Ferguson, 1994) and balancing home-life with work and study prevent some nurses from studying (Gopee, 2003; Stanley, 2003; Barriball, 2002; Gopee, 2002; Reid, 2000; Schuller, 2000; Barriball and While, 1996; Sheperd, 1995). Individuals feel pressurized by managers to study but experience most effects at home, not work (Dowswell et al, 1998a), and family and spouses attitudes towards nurses education and development can positively or negatively influence nurses' formal study (Ellis and Nolan, 2005; Gopee, 2003). The impact of study upon home-life is illustrated by Dowswell et al (1998a) who report how 20 participants, unprompted, described changes to their home lives, with changes to their role of parent or spouse which resulted in tensions at home.

Indeed, domestic responsibilities and childcare issues may currently present a larger barrier to university education than funding, with apparent gender distinctions as women

have been identified as more liable to family pressures which discourage CPE (Stanley, 2003; Barriball, 2002; Schuller, 2000). Gopee (2002) described human and social capital is involved in learning; individuals are required to invest in terms of time, mental and financial resources. They are also required to invest in terms of social capital, and family demands, gender differences and insufficient childcare influence uptake of formal study, particularly for single parent families. He went further to state whilst partners can provide social capital through moral support and childcare, if they are not also studying personal relationships can be negatively affected due to widening divergence of interests and feelings of inadequacy, something which Dowswell et al (1998a) also identified. Gopee (2002) states for some nurses, such risks may prevent them from accessing CPE.

As a part of a longitudinal study, Davey and Robinson (2002) distributed 1265 questionnaires to a purposive sample of nurses to determine the effects of having a degree, and reasons for not planning to obtain degrees. These were sent upon qualification and at intervals of 6 and 12 months, 2, 4 and 8 years. Responses (n=620 53%) from the final questionnaire showed 22% possessed degrees, 20% wanted these, and 46% did not want to obtain degrees. Although significantly more men than women were 'degree minded' as only 6% of respondents were male the generalisability of differences ascribed to gendered perceptions of CPE may be limited. 39% of women with children were 'degree minded' compared to 51% of those without, although 72% cited combining work, study and childcare as a barrier. The effects of combining work and study presented barriers to undertaking degrees for 39% of females, however, men most commonly cited lack of direct remuneration (48%) and beliefs it would not enhance their skills (45%). Whilst 25% of nurses not studying thought obtaining study leave and funding would be problematic, of those who were studying 70% had study

leave, and 73% funding, which was significantly different from staff possessing completed degrees ($\chi^2=3.750$ $df=1$ $p<0.05$). This study is limited by the multiple choice questionnaire which may be seen as leading participants' responses.

Despite policy to eliminate discrimination within the NHS (DH, 2000b) the inequality of access to CPE for part-time or permanent night staff compared to full-time or day-shift staff found in early studies (Ferguson, 1994; Barriball et al, 1992) persist (Scott, 2003; Barriball, 2002; Audit Commission, 2001). Nolan et al (2000) found 67% of nurses were perceived as disadvantaged by their part-time status in their national survey and 49% in their managerial survey, which was statistically significant ($\chi^2=82.1$ $p<0.00001$). Lower grades were also statistically significantly disadvantaged ($\chi^2=155.8$ $p<0.00001$) in accessing university courses (53% national survey, 27% managerial survey). In contrast, Barriball (2002) through χ^2 analysis on level of registration showed no significant difference in motivation to study, however participants with first level registrations were more likely to be prevented from studying due to service barriers whilst second level nurses were prevented due to educational demands.

The motivators and deterrents to undertaking CPE appear to be related to individuals and the circumstances in which they currently live and work and previous educational experiences. When adults choose to learn, their motives and what they choose to learn all affect learning as much as mental capacity and capability (Guba, 1990). In addition, from a social constructivist perspective, their position within society and concomitant roles also provides opportunities, or barriers, to accessing university education. That is, there are social, psychological, philosophical and political aspects which influence access to learning, and these also affect the outcomes of CPE.

The Outcomes of Continuing Professional Education

Professional body and government literature, and early definitions of CPE (Peden, Rose and Smith, 1992; Waddell, 1992; Waddell, 1991; Warmuth, 1987; O'Connor, 1979), implied its objective was to improve patient care and enable service development. However, the presence of the theory-practice gap indicates that knowledge is not always implemented (Gallagher, 2004; Hewison and Wildman, 1999; Eraut, Alderton, Boylan and Wraight, 1995), and later definitions of CPE also identify benefits to nurses (American Nurses Association, 2000). Whilst Campbell (2004) states CPD should be patient-centred and purposeful, and Jordan (2000) states public money should be directed solely toward clinical roles, the situation is further complicated by stakeholders holding differing opinions of what constitutes effective CPE (Anon, 2003; Scholes and Endacott, 2002; Jordan, 2000; Ottoson, 2000). As a result, disagreement exists as to whether the outcomes of CPE should be primarily for maintaining and developing professional competence (RCN, 2002; Cervero, 2001; Jordan, 2000; Hogston, 1995) or for the personal benefit which are realised, or a combination of both purposes.

The Impact of CPE on Professional Practice

Many years on from reviews which highlighted the lack of literature on the impact of CPE on practice (Ferguson, 1994; Barriball et al, 1992), despite mandatory PREP requirements (NMC, 2008a) and the integration of lifelong learning principles into NHS policies (DH, 2004b; DH, 2000a), there remains little evidence to support the assumption CPE results in clinically effective patient care (Beesley, 2004; DH, 2004b; NMC, 2003; DH, 1999a; Nolan et al, 1995; Bignall and Crotty, 1988). Although Cervero (2001) supports this behavioural perspective, stating formal study “can and often *does* improve professionals’ performance” (p26), and nurses perceive this

improves patient care (Furze and Pearcey, 1999; Wood, 1998; Warmuth, 1987), successful course completion does not necessarily lead to practice changes (McCormack, 2004; Cervero, 2001; Furze and Pearcey, 1999; Wood, 1998). Few studies conclude that CPE improves patient care (Gopee, 2003; Stanley, 2003; Hicks and Hennessy, 2001; Jordan, Coleman, Hardy and Hughes, 1999; Wildman, Weale, Rodney, and Pritchard, 1999; Jordan and Hughes, 1998; Francke et al, 1995; Hogston, 1995; Sheperd, 1995; Hughes 1990), some that it has no effect (Jordan, 2000; Kruijver, Kerkstra, Francke, Bensing and van de Weil, 2000) or is inconclusive (Adriaansen, van Achterberg and Borm, 2005; Tennant and Field, 2004; Smith and Topping, 2001). Others attribute conditional clauses on the extent to which it impacts on patient care (Ellis and Nolan, 2005; Wolfe, 1999; Francke et al, 1995; Cervero, 1985).

Nurses perceive a statistically significant difference in care provision following CPE ($p < 0.0001$) (Wood, 1998), and 73% of US nurses (Waddell, 1991) and almost 70% of UK nurses perceive patient care is improved following CPE (Sheperd, 1995; Francke et al, 1995). Early studies (Hughes 1990; Bignall and Crotty, 1988) with nurses and managers indicated CPE increases knowledge and improves practice, and Waddell (1992) in a meta-analysis of 34 published and unpublished studies, supported the hypothesis CPE impacts positively on patient care, despite 1/3 of these studies failing to report on the reliability or validity of data collection methods.

Prior to mandatory PREP requirements, Hogston (1995) used a grounded theory approach conducting unstructured interviews with an opportunistic sample of 18 nurses from one NHS Trust. CPE was perceived as fundamental in improving patient care through improving skills, updating knowledge and enabling prioritised and rationalised

practice. However, its impact was dependent upon attitudes of individuals and managers, with a learning environment on the ward enabling implementation of skills. The inclusion of *verbatim* excerpts of transcript increases the credibility, trustworthiness and dependability of his study (Oakley, 2000), however there is no audit trail for decision making, and the length of interviews is not stated. In addition, the speciality and grade of participants, related to autonomy and authority, are not revealed, despite this being influential in determining whether skills are implemented (Cervero, 1985). As such, the credibility and dependability of his findings are reduced (Tarling and Crofts, 2002).

More recently, Jordan et al (1999) took a self-selected sample of 7 community mental health nurses who had completed the same study module, matched with a comparator group of 7 nurses who were similar with regard to experience, caseload and geographical area. They adopted a positivist perspective and used a quasi-experimental design with interviews, observation and questionnaires to test both groups prior to, immediately following and six months after the module. Initial behavioural changes in both groups reverted to pre-CPE level six months following the study. Whilst senior grades felt more able to change practice, junior nurses felt vulnerable, unsupported and isolated, resulting in a negative impact on the service. Behavioural changes fell into the remit of autonomous practice, where managerial influence was least felt, and the skills most likely to be implemented were simple or congruent with existing practice, supporting Furze and Pearcey's (1999) findings.

Using a triangulated methodology within a grounded theory framework, Jordan and Hughes (1998) investigated nurses' perceptions regarding the use of skills learned during physiology modules. A purposive sample of part-time students (n=44) within

one cohort, representing different ages, grades and specialities, kept diaries for six months recording where the course impacted on practice and completed pre- and post-course questionnaires, and a stratified sample (25%) participated in semi-structured interviews. Data analysis through comparison, identification, and coding of themes provided 219 diary citations of where the course had improved practice, categorised into two areas; where enhanced knowledge led to greater insight into patient care, and where nurses questioned, even modified, medical decisions. Most changes occurred where medical input was minimal.

Following a pilot study, Wildman et al (1999) provided a convenience sample of 7 cohorts of nurses volunteering to undertake part-time diplomas (n=169) with a 45-item qualitative and quantitative postal questionnaire. This consisted of open and closed questions and Likert scales on personal and professional development, demographic details and 16 questions on the influence of the course on practice. Ninety-eight of 113 respondents identified practice changes following the course, and manager support was cited as essential to implement new skills. The reliability of this study is reduced due to modifications to the programme over 7 cohorts; 3 undertook integrated programmes, and 4 modular programmes, which may have changed opinions and perceptions. In addition, the value of CPE was stated by the researchers, not the participants and was based on an assumption formal study impacts positively on patient care.

Other studies state no changes or only small changes to practice following formal study. Kruijver et al (2000) selected 14 studies (including 1001 nurses and healthcare workers) comprising 4 randomised control trials, 4 studies with pre- and post-test design and 6 with a single group of pre-test and post-test design and subjected these to narrative

review. They found little or no effects in nurses' skills, practices or patient outcomes following CPE. This review may be subject to selection bias, as no inclusion or exclusion criteria were provided, and only studies written in English were reviewed (CRD, 2001). In addition, the majority were of weak design and their validity was not assessed; thus the results should be treated cautiously. However, Jordan (2000) also found little evidence to suggest formal study enhances patient care, with only 118 out of 2000 papers evaluating its impact on professional practice. She used the results from this and her own work to conclude that although CPE may enhance care this is more likely to be attributable to financial incentives than educational programmes.

Some studies have been inconclusive as to whether CPE impacts on patient care. Smith and Topping (2001) used a mixed methodology of case study, questionnaires and semi-structured interviews with 9 self-selected participants from a purposive sample of 14 nurses who had undertaken a specific course, to assess its impact on patient care. Self-report evaluations were performed during the course induction, at the end of the taught component and at the final review session. Data analysis used descriptive statistics and themed content analysis of transcribed interviews, with objective analysis by a second researcher. Whilst respondents believed their increased knowledge would enhance their practice, the researchers stated it was inconclusive if this would impact on patient care.

Similarly, Adriaansen et al (2005) were unable to conclude university study enhances patient care. They aimed to determine the effects of a post-qualification course in palliative care using a pre-and post-test quasi-experimental design with two well-matched convenience samples of nurses (n=57 registered nurses and n=50 licensed practical nurses), based in 2 localities, who were divided into 2 experimental groups and

2 control groups. Data were collected using two valid and reliable tools developed by the researchers and analysed through analysis of co-variance. Data analysis indicated increased knowledge, insight and self-efficacy, especially with regard to pain and symptom management; however this was not statistically significant compared to the control groups ($p>0.20$). That the researchers developed this course may have led to over-reporting of the success of its outcomes, and there may have been contamination of the control groups as they worked within the same areas as experimental groups. In common with Smith and Topping (2001), Adriaansen et al (2005) appeared to evaluate knowledge development rather than the impact of this on practice.

It is widely acknowledged measuring the impact of CPE is problematic as this defies quantification or objective measurement (Lawton and Wimpenny, 2003; Ryan, 2003; Audit Commission, 2001; Nolan et al, 2000; Furze and Pearcey, 1999; Scheller, 1993), however, some researchers have attempted to develop tools to evaluate its impact on practice. Ryan, Campbell and Brigham (1999) developed an evaluation model to measure variables identified by Cervero (1985) which used 4 instruments they had previously developed at different points prior to and following formal study to assess its different aspects. However, rather than evaluating the effectiveness of the total programme and the impact of CPE, this model focused on process, content and outcome measures. These tools were used by Brunt (2000) in a pilot study with nurses completing the instruments prior to, immediately following, and 3 months following CPE, and indicated this can lead to behavioural change; however Ryan et al (1999) advocate further research to determine the tools' reliability and validity, limiting the credibility of Brunt's (2000) findings.

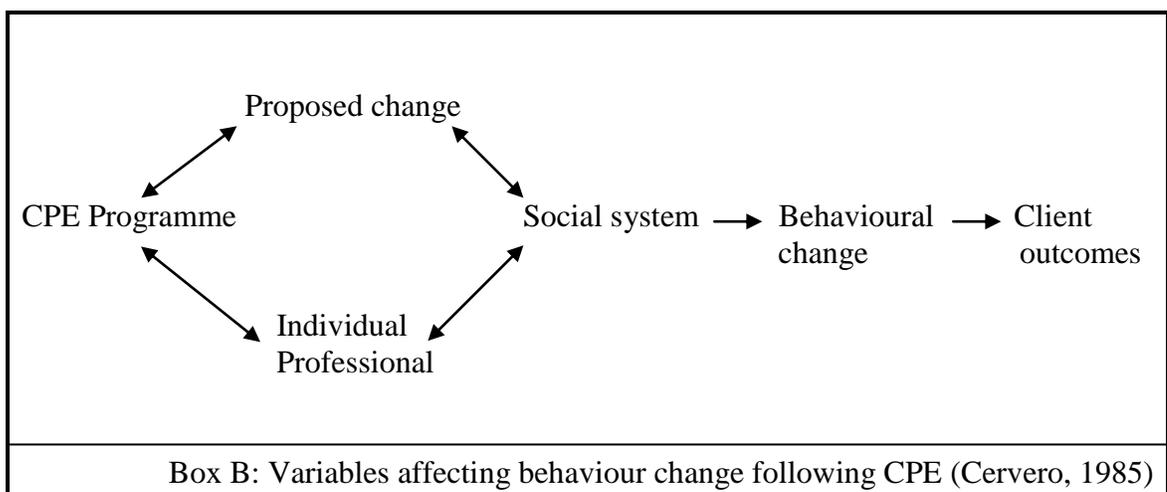
Hicks and Hennessy (2001) adopted a positivist stance, using a psychometrically reliable and valid tool to assess changes practice nurses made to patient care following a two-year course. In this pilot study, participants (n=15), produced self-reports on 30 competency statements before and after the course to assess the impact of CPE on practice, rather than process, content and outcome measures. Data for those completing the course (n=11) indicated some training needs remained, however in all but 7 tasks (6 research and audit, and 1 clinical examination related) skills deficits were reduced. The results were not statistically significant when considering participants' competence (Spearman Test $P=0.0005$), however the McNemar test for significance of changes indicated performance in a number of tasks had reduced training needs, from >1.5 to <1.5 , which was statistically significant ($\chi^2 = 5.14$ d.f.1, $p < 0.025$ one tailed). Whilst data from 6 of the 8 General Practitioners (GPs) in whose practices the nurses worked corroborated nurses' responses, adding to the reliability and validity of the evaluation tool, generalisability is limited due to the sample size and absence of a control group. It can be expected that competence would develop over a two-year period, especially given the increase in total time spent in the job (up to 33% for some participants) during this period, which brings into question the validity of this study.

Tennant and Field (2004) used a before and after quasi-experimental design in their pilot study to develop a tool to assess manager satisfaction with the content and impact on patient care of CPE. A convenience sample of 5 nurses working within one ICU formed the experimental group and 5 nurses not on the course in the same ICU the comparator group. Prior to the course the researchers identified 5 categories of practice based on managers' expectations, ascribing a 5 point rating scale to each, with 0 representing expected behaviour, +1 or +2 for above, and -1 or -2 for below, expected behaviour.

The mean self-assessment score pre-course for the whole cohort (n=18) was 3.2, for the study group 4.4 (n=5) and for the control -8.6 (n=3). Whilst post-course scores are limited by low response (27%), this provided a cohort average of 25.6. Managers rated the study group with an average of 17.4 and the control 15.2 which, as acknowledged, does little to suggest the course significantly improved nurses' skills and knowledge. The study is limited as those in the control group had less than 6 months ICU experience and the experimental group more than 6 months; thus the former will have had steeper learning curves (Benner, 1984), and enthusiasm to learn new skills. Generalisability is also limited by the small sample size and low response rates, the subjectivity of scoring, and location of participants within 1 ICU, with possible contamination of the control group through interaction with the experimental group.

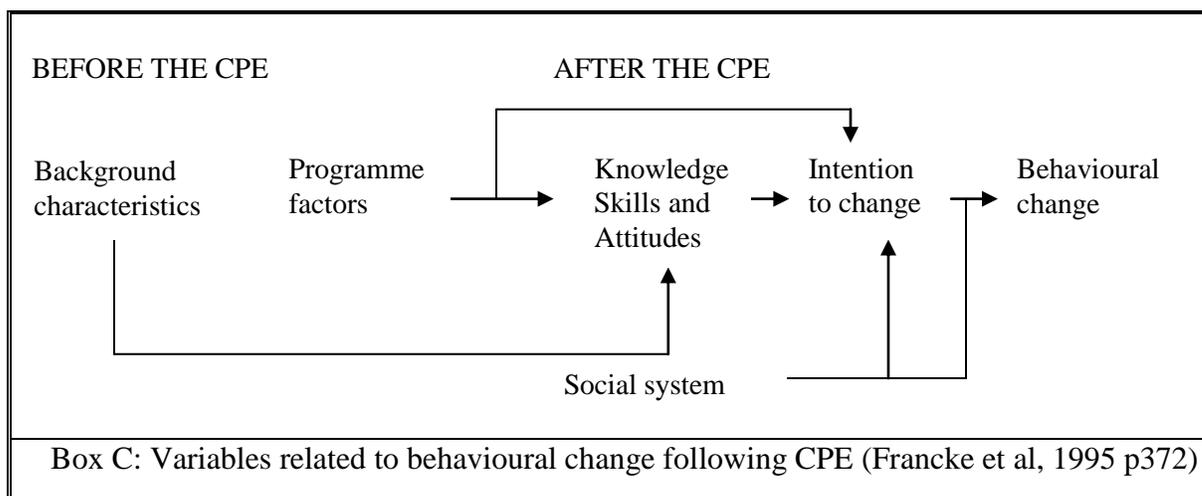
Thus, determining the impact of university courses on practice is not easy due to the multiple variables, intrinsic and extrinsic to nurses, which influence the extent to which new skills and knowledge are implemented. Ottoson (2000) placed learners at the junction of both education and practice, influenced by both of these; how knowledge is understood depends on the nature of these influences and learner characteristics, and some learners may disseminate knowledge without using it in their own practice. Warmuth (1987) describes skill implementation is dependent upon an educational effectiveness triad: motivation of the learner; the educational programme; and the work environment, all of which must be favourable to facilitate change. However, considering educational theory, Kolb's (1984) experiential learning cycle indicates professionals must have blocks on which to build new theory, test these out, reflect and try them again. That is, study must be undertaken at the correct stage in a professional's career to ensure these building blocks are present or learning will not occur.

Similarly, Cervero (1985) identified a number of variables in his “model for research and education” on which the impact of CPE was dependent (Box B). Although practitioner motivation and the identification of a specific need for formal study are described as essential to maximise its impact, these factors interact, and none were ascribed particular significance in determining behavioural change. As found by others (Ryan, 2003; Queeney, 2000; Jordan et al, 1999), skills which are small and congruent with existing practice were more likely to be implemented than those which are large, complex and disrupt current methods of working.



A decade later a more extensive range of factors were attributed to determining behavioural change (Box C), with particular emphasis placed on learner characteristics, a desire to change, and the environment in which individuals work (Francke et al, 1995). It has long been recognised that clinical environments have an atmosphere which may or may not be conducive to learning (Jacka and Lewin, 1987; Orton, 1981), and the values and norms within that environment, and power inequalities, are perpetuated through socialisation (Houle, 1980), creating a culture which accepts or rejects lifelong learning. The importance of social inclusion Francke et al (1995) described correlates with other findings (Ellis and Nolan, 2005; Knight, 2004; Stanley, 2003; Gopee, 2002; Jordan et al,

1999; Hardwick and Jordan, 1999), which also indicate significant factors in determining skill implementation are personal characteristics and the relationships between staff, both within and outside the nursing profession, which can be adversely affected by conflict and low staff morale.



In an American doctoral thesis, Wolfe (1999) adopted an antipositivist perspective, with self-report questionnaires and open-ended questions to elicit opinions from a purposive sample of 45 nurses and 6 managers before, immediately after, and 3 months following a CPE programme. Whilst nurses' specialities are not stated, Wolfe (1999) described a positive perception of behavioural changes, which was conditional upon the autonomy and the nature of the proposed change, empowerment and motivational levels. Paradoxically, and contrary to other studies, nurses continued to feel frustrated and inadequate despite skill implementation. In contrast to studies undertaken in the UK (Ellis and Nolan, 2005; Ellis, 2001; Cervero, 1985) this study did not identify the social system as influential in skill implementation, limiting its transferability to the UK.

Ellis and Nolan (2005) concluded the practice milieu was the most important determinant of change. Using a short course as a case study, operationalised within an

illuminative evaluation model, data was collected through documentary analysis and in-depth semi-structured interviews with educators, students and their managers prior to, immediately afterwards, and at 6 and 12 months following the course, leading to 121 interviews. Data analysis indicated students (n=14) were selected for the course on an *ad hoc* basis, and knew little about it or its impact on themselves or their practice, but felt they should “take what was going” (n=9), and none declined the opportunity to study. Those most enthusiastic before the course described most benefits, including increased knowledge and research appreciation, and being more questioning of practice. Six months on, nurses described a more holistic approach to patient care, with 3 nurses feeling the course had revitalised their work. However, at 12 months only 3 nurses spoke of positive course outcomes, which also included increased self-confidence and desire to undertake more CPE. Interestingly at 6 and 12 months a small number of participants who were initially disenchanted were more enthusiastic. Similar to Cervero (1985) and Francke et al (1995), the researchers conclude multiple factors including the method of selection, staff disposition towards a course and motives for studying, the quality of the education, and the practice milieu all interact to influence perceptions and outcomes of CPE. Although the practice milieu is described as the most significant determinant of change, their data indicates practitioner motivation and managerial support are also important, although perhaps these are interlinked. Whilst the study purports to provide a detailed account of the impact of CPE on professionals and their practice, participant responses were not explored in depth.

Although some studies state formal education increases nurses’ confidence and assertiveness (Stanley, 2003; Nolan et al, 2000; Wood, 1998; Nolan et al, 1995), others state staff *lack* confidence to implement skills (Jordan et al, 1999; Francke et al, 1995).

Professional jealousy exists amongst peers, and managers may perceive more assertive and confident practitioners as threatening following their CPE (Nolan et al, 2000; Jordan and Hughes, 1998), which can lead to resistance to change from medical and nursing colleagues. Instigating change is stressful and requires support (Stanley, 2003), however the literature is replete with examples that the NHS culture is not supportive of staff development and utilisation of new skills, especially if these encroach on others' territory (Scholes and Endacott, 2002), with tension and conflict reported (Jordan and Hughes, 1998). If the risks associated with implementing new skills outweigh the benefits, this will not occur (Scheller, 1993) and similarly, if staff do not receive positive reinforcement, or feel supported by they will be less likely to utilise knowledge (Beatty, 2000; Francke et al, 1995). Thus, as Wood (1998) concluded, new skills and knowledge may be lost in a culture of tradition and resistance to change.

Jordan and Hughes (1998) found senior nurses without academic qualifications felt threatened, despite their authority and expertise. The attitudes of 'old school' nurses were worst, the researchers argue due to 'professional insecurity', with others wanting to learn. Nurses perceived those in higher grades to be threatened by more junior staff who undertake CPE, and it was these staff who presented the largest barrier to implementing new skills, not medical colleagues, as Nolan et al (1995) also described. This is in contrast to Hogston (1995) who reports a metamorphosis within nursing where staff are beginning to appreciate the importance of education. Interestingly, and surprisingly, Jordan (2000) found senior staff were more supportive of changes following CPE if associated with academic outcomes of staff than patient well being. Thus, managers, not medical colleagues, appear to present one of the largest barriers to implementing skills, (Hardwick and Jordan, 2002; Scholes and Endacott, 2002; Nolan et al, 1995).

Hardwick and Jordan (2002) adopted an interpretivist stance to investigate the impact of post-registration degrees on practice, asking questions specifically relating to barriers associated with implementing skills. A short postal questionnaire consisting of open and closed questions was administered to a convenience sample of “highly motivated” (p530) graduates (n=58; 35 bachelors, 23 masters) geographically dispersed across the UK. Data from returned questionnaires (74%, n=30) was analysed descriptively and through content analysis, with *verbatim* transcripts included within the report, aiding credibility and trustworthiness (Guba, 1981). Ten respondents perceived no barriers to skill implementation, 14 felt barriers existed, and 6 were uncertain. Manager attitude was described as crucial to practice change, as nurses felt they had no autonomy. Thirty-eight per cent (n=11) of the sample felt valued and 38% unvalued: Of those who felt unvalued, 2 had been labelled as argumentative or trouble makers when attempting to implement change. They reported colleagues’ negative attitudes and resentment were manifest, and 13 respondents felt their graduate status was resented by managers (8 out of 13) and peers (also 8 out of 13); only 3 felt medical staff resented their graduate status. The credibility and trustworthiness of this study are strengthened by a transparent audit trail (Koch, 1994) however on examination the questionnaire included in the report appears to lead respondents, which may limit the findings presented.

Individual practitioner characteristics are also important in skill implementation (Ryan, 2003; Barriball, 2002; Cervero, 1985). Whilst Francke et al (1995) found younger nurses are more likely to change than older nurses following CPE due to the latter being set in their ways, Waddell (1991) found no relationship between experience, and age and behavioural change in his meta-analysis; no other studies to date have linked age to behavioural change. Instead, the literature identifies that learner commitment to study

and benefit is paramount to learning and implementing knowledge (Audit Commission, 2001; Barriball et al, 1992). Practitioners with little interest in CPE will be unlikely to alter their practice (Ellis and Nolan, 2005; Nolan et al, 2000), and as not all nurses appreciate being propelled into lifelong learning (Gopee, 2003), not all are motivated to develop. If an individual is motivated and volunteers to study, rather than being coerced, and can see its relevance to patient care, this more often leads to improved care (Ellis and Nolan, 2005; Gopee, 2002; Ellis, 2000; Francke et al, 1995; Cervero, 1985), as ‘deep’ rather than ‘surface’ learning occurs (Jordan et al, 1999; Ramsden 1988). Although it is asserted determination can overcome an environment hostile to change if the individual is sufficiently motivated (Williams, 2000), this is refuted by Ellis and Nolan (2005) who believe if the practice environment is not conducive, even the most enthused will become disenchanted, and new skills will not be implemented.

Thus, there are many influences which determine the impact of CPE on practice (Box D), which may be internal to the individual nurse, incorporating their knowledge, skills attitudes, habits and perceptions of work, or external, located in the organisation and context of care provision, available resources and time. Jordan et al (1999) report

Practitioner motivation Managerial/ collegial/ other professions’ support Time and resources, including staff shortages Practice milieu Individual authority, confidence and autonomy Nature, complexity, acceptability of change to individuals and those affected Adequacy of existing practice Applicability of CPE to work practices
BOX D: Factors influencing the implementation of skills and knowledge (Ellis and Nolan, 2005; Gopee, 2003; Ryan 2003; Gopee, 2002; Ellis, 2001; Schuller, 2000; Jordan et al, 1999; Wildman et al, 1999; Jordan and Hughes, 1998; Francke et al, 1995; Nolan et al, 1995)

barriers to skill implementation were encountered by 13 out of 14 interviewees, and others have indicated the most influential factor as to whether knowledge is applied to practice is the practice milieu (Ellis and Nolan, 2005; Stanley, 2003; Gopee, 2002; Beatty, 2001; Schuller, 2000; Hardwick and Jordan, 1999; Jordan et al, 1999).

Whilst no studies could be located which investigate the impact of CPE in perioperative practice, unpublished doctoral work by Tanner (2003) identified theatre nursing practice is greatly affected by professional relationships in this environment. She described the nurse-surgeon relationship was characterised by power and hierarchy, and the nurse-operating department practitioner (ODP) relationship by professional boundaries. In addition, she reported the theatre environment itself affected nurses' relationships and behaviour, which in turn affected patient care. Using her work and the findings reported above, this suggests change may not be easily implemented in perioperative practice.

Whilst new skills and knowledge can only be implemented if they are gained (Eraut, 1994), Warmuth (1987 p4) states "while it is impossible to utilise knowledge that is not possessed, it is quite possible to possess knowledge that is not utilised". Parker (1998) asserted exposure to new learning inevitably leads to knowledge assimilation, however Guba (1990) challenges this, stating knowledge is only created as a result of interaction with others. Schön (1983) and Eraut (1994) describes competence is gained primarily if not exclusively through knowledge application; that learners are not passive recipients of information but active in its creation.

Taking a different approach, Cervero (2001) rationalises the paucity of effective education results from professions being in a state of transition, propagated by government policies encouraging diversity in professional roles and locations for

delivering CPE, leading to a lack of direction. Tobias (2003) similarly described how professionals are developing, or 'travelling', but without compasses to guide them to their destination. This destination may be unknown, or perceived differently by each stakeholder, resulting in an *ad hoc* system of development and education, which may or may not be congruent with the needs of those stakeholders. If development is not tailored to meet the needs of both the individual and the service, then outcomes may have little relevance for the individual's practice or patient care.

Individually tailored learning has more positive effects on personal and professional development (Ellis and Nolan, 2005; Barriball, 2002; Evans, Ali, Singleton, Nolan and Bahrami, 2002; Ellis, 2001; Hinchliff, 1998), especially when individuals have ownership over their development (PARN, 2000). Personal development plans increase the effectiveness of CPE (Evans et al, 2002; Ellis, 2000) through organised, systematic, planning, and enable individuals to focus on their development. However, learning deficits cannot be remedied unless acknowledged (Carpenito, 1991) and whilst Cervero (2001) asserts nurses are able to identify knowledge deficits, professionals are not always cognisant of these (Jordan, 2000). Thus, learning needs may be incorrectly identified (Audit Commission, 2001) or incongruent with organisational or departmental needs (Tobias, 2003). If skills are divorced from either the practitioner's reality or the practice situation, skills will not be implemented (Barriball, 2002; Queeney, 2000; Eraut et al, 1995). To overcome this, Gibson (1998) advocates practitioners and managers utilise a Johari's window approach to determine individuals' needs (Box E).

Following a small pilot study (n=10), Barriball (2002) conducted semi-structured interviews with 217 nurses from a variety of specialities to compare and explore their

		STAFF PERSPECTIVE	
		Aware	Not aware
MANAGER PERSPECTIVE	Aware	Shared needs	Blind needs
	Not aware	Hidden needs	Undiscovered needs

Box E: Johari's window approach to identifying learning needs (Gibson, 1998)

view of all education from in-house study days through to university courses. In addition, the 18 questionnaires returned by non-participants (n=20) allowed comparison between the two groups of nurses. The findings she presents within her unpublished PhD thesis are part of a larger study (n=497) in which she was employed as a research assistant. Each interview lasted 45-60 minutes and all but 31 were audiotaped. Whilst 2 researchers conducted the interviews, which could have led to bias (Polit and Beck, 2004), pre-pilot interviews tested inter-interviewer responses and interview style, limiting this bias. The partial transcriptions made of each interview may have limited the findings through Barriball (2002) placing importance on the data which needed to be transcribed (Polit and Beck, 2004). In terms of outcomes, participants described practice, professional and personal benefits resulted from CPE, including increased knowledge, and self confidence, but were unable to articulate where these had impacted on patient care. She concluded increased effectiveness would be achieved through greater partnership between managers and staff, so learning addresses the needs of both groups and that increased support was required for nurses to implement new skills. She

suggests involving lecturer-practitioners may complement this approach to further increase the effectiveness of learning, but states further research is required in this area.

Work by Ellis (2001) supports Barriball's (2002) conclusions, as she describes how a triangulated approach between managers, employees and education providers may lead to a greater impact of CPE on practice, as education providers have an increased knowledge of the educational opportunities available to meet practitioners' needs. In her unpublished PhD study Ellis (2001) utilises a case study approach operationalised within an illuminative evaluation model. Data were collected from nominees to one course and their managers through documentary analysis and in-depth semi-structured interviews conducted prior to, immediately after and 6 and 12 months after the course. Outcomes of CPE were complex and dependent upon the nature of the selection process, nominees' expectations, the educational experience, and the practice milieu which was particularly influential in determining practice changes. Ellis (2001) states in a cost-conscious NHS, such a tri-partite method of selection is most effective, however from whose perspective is not stated, and the impact on patient care is not addressed by her research. This approach was developed further by Ellis and Nolan (2005) who proposed an idealized system of CPE need and its benefits to professionals, individuals, and practice which is dependent upon pre-course assessment of individuals, the practice area, the proposed course, and appropriate study in terms of content and delivery.

Rather than for immediate use knowledge and skills may be stored until required (Daley, 2001; Alsop, 2000). Daley (2001) adopted an antipositivist approach to determine knowledge acquisition, and how this becomes meaningful. Semi-structured interviews were conducted with a purposive sample of different professions, including 20 nurses, 9

to 24 months following CPE, supported by documentary analysis. The development of a concept map and encoding of data revealed themes which were recognized by participants, and illustrated that knowledge was gained only if of perceived relevance to both patient and practice needs. New knowledge had to be tested with positive results to become meaningful, after which it functioned as a web on which to draw, which was likened to a mosaic by one participant, the pieces of which were obtained from many sources. This study provides a transparent audit trail, increasing its trustworthiness, credibility and dependability (Parahoo, 1997; Koch, 1994). Others have indicated such reserves allow nurses to question medical decisions should the need arise (Jordan and Hughes, 1998) illustrating knowledge application and the effectiveness of the CPE.

Thus, the links between CPE and improvements in professional practice are both inconclusive and tenuous, with disagreement within the literature as to whether attending university post-registration impacts on patient care, and the impact of this on nurses' practices is affected by multifarious variables. It has been proposed to consider CPE effective only to the extent to which patient care improves is too limiting (Nolan et al, 2000; Peden et al, 1992), and some studies describe the benefits to nurses following formal study are equally as important as patient care outcomes.

The Impact of CPE on Individuals

Thirty years ago learning was dominated by behaviourism; that is if behavioural change was not observable following study, the learning was not worth undertaking (Cafferella and Merriam, 2000). Whilst Queeney (2000) maintains this opinion, others believe adult education focuses on self-development including developing critically reflective practitioners as desirable outcomes (Barriball, 2002; Wilson and Hayes, 2000b; Calpin-

Davies, 1996), which is congruent with existential changes to individuals rather than behavioural changes (Eraut, 1994). Although Smith and Topping (2001) describe these as ‘value-added’ benefits, for some these provide the primary motivation for attending formal study (Friedman and Phillips, 2002; Cafferella and Merriam, 2000; Nolan et al, 2000; Nolan et al, 1995), and consequently the effects of CPE may encompass more than changes to practice (Hogston, 1995). This view is supported by Waddell (1992) who found despite only 25% of nurses implementing new skills, 90% of nurses who had studied perceived a positive impact from this, indicating benefits accrued extend beyond behavioural change, benefiting practitioners on a personal level.

Nolan et al (1995) undertook a large-scale study, with intensive and extensive components, utilising qualitative and quantitative methodologies to discover the perceived value and outcomes of CPE for participants. In the intensive component, in-depth semi-structured interviews were conducted with a snowball sample of 50 nurses, nurse educators and managers, of which 46 were tape-recorded; some were conducted face-to-face, some via telephone and some within focus groups of 2-4. The number of each type of interview is not provided, and as such the findings may have been biased, as it is difficult to conduct in-depth interviews via the telephone (Legard, Keegan and Ward, 2003). Postal questionnaires (n=1255) consisting of 109 Likert-type scales and 6 open-ended questions were distributed to a purposive sample of students and a random sample from the United Kingdom Central Council (UKCC) (now Nursing and Midwifery Council (NMC)) register, with a low response rate (48%). Information sources for the construction of this questionnaire, and measures to ensure its validity and reliability are not stated. The qualitative data were analysed by content analysis, and the quantitative and analysis of variance by SPSS. Personal gain from CPE was rated more

highly (8.0) than changes to patient care (7.9); whilst some participants perceived changes to practice, most were concerned with improving career prospects and self-development including increased motivation, assertiveness and confidence.

These results were emulated in a second, larger study, employing the same methodology (Nolan et al, 2000), with 236 purposively selected interviewees (staff who had completed a course (n=100), nurse educators (n=84) and managers (n=52)), focus groups, and questionnaires distributed to a random sample of 1500 nurses drawn from the UKCC (NMC) register and 617 nurse executives from NHS trusts, with 71% (66% usable), and 53% (47% usable) response rates respectively. Both managers and nurses reported changes to nurses, not practice, following CPE. Although supporting their original study (Nolan et al, 1995), these findings may be limited due to insufficient information regarding the qualitative data collected, and the small response rate for the managerial questionnaire (47%). Nolan et al (2000) conclude the outcomes of CPE should be reconceptualised away from the impact on practice and focus on the impact on nurses, including respite from work allowing reflection, and changes to practitioners themselves following CPE, such as increased motivation, self-actualisation, advances and creation of career opportunities, and the desire to pursue additional education. These conclusions, whilst reflecting participants' responses, focus solely on staff who study voluntarily, limiting their transferability to nurses who are reluctant to study.

As a part of a larger study, Johnson and Copnall (2002) investigated nurses' perceptions of the benefits and barriers of undertaking post-registration diplomas. Following a small pilot study (n=10), self-administered questionnaires consisting of open and closed questions, Likert scales, ranking and fixed choice answer questions were distributed to

all nurses (n=885) working in paediatric areas of 10 hospitals across Australia, with a low response rate (44% n=391). Interviews were held with senior nurses from 4 hospitals, and focus groups (n=80) with 4-8 participants were held at major paediatric hospitals with notes made by a research assistant, and a consensus as to the main points. Senior nurses stated post-qualification diplomas demonstrated commitment to paediatrics, with 'several' junior staff believing these made little difference to patient care, and 'some' that it only made a difference if seeking promotion.

The benefits most often cited were the ability to link theory to practice (86%), increased employment opportunities (71%), experience gained during the course (66%), increased self-confidence (64%), gaining tertiary qualifications (62%), increased promotion opportunities (55%), acknowledgement by other professions (46%) and to gain overseas registration (32%). There were no statistically significant differences between course participants and non-participants ($\chi^2=9.21$ 1df $p=0.002$), however, increased employment opportunities were less frequently cited by non-participants ($\chi^2=14.37$ 2df $p=0.001$). The credibility and trustworthiness of data were developed through independent review, but are reduced by not audiotaping interviews and focus groups (Polit and Beck, 2004), with commitment to memory and field notes the basis for interpretation of participants' perceptions. The distribution of questionnaires between rural and urban areas is statistically significant, with 73% from rural areas and 15% from metropolitan hospitals ($\chi^2=91.02$ 4df $p<0.0005$), which is influential in nurses' opinions of CPE (Beatty, 2001), and may have biased the results, although respondents were distributed across years experience and grades. In addition, it is not stated from where fixed choice answers were sourced, which may have led to exclusion of factors deemed important by participants, and biased the results.

CPE may create feelings of empowerment following learning, which enhance self-actualisation (Wagner, 1989). Platzer et al (2000a; 2000b) undertook semi-structured interviews and reflective discussion groups with second year post-registration part-time diploma students (n=30). Field notes from discussion groups and transcribed audiotapes were analysed using an unspecified qualitative software package. Themes emerging from the coded data revealed students perceived themselves as more open-minded, with increased self-confidence and assertiveness following CPE. They felt more able to utilise new skills and challenge the *status quo*, were more understanding to other learners, and had increased autonomy which made them feel less rule-bound and more empowered. They reported this enabled them to challenge others and admit their lack of knowledge, which Eraut (1994) states is essential if patient care is to improve. This study is limited as discussion groups were not audiotaped, reducing its credibility and trustworthiness, as salient points may have been omitted from field notes which would have been detected through becoming immersed in data transcripts.

There is evidence to suggest nurses consider CPE develops not only individuals, but also the profession (Stanley, 2003). Nurses are reported to gain recognition from other professions through CPE (Johnson and Copnall, 2002), have increased professional status equal to that of medical staff (Jordan and Hughes, 1998), and they become more autonomous; however, this increased status and knowledge does not necessarily equate with increased power (Jordan and Hughes, 1998). Even though individuals may feel empowered through education and development, McCormack (2004) asserts CPE does not necessarily create empowered cultures, as these are created by cultural change which maximizes the opportunity to exercise autonomy. Thus, whilst individuals feel empowered through CPE (Barriball, 2002; Platzer et al, 2000a; Platzer, Blake and

Ashford, 2000b; Wagner, 1989), this may not persist on their return to the work environment due to the culture in which they are situated.

Many studies report how CPE increases nurses' confidence (Stanley, 2003; Barriball, 2002; Davey and Robinson, 2002; Hardwick and Jordan, 2002; Johnson and Copnall, 2002; Scholes and Endacott, 2002; Audit Commission, 2001; Dowswell et al, 1998a; Hogston, 1995; Sheperd, 1995), which enables them to be more questioning of practice and challenge medical staff (Barriball, 2002; Hardwick and Jordan, 2002; Platzer et al, 2000a; Platzer et al, 2000b; Wildman et al, 1999; Jordan and Hughes, 1998; Hogston, 1995). Whilst this may be due to enhanced communication skills as a result of new terminology learnt from CPE (Jordan and Hughes, 1998) and greater understanding of medical language, other studies report that increased knowledge, confidence, communication skills and assertiveness do not necessarily equate with practice changes (Ottoson, 2002; Fleck and Fyffe, 1997; Francke et al, 1995; Ferguson, 1994). Despite this, some studies (Davey and Robinson, 2002; Nolan et al, 2000; Hogston, 1995; Nolan et al, 1995) conclude that as a result of this increased confidence patients benefit as a secondary result. Similarly, Wood (1998) in his critique of studies from both positivist and antipositivist domains states that rather than improving patient care directly through skills acquisition, CPE develops practitioner confidence, knowledge, and self awareness, and increases awareness of professional issues, which he concludes enhances patient care. Barriball (2002) describes such growth and development and consequent impact on practice is valued by both managers and nurses.

Ferguson (1994) states CPE allows reflection on nurses' roles, describing the benefits of this as improving career prospects, retention, morale and job satisfaction. Barriball et al

(1992) highlight a paucity of evidence to support the link between CPE and retention; however they conclude insufficient study opportunities may decrease job satisfaction and consequently retention. There is still a dearth of literature exploring this topic (RCN, 2002); Maggs (1998) states the link between recruitment and retention and study is no longer high on NHS Trusts or employer agendas, and argues the link which once existed between these no longer exists. Whilst Barriball (2002) identified CPE increases career prospects, motivation, morale and retention, the literature indicates CPE equips nurses with knowledge and skills to enable them to leave the profession (Nolan et al, 2000). However, this may be very few nurses; Davey and Robinson (2002) found although only 17% of nurses with degrees studied for these in subjects outside of healthcare, 1/3 of nurses with degrees had used these to change to other areas of health care, and 1/3 described these as enabling careers outside of nursing.

Improved/updated knowledge, skills and attitudes

Increased job satisfaction, motivation and morale

Retention within speciality

Career development

Increased confidence and assertiveness

Enhanced communication skills

Increased awareness of research based practice

Increased status

Increased autonomy and reduced dependence upon medical staff

Box F: Potential effects on nurses following CPE (Stanley, 2003; Barriball, 2002; Hardwick and Jordan, 2002; Smith and Topping, 2001; Nolan et al, 2000; Wood, 1998; Nolan et al, 1995; Ferguson, 1994; Barriball et al, 1992)

Thus, the literature suggests many benefits to nurses from CPE (Box F), which may provide the motivation to study, and these may be greater than the benefits to practice following post-registration education. As such, the effects of university courses may be wider than ensuing changes to patient care, and nurses do not necessarily attend for altruistic reasons, as for some the primary objective is personal development.

Methodological issues

A variety of approaches have been employed to investigating CPE, the motivations with which this is undertaken, and its impact on practice and nurses. Some quantitative studies attempt to isolate variables which impact on practice with unsatisfactory results (Adriaanson, van Achterberg and Borm, 2005; Beatty, 2001; Kruijver et al, 2000), perhaps because aspects of nursing are not quantifiable (Dingwall, 1974) and CPE is difficult to measure (Lawton and Wimpenny, 2003; Nolan et al, 2000; Wood 1998; Fleck and Fyffe, 1997). Thus positivist methodologies including triangulation, quasi-experimental and mixed-method studies (Smith and Topping, 2001; Kruijver et al, 2000; Jordan et al, 1999; Nolan et al, 1995) may be inappropriate due to the multifarious variables present in individual lives, leading to multiple truths regarding CPE, and there may not be linear causal relationships as to why skills are not implemented or why some nurses decide to study. Few studies investigate CPE solely from an interpretivist perspective (Ellis and Nolan, 2005; Gopee, 2003; Stanley, 2003; Hogston, 1995; Sheperd, 1995), and although they included *verbatim* quotes, which enrich data, and increase its trustworthiness and credibility (Polit and Beck, 2004), they are subject to methodological weaknesses. Although Gopee (2003) described approaching his work from an interpretivist stance, he appeared to be searching for a grand truth, using triangulation and attempting to validate his findings with a deductive rather than inductive approach, suggesting a positivist perspective on data collection and analysis.

Rather than evaluating process, content, outcomes, and impact evaluations of CPE, most studies focus on process and content evaluations, including the context of CPE, learner satisfaction and knowledge, not on whether practice or practitioners change following CPE, or the extent to which this occurs (Ellis and Nolan, 2005; Ellis, 2001; Hughes,

1990; Bignall and Crotty, 1988), perhaps as these are more easily measured (Houle, 1980). Some studies attempt to address this by interviewing participants 6, 9 or 12 months following the course (Ellis and Nolan, 2005; Davey and Robinson, 2002; Ellis, 2001; Jordan et al, 1999; Jordan and Hughes, 1998, Hughes, 1990; Bignall and Crotty, 1988) which allows the 'feel good' factor to lapse to provide more accurate accounts of CPE (Jordan, 2000). In addition, rather than considering holistic accounts of nurses' experiences, many studies, with few exceptions (Ellis and Nolan, 2005; Stanley, 2003; Hogston, 1995) isolated particular aspects for investigation (Gopee, 2003; Apgar, 2001; Ellis, 2000), creating a fragmented approach to CPE evaluation. No studies were located which elicited solely participants' perceptions of their experiences as students.

Although most studies provide readers with definitions of CPE, none state this was provided to participants. Considering the multiple definitions of this and its synonymous use with CPD, this would have increased the dependability of the studies. Also there was no evidence that participants were asked to reflect upon recent or current study in most cases, although some reports were explicit in this (Ellis and Nolan, 2005; Ellis, 2001; Wolfe, 1999; Wagner, 1989; Bignall and Crotty, 1988). Whilst not preventing reminiscing on past courses, this would have encouraged participants to disclose and explore only current experiences and perceptions of university education, not retrospective accounts relating to previous courses they may have undertaken.

Voluntary attendance may result in larger perceived effects following study than if staff are coerced into attending (Morrison, 2003; Francke et al, 1995; Barriball et al, 1992), however, some studies do not state on what basis participants attended university (Tennent and Field, 2004; Gopee, 2003; Fleck and Fyffe, 1999; Sheperd, 1995). In some

studies participants were self-selected (Smith and Topping, 2001; Jordan et al 1999; Hogston, 1995), and may not be representative of all nurses who study. Few studies included non-participants within their subjects (Johnson and Copnall, 2002; Dowswell et al, 1998a; Berg, 1973), and these held different perceptions of CPE than participants.

The inclusion of questionnaires for scrutiny in some studies (Ryan, 2003; Davey and Robinson, 2002; Hardwick and Jordan, 2002) increases the authenticity, credibility and reliability of the findings. Some studies which utilised questionnaires were limited by low response rates (Johnson and Copnall, 2002; Beatty, 2001; Nolan et al, 2000; Nolan et al, 1995), and it may be respondents differ in characteristics and opinion to non-respondents (Parahoo, 1997), reducing their generalisability.

Although the interview location influences data elicited (Polit and Beck, 2004), Hogston (1995) does not state where interviews took place, and Stanley (2003) conducted these at universities or the nearest institution but does not state how many interviews were conducted in each location: Whilst participants may have assumed a sense of control if interviewed in the workplace, they may have feared being overheard; in university settings, they may have felt out of control. Only one study interviewed participants in their homes (Dowswell et al, 1998a), changing the balance of power and allowing participants to relax, however these interviews were conducted by 2 psychologists and a midwifery lecturer, which may have biased the findings.

The conclusions drawn from practitioners' self-reports (Hicks and Hennessey, 2001; Smith and Topping, 2001; Bignall and Crotty, 1988) may have a limited trustworthiness when the researcher is an academic (Ellis and Nolan, 2005; Gopee, 2003; Hardwick and Jordan, 2002; Johnson and Copnall, 2002; Smith and Topping, 2001; Nolan et al, 2000;

Wildman et al, 1999; Hogston, 1995; Nolan et al, 1995) as they may fear repercussions should they not provide answers they believed researchers wished to hear (Polit and Beck, 2004; Jordan, 2000). This may be exacerbated if the researcher is also involved in assessing participants' academic work as was the case in some studies (Johnson and Copnall, 2002; Smith and Topping, 2001; Jordan et al, 1999; Allan and Cornes, 1998; Jordan and Hughes, 1998), or was their line manager (Smith and Topping, 2001). Including managers, in an attempt to validate participants' comments (Hicks and Hennessey, 2001; Ellis, 2001; Nolan et al, 2000; Nolan et al, 1995; Hughes, 1990 Bignall and Crotty, 1988) and the presence of facilitators in discussion groups (Platzer et al 2000a; Platzer et al, 2000b) may have had similar effects.

Two studies (Nolan et al, 2000; Nolan et al, 1995) utilised the views of managers and also executives; if managers are unaware of the needs of their staff (Audit Commission, 2001), and their inclusion within studies investigating the outcomes of university courses is questioned, then the distance professionally between executives and staff questions the validity of this approach and nurses may provide more accurate accounts of the effects of CPE. Popay, Rogers and Williams (1998) state emic views should be regarded with equal if not higher importance than etic views, as the former live the experience and as such can give a better insight. Due to differences in the definition of effective CPE by different stakeholders, (Campbell, 2004; Scholes and Endacott, 2002), it may be inappropriate to elicit managers opinions.

Jordan (2000) states questionnaires and interviews should be validated by observations to reduce bias. Whilst some studies used observational techniques (Jordan et al, 1999), behaviours alter during observation (Hawthorne effect) (Oakley, 2000), questioning the

validity of this method as nurses may act to support verbal discussions. In addition, the changing emphasis on development of individuals rather than changes to practice makes observation an invalid method of demonstrating the benefits of CPE to nurses. This is not a new idea, with Houle (1980 p305) suggesting it “undignified” to expect learners to demonstrate increased competence or performance following CPE.

Some studies used documentary analysis to support interviews and questionnaires (Ellis and Nolan, 2005; Gopee, 2003; Daley, 2001; Ellis, 2001; Jordan and Hughes, 1998). Whilst this may corroborate staff responses, Scholes and Endacott (2003) state this is more likely to demonstrate efforts to meet assessment outcomes, or as Jordan (2000) states the impact of CPE on completing documentation, which may not indicate or measure changes in patient care or to nurses. The use of diaries (Jordan and Hughes, 1998) can elicit nurses’ perceptions and also could document practice changes, however they are difficult to analyse, especially if participants are ‘free-writing’ (Jordan, 2000) and may be subject to similar biases and fears of repercussions as interviews and questionnaires (Jordan, 2000). The returning of transcripts to participants prior to analysis (Stanley, 2003; Daley, 2001) increases the dependability and credibility of studies (Oakley 2000) when participants recognise these as their own experiences.

Whilst gathering data from multiple sources may strengthen validity (Golafshani, 2003; Ryan, 2003; Jordan, 2000), this and the use of computers within analysis of qualitative data, may lend a pseudo-scientific approach to an epistemologically interpretivist phenomenon with the intention of increasing its scientific rigour (Webb, 1999). Purists in qualitative research believe with explicit audit trails of decision making, as in some studies reviewed (Stanley, 2003; Hardwick and Jordan 2002; Platzer et al, 2000a; Platzer

et al, 2000b) this is as credible and trustworthy as quantitative research (Byrne, 2001; Holloway and Wheeler, 1996).

Thus, the literature is subject to methodological limitations, and studies need to focus only on nurses as participants, utilising in-depth techniques to determine the primary reasons for their study, and the perceived benefits derived from this to either individuals or their practice. These studies should be undertaken in a holistic manner investigating all aspects of nurses' experiences of university education to avoid perpetuating the fragmented picture of CPE which currently exists.

Chapter Summary

Despite the current emphasis of education within nursing practice, including the requirement for mandatory CPD, financial investment in development opportunities, and a wide spread belief better education improves patient care (Lawton and Wimpenny, 2003; RCN, 2002; Maggs, 1998), this area is not heavily researched. There are still few robust, rigorous or conclusive studies which determine nurses' primary motives to attend formal education and the outcomes for nurses or their practice, (Gopee, 2003; Smith and Topping, 2001; Nolan et al, 1995; Cervero, 1985). There is also a notable absence of literature detailing the processes of CPE and experiences of nurses as they pursue post-registration university education, with only 2 studies (Ellis and Nolan, 2005; Stanley, 2003) adopting holistic investigations into all aspects of CPE from nurses' perspectives.

Many studies investigate a particular aspect of CPE, with a particular assumption as to whether this affects behavioural change or change to nurses made from the outset, which has led to the creation of a fragmented picture and a paucity of conclusive evidence linking CPE to professional practice or practitioner development. The majority of

studies assume tangible, behavioural outcomes should be realised following university study (Adriaansen et al, 2005; Kruijver et al, 2005; Tennant and Field, 2004; Ryan, 2003; Daley, 2001; Hicks and Hennessey, 2001; Jordan, 2000; Jordan et al, 1999; Ryan et al, 1999; Wildman et al, 1999; Wolfe, 1999; Jordan and Hughes, 1998; Wood, 1998; Hogston, 1995). However, often studies purporting a positive impact of CPE on practice make tenuous links on how it *may*, rather than how it *does* impact on practice (Smith and Topping, 2001; Wildman et al, 1999; Hogston, 1995). In addition many used data elicited from managers' perceptions of the impact of courses and from a financial, value for money perspective including associated 'back-fill' costs (Brown, Belfield and Field, 2002), rather than exploring nurses' emic views regarding their perceptions of the processes and outcomes of study. Studies including non-participants (Johnson and Copnall, 2002; Dowswell et al, 1998a; Berg, 1973) indicated differences in the perceptions held by this group of nurses compared to colleagues who did study, indicating its importance when considering lifelong learning and developing a culture which values and is supportive of CPE.

A few studies, mainly those conducted more recently (Ellis and Nolan, 2005; Gopee, 2003; Johnson and Copnall, 2002; Hardwick and Jordan, 2002; Ellis, 2001; Smith and Topping, 2001; Nolan et al, 2000; Platzer et al, 2000a; Platzer et al, 2000b; Dowswell et al, 1998a; Francke et al, 1995; Nolan et al, 1995) adopt a more balanced perspective on the effects of CPE: It is now recognised that behavioural changes may not be the consequence of formal study or the motivation to undertake this, and from an existentialist perspective subsequent benefits may be to practitioners themselves, not to practice. This is reflected in the changing definitions of CPE which now incorporate recognition of the benefits of this to practitioners (American Nurses Association, 2000).

Changes following CPE include increased confidence and assertiveness, a perception of equality with other professions and potential for career development. However, there is a tendency for researchers to assume increased confidence and assertiveness translates to better patient care (Davey and Robinsion, 2002; Nolan et al, 2000; Hogston, 1995; Nolan et al, 1995; Houle, 1980), which may be over-simplistic, considering the interaction of the multifarious variables which prevent new skills from being implemented (Cervero, 1988; Francke et al, 1995). If this is the intended outcome for nurses, the literature indicates determination can reduce some barriers to skill implementation, and there is more chance of the CPE having the desired outcome if this is a part of well-planned and structured development, rather than on an *ad hoc* basis (Ellis and Nolan, 2005; Gibson, 1998). Such barriers are related not only to practitioner motivation, but also the autonomy and authority of nurses within the area in which they are employed, and the support received inter- and intra-professionally.

Despite weaknesses within the methodologies of the studies, this literature review pertaining to CPE, its effect on nurses and their practice has provided evidence which is of relevance in informing the direction of this study. No ongoing or completed literature to date, either published or unpublished, could be located which described perioperative nurses' perceptions regarding CPE. Transferability of existing studies to perioperative nurses may be limited due to the influence of gender within this paternalistic environment (McGarvey et al, 2000; Carter, 1994), and the importance of context on perceptions of CPE (Adami and Kiger, 2004). Thus, there is a need to investigate current emic perceptions of perioperative nurses with regard to university education to address an identified gap within existing knowledge. Specifically, as defined in Chapter I, the research goals of this study were to;

- 1) Explore and describe the lived experiences of perioperative nurses who participate in CPE regarding the motivation and deterrents to attending university
- 2) Describe the process of undertaking formal university education
- 3) Describe the perceived outcomes of formal study and the extent to which these impact on personal and professional development
- 4) Describe the perceptions of university study held by perioperative nurses who do not participate in this to explore their reasons for non-attendance
- 5) Relate participant and non-participant perioperative nurses' perceptions and experiences of CPE to the literature to investigate whether distinctions are apparent compared to ward- and community-based nurses

Chapter III

METHODOLOGY

The previous chapter identified that the exploration of nurses' perceptions of continuing professional education (CPE) is fragmented, with only two studies adopting more holistic approaches (Ellis and Nolan, 2005; Stanley, 2003): No studies could be located which included perioperative nurses' experiences and perceptions. Due to gender divides and patriarchal dominance within perioperative care (Alvesson, 2002; McGarvey, Chambers and Boore, 2000; Carter, 1994) it was believed the perceptions held by nurses within this speciality may be different from those of ward and community based colleagues, with whom the existing research had been undertaken.

A descriptive qualitative framework was chosen for this study to allow a comprehensive, holistic exploration of the complex relationships and interactions which surround CPE for perioperative nurses, from the decision to study to the resultant outcomes. The individual truths associated with this depend on past experiences and socialisation into a culture (Golafshani, 2003; Snape and Spencer, 2003; Ward, 2003; Rossman and Rallis, 1998; Holloway and Wheeler, 1996). Researchers also hold such individual truths, and it is necessary to explore these and underlying ontological and epistemological beliefs to allow readers to determine how these may have affected the study.

My location within the Study

I am a Caucasian, female nurse, who has worked within perioperative care since 1999. I am currently employed as a training advisor within the department in which the study was conducted, and involved in facilitating access to university courses. As such, I was

interested in understanding perioperative nurses' experiences of CPE, and was curious to discover the influence of formal study on inter-professional relationships with male-dominated professions; an interest which arose from reviewing literature relating to the barriers associated with implementing practice change following formal study (Knight, 2004). Conduct of this review, along with my work in perioperative care, has led to the acquisition of assumptions which will have influenced this study (Silverman, 2006).

An awareness of our presence within a study can enhance the process and outcomes (Etherington, 2004), however such "intellectual baggage" (Silverman, 2006 p377) relating to assumptions, preferences and prejudices needs to be acknowledged and explored in a reflexive manner (Silverman, 2006; Richards, 2005; Etherington, 2004; Polit and Beck, 2004; Schwandt, 2003; Warren, 2002; Glaser and Strauss, 1967). The intimate nature of data collection and its interpretation within the context of my assumptions and *a priori* beliefs mean the findings will have been affected by my position and perspectives on truth (Silverman, 2006; Etherington, 2004), which will have become entwined with those of participants (Hughes and Sharrock, 1997).

My personal beliefs are congruent with the interpretive research paradigm, and this, along with the research goals, guided the methodology (Byrne, 2001). I believe knowledge and understanding are unique to individuals, with interpretations of events and experiences depending on their observational viewpoint. That is, there is no objective reality waiting to be discovered, but a socially constructed knowledge of reality based on past experiences (Golafshani, 2003; Ward, 2003; Crotty, 1998; Schwandt, 1998; Streubert, 1995b; Lincoln and Guba, 1985), leading to multiple versions of individual truth. Whilst this knowledge is constantly changing in light of

new experiences, interactions, and interpretations (Oakley, 2000; Rossman and Rallis, 1998; Hodge, 1995), I believe that similarities do exist between individuals' worlds, which represent shared meanings. These are not immutable truths, but common to those in similar situations (Lafont, 2005; Rosenblatt, 2002), representing the intersection of reality frames (Natoli, 1997), and to some extent these are generalisable. My beliefs and assumptions are further explored within the following section.

Theoretical Framework

The literature contains much debate regarding qualitative and quantitative paradigms, however, rather than presenting two alternative epistemological views, many texts (such as Silverman, 2006; Polit and Beck, 2004; Parahoo, 1997) compare their differences in what Oakley (2000) terms as paradigm wars. I observed that often qualitative approaches appear to be justified in texts on research methodology only after quantitative approaches have been rejected, whilst quantitative designs are rarely justified. Although Oakley (2000) rationalises this may be due to the more powerful tradition of quantitative approaches, I believe such actions imply qualitative methods are diametrically opposed, and inferior, to quantitative. However, both can be equally valid (Denzin and Lincoln, 2003; Mason, 2002; Oakley, 2000; Arksey and Knight, 1999; Feyerabend, 1975) and robust (Lincoln and Denzin, 2003). Indeed similarities between their philosophical assumptions (Silverman, 2005; Benton and Craib, 2001; Rossman and Rallis, 1998) mean rather than being in opposition, qualitative and quantitative approaches lie along a continuum. Other than to identify the philosophical standpoint of this study, I do not contribute further discussion to the debate regarding superiority in theoretical approaches as this is outside the scope of this study.

The different epistemological positions of qualitative and quantitative approaches make them suited to different forms of inquiry. Quantitative approaches arise from natural sciences and are used to determine causal relationships using the etic views of researchers to interpret participants' experiences (Morse and Field, 1995), whilst qualitative approaches arise from social sciences and are used to explore correlations and focus on participants' emic views (Hughes and Sharrock, 1997). Thus, the choice of paradigm in which to locate a study is dependent upon its purpose (Seale, 2005; Silverman, 2005; Snape and Spencer, 2003; Cohen, Manion and Morrison, 2000; Oakley, 2000; Wimpenny and Gass, 2000; Arksey and Knight, 1999), the constraints of the setting (Morse and Field, 1995), and my own perspectives.

I wished to explore perioperative nurses' experiences and perceptions of CPE, and human experiences are not easily reduced to empirical, objective and rational science (Streubert, 1995b), due to the complexity of human nature, and the elusive, intangible quality of social phenomena (Cohen et al, 2000). Dilthey (1833-1911) believed in order to understand meanings for individuals, it is necessary to grasp the intent of the actors from the inside (cited in Schwandt, 2003), as only those experiencing phenomena can accurately describe these (Cohen et al, 2000; Hughes and Sharrock, 1997); that is to determine emic perspectives. This is more easily achieved through qualitative approaches, which enable researchers to get close to participants (Denzin and Lincoln, 2003). Thus, the study was located within the antipositivist paradigm (Burrell and Morgan, 1979) as this allowed me to appreciate the complex interactions of individual experiences (Polit and Beck, 2004; Golafshani, 2003; Streubert and Carpenter, 1995).

Qualitative research focuses on individuals' lived experiences seeking illumination and understanding (Golafshani, 2003; Snape and Spencer, 2003; Oakley, 2000; Rossman and Rallis, 1998; Schwandt, 1998; Hoepfl, 1997; Morse and Field, 1995; Holloway and Wheeler, 1996; Streubert and Carpenter, 1995; Field and Morse, 1985), and is related to discovery, rather than verification of facts (Oakley, 2000), with truth relative to the context and not absolute (Litva and Jacoby, 2002; Holloway and Wheeler, 1996). Whilst some authors purport qualitative inquiry is purely inductive (Litva and Jacoby, 2002; Morse and Field, 1996; Lincoln and Guba, 1985; Glaser and Strauss, 1967), with all description grounded in participants' experiences, others argue that such purity is not possible (Rossman and Rallis, 1998; Parahoo, 1997; Morse and Field, 1995). Qualitative research is rarely purely inductive due to the researcher's assumptions (Parahoo, 1997); as the study nears completion, it becomes more deductive, aiming to confirm data already collected (Morse and Field, 1995). Thus, I believe due to deductive reasoning pure induction is impossible, as whilst ideas are needed to analyse data, these ideas come from the data itself (Seidel, 1998a; Dey, 1993).

Ontologically, reality depends on how confident we can be about our knowledge of the existence of things (Benton and Craib, 2001), and whether these exist independently of human cognition (Baille, 2003; Rossman and Rallis, 1998; Burrell and Morgan, 1979). It was once considered humans had no shared sense of behaviour and thought, and an extreme perspective of the interpretative paradigm refutes a shared social reality (Hughes and Sharrock, 1997), and acknowledges multiple context-specific social realities experienced by individuals. However, during the 18th century it began to be realised despite individual uniqueness, shared realities do exist, developed through socialisation, individuals' ideographic experiences and voluntarism (Golafshani, 2003;

Holstein and Gubrium, 2003; Snape and Spencer, 2003; Cohen et al, 2000). It is through these shared realities and understandings that all human action and interactions are possible, and meaning is attached to these, which leads to predictable behaviour (Hughes and Sharrock, 1997). Indeed, Descartes and Bacon stated human knowledge is developed from an empirical basis and sensory experiences, and is positivistic in nature, and through recognition of patterns things become true by definition (Benton and Craib, 2001). Dilthey (1833-1911) believed creativity constituted the essence of all social forms, and history and society are human creations, and all human action is meaningful to its actor. Comte, in the 19th century, claimed human knowledge is derived not from thought alone but from empirical evidence, and human social life is a meeting of forces interacting, which produces a particular sequence of behaviour, and it was these I was attempting to document in my work.

I adopted a constructivist view of knowledge, where memory, emotion, understanding and perception are perceived as human constructs (Arksey and Knight, 1999). However, whilst knowledge is socially constructed and changes over time (Watson, 2006; Holstein and Gubrium, 2004; Golafshani, 2003; Schwandt, 1998) rather than being discovered (Schwandt, 1998), a degree of realism generates collectively shared norms, beliefs and reality (Lafont, 2005; Rosenblatt, 2002). Oakley (2000) asserts individuals live their lives as though reality exists (ontologically), and in defining an event or experience as real, this will be real in consequence, with people acting accordingly.

Although the qualitative paradigm respects voluntarism, and autonomy (Burrell and Morgan, 1979) with actions based on assumptions and past experiences (Warr, 2005), Hughes and Sharrock (1997) believe it is difficult to determine whether human action is deterministic or subject to voluntarism. Rossman and Rallis (1998) argue people do not

act in predictable ways and are free-willed, however, I believe all behaviour has a motivated character and is related to a causal mechanism that produces certain actions (Hughes and Sharrock, 1997). As such, whilst rules do not cause behaviour they may be its antecedent (Hughes and Sharrock, 1997), and Weber (1949) believed all phenomena are products of antecedent causally related conditions, and hence human nature is deterministic. He did not believe all social acts could be reduced to single all-embracing laws, but from the complex whole of social reality, limited and unique antecedents and consequences are abstracted and related to observed phenomena. Such 'adequate causation' (Hughes and Sharrock, 1997) provides probabilistic explanations, where causes may lead to actions, but may not be universally true.

Thus, I believe that human action can be explained by dispositional factors including attitudes, motives, feelings, beliefs and preferences, and sanctioned expectations to which individuals are subject, experienced as role expectations and learnt through socialisation. Hughes and Sharrock (1997) also believe some factors are imposed on individuals, and will be shared between those occupying the same occupational role. Whilst this could lead to a belief human nature is deterministic, the internalisation of belief systems comes from the construction of individual reality (Streubert, 1995a), and people who experience a situation may interpret it differently (Lafont, 2005; Golafshani, 2003; Schwandt, 2003; Denzin and Lincoln, 1998; Streubert, 1995a). In addition, there may be both private, individually held, thoughts and consequent behaviours relating to a phenomenon, and public thoughts and actions governed by socially constructed norms and values (Watson, 2006; Warr, 2005). This can create a multitude of truths where public actions are not necessarily convergent with private truths, but where individuals conform to expected social and cultural norms.

I believe people are free to act and purposive creators of a world which has meaning for them, and through interaction give meaning to their own and others' behaviours which leads to individual reality (Hughes and Sharrock, 1997; Schutz, 1963). However Durkheim stated some behaviours are predictable, as society is really there, facts people describe are real, and socialisation within a culture or society leads to a certain degree of predictability, due to socially agreed and permissible actions (Hughes and Sharrock, 1997; Burrell and Morgan, 1989). Similarly, I believe absolute freewill is illusive, as individuals' actions are constrained and influenced by rule-governed behaviour professionally and socially, as explored above, and by moral and political values meaning publicly acceptable actions may not always concur with privately held beliefs. I wished to describe not only public actions and beliefs, but also those truths which were more private to individuals, and to reflect this resultant plurality of meaning.

Rather than adopting one traditional qualitative approach of phenomenology, grounded theory or ethnography (Silverman, 2005), I used a pragmatic mix of these to better address the research goals (Fontana 2002). Initially, I intended to follow a purely phenomenological approach, utilising Heideggerian methods where a researcher's preconceptions are not 'bracketed' or transcended as required with Husserlian approaches (Parahoo, 1997). This would have suited the study goals and my beliefs, resulting in a description and interpretation of perioperative nurses' lived experiences of CPE enriched by my *a priori* beliefs, providing an alternative perspective. However, "any one qualitative approach can have the look, sound or feel of other approaches" (Sandelowski, 2000 p 337) and as a perioperative nurse, working towards a doctorate, conducting research in the department in which I am employed, to some extent this study was ethnographic, as I was immersed in the culture studied (Polit and Beck, 2004;

Rossmann and Rallis, 1998; Streubert and Carpenter, 1995; Atkinson and Hammersley, 1994). Similarly, whilst I rejected a purely grounded theory approach, as I did not intend to generate over-arching theory (Polit and Beck, 2004), the absence of previous literature made grounded theory appropriate for the initial inductive data analysis (Denzin and Lincoln, 1998; Strauss and Corbin, 1998; Glaser and Strauss, 1967).

Although Tobin and Begley (2004) argue qualitative inquiry is an emerging field, Silverman (2005) believes it is sufficiently established to break from the traditional philosophical, anthropological and psychological approaches initially used to reinforce its credibility. Baker, Wuest, and Stern (1992) argue there should be purity in methodological approach in qualitative work, however others argue for more pragmatic, pluralistic, approaches (Silverman, 2005; Johnson, Long and White, 2001; Sandelowski, 2000; Wimpenny and Gass, 2000). Whilst Baker et al (1992) describe 'method slurring' may compromise rigour, these advocates of more pragmatic approaches believe they are no less rigorous than an assumption of rigour purely by stating a traditional theoretical approach without further explanation. Johnson et al (2001) argue purity within methods is rare, even where this is stated by researchers, and to adopt multiple methods, or 'British pluralism' provides flexibility and rigour to research.

Reflexive approaches, acknowledging a researcher's positions and assumptions and why decisions have been made, retain flexibility which can strengthen qualitative work, and increase its dependability (Etherinton, 2004; Johnson et al, 2001; Lincoln and Guba, 1985). Indeed, reflexivity strengthens the case for a lack of purity, even within traditional approaches to qualitative research, as it shows no method is initially perfect, even within more established approaches (Johnson et al, 2001). This in turn supports

using more than one approach, as no method is pure (Johnson et al, 2001; Sandelowski, 2000). Thus, rather than constricting my research within one theoretical framework, I felt it was appropriate to adopt a reflexive, descriptive approach utilising a pragmatic mix of methods (Silverman, 2005; Johnson et al, 2001; Wimpenny and Gass, 2000), which reflected the study's underlying ontological and epistemological basis (Wimpenny and Gass, 2000).

My reflexive, descriptive approach is acceptable in a postmodern era, where boundaries exist to be crossed and violated rather than respected (Annells, 2006; Butler and Ford, 2003). Lyotard (1984) recognised changing circumstances no longer enabled people to believe their history was meaningful or had purpose, direction or coherence, leading to incredulity with grand narratives. That is no meta-narratives transcend all social, institutional and human situations and the notion of positivistically-derived grand overarching theory is no longer accepted, with individual explanations and experiences of life (Fontana, 2002; Hughes and Sharrock, 1997; Streubert, 1995b). Postmodernism thus respects multiple truths (Polit and Beck, 2004; Golafshani, 2003; Streubert, 1995a; Lyotard, 1984), and views reality as a social construction, subjectively created and dependent upon the time, place and context in which events occur, and based on past social, cultural and familial influences (Lafont, 2005; Etherington, 2004; Denzin and Lincoln, 2003; Ward, 2003; Natoli, 1997; Holloway and Wheeler, 1996).

If all human understanding is contextual, Lafont (2005) asserts an absolute objective truth may be illusory. However, whilst postmodernism recognises the absence of an ultimate foundation for knowledge (Ashenden, 1997) it does not necessarily deny the existence of one reality (Natoli, 1997), just that individuals have different perspectives

on Truth (Benton and Craib, 2001). The resulting truths are incomplete, partial, provisional and provincial (Etherington, 2004; Ward, 2003; Natoli, 1997), and individuals continually deconstruct and recontextualise their discourses to include or reject new information: This means there is no absolute Truth only endless revision of what is known in light of new information (Hughes and Sharrock, 1997).

There is no way of knowing whether we have gained access to absolute Truth (Rolfe, 2001; Hughes and Sharrock, 1997) as all accounts are equally as likely to be Truth and should be regarded as equal (Rolfe, 2001; Natoli, 1997). Listening to many participants telling similar stories does not prove an immutable truth, but commonalities within an experience (Lafont, 2005; Rosenblatt, 2002), as reality is dynamic and its interpretation is always partial, and individual versions of truth belong to different versions of reality (Etherington, 2004; Natoli, 1997). I thus acted as “bricoleur” (Denzin and Lincoln, 2003 p5) piecing together information from different participants to build a picture of reality which illuminates multiple perspectives of individual interpretations of formal study.

I intended to describe perioperative nurses’ subjective perceptions and experiences of CPE using a pragmatic descriptive qualitative approach (Silverman, 2005; Sandeloswski, 2000). In accordance with postmodernism, this allowed me to respect the existence of individual reality and the multiple discourses held regarding formal study, and in interpreting the the data, all participants’ narratives were viewed of equal importance and considered as different perspectives on the same Truth. I also acknowledged that voluntarism within human nature may be constrained by cultural, societal and professional influences, leading to shared understandings of phenomena where individual reality frames overlap (Natoli, 1997), and privately and publicly held beliefs and actions (Watson, 2006; Warr, 2005).

Data Collection

How Participants were Recruited

In qualitative research, sampling is closely related to the phenomenon to be described, data collection and data analysis (Tuckett, 2004; Ritchie, Lewis and Elam, 2003). A non-probability, purposive sample was chosen (Denzin and Lincoln, 1998), as participants need to be able to provide specific information regarding CPE. Rather than biasing research (Cohen et al, 2000), this enabled relevant, detailed information to be collected (Horsburgh, 2003; Ritchie et al, 2003), which facilitated data analysis.

Potential participants were all perioperative nurses employed within the same large teaching National Health Service (NHS) Trust. Access to the names of all perioperative staff and a database of staff accessing CPE allowed identification of all nurses who had attended university courses and those who appeared not to have accessed formal study. As more staff applied to undertake formal study, their names were added to a list of potential participants and they were included in the invitation process.

Personal letters of invitation and information sheets detailing the purpose and duration of the study and requirements of participants (Appendix III) were distributed to all nurses currently undertaking CPE or who had undertaken this within the last 3 months. Letters of invitation and information sheets (Appendix III) were also sent to all nurses who were identified as having never attended university courses. Due to the pace of data collection, these letters were sent in batches of 10 at intervals to ensure participants were not waiting for interviews past the 3 month deadline. Each potential participant was given 4 weeks in which to express their interest in participating. Those who wished to take part and were currently undertaking, or had recently completed, formal study

were assigned to group 1 (Participants in CPE) and those with no record of attending university post-registration to group 2 (Non-Participants in CPE).

Sample size

Qualitative studies are associated with small sample sizes (Baum, 2003; Holloway and Wheeler, 1996; Rubenstein, 1994) due to the labour intensive manner of data analysis (Polit and Beck, 2004; Arksey and Knight, 1999). Although data saturation is advocated to enable a comprehensive picture of a phenomenon to be developed (Higginbottom, 2004; Tuckett, 2004; Leonard, 2003; Parahoo, 1997; Morse and Field, 1995; Carpenter, 1995; Leininger, 1994), this may lead to large sample sizes, especially when comparative groups are used, as each group needs to reflect the diversity of its parent population (Ritchie et al, 2003). Thus it may be necessary to limit the sample size (Rossman and Rallis, 2003; Holloway and Wheeler, 1996) even if saturation is not reached; indeed saturation may be a myth due to the contextual and temporal nature of the findings (Morse, 1989).

It was originally intended to recruit approximately 40 participants representing both groups as it was assumed this would provide saturation without creating an unmanageable volume of data. However, at around interview 15 it became apparent that less new information was being revealed, and that whilst interviews were initially inductive they were becoming more deductive as participants were providing supportive evidence for previous narratives. This indicated that saturation was being reached (Seidman, 2006; Tuckett, 2004; Morse and Field, 1995) for those who participated in CPE, and these individuals reflected a range of perioperative nurses from different sites within the Trust, indicating sufficiency (Seidman, 2006). Following discussions with

academic supervisors, a decision was made to limit the number of interviews with Participants in CPE to a maximum of 25. It was not possible to recruit any nurses who met the criteria for Non-Participants in CPE.

Gathering the Data

The method by which data are gathered must reflect the ontological and epistemological position of a study, and be suited to the topic under investigation (Higginbottom, 2004; Denzin and Lincoln, 1998; Guba and Lincoln, 1994). As people's opinions are grounded in time, place and context (Poland, 2003) making them relative, and subject to change, it was appropriate to describe a 'snap-shot' (Jordan, 2000; Arksey and Knight, 1999) of perioperative nurses' perceptions of CPE rather than utilise a longitudinal approach to data collection.

Qualitative data collection can utilise a variety of methods, including observation, diaries, reflective accounts and interviews. Observation or diaries, which can be equated to observations (Jordan, 2000), were inappropriate as there was an interest in exploring both behavioural and existential changes which may result from CPE, which is not easily done through writing or observation. Questionnaires were also rejected as it is difficult to assess perceptions and attitudes through these (Parahoo, 1997), and they require knowledge in the topic area upon which to base questions (Morse and Field, 1995) to avoid these being based upon assumptions. In addition, questions can be difficult to word succinctly and unambiguously (Morse and Field, 1995), and may restrict data elicited (Polit and Beck, 2004; Holloway and Wheeler, 1996). They also lack flexibility (Parahoo, 1997) which is required when investigating a new subject area.

Initially focus groups appeared an appropriate method by which to gather data, as these can elicit opinions (MacNaughten and Myers, 2004; Lewis, 2003) and new ideas (O'Sullivan, 2003; Holloway and Wheeler, 1996), highlighting convergence and divergence within experiences (Warr, 2005). Whilst opinions on sensitive or controversial issues may not be divulged if there is no rapport with, or distrust of, other members (McNaughten and Myers, 2004; Holloway and Wheeler, 1996), focus groups appreciate the complex layers within individuals' experiences, and were congruent with the theoretical approach adopted. However, practicalities within the work environment made it impossible to release the recommended number of participants – which varies between 3 and 10 (McNaughten and Myers, 2004; Finch and Lewis, 2003; O'Sullivan, 2003; Ritchie, 2003; Holloway and Wheeler, 1996) – simultaneously for 1-2 hours (O'Sullivan, 2003) to allow these to occur, prohibiting this approach.

Although described as costly (Leonard, 2003) and time-consuming (Wisker, 2001), data were collected through in-depth, unstructured individual face-to-face interviews. Whilst telephone interviews are quicker and less expensive (Anthony, 2005; Cohen et al, 2000), these may not elicit as much in-depth information (Legard, Keegan and Ward, 2003; Thomas, Purdon and Nicolaas, 2003), and to spend an hour on the telephone, as required to obtain rich interview data (Parahoo, 1997), is tiring and affects data quality (McDermott, Vincentelli and Venus, 2005). Thus telephone interviews are more suited to shorter, less in-depth, interviews (Polit and Beck, 2004; Arksey and Knight, 1999).

Face-to-face interviews are ideally suited to gathering in-depth information regarding CPE, as they recognise the complexity of individuals' social and personal worlds (Duffy, Ferguson and Watson, 2004; Ritchie, 2003), and have previously been used to understand the social contexts of learning (Tierney and Dilley, 2002). Interviews may

be described as “conversations with a purpose” (Rossman and Rallis, 1998 p126; Legard et al, 2003; Burgess, 1984) or “special conversations” (Holstein and Gubrium, 2003 p3); however they are more labour intensive and complex (Legard et al, 2003; Arksey and Knight, 1999), with differences in objectives, the roles of those involved, and in how naturalistic they are (Legard et al, 2003). With the appropriate skill, planning and techniques (Duffy et al, 2004; Leonard, 2003) they “allow entrance into another person’s world” (Streubert and Carpenter, 1995 p43; Litva and Jacoby, 2002; Carpenter, 1995) and enable exploration of participants’ perceptions (Wisker, 2001). This results in rich, thick data (Geertz, 1973) from emic perspectives (Cohen et al, 2000) situated within the context of individual experience and personal history (Ritchie, 2003). Although it is possible to conduct joint interviews, one participant may dominate (Arksey and Knight, 1999), oppressing the other’s opinions (Briggs, 2003); individual interviews allowed all participants to be heard equally (Lincoln and Guba, 2003).

Some authors advocate triangulation of theory, method or data to increase credibility within research findings (Such as Seale, 2004; Denzin and Lincoln, 2003; Fine, Weis, Wessen and Wong, 2003; Snape and Spencer, 2003; Oakley, 2000; Arksey and Knight, 1999). However, method triangulation is frowned upon by purists of qualitative research, due to its positivistic premises (Silverman, 2005; Golafshani, 2003; Tobin and Begley, 2002; Byrne, 2001; Arksey and Knight, 1999), and was rejected as it was not intended to determine an absolute Truth. Data triangulation (Fine et al, 2003; Silverman, 2005) between participants and their perspectives was congruent with the study’s theoretical basis, and allowed expression of individual views and understanding of shared perceptions and experiences, which resulted in a better narrative of CPE (Natoli, 1997). This legitimised using interviews as the sole data collection method.

Discrepancy exists regarding the terminology used to describe interview techniques, with little consensus as to definitions of structured, semi-structured, and unstructured, or standardised, non-schedule standardised and non-standardised interviews (Denzin, 1970). Others prefer to label interviews as standardised, semi-formal and free flowing (Holstein and Gubrium, 2003) reflecting more participants' roles in responding to questions and the conversation which develops, rather than the researcher's role. Parahoo (1997) perceives interview techniques lie on a continuum, with the degree of standardisation (quantitative attribute) and flexibility (qualitative attribute) determining their proximity to each paradigm. Irrespective of the terminology used, interviews can be grouped into two classifications; the survey interview and the qualitative interview.

Survey interviews cover two types of interview; structured or standardised and semi-structured or semi-formal. Structured interviews were immediately rejected, as they require predetermined questions to be asked in the same order of participants (Cohen et al, 2000; Denzin, 1970). That is they are spoken questionnaires (Arksey and Knight, 1999; Parahoo, 1997), and share their strengths and limitations (Parahoo, 1997; Holloway and Wheeler, 1996). Originally semi-structured interviews appeared appropriate, as these allow participants to express their experiences in their own words (Morse and Field, 1995). However, substantial reading indicated divisions on their conduct, and whether pre-determined questions can be asked in any order (Duffy et al, 2004; Parahoo, 1997; Holloway and Wheeler, 1996; Denzin, 1970), or whether these must be asked in the same order of all participants (Arthur and Nazroo, 2003). There is also division whether questions can be supplemented and answers explored to seek clarification (Duffy et al, 2004; Arksey and Knight, 1999; Parahoo, 1997; Morse and Field, 1996), and as such, it was believed that this approach may restrict the quality of

the information participants would provide in this un-researched area. If researchers ask set questions, it could be considered that semi-structured interviews are researcher-led (Parahoo, 1997), and consequently, there is a risk that interviews may be conducted to verify assumptions rather than to allow participants to describe emic perspectives of CPE and this method was rejected. Some texts indicate semi-structured interviews have few set questions, relying on a topic guide (Polit and Beck, 2004; Leonard, 2003; Arksey and Knight, 1999); however this approach is usually reserved for qualitative or unstructured interviews.

Qualitative interviews encompass unstructured or non-standardised interviews (Parahoo, 1997; Denzin, 1970). They are characterised by flexibility (Duffy et al, 2004; Cohen et al, 2000; Arksey and Knight, 1999) and improvisation as there are no set questions or order for these (Arksey and Knight, 1999; Denzin, 1970). The conversation and questions are guided entirely by interviewees (Polit and Beck, 2004; Denzin, 1970), who are in control (Silverman, 2006; Parahoo, 1997) and able to tell their stories (Guba and Lincoln, 1981), making them suited to situations where little is known about a topic (Morse and Field, 1995). Although some texts describe an interviewer's skills are important in generating good quality in-depth data (McDermott et al, 2005; Polit and Beck, 2004; Legard et al, 2003), Silverman (2006) asserts this applies only if adopting a positivistic stance, where some standardisation is necessary. He and others (Holstein and Gubrium, 2004a; Morse and Field, 1995) believe poor quality qualitative interviews are rare, as researchers essentially listen to participants' stories directing them to pertinent issues. Thus, whilst their lack of structure and participant-led nature may give a high 'dross' rate (Holloway and Wheeler, 1996), unstructured interviews appeared to be the most appropriate method of data collection in this study.

Few interviews are entirely unstructured (Litva and Jacoby, 2002; Parahoo, 1997), relying on topic guides to focus interviews (Parahoo, 1997). Two topic guides were devised (Appendix IV) for participants in groups 1 and 2, to provide some parity between interviews (Rapley, 2004; Arthur and Nazroo, 2003; Legard et al, 2003), and to act as an *aide memoir* (Rapley, 2004). These were derived from the literature (Rapley, 2004) and personal own experiences and beliefs, and included areas for exploration rather than exact questions, to avoid influencing participants (Arthur and Nazroo, 2003). Although there was no set order for discussing the topic areas, certain questions were asked at specific points; those asked following demographic data collection to open up discussion (Polit and Beck, 2004; Morse and Field, 1995; Holloway and Wheeler, 1996) asking participants to describe their experiences, and those used to conclude, asking participants if they wished to share other information. An offer was also made at this stage to answer their questions (Polit and Beck, 2004; Arthur and Nazroo, 2003; Arksey and Knight, 1999).

It is difficult to explore a subject to any depth in under 30 minutes (Parahoo, 1997), and generally about one hour is required (Legard et al, 2003), but longer and participants and interviewers begin to tire (Field and Morse, 1985) due to the intensive nature of data collection (Oakley, 2000). The pace and length of interviews were determined by participants (Adler and Adler, 2003; Morse and Field, 1995), and these ranged from 40 minutes through to 1 ½ hours. With the exception of participant 5 as discussed below, all participants were interviewed once.

Interviews are also psychologically demanding for interviewers (Polit and Beck, 2004; Legard et al, 2003; Morse and Field, 1995), due to the concentration required to focus on

participants (Polit and Beck, 2004) and refer back to earlier parts of interviews (Arksey and Knight, 1999; Morse and Field, 1995). Although Legard et al (2003) suggest 3 interviews can be conducted per day, most texts recommended conducting only one or two (Polit and Beck, 2004; Leonard, 2003; Morse and Field, 1995). Considering the part time nature of this study and that all interviews were self-transcribed, following ethical approval (Appendix V) only one interview was conducted per week. This allowed time to transcribe and code each interview before collecting more data.

All interviews were conducted at participants' convenience to ensure they retained their locus of control and were not rushed, aiding quality and richness of the data (Field and Morse, 1985). As an interview location affects the data generated (Rapley, 2004; Adler and Adler, 2003; Holstein and Gubrium, 2003), participants chose where interviews would take place (Bell, 2005; Leonard, 2003; Parahoo, 1997; Morse and Field, 1995). In accordance with Legard et al (2003) who stated professionals generally prefer to be interviewed in their work place, all interviews except one took place in private rooms situated within participants' workplaces. These rooms were comfortable and free from interruptions and distractions (Adler and Adler, 2003; Arksey and Knight, 1999; Morse and Field, 1995) to uphold confidentiality allowing divulgence of public and private thoughts (Bell, 2005; Warr, 2005; Legard et al, 2003). The interview conducted outside the perioperative department also took place in a private room. To reduce the potential of perceived inequality in power, during interviews participants' dress was emulated (Arksey and Knight, 1999), and 'theatre blues' were worn if participants were also wearing these.

Interviews were audiotaped in their entirety with a new audiotape for each participant. The tape recorder was placed near to participants to pick up quiet voices, but out of sight to prevent distraction or intimidation (Polit and Beck, 2004; Holloway and Wheeler, 1996). Although the tape recorder was tested prior to interviews to ensure it was working (Arksey and Knight, 1999), spare audiotapes and batteries were available to allow these to be changed with minimal disruption if required (Legard et al, 2003; Holloway and Wheeler, 1996). Videotaping interviews was seen as inappropriate due to the potential reluctance of participants to appear on video (Silverman, 2005) and as non-verbal communication was perceived of little intrinsic value when considering CPE. Prior to commencing data collection, small talk was entered into with participants (Polit and Beck, 2004; Rapley, 2004; Morse and Field, 1995), avoiding the research area (Legard et al, 2003), allowing them to relax in the presence of the tape recorder (Polit and Beck, 2004; Holloway and Wheeler, 1996) and confirm their participatory consent (Appendix VI).

As language can create, highlight, limit and obscure facts or truths (Rosenblatt, 2002), the language used during interviews mirrored that of participants (Polit and Beck, 2004; Legard et al, 2003; Fontana, 2002). Due to the synonymous use of CPE and continuing professional development (CPD), participants were provided with the definition of CPE (Chapter I) at the beginning of their interview. They were also informed there were no correct answers, but only their opinions, to encourage open conversation (Legard et al, 2003). The first questions asked related to factual and demographic information, followed by a request for participants to describe their experiences. If participants articulated they were unsure where to begin, they were encouraged to begin wherever appropriate (Morse and Field, 1995).

Participants were able to speak freely, with minimal interruption (Bell, 2005; Polit and Beck, 2004; Rapley, 2004; Morse and Field, 1995) whilst they were talking and during pauses (Polit and Beck, 2004). Whilst they may influence interviews, utterances were added where appropriate to indicate interest in their perceptions and to encourage conversation (Holstein and Gubruim, 2003; Legard et al, 2003; Kvale, 1996): To eliminate these is to, in effect, stop the conversation (Holstein and Gubruim, 2003). Establishing trust is essential to elicit information (Polit and Beck, 2004; Holloway and Wheeler, 1996) and participants' responses were treated with respect and sincerity (Leonard, 2003; Carpenter, 1995). A sensitive and non-judgemental attitude was maintained (Holstein and Gubruim, 2003; Holloway and Wheeler, 1996; Kvale, 1996) acknowledging participants' status as experts regarding their own experiences (Popay, Rogers and Williams, 1998). Participants were encouraged to illustrate their experiences using examples (Arksey and Knight, 1999), enabling the development of a deeper understanding of CPE (Legard et al, 2003).

There is disagreement whether only open-ended questions should be asked during interviews (Morse and Field, 1995), or if a mix of both open-ended and closed questions elicits most data (Legard et al, 2003). Although the majority of the literature advises questions should not lead participants (Legard et al, 2003; Cohen et al, 2000), Rapley (2004 p16) argues interviewers should "just get on with interacting" with interviewees. Thus, broad open-ended questions (Morse and Field, 1995) which did not influence responses (Baker et al, 1992) or lead the discussion (Seidman, 2006; Polit and Beck, 2004; Leonard, 2003; Streubert and Carpenter, 1995) were asked along with closed questions, as these are difficult to avoid if conversing naturally (Legard et al, 2003). They also allowed the interview to be re-focus when required (Legard et al, 2003).

With each question, care was taken to avoid ambiguity or multiple questions (Legard et al, 2003; Holloway and Wheeler, 1996; Morse and Field, 1995).

Interviews are traditionally passive and one-sided, with researchers aiming to discover more about participants than *vice versa* (Holstein and Gubrium, 2004; Seale, 1999; Holloway and Wheeler, 1996; Morse and Field, 1995). Post-modern approaches aim to reduce patriarchal boundaries and perceived power differences between researchers and participants (Fontana, 2002; Oakley, 2000; Hughes and Sharrock, 1997) with the quality of interview data dependent upon relationships and interaction (Silverman, 2006; Rapley, 2004; Legard et al, 2003; Arksey and Knight, 1999; Guba and Lincoln, 1995), and at all times the participant was acknowledged as the expert regarding their CPE experiences. Both an active role exploring participants' responses and a passive listening role was adopted during interviews; if only one of these roles is assumed, the depth and quality of data will be reduced (Silverman, 2006; Rosenblatt, 2002; Parahoo, 1997). In adopting an approach which assumes knowledge is socially constructed within an interview (Holstein and Gubrium, 2004) interviews are more interactive, and respect the privileged position of the interviewee.

Openness within interviews also attempts to balance the power between the researcher and the interviewee (Etherington, 2004; Ellis and Berger, 2003). This can encourage participants' trust and divulgence of information (Polit and Beck, 2004; Adler and Adler, 2003) especially if interviewers acknowledges they share participants' feelings (Etherington, 2004; Adler and Adler, 2003). Whilst several texts advise against interviewers revealing personal information (Polit and Beck, 2004; Holstein and Gubrium, 2003; Legard et al, 2003) as it may obstruct data collection (Arksey and

Knight, 1999), the post-modern approach adopted respected collaboration with participants in knowledge construction (Lafont, 2005; Richards, 2005; Silverman, 2005; Holstein and Gubrium, 2003; Legard et al, 2003; Rosenblatt, 2002; Seale, 1999; Rossman and Rallis, 1998; Kvale, 1996). As such, self-disclosure was used where pertinent (Etherington, 2004; Holstein and Gubrium, 2004; Rapley, 2004; Holloway and Wheeler, 1996), to allow participants to reflect upon their own experiences from a different perspective. As such, knowledge was constructed jointly as participants considered more deeply their experiences (Watson, 2006; Etherington, 2004; Holstein and Gubrium, 2004).

Despite the development of topic guides, these were flexible, and incorporated new topics as these were identified by participants (Holstein and Gubrium, 2004; Polit and Beck, 2004; Arthur and Nazroo, 2003; Legard et al, 2003; Rossman and Rallis, 1998). This flexibility allowed participants to retain a degree of power (Holloway and Wheeler, 1996), which is essential to developing open discussion (Ritchie, 2003) and respected the constructivist nature of interviewing (Holstein and Gubrium, 2004). Information from the literature review and previous interviews was used to identify and explore incomplete replies, omissions or gaps (Legard et al, 2003; Arksey and Knight, 1999; Kvale, 1996) and to explore participants' reasons, feelings, opinions, and beliefs (Legard et al, 2003). In instances where participants sounded uncertain or doubtful, this was explored further encouraging elaboration. In addition all participants were asked to consider how they imagine others perceive CPE (Rosenblatt, 2002); Fielding and Thomas (2008) suggest this elicits participants' own opinions as they are unaware of how others would answer, and such indirect questioning allows people to reveal comments they would have not otherwise. At the end, participants were thanked for

their time and opinions (Arksey and Knight, 1999), and asked if they would like to receive a summary of the findings (Arksey and Knight, 1999; Morse and Field, 1995). All participants were invited to make contact if they wished to have all or part of their interview deleted, or other information included within their transcript.

Recording field notes during interviews is disturbing for participants (Polit and Beck, 2004; Legard et al, 2003; Holloway and Wheeler, 1996) so immediately afterwards notes were made of any salient points not captured on audiotape (Legard et al, 2003; Holloway and Wheeler, 1996; Morse and Field, 1995). Initial thoughts and impressions of participants' experiences and perceptions were also documented, along with how these were similar or dissimilar to those of previous participants (Seidel, 1998a). Although Field and Morse (1996) advise keeping objective and subjective comments arising from interviews separate it is believed that all comments are subjective as verbal and non-verbal communication and nuances are interpreted through culturally-grounded interpretation, and thus all information relating to each interview was kept together.

Immediately following each interview the audiotapes were listened to (Finch and Lewis, 2003), to enable inaudible words to be documented, and had equipment failed, field notes to be written (Polit and Beck, 2004). This was beneficial with regard Participant 5 as the audiotape had not recorded the conversation. When this was discovered, as much of the interview as could be recalled was documented, and permission was sought to re-interview her at a later date. This opportunity was used not to repeat the entire interview, as replication would have been impossible (Morse, 1989), but to explore further the most pertinent and revealing aspects of the previous interview.

As a clearer picture of perioperative nurses' experiences and perceptions developed, the initial beliefs and assumptions on which this study was designed changed, which necessitated flexibility in the research design (Etherington, 2004; Horsburgh, 2003; Litva and Jacoby, 2002; Parahoo, 1997). Following each interview, *what* had discovered and *how* this had been discovered were considered (Etherington, 2004). Reflection on the conduct of interviews, identifying where actions, non-verbal communication, and questions had elicited rich information, and where these had been less successful, led to modifications in subsequent interviews, and enhancements in interview technique. Reflection upon the topic guide at the end of each interview enabled this to be revised to accommodate new areas of interest: That is the topic guide evolved in-line with participants' responses (Rapley, 2004). As interpretation can only go as far as the knowledge one possesses (Dreyfus and Dreyfus, 1986), such a recursive, non-linear approach allowed this study to evolve. As such, emerging questions could be explored with participants in later interviews (Richards, 2005; Arthur and Nazroo, 2003). Thus, as the study progressed participants were asked questions both for inductive and deductive purposes (Rossman and Rallis, 1998). In this way, interviews were carried out with increasing proficiency, and the data collected became increasingly comprehensive, rich, and in-depth.

Reluctant respondents can be divided into 2 groups; those whose reluctance is due to access and those due to resistance (Adler and Adler, 2003). It was anticipated that individuals who did not undertake formal study may be reluctant to be interviewed (Adler and Adler, 2003; Knapper and Cropley, 2000), and consideration was given to conducting questionnaires with these people should too few be recruited to illuminate their perceptions of CPE. The speed at which these can be completed at the

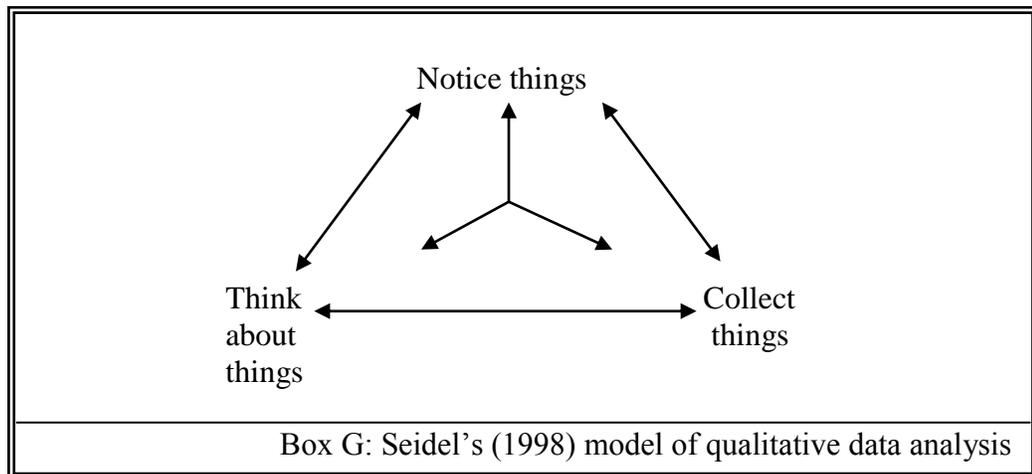
respondents' convenience (Parahoo, 1997) may have provided an insight into their perceptions whilst retaining their anonymity and reassuring them there would be no repercussions as a result of their responses. Although no Non-Participants in CPE were recruited, Participants in CPE provided a comprehensive insight into how those who do not pursue higher education differ from those who do study, and narrated this with consistency between interviews. As such, it was believed administering a questionnaire may not provide additional information.

Data Management and Analysis

Different techniques can be used to interpret participants' experiences, with content, thematic, conversation and discourse analysis the most commonly used (Seale, 2004). Content analysis is usual in research which does not adhere to one qualitative tradition (Polit and Beck, 2004; Brewer, 2003a; Sandeloswki, 2000), and was the approach used in data analysis, as it was not the intention to make interpretations based on language or tone of voice, or develop theory as are the intended outcomes of the other approaches. Whilst it is possible to utilise overarching theoretical frameworks for qualitative data analysis (Dey, 1993), it was believed this approach may have constrained the themes to emerge, and restricted the analysis of participants' experiences and perceptions. As a new area of interest, it was the intention to allow perioperative nurses' experiences and perceptions of CPE to emerge naturally and inductively from the data and to stand alone, rather than to attempt to fit these to existing theoretical frameworks. As such an overarching theoretical framework was not used in data analysis.

Interpretation of data has two phases; management, and analysis (Ritchie et al, 2003). Data were managed, reduced and then analysed prior to constructing a descriptive

account of perioperative nurses' perceptions of CPE, guided by both Seidel's (1998) (Box G) and Dey's (1993) (Box H) approaches to qualitative data analysis.



1. Read and annotate transcripts
 2. Create and assign categories
 3. Split and splice
 4. Link data
 5. Make connections – use maps and matrices if appropriate
 6. Find corroborating evidence
 7. Produce the account
- Box H: Dey's (1993) steps for analysing qualitative data

Seidel's (1998) jigsaw approach is a simplistic derivation of most models of qualitative data analysis, and reflects how ideas generated within field notes were used to influence data analysis in an intuitive, iterative and reflexive manner. A criticism of Seidel's (1998) approach is the implication that analysis emerges from categories through noticing things (Seidel, 1998; Agar, 1991) and Seidel (1998 p 7) acknowledges "the risk in following the jigsaw analogy too closely is that you might get too deeply into the pieces and end up finding the codes but losing the phenomena". To avoid this scenario, aid the identification of pieces of the jigsaw puzzle (Seidel, 1998a p3), and build a holistic picture of perioperative nurses' perceptions of CPE, Seidel's (1998) model was

supported by Dey's (1993) model of data analysis. Dey's (1993) model was chosen as it is not associated with one particular qualitative approach, and provided a sense of logical structure to identifying emergent themes rather than relying on thinking about codes and noticing new things as is required with Seidel's (1998) model.

Initially it was intended to utilise Dey's (1993) approach as the sole framework for data management and analysis, however it implies a linear process to data analysis. Seidel's (1998) model is more iterative and recursive and supported the reflexive, dynamic nature of data collection and its ongoing analysis. The combination of the principles and strengths of these two models, and the structure they afforded the data analysis, was perceived as increasing the trustworthiness of the findings, as they allowed the essence of participants' experiences to emerge. Placing these jigsaw pieces into the overall puzzle allowed the gradual development of a comprehensive picture (Seidel, 1998a) of CPE as perceived by perioperative nurses (Chapters IV to VIII).

Data Management

Data management begins with transcription, which is a key phase of data analysis and integral to its interpretation (Bird, 2005). Although Duffy et al (2004) recommend purchasing transcription services, particularly by part-time researchers, all interviews were self-transcribed, as transcriptions are interpretations (Poland, 2003; Tilley, 2003; Arksey and Knight, 1999; Denzin and Lincoln, 1998), with subjective decisions as to what to include and exclude (Bird, 2005; Etherington, 2004). Thus, there may be multiple interpretations of interviews, with syntax, punctuation and grammar and even words transcribed differently (Poland, 2003; Tilley, 2003; Cohen et al, 2000; Arksey and Knight, 1999; Denzin and Lincoln, 1998). Transcription errors are inevitable (Duffy et

al, 2004; Polit and Beck, 2004), and all work transcribers undertake must be checked by listening to the tapes (Richards, 2005; Duffy et al, 2004; Arskey and Knight, 1999), reducing the time saved.

Although up to 9 hours was spent transcribing each interview, repeated listening to audiotapes can reveal information not initially heard (Silverman, 2005). Poland (2003) argues using transcribers distance researchers from their data (Poland, 2003), and self-transcription allowed immersion in the data collected (Holloway and Wheeler, 1996), and familiarity with that data (Ritchie et al, 2003) which began to allow things to be noticed (Seidel, 1998a). As Watson (2006) described, in reading the transcripts, participants' voices could be re-heard, and the interview situation reconstructed, due to the immersion into and closeness with the data which was afforded by self-transcription.

When transcribing, efficiency must be matched with accuracy (Lapadat and Lindsey, 1999) and data must be presented in a way which allows coding (Lapadat and Lindsey, 1999). Whilst Hutchinson (2005) asserts transcription is unnecessary, and data can be coded directly from audiotapes, all other texts indicate *verbatim* transcription is essential. Although Arksey and Knight (1999) believe it unnecessary to transcribe all interviews, transcribing only the first few and summarising later ones, and Poland (2003) states with content analysis it is possible to selectively transcribe each interview, this can bias a study (Oppenheim, 1992) as data which initially appears insignificant and is not transcribed could be overlooked if later identified as significant (Seidman, 2006; Bird, 2005). It was important that all participants' voices were heard; to selectively transcribe may have silenced some participants, with interpretations of the data heard more clearly. Thus, all interviews were transcribed in their entirety (Bird, 2005; Morse and Field, 1995).

The possibility of using voice recognition software to aide transcription was investigated, but rejected. A considerable amount of time is required to enable the software to recognise participants' voices (Park and Zeanah, 2005), and even if the researcher acts as a "ghost" to dictate the tapes (Tilley, 2003 p754), mistakes are made in the voice recognition and in punctuation. In addition, the time taken to dictate a transcript may be greater or equal to the time taken for a proficient typist to type a transcription (Park and Zeanah, 2005). As proficient typing skills were possessed at the onset of this study, all interviews were typed whilst listening to the audiotapes.

Each audiotape was transcribed *verbatim* as soon as possible following an interview (Morse and Field, 1995); contemporaneous transcription allowed transcripts to more easily be annotated with pertinent information from field notes, contextualising the interview and making sense of responses (Wisker, 2001). Although it was not the intention to undertake linguistic or discourse data analysis, and participants' dialect was not transcribed, utterances and pause lengths were included as appropriate (Bird, 2005; Arksey and Knight, 1999), to provide an indication of when participants were hesitating or providing considered answers. Transcripts were also annotated with interruptions (Cohen et al, 2000). This approach was taken to avoid omitting information which may later have proved valuable in data analysis (Seidman, 2006; Bird, 2005).

Interviews were transcribed directly onto computer, using the Ethnograph qualitative data analysis programme (Seidel, 1998b), in single type with a double line space between speakers (Bird, 2005; Morse and Field, 1995), who were identified at the beginning of their speech (Polit and Beck, 2004). Once completed, the transcripts were read whilst audiotapes played, to check for accuracy (Arksey and Knight, 1999; Morse

and Field, 1995) and to continue to enhance familiarity with the data. Each interview was saved in a separate file, and details of the date, time and location of the interview, and the participant's pseudonym (Holloway and Wheeler, 1996) were recorded on separate 'face sheets' (Seidel, 1998b). A copy of each transcript and face sheet was printed and stored in a lever arch file, and a back up copy of each made on a removable disc to ensure information was neither lost nor inadvertently destroyed.

The original intention when this study was proposed was to use paper-based methods of data management and analysis, rather than computer aided qualitative data analysis software (CAQDAS). The reluctance to use a pseudo-scientific approach (Kelle, 2004; Seale, 2003; Spencer, Ritchie and O'Connor, 2003) was associated with the distancing effect of computers (Seale, 2005; Séror, 2005; Polit and Beck, 2004; Holloway and Wheeler, 1996) and an insinuation their objective and systematic approach (Seale, 2005; Kelle, 2004; Oakley, 2000) adds scientific rigour (Seale, 2005; Seale, 2003) to qualitative data analysis. During the planning of this study, it became apparent this original decision was possibly based on a lack of knowledge regarding CAQDAS. As CAQDAS is becoming increasingly used in qualitative research (Richards, 2005; Séror, 2005) and beginning to out-mode manual qualitative data analysis (Polit and Beck, 2004), it was decided this should be used in data management and to aid in data analysis.

The wrong CAQDAS programme can spoil data analysis (Spencer et al, 2003) and the needs of data analysis must be matched with a programme's functions. Of the programmes investigated, including NUD*IST, NVivo, and Atlas-ti, the Ethnograph was selected as it is the longest established and had the capabilities to assist in data management and analysis without unnecessary additional features, such as coding of

sound and audio (NUD*IST), and theory building and analysis of documentary evidence (ATLAS-ti). It was described as easy to use and easy to learn (Seale, 2005), making the advanced features of the other programmes outweighed by this simplistic approach. Thus, by not having superfluous features, the Ethnograph suited the needs of data analysis, and could assist in data management without compromising personal theoretical beliefs.

Participants can be provided with copies of transcripts to enable data verification (Etherington, 2004; Polit and Beck, 2004; Brewer, 2003a; Oakley, 2000; Rossman and Rallis, 1998; Carpenter, 1995; Morse and Field, 1995; Leininger, 1994; Lincoln and Guba, 1985), reduce power differences (Benton and Craib, 2001; Oakley, 2000), and imply openness and honesty, however this approach was seen as inappropriate. McDermott et al (2005) provided participants in their pilot study with interview transcripts, and almost all expressed discomfort with seeing their words in print, making this contrary to principles of beneficence (Beauchamp and Childress, 2001). Participants may request removal interview data if they disagree with what is written (Poland, 2003; Oakley, 2000; Sandelowski, 1993), or will not disagree out of politeness (Polit and Beck, 2004), which may mean resultant description and analysis is a distorted version of the truth (Oakley, 2000). Although in their main study McDermott et al (2005) provided participants with audiotapes of interviews rather than transcripts, it was believed this could make people who do not like the sound of their voice uncomfortable in the same way as reading a transcript. In addition, it was wondered how many people would listen to an entire audiotape. Hence, this is not seen as a valid method of data verification. In addition, member checks are a social event rather than a scientific test to determine authenticity (Bloor, 1997; Dey, 1993), and take more of participants' time,

which is not usually welcome (Litva and Jacoby, 2002). It was also inappropriate to expect participants to validate the findings of the whole study as they may not recognise their voices and experiences within the emergent themes (Horsburgh, 2003; Dey, 1993) due to interpretation of these from a particular perspective (Richards, 2005; Morse, 1994; Hodge, 1995).

Data Analysis

A debate exists as to whether data analysis begins during (Polit and Beck, 2004; Arthur and Nazroo, 2003; Arksey and Knight, 1999; Holloway and Wheeler, 1996; Carpenter, 1995; Streubert and Carpenter, 1995; Lincoln and Guba, 1985) or following data collection (Bird, 2005; Silverman, 2005; Legard et al, 2003; Strauss and Corbin, 1998). Others maintain data collection and analysis are inseparable (Richards, 2005; Polit and Beck, 2004; Arksey and Knight, 1999; Carpenter, 1995; Dey, 1993) and as data collection begins the researcher begins, subconsciously even, to analyse information (Lincoln and Guba, 1985). Rapley (2004) asserts analysis is an ongoing process which starts *prior* to the first interview, due to reading the literature and *ad hoc* conversations which create a deeper understanding of a phenomenon leading to theories which are tested deductively during interviews.

In this study, data analysis began during interviews, and continued beyond the conclusion of the last interview. Thus, analysis occurred at two levels;

- 1) Informal analysis during interviews, aiding their direction, enabling questions to be framed appropriately to elicit pertinent information
- 2) Formal analysis at the end of each interview, coding and categorising data to allow greater focus in subsequent interviews (Seidel, 1998a) and to determine

when saturation was reached (Parahoo, 1997; Leininger, 1994). In addition a protracted period of analysis occurred once saturation was achieved

Although field notes contained initial thoughts regarding participants' experiences (Seidel, 1998a), formal data analysis required immersion in the data. There was a need to become fully aware of what the data were saying (Oakley, 2000; Carpenter, 1995; Morse and Field, 1995; Dey 1993), staying close to it to allow an accurate description of participants' experiences and perceptions (Arksey and Knight, 1999; Dey, 1993) in an inductive manner as suggested within constant comparative analysis (Strauss and Corbin, 1998). The familiarity required for this (Carpenter, 1995; Morse and Field, 1995) occurred through reading and re-reading transcripts, and although Rossman and Rallis (1998) suggest transcripts should be read 4 times prior to analysis, there is no consensus to how many times the data should be read. Thus, these were read as many times as necessary to become familiar with them (Ritchie et al, 2003), noticing things of importance, prior to coding (Seidel, 1998a).

The data analysis models used make an important differentiation between coding and categorising; Seidel (1998a) refers to 'coding' data, whilst Dey (1993) refers to 'categorising' data. Dey (1993) believes the process of categorisation is less rigid, restrictive, and authoritarian than 'coding', which has connotations associated with the creation of strict rules and regulations with little room for debate. The majority of the methodological texts refer to the process of 'coding', and to utilise both terms within this study may lead to obfuscation. Thus, although the rationale behind Dey's (1993) argument of more fluid and flexible data 'categorisation' is supported and these principles were applied within this study, the word 'code', as used within Seidel's

(1998) model and the Ethnograph, is used for the initial annotation of transcripts and ‘categorisation’ and ‘theme’ for their amalgamation at each higher conceptual level.

Coding transcripts is essential in content analysis (Brewer, 2003a) to reduce the quantity of data, facilitating systemic and thorough analysis (Dey, 1993). Once a transcript had been read and understood, each phrase, sentence or paragraph within it was annotated with a code or multiple codes which arose from the data (Brewer, 2003a; Dey, 1993) and represented its contents (Polit and Beck, 2004; Morse and Field, 1995; Miles and Huberman, 1994). These codes were derived from participants’ words when possible, or synonyms where appropriate. Codes were either exclusive or inclusive; if inclusive, they could be assigned to the same piece of data, and if exclusive to either one piece of data or another, not the same piece (Dey, 1993). Over the course of the study, a list of the codes used, their inclusion and exclusion criteria (Dey, 1993), and examples of text to which these applied was developed within the Ethnograph meaning the code list evolved with successive interviews. This acted as an *aide memoir* in coding subsequent interviews, increasing the trustworthiness of the study (Arksey and Knight, 1999). A copy of each coded interview was made to a removable disc, and also printed and stored in a lever arch file.

Following coding, a précis of the interview was written detailing its contents, initial thoughts on the data, and, as more interviews were conducted, the relationship between different interviews. This summarising was imperative as the number of transcripts increased to allow memory of these to be refreshed without re-reading every transcript in its entirety.

Flexibility within coding is essential (Seidman, 2006; Dey, 1993), and after each interview had been coded and the précis written, previous transcripts were re-examined to determine whether new codes were also present within these previous transcripts. If codes suggested by the literature did not appear to be covered, transcripts were revisited to ensure these had not been overlooked (Dey, 1993). Where necessary, codes were split (subdivided) or spliced (merged) to ensure they remained relevant, inclusive, mutually exclusive and exhaustive of all data collected (Dey, 1993).

Codes which are exclusive are always relate in some way to an underlying concept or overarching category (Dey, 1993), and thinking about the relationships between these (Seidel, 1998a) allowed these to be sorted and sifted (Richards, 2005; Seidel, 1998a). This allowed similar codes to be clustered together (Stern, 1980) creating a smaller number of broader subcategories and categories (Ritchie et al, 2003; Miles and Huberman, 1994; Stern, 1980) where relationships existed. Similarly, categories were grouped where appropriate, allowing a larger picture of CPE to gradually emerge from the data. Themes were derived in one of two ways; by taking a code (known as a child in the Ethnograph), or category (parent) and using it as a theme (grandparent) under which categories fell, or by creating more abstract themes to describe groups of categories, all of which illustrated particular aspects of the puzzle.

As with the codes, sub-categories and categories and themes were inclusive, exclusive and exhaustive of the data (Silverman, 2005; Dey, 1993). Thus, using the Ethnograph, children (codes) became parents (categories) and grandparents (themes) as a deeper understanding of CPE was developed, and themes emerged from the data. As both categories and themes arose, the data were revisited to ensure their fit, and they were

refined as necessary through splitting and splicing (Polit and Beck, 2004; Seidel, 1998a; Miles and Huberman, 1994; Dey, 1993), making reference to original transcripts to ensure data had not been taken out of context (Spencer et al, 2003). As a deeper understanding was gained and the family tree (Appendix VII) emerged, such splitting and splicing of codes, categories and themes was less frequently required. If splitting or splicing was required at any stage, data were re-coded and re-categorised accordingly (Polit and Beck, 2004; Dey, 1993). As suggested in the literature (Silverman, 2006; Arksey and Knight, 1999; Dey, 1993) a second opinion was sought from academic supervisors on the codes, categories and themes which emerged. This showed consistency between the codes, categories and themes that were noticed. An excerpt from one of the coded transcripts is included in Appendix VIII.

Whilst data reduction may fragment data by taking participants' experiences out of context (Spencer et al, 2003), it brings data together in a conceptual framework which is useful analytically (Dey, 1993). It allowed consideration of the constituent pieces of the puzzle and the relationship between these (Seidel, 1998a), and using the Ethnograph fragments of text could be related back to original transcripts and re-contextualised (Seidel, 1998a). Data analysis involves examining the pieces of a puzzle and including and excluding different characteristics, to piece them together to build a picture (Denzin and Lincoln, 2003; Seidel, 1998a). Searching within the Ethnograph allowed determination of where codes and categories overlapped, their proximity to one another, and when one category appeared with another or in isolation. Where codes and categories were interspersed or if more than one applied to a paragraph this indicated they were related (Ritchie et al, 2003). Such constant comparative analysis (Strauss and Corbin, 1998) allowed transcripts to be analysed vertically, up and down one transcript,

and horizontally, comparing transcripts to determine similarities and differences (Silverman, 2005). This allowed delineation of points of interest *between* participants, and also significant passages *within* an interview (Spencer et al, 2003).

As transcripts were read and things of interest noticed (Silverman, 2006; Seidel, 1998a), including possible relationships between categories which cut across the themes, detailed memos were attached to the text, and Word documents kept detailing the emerging categories and themes. This allowed an understanding to develop of the relationships of these within and between interviews, and enabled identification of the similarities and differences (Seidel, 1998a; Strauss and Corbin, 1998). The dates notes were written were included, to document how knowledge had developed over time. In addition, at the end of data collection, all paper copies of transcripts were revisited, noting on each page changes to the coding and additional memos which needed to be added to those stored within the Ethnograph.

Data analysis as described above deconstructs participants' experiences, uncovering similarities and differences (Strauss and Corbin, 1998; Hughes and Sharrock, 1997) and hidden meanings and connections which may exist (Horsburgh, 2003). When saturation was reached, the stage of comprehension had been reached (Morse and Field, 1995) and it was necessary to reconstruct the emerging categories and themes to develop a comprehensive understanding of participants' descriptions of CPE. This process started by writing paragraphs about each category and theme (Morse and Field, 1995). These were written as far as possible using participants' words (Ritchie et al, 2003) and information contained within the Word documents, keeping the literature in abeyance (Morse and Field, 1995) and avoiding speculation about speakers' motives (Silverman,

2005). Using constant comparative analysis, these memos and descriptive paragraphs were searched for patterns and structure to connect and relate categories (Polit and Beck, 2004; Dey, 1993) within the themes and to find similarities and variation in these (Silverman, 2006; Morse and Field, 1995) until no new interpretations were found (Arksey and Knight, 1999).

Qualitative data analysis is a recursive process (Richards, 2005; Seidel, 1998a) and an iterative hermeneutic approach was necessary as it is impossible to understand the whole until the parts were understood, however it is not possible to determine the constituent parts until the whole was understood (Seidel, 1998a). Multiple reading of interview transcripts allowed new things about participants' experiences to be noticed (Meek, 2003; Seidel, 1998a) and greater understanding to be achieved, which allowed intuitive leaps between the data and its interpretation (Etherington, 2004; Moustakas, 1990). This allowed the data to be summarised with the emergent themes describing not only individual categories, but cutting across categories weaving the resulting analysis together (Polit and Beck, 2004), creating a larger and more abstract picture of perceptions of CPE (Ritchie et al, 2003). This analysis was represented visually in the form of a conceptual map (Wolcott, 2001; Dey, 1993)(Box J), to aid understanding. This was then related back to the literature to contextualise the findings within the wider knowledge (Chapters IV to VIII).

Ethical considerations

At all stages of data collection and analysis, it was necessary to adhere to research governance guidelines (DH, 2005) to ensure ethical principles were upheld, the *Data Protection Act* (HMSO, 1998b) to maintain confidentiality, and the "*Standards of*

Conduct, Performance and Ethics” (NMC 2008b). Beauchamp and Childress (2001) give 4 ethical considerations which must be upheld; autonomy to decide whether to participate; non-maleficence, that no harm will result; beneficence is the only motive; and justice. The ICN (1996) in addition state confidentiality, veracity and fidelity must be maintained.

The research proposal was submitted to the Local Research Ethics Committee (LREC) for approval in accordance with research governance guidelines (DH, 2005). Following their recommendations, minor changes were made to the consent form and patient information sheets to make these more comprehensive. Their suggestion to recruit participants through posters was not accepted, as it was believed that individuals who were reluctant to participate in university courses may be reluctant to participate in this study, as Knapper and Cropley (2000) describe differences between those who do and those who do not participate in formal study. The inclusion of non-participants was regarded as essential to form a comparator group which would support and validate information from the positive cases of those attending CPE (Silverman, 2005; Litva and Jacoby, 2002; Punch, 2000), and it was thought that personal letters may encourage individuals to be interviewed. The LREC were assured of the actions to be taken should participants become distressed during interviews, and reassured working relationships with potential participants would not make them feel obliged to participate. On submission of these changes and points of clarification ethical approval was obtained (Appendix V). Permission for this study was also obtained from the Trust’s Research and Development department.

Informed consent is vital (Lewis, 2003) and potential participants were given full details of their involvement (Polit and Beck, 2004; Christians, 2003) (Appendix III). Their

questions were answered (Holloway and Wheeler, 1996; Carpenter, 1995) and it was emphasised there would be no repercussions for either taking part or not taking part (Holloway and Wheeler, 1996). This information was reiterated prior to data collection (Carpenter, 1995), when informed voluntary consent was obtained (Polit and Beck, 2004; Christians, 2003; Mcauley, 2003) and documented on consent forms (Appendix VI), with a copy for the participant and one for the research records. All participants were aware they could withdraw their consent at any time (Seidman, 2006; Ryen, 2004; Legard et al, 2003), even during interviews or after data collection (Mcauley, 2003; Morse and Field, 1995). Explicit consent was obtained for audio-taping interviews (Carpenter, 1995) and to use *verbatim* quotes in writing up the findings, as others may be able to recognise participants, meaning confidentiality cannot be assured (Leonard, 2003; Oakley, 2000; Rossman and Rallis, 1998; Holloway and Wheeler, 1996; Morse and Field, 1995). Whilst no participants entirely retracted their interview, one requested certain details were omitted from their transcript, and this was respected.

In interviews participants cannot remain anonymous to the researcher (Mcauley, 2003; Cohen et al, 2000) however their confidentiality was crucial (Mcauley, 2003; Rossman and Rallis, 1998). To preserve this, data was anonymised immediately with codes (Ryen, 2004; Christians, 2003; Mcauley, 2003) which were stored separately from transcripts (Lewis, 2003; Holloway and Wheeler, 1996). Interviews were transcribed directly onto a computer, and saved in password protected files. The audiotapes were destroyed once interviews had been transcribed. Transcripts were kept throughout the study, with paper copies of these and the removable disc locked away securely.

Protection of participants is important, even when investigating subjects which do not appear to be delicate (Silverman, 2006), as it is impossible to predict participants'

perceptions (Polit and Beck, 2004; Legard et al, 2003; Lewis, 2003; Streubert and Carpenter, 1995) or how they will be affected by their experiences (Ritchie, 2003). No participants appeared distressed, however, had changes to their behaviour, mannerisms, or tone of voice been detected which suggested distress (Lewis, 2003) participants would have been given the choice to continue, change topic, or terminate the interview (Silverman, 2006; Legard et al, 2003). It is not a researcher's role to counsel participants (Polit and Beck, 2004; Ritchie, 2003); having gained Research and Development department approval, the NHS Trust occupational health department was available to refer participants if appropriate.

Siskin (1994) asserts researchers could be accused of seduction and abandonment; a researcher appears interested in participants and their experiences (seduces them) only as a means to an end, and never contacts them again once interviews are over (abandons them). In this study, all participants' views were valued, taken seriously and seen as central to its success. To ameliorate the effects of feeling abandoned, participants were provided with information leaflets containing comprehensive study details and contact details (Appendix III) prior to their consent to participate. Participants were also offered a second copy of this information immediately before their interview, which some participants accepted. Whilst no feedback on the findings was provided until data collection was complete, all participants received a summary of these findings on completion, implying openness and emphasising their importance in the study.

As a researcher, there is an ethical obligation for accurate and honest portrayal of research findings (Cohen et al, 2000), whether these are positive or negative, and to avoid falsification of data, fraudulent claims, omissions, and contrivances within data

collection, analysis and reporting (Christians, 2003; Mcauley, 2003). To protect participants' feelings and increase the readability and clarity of quotes, following data analysis it was ethically necessary to remove utterances (Poland, 2003; Arksey and Knight, 1999; Rossman and Rallis, 1998). Such editing did not bias the findings, as neither discourse or conversation analysis was undertaken. In the following chapters, the convention (...) illustrates where quotes have been edited.

Establishing Rigour

Rigour in descriptive methods is established through integrity, clear accounts, reflexivity and constructive critique of one's own work and that of others (Johnson et al, 2001). Sandelowski (1986) argues if an audit trail and trustworthiness are present within qualitative research, then rigour will also be present.

The Audit Trail

The whole study should be an auditable document (Koch, 1994), which allows thought processes and actions to be followed (White, Woodfield and Ritchie, 2003; Lincoln and Guba, 1985) and identification of how these may have affected the study (Horsburgh, 2003) and created bias (Koch, 1994). An explicit audit trail creates a transparent path through a study (Horsburgh, 2003; Oakley, 2000) rationalising decisions (Horsburgh, 2003) and is essential in adding rigour by allowing determination of both credibility and dependability (Silverman, 2006; Spencer et al, 2003; White et al, 2003; Holloway and Wheeler, 1996; Koch, 1994). An audit trail should enable exact repetition, although not necessarily replication of a study (Snape and Spencer, 2003; Sandelowski, 1993) due to its temporal and contextual nature (Holloway and Wheeler, 1996).

The audit trail in this study documents and makes explicit justifications for decisions made, from conceptualisation of the study, including the underlying assumptions, through to interpretative decisions involved in data analysis and suggestions for practice arising from the findings (Horsburgh, 2003; Arminio and Hultgren, 2002; Byrne, 2001; Oakley, 2000; Morse and Field, 1995). This is particularly important in aiding repetition of the study as it did not adhere to one particular traditional qualitative approach. The inclusion of consent forms, information leaflets, topic guides, transcript excerpt and family tree within the appendices contribute to transparency by making explicit the information provided to participants, and data collection and analysis methods.

Trustworthiness

Different criteria exist which allow judgement of trustworthiness (for example, Popay et al, 1998; Leininger, 1994). Lincoln and Guba (1985) describe 4 criteria which must be considered within qualitative studies which together constitute its trustworthiness; credibility, dependability, transferability, and confirmability.

Credibility

Credibility relates to the extent to which findings are believable. As the researcher is instrumental in data collection, this will have been influenced by the skills, competence and rigour possessed (Patton, 1987; Guba and Lincoln, 1981). Although a novice researcher, as a nurse the requisite listening and questioning skills for interviewing had been developed prior to this study (Polit and Beck, 2004; Arksey and Knight, 1999; Kvale, 1996), and were expanded and enhanced through reflexivity (Etherington, 2004; Polit and Beck, 2004; Patton, 2002) as the study progressed.

As the study was conducted, it was recognised that, as a perioperative nurse who was currently studying, some of participants' thoughts and feelings regarding CPE were shared. This allowed interpretation of their experiences with insider knowledge. Seidman (2006) believes researchers should be wary of assumptions by both the researcher and the interviewee when interviewing friends and acquaintances, and clarity was sought on participants' experiences. Knowledge possessed through experiences, background and reading made participants less likely to be deceitful through fear of being detected (Arksey and Knight, 1999), as did having a pre-existing rapport with them (Holloway and Wheeler, 1996). Including details of personal perspectives and assumptions also allows greater credibility (Rossman and Rallis, 1998; Morse and Field, 1995; Koch, 1994).

Data triangulation also increased credibility (Golafshani, 2003; Litva and Jacoby, 2002) through allowing issues to be identified by a number of participants and, further to this, similar answers were provided by participants working in the same theatre suites. Oakley (2000) explains the way to prove something is to omit people who may disprove the thing; thus the intention to include a comparator group would have allowed any deviations to be explored enhancing credibility (Silverman, 2005; Litva and Jacoby, 2002; Punch, 2000). Although it was not possible to recruit non-participants, making such comparison impossible, participants consistently described perceptions of why these people do not access CPE, aiding credibility.

Constant comparative analysis of data enhanced credibility (Lincoln and Guba, 1985) through flexibility (Spencer et al, 2003), which allowed new code words to be identified within previously collected data, and enabled codes made redundant through splitting

and splicing to be removed. In addition, this allowed emergent categories to be discussed with participants in later interviews, providing a different perspective on emerging themes, and interpretation of the data.

Interviewing until saturation confirmed the findings and similarities between experiences (Morse, 1989) and enabled a comprehensive description of CPE to be developed. Credibility was also enhanced by discussion with academic supervisors during planning, conduct and analysis stages (Oakley, 2000; Lincoln and Guba, 1985). Although credibility within qualitative studies is often determined by participants who recognise and validate what the researcher has written (Polit and Beck, 2004; Rossman and Rallis, 1998; Carpenter, 1995; Streubert, 1995b; Lincoln and Guba, 1985), member checks were not undertaken for the reasons discussed previously.

The topic guide, along with the tape recorder, can be considered as props increasing the interviewer's plausibility and professionalism, and legitimising the interview, helping to develop participants' trust (Rapley, 2004; Legard et al, 2003; Arksey and Knight, 1999). Through being prepared for each interview and respecting the value and importance of participants' opinions (Rapley, 2004; Arksey and Knight, 1999), trust was established, which enhances the information they provided and ensures credibility.

Dependability

Dependability is the stability of data collected over time and conditions (Lincoln and Guba, 1985) and is reliant upon credibility (Golafshani, 2003; Holloway and Wheeler, 1996); if credibility exists, so will dependability. Popay et al (1998) argue the hallmark of good qualitative studies is flexibility and adaptation and redesign where appropriate.

The reflexive attitude adopted and flexibility within data collection and analysis, as described above, thus contributed to dependability (Lincoln and Guba, 1985).

Interviewing participants who had only recently completed a period of formal study allowed parity in terms of recent experiences and allowed these, not retrospective accounts of previous study, to be explored, aiding trustworthiness (Punch, 2000). Although it is not possible to prevent participants reflecting on previous experiences, it was anticipated that this would be limited through this approach. Audiotaping interviews aids dependability (Legard et al, 2003; Litva and Jacoby, 2002; Streubert and Carpenter, 1995), as the resultant verbatim transcripts can be reanalysed in light of new information (Silverman, 2005), and adopting this approach ensured the findings were representative of perioperative nurses' experiences and perceptions' of CPE.

Despite an initial reluctance to use CAQDAS, using the Ethnograph allowed systematic and comprehensive data analysis, where all instances of a category were available for analysis. This aids the trustworthiness of the interpretations (Hutchinson, 2005; Seale, 2005; Sérór, 2005; Spencer et al, 2003; Cohen et al, 2000), as all instances of codes could easily be located and understood within its original context (Golafshani, 2003; Parahoo, 1997; Holloway and Wheeler, 1996; Dey, 1993). This ensured emergent themes were true to the original data (Spencer et al, 2003). Although Gergen and Gergen (2003) argue quotes suppress the voices of individuals whose words are not used, the quotes used to illustrate pertinent points allowed all participants to be represented and have their voices heard. The use of quotes allows readers to judge how findings were derived from data (Sandelowski, 1993), and aids dependability.

Confirmability

Confirmability relates to the extent to which similar findings would be discovered by subsequent research and the degree to which findings are determined by individual characteristics of the researcher and participants (Litva and Jacoby, 2002), and explicit mention of these has been made above and in the next chapter (Box I). Confirmability involves ensuring data could be traced to its originator and that its interpretation and conclusions are logical (Oakley, 2000; Holloway and Wheeler, 1996), which was aided by the use of the Ethnograph. In addition, the degree of confirmability is determined by the decision making trail (Litva and Jacoby, 2002; Streubert, 1995b), rich thick description, and reflexivity of the researcher. If credibility and dependability exist, confirmability will also be present (Holloway and Wheeler, 1996), and thus, as these exist, as described above, then confirmability must also exist.

Transferability

Qualitative research does not intend to create widely generalisable grand narratives (Higginbottom, 2004; Alasuutari, 1995) but to accurately describe a phenomenon under investigation (Rossman and Rallis, 1998; Morse and Field, 1995; Streubert, 1995b), and generate knowledge which may be extrapolated to the population from which the sample originates, and transferred to similar situations (Horsburgh, 2003; Holloway and Wheeler, 1996; Alasuutari, 1995). Such transferability is subject to temporal and contextual constraints (Oakley, 2000) and determined by readers (Silverman, 2005; Rossman and Rallis, 1998; Streubert, 1995b; Lincoln and Guba, 1985; Guba, 1981). The development of an explicit audit trail, rich, thick description (Geertz, 1973) in the findings, and acknowledgement of underlying assumptions (Rossman and Rallis, 1998) enhances transferability (Oakley, 2000) by allowing readers to make an informed

decision on the relevance and applicability of the findings to different situations (Lincoln and Guba, 1985).

Chapter summary

The goals of this study were located predominantly in the antipositivist or interpretive paradigm of epistemological inquiry, although it was acknowledged to some extent the nature of the social world is consistent with aspects of understanding and behaviours which fall into the positivist domain of inquiry. The ethically sound, rigorous, method designed to best meet these research goals did not adhere to one traditional qualitative approach but used a pragmatic mix of these within a descriptive qualitative framework, supported by a transparent audit trail. Trustworthiness was demonstrated throughout, from the selection of participants, and the nature of the interviews conducted, through to their transcription and analysis using a combination of Dey's (1993) and Seidel's (1998) approaches to data management and analysis.

The subjective, nominalistic and ideographic nature of multiple truths regarding CPE were respected, allowing this to be described using data collected through individual unstructured qualitative interviews, aided by topic guides, and this respect was continued into the reporting of the findings. The flexibility which was created through adopting a reflexive approach allowed modifications to be made where appropriate. This ensured credible, dependable and confirmable data collection and analysis, and allowed emergent themes to be explored as they arose from participants' descriptions, adding to the richness of the information obtained from participants.

This study respected voluntarism is paramount in human nature, whilst recognising that people act in certain ways because it is appropriate, and through their assumptions, past

experiences and socialisation in to a culture, rule-governed behaviour ensues. However, rather than determining a grand narrative, the following chapters illustrate experiences and perceptions of CPE held by nurses working within the hierarchical, patriarchal environment of perioperative care whilst respecting the individual truths held by participants. By not bracketing underlying personal preconceptions and assumptions, but acknowledging these, this added another layer to enrich the interpretations of people's experiences and perceptions, creating new knowledge.

This approach allowed the production of rich, thick description (Geertz, 1973) of the ideographic nature of CPE in the context of perioperative nurses' lived experiences (Schwandt, 1998; Streubert and Carpenter, 1995; Field and Morse, 1985). Visual conceptualisations of the grouping of different codes within themes, and the relationship of the categories of data collected from participants are included within the next chapter (Box J and Box K). Pertinent extracts from interviews are included within the following chapters to illustrate and illuminate the emergent themes within the findings (Holstein and Gubrium, 2004; White et al, 2003; Kvale, 1996; Morse and Field, 1995; Dey, 1993; Sandelowski, 1993). These are contextualised within the literature (Holloway and Wheeler, 1996; Carpenter, 1995; Dey, 1993) to determine the extent to which these findings were congruent or dissimilar from previous studies. Qualitative research is endlessly creative and interpretive, and it is impossible to develop concrete findings which would be generalisable to every situation in which perioperative nurses work: The provision of a clear method, transparent audit trail and the ensuing rich, thick description allows readers to determine the transferability of these findings and interpretations to other settings and contexts.

Chapter IV

OVERVIEW OF THE FINDINGS

This study was undertaken with the purpose of exploring and describing perioperative nurses' lived experiences of continuing professional education (CPE), something which had not been investigated previously. It was the intention to describe a holistic picture of CPE, from the initial decision whether to undertake formal study, and the actual process of studying, through to the outcomes derived from attending university, relating these to the existing literature to discern similarities and differences. In this original piece of work, there was an interest in whether the effects of close working relationships with different professionals within perioperative practice, namely operating department practitioners (ODPs), medical and anaesthetic staff, and influenced perioperative nurses' experiences and perceptions of post-registration university education. The study goals (Chapters I and II) were successfully achieved, with the exception of investigating non-participants' reasons for not undertaking formal study.

Data collection took place over 11 months, from February 2006 until January 2007. As described previously (Chapter III) data analysis began during the initial interview and continued until all participants had been interviewed, when a protracted period of analysis on transcripts, memos and thematic files was undertaken. The findings reported in the following chapters began to take shape after that initial interview, evolving into categories and themes as data collection and analysis continued, until a clear picture of perioperative nurses' perceptions of CPE could be reconstructed.

This chapter provides a background to the findings, presenting an overview of individuals who volunteered to participate, and explores why those who appeared to have never undertaken higher education declined invitations to participate. The grouping of level 2 codes used to annotate participants' stories are represented pictorially, along with a model of CPE derived from narratives perioperative nurses told relating to their experiences of post-registration education. Further codes relating to individual experiences at levels 3 and 4 of the family tree are included in Appendix VII.

Characteristics of Participants

Participants had unique descriptions of their experiences, as is to be expected with post-modern interpretation of events (Golafshani, 2003; Benton and Craib, 2001) based on socially constructed realities and past experience (Denzin and Lincoln 2003; Schwandt, 2003; Natoli, 1997): None of these interpretations was more valid than another, and for each participant was their individual truth relating to CPE. Individuals' experiences can only be understood if the context in which participants find themselves is understood (Holloway and Wheeler, 1996; Dey, 1993), and as such it is essential to describe participants' demographic details as these may affect interpretations derived from data analysis (Lafont, 2005; Fine, Weis, Weseen and Wong, 2003).

There were 331 registered staff employed in perioperative care at the National Health Service (NHS) Trust at the time the study, of which 56 were ODPs and 285 nurses; in total, 61 letters were distributed to this latter group inviting their participation (21.4% of the nursing establishment). Although letters were sent in batches of 10, one volunteer mentioned this study to a colleague; as she fulfilled the entry criteria she was sent a letter and information sheet and subsequently interviewed.

Twenty three nurses were interviewed (8.1% of the perioperative nursing workforce), all of whom were known as colleagues. These nurses had between 2½ and 30 years experience, of which between 2½ and 25 years was within perioperative care. Initially, the intention was to divide volunteers into 2 groups; one group who participated in CPE, and one group who appeared to have never participated in post-registration university education. However, only nurses who had accessed formal study accepted the invitation to participate in this study.

Group 1: Participants in CPE

Forty-six letters were distributed to perioperative nurses who were currently attending or who appeared to have attended CPE within the preceding 3 months. Of these, 28 people agreed to participate, however four had to later drop out due to work pressures, and another because she was emigrating. Despite arranging and re-arranging interview dates it proved impossible for these staff to be released for interview, and eventually they withdrew, but were apologetic for dropping out of the study. The 18 potential participants who declined to join the study did not state they would not be taking part or provide reasons for not participating. As stated within the information sheets sent to potential participants (Appendix III), after one calendar month it was assumed they did not wish to participate.

All 23 nurses in this group were female and worked in different departments representing perioperative suites throughout the Trust; all were currently studying or had attended CPE within the 3 months prior to joining the study. Further characteristics and demographic details for these participants are provided on the following page (Box I).

Interviewee	Nursing qualification	Grade (band)	Age band	Years qualified	Years in theatre	Highest qualification	Accessed CPE...	Works full or part time
P1	RN (Adult)	E (6)	40-45	5	5	DipHE	Voluntarily	Full
P2	RN (Adult)	E (6)	25-30	9	9	DipHE	Told	Part (34 hours)
P3	RGN	F (6)	50-55	12	12	BSc	Opportunistic	Full
P4 ¹	RN (Adult)/ODP	F (6)	30-35	10	8	BSc	Voluntarily	Full
P5	RGN	E (6)	45-50	25	25	BSc	Voluntarily	Full
P6 ¹	RGN/ODP	E (6)	30-35	13	10	DipHE	Voluntarily	Full
P7	SRN/RSCN	H (8a)	55-60	30	15	BSc	Voluntarily	Full
P8	SRN	D (5)	45-50	24	5	DipHE	Voluntarily	Part (28 hours)
P9	RGN/RNC	F (6)	30-35	14	14	DipHE	Voluntarily	Full
P10 ¹	SRN/ODP	F (6)	50-55	26	8 (4 ODP)	DipHE	Voluntarily	Full
P11	RGN	E (6)	25-30	8	8	BSc	Voluntarily	Full
P12	RGN	G (7)	40-45	20	20	MESOL	Voluntarily	Full
P13	RGN	F (6)	35-40	20	7	RGN	Voluntarily	Full
P14	RGN	G (6)	50-55	32	20	BSc Hons	Told	Full
P15	SEN/RMN	D (5)	50-55	24	2 ½	RMN	Voluntarily	Full
P16	SEN/RGN	E (6)	40-45	20	6	RGN	Voluntarily	Full
P17 ¹	EN/ODP	MTO3+2 (6)	40-45	25	19 (7 ODP)	NVQ3	Voluntarily	Full
P18	RGN	E (6)	35-40	15	15	BSc Hons	Voluntarily	Full
P19	RGN	E (6)	40-45	23	23	RGN	Voluntarily	Full
P20	RN (adult)	D (5)	40-45	3	3	DipHE	Voluntarily	Full
P21	RN (adult)	D (5)	40-45	2 ½	2 ½	DipHE	Voluntarily	Part (30 hours)
P22	RGN	E (6)	40-45	21	5	RGN	Voluntarily	Part (30 hours)
P23	RGN and midwife	E(5)	30-35	9	9	RGN	Voluntarily	Full

Box I: Key characteristics of Participants in CPE

Group 2: Non-Participants in CPE

Fifteen letters of invitation to join the study were distributed to staff who appeared from the theatre database to have never accessed formal study. Only one potential participant

¹ Originally qualifying as registered and enrolled nurses, these participants are dual qualified(nurse and ODP), but maintain their nursing registrations

explained that she would have liked to have taken part, but was unable to do so as she was emigrating imminently: The other 14 did not make contact, and provided no explanations why they would not be taking part. As for group 1, after one calendar month it was assumed these individuals did not wish to participate. Thus, whilst it was the intention to interview non-participants in CPE, no perioperative nurses within this group elected to be interviewed. As such, group 1 participants were asked their opinions of why people do not study, and to detail characteristics of these people.

It is possible to make assumptions as to why this group of people declined the invitation to participate, although these may not explain the real reasons why they decided not to join the study. The decision could be due to their attitude towards CPE, and a presumption on their part that as a member of the training and education team within theatres, the interviews may be a way of promoting formal university study, perhaps as an approach to their *Post Registration Education for Practice* (PREP) (NMC, 2008a) requirements. Alternatively, issues of power imbalance may exist within interviews due to differences in age, gender, perceived knowledge and status between the researcher and the interviewee (Kvale, 2006; Cohen et al, 2000; Oakley, 2000), and these may have prevented non-participants in CPE from volunteering to take part in this study.

The overall approach taken within this study intended to reduce power differences between the interviewer and participants (Chapter III). Although ethical approval for this study had been obtained and an open and honest approach adopted, implying openness and reducing power differences (Cohen et al, 2000), individuals may have felt uncomfortable or intimidated at the thought of sharing their thoughts due to power differences associated with the researcher's seniority and position within the theatre

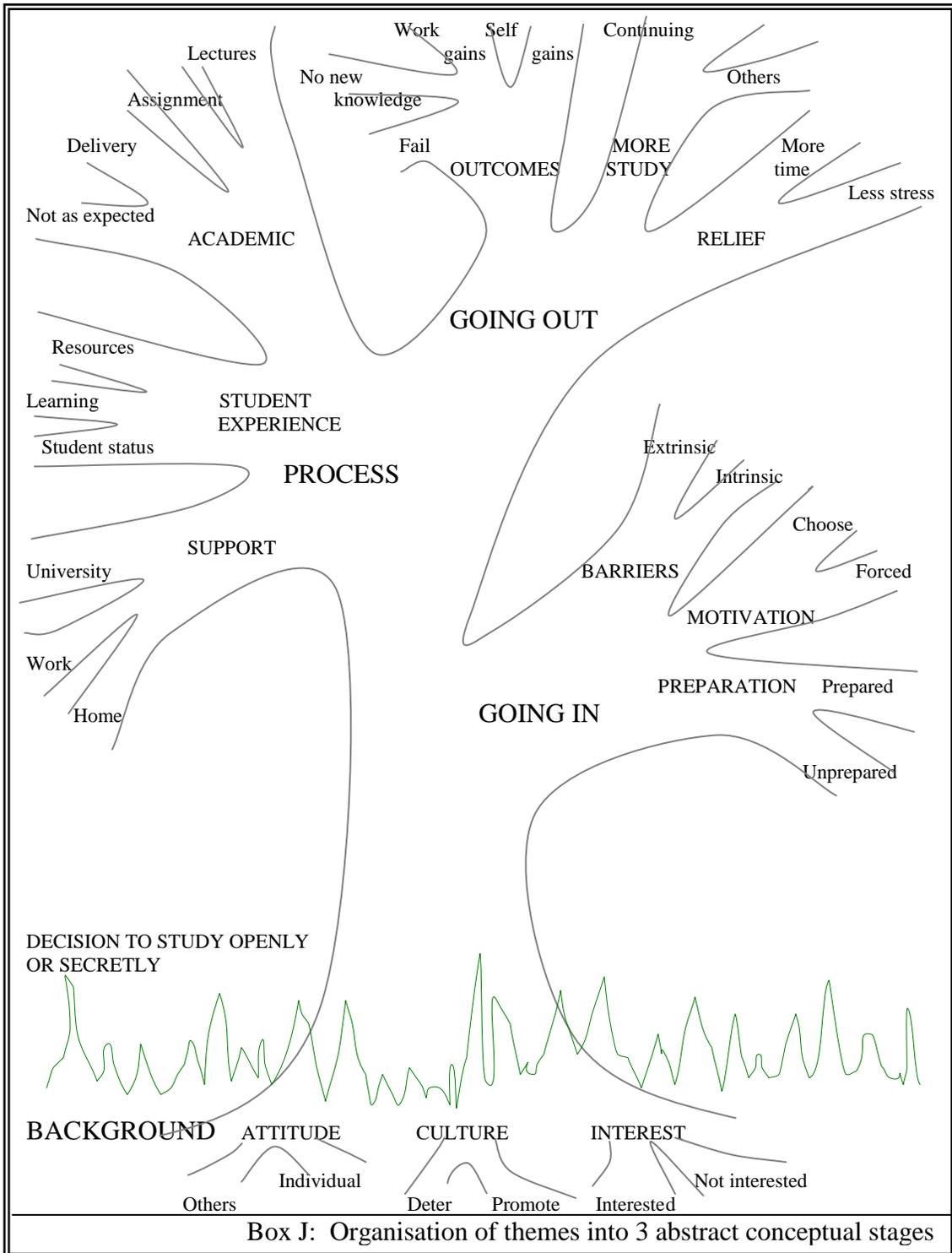
training and education team. They may have made judgements about the motives underpinning the study, and been concerned regarding the consequences of any interview in terms of their practice, and as a consequence decided not to participate. Interestingly, with the exception of one participant, these people did not state they would not be taking part even though they were seen on a daily basis, and never mentioned the study, supporting the view they may have declined for reasons of power and intimidation. Their concerns may have been further raised considering this work was undertaken for a doctoral degree when the majority of these people were in possession of diplomas in nursing.

The non-participation of this group was initially a source of disappointment, as suggestions why some nurses did not undertake university courses could only be intimated by those in group 1, meaning one of the study goals could not be achieved. However, on reflection, that staff declined to participate strengthens the viewpoint, put to the Local Research Ethics Committee (LREC) in response to their concerns (Chapter III), that staff would not feel obliged to participate merely because of working relationships. This view strengthens the ethical premise behind this study, and aids credibility to its findings, as those who agreed to participate are likely to have agreed to be interviewed of their own volition rather than through fears of repercussions should they not take part. Due to the inability to recruit to this group, all discussion relating to non-participating in CPE in the findings Chapters is based on the perceptions of those participants who had undertaken formal study.

Conceptualising Perioperative Nurses' Experiences of CPE

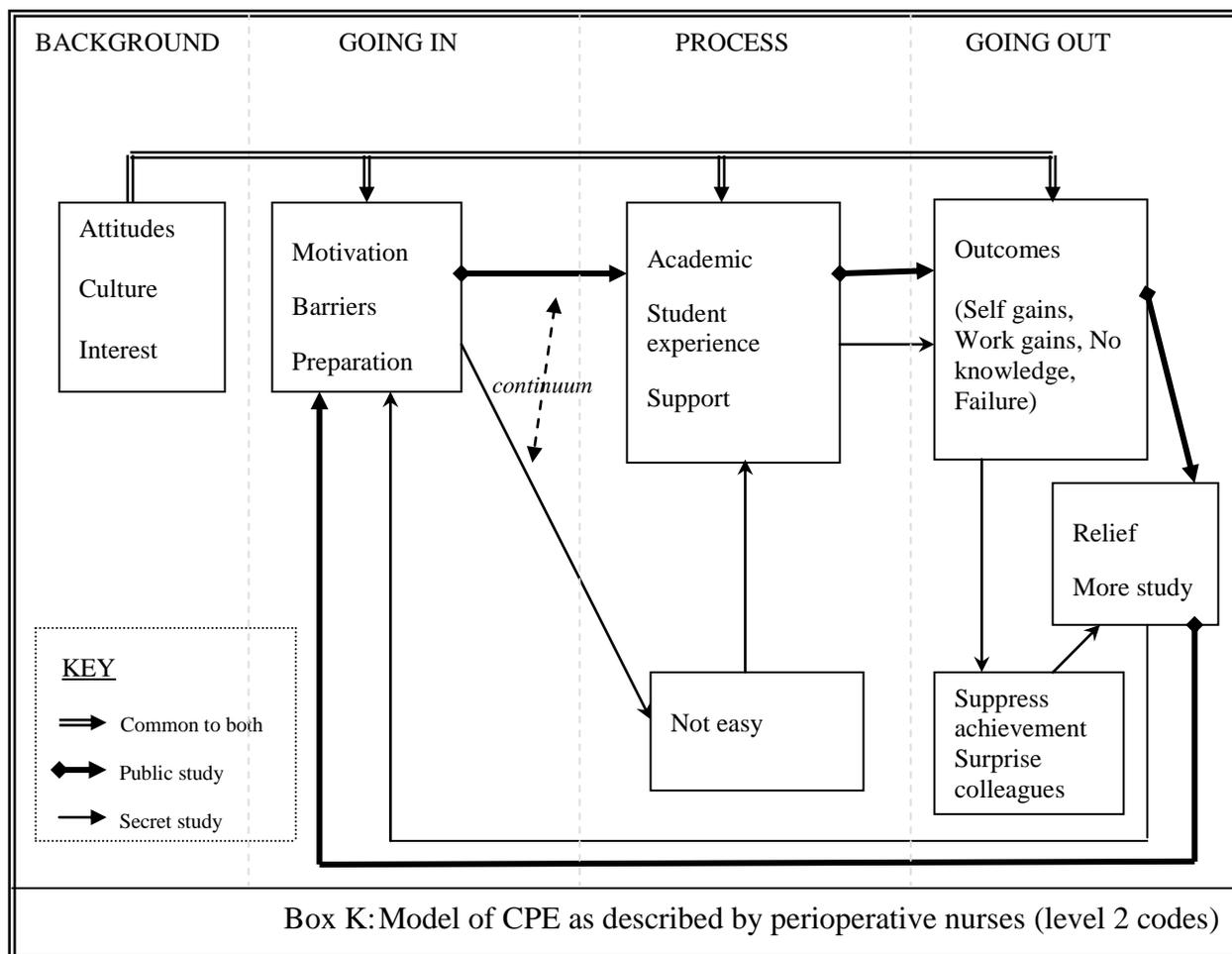
Despite individual perspectives on truth (Lafont, 2005; Benton and Craib, 2001; Natoli, 1997) there are similarities which can be derived between interviews. Coding and categorising interview of transcripts was undertaken as described in Chapter III. Combining these into themes enabled inter-related commonalities between experiences to be noticed, which allowed a picture of the phenomenon to emerge (Seidel, 1998a). Inclusion of an extract of coded transcript (Appendix VIII) illustrates how codes were assigned, and the family tree (Appendix VII) provides details of codes, categories and themes at levels 3 and 4. Whilst grouping of codes represents an interpretation of participants' experiences, inclusion of these contributes towards transparency within data analysis, and goes some way to allowing readers to understand the thought processes behind these initial stages of interpretation (Dey, 1993). It also provides more detail of nurses' experiences of CPE than it is possible to report in these findings.

Notes were made continuously during data analysis to identify emerging nascent categories, and areas which needed to be explored further within subsequent interviews (Etherington, 2004; Seidel, 1998a). When theoretical saturation was achieved, descriptive paragraphs were written about each theme, to assist with the visualisation of relationships between these themes (Morse and Field, 1995). The emergent themes were also connected at a higher, more abstract level to aid the conceptualisation of university study as experienced by perioperative nurses. These 3 conceptual stages (Box J) each had a number of constituent boughs and branches or themes and categories, descriptors of which can be found in Appendix VII. The background influences of attitudes and culture levels of interest rise through this tree, transcending all aspects of CPE, including whether to study in secret or publicly: a decision made at grass roots level, at the point



of entry to university and dependent upon multifarious factors, both intrinsic and extrinsic to the practitioner. Also located here is the level of interest a practitioner has in their study; again this impacts on all aspects of the journey through CPE.

To provide a comprehensive description of perioperative nurses' perceptions of formal study and how the themes within this are inter-related (Carpenter, 1995) these themes (Box J) were mapped pictorially as a flow diagram (Box K) to aid visualisation (White, Woodfield and Ritchie, 2003). This diagram also illustrates how the 'journey' through CPE, an analogy also made by Stanley (2003), is experienced and the similarities and differences in the journeys of those who study secretly and publicly.



The themes revealed by participants in describing their educational journeys mirror to some extent those of nurses working within other specialties (Chapter II), especially to those findings reported by Stanley (2003). Within each theme, however, differences were apparent which related to the nature of perioperative care and working within a

multi-professional environment. In addition the data revealed that in some cases participants studied secretly, with degrees of this from telling absolutely nobody they were undertaking CPE to telling only certain people: Little significance is attached to this secret study, or degrees of openness, within the existing literature.

Participants' educational journeys are described within the findings chapters, where the themes (Box J and Box K) and their relationships are discussed and the patterns revealed are explored (Dey, 1993), as are deviations from these (Seale, 2004), within the context of the abstract themes. Chapter V details the influence of individual attitudes and culture which pervades all aspects of CPE (the background theme illustrated above). Following this, focus is turned to the actual educational journey, from the factors which influence whether perioperative nurses access formal study (going in) through the processes of this, to the outcomes (going out) which result from attendance (Chapter VI). The final chapter describing the findings (Chapter VII) relates to the phenomenon termed 'secret study'; the extent to which participants reveal to others they are studying.

The constraints of the written word mean these findings are presented linearly, and indicate one course of CPE often leads to further study. However, this is not a circular process; rather it is helical in nature as people are more prepared when they re-enter education than at their initial contact

I could transfer the skills I'd learnt in my diploma and build upon them to do a degree, whereas if I'd have stopped ... I wouldn't have lost it all, but it wouldn't be as fresh as it was

[Participant 6, senior perioperative practitioner]

[I]f I hadn't of done the conversion I wouldn't have gone on and done the diploma ... I wasn't always confident that I'd be able to do that type of study, at that level, and I think as I passed that ... [it has] given me more confidence to do other things

[Participant 16, senior perioperative practitioner]

Interviewing participants revealed a mass of rich data detailing participants' individual experiences, the inclusion of which would extend beyond the research goals (Chapters I and II). Due to word count restrictions it was not possible to explore in detail every category derived during data analysis, and selectivity was required (Dey, 1993). The findings are reported at levels 3 and 4 of the family tree (Appendix VII), and only those which appeared to be unique to perioperative nurses' experiences and perceptions, or where current knowledge of CPE has been extended, are explored fully. Where themes have been excluded, the rationale for this has been identified.

In presenting participants' experiences, first narratives of their experiences of CPE were written, based on re-constructions of their experiences, holding the literature in abeyance. Once their stories had been committed to paper, pertinent quotes were inserted to illustrate the findings and place these within the context of the interviews (Silverman, 2005; Holstein and Gubrium, 2004; Kvale, 1996), strengthening the credibility of these narratives. Whilst full transcripts were used to analyse interviews, in presenting the findings, some quotes were edited for ethical reasons and to improve their readability (Poland, 2003; Arksey and Knight, 1999; Kvale, 1996). Where this has occurred, the convention [] indicates changes to the text and (...) that words have been removed.

The final stage in documenting the findings was to turn to the literature to explore similarities and differences between perioperative nurses' experiences and those of nurses from other specialities. Reference is also made to participants' experiences and perceptions which deviated from those most commonly described and alternative explanations are offered for these (Silverman, 2006; Seale, 2004, Dey, 1993). The intention in using this approach was to provide clarity between what was revealed by

participants and the interpretations of this data (Seale, 2004), to add to the credibility of the consequent descriptions (Silverman, 2006; Sandelowski, 1993).

The findings presented in the following chapters are not intended to present one overarching truth, but are interpretations on the perspectives of this (Natoli, 1997) based on participants' descriptions of formal study and the contextualisation of these within the existing literature. By virtue of this alternative version of truth, readers will gain a different focal point from that currently possessed which may combine with their own perceptions, or provide a different perspective. This may allow a greater understanding of nurses' experiences and perceptions of post-registration education and re-contextualisation of discourses (Ward, 2003; Natoli, 1997; Hodge, 1995) relating to how such formal study is experienced by perioperative nurses.

Chapter Summary

This chapter details participants' characteristics (Box I), and provides a tentative rationale why some staff declined invitations to participate in the study. Just as there are individuals within society who do not embrace the concept of lifelong learning (Gopee, 2001a), or exhibit characteristics of lifelong learners (Knapper and Cropley, 2000) there are those who do not embrace the concept of CPE within perioperative nursing, and it was these nurses who did not volunteer to participate.

The information participants provided has been organised to illustrate the themes relating to CPE as described by perioperative nurses (Box J). The relationship between the codes used to annotate participants' descriptions of their experiences and perceptions is presented as a conceptual model of CPE (Box K) which is pertinent to nurses working

within perioperative care. The themes to emerge focus on the background issues of the culture in which perioperative nurses worked and the nature of nursing as a profession, and the attitudes of managers towards nurses entering higher education; the decision on whether to undertake formal study; the experiences of nurses as they study; the outcomes of formal education; and the phenomenon of secret study.

The following chapters explore further the emerging themes within the model, and relate these to the similarities and differences within existing published and unpublished literature. They contextualise the experiences of perioperative nurses undertaking CPE, and explore their significance for nurses working within this area of patient care, and for other stakeholders involved in post-registration formal education as identified in Chapter I. Perioperative nurses' perceptions and experiences of post-registration university education have not previously been documented within the literature.

Chapter V begins this process by providing a description of the influence of the culture of perioperative nursing and the attitudes of others within the perioperative multidisciplinary team towards nurses undertaking university-based study. This theme was apparent in all interviews and impacted on all stages of participants' journeys as they travelled through CPE, from the decision to enter university to the outcomes derived from their study, as well as the degree of openness with which CPE is pursued.

Chapter V

CPE WITHIN PERIOPERATIVE PRACTICE

The model presented in the previous chapter (Box K) illustrates how continuing professional education (CPE) is embedded within the culture of perioperative practice. The culture in which participants were located along with managers' attitudes pervaded all aspects of CPE from the decision to undertake formal study and the openness with which this is pursued, through to its outcomes. Whilst other research demonstrates the influence of culture and managerial attitudes within CPE (such as Ellis and Nolan, 2005; Ryan, 2003; Stanley, 2003; Nolan, Owens and Schuller, 2000; Dowswell, Hewison and Hinds, 1998a), no research has investigated these within the context of the perioperative environment.

This chapter explores perioperative nurses' descriptions of the culture in which they work, and their colleagues' attitudes pertaining to CPE. These issues are then contextualised within the literature relating to professionalism within nursing, and socialisation into a profession, and the potential for horizontal violence amongst nurses. Individual attitudes and interest in education also pervade all aspects of CPE, and reference to these is made throughout this and subsequent chapters.

Cultural issues related to CPE

Despite requirements for nurses to continually develop through *Post-Registration Education for Practice* (PREP) (NMC 2008a), and government initiatives detailing the need for continually updating competence to practice (DH 2004a; DH 2004b), this did not appear to be embedded into all departments in which participants worked. Other

studies (Gopee, 2003; Audit Commission, 2001; Phillips and Friedman, 2001; Hinchliff, 1998) report organisational culture affects nurses' access to CPE, and participants described similar perceptions. This culture is not related to an anthropological definition, but the environment in which nurses find themselves, and shared patterns of professional behaviour which arise from interactions between shared assumptions, beliefs, norms and values (Egan, 2002). Whilst some participants believed their department endorsed CPE for all, others thought this was not so well supported, and conditions affected access to university

[E]veryone [here] is really into studying, and the attitude is right. Everyone supports each other, and is open in what they are doing

[Participant 5, senior perioperative practitioner]

In my area, there's not anybody who resents people learning, or training or developing further

[Participant 6, senior perioperative practitioner]

I work short in theatre if someone's got to go off on study, and ... when they come back they're more willing to put that extra bit in so that somebody else can go

[Participant 9, team leader]

It ... depends on the shop floor, allocation of resources, your motivation, and what you can bring to the department

[Participant 14, charge nurse]

Whilst national initiatives such as *Knowledge and Skills Framework* (KSF)(DH, 2004a), and *Agenda for Change* (DH, 2004b) aim to increase staff development, one participant asserted this is in conflict with their work environment

[W]e're in a bit of a quandary in the National Health Service ... [E]verybody wants us to ... be better educated ... but ... people are very stressed out with ... staffing levels

[Participant 10, team leader]

Despite national emphasis on staff development, developmental opportunities were not always available in individual areas due to other pressures including staffing problems.

This concurs with one of Schuller's (2000 p230) participants who described 'schizophrenia' within management attitudes towards staff development, where the importance of development is promoted, but money allocated elsewhere. However, rather than a case of money being diverted to areas of greater need, some participants' struggles to enter CPE appeared indicative of a culture which did not support the concept of staff development.

In areas where participants felt study was restricted, other signs suggested a lack of importance placed on staff development. Many had not had appraisals in agreement with earlier findings (Barriball, 2002), whilst others stated these were conducted infrequently, and consequently few participants had personal development plans (PDRs)

I've never had one [PDR] while I've been here! Never!

[Participant 1, senior perioperative practitioner]

I'd say about 5 years since I've had one [appraisal]

[Participant 12, charge nurse]

Nationally, it is estimated only 60% of NHS staff have an annual appraisal (Parish, 2007) however the number within theatres appeared to be lower, based on participants' comments. Although Parish (2007) states 20-30% of staff are unsatisfied with the appraisal process, many participants were saddened to not receive feedback on their development, and perceived this as manager apathy, which left them feeling undervalued. As Hamlin (2000) also documented, participants explained feedback is only provided should others feel their performance needs improvement. In the absence of appraisal, they were left trying to evaluate and reflect upon their own progress

[Y]ou try to see how you think you are progressing yourself, but nobody actually tells you ... whether you are doing really well ... or whether you could be doing better

[Participant 1, senior perioperative practitioner]

[H]opefully your manager or whoever would tell you if you weren't so you hope you do a good job of it

[Participant 16, senior perioperative practitioner]

This suggests for participants who do not have PDRs, CPE fills a void and provides external evaluation of their abilities, rather than just 'plodding along' with practical roles. Those few participants who had development plans spoke excitedly of how these both legitimised and provided a focus for their development

You can see your own progression and you don't mind working towards it

[Participant 1, senior perioperative practitioner]

[I]t's been on my review for ages to ... get my diploma. ... I've actually met ... something I've written down!

[Participant 8, perioperative practitioner]

Gopee (2003) identified development plans were important in instigating lifelong learning, however, participants indicated they would study even without such plans, even though it was not easy to choose appropriate courses to attend due to the nature of the speciality. This suggests there may be a greater need for perioperative nurses to have development plans compared to the ward nurses to facilitate appropriate study

I am ready to move on, but it's where do you move on to, and ... what do you do? ... I need ... goals

[Participant 1, senior perioperative practitioner]

[I]n theatres it's just not that ... clear cut ... the path for people to take. ... [O]n the wards, there's always courses to do things with patient centred care, whereas ... in theatre it's a bit more vague

[Participant 13, team leader]

Participants explained the courses they were able to access were not only influenced by their own needs, but also those of their manager, the wider National Health Service (NHS) culture and the political agenda. Participants experienced difficulty in entering CPE if there was incongruence between these needs

[Y]ou can't ask one department to allow you the time to go and study for something that is not ... going to be of any benefit to them. ... [They say] they can't release me, [I] can't have study leave, its not relevant

[Participant 1, senior perioperative practitioner]

The Trust want people to do the mentorship qualification else they're not going to get the trainees

[Participant 17, team leader]

[T]he only study days is only for mentorship, nothing else

[Participant 18, senior perioperative practitioner]

Participants thus appeared unguided and unsupported when trying to access CPE. In the absence of a transparent development plan to meet these differing needs, participants appeared to flounder until they found a course which met their needs, and which they would be supported to attend

I was going to do the ODP [Operating Department Practitioner][fast track], and I got told years ago not to bother ... because I was an RGN [Registered General Nurse] and ... only SENs [State Enrolled Nurses][were] looking into it. ... [W]e haven't got a child nurse here and if we don't have one soon we're not going to be able to operate

[Participant 9, team leader]

Despite the presence of the same professional groups, and the same internal pressures of staffing and workload, and external pressures from political drivers and professional bodies, CPE was not undertaken equally by perioperative nurses in all theatre suites. This implies something beyond the culture of perioperative practice influenced the culture regarding education and developmental activities.

Attitudes towards CPE

Previous studies found the decision to enter CPE is influenced by the attitudes of colleagues, senior staff and other professions working in the same area (Ellis and Nolan, 2005; Gopee, 2003; Ryan, 2003; Schuller, 2000; Dowswell et al, 1998a). Similarly, within perioperative practice, the attitudes of one's managers, peers and medical and

operating department practitioner (ODP) colleagues appeared to influence whether participants entered formal study, and the degree of openness with which they discussed their studies with colleagues.

Managerial Attitudes

[I]t depends on your manager's attitude as well

[Participant 13, team leader]

Managers' attitudes towards CPE have previously been identified as pivotal in determining the cultural milieu (Stanley, 2003; Schuller, 2000), and attendance at university (such as Ellis and Nolan, 2005; Ryan, 2003; Gopee, 2002; Hardwick and Jordan, 2002; Nolan et al, 2000). Participants also explained the influence of these attitudes, and often used the words 'lucky' and 'fortunate' in relation to being granted permission to study

I was quite fortunate, I had good support from my manager, who allowed me to ... do my degree

[Participant 4, team leader]

[L]uck played a part

[Participant 19, senior perioperative practitioner]

Managers held different attitudes towards their staff attending university, and in agreement with other studies (Ellis and Nolan, 2005; Ryan, 2003; Nolan et al, 2000; Schuller, 2000; Nolan, Owens and Nolan, 1995), participants described where managers were studying, staff were more likely to study. The most senior participant interviewed was 'all for' staff development, thought it 'marvellous' and encouraged her staff to study; participants for whom she was a manager reinforced these comments. A lack of interest from managers was a source of discontent for many participants, who spoke sadly of their situations, and how this complicated access to CPE

I'm being prevented from progressing as much as I'd like to academically
[Participant 1, senior perioperative practitioner]

She's not interested! ... I don't think she actually does any ... re-registration stuff
[Participant 2, senior perioperative practitioner]

I mentioned ... I was interested in doing my degree and [my manager] just said no. ... [S]he wasn't interested. ... I then moved to another area where the manager was really supportive
[Participant 5, senior perioperative practitioner]

A number of rationales were presented to explain managers' perceived attitudes towards CPE, and why some prevented access to enter higher education. Some participants explained these related to the anticipated departmental costs outweighing any benefits which may result from formal study, allowing an individual to attend university

I wonder if they think ... you're not going to want to come to work, or you might ring in sick more often or you've not got your full amount of energy
[Participant 1, senior perioperative practitioner]

[P]eople who haven't got those qualifications ... think it's just a paper exercise
[Participant 12, charge nurse]

[T]hey haven't seen the benefits themselves, so they can't really see why anyone else should bother
[Participant 13, team leader]

Thus, some participants perceived that managers viewed CPE as a futile exercise. However, as found by others (Gopee, 2003; Jordan and Hughes 1998) some participants believed managers may feel threatened if their staff gained qualifications they themselves did not possess. This related to their own insecurities in terms of academic ability, and confidence to enter university, and also their credibility as a manager

[T]hey are frightened to death that people'll come and tell them that they can do the job better, because they've got more knowledge. ... [I]f they're in a job that they feel is relatively secure, then ... it's [CPE] not a threat to them, then it's not a problem
[Participant 12, charge nurse]

[T]hey see ... people ... getting wads on paper ... and they haven't and maybe they see that as a threat

[Participant 13, team leader]

Thus, whilst some studies report managers are largely supportive of personal development needs being addressed through formal study (Phillips and Friedman, 2001; Nolan et al, 2000) participants believed managers had to perceive departmental benefits prior allowing staff to study. That is, managers, irrespective of their attitudes towards CPE, as leaders within the culture, acted as gate-keepers to university courses. Even if a participant could justify why they should study managers had the final decision in whether they would support the individual. In addition, as Maggs (1998) identified, certain qualifications were associated with specific grades and roles within nursing

I really wanted to do the IV training but ... we're not often giving drugs, so they [managers] said ... it's not suited in your work

[Participant 11, perioperative practitioner]

[T]here is an assumption ... when you get to a certain level, you should have certain courses already under your belt and if you haven't ... they won't support you

[Participant 12, charge nurse]

[M]y manager ... said '... [W]e can't let you go ...' I said 'why [not]? ... I'm going to achieve this, and I'll be able to do this, this, this and this when I come back'

[Participant 14, charge nurse]

Whilst managers may be supportive, 'sickness' and 'staffing levels' beyond their control were cited as hindering access to CPE, as was the political importance of the course which staff wished to undertake. Participants illustrated those wishing to undertake more theoretical courses with lower political profiles were disadvantaged compared to those wishing to attend practical courses, as reported in other areas of nursing (Stanley, 2003). This resulted in practice based modules being more easily accessed than those which were theory based or which completed academic awards

[Waiting] seems to be on things that I wanted, that perhaps they thought I didn't need to have

[Participant 1, senior perioperative practitioner]

I struggled ... to get the rest of the credits [for a diploma]

[Participant 19, senior perioperative practitioner]

Participants' responses implied within some departments, the demand for CPE may be greater than the number of people able to attend. As such, managers needed to determine who would be supported to study, and participants described different systems were used to establish equitable access

[T]hey put names into a hat. ... They look at ... who did the last course

[Participant 19, senior perioperative practitioner]

Despite such systems in some departments, participants tended to feel inequality existed in terms of access to CPE, as previously reported (Ellis and Nolan, 2005; Barriball, 2002; Nolan et al, 1995). Some senior participants went further to describe explicit inequality, whereby colleagues were repeatedly favoured for development opportunities

I think the NHS traditionally ... has earmarked people for certain roles and ... if you're not within that perception and you want to aspire, you've got to push. ... If your face fits you can get on ... and if it doesn't you won't. ...

[T]he same people get on the same courses all the time

[Participant 12, charge nurse]

[I]t's about sussing out who your manager is, what their frame of reference is, and if you play their game. ... People are ear-marked, because they might fall in line. ... [Some] people ... are allowed to go on many, many things ... and that is because these people are seen to be 'doers'

[Participant 14, charge nurse]

Whilst Ellis and Nolan (2005) report the majority of nurses in their study were asked if they wished to attend university, the majority of participants explained how they needed to actively 'push' and 'pester' managers to access CPE, or be overlooked

[H]ad I not have pushed ... they'd have quite happily said 'oh well, do it next year' ... and then the next year they'd have probably took the goal posts and moved them

[Participant 12, charge nurse]

I've had to keep ... pestering people. ... You just have to show the interest ... and keep reminding them that you want to do the course

[Participant 20, perioperative practitioner]

That is, even where systems were in place to reduce perceived inequality, it was not as simple as asking for names to be placed in a 'hat'. Whilst it could be argued for participants to repeatedly demonstrate their desire to study also illustrates their enthusiasm for this, such inequality and the need to 'pester' to enter CPE may mean some staff gain access to university at the expense of less vocal colleagues who may benefit equally given the opportunity.

The influence of the manager and their interest in formal study determined the ease with which participants were able to access university education. Whilst various rationales were used to explain managers' attitudes, participants were saddened if unable to attend university, or if barriers were encountered which made access more difficult, especially when inequality of access was perceived. In addition to managers' attitudes, the attitudes of nursing colleagues also influenced the culture relating to CPE.

Other Nurses' Attitudes

[F]or most of the time I've been nursing, it's been part of your PREP that you ... have to do so much studying. So I think people have adapted to it. ... I suppose some people do begrudge it

[Participant 22, senior perioperative practitioner]

Whilst the manager's attitude leads the culture with regard to CPE, other nurses' attitudes also appeared integral in shaping the overall cultural values. That is, as McGivney (1990) described, one's peer group influences an individual's actions in

terms of accessing education. As reported in other professions (Phillips and Friedman, 2001), participants believed their colleagues had differing attitudes towards CPE, and even in cultures reported to be predominantly supportive of nurses' development, 'a lot' of nurses did not wish to attend academic courses. Two disparate groups of nurses were described within perioperative nursing culture; those nurses who engage in formal study, labelled by participants as 'academic', and those who do not want to study, characterised as 'practical'. As identified by others (Furze and Pearcey, 1999; Houle, 1980), these attitudes affected the quantity and kind of education undertaken

One or two people ... seem to find it [CPE] a doddle, probably because they are just very academic people

[Participant 1, senior perioperative practitioner]

[I]f you're an academic type of person ... whereas I'm not. I like to get in and do my job

[Participant 2, senior perioperative practitioner]

[T]here [are] people who are more into all the research ... and the other ones who come into it because they want to care. ... You can tell who's more academic than hands on nursing

[Participant 9, team leader]

Several participants described how their desire to gain academic qualifications was seen as inappropriate by some of their colleagues, especially if these colleagues had not previously attended university. In such circumstances, participants justified gaining theoretical knowledge by relating this to, and emphasising, practical outcomes

Quite a lot of them were wondering '... You're only doing what we're doing anyway, so why are you doing it?'. ... I justified myself ... saying it was going towards doing ... Hickman line removal. ... [T]hat is how I justified it - to myself as well

[Participant 3, team leader]

This would imply for CPE to be considered meaningful from some nurses' perspectives, behavioural changes should result. This may be related to political, professional and

organisational drivers for nurses to acquire practical skills to allow them to undertake extended roles (DH, 2000a), however such practical developments need to be underpinned with theory due to accountability issues within nursing (NMC, 2008b).

In agreement with previous studies (Stanley, 2003; Alejandro, 2001), many senior participants illustrated how staff who were keen to develop academically also displayed enthusiasm in other areas of work compared to those who did not access CPE

[I]t is proactive people rather than people who just turn up and do a job and go home

[Participant 4, team leader]

[T]here are ... people who ... seem so enthusiastic and motivated about their job, that it surprises you that they don't want to undertake further study

[Participant 6, senior perioperative practitioner]

[They] come to work ... they enjoy their work, and ... if a problem comes ... they will sort it out. ... [T]hey just have ... this aura, that they do want to learn

[Participant 7, matron]

Although the majority of senior participants equated enthusiasm in work with an increased desire to study, this was not always applicable, and one participant explained her surprise that enthusiastic colleagues did not always want to study. However rather than a lack of desire, it may be individuals wish to study but are prevented due to extrinsic and intrinsic barriers (Chapter VI).

Whilst Beatty (2001) found no significant relationship between colleagues' support and their own CPE, participants perceived colleagues who were less likely to study were less supportive. This appeared to relate particularly to older nursing colleagues who did not study, and to a notion that CPE allowed participants to take 'time off' work. Many participants related this attitude to the impact of their study on colleagues

[S]ome of my colleagues, were ... of the opinion I was having a day off ... that I was ... shirking. ... [T]he department was very short staffed, and I think they felt it was unfair

[Participant 6, senior perioperative practitioner]

I got gripes that they were busy ... [and] had problems covering. ... [I]t was 'why do you need to go and do a theatre course? You can learn everything here. We'll teach you everything'

[Participant 14, charge nurse]

'I'm the fool that's doing the course', that's what they'll be saying

[Participant 21, perioperative practitioner]

Such comments left participants with negative feelings, and they used words such as 'guilty' and 'selfish' in relation to attending university, despite in most cases receiving work support to study. In an attempt to minimise the impact of their course on colleagues, perhaps due to these feelings, participants did not always utilise study days

I took annual leave to attend the university. I thought that was a fair compromise

[Participant 6, senior perioperative practitioner]

However, this did not necessarily mean colleagues would support a participant. Although reported previously (Gopee, 2003; Stanley, 2003; Nolan et al, 2000), such hostility may have been especially prominent at the time of data collection considering the KSF (DH, 2004a) was newly in place, new job descriptions had been issued Trust-wide, and staff were anxious as to the effects of these financially. This suggests colleagues' lack of support may not just relate to the physical work to be done in participants' absence, but also psychological relating to the implications of their not studying on their future role. As others report (Davey and Robinson, 2002; Hardwick and Jordan, 2002), and similar to the reasons attributed to some managers' negative reactions, participants described in some cases their CPE lead to resentment from peers and senior colleagues if they too did not have the same qualifications

[M]ay be they're just feeling a little bit threatened

[Participant 8, perioperative practitioner]

*[S]ome people do it in their own time ... but it can [still] be resented. ...
Because I've got academic qualifications, some of my peers resent the fact
that I've got them*

[Participant 12, charge nurse]

Some are jealous

[Participant 23, senior perioperative practitioner]

Whilst these findings demonstrate nurses' attitudes towards CPE, by virtue of their involvement in formal study, participants may hold different perceptions of this from colleagues who do not study. Further research would be required to gain insight into the similarities and differences between staff who do and do not access formal study.

Medical Staff Attitudes

I think they think you just train, and then that's it, end of story

[Participant 17, team leader]

As a part of the perioperative multidisciplinary team, medical staff's attitudes also contribute to the cultural milieu, however few studies explore their attitudes towards nurses' CPE (Hardwick and Jordan, 2002; Scholes and Endacott, 2002; Jordan and Hughes, 1998; Carter, 1994). Many participants believed doctors lacked awareness of, and interest in, nurses' academic qualifications, and were only interested in nurses as 'handmaidens' for the skills they possessed which enabled them to provide a service. However, others described if they were aware of a nurse's development they were generally supportive, even if they did not appreciate the need for academic qualifications to underpin existing nursing skills

[The surgeon] said 'Well why are you going?' I said 'It's so I can look after students'. He said 'But you do that well enough now'

[Participant 2, senior perioperative practitioner]

[T]he medical staff are oblivious to our qualifications. ... They may even do pass comment 'you go to university, and for what [emphasis]?' ... Some who did know were supportive, and curious ... as in, 'oh what are you doing?'

[Participant 6, senior perioperative practitioner]

[H]e [surgeon as mentor] was really good ... and ... took time and went through things with me

[Participant 10, team leader]

As such, it may be a lack of awareness which creates this perception, as once aware an individual was studying most doctors were perceived as interested in nurses' development. This is in contrast to findings by Carter (1994) who described a perception that doctors believed all nurses' continuing education should occur in clinical practice, and suggests attitudes towards nurses' post-registration development have altered over the last decade. Some participants suggested medical colleagues 'approved' of CPE and 'liked' that nurses were seeking 'more knowledge' by attending university. A few participants also suggested this reaction could be due to the medical staff themselves attending university, and being able to relate to nurses' experiences. This interest appeared particularly evident when the course was related to practical skill development

[S]ome of the more specialist modules ... they would see those ... as relevant ... but modules such as clinical governance ... I can see them thinking '...why do you need to know this?'

[Participant 6, senior perioperative practitioner]

[W]e had someone quite junior scrubbing who'd ... hardly done it. ... [A]fterwards, [the consultant] said '... I ... see the point of this course now'

[Participant 10, team leader]

Within theatres, participants undertaking courses which intended to extend their practical roles required assistance and mentorship from medical staff. Despite previous research describing a reluctance to allow nurses into traditional medical territories (Masterson, 2002), doctors were described as 'fabulous' and 'really supportive', by

participants whose CPE necessitated the involvement of a surgical mentor, and they explained how they willingly provided time to discuss aspects of clinical practice and develop the nurses' practical skills. However, whilst this time was freely given, one participant expressed doubts over their integrity

[A]lthough they ... seem really enthusiastic ... you often get the odd little comment like 'oh well, it'll take quite a while before that happens'

[Participant 4, team leader]

Whilst participants believed doctors were more interested in courses which intend to enhance practical skills, such courses may be threatening to the medical profession. As reported elsewhere (Scholes and Endacott, 2002; Jordan and Hughes, 1998) participants described resistance against role extension into traditional medical domains was evident in their areas of practice. They explained a gradual and reluctant acceptance of these was a result of government initiatives which impacted on perioperative care

[A]bout 4 or 5 years ago ... somebody ... brought up the ... anaesthetic practitioner [role] and ... the anaesthetists [said] '... [T]he Royal College of Anaesthetists will never allow somebody that's not a doctor ... to undertake this course ...'. But we're over a year into the course. ... [T]hey're just having to accept it

[Participant 4, team leader]

[T]here's all the European directives. There's a reduction ... in the doctors' hours. ... There's nobody else to do it

[Participant 14, charge nurse]

Whilst such initiatives may have arisen due to legislative changes, if medical staff support such development, on a practical note, they can be assisted during surgery and this may be the source of their interest. However, they may fear for their future role in theatre if perioperative nurses were allowed to develop extensively. In taking on mentorship roles medical staff can ensure where professional boundaries are crossed they are trespassed only to acceptable limits, and nurses remain in the subordinate handmaiden role, and as such it may be an act of self-preservation.

Whilst some participants described how their practical development may threaten medical staff, others perceived doctors may be uncomfortable with nurses' academic development, and the consequences of this to their professionalism and status

I can imagine some people being quite threatened ... having a scrub nurse telling you ... you shouldn't be doing that ... if their knowledge is greater ... than yours

[Participant 13, team leader]

I think they do feel threatened, now that nurses are taking up masters, doctorate ... and professors

[Participant 14, charge nurse]

If nurses begin to question the theoretical basis of medicine though increased knowledge, this could challenge its patriarchal dominance, closing the divide between the professions. Participants believed the magnitude of the threat posed by perioperative nurses' academic and practical development was dependent upon the grade of medical staff concerned, their socialisation into medicine and their role-frame for nurses

I wouldn't have thought a consultant would feel threatened because of their ... seniority ... their background, their education, their expertise

[Participant 7, matron]

[S]ome of the younger people ... benefit, because it takes some of ... the pressure off them. ... [T]hey ... [d]on't realise how much we've taken on, on our role. It's just expected ... that's what we'll do

[Participant 16, senior perioperative practitioner]

[T]he consultants I work with are quite confident - arrogant, sometimes - people, so I don't think they would be fazed by it

[Participant 17, team leader]

In general, perioperative nurses perceived medical staff as either apathetic towards or supportive of their development, and as Hardwick and Jordan (2002) also report, there appeared less resentment from medical staff to nurses developing academically than from nursing colleagues. No participants stated medical staff, unlike some nursing colleagues, had antagonised nurses with regard to their study, even where the CPE

encroached on traditional medical territories. However, they suggested there may be ulterior motives for this support, based on insecurities over professional boundaries and job roles, related to the seniority of the medical practitioner.

Operating Department Practitioner Attitudes

[T]here was always this divide between the two groups

[Participant 17, team leader]

Just as professional boundaries exist between nursing and medical staff, so they exist between nurses and ODPs. This divide is particularly evident when ODPs and nurses do not multi-skill (Timmons and Tanner, 2004), as in the Trust where this study was conducted. These professional boundaries and territories appear to have influenced interaction relating to CPE as no participants, even those dual qualified, sought or gained support from ODPs. Only one participant provided an insight into ODPs' attitudes towards CPE, which indicated similarities and differences with nurses' attitudes

[N]urses have always been keen to ... continue with education, whereas ODPs have always been quite willing to just stand back. ... I suppose ... a few of them are keen, but not many

[Participant 17, team leader]

There has only recently been a requirement for ODPs to present evidence of their continuing professional development (CPD) (HPC, 2008), and in light of this need, their attitudes may evolve. However, this participant described ODPs as a 'lazy bunch mentally', with a 'selfish attitude', that did not appreciate the benefits to their department from her CPE. She explained many were not supportive of her having 'every Friday off', or of others' education and development.

Her comments suggest that ODPs can be likened to older nurses who emphasise the practical nature of nursing and downplay the requirements for academic qualifications.

As with the lack of support from nurses, this may relate to insecurities relating to academic abilities

[S]ome of these have been qualified 15, 20 years - never done a course. ... I think it's fear of the unknown and coming out of your comfort zone, and ... they're frightened of education and development

[Participant 17, team leader]

As described the next chapter, attending university is a psychological challenge for some perioperative nurses due to the distance between their previous educational experiences and university education. Speaking to this one, dual qualified, participant indicates ODPs, especially those educated through vocational routes, may share similar views. However, information is limited as this was not the primary focus of the study, and to go beyond the assumptions stated here would require further investigation.

Discussion relating to CPE

[I]f people know about [CPE], then they're quite helpful

[Participant 15, perioperative practitioner]

Participants' discussions of CPE with work colleagues varied, depending on the presiding culture in individual departments, and whether they had chosen or been told to study. The extent to which participants revealed their study to colleagues was dependent upon the support from work to attend university, and perceived levels of support which would be received from colleagues (Chapter VI). If no support was received from work, and colleagues were perceived as unsupportive, then participants may study in secret (Chapter VII). Participants tended not to reveal their study unless asked, and appeared to limit the people who knew of their academic activities

[M]ost of [my nursing colleagues] know ... I'm doing it ... but I don't make a fuss about it

[Participant 7, matron]

If somebody ... asks me, I will ... tell them, but I don't go with a sandwich board

[Participant 14, charge nurse]

Not many people knew I was doing it. ... I don't see the point of ... going out and shouting about it. ... But also, I don't see the point of not telling people

[Participant 15, perioperative practitioner]

Although perioperative nurses work literally shoulder to shoulder with medical staff, many participants identified professional boundaries as a barrier, which left them unable to openly discuss their CPE. In most cases, discussion was intra-professional, and other professions tended to be informed only if affected by nurses' study, or if necessary for successful completion of their course. In all but one case, participants only spoke to others if they believed them to be supportive

[T]here are people who I've never mentioned really my study to. Just whether it be personality clash or professional clashes

[Participant 8, perioperative practitioner]

[I]f it's going to impact on what they're going to do, then why not tell them?

[Participant 9, team leader]

I don't really think about ... asking medical people about the mentorship course ... [b]ecause it's ... my teaching skills to my future students

[Participant 11, perioperative practitioner]

The medical staff won't know that I've done the course

[Participant 22, senior perioperative practitioner]

Whilst nurses may not disclose their CPE to medical colleagues, medical staff also remained silent about their own educational activities. In many cases, this provided participants' rationales to not disclose their study

It's not a thing that I would discuss with them! I'm sure they wouldn't come to me and say I'm doing this. ... Why would I say that to them?

[Participant 7, matron]

They don't say to us 'well I'm off to do this course', you think 'well are they really that bothered?'

[Participant 9, team leader]

The only reason we ever know they're on courses is because there's a list cancelled, or there's a registrar in there

[Participant 17, team leader]

Thus medical staff, like perioperative nurses, appear to be selective with whom they discuss CPE. Further study would determine the extent to which they are open with medical colleagues, or whether medical staff may also on occasion study in secret.

Differences were apparent between participants who volunteered to attend university courses and those told to study with regard to discussions relating to educational activities. Participants who volunteered to study appeared more active in their studies, and were judicious in deciding with whom to discuss their work, however those told to study spoke openly about this both within and outside nursing. They appeared passive in the CPE process, and observed the dominance of medical staff within the perioperative hierarchy

[The surgeon] said 'Why is [the charge nurse] making you go?' and I said 'Well speak to [the charge nurse] if you don't want me to go. She's the one who's sending me'

[Participant 2, senior perioperative practitioner]

Hamlin (2000) explains how oppressed group members allow others in authority to make decisions, and this is such an example where others have been accredited with instructing the participant to study. If participants volunteer to study, they appear to make an implicit statement relating to their academic ability and believe they can succeed in their chosen course, whilst those told to study do not make this assertion. Individuals who are told to study may seek widespread support due to lower levels of academic confidence than those who entered CPE voluntarily; something which may prevent voluntary study (Chapter VI) or encourage individuals to study secretly (Chapter VII). Participants are described below as not wanting to betray dominant discourses

within their profession: As such, being told to study is symbolic of oppressed group members, and an attempt to remain within the discourse of nursing as subservient to medicine, and where practical skills are valued above academic qualifications

I never trained at university. ... I'm not university minded. ... I'm more practical me than educational, the way I work. ... Being in the university ... it's enjoyable ... but ... not really my thing

[Participant 9, team leader]

Thus, to be told to study and disclose this to others allows the participant to develop themselves whilst remaining true to the popular beliefs regarding nurses and academic education. It may also be a survival strategy should the individual fail, which absolves them from blame, as they have never asserted their ability to obtain a certain academic standard, and this decision was made by the person asking them to study. Conversely, if they succeed, the psychological 'buzz' of passing (Chapter VI) can also be publicly declared, which may enhance these effects.

Not all perioperative environments were conducive to open discussion of CPE. Just as managerial and collegial attitudes are crucial in the decision whether to enter formal study, these attitudes and the perioperative nursing culture also affects the openness with which any study is pursued, and the discussion intra- and inter-professionally. The degree of openness with which this was discussed was on a continuum, with a few participants claiming to openly discuss their activities and a few telling no-one (Chapter VII). Those told to study tended to be located at the public end of this spectrum, whilst those volunteering were more selective in discussing their study with others. Their locations were based on perceived levels of support from colleagues and also the individuals' own academic confidence and potential repercussions should they fail, (Chapter VII). The support which was offered during a period of study appeared to be rooted within the nature of nursing as a profession.

The Nature of Nursing as a Profession

Despite one of the characteristics of a profession being to maintain currency with the subject (Houle, 1980), participants explained some perioperative nurses were reluctant to enter CPE, even though lifelong learning is more widely advertised than previously

[Y]ou've got ... adverts on the back of buses, radio, local radio programmes ... going out ... to the workforce ... and in schools from an early ... age
[Participant 14, charge nurse]

National moves to widen the entry gate to higher education, and encourage lifelong learning (DfEE, 1997a; DfEE, 1997b) have been mirrored in the NHS with the KSF (DH 2004a). However, despite the move of nurse education into higher education and an emphasis on lifelong learning within nursing (UKCC, 1986) and higher education (DfEE, 1997a), the ethos of perioperative nursing as a practical discipline persists, with many participants labelling nurses as either 'practical' or 'academic', as described above, suggesting a perceived incompatibility between these two characteristics.

Ryan (2003) describes moving CPE into universities emphasises the distance between theory and practice, and participants questioned the compatibility of post-registration qualifications with the practice of nursing. Rather than enhancing nurses' ability to care for patients, some participants saw university education as moving nurses away from patient care. Interestingly these participants were not only involved in formal study but striving towards, or in possession of, degree and masters level qualifications

[I]n future, I think most nurses will have degrees. ... [T]he basic stuff – hands on stuff – ... the care workers, the support workers, will be doing
[Participant 3, team leader]

[S]ometimes, nursing does deviate ... from practical nursing into more academic ... [t]aking away from the job that we were first qualified for - being actually ward level, hands on. ... [People] tend to become more office based ... [o]nce they've gone to do degrees
[Participant 21, perioperative practitioner]

Some studies report nursing is gradually embracing a more accepting attitude towards CPE (Gopee, 2003; Furze and Pearcey, 1999). However, the attitudes of nurses within perioperative care implies the anti-intellectualism within nursing reported by Miers (2002) still prevails despite changes to pre-registration education, and lifelong learning initiatives both within the profession and within society (DfEE, 1998; DfEE, 1997a; DfEE, 1997b). Surprisingly, despite placing an emphasis on developing practical skills through experiential learning, participants considered university courses were recognised as more 'official' than in-house training, and many used the word 'lazy' to apply to colleagues who did not wish to pursue academic study. Contrary to experiential learning, as historically occurred in theatres (Reid, 2000), there is an impression university has more to offer than practice in terms of developing staff

[It is] more formal ... through the university. ... [T]here is a danger ... sometimes with an in-house thing that people don't take it very seriously
[Participant 10, team leader]

This creates a paradox whereby some perioperative nurses describe nursing as practical, and dispute the need for academic qualifications, but in order to progress within nursing formal qualifications are required. Despite the need for academic qualifications, and the relationship of these to promotion, most participants explained how aside from perhaps having study time to attend university, academic activities had to be completed in their own time. Practice related to academic courses was undertaken during working hours

The theory work - I did in my own time, but all the practical side of it ... was included by just being flexible with my normal working hours really
[Participant 22, senior perioperative practitioner]

The provision of time for development of practical competencies rather than academic work suggests the culture promoted practice above theory, although this may be related to staffing issues, which provides a barrier to CPE for some participants (Chapter VI).

Considering managers' expectations that nurses will pass their study, and it is academic success which leads to successful completion, it could be questioned why it is considered acceptable to undertake practical aspects of a course in work time, but to have to undertake the majority of academic work outside of working hours.

Whilst professions outside of healthcare must self-fund if they wish to study, and do this in their own time (Phillips and Friedman, 2001), not all perioperative nurses felt they should contribute their own time. Whilst for most participants CPE involved working at home on assignments, some believed colleagues may be able to study at work

[I]f it's in works time, fine!

[Participant 2, senior perioperative practitioner]

I've seen people ... sitting down to do their assignments at work ... and some people potentially have the opportunity to do that quite a lot, depending on [their] role

[Participant 12, charge nurse]

All participants described studying at home, however, most were supported to some extent during their working hours. For some participants, a degree of compromise regarding the allocation of study leave was the only way to enter CPE. On occasion, participants contributed their own time only reluctantly, and this was a source of resentment. The amount of time individuals were willing to spend studying out of work appeared to relate to their interest in a course

I knew that I would have to give up my own time ... because you just can't get out, there's not enough of us to actually get out and do things, and [the charge nurse] ... she's not very supportive

[Participant 2, senior perioperative practitioner]

If it was something I was really interested in ... I would probably be quite happy to do some of it in my own time

[Participant 4, team leader]

[Y]ou have to ... do some in your own time ... as in the study days. Even though ... they're all funded, it's very difficult some of the time to get that through to the work place

[Participant 8, perioperative practitioner]

I may have then ended up, as a last resort, doing it in my own time

[Participant 19, senior perioperative practitioner]

The willingness to study outside of working hours appeared to relate to individuals' perceptions of nursing. Gopee (2003) argues if nurses view their occupation as a job through which they earn money to provide for themselves and their family, they are less likely to undertake education, particularly if this is in their own time, than those who view nursing as a profession, and wish to develop their careers.

Despite nursing promoting practical skills above academic qualifications, some perioperative nurses still studied, even where cultures did not seem to support CPE, and where their own personal beliefs were that nursing was practical rather than academic

[I]t's just ... like a different culture that you're dipping into

[Participant 19, senior perioperative practitioner]

[W]hy am I doing this course if I don't agree with it ... well a part of it is doing it for my benefit, not for work

[Participant 21, perioperative practitioner]

Many participants espoused the anti-academic nature of nursing, however as guests within the university culture, they retain their 'nurse' status. This suggests participants are able to differentiate between gaining academic qualifications as *individuals* to prove their ability, whilst as *nurses* retaining their practical roots. This appears to legitimise seeking academic qualifications when socialised into a culture focused upon practical skills. Whilst participants were able to make this distinction, further research may indicate those who did not enter higher education were unable to differentiate between qualifications gained as an individual, and those gained as a nurse.

Socialisation into the Profession

I was a new person in a new environment and you have to fit into the group norms

[Participant 12, charge nurse]

Lafont (2005) asserts part of socialisation into a culture is gaining familiarity with the normative patterns of interpretation and conduct a culture prescribes; in knowing the parameters of a culture, one can recognise what is permitted and what is considered taboo, and identify those who stand outside those permitted norms. Just as others have identified elsewhere within nursing (Gopee, 2003; Heaney, 2000; Schuller, 2000; Maggs, 1998; Houle, 1980), perioperative nurses explained as new staff are socialised into the profession, they begin to adopt the traits of the culture, and mirror their colleagues' habits. As such values and norms of a group self-perpetuate

If you're working with people who are striving to develop, then you tend to want to be carried along with them

[Participant 8, perioperative practitioner]

This did not just apply to newly qualified nurses, but also more senior staff moving between departments, and as Hamlin (2000) found, perioperative nurses would rather fit in with their peers than to pursue avenues which were outside dominant discourses. Previously active participants described in moving to a culture where CPE was not undertaken, and where managers were reluctant to support staff development, they began to question the need for their own development

[I]t makes you a bit sceptical, and a bit reluctant to undertake anything

[Participant 12, charge nurse]

[T]hey would become converted, and ... say 'well I will just follow the suit and I won't bother'

[Participant 14, charge nurse]

Although such responses agree with previous studies (Ellis and Nolan, 2005; Ryan, 2003; Nolan et al, 2000) participants still retained the desire to develop. Despite working in areas where CPE was not actively encouraged they did study

[I]f I didn't keep studying every now and again ... I'd get to the stage where I thought 'well I won't bother. ... I don't need to study anything else' and that would have been the wrong attitude

[Participant 1, senior perioperative practitioner]

As previously recognised (Watson, 2006; Warr, 2005) this results in two truths; one which is publicly declared (public truth) and governed by socially constructed norms and values, and one which may never be revealed (private truth) based on privately held thoughts. This may explain why participants studied when the dominant culture is anti-CPE, and why this may be done secretly (Chapter VII). In other cases, participants would not reveal their long term-plans

[H]opefully in the not too distant future, I might be a graduate. But ... I don't want to ... make that common knowledge

[Participant 17, team leader]

Whilst experienced perioperative nurses described adopting the traits of a culture into which they moved, if the prevalent culture espouses nursing as a practical profession, this may leave newly qualified nurses trying to obtain convergence between values learnt pre-registration and the culture into which they are immersed. The aims of higher education to encourage lifelong learning (DfEE, 1997a) thus may conflict with the practical perception of perioperative nursing, as illustrated by one participant

[I] look forwards to sitting down writing an assignment!. Oh! [blushing, covering face with hands] I just enjoy sitting down, reading, turning words around ... putting down your thoughts

[Participant 21, perioperative practitioner]

The embarrassment of this recently qualified nurse can be linked to disparity between an inadvertent revelation of a private truth, rather than espousing a public truth. Incongruence between her desire to achieve academically developed through her pre-registration education (private truth) and conditioning to promote nursing as a practical discipline (public truth) appears to be the cause of this embarrassment

I read in a journal ... people with degrees don't want to empty bed pans, which I don't know what to think about that. ... You're wanting to do lifelong learning and ... you need to ... progress, but are you coming away from what your original job is meant to be?

[Participant 21, perioperative practitioner]

Whether staff are newly qualified or moving to new department, socialisation causes the prominent traits of that culture to be internalised. Thus, they develop a public discourse on CPE which may not reflect privately held theory, and the culture perpetuates. This led to participants studying secretly (Chapter VII) or being selective in discussing their study with colleagues. Many participants explained standing outside dominant discourses may expose them to horizontal violence.

Horizontal violence

That to me sounds like a power thing. ... [Y]ou stress the negatives about the course, put everybody off, and then you will be the only one with this qualification. ... Have you come across 'horizontal violence?'

[Participant 4, team leader]

If socialisation involves identifying acceptable practices within a culture (Lafont, 2005), it inevitably highlights those standing outside these practices, and the findings indicated that this influenced the support offered by colleagues towards those who studied. Although Hardwick and Jordan (2002) suggest with the move of nursing into higher education, negative attitudes towards university education may slowly change, participants indicated that these may still persist within perioperative nursing. Even in

cultures identified as generally supportive of CPE, many participants felt one or two colleagues were unsupportive, and this appeared to influence the openness with which they studied. When considering the consequences of studying in such environments, participants became angry their choice to study was not supported

I'm being prevented from progressing as much as I'd like academically [sounds angry and upset]. I do understand people who don't want to study ... but ... [e]very course I've done I've enjoyed ... so I don't see any reason to stop
[Participant 1, senior perioperative practitioner]

Such was the depth of feeling one participant associated this with horizontal violence, as illustrated above. Horizontal violence has previously been identified within perioperative care (Hamlin, 2000), and may result from patriarchal dominance within this environment (McGarvey et al, 2000; Carter, 1994) and consequent feelings of oppression (Hamlin, 2000; Freire, 1970). Those affected are unable to exert the resultant anger towards oppressors and instead direct this towards colleagues who are seen as less powerful or to stand outside dominant discourses (Bartholomew, 2006). As described above perioperative culture appears to support practical skills development above academic study, and as such, socialisation into the culture may be an antecedent to the horizontal violence to which this participant refers.

Initially, horizontal violence may appear to be a strong term to use in relation to CPE, however as data collection continued, this participants' views began to be supported by others. In addition, although he did not use the term, Gopee (2003) also alluded to the presence of horizontal violence in his work discussing lifelong learning in nursing. As illustrated in the vignettes (Box L), the behaviours of colleagues left participants feeling angry, frustrated, and upset, and these can be associated with horizontal violence (Bartholomew, 2006; Hamlin, 2000). These vignettes were constructed largely from

Participant 1's story

I'm being prevented from progressing as much as I'd like to academically. A couple of times I've asked about doing degree units and been told I can't [sounds upset]. They can't understand why I'd want to study. I've thought about it lots and it can't be purely because they're not interested themselves, because there are a lot of things I'm not interested in but I'd never wonder why someone else wanted to do it. I've wondered often if do they not want you to progress, and if so why not? It makes me angry, and I feel that I'm not valued by my manager. I also worry that if I got a place my manager might make life difficult by arranging the off duty so I can't attend

Participant 8's story

Not all of my colleagues have been supportive. I don't know whether it's angered them, annoyed them, frustrated them that they're not doing it, or maybe they feel threatened that I will have a qualification they don't. I think some people don't see the necessity for the academic side, that it's just experience which counts in the workplace. Sometimes, colleagues have said something negative about my study days within my ear-shot, or asked me what I am studying. They are not asking because they want to help, ask quite spitefully, like they don't think I should be studying. That doesn't make me feel good about myself or about studying

Participant 18's story

I didn't train in this country, so I didn't know how British universities worked. Before I went to university, I asked my colleagues what I would be expected to do at university, and no one would tell me. They just said that I would learn when I got there. I didn't have the opportunity to look for books and didn't know what I could expect from the work I would be doing, or the sort of questions I should be asking. It was really a struggle for me. The first three months were like a hell because I didn't understand

Participant 23's story

My colleagues are mostly supportive, but not everyone liked that I was studying. One day a colleague from the next department asked me whether I was doing the mentorship course. When I said that I was, she asked me whether I am a band 6. She is a band 7, and she didn't seem very happy when I said I was a band 5, waiting for a band 6 post. Then she asked me how long I had been working in theatres. I don't know why she asked me that question, but I don't think she thought it was right that a band 5 was doing the mentorship course. Some of my colleagues seem to be jealous too. One said to another colleague 'oh she's doing the mentorship now' and she sounded like she disapproved. Or, sometimes, somebody will say they want to do the mentorship, and because I'm doing it they haven't got the chance

Box L: Vignettes illustrating horizontal violence

participants' words, then edited and written around to aid readability (Seidman, 2006; Ely, Vinz, Anzul and Downing, 1997).

These behaviours and consequent feelings of oppression were particularly described by participants when the culture did not promote academic development. Their examples illustrated whilst most often, it arose between less senior members of staff, it was also directed at lower grades by senior colleagues, and existed between peers at higher grades

[A]n E grade ... said - 'you [asked] a G grade what nursing magazine do you buy?' and they didn't like it. ... I just wanted to ... swap magazines, but that was seen as 'wow! She's ... done her 176, who is she?!' [angry, face reddening]

[Participant 14, charge nurse]

[M]ost of them they're F grades and G grades. ... [O]ne girl [asked] me 'are you doing the mentorship now?', [said snidely] I said 'yeah, I am' and she did ask me 'are you band 6?'. ... [S]he's a band 7

[Participant 23, senior perioperative practitioner]

Whilst all participants, including those subjected to horizontal violence, enjoyed their student status (Chapter VI), the prevailing culture often caused this enjoyment to be suppressed. As soon as they started to discuss these negative experiences, participants' expressions changed, and some began to avoid eye contact: They became visibly agitated and anger could be heard in their voices as they described their experiences. In one case, the depth of emotion was so strong, the participant began to cry. This participant spoke of her pride in completing a period of formal study, having not excelled at school or in her pre-registration education, but that this was countered by her sadness that she could not share this within the workplace due to past experiences

[I] try ... to bury it a little bit ... I suppose. ... [S]omeone ... bought me a card ... when I'd got my diploma ... and I ... put it in my locker. ... The only words [said] were '... So-and-so's nearly got her degree'. ... [Y]ou just ... perceive ... they've got bad vibes about it [tears in eyes] ... [I]nwardly you seethe [clenches fists in lap]

[Participant 8, perioperative practitioner]

Such public displays concur with the anti-intellectualism within the practical discipline of perioperative nursing as explored earlier. Many other participants described there is a perception CPE should be publicly disliked, suggesting it should be endured, not enjoyed with colleagues only informed of the negative aspects of studying

I don't think we ever come in and say 'oh that was great, I learnt loads, and it was really interesting'. I think they just hear us complaining about how much there is to do

[Participant 6, senior perioperative practitioner]

[P]eople come back from courses saying '... It was hard work'

[Participant 13, team leader]

Some participants appeared to be aware that vocalising the negative aspects of a course may deter others from undertaking formal study, but did not appear to regret these actions. In some cases they articulated an expectation they should 'complain' during a period of study

I wonder whether if sometimes whether the ones of us who do ... the courses put people off, because all they must hear is us complaining about how much work we've got to do, and how irritated we are by it!

[Participant 6, senior perioperative practitioner]

If you're doing something you must complain about it! I think you should tell everybody from the highest peak! Look how stressed I am!

[Participant 10, team leader]

Indeed, some participants went further to explain that they believed the effects of this horizontal violence may have greater consequences than to individual nurses. They believed through limiting nurses' access to university study, this may be stalling both the progression of nurses and of nursing within the perioperative environment

[Y]ou stress the negatives about the course, put everybody off, and then you will be the only one with this qualification. ... [N]urses kind of keep nurses at a lower level, and it's basically our fault that we don't kind of extend into these roles

[Participant 4, team leader]

[I]t's a bit of reverse psychology. ... I'm enjoying it, but I want you to know that it's tough, because I don't want you to ... do the same course because I want to be better than you

[Participant 14, charge nurse]

Despite the hard work involved and the negative comments participants described, which they believed may deter others from CPE, these participants continued to study. Such efforts to prevent others attending university, and the consequent feelings of oppression which result, may be an attempt to ensure only certain perioperative nurses being in possession of skills. This may be in an attempt to guarantee participants' futures within perioperative care compared to colleagues who had not studied.

However, despite the horizontal violence described above, participants made individual assessments on whether they would study (Chapter VI). In some cases, they still attended university, irrespective of such comments

[Q]uite a few people ... said 'what do you want to do that for? Its boring ... ', and it was the best course I'd done for a long time

[Participant 1, senior perioperative practitioner]

[I]t was a little off putting, but ... it didn't really put me off

[Participant 13, team leader]

[P]eople have said to me 'don't do this course' ... but ... other people ... thoroughly enjoyed it. ... So that's not really affected my outlook on it

[Participant 15, perioperative practitioner]

Whilst participants were able to enter formal education in spite of such negativity, it may be that individuals who would have been allocated to group 2 did not undertake university education as they were deterred by their colleagues' experiences. Further research is required to illuminate the perceptions of this group of people in relation to the effects of horizontal violence and CPE.

In dissuading colleagues from developing participants were the only ones in possession of (relatively) unique skills, which assisted in substantiating their future in perioperative nursing, and raised their kudos with medical staff (Chapter VI). These findings indicate that through the creation of an oppressive environment, which may deter others from accessing CPE, the academic development of nurses and nursing may be limited. As such, horizontal violence may also serve to maintain nursing as subservient to medicine within perioperative care.

Chapter Summary

In common with previous studies (Such as Ellis and Nolan, 2005; Gopee, 2003; Ryan, 2003; Stanley, 2003; Schuller, 2000) the culture and managers' attitudes towards staff development appeared influential in determining the ease with which participants were able to study and the openness with which this is pursued. The findings indicated that despite the move of all pre-registration nurse education and all CPE into university settings, professional body mandates (NMC, 2008a) and government initiatives (DH, 2004a) for nurses to continually development their competence, in some areas CPE may not be embedded into the culture of perioperative nursing. An absence of PDRs and development plans was also apparent in areas where participants struggled to access formal study, again as reported in other specialities (Barriball, 2002), which suggests a lack of any developmental opportunities. In such areas, participants' CPE appeared to fill a void, providing positive feedback on their development and achievements, when in the workplace they were informed only of developmental needs.

Participants described over time their study habits began to mirror those of colleagues, especially managers, irrespective the level of pre-registration and previous study habits,

something which also occurs outside of perioperative care (such as Ellis and Nolan, 2005; Gopee, 2003; Ryan, 2003; Nolan et al, 2000; Houle 1980). Within the culture, as documented elsewhere (Stanley, 2003; Schuller, 2000) managers were pivotal in influencing the cultural milieu, deciding who would be supported to study, how much study an individual could undertake and what courses could be attended. They were perceived by many as valuing CPE which had a practical focus above that which had a more academic orientation, as others have also reported (Stanley, 2003; Nolan et al, 2000), and acquisition of certain qualifications was associated with particular positions within the nursing hierarchy.

Participants believed managers would rather support staff to develop clinical skills which were expected to have a direct impact on practice, or had a high political importance, than those which allowed completion of academic awards, and where outcomes were more existential in nature. For some participants, a reluctance to allow staff access to formal courses was attributed to managers' lack of academic confidence and feelings of professional insecurity. Additionally, as previously documented (Ellis and Nolan, 2005; Barriball 2002; Nolan et al, 1995), explicit inequality was identified in some areas by participants, where certain staff were able to attend more CPE in order to fulfil the requirements of future roles for which they had been earmarked, making it more difficult for other staff to access formal education.

Not all nurses were supportive of others' study, and resentment was experienced from some colleagues, as others have found previously (Gopee, 2003; Stanley, 2003; Davey and Robinson, 2002; Hardwick and Jordan, 2002; Nolan et al, 2000). As such, conversations with nursing colleagues may be limited depending on the perceived levels

of support they may offer, however, participants explained inter-professional discussion was even more restricted. Whilst many believed doctors were uninterested in their CPE, when collaboration was necessitated by the course, they were supportive. In contrast to previous findings (Scholes and Endacott, 2002; Jordan and Hughes, 1999) this support appeared to exist even where the course traversed professional boundaries and participants explained this was due to a reluctant acceptance of nurses' extended roles due to government initiatives which impacted on perioperative care. In accordance with previous work (Harwick and Jordan, 2002) there was less resentment from doctors than nursing colleagues, and as such, nurses themselves could be considered to be hindering the academic development of nursing.

Despite medicine seemingly being able to combine both academic qualifications and practical skills, within perioperative nursing these do not appear to be able to co-exist, with nurses labelled as either practical *or* academic by colleagues. Nurses who were perceived as academic were viewed as less 'hands-on' than their practical counterparts, and participants described how academic development was perceived as a negative aspiration by some colleagues. These individual attitudes helped to shape the prevailing culture and as identified by others (Furze and Pearcey, 1999; Houle, 1980) attitudes affected participants' post-registration education.

When colleagues had negative attitudes towards CPE, and the culture was unsupportive of nurses who wished to develop academically, this did not always deter participants from entering university. The existence of two versions of truth has been acknowledged previously (Watson, 2006; Warr, 2005) and socialisation similarly led to some participants seemingly holding two truths; a public truth perpetuating perioperative nursing as a practical discipline, and a private truth not revealed to colleagues relating to

academic ambitions. This was evidenced by the recently qualified participant's embarrassment in revealing a privately held truth, developed during pre-registration education, that nurses should pursue academic qualifications, and thereby traversing the publicly held dominant discourse of perioperative nursing as a practical profession. In such situations, participants' usual approach to avoid horizontal violence and be seen to concur with this dominant discourse was to be selective to whom they revealed their study, with some individuals studying in secret (Chapter, VII). They also appeared to be able to differentiate between attending university as individuals to 'better themselves', as elaborated in Chapter VI, rather than attending as nurses for professional reasons.

The findings reported in this chapter indicate few differences between perioperative nursing culture and other areas of nursing practice, something previously not investigated within the context of CPE. They also reveal participants believe medical staff may be more supportive of, and show less resistance to, their development than nursing colleagues, despite perhaps feeling threatened by their advancing practical skills and theoretical knowledge. Compared to other areas (Hardwick and Jordan, 2002), such resistance to perioperative nurses development by nursing colleagues may more prevalent, however, this did not necessarily deter participants from study, but changed the degree of openness with which this was conducted.

The next chapter describes the journey perioperative nurses make as they travel through CPE. The culture in which participants worked and the attitudes of their multidisciplinary colleagues, as explored above, influenced all aspects of their journey from their decision to study and the openness with which this was pursued through to the outcomes which resulted from their educational activities.

Chapter VI

NEGOTIATING THE CPE JOURNEY

The background influence of organisational and workplace culture, and the attitudes of the multidisciplinary team, including managers, described in Chapter V, impacted on participants' experiences and perceptions of their studies. This chapter explores participants' journeys as they travel through continuing professional education (CPE) (Box K) beginning by describing the motivations and barriers which influence their decisions to embark on an educational journey (going in). Attention is then turned to their experiences as they travel through CPE (process), before focusing on the traveller who emerges and the outcomes of CPE (going out).

As explored previously (Chapter IV), the journey through CPE is helical; the individual who completes a formal course and returns to further study does not return to the point at which they originally entered university, as they are more knowledgeable of what their subsequent journey will entail. Thus, whilst the decision to study may represent the beginning of a journey, it may also be part of a longer, continuing journey.

Embarking on CPE

The motivation to study and barriers preventing this are reported extensively (such as Gopee, 2003; Ryan, 2003; Stanley, 2003; Davey and Robinson, 2002; Hardwick and Jordan, 2002; Phillips and Friedman, 2001; Nolan, Owens, Curran and Venables, 2000; Dowswell, Hewison and Hinds, 1998a; Sheperd, 1995), and impact on the outcomes derived (Ellis and Nolan, 2005). This section explores these from the perspectives of perioperative nurses, something to which no reference could be found in the literature.

Although Ellis and Nolan (2005) report nurses are largely unprepared to enter CPE, participants described in order to study, such barriers are overcome through mental preparation. Whilst participants emphasised the importance of this, discussion of such preparation, as an antecedent to attending university, is outside the scope of this work.

Motivation to Study

I am hungry for knowledge really. ... I don't want to ... be a dinosaur. ... Now they're [pre-registration students] doing diploma level you do feel a little left behind. ... [Y]ou can still teach them ... the practical side of the job ... but ... academically, we need to be up there with them

[Participant17, team leader]

In common with previous studies (such as Gopee, 2003; Stanley, 2003; Hardwick and Jordan, 2002; Dowswell et al, 1998a), participants entered university for a variety of personal, professional, or practice related reasons (Box M), either volunteering, or expected to do this by managers. Whilst participants identified both intrinsic and extrinsic motives for CPE, those told to study cited predominantly practice reasons, and volunteers both personal and practice drivers. Volunteers had usually attended university previously, either pre- or post-registration, suggesting personal outcomes were not apparent to those who had not attended university previously, and were told by others to study.

In many cases participants studied to develop theory behind existing skills. Whilst much is written about newly qualified nurses' theory-practice gap (such as Gallagher, 2004; Stark, Cooke and Stronach, 2000; Hewison and Wildman, 1996), participants felt they approached this from the opposite side, in that they had practical skills but not necessarily the underpinning theory. For many their intention was to be the 'best' in tasks relating to the theory covered by the CPE

Motivation		Participant																						
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Personal motivators	Experience of university education/student status						<input type="checkbox"/>		<input type="checkbox"/>							<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>		<input type="checkbox"/>
	Personal excitement/self-esteem	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Prevent apathy related to study/long time since last studied	<input type="checkbox"/>			<input type="checkbox"/>		<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>							<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
	Qualifications	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>														
	Prove to self capable of academic study	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
	Prove others wrong								<input type="checkbox"/>							<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	
	Aiming higher and higher academically			<input type="checkbox"/>			<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>							<input type="checkbox"/>	<input type="checkbox"/>					
	Challenge of achieving academic qualification					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>															
	Fear of slipping behind friends and family academically		<input type="checkbox"/>			<input type="checkbox"/>			<input type="checkbox"/>							<input type="checkbox"/>			<input type="checkbox"/>				<input type="checkbox"/>	
Time was appropriate to undertake CPE	<input type="checkbox"/>				<input type="checkbox"/>										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Create culture of lifelong learning at home						<input type="checkbox"/>											<input type="checkbox"/>			<input type="checkbox"/>				
Spend time out of the perioperative environment	<input type="checkbox"/>																						<input type="checkbox"/>	
Meet new people					<input type="checkbox"/>																		<input type="checkbox"/>	
Professional/ practice motivators	Career progression	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>									
	Promotion	<input type="checkbox"/>											<input type="checkbox"/>					<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		
	Future proofing	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		
	New/extended roles			<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>	<input type="checkbox"/>							<input type="checkbox"/>				<input type="checkbox"/>		
	Means to an end			<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>												<input type="checkbox"/>	
	Fear of slipping behind newly qualified staff academically		<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>				<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>		
	Professional credibility				<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	Within multidisciplinary team				<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>		<input type="checkbox"/>					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
	With students								<input type="checkbox"/>									<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
	Fear confrontation				<input type="checkbox"/>																			
Practice development																								
Closure of practice-theory gap	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>				
New skills and knowledge	<input type="checkbox"/>			<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>					
Keeping up to date with practice				<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>																
Time for reflection on current practice	<input type="checkbox"/>						<input type="checkbox"/>			<input type="checkbox"/>														
Departmental benefits							<input type="checkbox"/>		<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>							
Offered the opportunity		<input type="checkbox"/>	<input type="checkbox"/>							<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>									<input type="checkbox"/>	

Box M: Motivations for undertaking CPE

[I]t's like the theory behind it. ... It's all right doing it at work ... but there's a lot more to it'

[Participant 2, senior perioperative practitioner]

A lot of the stuff on the course ... we already do. ... By doing the course it validated what we do

[Participant 3, team leader]

I was just muddling through in my own merry way. ... I wanted to do it properly and ... the best I could

[Participant 13, team leader]

These participants explained academic verification of their practical competence was necessary as the goal posts in terms of pre-registration qualification had moved, and they felt they were 'slipping behind' younger nurses. As such, for many CPE was a compensatory measure, and as others also report (Ellis and Nolan, 2005; Gopee, 2003; Stanley, 2003; Hardwick and Jordan, 2002; Dowswell et al, 1998a), a part of this involved maintaining currency of nursing qualifications

I felt I was slipping behind. Despite the clinical skills I had, I didn't have anything academic to emphasise ... I did have this knowledge

[Participant 6, senior perioperative practitioner]

[Y]oung whipper-snapper nurses coming out with degrees and diplomas ... feel very much the ... 'I am' because they've got their diploma

[Participant 8, perioperative practitioner]

[Y]ou can still teach them ... the practical side of the job ... but ... academically we need to be up there with them

[Participant 17, team leader]

Whilst a few participants said they were resentful of the need to 'prove' themselves 'again' academically, most believed attending university increased their credibility with colleagues, which echoes previous work (Ryan, 2003). However, for others rather than to 'catch up' and maintain currency of qualifications, CPE was attended to gain knowledge and skills to enhance their skills and future careers

[W]e were doing quite a lot of kids and there's nobody ... child qualified ... and if we don't have one ... we're not going to be able to operate

[Participant 9, team leader]

I needed various courses, or various skills ... for the job ... I was looking to aspire to

[Participant 12, charge nurse]

[W]e're in a volatile climate ... and I don't know how long - if - my job will stay static. ... [I]f I've got another egg in my basket ... I've got more opportunities to move. ... [I]t's self-preservation

[Participant 14, charge nurse]

Perioperative nurses may study to gain skills and knowledge to further their careers, as reported previously (Gopee, 2003; Hardwick and Jordan, 2002; Smith and Topping, 2001), however, even where study was a precursor to career or role development, this coincided with personal aspirations, as found previously (Stanley, 2003; Gopee, 2002; Hardwick and Jordan, 2002; Apgar, 2001; Dowswell et al, 1998a). Whilst as in other studies (Friedman and Phillips, 2002; Nolan et al, 2000; Nolan, Owens and Nolan, 1995) no participant stated solely personal reasons for CPE, for some, practice gains appeared secondary to any self-development envisaged, suggesting, as others found (Ryan, 2003; Dowswell et al, 1998a), study is primarily for personal development

I want to ... be a surgical care practitioner. ... I've just undertaken the advanced scrub practitioner course ... and that's a ... lead into the surgical care practitioner's course

[Participant 4, team leader]

[It] would fit in nicely with what I [researcher's emphasis] want to achieve, and ... be appropriate ... if [researcher's emphasis] I needed to use it at work

[Participant 15, perioperative practitioner]

Such assertions suggest that citing practice reasons for CPE legitimises perioperative nurses attending university for personal gains. Further evidence for this was that not all participants who studied to increase their skills base agreed with subsequent intended role changes

[T]here was a spare place. ... I thought '... I won't be left out, I'll do it'. ... [W]e did this course [ASP] ... as a stepping point towards ... taking out ... Hickman lines ... which ... I can't say I'm that keen on doing

[Participant 10, team leader]

As others reported (Ellis and Nolan, 2005; Stanley, 2003; Hardwick and Jordan, 2002; Dowswell et al, 1998a), many participants studied primarily for personal benefits and explained they did not want to become 'stale', and wanted to do 'a bit more'. Often, they implied self-development was only possible once practical skills were in place

If I'm totally honest, it's more about me than patient care!

[Participant 4, team leader]

I'd been 2 years in the job ... cracked what I had to learn ... and I wanted to just do a bit more. ... I don't need the degree, I'm doing it for my own benefit ... not for work, because I don't want to go up the ladder

[Participant 21, perioperative practitioner]

I wanted to feel like I was achieving a little bit more, and not just doing the same thing, day in, day out

[Participant 22, senior perioperative practitioner]

Participants explained courses should be taken for professional development, however to study at lower levels than the highest qualification possessed was perceived as a 'backward step', illustrating a conflict between participants' desire to gain academic qualifications and the practical nature of nursing (Chapter V). For some, their greatest motive to study related to gaining academic qualifications, supporting previous findings (Hardwick and Jordan, 2002). That is, despite being socialised within a culture valuing practical skills above academic qualifications, participants appeared to value academic qualifications equally if not more than practical skills acquisition, which is in contrast to previous findings (Ryan, 2003; Apgar, 2001). Participants' aspirations to attain higher academic qualifications appeared to relate to the achievement of ambitions and self-actualisation again suggesting the primary motive for CPE is personal development

I always thought I would do a degree and masters was ... just a bit beyond that, and I thought ... if I push myself ... hard enough, I'll be able

[Participant 4, team leader]

*I don't see why you would put yourself though it if it wasn't challenging. ...
[I]f you've already got a degree there's no point studying at diploma level,
or even at degree level, as you won't benefit - its a backward step*

[Participant 5, senior perioperative practitioner]

*I did one course and said I'd never do another one, and then I did another
one a bit higher and said I'd never do another one, and here I am*

[Participant 12, charge nurse]

Thus, to use Dowswell et al's (1998a) findings, participants were pushed and pulled both personally and professionally to ensure their skills and qualifications were equal to colleagues. However, this did not just relate to work: As others identified (Gopee, 2003; Alejandro, 2001; Schuller, 2000; Dowswell et al, 1998a) similar factors existed outside of work, where friends and relatives had studied or were currently studying. McGivney (1990) explained that peer groups shape individuals' behaviours in terms of education, and participants described how relatives 'pushed' them to study, and provided external reinforcement of their academic ability

*My husband ... was doing his degree when I was doing my conversion. ...
He then went on to do a masters and a PhD while I was doing my degree*

[Participant 5, senior perioperative practitioner]

[M]y husband ... he's doing an OU degree

[Participant 8, perioperative practitioner]

My children ... they've done their masters, they're doing a PhD

[Participant 14, charge nurse]

Thus, participants not only wanted to gain similar qualifications to newly qualified colleagues, but to also to not fall behind relatives academically, as Dowswell et al (1998a) previously identified.

In contrast to participants who volunteered to study and described personal gains motivated them to study, those who believed their managers expected them to study described solely practice-based drivers relating to current or future job roles. The

majority of participants explained if they were expected to study, they felt compelled to attend. For many such expectations resulted in their first experience of higher education; for others, their first experience of higher education in the United Kingdom (UK)

I was bullied into it really

[Participant 2, senior perioperative practitioner]

[B]efore I got the job, I promised to take this ... course

[Participant 11, perioperative practitioner]

You've just been told, and you have to go

[Participant 20, perioperative practitioner]

Such feelings of being coerced into study have previously been described (Hardwick and Jordan, 2002), however, surprisingly, whilst some participants appeared to slightly resent being told to study, or felt 'bullied' into this, others preferred this to approaching managers for permission. Not only did this allow congruence with the prevailing anti-academic discourse (Chapter V), but was perceived as recognition and reward for their efforts, and that managers had confidence in their academic abilities

I felt kind of special that they had selected me ... and respected me enough to support me ... I felt really valued

[Participant 5, senior perioperative practitioner]

[W]hoever was putting you onto the course they would ... know what type of level they could expect from you

[Participant 22, senior perioperative practitioner]

Some participants accepted all opportunities to study, irrespective of their interest, as also identified by Ellis and Nolan (2005). This appeared to relate to issues of feeling valued by managers, and not wanting to fall behind colleagues, and a fear of being overlooked for future development (Chapter V).

Thus, participants entered CPE for both personal and professional reasons, with an emphasis on personal gains which would result. They were either told or chose to study,

with the intention of closing the practice-theory gap, to ensure their continued employment, and to avoid falling behind their peers within and outside work. As such, participants' motives appear to be primarily for personal gain and self-preservation rather than practice based reasons, however many participants also described practice motivators to legitimise their attendance. Despite these motivations, not all perioperative nurses find it easy to access post-registration university education.

Barriers Preventing Access to CPE

[T]here are some people ... who maybe would like to [study] but ... they can't take any more on

[Participant 7, matron]

The barriers to CPE are widely documented in the literature (such as Gopee, 2003; Scholes and Endacott, 2003; Davey and Robinson, 2002; Johnson and Copnall, 2002). All participants described overcoming barriers to attend university, but believed for some nurses these may prevent access to university education. Barriers were either intrinsic relating to the individual, or extrinsic relating to the culture in which they work.

Intrinsic barriers

Participants identified intrinsic factors potentially prevent CPE, even within supportive cultures. They identified risks inherent in entering university in terms of failure and self-doubts over their ability

I wasn't sure ... whether I'd be able to deliver the goods

[Participant 13, team leader]

[I]t's taking risks. ... We all ... dip in and out of our comfort zone, and think 'well really, should I be here?'

[Participant 14, charge nurse]

I wasn't going to set myself up for a fall. ... [E]ven with support, if you're not prepared to take the risk, then nobody's going to talk you into it. You've got to be ready for yourself

[Participant 16, senior perioperative practitioner]

Participants believed some colleagues may not want to leave their ‘niche’ at work and ‘risk’ stepping outside their comfort zone to attend CPE, as previously identified (Phillips and Friedman, 2001; Schuller, 2000). In many cases, such thoughts did not just relate to individuals’ doubts over academic ability, but also their other commitments and roles within and outside of work, and the ability to commit the required time to study. Many participants stated it was important to be ‘ready’ to take the risks involved in study, and how this would relate to other commitments.

In agreement with previous findings (Gopee, 2003; Furze and Pearcey, 1999; Barriball and While, 1996; Francke, Garssen and Huijer Abu-Saad, 1995; Houle, 1980), many participants believed age influenced access to CPE, with colleagues nearing retirement less likely to study

[M]ost jobs on a senior level require ... recognised qualifications ... but ... people ... aren't interested ... and they'll just sit it out until their retirement
[Participant 12, charge nurse]

[I]t tends to be the ones who feel that at their stage in their career ... they don't want to do that type of thing
[Participant 16, senior perioperative practitioner]

The majority of participants perceived retirement as a barrier, however, participants for whom retirement was approaching felt differently, and continued to study. This suggests, in congruence with Ryan (2003) it is attitudes towards study, rather than age, which are influential in whether CPE is undertaken.

The physical nature of the university was identified as preventing some perioperative nurses from studying, with the ‘huge’ buildings perceived as ‘scary’. Whilst this may discourage attendance, further analysis suggests a greater barrier related to the psychological concept of attending university rather than its physical presence

[I]t's scary! ... It ... used to be ... just the little old school of nursing, and little courses ... it was all hospital based. ... [Y]ou weren't part of the big wide university world

[Participant 8, perioperative practitioner]

I'm like the old fashioned state registered nurse. ... Mention university to me and ... [i]t's obviously far more complicated, and far more academic, than it ever was in my day

[Participant 10, team leader]

[I]t is a difficult step to go through what we've known in education to an academic environment. ... [T]he first few days ... I could have quite easily left ... [because of] the expectations I thought they had of me

[Participant 16, senior perioperative practitioner]

The reluctance to enter higher education appeared to relate to perceptions of academic ability, as reported elsewhere (Gopee, 2003; Davey and Robinson, 2002; Miers, 2002; Platzer, Blake and Ashford 2000a; McGivney, 1990) and the perceived differences between education in schools of nursing and university. The remoteness of higher education from previous education and practice can be further explained by considering the selective schooling systems in place in the United Kingdom which will have affected older participants. Streaming at school restricted access to subjects depending on academic intelligence, and practical subjects were viewed as inferior to academic subjects (Miers, 2002). That is, despite a widening of participation in university education, perioperative nurses may feel ineligible to enter university due to beliefs internalised during both pre-registration and formative education, as reported elsewhere (Gopee, 2002; Platzer et al, 2000a)

I went to school in the 60s and I didn't pass my 11 plus, I didn't go to a high school. ... University wasn't even thought about

[Participant 7, matron]

[A] person can have ... a self-fulfilling prophecy ... if somebody says '... you can't do it'. ... [T]hat big ivory tower that's full of academia ... you've got the academics who don't want to mix with ... the working class

[Participant 14, charge nurse]

When I started university, it's like ... 'what sort of people are going to be there?', 'what age group are they going to be?', 'am I going to be accepted?'
[Participant 15, perioperative practitioner]

McGivney (1990) identified that the past influences the future in terms of access to education, and explained individuals with low academic confidence or negative school experiences will not study for fear of failure. Interestingly, in contrast to Parker (1998) who found those entering lifelong learning were more likely to have been high achievers at school, many participants described leaving school with few qualifications, supporting McGivney's (1990) earlier work. Later entrants to nursing who received pre-registration education at university did not perceive this barrier, as Beatty (2000) also reported, irrespective of school experiences, suggesting such conditioning can be reversed.

Another potential barrier to CPE identified by participants was that to undertake further study would be to admit knowledge or skills deficits. This was perceived as particularly problematic for senior staff, and related to feelings of vulnerability and potential consequences associated with failure

[Y]ou're vulnerable because ... you're acknowledging that you don't know everything

[Participant 10, team leader]

[W]hether it's the culture of theatres or the culture of the NHS - but the more senior you are ... there is this reluctance to say '... I don't know'

[Participant 12, charge nurse]

[P]eople assume ... they've been there so long they know everything. So it's harder for them ... to take that step

[Participant 13, team leader]

This raises the question why individuals do not study secretly (Chapter VII), however even when studying in secret, failure may have psychological repercussions which impact on individual confidence as described later in this chapter.

Thus, as documented elsewhere (such as Gopee, 2003; Davey and Robinson, 2002; McGivney, 1990), intrinsic barriers relating to the concept of higher education and academic ability appeared to prevent participants from studying. To be socialised into a culture which values practice above theory appeared to compound individuals' perceptions, and leads them at least publicly, to adopt the dominant anti-intellectual discourse within perioperative practice. In addition to intrinsic factors, extrinsic factors over which individuals have little or no control also affect access to CPE.

Extrinsic barriers

The culture and attitudes within perioperative practice appeared to limit the acceptability of attending university, as explored in Chapter V. Participants also indicated other extrinsic barriers relating to staffing issues, funding and the commitment required to study could prevent access to higher education.

As found in other areas (Gopee, 2003; Scholes and Endocott, 2003; Apgar, 2001; Audit Commission, 2001; Sheperd, 1995) staffing was a barrier to CPE, which is not surprising considering theatres are short-staffed (Moore, 2002). Even where managers were supportive of staff development participants explained they usually had to wait to study, the length of which, as described in Chapter V, was dependent upon perceived benefits for the department and the political priority of the intended course

[Y]ou do find people ... queuing to get their slot

[Participant 6, senior perioperative practitioner]

[E]ven if I found something, likelihood is it would have to be in my time ... because we don't have the staffing. ... [I]t makes you a bit sceptical, and a bit reluctant to undertake anything

[Participant 12, charge nurse]

I was hoping to go back ... but I couldn't because of the staffing level

[Participant 20, perioperative practitioner]

This waiting had a negative effect, relating to the need to be ‘ready’ to study, and participants identified that often by the time they were able to study this was no longer appropriate

[P]eople get ... fed up of waiting, or by the time their turn comes there's other reasons, in their home life ... that it is not suitable to attend

[Participant 6, senior perioperative practitioner]

A lack of funding was historically a barrier to CPE (such as Davey and Robinson, 2002; Johnson and Copnall, 2002; Furze and Pearcey, 1999; Hogston, 1995), and despite Strategic Health Authority (SHA) funding for staff development, this persists

A lot of nurses [are] quite keen to get their degrees ... [but] if it's not needed for their jobs they're not going to be funded

[Participant 3, team leader]

[Y]ou have to ... [study] in your own time ... even though ... they're funded

[Participant 8, perioperative practitioner]

However, rather than course fees not being funded, as identified in these earlier studies, the problems participants described tended to relate to an absence of backfill money to maintain staffing levels during that study, and justification of CPE relating to job roles.

Whilst distance may previously have been a barrier to CPE (McGivney, 1990), and recent studies indicate this persists (Johnson and Copnall, 2002; Gopee, 2001a; Beatty, 2000), three participants were studying at a distance, implying this does not necessarily prevent access to university

It's straight down the motorway ... so it's not too bad.

[Participant 3, team leader]

[T]he internet ... had all the lecture notes and stuff on there

[Participant 10, team leader]

Technological advances may have increased the physical distance over which courses can be delivered, and as such, Davey and Robinson (2002) describe this may resolve staffing issues preventing access to CPE. However, despite these, distance remained problematic in some instances for these participants

We didn't ... go to 2 of the days ... because ... the weather was so atrocious
[Participant 3, team leader]

[I]t would be much better if ... you weren't having to travel that distance
[Participant 10, team leader]

As reported elsewhere (such as Gopee, 2003; Ryan, 2003; Stanley, 2003; Davey and Robinson, 2002; Johnson and Copnall, 2002), participants' commitments and priorities both within and outside of work also prevented access to CPE

We're going to have a couple of big holidays and then we'll be starting a family, and studying at university isn't going to be what I'll want to do
[Participant 2, senior perioperative practitioner]

[A]nybody's mad to do it if they've got very small children. ... [Y]ou've got to think about ... what you're doing at home
[Participant 10, team leader]

[I]ndividuals ... prefer to do ... overtime to get more money
[Participant 11, perioperative practitioner]

[T]hey've got other interests outside of work
[Participant 22, senior perioperative practitioner]

Whilst participants indicated other commitments outside of work prevent CPE, Gopee (2003) reported for some nurses with multiple commitments study was a form of escapism, where other responsibilities could be forgotten: As such, other commitments may not always deter nurses from study. However, participants needed to justify the commitment required in attending university, particularly where there were multiple commitments, and in the absence of financial reward study may not be undertaken, as others (Davey and Robinson, 2002; Johnson and Copnall, 2002) have identified

I'm not paid any different to the others who haven't got anything [qualifications] and ... I think why waste my time, my money and a lot of hard work ... - unless it's for personal gratification

[Participant 12, charge nurse]

Some of them, they say ... we don't get anything. ... So ... it's useless to just waste time ... going there

[Participant 18, senior perioperative practitioner]

Prior to enrolling on a course the motivations for and barriers against studying are evaluated. That is the human and social capital is assessed (Gopee, 2002) to determine the potential investment involved in attending university in terms of time, mental and financial resources. For some perioperative nurses, the potential costs, including the impact on their personal lives may outweigh any perceived benefits and they will not enter university, whilst for others the anticipated gains are greater, and they will study.

Travelling through CPE

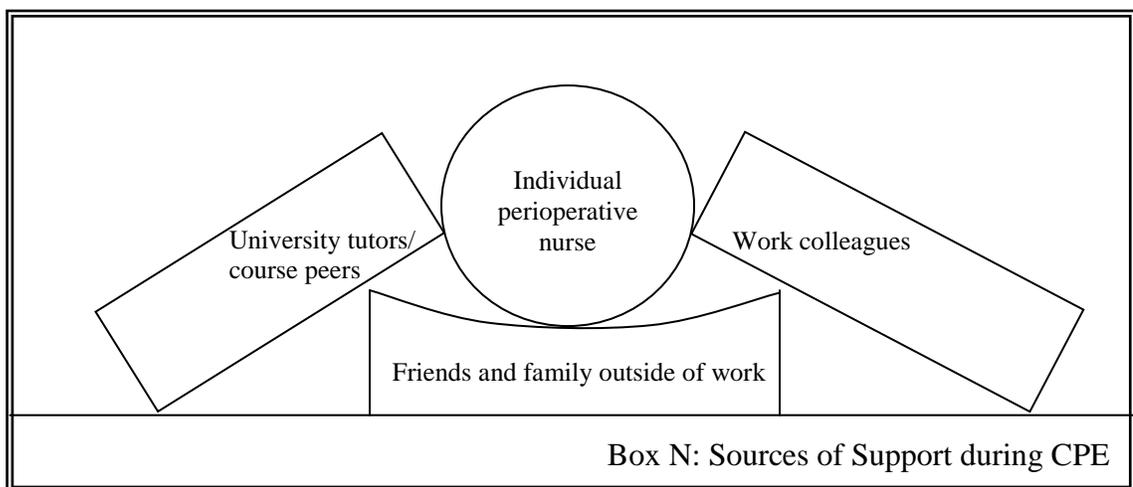
Participants spoke at length about their experiences during CPE, however few studies report these process aspects of attending university (Ellis and Nolan, 2005; Stanley, 2003; Gopee, 2002; Alejandro, 2001; Beatty, 2001; Beatty, 2000; Dowswell, Bradshaw and Hewison, 2000; Platzer et al, 2000a; Dowswell et al, 1998a; Francke et al, 1995). This section focuses on two themes within the CPE journey (Box K); the importance of support, and participants' experiences as students. Whilst these may not be peculiar to perioperative care, participants' emphasis on these demonstrates their significance.

Academic issues emerged as a third theme (Box J), however, the differences in the comparative ability to access CPE for those working different hours, and enrolled nurses compared to registered nurses, is well documented (such as Gopee, 2003; Barriball, 2002; Davey and Robinson, 2002; Audit Commission, 2001; Nolan et al, 2000). As perioperative nurses' experiences reflected these findings they are not reported here.

The Importance of Support during CPE

[Support] gives you the motivation to continue and to finish the course
[Participant 5, senior perioperative practitioner]

In agreement with previous studies (Stanley, 2003; Nolan et al, 2000; Cervero, 1988), all participants, irrespective of their seniority or experience, emphasised the importance of being supported through CPE to boost their confidence and reduce the risk of failure. Support was available from 3 perspectives; work colleagues, university tutors and peers, and those with whom participants shared their lives. The vulnerable perioperative nurse is situated centrally to these potential sources of support (Box N), which provide stability and maximise their chances of success.



As participants told their stories, some sources of support appeared more influential, and as reported previously (Stanley, 2003; Alejandro, 2001; Beatty, 2001; Beatty, 2000), that from friends and relatives was essential, and without this they would not study

I got quite a lot of support ... from my brother
[Participant 9, team leader]

[M]y husband ... gave me support, and without that support, I wouldn't have ... been successful. So, I owe a lot to my husband and my children
[Participant 14, charge nurse]

I don't think I could, I'd want, to do it without their support. ... [Y]ou need it ... if you're ... running the house, working full time, and then embarking on a course as well

[Participant 17, team leader]

As such, friends and relatives form the foundations of the supportive network, with participants attributing their successes to these people. Whilst support from university and work colleagues appeared to provide additional stability during CPE, this was not essential. If these individuals were unsupportive they appeared to exert forces on participants, including horizontal violence, threatening their stability. To avoid this, and to retain equilibrium within the support network, unsupportive individuals were avoided

If they are not supportive then you don't feel so good about studying

[Participant 5, senior perioperative practitioner]

The support provided from different sources varied, although participants described overlapping between the assistance these different people provided.

Support from those at Home

As explored above, and in other studies (Stanley, 2003; Alejandro, 2001; Beatty, 2001; Beatty, 2000), relatives' support appeared to be essential. In many cases, participants' relatives were also studying, and the support provided was reciprocal

[I]t's very, very ... focused on education ... for all of us ... We ... proof read things ... for each other. ... [Y]ou all just look after each other

[Participant 17, team leader]

The nature of this support drew on the talents of those at home, and whilst for the majority of participants this was practical in nature, if relatives were also studying participants often obtained academic support from these people

[M]y husband was studying and I often turned to him for support, to put ideas past him and ask for advice

[Participant 5, senior perioperative practitioner]

I've got a husband who'll do my tea and ... the cleaning

[Participant 7, matron]

[M]y husband did the washing, the cooking, the ironing, the shopping. He did everything, and he never once complained, because he saw I was happy

[Participant 14, charge nurse]

Whilst this support was appreciated by participants, seeking academic advice from relatives may be a high risk activity which rather than promoting success, provides false confidence if these people are unaware of course requirements. Whilst such active support was appreciated, and is reported elsewhere (Gopee, 2002), many participants identified an *absence* of family was also beneficial

He just lets me get on with it

[Participant 4, team leader]

[They] just give me the time really, to do ... the work

[Participant 22, senior perioperative practitioner]

Thus, CPE appears to be a family affair with a reciprocal arrangement. Participants attributed family involvement, either actively through practical and academic assistance, or passively through absenting themselves, allowing time for study, as essential to their success. Whilst they intimated such support is freely provided, this issue was not addressed directly: To develop such insight requires further study.

Support Provided by Work and Work Colleagues

For most participants, support from work included time and funding as reported elsewhere (Davey and Robinson, 2002) although this was dependent upon the culture in which they worked (Chapter V). Interestingly, whilst support was sought from nursing and occasionally medical colleagues, no participants approached operating department practitioners (ODPs) for this even though in some cases they had attended the same courses. The reasons for this remain unexplained.

Whilst to admit knowledge deficits may be a barrier to entering CPE, all participants, except those studying secretly (Chapter VII), sought colleagues' advice, suggesting once they are enrolled on a course this is less problematic. However, participants only sought support from those colleagues they perceived would be supportive, and best able to provide guidance. For many participants this guidance and support extended to 'reading each others' assignments' and help with 'punctuation', and other aspects within the remit of an academic supervisor

I felt as though I was in a room with people speaking a different language - literature searches, how to reference an article. I got a lot of my colleagues to help me who were already at university

[Participant 6, senior perioperative practitioner]

They just give me tips on how to do essay referencing and ... some people, they borrow [lend] me their books

[Participant 11, perioperative practitioner]

[Y]ou've got to ask for support. ... You can't just expect people to ... give you support. If you ask, people ... will help you

[Participant 19, senior perioperative practitioner]

As with relatives' support, this was a reciprocal arrangement, and participants seemed to prefer approaching colleagues for assistance rather than university lecturers. However, difficulties in accessing university lecturers, described below, may underpin this behaviour. Paradoxically, whilst this approach may *increase* the risk of failure should colleagues not understand the assessment criteria, participants' disclosure of difficulties to colleagues may *reduce* its ramifications (Chapter V). As such to seek colleagues' help may demonstrate participants' lack of academic confidence.

Whilst participants said they usually had to seek others' support, in a few cases, they explained colleagues offered their assistance. Most often this involved providing participants with books and journal articles

I'm quite willing with ... anything I do for any academic course, to pass them out to other people ... to hand it over

[Participant 6, senior perioperative practitioner]

[P]eople are very supportive ... and they'll be like, 'oh, I've got this article' or 'I've read this' or 'what about this'

[Participant 19, senior perioperative practitioner]

[S]ome of my colleagues ... ask 'do you need any help?' ... [O]ne of my colleagues, she brought me 2 books. ... One other girl, she brought her portfolio so I could have a look

[Participant 23, senior perioperative practitioner]

Whilst this was described as beneficial, no two people think the same, so the use of these articles is questionable. Accepting articles may be a symbolic acceptance of help and support, not necessarily the information provided, allowing participants to remain within cultural boundaries of nursing (Chapter V). An alternative perspective, although not mentioned by participants, reveals horizontal violence may perhaps belie this seemingly benevolent gesture, as such actions could belittle the intelligence of those who are struggling, simultaneously boosting the ego of those who have passed. This suggests in seeking colleagues' help, in some cases, rather than facilitating study, participants may unwittingly expose themselves to horizontal violence (Chapter V). Deeper insight may be provided through further research.

University as a Source of Support

Support from lecturers, as with that from most colleagues, had to be sought. Whilst not all participants approached lecturers for support, those who did explained this contributed to their success, as previously described (Stanley, 2003)

You need tutor support to know that you are meeting the outcomes ... especially ... when ... going from diploma to degree ... as they up the ante

[Participant 5, senior perioperative practitioner]

Whilst some participants who chose not to access tutorial support explained the difficulty in obtaining time to attend for tutorials around lecturers' availability, others indicated a reluctance to meet with academic staff. This appeared to relate to their academic confidence and suggested a consequent insecurity in approaching lecturers for support, relating to not wishing to demonstrate knowledge deficits

[I]t was such a distance ... you can't just go for a 40 minute tutorial
[Participant 10, team leader]

[T]he tutor ... because of his academic level was a little bit threatening, and that put me off
[Participant 12, charge nurse]

[M]y personal supervisor, she is always busy, and not around
[Participant 23, senior perioperative practitioner]

Even when obtained, contact with lecturers did not always realise the support required, as Stanley (2003) described, with two participants describing lecturers as 'anti-theatre nurses'. In some cases participants indicated tutorial support may *increase*, not *reduce* stress, as rather than, as participants wished, confirming ideas and providing clarity, lecturers' advice often lead to confusion

I had to do a final piece ... I chose consent and [the tutor] said that it wasn't relevant to theatre nursing care!
[Participant 5, senior perioperative practitioner]

I often came away feeling more baffled ... than I did before. ... It seemed to highlight a million and one things that I'd missed which meant I had to ... do more work, when I actually felt like I was getting on top of it
[Participant 6, senior perioperative practitioner]

Whilst only some participants were supported by university lecturers, all were supported by course colleagues. Only a few participants entered CPE with work colleagues, and whilst this initial support was perceived as valuable, over time friendships between fellow students provided similar support. The importance participants attributed to such support is suggested by their intentions on entering the classroom

I thought I'll just have to go in and plonk myself down next to somebody and make friends. That's just what you do isn't it?

[Participant 2, senior perioperative practitioner]

[T]he first evening's a little bit difficult, but once you start talking ... you think '... I have something in common with this person or that person'. ... [I]t's nice to relate to somebody

[Participant 15, perioperative practitioner]

The support provided by course colleagues went beyond social contacts, and they were viewed by all participants as a vital part of the support network. As reported by others (Stanley, 2003; Gopee, 2002; Francke et al, 1995), establishing these friendships and bonds allowed pooling of skills and knowledge

[T]he girl I was sat with ... was ... more helpful than ... anybody else. ... [I]t's daft stuff, like I write a lot faster than most people, so ... you copy off each other

[Participant 2, senior perioperative practitioner]

[I] hadn't done an essay for like years. ... [One student had] done a degree before, so I could pick her brains! ... [H]ow to reference and stuff

[Participant 13, team leader]

Whilst such bonds were equated with success, as reported previously (Francke et al, 1995) these were not always easily established. Nearly all participants explained the intimidating presence of more senior staff left them feeling uncomfortable, which, as Platzer et al (2000a) also found, impacted on group interaction. Participants inferred their reluctance to speak in class related to perceived inadequacy of knowledge, which is in contrast to Schuller (2000 p231) who described a modesty within learning where people do not want to 'show off' knowledge

I was a bit embarrassed to talk

[Participant 2, senior perioperative practitioner]

[P]eople sit back and keep out of it. ... [T]hey're ... a bit frightened to say ... what their views are, because... it can be quite intimidating

[Participant 16, senior perioperative practitioner]

I've not always wanted to chip in when ... people of a higher level [are] there because I felt my idea is miniscule ... and not as relevant, or I didn't have the same in depth knowledge

[Participant 17, team leader]

This perception was not confined to junior participants, and some managers were perceived as uncomfortable in the presence of more junior colleagues for similar reasons. One participant identified that managers took physical actions to distance themselves from junior colleagues by sitting together and wearing suits. This is suggestive of creating solidarity and may reduce feelings of vulnerability associated with CPE, particularly for senior staff

[T]he top managers ... they're all ... in their suits - power-dressing - and thinking '... don't come near me.' ... [T]hey feel a bit uncomfortable because they're with what I class as a shop floor worker. ... I recognise that ... with the suits and ... silences, in their non-participation and participation

[Participant 14, charge nurse]

If it's somebody senior ... you think 'oh my gosh ... you're a higher grade, and fancy saying ... that'

[Participant 22, perioperative practitioner]

Platzer et al (2000a) suggest socialisation into nursing makes nurses reluctant to speak in front of others for fear of criticism, and explain trust must exist prior to disclosing information in group discussions. However, such trust was not always apparent, and participants made judgements on how their thoughts may be received prior to speaking in the presence of more senior staff

[C]onfidentiality was a ... ground rule, but ... people weren't open because they were frightened of reprisals, of the managers ... reporting back

[Participant 14, charge nurse]

As interaction with course colleagues influences success (Stanley, 2003; Gopee, 2002; Francke et al, 1995), it was not surprising that participants believed an inability to form bonds with group members and voice their opinions impacted on their development

[Y]ou can really get stuck by not asking a particular question, that seems really simple, but once you understand that, everything else will slot in
[Participant 10, team leader]

You're not able to develop yourself ... because ... there are managers there. So you're not able to be open and honest, and that's important in learning
[Participant 14, charge nurse]

If it's a group ... full of individuals who don't want to speak, I don't think you get as much out of it. ... [Y]ou're more likely to have ... group discussions ... [and] get a lot more out of a gelled group
[Participant 17, team leader]

Thus, support was viewed as essential during a period of study, and was sourced from different avenues. The provision of academic support was considered by participants to not only be the remit of university tutors, and many appeared to prefer to seek this from course colleagues, work colleagues and relatives rather than academic staff. Whilst relatives occasionally provided academic support, they more usually provided time for study through increasing their responsibility for childcare and household chores. Development of extensive support networks may be indicative of an individual's lack of academic confidence with other people becoming alibis with whom any potential burden of failure is shared (Chapter V). As such, the support sought by participants may alter as their academic confidence grows, however this would require further research.

The Student Experience

[I]t's a look on life that you ... wouldn't normally have looked at
[Participant 15, perioperative practitioner]

Participants' experiences as students were similar, irrespective of whether academic study was a new experience or part of a continuing journey. Whilst some aspects of being a student were enjoyed, others were spoken of less enthusiastically, due to the impact of these on the lives not only of the participant, but also their families.

The Impact of CPE

The impact of CPE in terms of the stresses and sacrifices it necessitates is poorly documented (Ellis and Nolan, 2005; Stanley, 2003; Dowswell et al, 2000; Dowswell et al, 1998a), however, all but 2 participants, one seconded to study, the other prevented from studying, described sacrifices associated with academic study. Such were these demands, and the time commitments involved, that many participants explained even when at work, their course of study dominated their thoughts

[I]t's always at the back of your mind

[Participant 3, team leader]

[Y]ou have to be very careful with university courses. ... I think you get obsessed with them in a way, and ... you don't have the time or energy to do stuff ... at work. ... [T]here's only so much your brain can take at once

[Participant 10, team leader]

[I]t overflows into your evenings and ... your weekend. ... [W]eeks soon go by and ... [b]efore you know it you've ran out of time

[Participant 21, perioperative practitioner]

Participants explained the demands of CPE necessitated temporary shifts in priorities and sacrifices in their home lives, as reported elsewhere (Ellis and Nolan, 2005; Stanley, 2003; Dowswell et al, 1998a). These sacrifices appeared to relate to competing demands of their different roles as mother or carer, partner or wife, nurse and student

[I]t's all very well to ... say ... 'I've drawn up my plan and this is when I'm going to study ... ' It doesn't happen like that

[Participant 8, perioperative practitioner]

[W]hen you've got a family and ... housework to do and ... coming to work full time ... it was a bit of a nightmare

[Participant 10, team leader]

It's not difficult for me ... because I do not have family here

[Participant 11, perioperative practitioner]

As others have previously documented (Tennant and Field, 2004; Dowswell et al, 2000; Dowswell et al, 1998a), the demands of combining multiple roles and study were

described as creating additional stress and guilt, which left participants unable to relax or socialise. Whilst university is only entered with relatives' support, most participants felt their CPE impacted on family time, with relatives also making sacrifices

[Y]ou're watching telly thinking ... 'I shouldn't ... be doing this, I should be reading that chapter'

[Participant 13, team leader]

My husband ... thought 'shall we go away for the weekend?', and I said '... I can't go ... because I need to spend the time doing assignments'

[Participant 21, perioperative practitioner]

[W]e used to ... visit ... friends ... but ... I can't ... until this essay is finished'

[Participant 23, senior perioperative practitioner]

The all-consuming nature of CPE and consequent stress and guilt has been reported previously (Stanley, 2003), however, some participants described more of a work-life balance with regard to their study. These participants either planned to take breaks, or rationalised CPE as a set number of weeks after which they could resume other activities

[T]ime that I would have spent reading, I'm working ... which isn't a great sacrifice 'cos it's only for 12 weeks

[Participant 2, senior perioperative practitioner]

[O]ut of so many weekends ... you've definitely [got] to ... do something with your family and you've just got to plan it that way

[Participant 7, matron]

I'm thinking will I have to give other things up to ... accommodate this? But ... [t]hree months in a lifetime isn't very long at all

[Participant 17, team leader]

Such planning did not necessarily reduce participants' stresses, and irrespective of their motivations, interest, and enjoyment in the course, most described a sense of relief on its completion. As Stanley (2003) identified, this related to the removal of the pressures and stresses associated with the demands of CPE, and a resumption of previous roles

*I'll be glad when it's finished. I just want to go on holiday and enjoy myself.
... [A]t the moment ... I am stressed, and I'm snapping and getting a bit
agitated but once it's finished it will be so much easier*

[Participant 2, senior perioperative practitioner]

*[W]hen you're doing ... courses they are ... a nightmare ... and then as soon
as you've finished ... it all ... drains away ... and you do feel a lot better*

[Participant 10, team leader]

Although courses were seen as discrete units of time, after which other activities could be resumed, participants continued to study: From listening to their experiences it appeared that the sacrifices and challenges presented by academic issues are outweighed by participants' ability to refer to themselves as university students.

Enjoyment of Student Status

All participants, including those told to study, began to smile more as they spoke enthusiastically of their time as students, and using words such as 'enjoyable' and exciting'. Most explained their enjoyment began prior to the course commencing and continued throughout CPE, despite the stresses and sacrifices. This enjoyment was derived from physically attending university, undertaking academic activities, and the opportunities and resources available by virtue of their student status

*[A] huge range of resources ... has been opened up. ... [I]t's really nice to
... be a student and ... have those resources*

[Participant 8, perioperative practitioner]

*[G]etting your books ... bringing them home and flicking through them ...
[is] probably the nicest part of doing any course! I think what it is, is the
possibilities of learning more*

[Participant 10, team leader]

*[I] look forwards to ... writing an assignment! ... I just enjoy sitting down,
reading ... putting down your thoughts, and ... hopefully get a good result*

[Participant 21, perioperative practitioner]

Whilst some participants described the relationship between resources and learning created excitement and enjoyment, such resources can be accessed by all staff within the

Trust in which the study was conducted, suggesting that their feelings resulted from something other than access to educational resources. This enjoyment appeared to relate to possession of a student card, something mentioned by most participants

[T]here is that little sort of like oh, well ... I'm a student. You get a student card and you ... think 'yeah, I can do this'

[Participant 19, senior perioperative practitioner]

The student card appeared to be symbolic of acceptance into a perceived elite group, especially for those who believed they were ineligible to enter university, and represents external confidence in their academic ability. As such, not only did it allow individuals to attend university, and utilise resources, it also appeared to change participants' self-perceptions. Many described their student status made them feel young, and provided a sense of equality with family members. In addition to these psychological benefits, participants also identified practical benefits relating to possession of a student card

I felt quite young! I ... sort of felt equal ... to my son

[Participant 8, perioperative practitioner]

[M]y children ... were signing up for student discount, and ... said to me '... get your student card out'

[Participant 15, perioperative practitioner]

[T]o have a student card and get a few extra pennies off things ... is nice

[Participant 21, perioperative practitioner]

[T]hey did ask us 'are you students?' ... So we got some discount

[Participant 23, senior perioperative practitioner]

As with access to resources, similar discounts are offered to National Health Service (NHS) staff, however, participants appeared to prefer to produce student cards, rather than NHS identity cards, to receive discounts. Obtaining student discount publicly displays participants' status, and acceptance into university, raising their profile from 'nurse' to 'university student': As explored in Chapter V, such displays may not be possible in the perioperative setting, due to cultural constraints. This suggests attending

university was perceived as more than an opportunity to learn, and participants' excitement appeared to be rooted in their transition from 'nurse' to 'student'. Whilst Hamlin (2000) describes that nurses consider themselves as an oppressed group, as second-class citizens and lack self-esteem, participants believed their student status raised their standing within society

Somebody going off to university and bettering themselves

[Participant 19, senior perioperative practitioner]

[I]ts just got a bit of a status thing ... that you're at uni. ... That you are ... doing things - active, in your life ... not just ... cooking, washing, cleaning. You are ... using your brain, doing a bit more

[Participant 21, perioperative practitioner]

That is the role of student appeared to hold more status within society than that of a nurse or a woman. To have student status provided a departure for participants from the routine of traditional female roles of nurse and housewife, and placed them in a virtual spotlight. For participants conditioned to believe they were not academically able to enter higher education, challenging this perception may be the source of such excitement. Through using their student cards they were able to reveal that they were students to others, which illuminated their achievements and status.

Although participants enjoy their student status, even if they are forced to suppress this within the workplace due to the cultural milieu, once their CPE is completed sacrifices are removed, and work duties are resumed

[I]t's ... like a different culture that you're dipping into, and then it's back to reality ... back to working in PACU

[Participant 19, senior perioperative practitioner]

Emerging from CPE

Many previous studies discuss the tangible indicators resulting from CPE, and its impact on patient care (such as Hardwick and Jordon, 2002; Johnson and Copnall, 2002; Ellis, 2001; Smith and Topping, 2001; Wildman, Weale, Rodney and Pritchard, 1999). Whilst some studies suggest this is the ultimate goal of formal study (Jordan, 2000; Queeney, 2000) participants also identified personal benefits were derived from their studies, as reported elsewhere (Ellis and Nolan 2005; Gopee, 2003; Stanley, 2003; Scholes and Endacott, 2002; Nolan et al, 2000). As can be seen from comparing Boxes M and O, all participants stated more outcomes resulting from their study than initially envisaged when this was entered, and these fell into personal, professional and practice categories. For participants told to study for practice reasons, this change was particularly striking, as they identified personal outcomes from attending university.

Participants explained their interest levels influenced the outcomes derived from CPE, as previously described (Barriball, While and Norman, 1992). As others reported (Ellis and Nolan, 2005; Caferella and Merriam, 2000; Houle, 1980) participants felt choosing to study led to greater interest and increased outcomes, compared to those told to study

*[I]f ... you are interested ... you're going to get as much out of it as you can.
... If ... you're not ... you'd ... attain the qualification ... then forget about it*
[Participant 4, team leader]

*If you're not really interested ... you'll just do the bare minimum to pass ...
and never put the knowledge ... into practice*
[Participant 5, senior perioperative practitioner]

Despite managers' expectations that the individuals they supported to study should be successful, many participants believed there was less emphasis to succeed if told to study rather than putting themselves forward

Outcome		Participant																						
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Personal outcomes	Increased confidence and assertiveness in and out of work	<input type="checkbox"/>																						
	Increased self esteem (ego boost)	<input type="checkbox"/>																						
	Personal satisfaction	<input type="checkbox"/>																						
	Increased self awareness	<input type="checkbox"/>																						
	Proof of academic ability	<input type="checkbox"/>																						
	Increased study/ life skills	<input type="checkbox"/>																						
	Computer literacy	<input type="checkbox"/>																						
	Academic (referencing, writing, literature searching)	<input type="checkbox"/>																						
	Time management	<input type="checkbox"/>																						
Understanding of university processes and systems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Developed a more enquiring mind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Increased numbers of friendships outside of work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Seen as a role model to children at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Professional/ practice outcomes	Increased awareness of nursing elsewhere	<input type="checkbox"/>																						
	Networks of staff to be consulted during patient care	<input type="checkbox"/>																						
	Multidisciplinary team	<input type="checkbox"/>																						
	Improved working relationships	<input type="checkbox"/>																						
	Able to challenge staff more easily	<input type="checkbox"/>																						
	Increased credibility with multidisciplinary team	<input type="checkbox"/>																						
	Increased credibility with students	<input type="checkbox"/>																						
	Increased skills and knowledge	<input type="checkbox"/>																						
	Closure of the practice-theory gap	<input type="checkbox"/>																						
	Increased confidence in practical skills	<input type="checkbox"/>																						
	Broader outlook/ deeper understanding of practice	<input type="checkbox"/>																						
	Empathy with other students/learners	<input type="checkbox"/>																						
	Changes to practice	<input type="checkbox"/>																						
	Own practice	<input type="checkbox"/>																						
Practice involving others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
No changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Able to evidence and assert the need for change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Increased autonomy/empowerment in practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Share information with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Better able to teach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Refreshed with renewed enthusiasm to practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Seen as a role model at work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Box O: Outcomes derived from CPE

[If you [are] being told ... [y]ou may ... fail the course. I might feel that I've been pushed to do it. It's not what I want, so I'm not bothered

[Participant 20, perioperative practitioner]

[If somebody tells you to do it ... [y]ou feel like you have to do it, and sometimes you ... [m]aybe don't do it whole-heartedly

[Participant 22, senior perioperative practitioner]

[If ... somebody is pushing you ... you may ... not [do] that properly, you might fail. ... [If you want to do [it], that's different ... you need to pass

[Participant 23, perioperative practitioner]

Although the primary motivation to study may be personal gain, participants also identified professional and practice gains from CPE, and these are explored in this section. Whilst all participants were successful, the potential ramifications of failure are also explored, along with participants' decisions to continue studying. Discussion of the perceived quality of the education and effectiveness of teaching methods, which may hamper skill development and implementation (Gopee, 2001a; Sparling, 2001; Wolfe, 1999; Waddell, 1992; Waddell, 1991; Cervero, 1985), is outside the study goals.

Professional and Practice related Outcomes

[Y]ou let people go because you're going to ... get something out, out of it. ... They're going to gain, and the department's going to gain as well

[Participant 17, team leader]

In common with other studies (such as Adriaansen, van Achterberg and Borm, 2005; Ellis, 2001; Smith and Topping, 2001; Hogston, 1995) most participants believed they were more knowledgeable following CPE. Similarly, as also documented previously (such as Stanley, 2003; Johnson and Copnall, 2002; Nolan et al, 2000), participants believed this provided them with greater confidence and assertiveness. As such changes are discussed extensively in the literature, and participants echoed these, further repetition is not required. Rather, attention is focused on the effects of this knowledge and confidence on participants and their relationships with the multidisciplinary team.

Following CPE, many participants described increased enthusiasm and motivation for perioperative practice. Coupled with the increased confidence and knowledge gained from attending university, this was linked with providing credibility to disseminate information to colleagues

[T]he masters is ... giving me the confidence and ... understanding to do more, and ... I am filtering down what I have learnt to ... other ... staff

[Participant 7, matron]

[T]hey [university courses] give you a confidence ... because you can back up what you're doing ... [and] you ... come across like you know what you're talking about

[Participant 19, senior perioperative practitioner]

[I]t ... motivates you ... and gives you a bit more enthusiasm ... when you've done a course ... because ... you can get a little bit stale ... plodding on

[Participant 22, senior perioperative practitioner]

Whilst the importance nurses placed on sharing information with colleagues has been identified previously (Hogston, 1995), as Gopee (2002) reported, not all participants found it easy to share information due to perceived attitudes of colleagues

[I]t's often difficult ... to pass it on to others ... either ... they're not interested, or they think you're talking out the top of your head. ... I've shared it with my students ... [and] staff ... I felt would be interested ... but there are some ... I've maybe been wary of sharing the information with

[Participant 8, perioperative practitioner]

Dissemination of information appeared to be predominantly downwards, to students, suggesting participants may not feel confident sharing information with senior colleagues, perhaps, as Schuller (2000 p231) reports, because they do not want to 'show off' their knowledge. In such situations, some participants saw themselves as resources

I'm quite happy for anybody to ... talk to me ... or ask me about stuff. ... It's only when they have a problem that I'll get involved

[Participant 9, team leader]

[P]eople ... ask me questions

[Participant 22, senior perioperative practitioner]

Thus, participants described that their knowledge, enthusiasm and confidence in some cases allowed them to disseminate information or act as resources. However, as Ottoson (2000) previously reported, this did not necessarily equate with practice changes

I still do things the same regardless, because ... what I've been doing ... was correct in the first place - but now I know why!

[Participant 3, team leader]

I don't think my practice has changed a great deal

[Participant 10, team leader]

Although some studies indicate behavioural changes follow CPE (such as Gopee, 2003; Stanley, 2003; Hardwick and Jordan, 2002; Wildman et al, 1999), the majority report no correlations between skills and knowledge acquisition, and behavioural changes (such as Ellis and Nolan, 2005; Hardwick and Jordan, 2002; Smith and Topping, 2001). Many participants studied to substantiate current practices, closing the practice-theory gap, and as such change may not be expected. In addition, many did not have development plans (Chapter V), meaning skills may be incongruent with practice needs (Tobias, 2003) and cannot be implemented (Evans, Ali, Singleton, Nolan and Bahrami, 2002; Ellis, 2000).

A number of factors influence behavioural change following CPE, including individual motivation to change, the nature of the course, the nature of the proposed change and the environment in which individuals work (Ellis and Nolan, 2005; Abruzzese, 1996; Hogston, 1995; Warmuth, 1987; Cervero, 1985). Whilst educational effectiveness was outside the scope of this study, other factors identified in previous work appeared to influence the implementation of change in perioperative practice.

Following CPE, participants must wish to change, and perceive the need for change. That is, information taught on the course must be congruent with their individual discourses relating to nursing practice. As demonstrated elsewhere (such as Nolan et al,

2000; Jordan, Coleman, Hardy and Hughes, 1999; Sheperd, 1995), participants indicated change will only be implemented if perceived necessary and better than current practice

The people who run the course ... reckon ... scrub nurses should not [emphasis] play the dual role. ... I think it would make life very boring for scrub nurses ... if there was a first assistant. ... [A]s far as just being ... a scrub practitioner and nothing else ... it won't happen here

[Participant 3, team leader]

I don't know that we're changing ... we're forward thinking, and ... if changes are needed we will go along with the changes

[Participant 7, matron]

I maybe could have done a bit more ... [but] I didn't need to do it, so I didn't. ... It seemed ... the easy option

[Participant 22, senior perioperative practitioner]

For some participants, that practice changes were not made did not appear to be an issue, and as found elsewhere, there were positive connections between CPE opportunities and recruitment and retention (Ellis and Nolan, 2005; Audit Commission, 2001; Barriball et al, 1992). However, others appeared angry and frustrated they could not implement new skills into practice. These individuals suggested in such situations, their enthusiasm and motivation for perioperative practice wanes and they may find employment elsewhere

[Y]ou're undertaking the ... advanced scrub practitioner's role ... and the scrub nurse role. So you're not actually achieving to the best of your skills what you'd like to do as an advanced scrub practitioner

[Participant 4, team leader]

[I]t's quite frustrating really. ... I feel we've done it and not gone anywhere with it, which is quite annoying

[Participant 10, team leader]

[U]nless I get an opportunity to start utilising the knowledge ... I will start looking for roles elsewhere. ... I'm not ... getting any job satisfaction. ... I feel I am failing in what is required of me

[Participant 12, charge nurse]

That some participants wish to make practice changes and the consequent frustrations if unable, which are also reported elsewhere (Ellis and Nolan, 2005; Stanley, 2003),

suggests increased confidence, skills and knowledge alone are insufficient to initiate change. Others have identified autonomy is required to implement change (Davey and Robinson, 2002; Jordan et al, 1999), and as found in these studies, participants believed CPE increased their autonomy, however, junior participants described their authority within the team remained static, and as such prevented knowledge implementation

I'm a lowly D grade ... I felt very the underdog in lots of ways. ... [T]here are some people ... [who] wouldn't have wanted to actually listen to me
[Participant 8, perioperative practitioner]

[Y]ou need to be a lot more senior in the department
[Participant 15, perioperative practitioner]

Whilst Jordan et al (1999) also asserted seniority is required to facilitate change, no participants identified practice change suggesting holding senior positions may not guarantee change within perioperative practice. In common with previous studies (Ellis and Nolan, 2005; Gopee, 2003; Stanley, 2003; Ellis, 2001; Nolan et al, 1995) participants identified the practice milieu as the most influential determinant of change. In addition, they identified change required both rapport and trust with colleagues

The culture is ingrained and ... [y]ou've got to be accepted within that culture in order to change it. ... [E]very change ... will hit an obstacle ... because ... 'we've always done it that way' will come to the forefront
[Participant 12, charge nurse]

Just as change has to be acceptable to an individual if this is to be implemented, it has to be acceptable to others involved in the change, and the more people involved the more versions of truth. Although Williams (2000) explains determined individuals can implement change in hostile environments if they are motivated, participants did not reveal this occurred. As Ellis and Nolan (2005) also described, they became disenchanted and spoke sadly of their lack of support and inability to implement change

[A] lot of ... people ... won't change ... as they're ... set in their ways. Or ... they'll listen to what you've got to say and then immediately dismiss it
[Participant 1, senior perioperative practitioner]

If there aren't the staff ... to support you ... it does make a ... difference
[Participant 9, team leader]

Other studies have identified nurses may resist change due to professional jealousy between colleagues (such as Davey and Robinson, 2002; Scholes and Endacott, 2002; Nolan et al, 2000), and Hardwick and Jordan (2002 p527) report negative attitudes amongst colleagues were 'manifest', and those who attempted to instigate change in unsupportive environments were perceived as 'troublemakers' and 'argumentative'. This suggests participants do not attempt to change due to perceived negative reactions, and the risk of horizontal violence (Chapter V). In some cases, as identified above, this inability to implement change led to frustration and anger, which encouraged participants to seek employment elsewhere.

Whilst difficulties may be experienced in implementing changes which affect nursing colleagues, participants may experience problems instigating changes which cross professional territories due to a greater chance of incongruence with individuals' truths. It may be perioperative nurses do not have the authority required to instigate changes affecting professions who are perceived to hold more power, as increased knowledge does not equate to increased power (Jordan and Hughes, 1998). The doctor-nurse game identified by Stein (1967) over 40 years ago, is still evident within perioperative nursing

I had to blend in and play their game. ... I conformed to some of the norms, and ... played the mind game with them
[Participant 14, charge nurse]

Thus the presence of a nursing hierarchy persists within theatres and impacts on potential skills and knowledge implementation. Whilst CPE may not lead to behavioural

change within perioperative practice, the increases in confidence and autonomy which were widely reported by participants impacted on inter-professional working.

Working in the Perioperative Team

Most participants believed attending university changed their relationships with members of the perioperative multidisciplinary team, in particular with surgical and anaesthetic staff, and this appeared to be one of the most significant outcomes identified following CPE. No participants described changes to their relationships with ODPs.

As in other areas of nursing (Davey and Robinson, 2002; Ellis, 2001; Smith and Topping, 2001; Hogston, 1995), participants identified following CPE they had a more reciprocal and collaborative relationship with medical staff, and believed they were able to talk more professionally with these people. Participants' suggested medical staff may appreciate their enhanced knowledge, and view them as more credible, following CPE

*I started off ... saying ... 'I'm doing a ... study on inadvertent hypothermia',
whereas ... if I hadn't ... I'd have ... talked about patients being cold*

[Participant 8, perioperative practitioner]

*[T]hey do accept that we've got skills and knowledge that they can use. ...
[Q]uite often they actually ask for our opinions*

[Participant 16, senior perioperative practitioner]

*[Y]ou can ... join in with what [the doctors are] talking about. ... You're not
just ... the PACU [Post-Anaesthetic Care Unit] nurse who wakes patients up,
you do actually have some knowledge about anaesthetics*

[Participant 19, senior perioperative practitioner]

However, there is a lack of inter-professional communication relating to CPE (Chapter V), which suggests it may be participants' increased confidence and knowledge, rather than medical staffs' awareness of their study, which allowed corroboration in patient care and changes to inter-professional relationships. Whilst Snelgrove and Hughes (2000) described nurses are reluctant to challenge medical staff, due to perceived

powerlessness, this seemed to change following CPE, and most participants explained the confidence afforded by gaining knowledge and academic qualifications meant they no longer fear challenging, or being challenged by, doctors

[M]y degree made me have the confidence to question the surgeons ... [and] I'm ... not afraid to be challenged about my practice

[Participant 5, senior perioperative practitioner]

I always thought ... consultants ... had the power. ... Now I ... think, 'well, no I don't agree with you ...'

[Participant 7, matron]

[S]urgeons ... can be quite scary. ... After I've done all these things ... nobody scares me. ... [T]hat knowledge base ... gives you much more confidence in dealing ... with the surgeons

[Participant 10, team leader]

Similar findings have been documented previously, where following a period of study nurses were reported as empowered and more able to challenge the *status quo* (such as Gopee, 2003; Barriball, 2002; Hardwick and Jordan, 2002; Wildman et al, 1999), however these studies implied nurses were more able to challenge nursing colleagues, not medical staff. As suggested by Daley (2001) increased knowledge following CPE appeared to function as a 'web of information' to draw upon, with participants feeling less vulnerable in interacting with surgeons and anaesthetists. Despite this, one participant explained she would not challenge all surgeons

[I]t gives you much more confidence in dealing ... with the surgeons. ... I wouldn't challenge all of them ... just certain ones

[Participant 10, team leader]

For some participants, achieving academic qualifications appeared to reduce the power differential between nursing and medicine. This, and the response from medical staff in terms of treating them more credibly, appeared to lead to changes in their relationship

[O]nce they knew ... you had a qualification ... they are more used to dealing with ... their attitude towards you changed. They started to speak ... more openly, maybe because they know you'd understand. I notice to others, they use 'school-boyish' language, like they use to patients

[Participant 5, senior perioperative practitioner]

I ... hope ... they would see us as more professional, more educated

[Participant 7, matron]

It's only through ... education ... do we become nursing and medical [holds hands to represent equality]. ... [I]f we stayed at diploma, we are ... back to that handmaiden concept

[Participant 14, charge nurse]

This increased acknowledgement from other professions has been identified previously (Johnson and Copnall, 2002) and may be attributable to medical colleagues relating to nurses' experiences of university as they themselves have attended university. However, whilst CPE may be entered to raise the status of nursing (Ryan, 2003; Stanley, 2003; Jordan and Hughes, 1998; Nolan et al, 1995), and it may change the doctor-nurse relationship and enable more collaborative working, the majority of participants stated attending university and gaining academic qualifications did not necessarily equate to parity between the two professions

I would hope they ... see us differently. ... I won't say on an equal footing, but more that we could work together

[Participant 7, matron]

I ... wouldn't say equal, I mean ... they're so brilliant most of them. ... I've ... no grand thoughts that they would see me having a diploma as anything worthy of consideration

[Participant 8, perioperative practitioner]

[W]hy feel threatened by a nurse?

[Participant 14, charge nurse]

Although Jordan and Hughes (1998) asserted through attending university and gaining qualifications nurses' status is elevated to that of medical staff, participants indicated that despite the closure of the practice-theory gap, increased knowledge and confidence, and possession of academic qualifications, their subservience compared to surgeons and

anaesthetists persisted. Whilst CPE may not be perceived as promoting equality for nurses and medical staff, or lead to direct practice changes, for most participants the confidence and knowledge it provided impacted on their inter-professional relationships. In congruence with previous findings (such as Davey and Robinson, 2002; Hardwick and Jordan, 2002; Nolan et al, 2000), formal study may thus have an indirect impact on patient care through allowing greater collaboration between the professions.

Personal Outcomes

I don't think there is any point in studying if you do not intend to change. I am more confident and more assertive as a result. ... [I]t has more kudos if you ... have a degree

[Participant 5, senior perioperative practitioner]

All participants described personal gains resulted from their studies, and as found previously (Nolan et al, 2000; Nolan et al, 1995; Barriball et al, 1992) personal benefits were more often identified than overt practice gains following CPE. These personal benefits were similar to those previously reported in the literature (such as Stanley, 2003; Hardwick and Jordan, 2002; Nolan et al, 2000). Participants implied such personal gains were equally, if not more, important than practice gains

[I]t's been ... more [on a personal] level than ... what I've brought to work

[Participant 8, perioperative practitioner]

I realised that it makes me grow as a person

[Participant 11, perioperative practitioner]

I've probably done a lot of it for myself really

[Participant 22, senior perioperative practitioner]

The personal gains went beyond academic qualifications and awards, and participants spoke excitedly of the 'buzz' and 'boost' they experienced in passing, and the 'immense' sense of achievement at the end of a course. As Nolan et al (2000) also

recognised, to achieve academic goals appeared to contribute towards the self-actualisation for which Maslow (1943) asserted individuals strive. For some participants these feelings appeared to emanate from the awakening of latent academic potential, particularly for those who were at school when streaming was in place

I went to school in the 60s and I didn't pass my 11 plus. ... University wasn't even thought about. ... If you'd ... told me ... I'd have got a degree ... I'd have never believed you. ... [T]here's a little bit of pride there

[Participant 7, matron]

[I was] proud that I'd done it. ... [G]etting a diploma was ... the icing on the cake ... because ... I'd done my SRN [State Registered Nurse] training ... and I failed

[Participant 8, perioperative practitioner]

I never came out [of school] with very many qualifications ... so ... it gave me the confidence to say 'yes I can do something at a ... higher level'

[Participant 12, charge nurse]

Participants generally described the realisation of their academic ability in positive terms, however, for one participant this was tinged with regret. She did not expand on whether she would have studied nursing or followed other ambitions

[S]ometimes I wish [sigh] that I could have gone to university as a young woman ... done your degree over 3 years

[Participant 7, matron]

Stepping out of the workplace and into the classroom allowed participants an opportunity to consider new perspectives of familiar situations. Whilst one participant explained such reflection was 'painful', in all cases, as reported elsewhere (Phillips and Friedman, 2001; Wildman et al, 1999; Wood 1998), it provided greater self-awareness

[T]he benefit was to see things from a different perspective, to see that everyone has different views and opinions

[Participant 5, senior perioperative practitioner]

[I]t ... brought to the fore a lot of my strengths, and having just written a list of strengths and weaknesses ... for once in my life, my strengths were longer than my weaknesses

[Participant 8, perioperative practitioner]

Whilst CPE may provide assessment of participants' progress and achievements for those without personal development reviews (PDRs) (Chapter V), such reflection also identified areas for further development. Participants described taking further action in these areas; that is, CPE identified not only achievements, but developmental challenges

I'm still not very good ... at ... challenging and saying ... 'get off my back'
[Participant 8, perioperative practitioner]

It identified some flaws like my computer skills, which I am gradually enhancing
[Participant 12, charge nurse]

The existential benefits identified were not necessarily related to official course outcomes, and for nearly all participants included increased computer skills. Similarly, most participants believed their increased confidence and assertiveness impacted not only on inter-professional relationships, but also outside of work

A bit more computer literacy is ... good
[Participant 2, senior perioperative practitioner]

[M]y life at home changed dramatically. ... I wasn't ... saying what I really felt I ... was inwardly stewing and brooding. ... [I]t's like this core of molten hot larva ... you're ready to blow ... but ... you're embarrassed. I don't care any more. The volcano explodes, but ... it's ... controlled
[Participant 8, perioperative practitioner]

Thus, CPE results in both personal and professional gains. The existential gains derived may be greater than practice benefits due to the nature of perioperative care, and participants' authority to implement changes within this environment. Whilst all participants successfully completed their courses, and described realising personal and professional gains, not all perioperative nurses will be successful.

The Effects of Failure

I didn't want to fail ... I would have been mortified

[Participant 5, senior perioperative practitioner]

Despite enjoyment of their student status, a fear of failure appeared to dominate participants' thoughts, even though all those who were studying at the time of their interview subsequently passed their courses. Such were these fears that one participant mentioned this four times, implying the depth of the associated feelings

I shall be a bit gutted if I've put a lot of effort in. ... Oh, god! What if I fail?!

[Participant 21, perioperative practitioner]

If you failed ... it would ... knock your confidence and make you feel a bit useless and thick ... [Y]ou're ... letting yourself down

[Participant 22, senior perioperative practitioner]

I would feel horrible. ... I can't think if I'm failing this course now

[Participant 23, senior perioperative practitioner]

Far from the feelings of self-actualisation associated with successful CPE, described above, failure was perceived by all participants as having a negative psychological impact. For the majority, this appeared to relate to practical repercussions, particularly if the participant had chosen to study and the course addressed the practice-theory gap

[W]hen I did the conversion ... a girl ... failed ... part of the course and didn't convert. She was ... demoted

[Participant 5, senior perioperative practitioner]

If I ... failed ... I'd question my ... skills and up to now you can't say if you ... do it well. ... [T]hat could knock you

[Participant 16, senior perioperative practitioner]

Managers allow staff to study for the anticipated departmental benefits (Chapter V), and as such participants felt the effects of failure may spread wider than the individual, particularly if told to study to fulfil an identified practice need. Thus, whilst being told to study may create an alibi should the individual fail, as explored previously, reducing

its psychological impact, participants suggested feelings of disappointing colleagues were exacerbated. In such situations participants described increased focus was placed on them, and consequently there was increased awareness by others should they fail

[Y]ou feel compelled that you must complete it all successfully because you are letting the Trust and your colleagues down

[Participant 12, charge nurse]

If somebody has made you do a course, you could be letting them down or your department down. ... [W]hoever you were working for would be aware that you hadn't got anything out of it

[Participant 22, senior perioperative practitioner]

Even in supportive environments participants feared failure, and appeared to be embarrassed at the possibility this may happen. Whilst this was associated with negative psychological consequences, there were also practical repercussions to this, particularly if individuals were studying to address the practice-theory gap or had been told to study.

Continuing to Study

[I]t's as if you're ... on ... a wheel of learning ... [a]nd ... to keep getting off and ... on again it's more difficult, than just keeping on and finishing it. ... But ... if I kept going, and kept going, and kept going I'd just have burn out

[Participant 19, senior perioperative practitioner]

Irrespective of their initial qualifications and the stresses and sacrifices associated with their study, the majority of participants wished to re-enter CPE and to continue learning, as described elsewhere (Ellis and Nolan, 2005; Gopee, 2003; Alejandro, 2001; Dowswell et al, 1998a). In some cases, participants explained study had become a way of life, similar to the 'pull' of education Dowswell et al (1998a) report, which related to realisation of academic abilities and the challenge of attempting higher levels of study

When I get to the end ... I think I'm going to have at least a year, or even 2 years, and not do anything, and then within about 6 weeks of finishing ... I always end up looking for something

[Participant 4, team leader]

[I]t does get you thinking about what you can do. ... [T]here is part of you ... that thinks '... maybe I can do that little bit more'

[Participant 16, senior perioperative practitioner]

A lot of people ... get the bug a bit, and want to do a little bit more

[Participant 22, senior perioperative practitioner]

Despite what some participants identified as the 'addictive' nature of CPE, all participants explained obtaining results was important prior to continuing, especially if higher academic levels were involved. Even then, few participants re-entered university immediately, and resting between courses was described as essential

I'm just having a little bit of a rest! Get the results ... and then see [what to do]

[Participant 3, team leader]

If I get a good result, then I will carry on

[Participant 21, perioperative practitioner]

You'd want a bit of a break, where you don't have to be constantly doing it

[Participant 22, senior perioperative practitioner]

Participants were enthusiastic when talking about CPE, and their student experiences, and used the words 'break' and 'rest' implying their desire to re-enter education. This suggests rather than a break from education, resting allows individuals to receive their results, recover from the stresses and sacrifices associated with study and spend time with their family. The length of time between courses appears vital: Too short and the risk of burn out is increased, too long and subsequent entry to CPE is more difficult

[T]o go back after a period of time it is quite daunting, because you think 'what's changed?' ... 'Are they looking for anything different?'

[Participant 4, team leader]

[I]t's so scary coming back after a big break

[Participant 8, perioperative practitioner]

[Y]ou just get into a rut. ... The longer you leave it, the harder it is

[Participant 13, team leader]

The ideal length of rest could not be determined from interviews, although one participant indicated she was taking a one-semester break. Further investigation may reveal that the amount of time required differs, based on initial qualifications, the duration or level of the study, or individuals' other commitments and priorities.

As previously identified, (Gopee, 2003; Alejandro, 2001; Dowswell et al, 1998a; Berg, 1973) it is the initial entry to university which is most difficult, and similarly once participants' initial inertia had been overcome, university no longer presented such a mental hurdle. Once the initial barriers preventing access to CPE are overcome, subsequent courses are entered by participants who are more knowledgeable about the process and their academic ability, illustrating the helical nature of this journey

I'm finding it easier the further I progress

[Participant 6, senior perioperative practitioner]

It gave me confidence ... [to] apply to do another course because ... I'd achieved that level

[Participant 13, team leader]

When re-entering university, participants appeared not to experience the same concerns as in their initial exposure to CPE, making their journey (Box K) helical, rather than circular. Participants' experiences suggest that if study is accessed frequently, the helical structure is ascended and they are increasingly prepared to study as the intrinsic barriers associated with accessing university courses are diminished. Where this is not accessed regularly, the helix is descended, and individuals gradually return to its base, where they experience similar concerns and intrinsic barriers as prior to their initial entry

I would really struggle to pick up, access the academic skills. ... I wouldn't have lost it all, but it wouldn't be as fresh

[Participant 6, senior perioperative practitioner]

Although participants described worries relating to increased academic levels and periods between CPE, they were more likely to continue studying once ‘on the wheel’, and knew what to expect from university. The challenge for participants was to make this initial entry and overcome such fears, which was not easy within the culture and multidisciplinary nature of the perioperative nursing environment.

Chapter Summary

This chapter has expanded upon the helical model of the CPE journey presented in Chapter IV to provide an overview of perioperative nurses’ experiences and perceptions of attending university. Whilst participants’ descriptions indicated similarities with existing literature, they also extended the knowledge relating to CPE in some areas.

In common with previous studies (such as Gopee, 2003; Stanley, 2003; Hardwick and Jordan, 2002; Dowswell et al, 1998a), participants identified personal, professional and practice based reasons for attending university, with differences between those told to study and those volunteering to study. Participants who volunteered to study placed an emphasis on gaining theory behind existing practices and not falling behind newly qualified nurses, or relatives, academically, or going ‘stale’, as reported elsewhere (Gopee, 2003; Hardwick and Jordan, 2002; Alejandro, 2001; Dowswell et al, 1998a). They appeared to justify these personal reasons to study with practice benefits to gain entry to university, whilst those told to study cited mainly practice based reasons to study. To have knowledge and qualifications appeared to be a compensatory measure for participants, and a form of self-preservation to protect their future careers. As no participants attended CPE for solely practice gains these findings suggest, as documented previously (Ryan, 2003; Dowswell et al, 1998a) for some participants

university courses are attended primarily for personal or existential benefits rather than practice based reasons. There were differences in the perceived need for participants to pass their CPE and the resultant consequences, with participants who volunteered to study placing greater emphasis on the need to be successful.

Participants described having to overcome both intrinsic and extrinsic barriers to access university education, and these reflected those in the existing literature (such as Gopee, 2003; Scholes and Endacott, 2003; Davey and Robinson, 2002; Johnson and Copnall, 2002). Differences were apparent between participants educated pre-registration at university and those trained in schools of nursing, with these formative experiences appearing to influence perceptions of academic ability, as also found by others (Gopee, 2003; Davey and Robinson, 2002; Gopee, 2002; Platzer et al, 2000a), and consequent eligibility to access higher education: Once participants had entered university, and overcome such intrinsic barriers, subsequent courses were undertaken more easily due to greater understanding of the processes involved.

Funding was historically a problem (such as Davey and Robinson, 2002; Johnson and Copnall, 2002; Furze and Pearcey, 1999), and still persisted, but appeared to relate to backfill money, and hence staffing, rather than direct funding of courses. Distance has been cited as a barrier to attending university (Johnson and Copnall, 2002; Gopee, 2001a; Beatty, 2001), however this did not always deter participants from studying. Although some work cited age as a barrier to CPE (Gopee, 2003; Furze and Pearcey, 1999; Barriball and While, 1996; Francke et al, 1995; Houle, 1980), this did not seem to be borne by participants. A reluctance to study did not appear to be based on age *per se*, but was related to when participants qualified as nurses and their consequent confidence

to enter university, based on past experiences and whether relatives had studied at university. As such, in common with Ryan's (2003) findings, it appeared to be attitudes to study which influenced access to CPE rather than age.

As documented previously (Stanley, 2003; Dowswell et al, 2000), participants identified the importance of support during CPE, particularly from family members who formed the foundation of the support network during a course (Box N). The ease with which support could be sought from university lecturers, course colleagues and work colleagues depended upon the cultural milieu in the workplace (Chapter V), and the seniority of course colleagues, which impacted on group bonding, discussion within the classroom, and the outcomes derived from CPE. When participants sought support from work colleagues, this appeared to perpetuate the public discourse of perioperative nursing as a practical discipline, particularly for those told to study and who had not asserted their academic ability. Not only did this appear to reduce the risk of horizontal violence, it also seemed to develop support which would lessen the impact should the participant fail. Whilst seeking support was important for participants, only that from relatives was essential, and if negative reactions were anticipated from either university tutors or work colleagues, then these people were not incorporated into the supportive network. Hostile reactions from either of these sources appeared to exert pressure on the participant, influencing their success.

Although participants, and others previously (Ellis and Nolan, 2005; Stanley, 2003; Gopee, 2002; Dowswell et al, 1998a), identified the impact of combining CPE with other multiple roles, all participants enjoyed their student status. This enjoyment appeared to relate to a sense of equality with younger family members and acceptance

into what was perceived as an elite group, particularly for those conditioned to believe they were ineligible to attend university. Despite the significance participants placed on the possession of student cards, no research could be located which explored this in more detail. The public use of their student cards provided not only tangible benefits, but also demonstrated participants' status as students who are 'bettering' themselves; something they may be unable to do at work, depending on the cultural milieu and perceived risk of horizontal violence.

In accordance with previous work (Ellis and Nolan, 2005; Houle, 1980), participants who chose to study reported greater interest in this and outcomes compared to those told to study. In common with earlier studies (such as Ellis and Nolan, 2005; Gopee, 2003; Stanley, 2003; Nolan et al, 2000) participants identified personal existential gains including increased confidence and critical thinking skills resulted from CPE rather than practice gains. The extent to which knowledge and skills were implemented appeared similar to other findings (such as Ryan, 2003; Scholes and Endacott, 2003; Jordan and Hughes, 1998). In contrast to previous work, which identified CPE had a direct impact on patient care (Hardwick and Jordan, 2002; Johnson and Copnall, 2002; Ellis, 2001; Smith and Topping, 2001; Wildman et al, 1999; Nolan et al, 1995) participants articulated this had only an indirect impact, which arose through increased collaboration with medical staff facilitated by increased confidence and perceived credibility following a period of study.

The findings reported in this chapter suggest the experiences of perioperative nurses as they travel through CPE are similar to those reported in previous studies. However, the emphasis they placed on not wanting to fall behind colleagues academically or in terms

of skills, and resultant changes in relationship with medical staff appear significant findings, but which receive little attention in the existing literature. Similarly, participants' perceptions of the effects of being students in terms of raising their status from 'nurse' to 'student', is something not well documented in the literature.

The discussion above and in Chapter V indicated that participants only sought support from those colleagues most able to support them, whilst those who were perceived as unsupportive were avoided to reduce the risk of horizontal violence. In some cases, participants did not tell any of their colleagues they were studying, and this is something to which little reference could be found in the literature pertaining to nursing or to other professions. The next chapter presents the first documented evidence to explore the phenomenon of 'secret study', where participants remain silent in front of colleagues and travel the CPE journey alone.

Chapter VII

THE PHENOMENON OF SECRET STUDY

The previous chapters illustrate the culture in which perioperative nurses work influenced their experiences and perceptions of continuing professional education (CPE). As in other studies (such as Ellis and Nolan, 2005; Ryan, 2003; Stanley, 2003; Nolan, Owens, Curran and Venables, 2000), not all perioperative departments appeared to support staff development and negative reactions to CPE were described by some participants. Unlike in these previous studies where others' attitudes influenced the decision whether to study, participants explained the levels of support determined the openness with which study would be undertaken. Whilst most participants were selective in revealing to colleagues they were studying, some believed it necessary, at some point in their careers, to study in complete secrecy.

Previous studies identified nurses may not reveal their degree status to colleagues due to perceived negative reactions (Hardwick and Jordan, 2002; Miers, 2002), however to undertake the process of formal study in secret was an aspect of CPE to which no reference could be found during the initial literature review. Once this theme emerged, it was discussed with participants; if they did not describe studying in secret they were asked whether they felt this may happen in their area of work. Although since the interviews were conducted, Deppoliti (2008) has made reference to secret study, she made only cursory reference that nurses may study without revealing this to others. As such, although only a few participants studied in secret, this is a significant finding which provides the first insight into, and exploration of, secret study.

This chapter addresses the nature of secret study and its apparent prevalence from the perspectives of perioperative nurses, and provides vignettes of participants who studied secretly. It explores the motives for studying without colleagues' support, the practicalities of studying in secret, and the outcomes derived. Also considered are other participants' reactions to the notion their colleagues may study in secret.

The Nature of Secret Study

Those participants who studied secretly implied their entire educational journey was undertaken in a covert manner without the knowledge of their workplace, from funding to attending university. Depending on the motives which led to secret study, this decision was not always made willingly, and some participants described resentment and anger in using their own time and money to study. This anger appeared more vehement if associated with perceived inequality in access to CPE

I was angry ... [my manager] didn't want me to study. I knew I could do it, and after the anger wore off, I decided to do it anyway. I studied in my own time and paid for it myself, and arranged my off duty so I could attend lectures. ... I didn't tell anyone at all

[Participant 5, senior perioperative practitioner]

[T]here are a few courses ... I have ... gone to in my own time

[Participant 12, charge nurse]

I did it in my own time, and I didn't tell anybody [emphasis, sounds angry]

[Participant 14, charge nurse]

Participants who studied secretly sought educational opportunities, and thus entered CPE voluntarily. They were angry that the attitudes of colleagues within the workplace necessitated they seek appropriate courses and study without the support of work

I went on a fact finding mission. ... [A]ll the negativity towards me ... gave me the anger ... and the kick start, to do it myself. ... The university sent me all the details

[Participant 14, charge nurse]

‘Secret study’ appeared to be the opposite of ‘public study’ where support was sought from the perspectives illustrated in Chapter VI. Most participants were located between these two extremes and withheld information from nursing and non-nursing colleagues to a greater or lesser extent, and as such the openness with which they studied can be perceived as a continuum with secret study and public study lying at either end.

Secret study is defined within this study as not revealing academic activities or outcomes to anyone within the workplace. This definition was described by those who studied secretly, and also could be related to by the majority of other participants, however, one participant offered an alternative view on secret study, relating not to the processes, but to its outcomes

I have done university training with people who'll find [information] themselves, and keep it to themselves! As if 'I've gone to all this work to find it, I'm not sharing'!

[Participant 6, senior perioperative practitioner]

This alternative perspective is more akin to that previously reported in the literature (Hardwick and Jordan, 2002; Miers, 2002) where it is not the decision to enter study or the process, but the outcomes, which remain tacit, and is suggestive of either an inability or unwillingness to share information, or horizontal violence between nurses. To incorporate this perspective would extend the parameters of the definition of secret study, and necessitate redefining this phenomenon. As only one participant described secret study entailed withholding information, it suggests this is not the most widely held interpretation. As such, as a newly emerging area of interest, concentration is focused on the wider-held definition of secret study, relating to CPE undertaken by perioperative nurses without the knowledge or support of other members of the multidisciplinary perioperative team.

The Prevalence of Secret Study

Only three participants described studying in complete secrecy: most participants selectively told others of their CPE, as discussed in Chapter V, with two participants at the public end of the continuum. Whilst this provides insight into the prevalence of secret study, other participants may have studied secretly, but did not state or infer this was the case. Although only three participants revealed they had studied in secret, due to the nature of this phenomenon its prevalence may be greater

I'm not sure whether anyone [else] here has done [studied secretly], but then maybe I wouldn't know if they truly wanted to be surreptitious about what they were doing

[Participant 5, senior perioperative practitioner]

You would be amazed at the number of people doing things in secret

[Participant 9, team leader]

In addition to the three participants who had studied in complete secrecy (P5, P12, P14), two others knew someone who had studied secretly (P9, P11). Furthermore, almost all other participants could understand why, in certain situations or at certain points in their lives, perioperative nurses may wish to study secretly (P1, P2, P3, P4, P6, P8, P13, P16, P17, P18, P21, P22, P23). Only 5 participants could not understand why individuals could be persuaded to take this course of action (P7, P10, P15, P19, P20).

Those who could perceive a need for secret study and were not shocked by this concept were mainly more junior staff. The most senior participant, who was 'all for' staff development, and believed this was 'marvellous', was the most shocked by the concept of perioperative nurses attending university and not revealing this to colleagues. Other more senior participants expressed similar sentiments, and lack of understanding of the secrecy surrounding CPE

I am surprised people do it in secret. ... Most probably ... that's never crossed me because of the position ... I'm in. ... That's really shocked me!

[Participant 7, matron]

Bizarre!

[Participant 10, team leader]

Why do they ... study secretly? I can't understand why they'd do that?

[Participant 19, senior perioperative practitioner]

That these more senior staff should have such reactions to the concept of secret study suggests junior participants who perceive the need for covert study are successful in keeping this from managers. However, those who studied secretly were more senior staff, so whilst junior staff may relate more easily to the need for secret study, those more entrenched in the culture may wish to publicly revoke the notion of perioperative nursing as both practical and academic, and articulate the prominent anti-academic discourse (Chapter V). Thus, despite their alleged surprise at others' study, they may privately study. Only one junior participant could not relate to secret study, however, rather than expressing surprise relating to this, she spoke of her sadness that some individuals felt this was necessary. Other participants echoed these sentiments

[T]hat's ... a pity ... though for some people

[Participant 13, team leader]

[I]t's a bit sad

[Participant 21, perioperative practitioner]

That some participants divulged they had studied secretly, and others could empathise with the potential need for this suggests others had or were studying in secret. This action may have perhaps been taken to concur with the dominant anti-academic discourse while privately they wished to study. Thus, whilst this chapter documents the experiences of those who revealed they had studied in secret, other participants may have also studied in this way but did not feel comfortable disclosing such information.

Participants who undertake Secret Study

The findings did not reveal a ‘typical’ profile of a secret studier, however further research may reveal commonalities it was not possible to detect from the small number of participants who revealed they had studied in secret. Vignettes (Box P) are included as exemplars of the interaction of the factors which appeared to influence participants’ decisions to study secretly, to allow insight into this previously unreported phenomenon. These were constructed in the same way as those illustrating horizontal violence (Chapter V).

These vignettes illustrate three main factors influence participants’ decisions to study in secret; the culture in which they worked and the consequent level of support they anticipated would be received from managers and colleagues; their academic confidence; and the fears of the impact of potential failure. Further illumination of the interaction of these factors is illustrated in Box Q and later in this chapter.

The Motive to Study in Secret

Irrespective of the degree of openness with which CPE was undertaken, all participants described similar motives which prompted their study, and as explored in Chapter VI these were based primarily on personal needs. However, unlike those who wished to be supported by work, participants who studied covertly did not need to augment desired personal gains with practice gains to legitimise attending university courses, and in some cases studied solely for anticipated personal outcomes: Where participants attended university for anticipated work outcomes, this was associated with self gains. This further emphasises the argument (Chapter VI) that formal study is undertaken primarily for personal gains, although work may benefit as a secondary outcome

Participant 5's story

My manager was not interested in my progressing academically. At first I was angry but I knew I could do it so after the anger wore off, I decided to do it anyway. Although my study was based on my work, it wasn't directly related, and therefore they didn't need to know, so I didn't tell them. I didn't feel I could tell anyone I worked with I was studying. I'd only been there a short time, and I didn't know how they all felt about studying, and I didn't want my manager to find out. It was very difficult not to tell anyone. My manager never found out I was studying. If I was unhappy where I was I would be tempted to study secretly again, but I can't ever see it happening where I am now, as the attitude is right and everyone supports each other. [Support low, confidence high, fear of failure low]

Participant 12's story

I've had a reluctance to put me forward for things and there are hurdles, mini-hurdles, stopping you studying. Courses are earmarked for certain people, which I resent, and I will push to get on them as I know I am capable. One course I did, I arranged it on my time, in my day off. I didn't tell the work - my manager ended up being on the same course, but I didn't know that. There are a few courses I have arranged and gone to, in my own time. You get resentment from colleagues but people should be able to do whatever they want in their own time. Some of my peers resent the fact I've got academic qualifications. [Support low, confidence high, fear of failure high. Manager present]

Participant 14's story

I didn't want it to get back that 'she's a swat'. My manager didn't want me to study, but I thought 'you want people just to scrub, scrub, scrub but you're not going to stop me '. It gave me the anger, and the kick start, to do it myself. The university sent me all the details, I paid my course fees, and said, 'I'm going to prove I can do it'. I came back feeling good, and because of what I'd learnt wanted to do counselling. I knew I was capable. I did it in my own time, and didn't tell anybody [sounds angry] I was doing it or that I'd done it, because they would say 'she's trying to better herself, who does she think she is'. There's no point rocking the boat, because the messages get to the surgeons, and they give you a hard time. I don't tell people my qualifications unless they ask. [Support low, confidence high, fear of failure high]

Participant 9's story about her friend

I've got a friend that studies secretly in case she fails. She does a lot of studying and doesn't tell you, purely because she's got to succeed at a high level, and if she doesn't get it she'll not tell you. But that's fear of failure on her part, and she has a very big sense of she has to achieve things. I think she's always in competition with other people whereas I'm sorry but if you've tried and you've failed, there's nothing wrong with admitting that but it depends on your support networks. [Support low, confidence low, fear of failure high]

Box P: Vignettes illustrating secret study

[I study] mainly to prove that I can do it. ... I was determined to prove that I could do it

[Participant 5, senior perioperative practitioner]

I thought ... I could ... learn and apply [that] in the workplace for other people's benefit

[Participant 12, charge nurse]

Initially, the degree of openness with which study was pursued appeared to relate solely to the anticipated level of support participants believed would be afforded by work colleagues. However, as more participants were interviewed, it was noticed that this decision also related to their intrinsic self-confidence they could pass and the repercussions of potential failure in terms of their practice and inter-professional relationships. Each of these issues was influential in determining the openness with which participants studied, and in combination could result in secret study. That is, the decision to study secretly was based on interacting factors, as illustrated in the vignettes (Box P), relating to the culture in which the individual worked and factors intrinsic to the individual.

The Culture in which the Individual Works

[I]t's important to be open with things - but it is not always possible. ... [Y]ou don't know what will happen if they find out

[Participant 5, senior perioperative practitioner]

The culture and attitudes of others within the work environment was shown in previous chapters to be influential in determining the uptake of formal education and the support provided to the individual, and this has also been reported elsewhere (Ellis and Nolan, 2005; Ryan, 2003; Schuller, 2000). Not all participants who studied secretly wanted to keep their educational activities secret, but felt this was necessitated due to anticipated reactions from colleagues. They explained in some cases others' negative attitudes provided a motive for secret study as they did not wish to be seen to traverse cultural

boundaries of nursing when working in areas which were unsupportive of staff development, where practice and academia were not perceived to be able to co-exist.

Support and Managerial Influences

Whilst other studies documented others' attitudes affected whether CPE is undertaken (Ellis and Nolan, 2005; Ryan, 2003; Schuller, 2000), participants who wished to undertake formal study explained they would not necessarily be deterred by negative reactions. They described the actual or perceived levels of support they expected to receive from colleagues were pivotal, not in deciding whether to study, but in deciding whether to reveal their desire to study to these people. In the absence of support, in areas where practical skills acquisition was promoted above academic development, participants felt they had no option but to study secretly

[T]here was no need for my manager to know, as I was doing it in my own time, and paying for it myself ... so I didn't tell them

[Participant 5, senior perioperative practitioner]

I was told '... we haven't got the staff to allow this to happen ... '. So I thought '... [Y]ou're not going to stop me. You want people just to, to scrub, scrub, scrub, and you're not investing in me, well, I'll do it myself'

[Participant 14, charge nurse]

Participants appeared to consider these predicted attitudes and the nature of the course they wished to study, and assess the consequent support they believed they would receive. Those who did not study secretly empathised with the need to study secretly

[I]f you know you're not going to get the support, you've really got no option

[Participant 13, team leader]

[A] few years ago, I may have been like that [studied in secret], because I've not always had the support ... in the workplace

[Participant 17, team leader]

If others were perceived as antagonistic to the notion of their intended study, they would not ask for study leave. This assessment seemed to be influenced by previous experiences, observing their managers' reactions to others' study requests, or general perceptiveness. It also appeared to be dependent upon the priority of the course, and whether it was intended to develop academic knowledge or practical skills and the concurrence of this with the dominant discourse of nursing in a particular area: As such the decision whether to request leave was closely bound into perioperative nursing culture, and one course may be accepted by managers as valuable to the department, and others rejected

[I]t depends on why they're studying

[Participant 6, senior perioperative practitioner]

[O]ne of my colleagues ... wanted to do some higher studies ... but when she did ask they said something about the budget, financial crisis. So, no [she wasn't allowed]. After that, she didn't ask

[Participant 23, senior perioperative practitioner]

To ask for study time, but be refused, would alert managers that individuals wished to study, and one participant explained she intended to study in secret as she did not believe she would be supported by her workplace to attend university to meet her aspirations of obtaining a degree. Rather than ask for study time, if participants believed their request would be refused by managers, they would rather study secretly than risk this scenario and its repercussions in terms of acting contrary to the predominant culture in which they worked (Chapter V), and increased risks and effects of failure effects of this (Chapter VI).

The jealousy and feelings of being threatened by colleagues who advance academically, which may lead to horizontal violence, as explored in Chapter V and reported elsewhere (Jordan and Hughes, 1998), could be the source of negativity and refusing to allow

attendance at CPE. One participant described how in a culture which does not value academic development, perioperative nurses may not wish to be perceived by others as becoming too knowledgeable, and suggests this may provide a rationale for secret study

[Y]ou ... want to discuss whatever you've been doing at university, and ... it's very hard. ... I wonder if that's why people are secretive, because they don't want to come across as being ... a clever dick

[Participant 7, matron]

[A]n E grade had fed back to me and said - 'you had said to a G grade what nursing magazine do you buy?' and they didn't like it. ... I just wanted to ... swap magazines, but that was seen as 'wow! she's been and done [a course] who is she?!' And with that, I thought right I'll do the counselling, and I won't tell anybody

[Participant 14, charge nurse]

Schuller (2000 p231) also explains how nurses do not want to “show off” their academic knowledge to colleagues, as this could potentially lead to negative reactions. As such, not informing others of CPE is suggestive of a self-preservation strategy to avoid horizontal violence, and also strengthens the argument made in Chapter V, that the pursuit of knowledge by perioperative nurses is perceived as a negative aspiration, and is an antecedent to horizontal violence. In studying secretly, participants are able to publicly uphold the dominant discourse of perioperative nursing as a practical discipline, whilst privately pursuing academic ambitions, meaning cultural boundaries of perioperative nursing are not traversed. Such action reduces the risk of perioperative nurses exposing themselves to potential horizontal violence in cultures unsupportive of staff development. That is, the decision to study in secret prevented participants from ‘rocking the boat’ and prevented them from acting contrary to the dominant discourse of perioperative nursing as a practical profession.

Cultural Boundaries

A part of socialisation into the perioperative nursing culture involved adopting, at least publicly (Watson, 2006; Warr, 2005), the dominant traits of that culture, as explored in Chapter V. As Hamlin (2000) explains happens elsewhere in nursing, participants did not wish to act contrary to the culture with regard to CPE, and the openness with which study was pursued was based on a need to conform to prevailing values. If new to an area, participants were more likely to study in secret to avoid ‘rocking the boat’ whilst they determined these prevailing cultural values towards nurses attending university

I'd only been there a short time when I started my course, and I didn't know how they all felt about studying, and I didn't want my manager to find out, so I didn't tell anyone at all

[Participant 5, senior perioperative practitioner]

I was ... in a new environment and you have to fit into the group norms. ... [I]nitially ... with ... me being a new kid on the block, there was some resentment there

[Participant 12, charge nurse]

Such actions were thus taken to avoid stepping outside cultural norms, and becoming a victim of horizontal violence. However, it was not only nursing colleagues’ anticipated reaction to participants’ CPE and development aspirations which led to secret study, as some participants explained how other professions also influenced their decisions

[I]f you rock the boat, the messages get to the surgeons, the surgeons give you a hard time at the table ... because of the organisational dynamics

[Participant 14, charge nurse]

Whilst a motive for CPE may be promotion and moving to other areas (Chapter V), some participants, in considering secret study described this may provide a second reason the ‘boat may be rocked’. Some participants believed managers did not allow staff development in an attempt to retain individuals in theatres (Chapter V), which suggests some perioperative nurses are more likely to study secretly, rather than publicly

declaring these intentions, when working in a hostile environment. Participants implied if they were seeking promotion or a move from an area, to study secretly would avoid upsetting relations in the area and dislodging the equilibrium required for successful study, as described in the previous chapter, prior to completion of the course

I suppose it would be feasible ... if they ... wanted to move to another area, but not had any support from management or ... their colleagues ... to undertake some kind of course to ... introduce themselves to another area ... before they actually did move

[Participant 4, senior perioperative practitioner, team leader]

[T]o get out of an area they didn't like

[Participant 5, senior perioperative practitioner]

Some people see studying as the only route to promotion and ... sometimes they're not quite so open with it, when that's ... their aim. [They m]ight not be so public about what they're doing

[Participant 6, senior perioperative practitioner]

Whilst participants provided reasons why study may be undertaken covertly, in considering the impact of the culture on preventing people discussing CPE, one senior participant was saddened to think this may happen in her own area, as this was contrary to her own private discourse of the acceptability of nurses entering formal study

I feel quite sad ... if somebody feels that they have to do that, to move from a place or to further themselves. ... I just think if anyone wants to ... further their knowledge ... I'm all for it. I just think it's marvellous

[Participant 7, matron]

Although this participant was saddened by her thought, participants rationalised colleagues' potential negative reactions, and related these to other's fears of entering CPE, and the notions of 'jealousy' and 'bettering' oneself, as explored in Chapters V and VI. As previously reported (Davey and Robinson, 2002; Hardwick and Jordan, 2002) it was this which led them to study secretly

[T]here are a few courses ... I have gone to, in my own time, because if you don't ... you don't get the time. And then you have a ... scenario ... that '... it's the same people get on ... courses all the time' and you get resentment

[Participant 12, charge nurse]

I registered ... and I did it in my own time, and I didn't tell anybody [emphasis, sounds angry] ... I was doing it, because they would ... say '... she's an E grade staff nurse, she's trying to better herself, who does she think she is?'

[Participant 14, charge nurse]

I imagine ... there would be ... an element of jealousy there maybe? Somebody going off to university and bettering themselves

[Participant 19, senior perioperative practitioner]

The previous chapter reported individual beliefs relating to academic ability which were internalised during formative education acted as a barrier which may prevent CPE, and those participants who studied in complete secrecy tended to be older. This suggests they were afraid to study as it was remote from previous education and practice, as discussed in Chapter VI and as found by others (Davey and Robinson, 2002; Gopee, 2002), and in doing so traverse the cultural boundaries of nursing as a practical discipline. They did not want to cause controversy with their peers, so studied in secret

Because I've got academic qualifications, some of my peers resent the fact that I've got them

[Participant 12, charge nurse]

I've studied secretly ... because I didn't want it to get back that '... she's a swat, she's trying to do this, she's trying to know more than us'

[Participant 14, charge nurse]

In this way, older participants, educated through nursing schools, were publicly reinforcing the practical nature of nursing, whilst privately undertaking CPE for the reasons described in the previous chapter. Older nurses educated through universities were more open with their study, and appeared to adopt a more pragmatic notion of nursing as both a practical and an academic discipline (Chapter V).

In addition to external, cultural, factors which encouraged participants to study in secret, participants also identified intrinsic factors which influenced the openness with which CPE was approached and undertaken.

Individual Characteristics of the Perioperative Nurse

[I]f I'd ... have been doing this a few years ago ... I probably would have gone down that road in case I'd failed, because I was frightened of failure
[Participant 17, team leader]

In addition to the culture providing a motive for secret study, factors intrinsic to the individual's academic confidence and their fear of failing the course they wish to pursue led to secret study. Whilst these issues are intrinsic to the individual, they also related to the culture in which they work, and the resultant support individuals receive from their manager and colleagues to study and also in the event of possible failure.

Lack of Confidence in Academic Ability

The previous chapter illustrated how most participants perceived personal outcomes relating to knowledge and confidence, which contribute to self-actualisation and boost their self-esteem, as important outcomes of CPE. For some participants with low confidence in their academic ability, the risk of failure and possible impact of this provided the motive to study in secret. Although the psychological effects of failure (Chapter VI) would still occur, in studying secretly participants described colleagues would have been unaware of this failure, lessening its ramifications (Chapter VI)

[If p]eople ... frightened of failing ... don't publicly acknowledge that they are undertaking any study, if they were unsuccessful ... nobody would know
[Participant 6, senior perioperative nurse]

For some participants attending one module equated to putting their ‘toe in the water’ to assess their academic ability, with their results determining whether they enrolled for complete programmes (Chapter VI). In some cases in unsupportive cultures or where participants lacked academic confidence, this first module is undertaken secretly, with subsequent modules undertaken more openly, as discussed below. As such the need to study secretly is dynamic, changing over time as participants change and as their motives for study change

*I admire anybody who can do that, but I don't think I could ... now. ...
[B]efore, when I worked part time ... I probably could have managed it*
[Participant 17, team leader]

Closely linked to the lack of self confidence is the fear of failure, an idea discussed in the previous chapter, and identified by all but one participant. The issue of failure, and more significantly its ramifications were reasons why some participants described secret study was preferable to public or selective study.

Fear of the Consequences of Failure

The majority of participants spoke of their fears of failing CPE, even when supported by colleagues (Chapter VI). The same fears were identified by participants who studied secretly, and also by other perioperative nurses when considering the reasons why their colleagues may study in secret

If you're not a person who likes to admit to failing
[Participant 16, perioperative practitioner]

*I probably would have gone down that road [secret study] ... because I was
frightened of failure*
[Participant 17, team leader]

However, some participants described it was not their lack of academic confidence, but the potential psychological and practice ramifications of failure (Chapter VI) which prompted them to study secretly. Whilst for some perioperative nurses, such fears prevented study, for those prepared to 'risk' entering CPE, to do this secretly was a strategy which reduced the consequences of potential failure

[A] friend ... does a lot of studying and doesn't tell you ... purely because she's got to succeed at a high level. ... But that's fear of failure on her part. ... [S]he does have a very big sense of she has to achieve things ... with this job. I think she's always in competition with other people

[Participant 9, team leader]

In studying secretly, the psychological 'knocks' to participants' confidence (Chapter VI) associated with failure may still be present, however, through limiting the number of people aware of their study, this limits the impact and consequences of failure in terms of their practice. In addition, that colleagues were unaware an individual was studying meant they would not be asking whether individuals had been successful, which may also limit the psychological effects of failure. However, this would require further investigation.

Thus, both cultural and individual factors appeared to influence whether participants studied in secret. These antecedents to secret study interact, and in combination these determined participants' locations along the continuum between secret and public study.

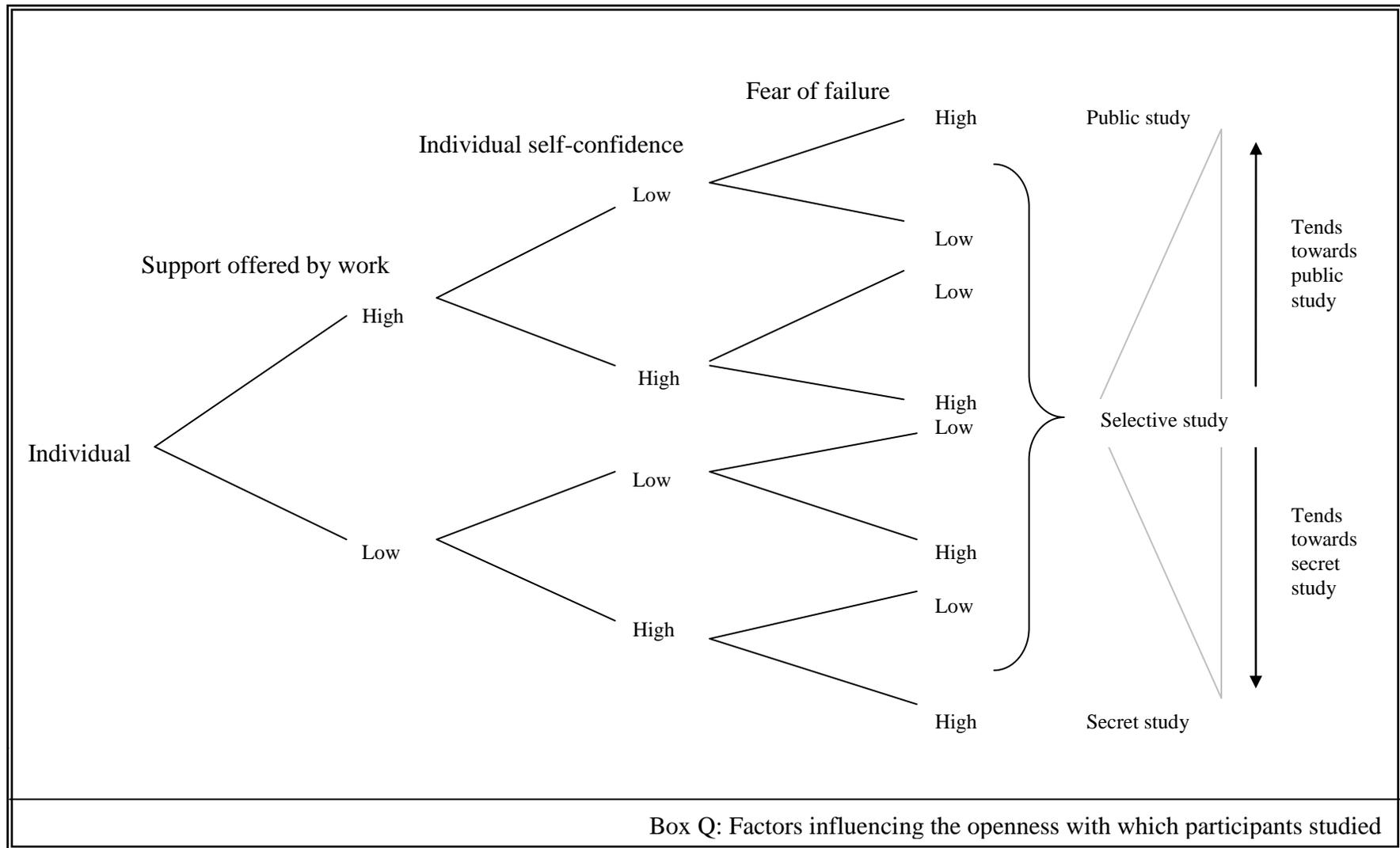
Interaction of these Factors

[I]t's about sussing out ... your manager ... their frame of reference ... the shop floor, allocation of resources, your motivation ... and those are only a few of them

[Participant 14, charge nurse]

The decision to study secretly, publicly, or selectively is dependent upon the interaction of the factors illustrated above and in earlier vignettes of participants' experiences (Box P). These relate to the culture and the consequent perceived degree of external support from multidisciplinary team colleagues, as well as intrinsic factors relating to the participant's self-confidence, and potential repercussions of failure.

In deciding how openly they should study participants appeared to evaluate these factors, and the combination of the highs and lows for each gave an indication of their location on this continuum. As the model (Box Q) indicates, in supportive cultures irrespective of an individual's self confidence and fears of repercussions, there was a tendency for the individual to study with increasing openness: Where cultures are unsupportive, there was a tendency towards secret study. Those participants having high support from work and low self-confidence who study more publicly tended to be those told to study, which, as suggested previously, allowed them to create alibis, whereas those without work support, but with high intrinsic confidence in their academic ability appeared more likely to study in secret. The majority of participants were situated towards the centre of the spectrum, and were selective towards discussing their CPE activities, with some participants, as indicated above, occupying the extremes of public and secret study.



The Practicalities of Studying in Secret

Participants related similar experiences of the process of studying, irrespective of their location on the continuum of openness, and the categories to emerge fell within the themes identified in Chapter IV. However, some differences were apparent for participants who studied secretly, due to the covert nature of their studies. The issues of time management and support appeared to differ most for those studying in secret, and where time and support were not provided by work these had to be sourced from elsewhere. In addition, those who did not study in secret described the practicalities of maintaining secrecy surrounding CPE as potentially difficult

[I]t's quite difficult to keep something very ... quiet ... I don't think I could do it in secret, I have to say! I'd probably put my foot in it and ... it would be obvious

[Participant 13, team leader]

I would think it's a bit difficult doing it on the quiet

[Participant 17, team leader]

One participant revealed despite her intentions to study secretly, this was not an option. Although she told no one she had applied for the course, her study was made known to her manager the moment she walked into the classroom

I didn't tell the work - my manager ended up being on the same course, but I didn't know that

[Participant 12, charge nurse]

In order for both participants to enter the classroom unaware the other was intending to study means neither can have discussed their intentions with the other. Thus, it is possible to assume both individuals were studying secretly; if the manager had divulged their attendance, the participant could have decided whether to withdraw from that course or reveal they too would be attending. This situation supports the possibility that secret study may be more common than indicated by participants.

Although participants identified difficulties with studying covertly, some did travel this path, and indeed completed their journeys successfully, despite the issues relating to time management and support.

Time Management

[W]hen are you going to fit all your reading and things in? ... And working full time, how on earth would you manage it?

[Participant 17, team leader]

The time consuming nature of undertaking formal courses, particularly in relation to completing written work, the stress this caused, and sacrifices this necessitated, impacted on participants and their families (Chapter VI): Indeed the time commitment required in combination with other commitments was described previously as a potential barrier to perioperative nurses entering higher education. The social capital involved in CPE has been indicated as being high (Stanley, 2003), and previous work has demonstrated the impact of this for those studying with the support of work is greater at home than at work (Ellis and Nolan, 2005; Dowswell, Hewison and Hinds, 1998a). For participants who studied in secret there was an additional requirement impacting on this social capital as, in addition to completing written work in their own time, they also had to attend university outside of working hours. As such, this suggests the impact of that study on their families (Chapter VI) would be exacerbated. The emphasis participants placed on the need for study leave suggests those studying secretly may find it difficult to negotiate a successful journey through their university courses

[I]t's ... so difficult doing all of it in your own time. ... [T]o try to fit it in on days off or annual leave days ... it's ... very hard

[Participant 6, senior perioperative practitioner]

[W]hen are you going to fit all your reading and things in? ... And working full time, how on earth would you manage it?

[Participant 17, team leader]

Participants who were studying secretly arranged shifts to accommodate time to attend university without divulging the need for these arrangements to managers

I paid for it myself and did it in my own time. ... I arranged to have one day off every 4 weeks to attend university and did it that way

[Participant 5, senior perioperative practitioner]

I'm doing a course ... at the minute ... out of nursing - it's a massage course. ... I've just requested on the off duty to have that ... night off

[Participant 22, senior perioperative practitioner]

In a culture where CPE is unsupported, and where staff are encouraged to develop practical skills but not obtain academic qualification, staff describe the importance of arranging shift patterns and taking annual leave to accommodate their study. They explained they do this covertly to avoid colleagues becoming obstructive in terms of 'fixing the off duty', something which Hamlin (2000 p39) relates to horizontal violence and terms 'sabotage' and an attempt to prevent the individual being successful. Some participants who studied secretly believed if managers became aware they were studying, they may deliberately prevent them attending university

They might think ... the management, might make it difficult for them. By arranging their off duty so they can't get to what ever it is they're studying! Or denying their requests for early finishes on a particular day

[Participant 1, senior perioperative practitioner]

[If [managers] find out - they might make it impossible for your requests to be granted on the off duty. ... [If that had happened ... I wouldn't have been able to attend university. I don't think I would have passed ... if she had found out, and not allowed me to have the off-duty requests

[Participant 5, senior perioperative practitioner]

If the course is of longer duration problems with arranging shift patterns to accommodate university time may be exacerbated, as managers may spot reoccurrences and patterns in the individual's requests, and in areas hostile to staff development may deliberately prevent these requests being granted. To be unable to attend university

impacted on the individual's learning which may affect the outcomes gained; if the course requires certain attendance levels this too could impact on the individual's success. Participants believed revelation of their student status did not only potentially impact on their studies, but also on their role at work

[I]f you rock the boat, the messages get to the surgeons, the surgeons give you a hard time at the table ... because of the organisational dynamics

[Participant 14, charge nurse]

If managers were perceived as unsupportive or uninterested in staff development they were not approached for study leave, despite the additional stresses and sacrifices realised. To study in secret appeared to be preferable in these circumstances to avoid the potential repercussions of being refused study leave, as outlined above. Whilst participants who studied secretly intimated they were perceptive in judging managers' potential reactions to their desires to attend university, one participant, who did not divulge studying in secret, described this was not so easy to determine

[S]ometimes people do surprise you and say ' ... we will support you'. ... I suppose there are certain instances where you know for definite that they're just going to say 'no'

[Participant 13, team leader]

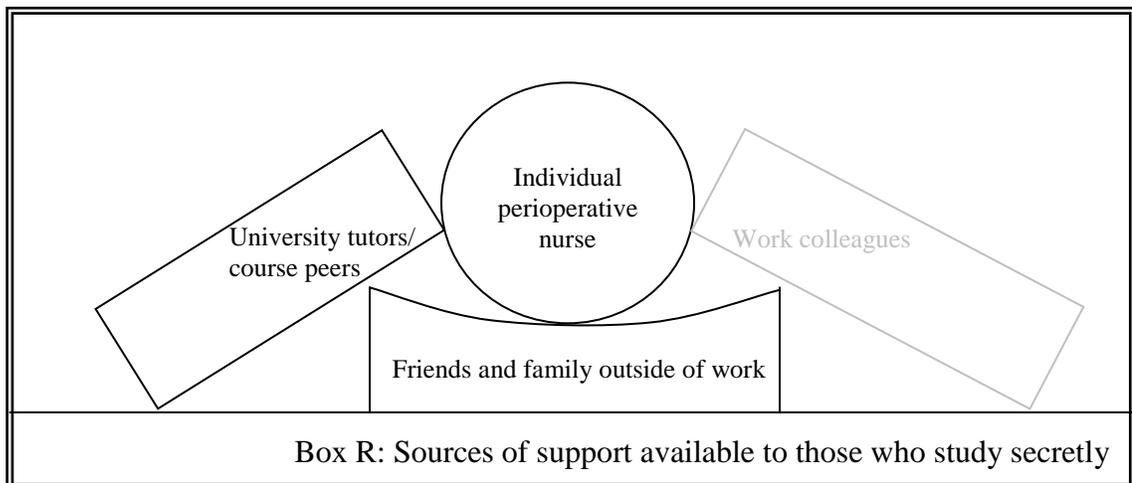
Such a comment suggests in some cases, the additional sacrifices and stresses caused by covert study may be unwarranted, as requests for leave may have been granted. However, those participants who had studied secretly felt the consequences of asking for leave, and alerting their manager to their wish to study, but then being refused, outweighed the short-term sacrifices necessitated by studying in secret.

Issues relating to Support

[I]t would be a shame. You're denying yourself all the access to all the support that could be there

[Participant 6, senior perioperative practitioner]

Support is vital for individuals who are studying (Stanley, 2003; Nolan et al, 2000; Cervero, 1988) and this was highlighted by participants, irrespective of their location on the openness continuum. The previous chapter presented a model of the support available to perioperative nurses undertaking post-registration education (Box N), and explored how this influenced participants' success in CPE. Whilst participants who studied secretly also described the need for support, the data indicated the sources from which this could be sought were reduced (Box R)



Although without work colleagues' support the individual perioperative nurse appears more vulnerable and unstable, in areas perceived as unsupportive or where failure will have repercussions, participants believed to withhold their study activities from colleagues helped to maintain their stability. To reveal their studies to colleagues in this type of environment may exert pressure on the individual and affect their stability, making success less likely. However although it is possible to study in the absence of

work support (Chapter VI) this is not always easy, and participants identified practical difficulties if colleagues were aware of their CPE

It was [difficult], I needed to speak to people about it

[Participant 5, senior perioperative practitioner]

It's difficult to say - I'm struggling ... but then if you don't say it, you're not going to get any help. ... [Y]ou can't expect the support

[Participant 9, team leader]

In the absence of work support, participants turned to relatives to provide both academic and practical support, again drawing on their strengths (Chapter VI). As for those studying openly, relatives appeared to provide the foundations of stability and support through CPE, and, interestingly, this support also appeared to be sought above that from university tutors. Perhaps, as proposed in the previous chapter, this may relate to participants' insecurities, or availability of these people

I felt very alone - my husband was studying and I often turned to him for support, to put ideas past him and ask for advice. The university weren't very helpful - the tutors weren't often around for tutorials and I didn't feel supported

[Participant 5, senior perioperative practitioner]

[M]y husband ... gave me support, and without that support, I wouldn't have ... been successful. So, I owe a lot to my husband and my children. ... I didn't get any support in my work place. I got ... [s]upervision from my tutors at [university] and personal supervision from my supervisor

[Participant 14, charge nurse]

The importance of familial support has previously been reported (Stanley, 2003; Beatty, 2001; Beatty, 2000). Considering the increased demands on the time of individuals who chose to study secretly, and the consequent need to spend greater amounts of their own time studying than colleagues studying more openly, this suggests the contribution and support provided by relatives (Chapter VI) may be increased, however this was not explored.

Also not explored with particular regard to secret study were the effects of the possession of a student card, however, the use of this to demonstrate a student's elevated status from 'nurse' to 'student' and access to resources both occurred outside of work. This suggests similar gains may be realised from publicising their student status as for participants studying more openly (Chapter VI). Further research would provide greater insight into this from the perspective of secret study.

The practicalities of studying in secret, in terms of time management and support, as well as the motives leading to study secretly, were described by participants as having an impact on the outcomes derived from that period of study.

Outcomes Following a Period of Secret Study

In common with existing literature (such as Ellis and Nolan, 2005; Hardwick and Jordan, 2002; Smith and Topping, 2001; Jordan, Coleman, Hardy and Hughes, 1999), the previous chapter documented that participants perceived personal gains were more likely to arise following a period of study than direct practice gains. Similarly, participants who studied secretly also reported personal gains to be greater than benefits to their practice following formal study

I am much more confident. I've obviously gained a lot more knowledge
[Participant 5, senior perioperative practitioner]

As for colleagues who studied more openly, and like findings reported in previous work (Davey and Robinson, 2002; Daley, 2001; Ellis, 2001), participants explained the increased confidence and knowledge which resulted from CPE and earning academic credit and awards had an indirect impact on their work. They particularly described this with regard to their relationships with medical staff.

Given that the previous chapter reported participants who studied with some degree of openness were unable to illustrate how CPE had impacted on their practice, it is not surprising that participants who studied in secret reported no changes to practice. Participants intimated those who studied secretly may be prone to resistance from others should they attempt to implement practice changes. As change will only be realised if others see the need for this and it does not question existing practice (Nolan et al, 2000; Jordan et al, 1999; Sheperd, 1995), if perioperative nurses have not informed others of their study, then colleagues may question their motives for attempting to instigate change. In addition, colleagues may be suspicious of their actions, making change even less likely for this group than for those studying with a degree of openness, compounded by others being unaware the individual has studied, and their reactions

[If you do anything in secret, doesn't that mean ... you're either going to surprise someone or you're ashamed of it

[Participant 7, matron]

[If you've done a course that's given you ... skills, when you go back to work, people will wonder where you got those skills from

[Participant 13, team leader]

To study in complete secrecy means medical staff will also be unaware of CPE activities. As such, this surprise could extend to other professions, and should proposed changes traverse professional boundaries, increased difficulty may be experienced in implementing changes, as previously found (Scholes and Endacott, 2002; Jordan and Hughes, 1998). The previous chapters described medical staff are perceived as usually supportive of nurses development, however, to study in secret may not be conducive to doctor-nurse relationships. If nurses study in secret, the medical staff may become suspicious of their motives and defensive of their professional boundaries within theatres, leading them to become obstructive in their attitudes to any proposed change.

The nature of the culture in which an individual works also appeared to affect the outcomes which result from secret study. Whilst one participant suggested individuals who study secretly are ashamed, the suppression of their achievements and study may be enforced, as described in Chapter V, and relate to a culture which promotes practical skills above academic qualifications

[I] try ... to bury it a little bit ... I suppose. ... [S]omeone ... bought me a card ... when I'd got my diploma ... and I ... put it in my locker. ... The only words [said] were '... So-and-so's nearly got her degree'. ... [Y]ou just ... perceive ... they've got bad vibes about it

[Participant 8, perioperative practitioner]

Just as the culture affected how open nurses can be with regard to the academic qualifications (Hardwick and Jordan, 2002; Miers, 2002), participants who study completely or partial secrecy may have to suppress their achievements at the end of their course due to the culture in which they work. As such, these individuals will be unable to implement practice changes, however the personal gains relating to increased confidence and knowledge may allow indirect changes to practice and increased collaboration (Chapter VI).

Those who choose to study secretly and self-select courses to attend may choose courses which meet their own needs but are incongruent with the views and needs of other stakeholders (Tobias, 2003; Evans, Ali, Singleton, Nolan and Bahrami, 2002; Ellis, 2001), which means practice gains will not be realised

I thought ... I could go ... and learn ... and use and apply [the knowledge] in the workplace for other people's benefit. It turned out ... the course wasn't quite what I anticipated

[Participant 12, charge nurse]

Whilst personal gains may still be realised, the other outcomes which are anticipated may not be realised if courses are chosen randomly by participants without guidance from others (Ellis, 2001). This suggests greater direction is required for such participants, to ensure the outcomes from a period of study meet the expectations with which CPE was entered, and address the needs of the relevant stakeholders involved.

The previous chapter, and other studies (Stanley, 2003; Alejandro, 2001; Dowswell et al, 1998a), described how most participants wish to re-enter formal education, albeit following a brief rest; participants who studied secretly also wished to re-enter education, either secretly or with more openness

[In the past] I wouldn't tell anybody in case I didn't ... complete the course ... or pass it. But ... I'm different now, I am a more confident person, I've got the support in place. ... I'll ... be up front with you because I'm not going to fail

[Participant 17, team leader]

Most participants who studied covertly did this only once, depending on the motives with which they entered the CPE, illustrating the dynamic nature of self-confidence, as future modules may be studied with more openness as their confidence develops. Whilst intrinsic self-confidence grew through formal study, if the participant's motive for studying secretly was the culture in which they worked, and they remained in this area, or if the ramifications of failure are feared, they would consider studying in secret again, as change in these factors was beyond their control

Me: Do you think you'd be tempted to study in secret again?

Participant: If I was unhappy where I was yes. I can't ever see it happening where I am now, as everyone is really into studying, and the attitude is right. Everyone supports each other, and is open in what they are doing

[Participant 5, senior perioperative practitioner]

As the individual becomes more self aware and their academic confidence grows, they ascend the helical structure depicted in Chapter IV, and are more easily able to undertake formal study. Thus, whilst the culture may stay constant, and the ramifications of failure differ depending on the course studied, increased academic confidence may enable individuals to divulge their CPE and access the support described in Chapter VI as influential in their success.

Thus the motives for study, the culture in which the individual works, their self-confidence and potential ramifications of failure determine whether subsequent study is undertaken covertly. However, in re-entering university, even if studying secretly, participants are more aware of the processes of study and the potential outcomes to be realised. As such, the helical model of CPE (Box K) is borne out equally by those who study secretly as for individuals located elsewhere on the continuum of openness.

Chapter Summary

Previous work demonstrated a link between an individual's desire to study and the culture in which they work and colleagues reactions (such as Ellis and Nolan, 2005; Ryan, 2003; Stanley, 2003; Nolan et al, 2000; Schuller, 2000; Dowswell et al, 1998a), and whether nurses will reveal their academic qualifications to colleagues (Hardwick and Jordan, 2002; Miers, 2002). This chapter has illuminated a new angle on the concept of secret study, whereby in some circumstances, perioperative nurses will withhold their actual study from colleagues. Whilst Deppoliti (2008) documented the existence of this secret study, she did not attribute significance to this: To participants, the degree of openness or secrecy with which they studied appeared important.

Whilst only a few participants revealed they had studied secretly, this does not reduce the significance of these findings. In addition to those studying secretly, many participants, particularly lower grades, could appreciate the circumstances under which this may be required, and as such the actual prevalence of secret study could be higher than indicated. Participants may also perceive a greater need to study in secret at different points in their career, perhaps only studying secretly once, depending on their motives for that study. The helical model of CPE (Box K) appeared relevant, irrespective of the openness with which participants studied.

As previously identified (Watson, 2006; Warr, 2005), some participants appeared to hold both a public truth relating to CPE, governed by socially constructed norms and values relating to perioperative nursing, and also a private truth, which encouraged them to study secretly. Prior to revealing their intention to study participants appeared to assess the acceptability of their chosen course within the dominant discourse of the culture in which they worked. Unlike participants who studied more openly, who supported their personal desire to study with practical motives for their courses (Chapter VI), those studying secretly usually described solely personal motives for entering higher education. This strengthens the argument (Chapter VI) that formal study is mainly undertaken for anticipated personal benefits and citing practical gains legitimised attendance during the working week, as those studying in secret were not in receipt of such support, and emphasised personal benefits above practice gains. In addition to assessing the culture, participants also considered their academic confidence, the possibility of failure and its potential ramifications. The interaction of these factors influenced participants' located on the continuum of openness within study (Box Q), and the extent to which their educational activities would be revealed to colleagues.

To study secretly was not easy, and practical problems arose in terms of maintaining the covert nature of this, and also in terms of obtaining study leave. Just as in other work (Stanley, 2003; Nolan et al, 2000; Cervero, 1988), support was related to success, and for those studying secretly, family support (Chapter VI) appeared to have enhanced roles in participants' success. On return to practice, further problems were encountered if participants wished to implement their new knowledge, with managers describing the 'shock' of colleagues suddenly having new knowledge. As such practice gains from secret study may be rare, due to individuals not wanting to move outside cultural norms in their place of work. Thus, similarly to those studying more openly, and as reported elsewhere in the literature (Nolan et al, 2000; Nolan, Owens and Nolan, 1995), participants reported personal gain, not direct practice changes, resulted from CPE. However, the increased confidence and knowledge gained by participants who studied secretly may have an indirect impact on patient care through changing the relationships with medical staff in the same way as experienced by participants who studied more openly (Chapter VI).

The concept of secret study, where the process of academic study was not revealed to colleagues, and the significance attached to this by participants, is a new area of interest which is previously undocumented. Exploration of CPE from perioperative nurses' perspectives has highlighted the concept of secret study and places this in the public arena. Further research would provide greater illumination of the tentative findings presented in this chapter relating to experiences and perceptions of post-registration university education from the perspectives of those studying secretly, and the extent to which university is entered without the knowledge of colleagues. It could also

determine whether this phenomenon occurs only within perioperative nursing or across other specialities.

The final chapter discusses the significance of these findings and those within the preceding chapters, and acknowledges the limitations which may have influenced the study and its consequent findings. It also emphasises the importance of this study within the context of the current literature, and makes suggestions for both perioperative nursing practice and higher education which have emerged from the findings. Details are also provided of how the findings could be confirmed and extended through further research, along with personal reflections on this study.

Chapter VIII

DISCUSSION

As a training advisor assisting perioperative nurses to access university courses, there was an interest in understanding why some colleagues appeared to undertake a great deal of continuing professional education (CPE) whilst others attended none, and met their *Post-Registration Education for Practice* (PREP) (NMC, 2008a) requirements by other means. The existing literature (Chapter II) mainly explored this from managers' and educators' perspectives (such as Smith and Topping, 2001; Nolan, Owens, Curran and Venables, 2000) with few addressing this from nurses' perspectives, and none focusing on perioperative nurses.

This study is the first to provide a comprehensive and holistic interpretation of perioperative nurses' perceptions and experiences of post-registration university education. It describes participants' journeys from the initial motivations and deterrents whether to enter higher education, through participants' experiences as students, to the outcomes derived, and does this in isolation from cost benefits or evaluative statements rating university modules and programmes. Whilst four other studies (Cooley, 2008; Gould, Drey and Berridge, 2007; Ellis and Nolan, 2005; Stanley, 2003) have investigated holistic views of nurses' experiences of university study, two of which were undertaken after the initial literature review, these were not investigated from perioperative nurses' perspectives. It was believed that other professions with whom perioperative nurses work, and associated gender issues may influence their experiences and perceptions of formal study. This may limit the transferability of these earlier findings to perioperative care due to the patriarchal structure and the predominance of

males within this environment. Thus, this work is both original and of contemporary importance to a developing field of knowledge.

The goals which guided this work (Chapters I and II) were to explore and describe the different stages of perioperative nurses' educational journeys. The findings however exceeded these, as they include interpretation and theory generation in relation to CPE. Using the definitions proposed by Daly, Willis, Small, Green, Welch, Kealy and Hughes (2007) moving beyond the original goals in this way changes the work from a descriptive to a conceptual study, and raises its position within the hierarchy of qualitative studies.

The initial literature review (Chapter II) focused on motivations and barriers to accessing university courses along with outcomes, as studies investigating this were prolific. The emphasis participants placed on other aspects of their studies warranted a second literature search using different search terms (Appendix II). This chapter contextualises the findings within the literature sourced in both reviews. Throughout, the discussion is supported by reference to the findings and relevant wider literature in parentheses. In these, reference is first made to chapters where the findings are located and contextualised within the initial literature consulted, and then to the wider literature identified in this second literature search. This chapter also acknowledges the limitations which may have affected the findings and makes suggestions for practice and identify stakeholders to whom these may be of interest. Plans for the dissemination of the findings are also presented, along with suggestions for further research which would confirm and extend these findings.

Main Findings

The themes associated with perioperative nurses' experiences and perceptions of CPE which emerged from the data (Box J) developed into a helical model of CPE (Box K). This model was applicable to all participants, irrespective of their position on the continuum from public to secret study (Chapter VII). The similarity of these themes to those in Stanley's (2003) study (Box S), confirms transferability of her work to perioperative nursing, whilst the findings in this study provide additional understanding of undertaking formal study from perioperative nurses' perspectives.

Theme	Stanley's (2003) theme
Background	None apparent
Going in	The traveller
Process	The traveller The guide
Coming out	The guide Journey's end
Box S: Relationship of themes to those of Stanley (2003)	

The intrinsic and extrinsic motivations with which participants entered CPE (Box M), the outcomes which resulted (Box O) and the barriers associated with accessing formal study echoed those in the existing literature (Chapters V and VI). These also reflected barriers to lifelong learning within society (Chapter I; Aldridge and Tuckett, 2008), with differences based on participants' pre-registration education (Chapters V and VI). Studies published since the initial literature review (Chapter II) (such as Cooley, 2008; Timmins, 2008; Bahn, 2007a; Bahn, 2007b; Gould et al, 2007; Murphy, Cross and McGuire, 2006) also reflect these findings. Whilst not extending knowledge in these areas, this study confirms their transferability to the perioperative setting.

The culture in which participants worked (Chapter V) impacted on all aspects of their study, and they emphasised process aspects of this, including support, their experiences as students, and changing relationships with medical staff (Chapter VI), which are under-reported in the literature (Cooley, 2008; Gould et al, 2007; Ellis and Nolan, 2005; Stanley, 2003; Dowswell, Bradshaw and Hewison, 2000). Participants also indicated in some circumstances they may study secretly, negotiating the educational journey without revealing this to colleagues (Chapter VII). The concept of secret study appeared important to participants, however the only researcher to refer to this previously (Deppoliti, 2008) did not explore this in depth, or attribute significance to its existence. Space prevents in-depth discussion of all emergent themes, and it is these issues of culture, student status, support and the doctor-nurse relationship, where knowledge has been extended, and the phenomenon of secret study, on which attention is focused in this final chapter.

The Influence of Culture on Experiences of CPE

Nationally, there appears to be a dichotomy within the National Health Service (NHS), where Government and professional body initiatives (such as NMC, 2008a; DH, 2004a) encourage staff development supporting the notion of clinical governance through education, particularly for those viewed as laggards (Houle, 1980), but disbanding the NHS University sends contrary signals. The Audit Commission (2001) assert responsibility for engendering a culture which supports and values staff development and training comes not from departmental managers, but from board and senior management levels. In contrast, participants equated a paucity of learning opportunities with managers, suggesting national initiatives are not supported at a local level.

The findings indicated the culture and managers' attitudes pervade all aspects of CPE, and if managers were supportive the culture was more likely to foster positive attitudes to university study (Chapter V; Eraut, Maillardet, Miller, Steadman, Ali, Blackman and Furner, 2004; Eraut, Alderton, Cole and Senker, 2000). That is, if managers studied, they tended to be more supportive and participants were more likely to be able to study. Participants were not always able to access formal education and in these situations, managers were perceived as unsupportive (Chapters V and VI; Cooley, 2008; Timmons, 2008; Gould, Kelly, White and Glen, 2004). In such cases, the assessment which follows a period of formal study may substitute for feedback from managers on participants' abilities in the absence of developmental reviews (Chapter V).

Equal access to training and development is seen as important by all staff (Maben and Griffiths, 2008; Gould et al, 2007; Meadows, Levenson and Baeza, 2000). Whilst Gould et al (2007) report no favouritism by managers, participants indicated inequality in access to university education, and explained that discrimination influenced managers' selection of staff for CPE (Chapter V; Bahn, 2007b). They used words such as 'lucky' and 'fortunate', and described feeling rewarded if offered study opportunities (Chapter V). This suggests, contrary to implications in the *Knowledge and Skills Framework* (KSF) (DH, 2004a), staff development, and as a part of this formal study, is the exception rather than the norm within perioperative nursing practice.

Nationally 9 out of 10 individuals believe education is beneficial (Aldridge and Tuckett, 2003) and it can be assumed some of these will be nurses. Cervero (1988) identified that in cultures which foster successful CPE there are positive attitudes towards lifelong learning. Current pre-registration education aims to develop intrinsic desire to undertake

formal study (Ryan, 2003; Maggs, 1998; Houle, 1980), and Wallace (1999) asserted the move of nurse education into Higher Education should pose no threat, especially to experienced nurses. However, whilst nurses in other areas are perhaps starting to embrace academia (Bahn, 2007a; Gopee, 2003; Furze and Pearcey, 1999), some participants' responses (Chapter V) suggest in perioperative care this may not be the situation, something which Bahn (2007a) argues implies a reluctance to fully accept the role of the 21st Century nurse.

Despite the move of all nurse education into university, initiatives to develop nurses' competence, and changing attitudes towards lifelong learning in society (Chapter I) participants believed some managers who did not have the confidence to enter university may feel threatened by their subordinates gaining qualifications they themselves did not possess (Chapter V; Gould et al, 2007). Variations in pre-registration educational preparation appeared to be dividing factors in these attitudes towards participation in higher education (Chapter VI; Deppoliti, 2008). Thus, whilst the move of nursing into higher education may change attitudes towards academic study and remove the anti-intellectualism in nursing (Hardwick and Jordan, 2002; Miers, 2002), the findings suggest that dominant discourses regarding academic study will only be re-contextualised as university graduates assume higher positions within the perioperative nursing hierarchy and those trained in schools of nursing retire.

Some participants perceived clear demarcations between practice and academia, and described nursing as practical, not academic. These participants asserted they were not 'academic' despite their studies, and many implied pursuit of academic qualifications was seen by colleagues as a negative aspiration (Chapter V; Miers, 2002). Walsh (2000)

argues the majority of nurses leave university with diplomas which he states is a symbolic reluctance to be educated to degree level; that is, nursing is more practical than academic. However, there may be financial reasons for this trend, as the majority of participants were in pursuit of first or higher degrees, suggesting Walsh's (2000) theory may not be applicable within perioperative care. Interestingly, participants who perceived nursing as practical explained they studied for personal gains as *individuals* rather than as *nurses* (Chapter VI). This distinction appeared to allow them to remain within the dominant discourse of perioperative nursing as practical, whilst pursuing academic qualifications as individuals, thereby avoiding the horizontal violence some participants associated with stepping outside the dominant discourses relating to CPE (Chapter V).

Participants appeared to place great importance on becoming integrated into dominant discourses regarding CPE, as demonstrated by a recently qualified participant whose embarrassment following an admission to enjoying academic study (Chapter V) is testament to the need to conform to group norms. Individuals are keen to avoid intra-group conflict (Tuckman, 1965), and women particularly have a psychological need for connectedness and a sense of belonging (Deppoliti, 2008; Lew and Bettner, 1996; Adler, 1937). Through socialisation, individuals adopt the attitudes, values and unspoken messages within a group (Mooney, 2007; Howkins and Ewens, 1999) to become a part of that group. Socialisation appeared to influence participants' attitudes towards attending university, not only for newly qualified junior staff, but also for senior staff moving from other areas, with individuals mirroring colleagues' study habits and conforming to expected standards and norms, irrespective of their previous beliefs relating to CPE (Chapter V). It is known that some people in a community have

increased influence on new-comers (Blaka and Filstad, 2007), and within perioperative care these people appeared to be managers. Participants suggested managers acted as gate-keepers (Chapter V), who influenced whether formal study was undertaken and the support they could expect should they enter higher education.

The Role of Support

Participants stated support from a network of family, fellow students and also perhaps university staff and work colleagues (Box N and Box R), is essential during CPE (Chapter VI; Cooley, 2008; Deppoliti, 2008). The sources from which this was obtained depended on how openly the study was pursued. Knowles (1990) identified enhancing self-esteem as the deepest need in human development, and being supported appeared to provide social capital which increased participants' self-esteem. It also reduced the risk of failure through provision of financial, practical and psychological support.

Family members were influential in determining participants' success (Chapter VI; Cooley, 2008) and most concurred with Curry (2005 p26) who asserted a supportive partner is "the most important asset in your education experience". This is not surprising when most participants described experiencing conflict in combining work and domestic commitments due to altered work/life balance (Chapter VI; Gould et al, 2007). To overcome this, and reduce the consequent stress and guilt, participants were supported practically by relatives and described how their normal female roles were relinquished or redefined during CPE. That is, relatives were also required to make sacrifices and redefine their roles, taking on increased responsibility for childcare and household chores. All participants implied this support was freely provided, despite the stresses and impact of their study on family life (Chapter VI).

Some participants valued the support of university staff, especially if academic levels had been raised (Chapter VI; Gould et al, 2007), and this has been identified as key to success (Hylton, 2005). However, not all participants found it easy to relate to lecturers, and although some described teaching staff as supportive others reported difficulty in contacting them (Chapter VI; Bahn, 2007a). In addition, some participants believed lecturers were ‘anti-theatre nurse’, and, as Stanley (2003) also reported, explained tutorials sometimes lead to confusion. Participants’ reluctance to seek support from lecturers may reflect insecurities in their academic confidence (Chapter VI).

Within the university, participants also sought camaraderie and practical support from course colleagues (Chapter VI), although some felt uncomfortable interacting with colleagues of different grades. Whilst intimidation by senior staff has been identified as making group interaction impossible (Platzer, Blake, and Ashford, 2000a), participants also indicated they disliked speaking in front of junior colleagues. They also stated this impacted on their learning and consequently on their success (Chapter VI). In terms of group theory (Tuckman, 1965), participants intimated these groups never moved beyond stages of ‘storming’ and ‘norming’ as trust could not be established, and thus ‘performing’ was not achievable. Whilst previously such anxiety has been related to the learning situation and group size (Quinn and Hughes, 2007; Hinchliff, 2001), and teaching methods (Hylton, 2005), or not wanting to “show off” (Schuller, 2000 p231) knowledge, participants suggested this related to fears of repercussions (Chapter VI). Thus, Platzer et al’s (2000a) assertion socialisation leads to nurses being reluctant to speak in front of others for fear of criticism may apply not only in practice but also in educational settings.

Not all participants felt supported by their work colleagues during CPE (Chapter V; Cooley, 2008) even though the Code of Conduct (NMC, 2008b) dictates nurses should work collaboratively. Whilst Beatty (2001) found no significant relationships between colleagues' support and their own educational activities, participants said colleagues who did not study tended to be less supportive and viewed attending university courses as 'taking time off' from work (Chapter V). Such views suggest for some colleagues perioperative nursing is a practical discipline, incompatible with academic study, however such views may also relate to the psychological barriers which prevent individuals from attending university (Chapter VI). Colleagues who are unable to access higher education through their own perceptions of illegitimacy (Chapter VI) may fear for their own futures within theatres, and displace these fears onto others who wish to study in the form of antagonistic behaviours.

The lack of support from work colleagues could be considered as horizontal violence (Chapter V), which was first described by Freire (1970) and applied to nursing over 25 years ago (Roberts, 1983). Horizontal violence may occur when nurses are viewed as an oppressed group (such as Rowell, 2007; Bartholomew, 2006; Hamlin, 2000) and subordinate compared to doctors (Rowe and Sherlock, 2005; Hamlin, 2000), with consequent powerlessness and low self-esteem (Freire, 1970). Alternatively, it may arise as a result of the environment due to pressures of staffing and targets (Rowell, 2007; Bartholomew, 2006; Lewis, 2006; Griffin, 2004; Farrell, 2001). Nurses are powerless to direct the resulting anger towards its source (Bartholomew, 2006; Duffy, 1995; Roberts, 1983) and instead this is vented towards nursing colleagues who appear to stand outside group norms (Duffy, 1995; Roberts, 1983) in the form of horizontal violence as a reaction to the situation in which nurses find themselves. Horizontal

violence potentially has many physiological and psychological manifestations, (Bartholomew, 2006; Griffin, 2004; Dunn, 2003; Hamlin, 2000), and was identified in many interviews. Participants experienced devaluing of qualifications and achievement, lack of interest and discouragement from both colleagues and, in some cases, managers (Chapter V), all of which can be regarded as horizontal violence (Bartholomew, 2006).

Whilst most studies identify that managers are usually the source of horizontal violence (Fudge, 2006; Hamlin, 2005; McKenna, Smith, Poole and Coverdale, 2003), this study supports Rowe and Sherlock (2005) who found the majority of horizontal violence in American hospitals was perpetrated by staff nurses, not managers (Chapter V). Rather than adopting specific techniques to reduce horizontal violence (Broome, 2008; Bartholomew, 2006; Fudge, 2006; Griffin, 2004), participants appeared to limit the potential for this by only discussing their CPE with colleagues who they thought would be supportive. Usually such communication was intra-professional unless involvement of other professions was required by their course, or the individual had been told to study (Chapter V), creating degrees of openness with regard to study (Box Q).

Participants reported less resistance and resentment relating to CPE from doctors than from nursing colleagues, even if professional boundaries were crossed (Chapter V). This suggests doctors support nurses' development, which is in contrast to earlier work (Snelgrove and Hughes, 2000; Carter, 1994) where doctors were either ambivalent towards or against formal post-registration nurse education. Whilst the extent of such support may depend on the course itself, and the surgeon's grade and age, those mentored by surgical staff felt supported in developing clinical skills (Chapter V). Although this may be a reluctant acceptance, instigated by changes to junior doctor

working hours (Council of the European Union, 1998; DH, 1991), participants welcomed this support, even though it could be viewed as reaffirming nurses' subservience within perioperative care, with doctors controlling nursing practice and ensuring professional boundaries were only traversed to acceptable limits.

Despite the prevalence of horizontal violence, all participants who studied openly sought support, including academic support (Chapter VI), from nursing colleagues whereas not all sought this from university lecturers, suggesting they preferred to be supported by colleagues. Whilst this could be due to the lack of support some participants believed they would receive from university staff, as described above, it may also relate to their fear of failure. The acceptance of support (Chapter VI) may be a symbolic gesture which demonstrates a lack of confidence and simultaneously perpetuates the dominant discourse that nurses are not academic, reducing the risk of horizontal violence, and providing support should the individual fail. Thus, the construction of extensive support networks may be indicative of a lack of academic confidence and an attempt to maximise success, which is also instigated by the need to concur with dominant discourses in the workplace. Whilst not speaking to tutors may increase the risk of failure if colleagues were unaware of assessment criteria, speaking to colleagues may reduce the risk of its ramifications through gathering alibis with whom to share the burden of any failure (Chapter V). It would be interesting to investigate whether participants' support networks change as their academic confidence grows, and if in subsequent courses university staff are more easily approached for academic support.

Student Status and Experiences as Students

The student experience and possession of student cards appeared significant for all participants, irrespective of whether told to attend university, or volunteering to study. Despite this, few studies have previously discussed nurses' experiences of being students (Cooley, 2008; Gould et al, 2007; Ellis and Nolan, 2005; Stanley, 2003), and none recognised the significance of the possession of student cards.

Volunteering to study was a major decision for participants (Chapters V and VI). The literature dedicated to easing the transition to higher education for prospective students (such as Cottrell, 2008; Curry, 2005) aimed at both nurses and non-nurses indicates such trepidation exists not just for perioperative nurses, but within society as a whole both in the United Kingdom (UK) and abroad. Participants' emotions and experiences in terms of adapting to student status can be related to Shane's (1980) 'returning to school' syndrome; initially participants were excited about studying and its new experiences and were in the 'honeymoon' phase (Shane, 1980). This was then replaced with a period of 'conflict' where existing knowledge was called into question and participants experienced self-doubt in terms of their ability and the competing demands faced at home, and support was vital.

In addition to providing access to resources (Chapter VI), student status seemed to change participants' self-perceptions, and the possession of a student card seemed to symbolise these changes. Whilst no literature illustrating the concept of student cards could be located, all participants described their importance, not only for tangible student discounts but also for more psychological benefits. Possession of a student card confirmed participants' acceptance into university, and provided external reinforcement

of their academic ability (Chapter VI). They appeared to be part of the excitement experienced during the 'honeymoon' phase of study (Shane, 1980), especially for those conditioned to believe they were ineligible to enter higher education.

"The cultural narration of nursing is for nurses to be subordinate" (Freshwater, 2000 p481) and even in the 21st century, medicine is widely portrayed as dominant to nursing due to its emphasis on 'curing' and the intellect and skills this requires, rather than 'caring' which is seen as an extension of females' natural attributes and roles within the home (Hahessy, 2007; Bojtör, 2003; Wynd, 2003; Wuest, 1994). Some studies indicate nurses study to raise the status of nursing (Bahn, 2007b; Ryan, 2003; Stanley, 2003; Jordan and Hughes, 1998, Hogston, 1995). Whilst this was not an explicit motive for participants' study, it did appear to remove them at least temporarily from female domestic roles (Chapter VI), which, as Gopee (2003) described, may for some be a form of escapism. Stepping out of traditional female roles may contribute to participants' perceptions they are doing a 'bit more' with their lives (Chapter VI). In contrast to Botjor (2003) who asserted that despite higher education nurses have not altered their social or occupational status, participants appeared to equate being a university student with increased status and kudos than being a nurse or a woman. Student status appeared to allow them to move away from the publicly perceived image of nurses as unintelligent (Neilson and Lauder, 2008) and verify their intelligence to both colleagues and friends and family. Participants appeared to publicise their student status by using their student cards to obtain student discount rather than NHS discount (Chapter VI).

Not all associations with student experiences were positive and although the CPE was related to work, participants said it was at home the effects were most felt (Chapter VI).

All participants identified balancing work and domestic responsibilities with the demands of being students led to stress and left little time for relaxation (Chapter VI; Evans, Brown, Timmins and Nicholl, 2007; Tennant and Field, 2004; Dowswell et al, 2000). Attending university involved commitment in terms of human and social capital and the time and energy required impacted negatively on participants' social networks, although the effects of this appeared to be reduced by creating supportive networks (Chapter VI; Evans et al, 2007; Nichol and Timmins, 2005). Although Evans et al (2007) report nurses aged 20-30 found stressors associated with formal study caused greater stress, analysing the findings by age inferred older participants who had not previously studied at university experienced more stress than those of any age who were university graduates.

Despite the stresses, participants explained that successful completion of CPE led to them experiencing a 'buzz' or 'boost', which can be a part of self-actualisation (Maslow, 1943), especially if they were educated pre-registration at schools of nursing, with some describing the 'addictive' nature of university study (Chapter VI). If participants had previously studied, they were more likely to study in future, in spite of the stresses and sacrifices (Chapter VI), for existential gains and the ability to refer to themselves as students. Kierkegaard saw realisation of personal potential as the meaning of existence, and participants also emphasised the importance of attending successively higher courses in order to achieve their academic potential (Chapter VI; Gould et al, 2007).

McGivney (1990) identified that individuals may feel threatened on entering university as they are uncomfortable in this setting, and whilst this may be a barrier to university study for perioperative nurses, all participants wished to continue to study (Chapter VI).

This suggests they had reached the third stage of the 'returning to school' syndrome termed 'biculturalism' (Shane, 1980) where they were as comfortable in university as in work, irrespective of their formative educational experiences. In continuing to study participants were able to enter further CPE with greater knowledge, and ascend the helical model of CPE (Box K). However, they indicated if the break between courses was too long they may begin to descend this helix, making subsequent study more difficult.

Thus, describing themselves as students appeared to have psychological effects for participants which allowed them to head towards self-actualisation. The effects of this were not only felt outside of work, but were described as leading towards long lasting changes in their relationships with medical colleagues.

The Influence of CPE on the Doctor-Nurse Relationship

It is still widely accepted in society that men are higher than women in status, and doctors have greater status and power than nurses, despite more women entering medicine and more men entering nursing than previously (Neilson and Lauder, 2008; Hahessy, 2007; Rowe and Sherlock, 2005; Randle, 2003; Meadows et al, 2000). Stein, Watts and Howell (1990) described the doctor-nurse game (Stein, 1978; Stein, 1967) as having changed, with nurses having higher status and providing advice for doctors. However, participants indicated the doctor-nurse game is still played in theatres, due to gender and professional boundaries and close inter-professional working. That is, whilst doctor-nurse relationships in theatres may be different from other patient care areas with increased familiarity and blurring of roles (Tanner and Timmons, 2000), medical dominance still exists (Chapter VI; Finn, 2008; Timmons and Tanner, 2004; Tanner,

2003; Tanner and Timmons, 2000). Participants described 'getting on well' with surgeons, however this appeared to be on a social rather than a professional level (Tanner and Timmons, 2000). This suggests as females, perioperative nurses may be doubly disadvantaged, firstly being suppressed by the dominant group, and secondly oppressed due to their subordinate status in society (Farrell, 2001; Freshwater 2000).

Changes to professional relationships may be a motive for CPE (Smith and Topping, 2001; Gould, Smith, Payne and Aird, 1999). No participants cited this as a motive however all perceived changes to their relationships with medical staff following formal study. Whilst many were able to articulate how CPE impacted on these relationships, others were unable to identify this explicitly but provided anecdotes which illustrated such changes had occurred (Chapter VI), suggesting this is a widespread outcome of formal study for perioperative nurses. This is a significant finding, and implies that through education, nurses become 'liberated practitioners' (Dearnley, 2006), acting and thinking differently with greater autonomy, independence and confidence (Chapter VI).

Individuals have a need to belong and to cooperate with others as equal partners (John, 2000; Lew and Bettner, 1996), and Rowell (2007 p4) stated "To be able to engage a physician in a discussion over different approaches to patient care the nurse must feel equal in power, professional stature and professional knowledge". The literature suggests theatre nurses do not feel either understood or appreciated by medical colleagues (Coe and Gould, 2007; Mardell, 1998). Whilst others state CPE allows nurses to gain a status equal to medical staff (Hahessy, 2007; Jordan and Hughes, 1998), participants did not believe parity existed between the two professions following study. However, they stated they received greater recognition and credibility and were treated

more professionally compared to colleagues who had not studied (Chapter VI; Deppoliti, 2008; McCallin and Bamford, 2007; Johnson and Copnall, 2002).

Within communities of practice, roles are continually being reaffirmed and legitimacy of others' discussions confirmed (Goodwin, Pope, Mort and Smith, 2005; Wenger, 1998). Participants believed university education increased their potential for collaboration and sense of belonging to a team. They described doctors asked their opinions more than prior to attending university (Chapter VI). This suggests communities of practice are strengthened by CPE through legitimising nurses' knowledge, irrespective of their differences in power and status both socially and within the NHS.

Using Kramer and Schmalenberg's (2003) category scale, CPE moves participants away from 'student-teacher' relationships where doctors explain what is happening and teach nurses, towards definitions of either 'collaborative' where nurses are valued for their contribution to patient care, and where there is mutual trust, respect and power, or 'collegial' where the disciplines are equal but have different powers and knowledge. Additionally, following formal study, some participants explained that academic qualifications gave them personal confidence and the assertiveness to challenge medical staff (Chapter VI; Bahn, 2007a; Dearnley, 2006), and increased their status. Thus, from a feminist perspective learning and gaining higher level academic qualifications appeared to have a transformatory effect which raised nurses' status and an emancipatory effect allowing them to redress the imbalance of power between the two professions and their subordinate status (Freshwater, 2000; Friere, 1970).

Finn (2008) asserted when nurses seek increased self-esteem or more equal recognition they are not challenging the redistribution of power, as they approach teamwork with a

'relational' aspect. She described that nurses value 'respect', 'appreciation' and 'courtesy' within a 'relational' repertoire of teamwork whilst surgeons appreciate more 'technical-instrumental' aspects, including efficiency, coordination and communication. Participants indicated that following a course they are more able to 'help' surgeons and make 'suggestions' (Chapter VI), which from a relational perspective, enhances teamwork for nurses through increased respect, however from the surgeon's technical-instrumental perspective, teamwork may not have changed. Despite all participants describing these changes to their relationships with medical staff, most did not discuss their CPE with doctors. This suggests it is the increased knowledge, assertiveness and confidence which results from formal study (Chapter VI; Bahn, 2007a) rather than doctors' awareness of this study, which leads to these changes and improved collaboration and teamwork.

No participants described direct practice changes as a result of their studies (Chapter VI). Instead, they experienced existential changes which reflected a move away from the handmaiden image of the diligent and obedient perioperative nurse (McGarvey, Chambers and Boore, 2000; Carter, 1994) to a more confident and autonomous practitioner who is able to advocate for their patients (Chapter VI; Hahessy, 2007; O'Brien-Pallas, Hiroz, Cook and Mildon, 2005). This suggests patients benefit indirectly through participants being better able to work as part of the team (Chapter VI; Bahn, 2007a; Hahessy, 2007). Despite this some studies state the ultimate aim of CPE should be practice change (Jordan, 2000; Queeney, 2000), and money should be directed at courses which develop practice rather than professional outcomes (Jordan, Coleman, Hardy and Hughes, 1999). The findings suggest in the perioperative environment, where the doctor-nurse game (Stein, 1978; Stein, 1967) is still played (Hamlin, 2000),

this may not always be appropriate. As such they support Nolan et al's (2000) conclusion that the outcomes of CPE should be re-conceptualised away from the direct impact on patient care to focus on the impact on practitioners and the consequent indirect benefit to patients, which arise through changes to the doctor-nurse relationship.

The Concept of Secret Study

It is recognised that some nurses hide academic qualifications from peers due to fear of reprisals (Daiski, 2004; Hardwick and Jordan, 2002), however participants indicated in some cases they may undertake CPE in secret (Chapter VII). Although Deppoliti (2008), in an American study reports some nurses did not tell colleagues they were entered into the licensure exam, thus implying secret study, this study is the first to attribute significance to the concept. Whilst only 3 participants revealed they had studied secretly, nearly all could appreciate the need for this in some circumstances, indicating its significance. If the prevalence of secret study is greater than the findings suggest (Chapter VII), this may present an alternative reason why non-participants declined to participate in the study (Chapter IV). It may be some nurses who appeared from the database to not be studying were studying secretly, and declined to be interviewed for fear of having their cover blown. Further research is required to investigate the prevalence of secret study.

Whilst others stated colleagues' and managers' attitudes affect whether formal study is undertaken (Ellis and Nolan, 2005; Ryan, 2003; Schuller, 2000) participants explained these were not necessarily pivotal in deciding *whether* to study, but in deciding to whom to *disclose* that study. Bahn (2007b) also found where there was inequality in access to university courses, or managers were unsupportive, nurses remain determined to develop. The concept of secret study suggests in the presence of such feelings, some

nurses may study in secret, without revealing this to colleagues. Although Cooley (2008) asserted emotional support from colleagues is pivotal to success in CPE, the findings suggest otherwise, as participants were successful even if colleagues or the culture as a whole did not support nurses attending university. In such situations, participants believed their success was dependent upon *not* divulging their studies. These perceived levels of support along with the individual's academic confidence and the ramifications of potential failure influenced the extent to which participants revealed their study to nursing and non-nursing colleagues (Chapter VII; Box Q).

Prior to disclosing secrets, individuals determine the advantages and disadvantages of telling others, and of being perceived as either conformist or non-conformist with dominant discourses (Jetton, 2004; Vrij, Paterson, Nunkoosing, Soukara and Oosterwegel, 2003), and participants appeared to evaluate these with regard to CPE. Jetton (2004) identified individuals peripheral to a group are more likely to declare group loyalty, however those central to a group are more likely to risk repercussions should they break group rules. Applying this to formal study suggests established staff, educated in schools of nursing, are more likely to be exposed to horizontal violence for studying openly than newly qualified nurses for traversing the practical discourse of perioperative nursing, however newly qualified nurses are more likely to want to conform. Thus, both newly qualified and established nurses may have motives to study secretly. As discussed earlier, nurses may suppress their values to belong to a group to avoid marginalisation and exposure to horizontal violence (Bartholomew, 2006; Freire, 1970). The concept of secret study suggests nurses do not need to suppress their values, so long as they publicly appear to support the dominant discourses relating to post-registration university education.

The literature recognises that public actions and private thoughts may not be congruent (Watson, 2006; Warr, 2005). Some participants appeared to hold two discourses regarding whether nurses should undertake CPE; a public discourse developed during socialisation incorporating widely held values and beliefs of nursing as a practical profession, and a private discourse retaining original values and beliefs based on past experiences and activities of relatives (Chapters VI and VII). It appeared to be such private discourses, developed pre-registration and through previous educational experiences, which led to some participants studying secretly. Secret study appeared to allow participants to avoid being perceived as standing outside dominant discourses regarding CPE, and as such may be a mechanism to prevent being subjected to horizontal violence (Chapters V and VII).

As Deppoliti (2008) reported, participants with low self-confidence tended to study secretly, as although the psychological effects of failure remained (Chapter VI) fewer people would have been aware had they failed. Ryan (2003) suggested nurses study to demonstrate their professional competence, and participants explained secret study tested their academic ability prior to studying more openly, and this related to potential ramifications of failure. Professional identity develops over time and through successfully negotiated interactions with others leading to inter-professional understanding, trust and effective working relationships (Pullon, 2008), and participants perceived if they failed a formally assessed course such trust and relationships may be destroyed. Thus, for some participants there were 'risks' in entering CPE in terms of participants' credibility and reputation (Chapters V and VII). This seemed especially relevant to senior staff and those studying to close the practice-theory gap, where continuation of existing practical skills may be affected should they fail an academic

course. That is, the possible disadvantages associated with disclosure (Vrij et al, 2003) encouraged nurses to withhold their CPE activities from colleagues and study secretly.

Keeping a secret involves mental effort (Vrij et al, 2003), however, participants believed this was necessary to avoid repercussions, even though this impacted on process aspects of CPE in terms of time management and support (Chapter VII). Participants indicated the time involved in academic activities during secret study had a greater impact than if they were supported by work, which suggests the consequent guilt and sacrifices (Chapter VI; Cooley, 2008; Evans et al, 2007; Timmons and Nicholl, 2005) are also increased. Similarly, the increased reliance on relatives in the absence of work support implies the stresses and sacrifices for family members (Chapter VI) may also be greater than if the participant is studying with work support.

Practice changes were not identified following CPE for participants studying openly, and thus it was no surprise those studying secretly also described no practice outcomes (Chapter VII). Similar to those studying more openly, participants studying secretly reported personal gains from their study including increased confidence and knowledge and better inter-professional relationships. Above, it was proposed that existential changes lead to greater collaboration and impact indirectly on patient care, and this is supported further by participants who studied secretly, who also described enhanced inter-professional relationships. This suggests whilst it might be difficult for individuals to study secretly (Chapter VII), those who are successful benefit no less from this than colleagues who study more openly.

Following successful completion of one course, participants implied they may study more openly on subsequent courses due to increased academic confidence, depending on

the culture in which they worked (Chapter VII). As such, for some participants, secret study may be the first step in continuing professional education, after which confidence and independence flourishes, and the helical structure (Box K) is ascended.

Limitations

Despite careful planning and a reflexive approach to data collection and analysis, this study, like any study (Punch, 2000) was subject to limitations which may have affected its findings. The statement of such limitations is important to describe the boundaries of a qualitative study, and suggest its transferability (Lewis and Ritchie, 2003).

In qualitative research, the researcher is the main tool for data collection (Parahoo, 1997). Whilst working as a training advisor alongside participants provided a privileged position in data collection and analysis (Arksey and Knight, 1999; Kvale, 1996; Miles and Huberman, 1994) this may have created role conflict, and led to bias and assumptions which may have missed important data (Seidman, 2006; Holloway and Wheeler, 1996). Also, the success of interviews depends on an interviewer's personal and professional qualities (Legard, Keegan and Ward, 2003) and techniques (Rossman and Rallis, 1998; Oppenheim, 1992): Later interviews were conducted with increased competence compared to earlier interviews where inexperience may have affected the quality of the data collected.

Participants may repeat what others have told them during interviews (Poland, 2003), or give responses they think the researcher wishes to hear or play antagonist (Leonard, 2003; Rossman and Rallis, 1998). Arksey and Knight (1999) suggest people under-report that which is seen as socially unacceptable, and over-report that which is

perceived as more desirable. This may have been exaggerated by current initiatives in the NHS to raise the profile of lifelong learning and development (such as DH, 2004a), the presence of the tape recorder (Rapley, 2004; Arksey and Knight, 1999), and by assumptions they may be cajoled into undertaking CPE as a result of the researcher's location in the study. Although precautions were taken to avoid disruptions during interviews some were interrupted, which may have limited participants' concentration and the information divulged, with 'public' truths rather than 'private' thoughts expressed as some of the intimacy and trust established within the interview was broken down (Arksey and Knight, 1999).

The data collected in qualitative research are socially situated and constructed in that time and place (Holstein and Gubrium, 2004; Brewer, 2003a; Parahoo, 1997). In an interview situation, participants interpret the world around them; researchers transcribe the interview, making inevitable errors (Polit and Beck, 2004) and subjective judgements about its meaning and significance (Silverman, 2006). The consequent analysis is thus an interpretation of participants' interpretations of their experiences: readers will then make further interpretations of relevance. Whilst this may create new perspectives which participants had not considered (Silverman, 2006; Hodge, 1995), these three stages of interpretation may become increasingly divergent from participants' views.

Few studies have recruited non-participants in CPE (Johnson and Copnall, 2002; Dowswell et al, 1998a; Berg, 1973), and whilst this was one of the study goals (Chapter I), no participants could be recruited to this group. Knapper and Cropley (2000) identified non-participants may differ from those who pursue continuing education, and

as such the barriers to higher education described by participants may not reflect why some perioperative nurses do not study. As such, whilst the findings provide an insight into possible perceptions of perioperative nurses who do not enter formal post-registration education, they may not be generalisable to the population from which participants came, or to other perioperative areas.

Lincoln and Guba (1985) argue the key point of qualitative research is not generalisability, or whether findings can be replicated, but the significance of those findings. Despite its limitations, this study was methodologically robust, and has extended the knowledge-base related to CPE: Further research may indicate these findings could be extrapolated to nurses working in other areas. The findings have implications for both clinical perioperative nursing practice and higher education.

Implications for Perioperative Nursing Practice and Higher Education

This study has advanced understanding of nurses' views and experiences of CPE, and extends and complements the knowledge base in this area. Recognition of perioperative nurses' experiences and perceptions of formal study, and the contribution of post-registration education to practice, is important due to increased emphasis on cost-effectiveness within the NHS. The findings suggest some transferability of the existing literature to perioperative nurses, with regard to motivations and barriers associated with attending university, and consequent outcomes from a period of study. They also extend the knowledge base with regard to student experiences, support and relationships with medical colleagues, and provide the first insight into the concept of secret study. Thus, this work is of relevance to clinical practice, and contributes to the current interest in student experiences of higher education. Whilst dissemination of the preliminary

findings (Tame, 2006) suggested transferability and generalisability beyond the Trust in which the study was conducted, transferability will be determined by readers (Guba, 1981), who assess the similarities between this study and their own situation.

Awareness of attending university courses from students' perspectives may not only facilitate nurses' experiences of study, but may also empower nurses working within the perioperative environment. Whilst issues of gender and inter-professional working constrain the extent to which new skills and knowledge can be implemented following CPE, if the nurse feels supported during their studies, this can lead to existential change which has an indirect impact on patient care. The increased confidence and autonomy which results from study enables them to better advocate for patients by beginning to question medical staff decisions, thereby challenging the patriarchal dominance in theatres. Thus, as more nurses are encouraged to attend and supported through courses, and their academic confidence develops, this may strengthen nurses' positions in theatre, renegotiating the boundaries of perioperative nursing practice, and consequently reducing the oppression associated with horizontal violence.

Draper and Clark (2007 p515) argue that "it is imperative that we are able to articulate the added value of CPE to direct patient and client care to employers, and those commissioning health care education". Strategic Health Authorities are making year on year cuts to training budgets (Wragg, 2007 personal communication), due to lack of evidence demonstrating the effectiveness of CPE (Draper and Clark, 2007). As a consequence, they may prefer to divert their increasingly limited funding for education to in-house courses rather than commission university education (Draper and Clark, 2007). Despite an absence of practice changes following formal courses, if, as

suggested in this study, this leads to improved relationships between medical staff and nursing staff and enhances collaboration, then this tentatively indicates university courses improve patient care. Whilst further evidence is required, this justifies and legitimises post-registration university courses for perioperative nurses in terms of the implications for practice.

Thus, the findings have direct implications for perioperative nurses and their managers and also for educators working within universities, designing and delivering courses. An understanding of perioperative nurses' experiences and perceptions of CPE, as described in the preceding chapters, makes it possible to take action to enhance the outcomes associated with formal study.

Suggestions for Practice

The descriptions of perioperative nurses' experiences and perceptions of CPE suggest the need for changes in both clinical practice and post-registration higher education to improve the perioperative nurse's journey. Such changes may make it easier for individuals to enrol on a course, enhance their experiences as students, and increase the effectiveness of the outcomes derived from their courses.

To encourage more access to CPE there should be more open inter-professional discussion regarding this to develop a culture where this is supported for *all* perioperative nurses. Current educational opportunities should be advertised openly, placing these into the public domain, to allow staff to plan their development, and encourage greater equity in access to courses. In addition this would imply anyone reading the notice would be able to access the course, legitimising entry to university. In

assessing whether to allow staff to attend their chosen course, managers should re-conceptualise their thoughts away from the direct impact on practice which may arise, and consider that even in the absence of practice changes, *all* participants described indirect impacts on patient care through enhanced collaboration with medical colleagues and a greater sense of belonging.

Managers should recognise secret study as a possibility when staff are arranging regular days off, or re-arranging shift patterns, and accommodate these where possible. However managers should also consider the multiple reasons for secret study (Chapter VII) and that some staff may have low academic confidence and fear the repercussions of failure. Therefore they should try to accommodate shift requests where possible, but not divulge their suspicions about why these may be required, or discuss these with the staff member, as staff may not want their secret revealed. The model presented in Chapter VII (Box Q) may be useful in predicting whether perioperative nurses are likely to study secretly, allowing specific support to be targeted at these individuals.

To redress low confidence levels and the remoteness of university from previous nursing education and practice, it may be beneficial for universities to offer courses to bridge past training and university education, holding these in familiar surroundings to reduce anxiety and ease the transition to academic study. Although being told to study reduced participants' sense of vulnerability and risk, this is not proposed as a method to increase uptake of CPE due to the stress and anxiety resulting from concomitant roles, and the reduced sense of obligation to be successful compared to self-nomination.

In designing and delivering CPE, university staff need to consider the notions of human and social capital which participants associated with academic study. They should also

be aware some students may be studying secretly, which may affect their progress, especially if the outcomes require input from work colleagues. Additional support may also be needed by students completing all educational activities in their own time. Whilst participants appreciated the diversity in knowledge and background which comes from meeting colleagues, they are not always confident to speak in front of colleagues of different grades due to fear of repercussions. As such, dividing a group into smaller groups based on seniority may facilitate more open discussion prior to reuniting the group to feedback and share ideas. In addition, educators should incorporate change management into their courses, and encourage staff to plan how to address aversive cultures and implement practical changes on the completion of the course.

Dissemination of Findings

It is essential to disseminate the findings of research, in order to justify its conduct (DH, 2005; Morse and Field, 1995), and the subjection of results to public scrutiny is vital to evaluate the robustness of a study (Horsburgh, 2003). The contribution to the body of knowledge made by this study has implications for all stakeholders involved in CPE within perioperative nursing, and has relevance for higher education. Bassett and Bassett (2003) argue nurses have a duty to disseminate research findings as widely as possible, and as such these findings will be disseminated locally in the Trust from which participants were recruited, and nationally to audiences of nurses and educators.

To demonstrate openness and the appreciation of participants' time, each has been provided with a summary of the findings, and informed of how they can access a copy of the complete study. A copy of the study will be made available to the local Strategic Health Authority as the body who remains the main source of funding for CPE. This thesis will also be available in the local University library to allow wider readership.

Fullilove, Green, Hernández-Crodero and Fullilove (2006) warn if resistance is anticipated to new ideas then more novel methods of dissemination than traditional methods of conferences and journal articles should be considered. Participants indicated that not all managers are supportive of their staff attending university, and as such, the written word or formal conferences may not be appropriate to disseminate the findings to this group of people. Happell (2007) suggests oral dissemination of findings may be more appropriate than written dissemination within nursing, and as such the findings will be shared with theatre managers at a local level through informal discussions. This should maximise their awareness of perioperative nurses' experiences and perceptions of CPE, and consequently enhance the feasibility of implementing the above suggestions.

A part of this work has already been disseminated through presentation of preliminary findings in response to a call for papers session at the Association for Perioperative Practice (AfPP) international congress on 12 October 2006 (Tame, 2006). Further dissemination is planned for April 2009 (Tame, 2009) when the findings will be presented at the European Operating Room Nurses Association (EORNA) Conference. These international conferences draw audiences from both clinical and education backgrounds.

Following submission of this thesis, an application will be made to re-present the research findings in their final form at the AfPP congress. Articles based on the findings, in particular those relating to the areas where knowledge of CPE has been extended, will also be submitted to journals which attract readers from both clinical practice and higher education.

Personal Reflections on Work to Date

This ethically sound study used a descriptive qualitative design and a reflexive approach to data collection and analysis to provide a holistic illumination of CPE through the ideographic experiences of perioperative nurses from an emic perspective. This allowed me to document a rich, thick description (Geertz, 1973) of participants' perceptions which appreciated the multiple truths present within individuals' lives (Daly, 2003; Golafshani, 2003; Ward, 2003; Burrell and Morgan, 1989). Connections of these with gender and inter-professional working, which previously had not been documented, and new findings relating to secret study and the doctor-nurse relationship in perioperative care make my study an original piece of work (Murray, 2002). The overall approach adopted suited the topic under investigation and my perspective and epistemological beliefs and assumptions regarding formal study, and allowed me to meet the study goals (Chapters I and II) with the exception of eliciting views of non-participants.

Development of a clear decision-making trail identifies how my position may have influenced the findings. This allows repetition of the methodology (Snape and Spencer, 2003), although perhaps not the findings, as these are socially constructed and situated in the time and place in which the study was conducted (Brewer, 2003b; Parahoo, 1997), and will have been influenced by me (Polit and Beck, 2004; Byrne, 2001; Oakley, 2000; Natoli, 1997; Morse and Field, 1995). This transparency resulted in a rigorous study with good credibility, dependability and confirmability (Guba, 1981). Credibility within my work is also demonstrated through consistency of experiences and perceptions between participants with the same manager. Whilst transferability of the findings may be limited due to subjective and individual nature of both the culture and the participants this is not the aim of qualitative research (Higginbottom, 2004; Horsburgh, 2003).

Whilst the methodology and method (Chapter III) were robust, I would make some changes if repeating this study. I would utilise anonymous questionnaires with both open and closed questions, in an attempt to access the perceptions of non-participants in CPE. I would also include operating department practitioners (ODPs) as a comparison group, as individuals working alongside perioperative nurses and similar in status, but dominated by males and a newly emerging profession. Although focus groups were impractical (Chapter III), I would once again attempt to conduct these alongside interviews to generate group discussion which may provide further insight into experiences and perceptions of attending post-registration university courses.

In future studies I intend to explore the use of digital recording equipment, which is perceived as advantageous compared to audiotapes (Fernandez and Griffiths, 2007). In terms of data analysis, the Ethnograph had the basic capabilities needed for this study, and allowed me to become comfortable in using computer aided qualitative data analysis software (CAQDAS). However, I now feel confident to extend the basic skills learnt with the Ethnograph to more advanced programmes, such as NVivo and At.lasti, with enhanced and better features.

Further Work

This study has indicated the transferability of previous work to the perioperative setting, particularly with regard to motivations and barriers associated with formal study and its outcomes. It has also provided new insights into perioperative nurses' experiences and perceptions of attending university, which extends knowledge relating to CPE, many of which appear to relate to the culture and attitudes within perioperative nursing. It is not possible to assert at this stage whether the findings are attributable to the culture of

theatres, or an effect of socialisation of nurses into perioperative care. Whilst other studies explore CPE, few explore culture and relationships within perioperative care, and further work is required to explore whether the assumption that theatres is a unique environment is upheld. This would indicate the extent to which perioperative nurses' experiences of CPE echo those of colleagues in other areas, and the relationship of these to the culture of perioperative nursing. Similarly, this would indicate the transferability of the findings to other perioperative settings and other nursing specialities.

Further work involving both female and male perioperative nurses, is required to illuminate the findings (Chapter VII) regarding secret study and its prevalence. Such work could also provide insight into the credibility, confirmability and transferability of the model of secret study (Box Q) and its usefulness in predicting openness during a period of study. It would also be of interest to understand how family members and medical staff feel about, and are affected by, perioperative nurses' study and whether changes to the doctor-nurse relationship described by participants are also perceived by medical staff. More research is also needed to explore the experiences of perioperative nurses in their roles as students, and the stressors associated with this additional role, and the concept of student card possession. It would also be useful to determine the length of the ideal break which allows recovery following a period of study, whilst not increasing the stress associated with returning to study. This further work would complement these findings, and deepen the understanding of perioperative nurses' experiences and perceptions of CPE.

To extend the parameters of the study goals (Chapters I and II) and the findings, it would be of interest to repeat this work with ODPs to determine similarities and differences

between the two professional groups, which may further illustrate the role of gender and power in perioperative practice. Further to this, it would be beneficial to determine the role of support for surgeons and anaesthetists, and whether the selective nature of revealing CPE is also apparent in this group, who could be considered as more powerful within the perioperative environment than both ODPs and perioperative nurses.

Although this work presents a comprehensive and credible description of perioperative nurses' experiences and perceptions of CPE, individual truth is situated and provisional (Etherington, 2004; Rosenblatt, 2002; Natoli, 1997). As such, the findings will be contemporary, and may be affected by the full implementation of the *Knowledge and Skills Framework* (DH, 2004a), imminent changes to professional regulation and re-registration (DH, 2008b; HMSO, 2007) and proposals to move all pre-registration nurse education to degree level (NMC, 2007). Furthermore, with regard to the future, opinion is divided on whether nurses will be expected to make increased investment in CPE as a result of continuing cost savings within the NHS (Quinn and Hughes, 2007; Wragg, 2007 personal communication), or whether, in line with recommendations relating to increasing the funding for education, and increased accountability for publicising expenditure relating to continuing professional development (CPD) (DH, 2008a), they will be funded to study in work time rather than during annual leave (Snow, 2008). As these may all influence attitudes towards education and development, and the CPE perioperative nurses undertake, it would be useful to repeat this work to understand the consequent effects of these changes on perioperative nurses' experiences and perceptions of continuing professional education.

Chapter IX

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APPENDICES

Appendix I	Initial search strategy
Appendix II	Second literature search strategy
Appendix III	Information sheets
	Participants in CPE
	Non-participants in CPE
Appendix IV	Original topic guides
	Topic guide 1: Participants in CPE
	Topic guide 2: Non-participants in CPE
Appendix V	Local Research Ethics Committee approval
Appendix VI	Consent forms
	Consent form 1: Participants in CPE
	Consent form 2: Non-participants in CPE
Appendix VII	Family tree to level four
	Explanation of themes and categories
Appendix VIII	Excerpt from transcript

Appendix I

INITIAL SEARCH STRATEGY

Databases	Search Terms
Bookfind online Cinahl Cochrane Library EBSCO Academic Search Elite Effective Practice and Organisation of Care Group Elsevier Science Direct Index to Theses Ingentaconnect National Research Register Networked Digital Library of Theses and Dissertations Proquest Proquest Digital Dissertations REGARD ReFeR research findings register SIGLE Swetswise Zetoc	1. Continuing Professional Development 2. CPD 3. Continuing Professional Education 4. CPE 5. Post-registration Education and Practice 6. PREP 7. #1 and nurses 8. #2 and nurses 9. #3 and nurses 10. #4 and nurses 11. #5 and nurses 12. #6 and nurses 13. #1 and benefits 14. #2 and benefits 15. #3 and benefits 16. #4 and benefits 17. #5 and benefits
Web-sites, Search Engines and Subject Gateways	18. #6 and benefits 19. #1 and values 20. #2 and values 21. #3 and values 22. #4 and values 23. #5 and values 24. #6 and values 25. #1 and patient care 26. #2 and patient care 27. #3 and patient care 28. #4 and patient care 29. #5 and patient care 30. #6 and patient care 31. #1 and barriers 32. #2 and barriers 33. #3 and barriers 34. #4 and barriers 35. #5 and barriers 36. #6 and barriers 37. #1 and obstacles 38. #2 and obstacles 39. #3 and obstacles
Hand Searched Journals	40. #4 and obstacles 41. #5 and obstacles 42. #6 and obstacles 43. #1 and nurses and perceptions 44. #2 and nurses and perceptions 45. #3 and nurses and perceptions 46. #4 and nurses and perceptions 47. #5 and nurses and perceptions 48. #6 and nurses and perceptions 49. perioperative nursing 50. #1 and perioperative nursing 51. #2 and perioperative nursing 52. #3 and perioperative nursing 53. #4 and perioperative nursing 54. #5 and perioperative nursing 55. #6 and perioperative nursing
Appendix I: Search Strategy	

Appendix II

SECOND LITERATURE SEARCH STRATEGY

Databases	Booknews	<u>Search Terms</u>
	British Education Index (BEI) Cochrane Library EBSCO Host (Academic Search Elite, Cinahl, medline, psycINFO, psycBOOKS, psycARTICLES) Education Resources Information Center (ERIC) ESRC Society Today Index to Theses IngentaConnect National Research Register Archive Networked Digital Library of Theses and Dissertations Proquest Proquest Dissertations and Theses Science Direct SIGLE Swetswise UK Clinical Research Register (UKCRN) Web of knowledge Zetoc	1. Horizontal violence 2. Bullying 3. Harassment 4. Lateral violence 5. Doctor nurse game 6. Inter-professional relationship 7. Teamwork 8. Collaborative working 9. Nursing and professionalism 10. Social dominance orientation 11. Authoritarianism 12. Double high 13. Nursing status 14. Student status 15. Student status and enjoyment 16. Secret study 17. Embarrassment and study 18. Embarrassment and education 19. Enjoyment and study 20. Enjoyment and education 21. Support and (CPD or CPE) 22. Culture and (CPD or CPE) 23. Socialisation and nursing 24. Medicine and (#13 or #14) 25. Nurses and (#1 or #2 or #3 or #4) 26. Nurses and (#7 or #8) 27. #5 and nurses 28. #6 and nurses 29. #14 and nurses 30. #16 and nurses 31. #17 and nurses 32. #18 and nurses 33. #19 and nurses 34. #20 and nurses 35. #21 and nurses 36. #22 and nurses 37. #5 and nurses and (theatre or perioperative)
Web-sites, Search Engines and Subject Gateways	American Operating Room Nurses Association (AORN) Association for Perioperative Practice (AfPP) Audit Commission Department of Health (DH) Education-line Google Google scholar Intute: Social Sciences Lifelong learning (www.lifelonglearning.co.uk) National Foundation for Education Research (NFER) National Library for Health (NLH) National Institute for the Advancement of Continuing Education (NIACE) Nursing and Midwifery Council (NMC) Professional Associations Research Network (PARN) Royal College of Nursing (RCN) ScHARR Times Higher Education Supplement (THES)	

<p>Hand Searched Journals</p>	<p><i>American Operating Room Nurses (AORN) Journal</i> <i>Journal of Perioperative Practice</i> (formerly <i>British Journal of Theatre Nursing</i>, <i>British Journal of Perioperative Practice</i>) <i>Journal of Advanced Perioperative Practice</i> <i>NMC News</i> (formerly <i>Register</i>) <i>Nurse Education Today</i> <i>Social Research Update</i></p>	<p>38. #6 and nurses and (theatre or perioperative) 39. (#7 or #8) and nurses and (theatre or perioperative) 40. #9 and nurses and (theatre or perioperative) 41. #14 and nurses and (theatre or perioperative) 42. #16 and nurses and (theatre or perioperative) 43. #17 and nurses and (theatre or perioperative) 44. #18 and nurses and (theatre or perioperative) 45. #19 and nurses and (theatre or perioperative) 46. #20 and nurses and (theatre or perioperative) 47. #21 and nurses and (theatre or perioperative) 48. #22 and nurses and (theatre or perioperative) 49. #23 and nurses and (theatre or perioperative) 50. #24 and nurses and (theatre or perioperative) 51. #5 and (#10 or #11 or #12) 52. #6 and (#10 or #11 or #12) 53. (#7 or #8) and (#1 or #2 or #3 or #4) 54. #12 and #6 55. #12 and (#7 or #8) 56. #13 and #14 57. #14 and (#1 or #2 or #3 or #4) 58. #14 and #9 59. #14 and (#10 or #11 or #12) 60. #16 and (#1 or #2 or #3 or #4) 61. #23 and (#1 or #2 or #3 or #4) 62. #23 and #5 63. #23 and #13 64. #23 and #14 65. #23 and #15 66. #23 and #16 67. #23 and #17 68. #23 and #18 69. #23 and #19 70. #23 and #20 71. #23 and #21 72. #23 and #22</p>
<p>Appendix II: Search Strategy</p>		

Appendix III

INFORMATION SHEETS

INFORMATION SHEET 1

PARTICIPANTS IN CPE

Study title

An inquiry into perioperative nurses experiences of continuing professional education.

Invitation paragraph

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

Thank you for reading this.

What is the purpose of the study?

The purpose of this study is to investigate perioperative nurses' thoughts and feelings regarding continuing professional education (university courses) which some nurses chose to do to meet their PREP requirements for re-registration. I am particularly interested in the motivations and deterrents for undertaking university courses and their consequences for perioperative nurses as individuals. I am also investigating whether university courses impact on nursing practice.

Although some studies investigate this in ward situations, no-one, to my knowledge has ever looked at this within perioperative practice settings. I hope by studying this, and finding out about people's experiences of continuing professional education that it will be possible to make this more effective and beneficial for individuals who wish to undertake university courses.

Why have I been chosen?

I am looking for about 40 nurses to volunteer to take part in this study, some of whom will have recently undertaken university courses and some who chose to meet their PREP requirements in other ways. You have been chosen to participate within this study as you work within perioperative care within Hull and East Yorkshire NHS Trust, and you have recently undertaken a university course.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you do not wish to take part in the study, or you sign the consent and then decide you can no longer take part, there will be no repercussions. You may withdraw from the study, or refuse to have your words used in the final report of the study at any time, even during an interview or after the interview has occurred. I will then destroy any record of our conversation together. Whether you take part in this study or not, will have no influence on whether you can attend any other university courses in the future.

What do I have to do?

If you choose to take part in this study, you will be required to spend about 30 minutes to an hour of your own time with me talking about your experiences of continuing professional education. This will be arranged at your convenience. All interviews will be audio taped and I will write this conversation word for word onto paper. You will be given the opportunity once this has occurred to state that this is a true record of our conversation, and the tapes will then be destroyed.

If you wish to take part in this study, you will be required to sign a consent form confirming you understand what is involved and that I have answered any questions you may have. You will also need to sign to say whether you consent to your words being used in the final report of my findings.

Will my taking part in this study be kept confidential?

Your decision to take part in this study will be kept confidential, and anything you say will be held in the strictest confidence and not discussed with anyone else. All information held about you will be kept in locked files and on my home computer with documents requiring passwords to uphold the confidentiality of the information provided.

Although myself and my supervisors at Hull University will be the only ones to see these records of our conversation, and tapes will be destroyed as soon as the words are on paper, I will use the exact words of some participants to describe the different types of experiences people have when they undertake university courses to illustrate my findings. Although each person who takes part will be made anonymous through the use of a code, there is a small chance you may be recognisable using your words in this way, from conversations you may have had with other people. If you wish to participate in the study and tell me about your experiences, but do not wish me use your words in this way then this is your decision.

What will happen to the results of the research study?

Those who take part will receive a copy of the findings at the end of the study. The results will be published within nursing journals and will also be contained within my PhD thesis, which will be available at Hull University from September 2008. You will not be identified in any of these publications.

Who is organising and funding the research?

This study is being organised by myself with the help of two academic supervisors at Hull University within the Faculty of Health and Social Care.

There is no money associated with involvement in this study, either for participants or the NHS.

Who has reviewed the study?

This study has been reviewed and approved by the Hull and East Riding Local Research Ethics Committee.

Contact for Further Information

If you should have any further questions about this study, either before during or after your interview, please contact me on 01xxx xxxxxx or 07xxxxxxxx.

All those who take part in this study will be provided with a copy of this information sheet and a signed consent form to keep for future reference.

Thank you for taking part in this study.

Mrs Susan Tame (nee Knight)

INFORMATION SHEET 2

NON-PARTICIPANTS IN CPE

Study title

An inquiry into perioperative nurses experiences of continuing professional education.

Invitation paragraph

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

Thank you for reading this.

What is the purpose of the study?

The purpose of this study is to investigate perioperative nurses' thoughts and feelings regarding continuing professional education (university courses) which some nurses chose to do to meet their PREP requirements for re-registration. I am particularly interested in the motivations and deterrents for undertaking university courses and their consequences for perioperative nurses as individuals. I am also investigating whether university courses impact on nursing practice.

Although some studies investigate this in ward situations, no-one, to my knowledge has ever looked at this within perioperative practice settings. I hope by studying this, and finding out about people's experiences of continuing professional education that it will be possible to make this more effective and beneficial for individuals who wish to undertake university courses.

Why have I been chosen?

I am looking for about 40 nurses to volunteer to take part in this study, some of whom will have recently undertaken university courses and some who chose to meet their PREP requirements in other ways. You have been chosen to participate within this study as you work within perioperative care within Hull and East Yorkshire NHS Trust, and from the records held within the department you do not appear to have recently undertaken a university course.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you do not wish to take part in the study, or you sign the consent and then decide you can no longer take part, there will be no repercussions. You may withdraw from the study, or refuse to have your words used in the final report of the study at any time, even during an interview or after the interview has occurred. I will then destroy any record of our conversation together. Whether you take part in this study or not, will have no influence on whether you can attend any other university courses in the future.

What do I have to do?

If you choose to take part in this study, you will be required to spend about 30 minutes to an hour of your own time with me talking about your experiences of continuing professional education. This will be arranged at your convenience. All interviews will be audio taped and I will write this conversation word for word onto paper. You will be given the opportunity once this has occurred to state that this is a true record of our conversation, and the tapes will then be destroyed.

If you wish to take part in this study, you will be required to sign a consent form confirming you understand what is involved and that I have answered any questions you may have. You will also need to sign to say whether you consent to your words being used in the final report of my findings.

Will my taking part in this study be kept confidential?

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Although myself and my supervisors at Hull University will be the only ones to see these records of our conversation, and tapes will be destroyed as soon as the words are on paper, I will use the exact words of some participants to describe the different types of experiences people have when they undertake university courses to illustrate my findings. Although each person who takes part will be made anonymous through the use of a code, there is a small chance you may be recognisable using your words in this way, from conversations you may have had with other people. If you wish to participate in the study and tell me about your experiences, but do not wish me use your words in this way then this is your decision.

What will happen to the results of the research study?

Those who take part will receive a copy of the findings at the end of the study. The results will be published within nursing journals and will also be contained within my PhD thesis, which will be available at Hull University from September 2008. You will not be identified in any of these publications.

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This study is being organised by myself with the help of two academic supervisors at Hull University within the Faculty of Health and Social Care.

There is no money associated with involvement in this study, either for participants or the NHS.

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Contact for Further Information

If you should have any further questions about this study, either before during or after your interview, please contact me on 01xxx xxxxxx or 07xxxxxxxx.

All those who take part in this study will be provided with a copy of this information sheet and a signed consent form to keep for future reference.

Thank you for taking part in this study.

Mrs Susan Tame (nee Knight)

Appendix IV

ORIGINAL TOPIC GUIDES

Topic Guide 1: Participants in CPE

Whilst these will not be asked in order, the first 2 questions will be asked following an introduction and re-affirmation of the consent to participate in the interviews. The remaining areas will then be used as the basis of discussion throughout the interviews with participants in CPE. They would not be asked verbatim, but are expressed as questions here to act as an *aide memoir* and to contextualise these for the researcher's benefit.

- Name, qualifications, length of time practicing as a nurse
- Course attended, duration,
- How this was perceived by the participant (liked/disliked)
- Why the course was chosen to be attended/primary motivation for attending
- Was there anything which put you off attending?
- How did other people who you work with feel about you attending these study days?
- Were there any impacts on your home life as a result of studying?
- Has your professional practice changed as a result of attending the CPE?
- Do you feel you have changed as a person or as a nurse since attending the CPE?
- Benefits of attending – more to practitioner or to practice, or equally
- Implementation of skills in clinical area (if appropriate, depends on other answers) – barriers

The interview would conclude by thanking the participant for their time and reminding them that I will forward a copy of the transcript for them to read and that the tapes will be destroyed when they confirm this is an accurate translation of our conversation.

Topic Guide 2: Non-Participants in CPE

Whilst these will not be asked in order, the first question will be asked following an introduction and re-affirmation of the consent to participate in the interviews. The remaining areas will then be used as the basis of discussion throughout the interviews with non-participants in CPE. They would not be asked verbatim, but are expressed as questions here to act as an *aide memoir* and to contextualise these for the researcher's benefit.

- Name, qualifications, length of time practicing as a nurse
- Reasons not to attend CPE – what are these? Are they felt at home or at work?
- Are these barriers most felt at home or at work?
- Are there any circumstances when you would consider undertaking CPE?
- What would encourage you to attend these courses?
- Do you think there are any benefits to attending CPE that you cannot gain through experience at work or from attending in house courses?
- Why do you think other members of staff attend these courses?
- Do you think they change, either as people or in the way they practice following CPE?

The interview would conclude by thanking the participant for their time and reminding them that I will forward a copy of the transcript for them to read and that the tapes will be destroyed when they confirm this is an accurate translation of our conversation.

Appendix V

LOCAL RESEARCH ETHICS COMMITTEE APPROVAL

05 September 2005

Miss Susan Louise Knight
Training Advisor

Dear Miss Knight

Full title of study: A phenomenological inquiry into perioperative nurses' perceptions of continuing professional education
REC reference number: 05/Q1104/126

Thank you for your letter of 22 August 2005, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

The favourable opinion applies to the research sites listed on the attached form.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Application	1	15 July 2005
Investigator CV	Susan Knight	(None Specified)
Investigator CV	Dr Peter Draper (Academic Supervisor)	(None Specified)
Protocol	1	11 July 2005
Covering Letter		15 July 2005
Interview	1	11 July 2005

An advisory committee to

Strategic Health Authority

Schedules/Topic Guides		
Participant Information Sheet	Revised version 2 Participants in CPE	22 August 2005
Participant Information Sheet	Revised version 2 Non-Participants in CPE	22 August 2005
Participant Consent Form	Revised version 2 Non-Participants in CPE	22 August 2005
Participant Consent Form	Revised version 2 Participants in CPE	22 August 2005
Response to Request for Further Information	Letter addressing the concerns of the committee	22 August 2005

Management approval

The study should not commence at any NHS site until the local Principal Investigator has obtained final management approval from the R&D Department for the relevant NHS care organisation.

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Notification of other bodies

The Committee Administrator will notify the research sponsor and the R&D Department for NHS care organisation(s) that the study has a favourable ethical opinion.

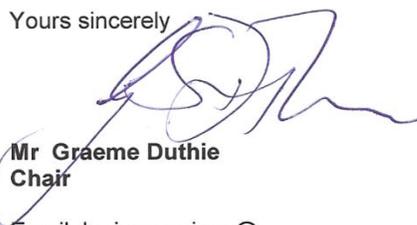
Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

05/Q1104/126	Please quote this number on all correspondence
---------------------	---

With the Committee's best wishes for the success of this project,

Yours sincerely



Mr Graeme Duthie
Chair

Email: louise.carrison@

Enclosures:

Members list for August 2005
Standard approval conditions
Site approval form (SF1)

SF1 list of approved sites

Local Research Ethics Committee
LIST OF SITES WITH A FAVOURABLE ETHICAL OPINION

For all studies requiring site-specific assessment, this form is issued by the main REC to the Chief Investigator and sponsor with the favourable opinion letter and following subsequent notifications from site assessors. For issue 2 onwards, all sites with a favourable opinion are listed, adding the new sites approved.

REC reference number:	05/Q1104/126	Issue number:	1	Date of issue:	05 September 2005
Chief Investigator:	Miss Susan Louise Knight				
Full title of study:	A phenomenological inquiry into perioperative nurses' perceptions of continuing professional education				
<p><i>This study was given a favourable ethical opinion by _____ Local Research Ethics Committee on 05 September 2005. The favourable opinion is extended to each of the sites listed below. The research may commence at each NHS site when management approval from the relevant NHS care organisation has been confirmed.</i></p>					
Principal Investigator	Post	Research site	Site assessor	Date of favourable opinion for this site	Notes ⁽¹⁾
Susan Knight		NHS Trust	Research Ethics Committee	05/09/2005	

Approved by the Chair on behalf of the REC:

[Signature]
(delete as applicable) (Signature of Chair/Administrator)

[Signature]
..... (Name)

Appendix VI

CONSENT FORMS

Centre Number:
Study Number:
Participant Identification Number:

CONSENT FORM 1 – PARTICIPANTS IN CPE

Title of Project: An inquiry into perioperative nurses experiences of continuing professional education

Name of Researcher: Mrs Susan Louise Tame (nee Knight)

Please initial box

1. I confirm that I have read and understand the information sheet dated 22 August 2005 (version 2) for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, with no influence on whether I can attend any other university courses in the future.
3. I understand that although every attempt will be made to keep my responses anonymous, there is a slight chance that I may be recognised through the use of my actual words contained within the final report. I consent to my words being used in this way
4. I agree to take part in the above study.

_____ Name of Participant	_____ Date	_____ Signature
_____ Name of Person taking consent (if different from researcher)	_____ Date	_____ Signature
_____ Researcher	_____ Date	_____ Signature

2 forms to be completed; 1 for the participant and 1 for the researcher

Centre Number:
Study Number:
Participant Identification Number:

CONSENT FORM 2 – NON-PARTICIPANTS IN CPE

Title of Project: An inquiry into perioperative nurses experiences of continuing professional education

Name of Researcher: Mrs Susan Louise Tame (Nee Knight)

Please initial box

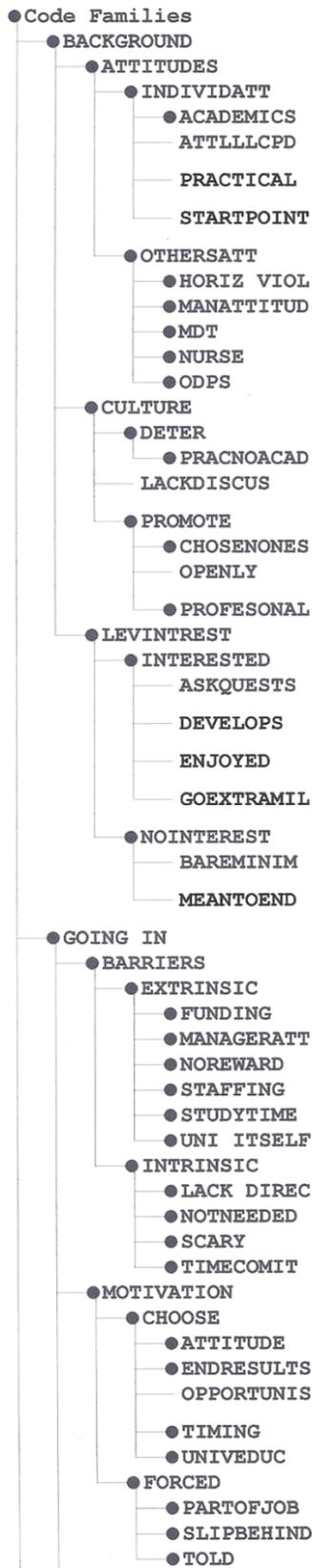
1. I confirm that I have read and understand the information sheet dated 22 August 2005 (version 2) for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, with no influence on whether I can attend any other university courses in the future.
3. I understand that although every attempt will be made to keep my responses anonymous, there is a slight chance that I may be recognised through the use of my actual words contained within the final report. I consent to my words being used in this way
4. I agree to take part in the above study.

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent (if different from researcher)	Date	Signature
_____	_____	_____
Researcher	Date	Signature

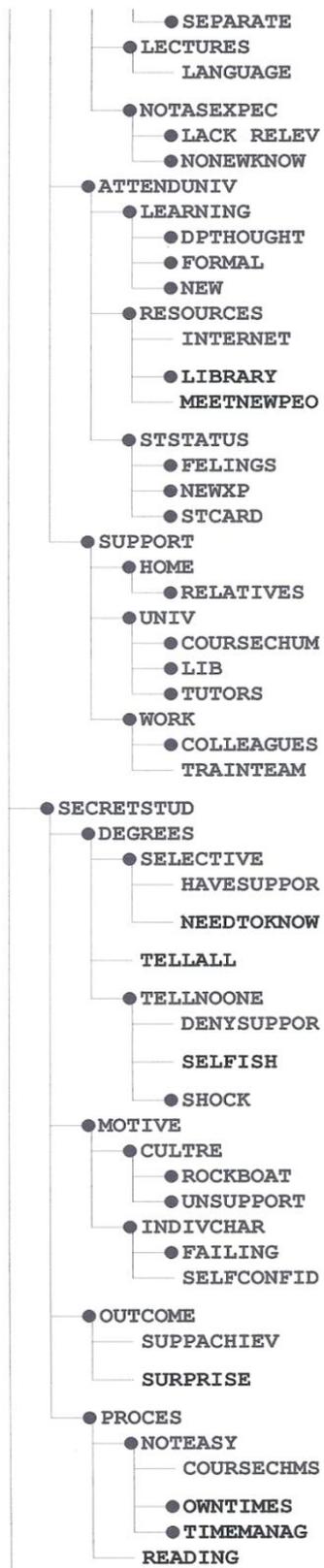
2 forms to be completed; 1 for the participant and 1 for the researcher

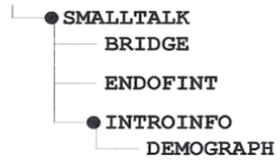
Appendix VII

FAMILY TREE TO LEVEL FOUR









Explanation of Themes and Categories

Background (Theme)

Categories relating to background information, against which participants' experiences of CPE are embedded. These categories cut across all other themes and are referred to within all findings chapters.

Attitudes

Multidisciplinary team colleagues' attitudes, individual nurses' attitudes and the influence of practical and academic perception of nurses and nursing is related to the culture in which individuals work and the process and outcomes of CPE. (Discussed in Chapter V, referred to in VI and VII)

Individual attitudes

Attitudes of individuals towards CPE (Chapters V, VI and VII)

- *Practical* Individuals describe themselves or others as practical, and nursing as a practical profession (opposite to academic)
- *Academic* Individuals referred to themselves or others as academic, and perceive that nurses may undertake academic qualifications (opposite to practical)
- *Start point* The nurse's initial qualification, and any previous experience of higher education, influences their attitudes towards CPE

Others' attitudes

Attitudes of others towards perioperative nurses accessing higher education (Chapters V, VI and VII)

- *Manager* The participants' manager's attitudes towards CPE, and towards their staff attending university. Managers own interest in formal education influenced whether they encouraged or supported staff to study
- *Medical colleagues* Medical colleagues were usually supportive of participants' academic endeavours. Some participants were cynical of their rationale, believing they feel threatened by nurses' educational advancements
- *ODP colleagues* Usually described as uninterested and uninvolved in perioperative nurses' CPE
- *Nursing colleagues* Other nursing colleagues' attitudes towards study determined their reaction to colleagues undertaking CPE. Appeared to relate to the individual's own self-confidence and academic ability. Negative reactions sometimes referred to as grounded in jealousy
- *Horizontal violence* A consequence of others' attitudes towards perioperative nurses accessing CPE. Occurs when colleagues state nurses need not study in an attempt to concur with medical staff who are perceived to have this opinion

Culture

The cultural milieu within theatres and interdisciplinary discussion influenced nurses' motivation to study, their experiences as students, and outcomes of formal study. The prevailing culture either promoted or deterred study, and linked to managers' attitudes towards CPE (Discussed in Chapter V, referred to in VI and VII)

Deter

The culture deters staff from accessing CPE and is generally unsupportive of staff development (Chapters V, VI and VII)

- *Practical not academic* Practical development is promoted, but academic activities are perceived as relevant only to those working in universities

Promote

CPE is promoted, however not necessarily equitably (Chapters V, VI and VII)

- *Promote for the chosen few* Certain perioperative nurses are perceived to be groomed for certain jobs, and as a consequence have preferential access to CPE
- *Openly* CPE is promoted openly with all opportunities available for all
- *Professionalism* The continuing professionalisation of nursing is perceived as promoting CPE as part of lifelong learning

Lack discussion

Issues relating to the discussion of CPE either intra- or inter-professionally (Chapters V, VI and VII)

Level of interest

The level of interest in CPE impacts on participants' motivations to study, and their engagement in their studies. It also influences the outcomes of a period of study and whether participants attempt to integrate these into practice (Chapters V, VI)

Interested

Study stimulates interest, which leads participants to enjoy CPE and enhances its outcomes. Interested participants displayed certain characteristics (Chapters V, VI)

- *Ask questions* Participants ask questions to get answers to specific queries they have relating to the CPE or practice
- *Develops over time* Whilst not initially interested in the CPE, participants' interest develops over a period of time
- *Enjoyed* Certain aspects of CPE are enjoyed above others, in particular, attending lectures and the ability to refer to themselves as university students
- *Go the extra mile* Interested participants put in effort to achieve not only course outcomes but also their own personal outcomes

Not interested

The participant is uninterested in CPE, the process is not enjoyed and outcomes are restricted (Chapters V and VI)

- *Bare minimum* The uninterested participant does only the work needed to pass
- *Means to an end* The CPE is a pre-requisite to work or academic goals. It will enable other opportunities and participants are more focused on, and interested in, that end goal than the current CPE

Going into CPE (Embarking on CPE) (Theme)

This theme groups categories relating the motivations which lead perioperative nurses to enter CPE, and factors which deter this, as well preparation undertaken prior to CPE. (Discussed in Chapters V, VI and VII).

Barriers

A range of intrinsic and extrinsic barriers prevent access to CPE. Some participants overcame both intrinsic and extrinsic barriers and studied (Chapters V, VI and VII)

Extrinsic

Extrinsic barriers to CPE over which participants had no, or limited, control (Chapters V, VI, and VII)

- *Funding* Lack of money to pay course fees, or for ‘backfill’
- *Staffing* Linked to funding, too few staff, or high sickness levels
- *Study leave* Linked to staffing and funding, a lack of study time during the working week
- *Manager attitude* Linked to the culture, managers disapproval of staff development
- *The university environment* The nature of the university and course requirements
- *No rewards* The absence of monetary or promotional reward following study

Intrinsic

Internal factors which prevented perioperative nurses accessing CPE, or had to be overcome before they undertook formal study (Chapters V, VI)

- *Lack of direction* An absence of an identified career development plan. This is linked to manager attitude and the value placed on staff development, including whether staff had personal development reviews
- *No need to attend CPE* Participants believed some colleagues felt they would not gain new knowledge by studying, or were apathetic due to imminent retirement
- *Scared of entering CPE* Participants believed others were fearful of higher education, and could identify with this despite attending CPE. Related to perceived academic ability, a sense of vulnerability and the concept of ‘university’, which was grounded in previous educational experiences, and awareness of other university graduates
- *Time commitment* The time taken up by study and the sacrifices required may prevent CPE, and was exacerbated if study leave was not permitted

Motivation

The rationale why participants enter, or continue, their education (Chapter VI)

Choose

Participants enter CPE of their own volition, rather than feeling forced to attend (Chapter VI)

- *Attitude* Those who choose to study have a different attitude to those who do not: They are interested in learning new things, and enjoy CPE
- *Experience of university education* Some participants wished to experience university education for the first time, whilst others believed it would enhance professional credibility, particularly with other professions. Attending post-registration was described as more valuable than pre-registration, addressing a perceived practice-theory gap
- *The end results* The anticipated outcomes in terms of practice development, personal gain or professional development encourage CPE

- *Opportunistic attendance* A few participants described they did not plan to undertake specific courses but took the opportunity when offered
- *Timing* Whilst timing can prevent access to CPE, if the time was appropriate, and they believed they could benefit, participants would study

Forced

Some participants felt obliged to undertake certain courses, for different reasons, and were less interested in the course than if they had chosen to study (Chapter VI)

- *An expected part of the job* The CPE was role-related. Participants studied due to promotion, to gain qualifications to support their new role
- *Fear of slipping behind colleagues* Participants felt they were falling behind when colleagues were qualifying with diplomas and degrees, or when peers were extending practical skills. They felt compelled to gain the same qualifications as their peers to attend to avoid falling behind practically or academically
- *Told to attend* A few participants were told directly they needed to attend particular courses

Preparation (Excluded from thesis)

Participants' mental and physical preparation prior to enrolling on CPE, and once offered a place, affected their experiences of CPE and its outcomes

Prepared

Participants prepared prior to enrolling on CPE, and once a place had been gained. Most often these participants had chosen to study

- *Make easier* Preparation makes academic study easier. Reading and talking to others provides a background to the subject and the course
- *Research* As a result of preparation, participants cite personal objectives and were focused on how CPE could help them achieve their personal goals, even if it was not particularly enjoyed but a means to an end

Unprepared

Some participants, usually those told to attend, did not prepare, and were unable to describe outcomes to be achieved

- *Struggle* A lack of preparation led participants to struggle with the demands of the course, particularly with regard to academic writing and computing skills
- *Surprises* Participants who were unprepared were surprised in terms of the volume of work to be completed

Going out (Theme)

This theme groups categories relating to the end of a period of study. For some, rather than representing the end of a journey, the outcomes of CPE provides the impetus for additional study (Discussed in Chapters IV, VI and VII).

More study

Participants are likely to re-enter university education, or encourage others to attend academic courses, following CPE (Chapters IV, VI and VII)

Continuing

Participants describe CPE leads to further study (Chapter VI and VII)

- *Addictive* Despite the struggles, a sense of achievement leads to further study, due to the psychological boost derived: This makes CPE addictive
- *Prior experiences* Participants develop confidence in their academic ability which provides a grounding for further study
- *Conditions* Participants' heightened awareness of CPE results in conditions being ascribed prior to re-entering formal education, including achieving good grades in current courses, obtaining study leave, and standalone modules
- *Rest* Resting between periods of study prevents burn out

Encouraging others to study

Participants' experiences during CPE led them to encourage others to study (Excluded from thesis)

- *Recommendations* Participants' recommend others should attend study, based on their own experiences
- *Role-modelling* Participants believe they inspire others to study, acting as role-models which both colleagues and their children wish to emulate

Outcomes

The effects of study in terms of personal, professional and practical development and knowledge acquisition (Chapter VI)

Personal gain

Numerous personal gains which result from CPE (Chapter VI)

- *Self-esteem* Academic success boosts self esteem. Increased self-awareness and skills, including computer skills, increases confidence within and outside work
- *Pride* Participants feel proud in passing their course. The personal satisfaction derived renews enthusiasm for nursing
- *Career* CPE enhances career prospects by developing knowledge and skills and increasing professional credibility
- *Not noticed* Participants do not notice differences in themselves following CPE, but acknowledge these may be more easily observed by others

Professional and practice gains

Participants identify professional or practical benefits from studying (Chapter VI)

- *Behavioural change* For some behavioural change was absent, and for others it was conditional based on work environments and colleagues' attitudes. Most changes were small and limited to participants' own practice; they lacked authority to make major change. Most identified they could have done more but lacked enthusiasm, as there was no requirement to instigate change
- *Relationship with medical staff* Changes to relationships with medical staff, with more reciprocal discussions than prior to CPE. Increased confidence when conversing with doctors due to increased knowledge
- *Increased knowledge* This related to closing the practice-theory gap and patient care outside of theatre, enabling a broader outlook and stimulated interest in nursing

- *Patient gains* Participants are better patient advocates, and have new support networks to facilitate patient care. Patients benefit directly through sharing good practices and dissemination of knowledge, however this was only cascaded downwards through the nursing hierarchy and to those perceived as supportive

Failure

Participants describe how they feel, or believe they would feel, if they were unsuccessful in CPE. This was described in negative terms (Chapter VI)

- *Egg on face* Participants would be embarrassed
- *Let down* Participants disappoint themselves, their departments, and managers
- *Doubts* Academic failure leads to doubts over practical and academic ability and their career

No new knowledge

Participants did not gain knowledge from CPE (integrated into outcomes relating to personal, profession and practice gains, Chapter VI)

- *Forced to study* A lack of interest through being told to study lead participants to do the bare minimum and not gain new knowledge
- *Knew already* Participants did not learn new knowledge or skills as previous courses covered the same information

Relief

Participants are relieved when the CPE is completed. This relief is shared by their family as CPE impacts on all who inhabit the same household (Chapter VI)

More time

Part of the relief is being able to devote more time to leisure activities (Chapter VI)

Reduced levels of stress

On completion of CPE, the stresses and sacrifices associated with combining the roles of student with other roles within participants' lives are removed (Chapter VI)

Operating Department Practitioners (Theme – Excluded from thesis)

This theme groups participants' perceptions relating to ODPs' attitudes towards CPE. Whilst reference to these is made in Chapter V as part of the background against which perioperative nurses' CPE is set this theme was outside my study goals.

Different from NVQ

ODPs with NVQ or C&G level qualifications are described as less likely to study than those with diplomas, as this is academically removed from their previous education

Might fail the course

ODPs do not engage in CPE as they fear failure

Lack of interest

ODPs are perceived to lack interest in CPE due to their professional history

Stuck in a rut educationally

Similar to the barrier preventing some perioperative nurses entering CPE, participants believe ODPs are apathetic towards study

Never needed to develop Prior to mandatory CPD requirements (HPC, 2008) ODPs never had to evidence their development, and this is not yet embraced by ODPs

- *KSF* Participants believed the KSF may encourage ODPs to study

Pushed

Participants described how, unlike nurses, ODPs must be pushed to study and to develop academically. They will only study if this is of direct relevance to their practice

Process (Theme)

This theme groups categories describing perceptions and experiences of perioperative nurses during CPE. Only the categories of attending university and support are described in depth (Chapter VI).

Academic (Excluded from thesis)

Participants describe the academic aspects of the course are difficult

Assignment

The assessed academic work required to complete CPE

- *Hard* The academic assignment is difficult compared to practical aspects of CPE. This related to developing academic writing skills and the overwhelming nature of the assignment
- *Planning* Meeting university deadlines necessitated careful planning. Participants are easily distracted from planning and producing academic work
- *Type* The assessment method was significant, and some were preferred above others. Essays were acceptable and exams were either liked or not liked; no participant enjoyed role play

Delivery

Participants describe the basis on which they attended CPE

- *Combined work and study* Participants describe the overwhelming and time consuming nature of the academic workload, the continual pressure exerted on individuals, and time management of combining study with work. This led to sacrifices in terms of social and familial roles
- *Separate* Attending CPE full time. Of particular importance was the continuity afforded by this, particularly in developing clinical skills. Support networks were developed more easily than if attending university less frequently
- *Pre-and post- registration* Participants were studying alongside pre-registration students; the two groups were disparate in approach to study

Lectures

Lectures were problematic for some, particularly with regard to the academic language used

Not as expected

Irrespective of the preparation undertaken, the course was not always as anticipated

- *No new knowledge* Knowledge development was an important outcome of attending university, even when this was not utilised in practice. Participants were disappointed when they did not learn new knowledge
- *Lacks relevance* The course lacks direct relevance, but participants know they may benefit from certain aspects of it

Attending university

Aspects of participants' experiences relating to attending university and being students, rather than formal academic issues (Chapter VI)

Learning

Participants described learning which occurred at university (Chapter VI)

- *New Learning* new information was both a motivator to study, and also an outcome of this for some participants
- *Deep thought* The opportunity to discuss patient care was described as a beneficial. Reflection on past experiences and sharing these with others, allowed participants to gain a wider picture of patient care and nursing, and for their thoughts to be confirmed. Whilst senior staff may stifle conversation, it is from these people and their experiences, that new ideas were formed
- *Formal* University is described as more formal and serious than other education. This formality assisted participants to remain focused on their study

Resources

Access to resources was described as beneficial, even though these, or similar, resources are available to participants in their workplaces (Chapter VI)

- *Internet* The internet and using this as a resource for locating evidence. As this was already available to participants, participants may have appreciated their enhanced searching abilities resulting from CPE rather than internet access *per se*
- *Library* Described as beneficial for the books it contained, but also as representative of the possibilities of learning - selecting books to envisage what may be taught on the course and the expectations
- *New people* The people participants met and course tutors provided support and remained as contacts and points of reference following the course

The effects of student status

Attending university was not just about learning and participants enjoyed being able to refer to themselves as students. The effects of being classed as students were mentioned by all participants (Chapter VI)

- *New experiences* As students, participants described new opportunities and experiences were open to them which were otherwise unavailable
- *Student card* Many participants described the benefits of possessing student cards. They confirmed the nurse's student status and were used to receive discounts
- *Feelings* Participants felt proud to be able to refer to themselves students, and valued by their departments, especially if told to study and supported through study leave. Participants also describe their student status made them feel young,

and on a par with younger nurses and other students. For some participants this brought back memories of previous university study, and others who had not previously studied at university were more able to identify with younger relatives who were, or had been, studying at university

Support

Support allowed participants to feel comfortable in entering and undertaking CPE. Physical support, practical help, or emotional support was sought from both within and outside of work (Chapter VI)

Home

All participants described the importance of receiving support from those at home both prior to and during CPE (Chapter VI)

- *Adults* Adult family members were integral in providing practical support. In allowing participants to relinquish normal roles, including child care and housework, this provided time for CPE. In addition, for those whose relatives were graduates, academic support was also provided
- *Children* Younger children understood parents needed time to study. However, parents described many of the sacrifices made during CPE implicated their children, leading to feelings of guilt

University

The support the participant receives from university (Chapter VI)

- *Tutors* Support for academic assignments through tutorials, and on line for those studying at a distance, was described as increasing success. However, a few described tutorials as stressful, creating more questions. Some tutors were described as uncaring, unavailable, or threatening and in some cases, this attitude was perceived to be directed only at perioperative nurses
- *Library* Participants received support from the library relating to academic writing and literature searching
- *Course colleagues* Support provided by course colleagues of similar grades was invaluable, especially if they had previous experience of CPE. Where groups comprised mixed grades, less support was described and the presence of senior grades was felt to stifle class discussions, which impacted on outcomes

Work

The support received by participants from work (Chapter V and VI)

- *Colleagues* Colleagues who had studied the same course or at the same level acted as mentors, supporting participants academically. Not all participants were supported by colleagues, which led to feelings of anger, and was attributed to colleagues' own positions within theatre, their previous education, and the acceptability of the CPE
- *Training team* The theatre training and education team provided information on available courses before CPE and was described as supportive during the study

Secret study (Theme)

This theme groups categories relating to the experiences of participants who study without revealing this to work. All participants were situated on a continuum from

public to secret study, with a few lying at either end. Reference to secret study is made throughout the findings, with in-depth discussion of this in Chapter VII.

Degrees of secrecy

Participants differed in terms of the degree of openness or secrecy with which they studied (Chapter IV, V, VI and VII)

Selective

Most participants were selective to whom they revealed their CPE, and the decision was made on how others receptive colleagues would be (Chapter IV, V, VI and VII)

- *Have support* Participants tell only colleagues they believe will be supportive. Any discussion is usually with nursing colleagues, not other professions
- *Need to know* Participants tell others they are studying based on a need-to-know basis. If others have information which will benefit participants or involvement of other professions is crucial to success, then selected others will be told

Tell everyone

Participants tell everyone they are studying. These participants were told to attend CPE and lack confidence in their academic ability. In telling colleagues, including those from other professions, this asserts the individual has not self-nominated for the course, and prepares others for the possibility they may fail. Relates to the nature of nursing, where practical abilities are valued above academic qualifications (Chapter IV, V, VI, and VII)

Tell no one

The participant is truly secretive and tells no-one at work that they are studying. (Chapter VII)

- *Deny support* Participants denied themselves access to support from work
- *Selfish* (Excluded from thesis) Participants are open with their study, but knowledge derived is not disseminated to others
- *Shock* Participants are shocked and saddened by the concept of secret study. Participants state they would be shocked by colleagues suddenly trying to implement new skills following secret study

Motive

Participants describe the motive to study in secret, or why this may be done by other perioperative nurses (Chapters V, VI and VII)

Culture

The culture in which the individual works encourages the participant to study secretly (Chapter V and VII)

- *Unsupported* If a participant perceived they would be unsupported by colleagues they may study secretly. Rather than be refused an opportunity to study participants did not request to study, but booked the course and attended secretly
- *Rock the boat* Participants who were new in post or recently promoted describe not wanting to disrupt group dynamics through publishing their desire to study. Related to horizontal violence

Individual characteristics of participants

Individual characteristics of perioperative nurses lead to secret study (Chapter VII)

- *Self confidence* Participant may not have the self-confidence they can pass CPE. They study in secret to avoid the consequences of failure, as others will be unaware should they fail
- *Fear of failing* Participants fear the ramifications of failure, including a loss of credibility from colleagues, and not being able to continue their practices if the CPE aimed to address a practice-theory gap. For some this is a barrier to study, for others a reason to study in secret

Outcome

Outcomes following a period of secret study, which differed from those derived from open/selective study (Chapter VII)

Suppress achievement

Participants celebrate their success quietly, as no one knew they were studying, and it is too late to tell colleagues once a course is completed. Related to an inability to instigate change

Surprise

Participants surprise others if they attempt to instigate new skills or knowledge. Similarly others describe they would be surprised if a colleague announced they have new skills or knowledge when they did not know their colleague was studying

Process

The processes of secret study which differed from colleagues who were studying openly or with the support of selected colleagues (Chapters VI and VII)

Not easy

To study secretly was not easy for a number of reasons (Chapter VII)

- *Colleagues* Prior to a course, it may be impossible to identify who will also be attending that course; if a work colleague attends, this prevents secret study. During the course, it is difficult maintain the secrecy of their study
- *Time management* Participants studying secretly must manage their time to accommodate study in the absence of study leave. This increases the stress experienced
- *Own times* The participant arranges their off duty to facilitate secret study. In doing so, they may inadvertently alert others to their study through the need to have set periods of time off duty

Reading (Excluded from thesis)

Part of studying secretly involves reading in secret. Whereas those studying more openly could use quiet periods of time at work for reading, this opportunity was not afforded to those studying secretly. Alternatively, participants read articles during work, but covertly

Small talk (Theme – Excluded from thesis)

This theme groups sections of the transcripts which did not relate to participants' experiences and perceptions of CPE. Only the data relating to demographic details is referred to directly within the thesis (Chapter IV)

Bridge

Passages of conversation between two sections of an interview

End of interview

Passages at the end of interview

Introduction information

Information provided at the beginning of interviews, which impacted on experiences and perceptions across all themes

Demographic details

Participants' demographic details, including age group, length of time registered as a nurse, initial pre-registration qualification, the course attended and their level of seniority (Chapters IV)

Appendix VIII

EXCERPT FROM TRANSCRIPT

Me: Ummm	1026				
Participant: ... but I... through this	1028				
higher thinking and higher... analysis	1029				
I was able to put her in the cupboard,	1030				
as it were...	1031				
Me: Yeah	1033				
Participant: ...and think well 'that,	1035				
that's basic manners,	1036				
Me: Uh huh	1038				
Participant: ...and.. you know, me, a	1040				
working class girl, can rise above	1041				
that.	1042	-#	-%		-@
Me: Yeah	1044				
Participant: I hope I've answered your	1046				
question	1047				
Me: Yeah, yeah, you have, yeah	1049				
Participant: I'm sorry if I've digressed	1051	-\$			
#-SCARY \$-LACK CONFI \$-FAILURE \$-LOSEESTEEM ^-VULNERABLE					
Me: No, no, that's fine. Something else	1053	-#-\$			-^
that's come out of the other	1054				
interviews is that people who are in	1055				
positions where they are senior, or if	1056				
they've been in an area for a long	1057				
while and built up a certain degree of	1058				
respect in that area...	1059				
Participant: Ummm	1061				
Me: ..are a little bit fearful of going	1063				
on courses, in case they actually	1064				
don't pass the course....	1065				
Participant: Ummm	1067				
Me: ...because then, that respect	1069				
they've built up, whether that's	1070				
through seniority, or just being	1071				
somewhere for a long period of time,	1072				
might be lost, and their credibility	1073				
might be lost as well. Have you come	1074				
across that at all?	1075				
Participant: Ummm.. Do you want to	1077				
just... I don't know whether you just	1078				
want to switch the tape off a minute	1079				
whilst I just think?	1080				
Me: No, say whatever comes into your	1082				
head that's fine. I've got another	1083				
one, as I say	1084				
%-RISKTAKERS %-INDIVIDATT @-PROCESS					
Participant: Right OK. Um...It is, I	1086		-%		-@
think, I think it's taking risks isn't	1087				
it?	1088	-\$			
Me: Ummm	1090				
Participant: We all go out, we, we all	1092				
sometimes, we all dip in and out of	1093				
our comfort zone, and think 'well	1094				
\$-ASSESSMENT \$-METHOD \$-WRITEESSAY \$-ACADEMIC \$-ASSIGNMENT \$-HARD					

\$-ACADWRITE
 really, should I be here?'. I'll go 1095 |-\$ | | | |
 back to that tribal.. and the managers 1096 -# |-%-* | | |
 there, who perhaps have never, ever 1097 | | | | | |
 done any... academic writing... 1098 | | | | | |

 Me: Ummm 1100 | | | | | |

 Participant: ...although it's, it's not 1102 | | | | | |
 about the academic writing, on, er, on 1103 | | | | | |
 tribal, and... perhaps they... - which 1104 -\$ | | | | | |
 you've just made me think about 1105 | | | | | |
 something which I'm going to take back 1106 | | | | | |
 to my action learning set tomorrow - 1107 | | | | | |
#-SUPPORT #-COURSECHUM #-MANAGERS \$-DISTANCED \$-SUITS
 um, could it be that when the top 1108 -#-\$ | | | | | |

%-PROTECTION
 managers come to the tribal, they're 1109 | |-% | | | |
 all dressed up in their suits - power- 1110 | | | | | |
 dressing - and thinking 'well this is 1111 | | | | | |
 me.... don't, don't come, don't come 1112 | | | | | |

***-STATUS**
 near me.' There's, there's this 1113 | |-%-* | | | |
 barrier, you know the comfort, the you 1114 | | | | | |
 know, the personal space... And 1115 | | | | | |
 perhaps they too feel a bit 1116 | | | | | |
 uncomfortable because um they're with 1117 | | | | | |
 what I class as a shop floor worker... 1118 | | | | | |
 and perhaps that is, that is one 1119 | | | | | |
 message they're giving, they're giving 1120 | | | | | |

%-VULNERABIL
 out. And yeah, I can, I can 1121 |-\$-%-* | | | | | |

\$-COMFOTZONE
 understand... I'm, I'm just trying to 1122 |-\$ | | | | | |
 think of an example of where I've been 1123 | | | | | |
 whereby um, I've been with managers 1124 | | | | | |
 and they've.. you know they've been, 1125 | | | | | |
 been in and out of a comfort zone.... 1126 | | | | | |

***-SILENCE ^-SUITS**
 I'm just, I'm just trying to think. 1127 | | |-%* |-%^ | | | |
 Tribal, I, I recognise that with, with 1128 | | | | | | | |
 the suits, and um, the silences in 1129 | | | | | | | |
 their non-participation and 1130 | | | | | | | |
 participation in some of the.. um, you 1131 | | | | | | | |
 know when you, when you have to go off 1132 | | | | | | | |
 and practically apply... what, 1133 | | | | | | | |
 whatever subject you're looking at... 1134 | | | | | | | |

 Me: Ummm 1136 | | | | | | | |

 Participant: .. um, so that's tribal.... 1138 | | |-%* | | | | | |
 [pause].. I'm just thinking of um, 1139 |-\$ | | | | | | | |
 some other studies. I'm sure as I'm 1140 | | | | | | | |
 talking to you more it will come 1141 | | | | | | | |

\$-SILENCE *-STUPID
 Me: So, these silences - are they when 1143 |-\$ |-%* | | | | | |
 they don't want to say something for 1144 | | | | | | | |
 fear of being wrong? 1145 | | | | | | | |

 Participant: Yeah, I suppose. They're 1147 | | | | | | | |
 quite territorial 1148 | | | | | | | |

 Me: Uh huh 1150 | | | | | | | |

^-REPERCUSS ^-LACKCONFID
 Participant: They're quite territorial. 1152 | | |-%* |-%^ | | | | | |
 Um, for example I'd... the um, ground 1153 | | | | | | | |
 rules were set in this tribal, and I 1154 | | | | | | | |
 think there were about 60 people and 1155 | | | | | | | |
 it dwindled down the number. Um.. 1156 | | | | | | | |
 confidentiality was a part of a ground 1157 | | | | | | | |
 rule, but because managers were 1158 | | | | | | | |

there... no matter what - 1159
 confidentiality or not - really people 1160
 weren't open... 1161

Me: Ummm 1163

Participant: ...because they were 1165
 frightened of reprisals... 1166

Me: Right 1168

Participant: ... of the managers 1170
 listening and off loading, and their 1171
 reporting back. So... although 1172
 there's, there's advantages and 1173
 disadvantages - going back to this 1174
 tribal - of having a mixed bunch of 1175

***-COMFOTZONE**

people... I'm still trying to think 1176 | | | -* | -^
 of, of - going back to your question - 1177 | | | | |
 the example of a person being 1178 | | | | |
 uncomfortable. And I think, and I 1179 | | | | |
 think a lot of it could be the 1180 | | | | |
 silences... 1181 | | | | |

Me: Uh huh 1183

Participant: ... in the group.. 1185
 [pause]... yeah. [pause] I think, I 1186
 think role play.. is an example 1187
 whereby, in learning, that these 1188
 managers.. would not be, would not 1189
 feel comfortable in, unless they 1190
 adopted.. er, a management role. 1191

Me: Umm 1193

Participant: Not a leadership role, a 1195
 management role, took.. a, a, a part 1196
 of, of like dictating. They would not 1197
 like to be the client... 1198

Me: Uh huh 1200

Participant: ..[pause].. and they just, 1202
 they just see it's.. you know, 1203
 deliver, deliver, deliver... because 1204 | -\$ | | |
 they are.. told what to do, and where 1205 | | | | |
 to think in here [draws square in the 1206
 air] - in this box [draws square 1207
 again] 1208

Me: Uh huh 1210

Participant: So perhaps... perhaps it's 1212
 because um, they're not given that 1213
 opportunity to... to think in other 1214
 directions. I don't know, I, I might 1215
 be wrong. There's lots of ifs and 1216
 buts there 1217

Me: Yeah, yeah. It's just that by 1219
 talking about it, sometimes you can 1220
 come up with new ideas 1221

Participant: Yeah, yeah 1223

#-BARRIERS #-MANAGERATT #-MOTIVATION #-DETER \$-UNINTEREST %-SECRETSTUD

Me: You said before about um, managers 1225 -#-\$-%
 not necessarily being obstructive to 1226 | | |
 people who want to go on and develop, 1227 | | |
 but people putting up so many barriers 1228 | | |
 to other people developing, that they 1229 | | |

```

just say 'well, I can't be bothered. 1230
If they're not interested in me, then 1231
I won't be bothered'... 1232
Participant: Yeah 1234
Me: ...Do you think that could work the 1236M
other way, to drive people to say 1237
'well, you're not interested in me, 1238
but I'm going to prove you wrong. I'm 1239
going to study, in my own time, 1240
secretly without you knowing'? 1241
#-MOTIVE #-KNOWITALL @-CULTURE @-DETER
Participant: Ummm...I've done that. 1243M -# -@
I've studied secretly without people 1244
knowing because I didn't want it to 1245
get back that 'oh well, she's a, she's 1246
a swat, she's trying to do this, she's 1247
trying to know more than us'... I did 1248
that when I worked at er.. another 1249
$-STAFFING $-WAITTURN $-FEDUP *-MANAGERATT *-INHIBITPRO *-RETENTION
Trust, not so far from here. Um, I 1250 -#-$ |-*
wanted to go and find out.. about 1251
#-STUDYTIME #-RELEVANCE #-OWN TIME #-EAGER #-WORK-RELAT
courses and um... I was told 'oh well, 1252 -#
you know we haven't got the staff to 1253
allow this to happen, um.. and, and 1254
so, you know, well, next time maybe'. 1255
So I thought 'well, I'm going to do 1256
it, you're not going to stop me. You 1257 |- $
want people just to, to scrub, scrub, 1258
scrub, and you're not investing in me, 1259
well, I'll do it myself'. So I went 1260
on a fact finding mission, and 1261
because, because of all the negativity 1262
towards me, and because they weren't 1263
investing in me, it gave me the anger, 1264
the self-anger and the kick start, to 1265
do it myself... 1266
Me: Ummm 1268
Participant: ... so I wrote to um.. - I 1270 |-*
was still er, an E grade staff nurse 1271
$-MANAGERATT
then - I wrote to er xxxx [large 1272 |- $
teaching hospital], and enquired about 1273 -#
#-FUNDING #-STAFFING #-STUDYTIME #-OWN TIME #-EAGER *-INHIBITPRO
the ENB 176. They sent me all the 1274 -# |-*
details, and er, I took it to my 1275
manager and she said 'well, um we 1276
^-PUSHTOGO
can't, we can't er let you go, we 1277
can't second you, we can't pay for 1278
you'... I'm not looking at you when 1279 -#
I'm talking to you Susan because I'm 1280
just thinking... 1281
Me: That's fine! 1283
Participant: I'm just like thinking it 1285
through as the stages... And she said 1286
to me 'I can't let you go, I can't do 1287
this' and I said 'why? You know, I'm 1288
going to bring this back for you and 1289
I'm going.. By going away, by doing 1290
this, I'm going to achieve this, and 1291
I'll be able to do this, this, this 1292
and this when I come back', and she 1293
said 'well, you know, you can put it 1294
in writing, and you can... put it in 1295
writing to the director of nursing'. 1296

```

#-FUNDING #-PAYSELF
 So I wrote a letter to the director of 1297 -# | | | |
 nursing and um, she said 'well, you 1298 | | | | |
 can go on it, as long as you pay your 1299 | | | | |
 own course fees' 1300 -#-\$ | | | | |

Me: Uh huh 1302 | | | | |

Participant: So... And she said 'we'll 1304 | | | | |
 pay your wages, and we'll let you go. 1305 | | | | |
 She didn't stipulate that I had to 1306 | | | | |
 work there for 2 years when I came 1307 | | | | |

#-PAYSELF #-FUNDING
 back, which was good. So I went away, 1308 -# | | | | |

\$-OUTCOMES \$-INC KNOWLE ^-STIMINTERS
 I paid my course fees.. came back 1309 |-\$ | | | | ^-
 with... something good that I felt I'd 1310 | | | | | |

~-MORESTUDY ~-CONTINUING ~-ADDICTIVE ~-RESULTS
 learnt a lot about. And then because 1311 -#-\$ |-* | | | ~-
 of what I'd learnt on that 176 and 1312 | | | | | |

#-MOTIVATION #-CHOOSE #-PASTXP #-BARRIERS #-MANAGERATT #-STUDYTIME
 \$-EAGER *-OWN TIME *-DEMORALISE *-DRIVEAWAY
 998, I... wanted to do counselling, 1313 -#-\$ |-* | | | | |
 and I was told 'well, you know, we 1314 | | | | | | ^-
 can't let you go, because of the days, 1315 | | | | | | |
 so.. you know, you'll either have to 1316 | | | | | | |
 miss some, or do it in your own time'. 1317 | | | | | | |

^~MOTIVE ~-PROCES ~-OWNTIMES
 So I registered at xxxx [city away 1318 -# | | | | | ^-
 from that where the study was 1319 | | | | | | |

#-TELLNOONE
 conducted] and I did it in my own 1320 -# | | | | | | |
 time, and I didn't tell anybody 1321 | | | | | | |
 [sounds almost angry at this point as 1322 |-\$ | | | | | | |
 emphasising all words] I'd done it, I 1323 | | | | | | |
 was doing it... 1324 | | |-* | | | | |
 -# | | | | | | |

Me: Ummm 1326 | | | | | | ~-

#-KNOWITALL #-PRACNOACAD \$-OTHERS \$-LACKSUPPOR \$-HORIZ VIOL
 Participant: because they would then say 1328 -#-\$ | | | | | | |
 'oh well, she's an E grade staff 1329 | | | | | | |
 nurse, she's trying to better herself, 1330 | | | | | | |
 who does she think she is, she even, 1331 | | | | | | |
 she even asked me' - because someone 1332 | | | | | | |

*-UNSUPPORT *-SELFPAID
 fed back to me, a G grade fed back to 1333 | | |-* | | | | |
 me, no an E grade had fed back to me 1334 | | | | | | |
 and said - 'you had said to a G grade 1335 | | | | | | |
 what nursing magazine do you buy?' and 1336 | | | | | | |
 they didn't like it... 1337 | | | | | | |

Me: Umm 1339 | | | | | | |

Participant: ...and all I could say, in 1341 | | | | | | |
 all innocence was I just wanted to 1342 | | | | | | |
 know so I could swap magazines... 1343 | | | | | | |

Me: Ummm 1345 | | | | | | |

Participant: ..but that was seen as 1347 | | | | | | |
 'wow! she's been and done her 176, who 1348 | | | | | | |
 is she?!' And with that, I thought 1349 | | | | | | |
 right I'll do the counselling, and I 1350 | | | | | | |
 won't tell anybody, and I did that 1351 | | |-* | | | | |
 -# | | | | | | |

#-ROCKBOAT
 Me: You didn't want to rock the boat 1353M -# | | | | | | |
 then? 1354 | | | | | | |

Participant: I... There's no point, 1356 | | | | | | |
 because if you rock the boat, the 1357 | | | | | | |
 messages get to the surgeons, the 1358 | | | | | | |

surgeons give you a hard time at the	1359				
table, and if they, if you tell me	1360				
they don't, it, it happens in these	1361				
parochial outside places...	1362				
Me: Ummm	1364				
Participant: ...because of the	1366				
organisational dynamics which [sigh]	1367				
we're talking about now, but the	1368				
organisational dynamics. It happens.	1369				
And that also happened with education	1370				
and development and learning..	1371				
Me: Uh huh	1373				
Participant: ...yeah	1375				
		-#-\$-%		-@-^	
#-CULTURE #-PROMOTE #-CHOSENONES #-BARRIERS #-MANAGERATT #-INHIBITPRO					
\$-FACEFITS					
Me: So.. I've forgotten what I was going	1377	-#-\$			
to say now...So, it's all um, about	1378				
the culture in which you work then	1379				
isn't it, and your face fitting?	1380				
*-CHOSENFEW @-INEQUALITY					
Participant: Yeah, as we discussed	1382			-* -@	
before about equal ops. Um, it just,	1383				
it just depends on who you are, and	1384				
what you are...	1385				
Me: Ummm	1387				
Participant: ...because people complain	1389				
to me and say, 'well, you know, um...	1390				
I've been allowed to do this course...	1391				
%-PLAYGAME					
and that's it', and yet there are	1392			-%	
other people....- where we work -...	1393				
Me: Ummm	1395				
Participant: ... are allowed to go on	1397				
many, many things...	1398				
Me: Uh huh	1400				
Participant: ... master modules...and,	1402				
and tribal...	1403				
Me: Uh huh	1405				
Participant: ...and that equal	1407				
opportunity has not been given to	1408				
other people	1409				
Me: Ummm	1411			- \$	
Participant: ... and that is because..	1413				
these people are seen to be doers...	1414				
Me: Uh huh	1416				
Participant: ... but when you critically	1418				
evaluate these people..[pause]..they	1419				
haven't... they sometimes are not	1420				
\$-LACK DIREC \$-PPDR \$-UNAWAREOPS \$-LACKPR					
connected with what is going on. So,	1421			- \$-%-*	
I think a manager should have,	1422				
perhaps, on one occasion, that I can	1423				
think of with regards to equal opps,	1424				
and people have this..an equal	1425				
opportunity to, to access study days	1426				

and courses... 1427 | | |

Me: Ummm 1429 | | |

Participant: ...for example tribal, um 1431 | | |

perhaps people should have been asked 1432 | | |

who were interested in doing it, if, 1433 | | |

if it wasn't identified in a PPDR, and 1434 |-\$ | |

again, looking at this knowledge and 1435 | | |

skills framework, which, we're still 1436 | | |

-\$-OPPORTUNIS %-STAFFING %-WAITTURN

trying to decipher. If people 1437 |-\$-% | |

expressed an interest, those people's 1438 | | |

names should have been put in a hat... 1439 | | |

Me: Ummm 1441 | | |

Participant: ...and then said 'well, you 1443 | | |

name's been drawn out for next time. 1444 | | |

We'll see what the, what the take up 1445 | | |

is... 1446 | | |

Me: Ummm 1448 | | |

Participant: ...and you, you could go on 1450 | | |

the 3rd cohort'. And that's how it 1451 | | |

should have been done 1452 | |-\$ | |

Me: Rather than being in the right place 1454 | | |

at the right time? 1455 | | |

Participant: At the right time yeah, and 1457 | | |

that's what it's about. Same with 1458 | | |

managers - right place at the right 1459 | | |

time 1460 | | |

Me: Uh huh 1462 | |-\$ | |

-\$-FACEFITS \$-PLAYGAME

Participant: And if your face fits, and 1464 |-\$ | |

if you.. if you toe the line.... If 1465 | | |

you don't toe the line..they'll get 1466 | | |

rid of you 1467 | | |

Me: Ummm? 1469 | | |

Participant: Yeah, and that...I know 1471 | | |

that happens in all walks of life 1472 |-\$-#-\$ | -@

#-SUPPORT #-PROCESS \$-TELLNOONE \$-SECRETSTUD \$-DENYSUPPOR \$-OTHERS

-\$-NURSE \$-LACKSUPPOR

Me: Ummm. Just going back to this 1474 |-\$-#-\$ | |

counselling... What sort of support 1475 | | |

did you get whilst you were doing it, 1476 | | |

if you were doing it completely on 1477 | | |

your own? 1478 | | |

%-MENTOR %-COLLEAGUES

Participant: Umm... I didn't get any 1480 | |-\$ | |

support in my work place. I got 1481 | | |

support from... er, my supervisor, who 1482 |-\$ | |

was an employee... at my, at my Trust, 1483 | | |

my past Trust. He was an employee, 1484 | | |

um... in the same Trust, and he was 1485 | | |

very much connected, because he was 1486 | | |

doing his masters in counselling... 1487 | | |

Me: Ummm 1489 | | |

Participant: ...so he was my supervisor, 1491 | | |

and under the er British Association 1492 | | |

for Counselling Services, for every 1493 | | |

um.. for every 24 hours of counselling 1494 | | |

that you deliver, you yourself should	1495			
have 1 hour supervision	1496			
Me: Right	1498			
Participant: So that's the support I	1500			
got...	1501			
Me: Uh huh	1503			
Participant: .. from my supervisor.	1505			-%
\$_UNIV \$_TUTORS				
Supervision from my tutors at um xxxx	1506			-\$
[place where P14 did her counselling]	1507			
%-COLLEAGUES %-MENTOR				
and personal supervision.. from my	1508			-%
supervisor.. That's what I got	1509			-%
				-\$
\$_RELATIVES				
Me: Uh huh. What about at home? Did	1511M			-\$
your husband support you?	1512			
%-FINANCIAL				
Participant: He supported me um...	1514			-%
[pause]... in the way of he encouraged	1515			
me, as far as finances were concerned,	1516			
he encouraged me. um...he didn't like	1517			
me to counsel him!	1518			
				-%
Laughter	1520			
%-HELPSHED %-CHILDCARE				
Participant: Um... but I think where I	1522M			-%
got real support from my family was	1523			
when I was doing the 176 and the 998,	1524			
because I had to leave on Sunday..	1525			
Me: Uh huh	1527			
Participant: ...to attend for Monday,	1529			
and come back late Thursday night	1530			
after lectures, and then... During	1531			
that week, as my children were still	1532			
in er junior school - end infant and	1533			
junior school, they were all small -	1534			
so my husband was doing the washing	1535			
because, because I was away..	1536			
Me Uh huh	1538			
Participant: ... I lived in the nursing	1540			
home, and my husband did the washing,	1541			
the cooking, the ironing, the	1542			
shopping.. He did everything, and he	1543			
never once complained, because he saw	1544			
that I was happy, the family were	1545			
happy - although perhaps he wasn't	1546			
happy at times when he was ironing	1547			
*-INTEGRAL				
late at night time... But he gave me	1548			-%*
support...	1549			
Me: Uh huh	1551			
Participant: ...and without that	1553			
support, I wouldn't have been able.. I	1554			
wouldn't have been successful	1555			
Me: No	1557			
Participant: So, I owe a lot to my	1559			
%-OTHERSATT %-NURSE %-LACKSUPPORT				
husband and my children, um... but I	1560			-\$-%

@-ASSERTIVE ^-INC CONFID
 Usol.. you know on wounds and standing 1628 | | | | -@-^
 up and being account... all the issues 1629 | | | | |
 on accountability... 1630 |-\$ | | | |

Me: Uh huh 1632 | | | | |

\$-SELF-AWARE ~-MULDISTEAM
 Participant: ..and, and, and being 1634 |-\$ | | | |--
 self-aware. To be able to be 1635 |-\$-% | | ^ |

\$-INC CONFID %-OTHERATT %-SETINWAYS %-PLAYGAMES
 assertive and say 'no'. To have the 1636 |-\$-% | -@ |
 confidence to be able to say 'no, this 1637 | | | | |
 is not right'. And so when I came 1638 |-\$ | | | |
 back, I had to be very careful, and I 1639 | | | | |
 had to blend in and play their game a 1640 | | | | |
 little bit.. 1641 | | | | |

Me: Ummm 1643 | | | | |

Participant: ... but I also, I'd not to 1645 | | | | |

\$-INC CONFID \$-ASSERTIVE
 just shy away from that. I still had 1646 |-\$-% | | | |
 to stand up and be forthright, and say 1647 | | | | |
 'no, this is not right' 1648 | | | | |

Me: Your behaviour did change then? 1650 |-\$ | | | |

\$-PLAYGAMES \$-BACKUP %-PRACTATT %-CONFIDENCE %-WORK-GAIN %-P-T GAP
%-INC CONFID %-ASSERTIVE
 Participant: It, it.... My behaviour did 1652 |-\$-% | | | |
 change. I, I, I conformed to some of 1653 | | | | |
 the norms, and play..I played the mind 1654 | | | | |
 game with them.. 1655 | | | | |

Me: Umm 1657 | | | | |

Participant: ...because I, I had the 1659 |-\$ | | | |
 ability because i was given knowledge, 1660 | | | | |
 but I also had other... from.. other 1661 | | | | |
 studies, I was able to understand and 1662 | | | | |
 analyse organisational theory - from 1663 | | | | |
 business studies - ... 1664 | | | | |

Me: Ummm 1666 | | | | |

Participant: ... which equipped me 1668 | | | | |

Me: Right. So.. 1670 | | | | |

Participant: If I've digressed, Sue, I'm 1672 | | | | |
 sorry... 1673 | | | | |

Me: No, that's good, that's the sort of 1675 | | | | |

#-DELIVERY ^-PROCESS
 information I need, yeah. Um, do you 1676 -# -* -^
 think it's better doing a, um 1677 | | | | |
 secondment for 6 months then, or doing 1678 | | | | |
 a day release over the same period of 1679 | | | | |
 time? 1680 | | | | |

Participant: I think... I think a 1682 | | | | |
 secondment.... er... is good 1683 | | | | |

Me: Can I just stop you to turn over the 1685 | | | | |
 tape? 1686 | | | | |

Participant: Yeah, yeah 1688 | | | | |

Pause whilst I turn over the tape 1690 | | | | |

\$-SEPARATE \$-CONTINUITY
 Participant: A secondment is good, um, 1692 |-\$ | | | |