Brokering: How nurse educators manage inclusion within nurse education

Kathy Martyn
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Abstract

This thesis explores how nurse educators managed inclusion of disabled students within educational programs that lead to registration as a nurse with the professional body, the Nursing and Midwifery Council, England. Nurse education within the United Kingdom is based within Higher Education Institutions and in common with other undergraduate programs, has seen an increase in the number of applications from people who disclose a disability. Most commonly applicants have a specific learning disability, but applicants may also have, amongst others, physical, sensory impairments, mental illness, physical illness, and autistic spectrum disorders. Nurse Education has traditionally had a broad entry gate, welcoming students from diverse educational backgrounds and places no restriction on disabled people from applying to become nurses. The professional guidance simply requires that a student on completion of a program is able to work effectively in clinical practice without supervision. Using Classic Grounded Theory this study set out to understand the social processes involved as participants managed inclusion onto and within nurse education programs. This study showed that nurse educators’ main concern was that on completion of a course a student nurse is able to ‘do the job’ within the ‘real world of nursing’. The presence of a disabled student, fractured their normative thinking of what it meant to be a nursing student and required them to re-evaluate their understanding of disability, being disabled and becoming a nurse. Their beliefs about being a nurse were predicated on the nurse being ‘fit and able’ and working full time in a service that they considered to be inflexible in its working practices and unsupportive of people who differ from the ideal worker. Nurse educators work at the intersection between education and employment and this study demonstrated that societal values about the limitations associated with being disabled, and their employability remain prevalent, despite an educational culture that supports the rationale for ‘equal opportunities’. The basic social process of brokering demonstrated how nurse educators reconciled their concerns and mediated between higher education and clinical practice, to enable inclusion of a disabled student. Nurse educators justified their actions by
having a professional and educational ideology based on concepts of social justice and individual rights: and a belief that contemporary health care practice; influenced by a political economy of disability and a ‘business ’ case for health care, does not have a climate for diversity and inclusion.
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Thank you
Authors declaration

I declare that the research contained in this thesis, unless otherwise formally indicated within the text is the original work of the author. The thesis has not been previously submitted to this or any other university for a degree and does not incorporate any material already submitted for a degree.

Signed:

Dated: 30 September 2014
Chapter One

1.0 Introduction

The aim of this classic grounded theory study is to explore the experiences of nurse educators working with disabled students in Higher Education Institutions (HEI) that provided educational programs for registration as professional nurses with the Nursing and Midwifery Council (NMC). This thesis presents the emergent grounded theory which explains the means through which nurse educators resolved their concerns associated with providing an equality of opportunity and supported inclusion for all students, when working at the intersection between two organisations. In understanding the processes that nurse educators undertake, the terminology and language used reflected their professional backgrounds as educators and nurses. The use of language in this study is important, as it not only sets the tone of the research process but also reflects how individuals consider themselves and others, in the exploration of disability, being disabled and becoming a nurse.

1.1 Language of disability

In recognising the sensitive nature of exploring and understanding disability issues in the context of nurse education, it is important to clarify the terms used in this study. As a researcher, I have struggled with finding the appropriate term to refer to students, who are labelled as disabled that is neutral but conveyed the differences between differing students that are referred to by the participants accurately.

Since the development of the social model of disability¹, research by disability activists and others has predominantly considered how an

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¹ Social model of disability is the term coined by Oliver 1983 to describe an alternative model to the biomedical model that was prevalent at the time.
individual is disabled not by their physical or psychological being but society, the environment and the wider political context. As a consequence researchers who focus on individuals who face exclusion due to disabling factors; or how society considers and supports the concept of ‘equality of opportunity’ and the ‘right to access,’ have used a plethora of terms that recognise the ability and rights of the individual in what is known as ‘person first’ terminology.

In this study, I will use the term ‘disabled student’ as it is a term in common usage within higher education and identifies those students who have been identified as being disabled. Disability in this context encompasses many different factors that impact on a student’s ability to study and is based on the definitions encompassed by the Equality Act (2010). This term, as it is used within higher education, also refers to the funded support available to students through funding organisations, known as the ‘disabled student’s allowance’ (DSA); and reflects the support provision that is commonly found within the higher education sector. The reasonable adjustments or accommodations commonly provided within HEI often include things such as additional time and software to support learning in what could be considered a standardised package of support. Thus in using this term, whilst I recognise that for many being disabled is as a consequence of the wider social and physical environment, this term, as it is used within HEI, will run the risk of assuming that all people with impairments are identified as a disabled homogenous group.

1.2 Structure of this thesis

In order to guide the reader through this grounded theory thesis, an outline of the structure is provided.

Chapter two: In completing a classic grounded theory the traditional literature review, which sensitises the reader to the research area and established the research question is absent, a grounded theory does not
incorporate extant literature until the emergent theory has formed (Glaser 2008). However, in keeping with the requirements of a doctoral thesis at the supporting University, it does commence with a generic overview of disability, disability studies, higher education and nurse education. This captures my knowledge, by virtue of my job role, of current disability issues within the public domain and higher education. In doing so it provides the background contextual information that underpins the positioning of disabled people within the 21st century and the legislative processes that regulate and guide professional nursing, education, work and society in general, but will not focus on the issues being researched. In keeping with the selected methodology, this chapter will make explicit my 'latent' understanding of the significant drivers that have influenced my professional work and the decision to pursue this research.

Chapter three: The epistemological and methodological research issues are explored, and the rationale for the use of the classic grounded theory methodology made transparent. In particular the issue of being objective, the purpose of the secondary literature review, research rigour and credibility will be explored.

Chapter four: The research procedures and essential methodological steps used throughout the study will be described, demonstrating how the concurrent data collection and data analysis will lead to the emergence of the findings. Each of these steps is adhered to rigorously, ensuring the procedural credibility of this study.

Chapter five: This consists of the findings and the emergent categories that account for the main concerns and issues raised by the participants. In keeping with the methods and methodology used, the categories are refined, and the core category identified.

Chapter six: The emergent core category and the basic social process undertaken by nurse educators as they managed inclusion when working with disabled students studying to become nurses will be illuminated. The grounded theory 'brokering' will be discussed, and concepts compared and contrasted with the relevant extant literature. Although this theory is derived from the substantive area of nurse education, the conceptual
nature of brokering suggests it has potential relevance to other areas. It is in the discussion of the extant literature derived from other areas that will highlight the contribution of this thesis to theories that surround ‘policy’ and ‘practice’ within organisational working, professional working and employment.

Chapter seven: Will outline what this study adds to the debate about diversity and inclusion within higher education and employment recognising the limitations imposed by focussing on one professional group. It will evaluate the credibility of the emergent grounded theory and summarise its contribution to extant theory, research and practice.
Chapter two: Disability in society, education and healthcare

2.0 Introduction

The subject of ‘disability’ in society has been widely researched over the past fifty years, and this chapter positions this study within the field of disability research in general, through a generic discussion of what is known. This chapter, in keeping with the methodology of Grounded Theory (Chapter 3, section 3.4), is not an extensive review of the literature on the substantive area being explored. Instead, this chapter will through literature, delimit the context within which this study is based by charting significant contextual features; and lead towards an explanation as to why it is timely and relevant to explore how nurse educators work with an increasingly diverse student population.

The literature review will begin with an exploration of the term ‘disability’ and how ‘models’ of disability have shifted over time. It will then review how models of disability have influenced legislation, higher education and employment. Finally, it will consider disability in the context of nurse education and nursing practice.

2.1 Definitions and Models of Disability

Defining disability is conceptually difficult (Grue 2011) as researcher’s grapple with describing the differences between disability, impairment and handicap, and the relationship between ‘disability’, the individual and society (Barton 2005, Shakespeare 2006, Oliver and Barnes 2012). A model of disability arguably requires the construction of a disability identity and the identification of what cultures consider normal, the values and beliefs associated with normality (Barnes and Mercer 2010). Gleeson (1999) has suggested that throughout human existence people with impairments have been variably included or excluded from the mainstream of community life, depending on the society’s cultural values.
and beliefs. In this manner multiple models of disability (Barnes 2000) have been developed and, whilst none claim to be definitive or to be theoretical models; each has had the capacity to impact on all facets of disabled people’s life and the legislative frameworks within which people live.

Over the past seventy-five years, the different models in common usage have considered the biomedical, social and political aspects of disability or living with a disability. Sociological research and the concept of disability and its association with illness and health were strongly influenced by the work of the seminal sociologist Parsons, (1902-1979). Parsons (1951) used a functionalist approach to analyse illness-related behaviour and the role of the medical profession in society. In his account of social order through the individual performance of social roles he identified the concept of the ‘sick role’ as a form of legitimised deviance and in doing so Parsons effectively defined health as ‘normal’ (Parsons 1951). Health was, therefore, championed as a stable state that underpinned role capacity and the social order of the community, whereas illness was disruptive and created an imbalance, which those deemed to be normal, sought to manage and control. In the ensuing research and discussion that has surrounded the concept of disability; two models of disability have emerged as key to how disability is seen in society: the biomedical model and social model of disability. Although the social model is preferred and underpins the equality legislation within the United Kingdom, Parson’s medical perspective has influenced social and health care, fuelled in part by the power of the medical establishment. However, the limitations of the simple binary division between health and illness is increasingly evident as it does not satisfactorily explain the impact of acute and chronic illness, or consider that impairment and illness may be distinctly different concepts.

In the biomedical model, disability is seen as a deficit or problem of the individual and it is this deficit that limits individual achievement. The biomedical model sees disability as a tragedy to the individual which Oliver (1996) argued positioned disability in health terms as a pathology and in welfare terms as a social problem. In this model, the disabled
person is expected to make the best of their situation through individual adjustment and to develop coping strategies under the guidance of an appropriate professional (Finkelstein 1993). The language of disability in the biomedical context is one of limitation, disability and handicap. In the absence of a cure, these are seen as permanent static states and the disabled person becomes identified and distanced from those without impairments. The biomedical model thus fuelled a common sense understanding of the limitations associated with being disabled and positioned the individual as the passive recipient of ‘favours and support’ (Morris 2011). In addition it defined the eligibility criteria for financial support through the benefits systems, exclusion from the workplace due to environment and social barriers, and perpetuated a view in society that the accommodation of the disabled is only made possible through the actions of the non-disabled majority.

In contrast the social model of disability which, whilst not denying the impact of the inherent disability on individuals, looked to the way in which society limited the opportunities for individuals to participate in social and economic activities, and as such created a dependency, a state of disablement. Pfeifer (2001) argues that there many different interpretations of the disability paradigm within the social model each stemming from different ontological and epistemological roots, with two the social model of the United Kingdom, and the oppressed minority model - being the ones most commonly used.

The social model was a term coined by Oliver in 1983, when he described the distinction between impairment and disability made by the Union of the Physically Impaired Against Segregation (1976) as ‘the individual and social model of disability.’ Since its inception, the social model has been influential in the political understanding of disability and the language of the legislative frameworks and disability policy within the United Kingdom and the developed world. The social model of disability is cited within all recent (post-1980) UK disability legislation and is commonly described as the rationale that underpins current disability policy. In all public institutions, for example, it is a requirement that the organisation can demonstrate how they have considered the social model of disability in
the daily management of their services. In this model, disability is not the attribute of an individual, but a constraint that is created by the social environment that perpetuates the isolation of people from full participation in society (Oliver 2004). Critics of the social model as it most commonly used (Shakespeare and Watson 2001, Gabel and Peters 2004) argue that whilst it addresses some of the failings of the biomedical model, it fails to address the reality of the individual experience. In a society, few people can claim full independence, by the very nature and way a society is formed, but of having interdependence through which their collective cultures function (Shakespeare 2006).

Dissatisfaction with the biomedical definition of disability and its focus on ‘ill health’, and the social model which disembodies the individual, had led to the continued search for alternative ways of framing the experience of disabled people. Alternative models such as the ‘impaired model’ (Mulvany 2000, Hughes and Paterson 1997) and the ‘rehabilitation role’ (Safilios-Rothschild 1970) emerged in response to the individual experiences of people who are defined as being disabled. Hahn 2002 and Mitra 2006 both developed the underpinning concepts of the social model of disability through their descriptions of the oppressed minority model. In which they argued that a person with a disability faced discrimination and segregation through sensory, attitudinal, cognitive, physical, and economic barriers. As such being disabled is similar to those of an oppressed minority group. As a consequence people with disabilities suffer ‘extraordinarily, high rates of unemployment, poverty and welfare dependency; school segregation; inadequate housing and transportation; and exclusion from many public facilities’ (Hahn 2002 page 171).

These models attempted to extend the biomedical approach to encompass the ‘differences’ experienced by individuals who did not fit with the Parsonian perspective of ‘health’, and took into consideration the impact of society on personal functioning. The impaired and rehabilitation models of disability position the individual as accepting that they are unlikely to recover and that being dependent is a permanent state. Whilst both the impaired and rehabilitation models suggested that an individual must live in a given state; they recognised how capability and function
could be enhanced by society. However, neither provided a full understanding of the concept of disability, and the contribution disabled people make to society.

More recently contemporary researchers such as Grue (2011) and Shakespeare (2009) are influencing contemporary literature in an emerging re-alignment of the medical and social model of disability. In this manner a ‘new way’ of thinking about disability that does not negate the embodiment of disability within the individual, nor the impact of society as a disabling entity, but focusses on the reality of the individual experience of disability is being developed. This coming together opens up opportunities for the emergence of new research and new dialogues that recognise the experience of the person.

Current disability research is influenced by the failure to adequately understand the lived experience of the individual and by disability activists’ dissatisfaction with what is known about the lives of people with disabilities, and how people with disabilities are portrayed in society (Albrecht et al. 2001, Olive and Barnes 2012). People with disabilities are increasingly more visible in public life, featuring in mainstream television and driving their own research agenda. Within the field of disability research, there is increased activity by people with disabilities and a shift away from the passive acceptance of how they are portrayed by able others. This activity highlights how the concept of disability continues to be influenced by culture and environment, and that an adequate conceptual definition will require a broader more nuanced approach (Thomas 2007, 2004).

These shifting definitions of disability in society reflect the ever-changing context in which people function. In recent history, Oliver and Barnes (2012) argued that the politics of disablement was strongly influenced by the industrial revolution as an agrarian economy was replaced with industrialisation. As a consequence, the capitalist ideology in the 19th- and 20th centuries reinforced the social creation of ‘disability’ as an individual medical and social problem. The political and economic climate of the 21st century continues to challenge the concept of disability. The
emergence of new social and economic policy, in response to the increased need for ‘fiscal prudence’, challenges how disabled people are portrayed in society, and how they are supported by the state. In this way, disabled people are positioned as either being a drain on resources through the benefits system or needing additional support in mainstream life including education and work. Barnes (2003) argued that

“The pursuit and maximisation of profit and competition between individual workers, disables people with any form of perceived functional limitation/impairment, whether physical sensory or intellectual, and the more overt the impairment, the more severe the disadvantage or disability”. (Barnes 2003 page 2)

Oliver and Barnes (2012) continue to argue that the dominant meanings attached to disability today, despite ‘a radical reappraisal of the meaning of disability by disability activists’ (page 11), reflect the view that disability in society is predominantly a health issue and that disabled people are ‘empowered’ only by the acts of the able majority. The concept of ‘personal tragedy,’ as implied by the biomedical model, has had a significant and lasting influence on social policy and how individuals with a disability are seen in society. This apparent ‘common sense’ understanding of disability has changed little despite the obvious abilities of disabled people within society. Grue (2011) argues that in spite of new equality legislation, the concept of disability as ‘personal tragedy’ continues to remain a potent explanation of public understanding of disability today.

2.2 Disability Policy and Legislation

The growing awareness of the principles of equal rights that is epitomized in critical disability studies reflects a developed world that has increasingly recognised the inherent inequality amongst individuals within society that has prevailed through recent history. Since the 1980’s, there has been a systematic shift towards greater inclusion and recognition of

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2 It is recognised that much of the critical disabilities discourse is situated in the Western developed world and may not reflect the dialogue or discourse in developing countries or other cultures.
minority and marginalised groups. For example, an endorsement in statute of the rights of woman and ethnic minority groups in the 1970’s, the ending of Apartheid in South Africa in the 1980’s and the Civil Partnership Act 2004 recognising the rights of same-sex relationships.

This shift in emphasis towards inclusion and recognition is evident in both education and employment throughout the developed world. The need to reconsider and revisit current definitions of disability has been fuelled by the emergence of the active voice of disabled people in the United Kingdom (UK) and the world, as they increasingly demand that their voice be heard not just in research and engagement with research, but also in the everyday understanding of disability by non-disabled and disabled people alike.

In the UK, the shift towards being more inclusive can be traced back to 1944 Education Act, which acknowledged the integration of children with disabilities in education. However, it was not until sometime after the 1978 Warnock Report on Special Educational Needs, and the 1980 Education Act, that a gradual reduction in the segregation of children away from mainstream schooling was evident. In 2001, the implementation of the Special Educational Needs & Disability Act (SENDA), required Local Education Authorities (LEA) to place a child with special educational needs (SEN) in mainstream schooling, unless it was incompatible with efficient education or against the wishes of the parents. More recently the change in SEN funding within schools (DfE 2012) whereby ring-fenced, funding for support has been withdrawn for the majority of pupils, sends a message that learning opportunities for all pupils is based on inclusive provision and educational practices. This inclusive educational approach aims to improve the learning opportunities of those who previously would have received additional funded support through SEN funding and also the needs of the gifted and talented, which many consider have become neglected, as the focus had been on supporting the pupil who struggled. At its core is an assumption that educational provision for all within the state-funded system is based on the premise that inclusive practices and equality of opportunity are ‘rights’ and as such embedded within educational systems.
A similar response to improving the life opportunities for people with disabilities was evident in employment following the 1944 Disabled Persons (Employment) Act, which recognised the right for paid work by disabled people. However, by 1989, the government Office of Population Censuses and Surveys (OPCS) of disability found that only thirty-four percent of disabled people under pension age living at home were working (Martin, White and Meltzer, 1989). Since then, although disabled people are seen in employment and in significant positions within society, people who achieve positions of influence are, much like those without disabilities, considered to be ‘exceptional,’ gifted and talented. Whilst for the ‘exceptional’ few their inclusion within the workplace is evident, for many disabled people barriers to work opportunities and career aspiration still exist. Berthoud (2011) suggests that the position of disabled people in the workforce remains problematic and that the workplace has changed little. Despite an improving trend in the employment alongside that of other marginalised groups such as women, the gap between non-disabled and disabled people in employment remains high (ONS 2012). In the current economic climate some disabled people increasingly see themselves and are seen by others, as permanently unable to work; despite the new emphasis on disability rights in public discourse (ONS 2014)

In 1995, the Disability Discrimination Act (DDA) came into force in the UK protecting the rights of the individual by making it illegal to discriminate against people with disabilities. The DDA defined a person with a disability as:

“A person with a physical or mental impairment which has a substantial and long-term adverse effect on a person’s ability to carry out normal day-to-day activities. This includes people with:

- Mobility impairments
- Sensory impairments, such as those affecting sight or hearing
- Mental impairments including impairments relating to mental functioning such as learning disabilities
- A clinically well-recognised illness including mental illness recognised by a respected body of medical opinion
- People who have had a disability within the definition, but have since recovered” (DDA1995).
Between 1995 and 2006, the DDA Act was sequentially amended to encompass the changing world view of disability in society and the ongoing disability discourse that increasingly made the voice of the individual heard. Firstly in 2004, the DDA made it unlawful to discriminate in the employment of disabled people, and finally in 2005 the Act was extended to include progressive conditions such as HIV and Cancer, and to make it unlawful for public bodies to discriminate against disabled people. The amendments in 2005 included a new duty on public authorities, requiring them to eliminate harassment and unlawful discrimination against disabled people; to promote positive attitudes towards disabled people; to encourage participation by disabled people in public life, and to promote equality of opportunity (DDA 2005).

More recently, further extension of disability legislation in the UK, has led to the 2010 Equality Act that effectively brought together all Equality legislation including the Disability Discrimination Act 1995, and its amendments 2005, 2006. The overarching aim of this new legislation is to ensure individuals are not discriminated against and that their life opportunities are not lessened by virtue of their health, gender, race, or disability. It identifies nine protected characteristics (Box2.1) and requires all public bodies, including education and health, to demonstrate their inclusivity and to provide opportunities for all to achieve their potential.
Age
Where this is referred to, it refers to a person belonging to a particular age (e.g. 32-year olds) or range of ages (e.g. 18 - 30-year olds).

Disability
A person has a disability if s/he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.

Gender reassignment
The process of transitioning from one gender to another.

Marriage and civil partnership
Marriage is defined as a 'union between a man and a woman.' Same-sex couples can have their relationships legally recognised as 'civil partnerships.' Civil partners must be treated the same as married couples in a wide range of legal matters.

Pregnancy and maternity
Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.

Race
Refers to the protected characteristic of Race. It refers to a group of people defined by their race, colour and nationality (including citizenship) ethnic or national origins.

Religion and belief
Religion has the meaning usually given to it, but belief includes religious and philosophical beliefs including lack of belief (e.g. Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.

Sex
A man or a woman.

Sexual orientation
Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.

Box 2.1 Nine Protected Characteristic and Definitions Adapted from Equality and Human Rights Commission Guidance Equality Act 2010
The continued development of government policy and legislative reform to address the needs of the individual has led to the UK’s adoption of the United Nations (UN) Convention on Disability Rights and the appointment of a Minister for Disabled People (ODI 2012). However, whilst policies for promoting equality of opportunity are evident; welfare and fiscal reform continue to challenge the development of an inclusive society. The Welfare Reform Act 2012 with the introduction of universal credit and removal of the disabled living allowance may contribute to the further divide between those with a disability and those who are non-disabled in society. At its core is a focus on limiting the reliance on benefits and the move towards promoting employment. The coalition government’s stated aim being to make it financially beneficial to be in employment (Joseph Rowntree Foundation 2014)

### 2.3 Disability and Higher Education

Embedded within the requirements of the Equality Act 2010, is the public sector equality duties within which public bodies are required to ‘take steps not just to eliminate unlawful discrimination and harassment, but also to actively promote equality’ (EHRC 2012). The public sector equality duties cover all nine equality strands: age, disability, gender, gender identity, race, religion or belief, and sexual orientation. The Equality and Human Rights Commission (EHRC) describe the single public sector equality duty as requiring public authorities to:

- **Eliminate discrimination, harassment and victimisation.**
- **Advance equality of opportunity.**
- **Foster good relations.** (EHRC 2012)

Higher Education Institutions (HEIs) within the UK are committed to supporting widening participation. Current statistics suggests that the widening participation programs have been successful with as a many as seventy-three thousand, one-hundred and thirty-five disadvantaged students studying courses within HEI (HESA 2012/13). As a consequence, HEIs provide a range of support services for all students that focus on enabling inclusion. Although widening participation programs
have focussed on socially disadvantaged students, the focus on being inclusive is also reflected in the inclusion and support of disabled students. In England, HEI’s have funded student support through central University money and students accessing the disabled students allowance through Student Finance England (SFE) or specific professional funding bodies such as the NHS bursary unit. However, increasingly HEI’s are being asked to provide support for all students through their core budget as fiscal reform of the disabled student’s allowance is being considered.

2.4 Nursing Education in Higher Education and Healthcare

The education of nursing students and the provision of effective health care service do not occur in a vacuum. Moreover, alongside the policies associated with the provision of health care and professional education, are the social policies associated with the rights of the individual within society, education policy, fiscal policy, and employment policy. Higher Education and Healthcare environments are examples of complex public organisations that are constantly changing and adapting to new situations, as they respond to internal and external influences from government policy, to the changing demands of society and public expectations of service provision. The influence of the public debate on the development of a diverse and inclusive healthcare workforce and the political debate on how to manage an effective healthcare service with finite resources bring into sharp focus the role of nurse education in its stated aim to produce well-educated competent registered nurses.

The key internal and external influencing factors that impact on the environmental context of higher education and health care are summarised in the diagram 2.1.
Diagram 2.1 The major internal factors for higher education (HEI) and National Health Service (NHS) are identified surrounded by major external factors that influence organisational function and processes.

The Department of Health (DH) in their strategy document *Liberating the NHS: Developing the Healthcare Workforce from Design to Delivery* (2012a) summarised the relationship between education and health care by stating that

“The continuing success of the healthcare and public health systems is dependent on partnerships with higher and further education…Therefore, the mutual dependence of health, education and research means a strong working relationship is essential” (DH 2012a page 8).

This partnership working, and mutual collaboration between organisations and between individuals becoming a core strategy to ensure that education, healthcare and health care practices remain at the forefront of practice development and reflect the needs of contemporary service.

In the DH vision for education and training, five key domains were identified (Box 2.2) linking the educational aspirations with the workforce requirements. This aspirational vision sets out to provide the benchmark through which educational provision and workforce requirements support
inclusive practices whilst ensuring the delivery of effective health care services.

1. **Excellent education**
   – Education and training are commissioned and provided to the highest standards, ensuring learners have an excellent experience and that all elements of education and training are delivered in a safe environment for patients, staff and learners.

2. **Competent and capable staff**
   – There are sufficient health staff educated and trained, aligned to service and changing care needs, to ensure that people are cared for by staff who are properly inducted, trained and qualified, who have the required knowledge and skills to do the jobs the service needs, whilst working effectively in a team.

3. **Adaptable and flexible workforce**
   – The workforce is educated to be responsive to changing service models and responsive to innovation and new technologies with knowledge about best practice, research and innovation that promotes adoption and dissemination of better quality service delivery to reduces variability and poor practice.

4. **NHS values and behaviours**
   Healthcare staff have the necessary compassion, values and behaviours to provide person-centred care and enhance the quality of the patient experience through education, training and regular Continuing Personal and Professional Development (CPPD), which instils respect for patients.

5. **Widening participation**
   – Talent and leadership flourishes free from discrimination with fair opportunities to progress & everyone can participate to fulfil his or her potential, recognising individual as well as group differences, treating people as individuals, and placing positive value on diversity in the workforce, and there are opportunities to progress across the five leadership framework domains.

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Within this vision, the rhetoric of the equality and diversity debate is enacted through recognising that widening participation is a key strategic aspiration in ensuring the workforce reflects the society it serves.

The relationship between the aspirations of the NHS and service provision, in the education of health care workers, is made concrete
through the Local Educational Training Boards (LETB) who are charged with ensuring that they

“Align education to the service vision and educate nurses, midwives and health visitors to use their professional judgment about what is right for patients and families.” (DH 2012b page 15)

An educational contract forms the framework for collaboration and agreement, with each organisation (HEI and NHS) assuming responsibility with resourcing different contractual elements. Within this contract, nursing students follow a designated educational route through higher education and clinical practice. This route includes theoretical input delivered by higher education and a range of clinical based, educational and practical experiences provided by health care providers to facilitate the development of clinical competence. The combination of these two elements provides the student with the opportunity to meet the professional requirements that lead to registration with the professional body, the Nursing and Midwifery Council (NMC). The NMC set the standards for nurse education and stipulate that for registration a minimum of two thousand three hundred hours should be completed both in ‘theory’ and in ‘practice’ (NMC 2008)

Nurse Education in the United Kingdom (UK) is located within the context of Higher Education. The educational programmes are designed to meet the requirements of the professional body, the Nursing and Midwifery Council (NMC) and the academic requirements of individual Higher Education Institutions (HEI). In general, courses that lead to professional registration are three years in length and since 2011 all courses are at a degree level. In addition whilst HEI’s set their academic entry requirements, all institutions offering pre-registration courses must ensure students achieve the competencies for entry onto the Nursing and Midwifery register (NMC 2010a).

In 2011-12, Higher Education Institutions in England provided education for 12,000 nursing students (Multi-Professional Education and Training (MPET) 02B - Non-Medical Education and Training [NMET] Commissions, 2002/03 to 2011/12), as an integral part of the strategic workforce planning for Nursing in England. Although numbers of students at each
HEI vary, on average, HEIs contracted to provide pre-registration education, will have annual intakes of one hundred and fifty students.

The legislative framework, culminating in the Equality Act 2010, impacts on Higher Education Institutions (HEI) and the provision of Nurse Education programs, as both the educational establishment and the professional body are required to meet their public duty obligations as defined in the Act.

The inclusion agenda and the shift towards a more inclusive society that welcomes disabled people in education and employment are evident in the numbers of disabled people applying to study in HEI. General statistics on students applying to HEI’s, provided by UCAS, identified that thirty-four thousand, six hundred and twenty-five students disclosed a disability at application and were offered places for courses starting in 2011 (UCAS data set 2013). This data suggests that in the five years up to the academic year 2013 there had been an increase of over fifty percentages in the number of applicants disclosing a specific learning difficulty (SpLd). There is also a tripling of the number who disclosed a mental health difficulty or as being on the autistic spectrum (UCAS data set 2013). In 2005, the Nursing and Midwifery Admission Service\(^3\) (NMAS) reported that of twelve and half thousand nursing students, thirteen hundred (1300) disclosed a disability at application. It would be reasonable to suggest that as the number of nursing students has remained relatively constant over the period 2005-13 that in 2013, a similar increase in the number of students disclosing a disability is evident within the nursing student population.

However, although this number reflects those that disclose at application, it may not be accurate as there is no obligation, in law, for students to disclose a disability on the application to the course. Wright and Eathorne (2003) discussed in their review that many nursing students are reluctant to disclose a disability as they are fearful of the potential repercussions. Non-disclosure they suggested is linked to the student’s apprehension.

\(^{3}\) NMAS was merged with UCAS for all applications in 2008
about how this will be received by the HEI, and within health related courses in particular (Quinn et al. 2009). Students' being concerned that the disclosure may jeopardise the offer of a place on the educational program and opportunities for subsequent employment in health care.

The Equality Challenge Unit (2012) highlighted specific factors, identified by Rose (2005) that would influence an individual’s decision on disclosure, including the following:

“Identification with the term ‘disabled’ which, for a number of reasons, may not be a term adopted by all those with disabilities.

Confusion regarding what constitutes a disability under the Disability Discrimination Act

Disabled individuals may feel their disability is not relevant to their job or studies, so may consider there is no reason to disclose it.

Concerns relating to discrimination and culture in the institution.

Lack of opportunities for individuals to disclose throughout their career or student life, not just when they join an institution.

Poor design of equality monitoring forms used to invite disclosure of disability status – these may fail to provide a clear definition of disability, explain what support mechanisms are available, or use social model terminology.” (Rose 2005)

The reluctance to disclose a disability and the prevalence of ‘disabilities’ within the general student population would suggest that the true number of disabled students undertaking nurse education is greater than the number disclosed during the application process. Within one local HEI, academic and student support staff, anecdotally report that during a three-year pre-registration nursing program a significant number of students will disclose a disability during their period of study. This disclosure is often in response to poor performance on the course or in the appeals process; following a failure and decision to be withdrawn from the course. Personal discussions with colleagues at professional meetings, attendance at conferences and the formation of a professional group representing ten universities delivering nurse education, Disability in Professional Practice Special Interest Group (DiPPSIG), would support this view.
At the researcher’s place of work, the annual monitoring process had identified an increase in the number of students supported by central university services and an increase in the applications for disabled students allowance (DSA) in the academic year 2010-11. There was also an increase in the use of mitigation (information to support not achieving the standards required) for poor performance related to disability, and an increase in the number of ‘variation of assessment methods’ (VOAM) forms received by the school.

The requirements of HEI to meet their legislative obligations in the education of students and, in the context of nursing, the requirements of professional bodies and NHS to support the inclusion of disabled people, is likely to lead to more disabled applicants considering nursing as a potential career.

2.5 The role of nurse educators

The provision of education within HEI (the theory component) and clinical experiences within health care settings (clinical practice/practice learning opportunities) are managed through nurse education by administrative and educational processes. Central to this process are lecturers, who have an NMC recognised professional registration (NMC 2010b) and are responsible for the delivery of the educational programs and support of students. The role of the nurse lecturer in nurse education has been subject to much debate since the transfer of nurse education into HEI (Barrett 2007). This debate centres on their roles within academia and their relationship and roles with clinical practice. As a result a plethora of different role titles have emerged including nurse lecturer, nurse educator, clinical educator, personal tutor, practice facilitator, and personal development tutor, which have attempted to capture the essential roles within education. Some roles such as ‘personal tutor’ are common within HEI whilst others such as clinical educator focus on the clinical elements which are considered to be essential in education nurses (Newton and Smith, 1998; DH, 1999; McSherry et al, 2012; NMC, 2010.) Braine and
Parnell (2011), Ramage (2004) argued that nurse educators had multifactorial roles that reflected the differences between the jobs and roles in education and health care organisations (McArthur-Rose 2008). The roles for nurse educators have been described in four key areas research, teaching, clinical and management. In these areas, nurse educators must have clinical credibility (Topping, 2004, 2009; Bradbury-Jones and Taylor 2011), provide pastoral support of students in academia and clinical practice (Aston and Molassiotis, 2003; Gilmour et al., 2007; Smith 2007; and manage attrition and retention (Deary et al 2003; Bowden 2008; RCM, 2011; DH 2006; McIntosh et al. 2013).

These complex, multifactorial roles commonly culminated in the nurse educator acting as a personal tutor to individual or groups of students (Thomas, 2006; Stephen et al., 2008: Braine and Parnell 2011; Knight et al., 2012, Gardener and Lane, 2010). In doing so, the level of support provided by nurse educators was predetermined by a contractual relationship between their employers (as their job role) and their role specification. In this ‘pastoral role’ they developed an important interpersonal relationship that influenced the student experience (Bowden 2008); role modelled elements of care and caring (Hall, 2010; Dobinson-Hammington, 2006) and supported failing students (Litchfield, 2001).

The literature suggests that nurse educators continually balanced the demands of education and practice and that there was a general level of student support, endorsed by the NMC standards for education (NMC 2010). Commonly in the standards required to provide nurse education, nursing students could expect the following:

- **Students on nursing courses would be supported through their academic and practice development.**
- **Students on nursing courses would be in receipt of pastoral support that would foster a positive teacher-student interaction and that viewed students as people in need of care.**
- **Students would become increasingly independent as their knowledge and skills developed.**

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4 The term nurse educator will be used throughout this thesis to describe the role of the participants who engaged in this study
Nurse educators are also involved in the recruitment, selection of students onto courses that culminate in entry onto the register with the NMC. Decisions made by nurse educators during the application and interview process determine whether a candidate (with or without a disability) will commence a course leading to professional registration with the NMC. The decision and actions of nurse educators at this stage, acting as gatekeepers to the profession, can have a profound effect on the opportunities given to an individual and their career aspirations for the future (NMC 2010).

The number of student nurses recruited by an HEI is guided by workforce planning and the predicted requirements of local strategic health authorities in their provision of NHS services, in line with government policy. Applicants applying to study nursing in the UK have to be able to meet the academic requirements for entry to the course, have a satisfactory Criminal Records Bureau (CRB) check and be cleared as ‘fit’ through gaining Occupational Health (OH) clearance as ‘fit for practice.’ This OH clearance requires an applicant to complete a questionnaire and, if required, see the OH team who may then wish for further information from a general practitioner or another professional. This information, at the researcher’s place of work, is obtained after the applicant has been offered a place on the course. The role of the Occupational Health (OH) service is to support the NHS goal as a model employer and to support individuals in the work setting (NHS 2011). They also provide guidance on workplace adjustments for people returning from periods of sickness and those who are eligible through the legislative requirements of the Equality Act 2010.

2.6 Supporting disabled nursing students

Nurse educators are actively engaged in supporting all students within their courses and programs, through their roles as University lecturers and in their relationship with the provision of clinical experiences, that make up
fifty percent of a nursing course (NMC 2010a). In supporting disabled nursing students, reasonable adjustments to the educational programme are identified. In many HEI’s this is through central student support services with nurse educators becoming involved in establishing how reasonable adjustments are considered in all elements of a course; to ensure disabled students have equality of opportunity to achieve the professional requirements for registration with the Nursing and Midwifery Council (NMC). In the NMC Education Standards, Standard two states ‘Nursing and midwifery education must address key aspects of equality and diversity and comply with current legislation’ (NMC Education Standard 2 2010a).

Reasonable adjustments are difficult to define, but in producing guidance for HEI the Equality and Human Rights Commission (EHRC) has defined reasonable adjustment as the HEI being required to take reasonable steps to:

- Avoid substantial disadvantage where a provision, criterion or practice puts disabled students at a substantial disadvantage.
- Avoid substantial disadvantage, where a physical feature puts disabled persons at a substantial disadvantage; this includes removing the physical feature in question, altering it or providing a reasonable means of avoiding it.
- Provide an auxiliary aid where without one, disabled students would be put at a substantial disadvantage.
- You owe this duty to existing students, applicants and, in limited circumstances, to disabled former students.
- You cannot justify a failure to make a reasonable adjustment; where the duty arises; the issue is whether or not an adjustment is ‘reasonable’, and this is an objective question for the courts ultimately to determine.
- The duty is an anticipatory and continuing one that you owe to disabled students, regardless of whether you know that a particular student is disabled or whether you currently have any disabled students. You should not wait until an individual disabled student approaches you before you consider how to meet the duty. Instead, you should plan ahead and anticipate the requirements of disabled students and the adjustments that might need to be made for them. You are not expected to anticipate the needs of every prospective student, but you are required to think about and take reasonable and proportionate steps to overcome barriers that may impede people with different kinds of disabilities (EHRC 2012).
The NMC endorse the requirements of the Equality Act 2010 but have placed responsibility on the HEI to ensure they are meeting the legislative requirements. In contrast, other professional bodies such as the General Medical Council have produced more explicit guidance for medical schools with examples of reasonable adjustments developed throughout the United Kingdom (GMC 2010).

2.7 Contextual factors and the delivery of education and health care.

The impact of the wider economic climate and the debate about its impact on education and health care became evident during the period of this study. This study commenced at the beginning of an economic depression\(^5\), since which governments across the world have sought to ‘balance their books’ through austerity measures that have impacted on personal incomes, job availability and service provision. Health care and education have not been immune to these issues, and health, education and social policies have undergone reforms that are aimed at controlling expenditure whilst maximising service provision and promoting equality. Most notable are the Department for Business, Innovation and Skills [DfBIS] report ‘Securing a sustainable future for Higher Education’ (2011), Department of Health structural reform plan (2009), and the Department for Work and Pensions [DfWP] ‘Helping people to find and stay in work’ (2012).

Health care is also subject to public scrutiny, and concerns about standards of care and compassion and care were highlighted through a succession of high profile failures in the provision of care services within the UK. The scandal associated with Winterbourne View (DH 2012c) and in 2010, Stafford Hospital, and the subsequent Francis Report (2013) influenced not only how individuals viewed care but also promoted a risk-averse culture whereby considering new ways of working became tempered by concerns about maintaining standards. The subsequent Department of Health response to these high profile cases, highlighted the

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\(^5\) It is widely acknowledged that the economic depression commenced in 2008
need for service providers to be accountable for the standards of care and ensuring the workforce is of high quality and is professional (DH 2013a, DH 2013b). In addition the Willis Commission final report 'Quality with Compassion: the future of nursing education (2012) made recommendations for the improvement of nurse education, and how the commitment of LETB, HEI and employers (NHS) was essential to provide resources to support education, and enhance professional development. Together these legislative policies, reviews and reports, alongside the built environment and infrastructure, form the landscape within which nurse education and nursing practice are situated.

In 2012, three-hundred and seventy-one thousand registered nurses were employed in the NHS (NHS Confederation 2013) making them the largest occupational group in the health care workforce. Alongside the development of equality legislation, NHS Employers have produced guidance, 2011, for the development of a diverse and inclusive workforce. In this document, they have brought together a range of policy and guidance documents with their stated aim of promoting ‘equality and diversity in public sector employment’ (page 12) and having a workforce that is representative of the society that it serves. It is argued that becoming more inclusive leads to a professional workforce that is more culturally sensitive when delivering health care. The literature on diversity and inclusion within the health care workforce has predominantly focussed on race and culture, with disability and the inclusion of disabled people remaining poorly researched. The Sullivan Commission Report Atlanta USA, (2004) was titled the ‘Missing Persons: Minorities in the Health Professions’ and whilst as with much of the literature it focussed predominantly on race and culture it argued that health professional education remained ‘mired in the past and, despite some improvements, inherently unequal and increasingly isolated from the demographic realities of mainstream America’ (page 1). Where disability is addressed, as in the BMA report 2007, titled Disability Equality within Health Care, it exclusively focuses on how health care can be more inclusive in its delivery to disabled people, and not how the workforce can be developed to reflect the diverse population that is served. Dearnley et al. (2010)
considered the need for inclusion of disabled practitioners to develop a health care workforce that better reflected society, and concluded that there was a need for a cultural shift towards inclusive anticipation as opposed to reactive adjustments.

In 2007, the Disability Rights Commission had formally investigated the ‘fitness standards’ identified as being required by professional bodies for three professions, Social Work, Nursing and Teaching. In a formal investigation intolerance to disability within Nursing was related to the responses of nurse educators in participating HEI, towards students with disabilities and the implementation of ‘fitness standards,’ From their report, they identified that there was a

“Statutory requirement for ‘good health and good character’ throughout England, Scotland and Wales. There is no acknowledgment of the DDA within the legislation or regulations, and the Nursing and Midwifery Council (NMC) has only just started to address the potentially discriminatory effects of these requirements” (DRC 2007 page 6).

They also concluded that:

“Nursing as a profession seems to be particularly intolerant of disabled practitioners. This may be linked to the perception of nurses as ‘superhuman’ and a desire to maintain the boundaries between those who care and those who are cared for. Without a doubt, the Clothier report has had a lasting effect. Despite more than a decade of legal and social progress for disabled people, the perception remains that disability, particularly a mental health condition, automatically means the presence of risk” (DRC 2007 page 20).

Since the publication of the DRC report in 2007 and in response to the findings, the NMC (2010) has updated and provided new guidance to HEI providers of nurse education as to the professional requirements for ‘Good Health and Good Character.’ Within which their commitment to being inclusive and to ‘respect and value everyone for their contribution, celebrate people’s differences and provide equal opportunity for all’ (page 4) is stated. In doing so, the NMC also affirms that the profession sits within a legal framework and that any reasonable adjustment for differences needs to ensure that the student or registered nurse achieves ‘safe and effective practice without supervision’ (NMC 2010a page 8).
2.8 Research related to disability and nurse education

Research related to disability and nurse education has predominantly focussed on specific aspects of either disability or inclusion from the perspective of the student. For example, Wray et al 2011, Evans 2014; Kendall-Raynor 2010, Sanderson-Mann and McCandless 2006 have considered the experiences of students with specific disabilities such as SpLd (dyslexia, dyspraxia, and dyscalculia); sensory impairment or physical impairments. Others, Ashcroft, et al. 2008, Maheady 2006, Scullion 2010, have considered aspects of reasonable adjustment, awareness of the legislation in the context of individual students as case studies. Wood and Marshall (2010), based in the USA, completed a survey of 600 hospitals, using an Employment Attitude Scale. They explored how the concept of disability is understood in the context of education and employment, and how nurse managers in America support disabled practitioners. This study, in general, found that nurse managers were supportive of disabled students and practitioners and that support reflected their personal experiences of disability. However, the study also identified the need for a ‘study of the appropriate balance among important questions of legal mandates and fairness to nursing students and nurses in practice who have disabilities, appropriate accommodation to optimize their practice, public perceptions, and patient safety’ (Wood and Marshall 2010 p 187).

The Disability Rights Commission’s Formal Investigation into the regulation of professionals’ health in nursing, teaching and social work, Maintaining Standards: Promoting Equality published in September 2007, considered how the professional body in its guidance to its members, and in the daily work or registered nurses, had responded to the legislation. Most studies considered what professionals knew about the legislation, or the impact legislation will have on nursing practice. There has been limited research that explores the relationship between how the concept of disability, as opposed to the impact of specific disabilities, is understood by individuals in the context of nurse education, and how inclusion is managed within the professional context.
Education of professionals on health related courses encompasses both education and development of skills for employment. In doing so the course highlights the legislative aspirations associated with inclusion in education and employment, in a manner that is more explicit than many other courses where the student’s ultimate employment may not be directly related to the course studied. In professional courses, such as nursing, students must not only meet the requirements of the HEI in which the course is situated, but also the requirements of the professional body. Destination statistics, gathered from one local HEI, demonstrating 100 percent employment for students on completion of a nursing course (UB Destination Data 2010-11).

2.9 How does this study contribute to the research on disability and nursing?

Both education and employment in nursing are influenced by Equality Legislation and Professional Legislation. As such nurse educators are positioned in a pivotal role in creating equality of opportunity for disabled people who wish to be nurses. Studies in this area have considered the impact of disability on the individual student and their experiences in education and clinical practice; the support of disabled students on courses including negotiating reasonable adjustment, and how the profession promotes or does not promote equality of opportunity. However, there is limited research that seeks to understand how individuals, involved in the delivery of educational programs, navigate the potential tensions associated with disability in the context of education and the workplace, or how they enable and support disabled nursing students in the reality of professional education.

The subject of disabled students is one that is often discussed, both in formal and informal settings, within my place of work, and throughout these discussions there is often a sense of unease and concern. These concerns were also hinted at by the Disability Rights Commission formal investigation into the Fitness Standards of Social Work, Teaching and
Nursing (DRC 2007). There is limited research that has explored what underpins the DRC statement that Nursing is particularly ‘Intolerant of disabled practitioners’ (DRC page 20).

The impetus for this study arose from being sensitised to the feelings of concern and unease of nurse educators as they discussed disability and students with disabilities during the course of my work in one HEI. In these discussions, comments appeared to be guarded and limited to ‘safe areas’ as colleagues espoused their professional ideals of equality and their responsibilities to meet equality legislation and professional guidance. This thesis sets out to theorise the social processes involved as nurse educators went about their daily business of managing inclusion within the context of nurse education, and how this is informed by their understanding of the ability of disabled students to be registered professional nurses. In doing so, it will contribute to an understanding of disability and how disability is perceived in the wider context of professional education, and in particular within the substantive area of nurse education.
Chapter 3 – Methodology

3.0 Introduction

In this chapter the philosophical and selected procedural elements that differentiate classic grounded theory (CGT) from grounded theory (GT), and qualitative data analysis (QDA) are explored.

This study used the methodology of Classic Grounded Theory (CGT) as described by Glaser and Strauss (1965, 1967) and Glaser (1968). The aim of grounded theory differs from general qualitative data analysis in that instead of looking for an accurate description of the phenomena it seeks to provide a conceptual overview that is abstract of specific people, place and times (Glaser 2002), but that is grounded in the data. As such, this methodology is particularly suited to a Ph.D. thesis as it offers a means to develop original theory rather than fine tuning existing theorist work (Bryant and Charmaz 2007a). In keeping with the selected methodology, the research was to explore a ‘problem area’ (Glaser 2014) and as such no preconceived research question was identified. Instead, I set out to explore what I considered to be an ‘unknown’ area, the sense of ‘unease and concern’ that I had witnessed within one Higher Education Institution (HEI). These concerns were most evident when people were discussing students who had disclosed a disability whilst they were studying; or during discussions about the suitability of disabled applicants for nursing courses. I was interested in understanding these concerns and how nurse educators coped, addressed and responded to disabled students, as they engaged in the process of educating student nurses to produce the knowledgeable and professional workforce of the future.

As a study located within the classic grounded theory methodology, this chapter will explore the main tenets of CGT, and in particular the issue of being objective, and remaining open, when exploring a substantive area that is closely linked to my role within HEI. It will begin by outlining what is known as a ‘family’ of GT methodologies, that have arisen since it was described in the 1960’s drawing on the work of the originators, Glaser and
Strauss (1967), and the contemporary grounded theorist of the 21st Century. In this process, I will explore the ‘different’ forms and underpinning philosophies of GT and substantiate the use of CGT as the most appropriate methodology for this thesis. It will then explore how the researcher can avoid ‘forcing the data’ through preconceptions and the importance and consequences, of delaying the literature review until the substantive theory has emerged. Finally, it will consider how CGT is evaluated and the issue of academic rigour and credibility.

3.1 Grounded Theory

Glaser and Strauss (1967) suggest that the purpose of social research is to enable the prediction and explanation of behaviour; to be useful in theoretical advance of sociology and to be usable in practical applications. In meeting these aims, they argued that theory should be grounded in the data and as such theory cannot be divorced from the process, the research methods, by which it is generated (Glaser and Strauss 1967). Bryant and Charmaz (2007) have argued that as the relevance of ensuring that theory is grounded in the data has captured the imagination of qualitative researchers, GT has become the ‘most widely used and popular qualitative research method across a wide range of disciplines and subject areas’ (page 1). However, in its use it has become a widely contested concept, as it is referred to within the literature as both the result of the research process, and the research method (Charmaz 2003). In positioning this study as a CGT, exploration of these concerns and the underpinning philosophy of GT, will substantiate the use of CGT as the most appropriate methodology.

Grounded Theory was originally described by Glaser and Strauss (1967) in their book *The Discovery of Grounded Theory; Strategies for Qualitative Research*. In this book, they made explicit the analytical approach they had developed in their research Awareness of Dying (Glaser & Strauss, 1965); a study of hospital staff’s care and management of dying patients. In *Discovery of Grounded Theory; Strategies for Qualitative Research*, GT
was offered as an inductive, theory-discovery methodology that allowed
the researcher to develop a theoretical account of the general features of
a topic, while simultaneously grounding the account in empirical
observations or data. In this work, they demonstrated how by starting with
a general area of ‘concern’ they generated a substantive theory grounded
in empirical data that would work in the real world. The grounded theory
would, therefore ‘fit’ and as such have ‘grab,’ in that it is understood by the
participants and others (Glaser and Strauss 1967).

Since its emergence, the subsequent evolution of grounded theory has
led to the development of two distinct schools of thought; Classic
Grounded Theory (CGT), as described by Glaser and Grounded Theory
(GT) as described by Strauss and later Strauss and Corbin. More
recently, contemporary grounded theorist have further refined the concept
of grounded theory into what is widely referred to as second generation
grounded theory (Charmaz 2007). This positions GT within differing
methodological traditions including constructivist (Charmaz 2000),
interpretive (Lowenberg 1993), pragmatist (Locke 2001) and neo-
empiricist (Johnston 2009). The evolution of the methodology has in part
been in response to the concerns raised by the ‘need’ of novice
researchers for clarity as to the ontological and epistemological basis of
GT and the research methods, the process through which grounded
theory is completed (Heath and Cowley 2004). Mills et al. (2006)
contends that the variations of grounded theory are on a methodological
spiral which positions the different forms differently according to their
epistemological underpinnings. However, Glaser argues that as such,
each of these is in effect a remodelling of grounded theory and as such
cannot be considered as grounded theory in the way it was originally
conceived (Glaser 2004).
3.1.1 Underpinning philosophical base

Glaser (1978) argued that as a methodology grounded theory can be aligned with any philosophical base, and that the philosophical base is irrelevant, as focusing on the underpinning philosophical position when undertaking a grounded theory is an unnecessary distraction to the research process. However, Annells (1996) proposed that in using grounded theory the research will inevitably reflect the researcher’s notions of the ‘nature of reality, the relationship between the knower and what can be known, and how best to discover reality’ (page 379). As a novice researcher, I considered that understanding the underpinning theoretical perspectives that have influenced the concept of grounded theory, both as it was initially described and in its development, would develop my understanding of the methodology. In the process of exploring the philosophical perspectives that are commonly cited in grounded theory research, my knowledge of the grounded theory methodology is enhanced, and as a consequence decisions made within the research process made transparent. As a novice grounded theorist and in meeting the requirements for a doctoral thesis exploring the philosophical assumptions that have been made about grounded theory are also consistent with substantiating and justifying the use of the selected methodology.

The continued debate surrounding the philosophical basis of grounded theory has been articulated by many authors including Bulmer 1984, Fine 1995, Abbot 1999, Bryant and Charmaz 2009. In general, they locate the philosophical basis of Grounded Theory within the originator’s backgrounds. Glaser from Columbia University with the methodologist philosophy of Paul Lazarsfeld, and critical theorist Robert Merton (Holton 2011); and Strauss with the pragmatist, symbolic interactionist and ethnographic traditions of the Chicago school (Charmaz 2007). Nathaniel (2011) added to the debate by arguing that both Glaser and Strauss were influenced by the ideas of Charles Sanders Peirce (1839-1914). Peirce is considered to be the father of pragmatism, and was himself influenced by the critical philosophy of Kant, Hegel and Scotist ‘common sense’ realism.
(Burch 2014: Peirce 1955, papers published after his death). Kant (1724-1804) developed ideas of moral philosophy and abstract concepts of ‘being’ and ‘knowing’; arguing that individuals know the world as it appears to them from within the constraints of the subjective condition of their experiences and thought. In this way, Kant considered the mind as actively setting the conditions that made knowledge possible and in doing so the individual created ‘order’ out of the objects that made up the world. Kant considered that the concept of an ‘inner’ mind presupposed an apprehension of the outer reality of the world of stable, re-identifiable things that in turn guided the way we act. The relationship between the creativity of the inner mind and the outer reality of a stable world can be understood by examining some of the taken for granted concepts that feature in our lives. For example, as a nurse with a physiology degree I often make reference to the periodic table, with its ordering of the known elements into a pattern that both describes their properties and their relationship with each other. Historically the ordering of the elements preceded an understanding of the complete structure of the elements and resulted from the imaginations, the working of the inner mind of ‘alchemists’ from the 17th Century onwards. As science progressed, and our knowledge of the elements increased, so the accuracy and relevance of these early thinkers and the creativity of modern thinkers has led to the development of the ordered periodic table as it is known today. It can be argued that new understandings and concepts about the elements were constantly compared with the original ideas and over time these became grounded in. and substantiated by the data to emerge and form the eventual pattern of elements as they are known today. As more elements are described their properties will be compared with the known elements and their place and relationship with the ordering of the elements will become transparent. In this manner, it was (and continues to be) the importance of the conceptualisation of ‘objects’ as a presupposition as to how things are that influenced and shaped not only the direction of research, but also our understanding of the ordered world. It is in the manner through which the world is ordered, and an understanding as to how the issues and concerns are resolved that resonates with grounded theory.
In CGT, this pre-supposition is akin to pre-conception and as such, without constant comparison with the data, has the potential to distort and force the data to substantiate what is thought to be known. However, pre-conceptions can be rigorously challenged by the application of Kantian logic. Kantian logic is understood as the application of scientific thought and latterly scientific method of ‘experience and reasoning’ (Haack 2007). In CGT, it is the application of ‘scientific thought’ in the process of ‘conceptualisation and abstraction’, and the rigorous application of research procedures that are arguably central to the development of grounded theory. Through attention to the methodology, the researcher can avoid simply using qualitative data analysis in what is known as ‘method slurring’ (Evans 2013).

It was in Peirce’s development of a systematic philosophy and the logic of induction, abduction and deduction which many of the key processes associated with grounded theory are seen. Thornberg (2012) discussed the impact of Peirce on the development of CGT and GT through the concept of abduction, which Peirce referred to as ‘something between deduction and induction.’ The process of abduction enabled the researcher to develop a theory to explain the ‘surprising’ data, and described the way in which the researcher through a selective and creative process developed a tentative hypothesis (Nathaniel 2011). The emphasis on being creative is one that is constantly referred to by Glaser as he discusses conceptualisation as being the ‘naming of patterns’ to find a word that best captures its ‘imageric meaning’ (Glaser 2002).

The influence of Hegel (1770-1831) on the development of Peirce’s ‘pragmaticism’⁶ and grounded theory can be linked to the concept of ‘dialectical thinking’. Dialectical thinking refers to the ability to view issues from multiple perspectives and to reconcile seemingly contradictory information and postures. In doing so, Hegel makes reference to a sequence of logical categories: being, becoming, one, many, essence, existence, cause, effect, universal, mechanisms, and ‘life.’ Each can be

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⁶ Peirce wrote pragmatism as pragmaticism to differentiate from the common understanding of pragmatism at that time
examined and can reveal internal tensions and inadequacies. In this process, each category that is identified is made to generate another more promising category, which in its turn can then be subject to the same scrutiny. Whilst Thornberg (2012) recognised the impact of Peirce in the development of grounded theory, it is Schurz (2008) discussion of the differing patterns of abduction that can be seen to resonate with the underpinning philosophical influences of grounded theory; as he stated; “in abduction problems, we are confronted with thousands of possible explanatory conjectures (or conclusions): everybody in the village may be the murderer. The essential function of abduction is the role of (re)search strategies, which tell us which explanatory conjecture we should set out first to further inquiry” (Schurz 2008 page 203-204). This description resonates not only with the concept of pragmatism as articulated by Peirce, but also in the methodology and methods of grounded theory. It is in the constant comparison (see section 4.2.) of categories and concepts with themselves and data that leads to the emergence of the grounded theory, the core or central category. This generation of categories through creative thinking conceptualises the emergent thoughts and ideas that are grounded in the data and provides the insight to an explanatory hypothesis that accounts for the behaviours being observed (Glaser 1998). This logical exploration of the area being investigated, and remaining open to all possibilities continues until the main category or concern emerges, is key to CGT. It is in this way that potential explanatory conjectures are eliminated until the conjecture remaining provided the most-plausible description of the issues to be resolved. Glaser (2008) argued that in viewing the data from different perspectives, different theories can emerge, but through inductive processes the most-promising theory; the core or central category will appear as it explains the social behaviour being observed. This grounded theory will then provide an explanatory mechanism that will account for the variation in the data and the social behaviours of individuals, as concerns are resolved. In classic grounded theory the application of the grounded theory procedures and the constant comparative method enables the researcher to challenge continually emerging concepts by grounding them in the data until they emerge, saturated and in a form that is readily understood by others.
3.1.2 The influence of symbolic interactionism

The relationship between symbolic interactionism (SI) and the methodology of grounded theory is widely documented (Bryant 2009, Clarke 2003, Morse 1994, Strauss 1987). Although SI is commonly attributed to the work ofStrauss, exploring SI in the context of undertaking a CGT will help in developing my understanding of grounded theory in general and to understand the methodological differences and similarities between CGT and GT.

SI as outlined by Blumer (1969) and Mead (1934) sees people as actors and as such it is the dynamic relationship between differing actors and the responses between actors that give rise to complex social systems. Thus, exploring the relationship between SI and CGT is relevant as I set out to understand how in a social system, nurse educators addressed, coped and responded to disabled students.

Herbert Blumer (1969) described three key concepts as central to SI: -

- that human action towards things is determined by the meaning the things have for them;
- those meanings arise from the interaction between individuals and things within the social world and
- that those meanings are not fixed but are modified through a process of interpretation as the individual encounters things within the social world.

This pragmatic approach by individuals to situations is achieved through interpretation and imaginatively rehearsing options before they act. This pragmatic approach also draws on the idea of ‘common sense,' where thought enables individuals to engage in prediction, action and problem-solving. Shalin (1991) argued that pragmatism, in the context of interactionism and symbolic interactionism, is understood as a ‘humanistic movement in philosophy, whose proponents sought to undercut the extremes of classical rationalism, through a renewed emphasis on the role played by humans in the production of reality as objective and meaningful’
Thus, through SI individuals can be seen as constantly adjusting and shifting in response to each other and as they make sense of the world in which they are situated. In this process, the individual will continually seek to understand and to explore their concerns, and it is the recognition of their ‘behaviours’ through which ‘concerns’ are resolved that resonates with CGT. Often this behaviour will not be conscious to the individual, and it is the purpose of the classic grounded theorist, through conceptual abstraction, to provide an explanation for the latent behaviour within the social setting (Holton 2009). In this way, the explanatory mechanisms emerge from the sub-conscious behaviours of the participants.

In this study, it is in understanding the behaviours of nurse educators as they resolved their concerns as they ‘work with disabled students’ in nurse education that will emerge as the grounded theory. Although assuming that SI theoretically explains these behaviours runs the risk of pre-conception; through the research procedures and the constant comparative approach (see section 4.2) emergent concepts will be grounded in the data. The methodology of grounded theory is essentially not about the ‘people’, or accurate description, but about recognising the pattern of the behaviour in which people engage. At this stage, it is the objectivity of the researcher within the research process that will ensure that the main concern conceptualised in the grounded theory will be abstracted from data that is formed of ‘incidents’ and not the people themselves. In this process, the concepts that are not grounded in the data are rejected, or side-lined. In doing so, what will emerge is the central or core category that will reflect the importance of each person’s interpretation of a situation that is reflected in what Glaser (2002) refers to as the ‘perspective base’ (page 4).

In this study, I set out to theorise how my participants coped, addressed and responded to a diverse range of students, in the context of nurse education. Recognising the perspective base of the nurse educators enabled me, as a researcher, to figure out ‘what was going on?’ Glaser argued that participants will have multiple perspectives and that it is the role of the researcher to ‘raise these perspectives to the abstract level of
conceptualization hoping to see the underlying or latent pattern, another perspective’ (Glaser 2002, page 5). The aim, therefore, was to raise their individual perspectives to the abstract and conceptual level, to make transparent the latent pattern that would describe their central concern and how this was, or was not resolved.

3.1.3 Summary

GT, as originally described by Glaser and Strauss, is a general method of research which can be aligned with differing philosophical traditions. For the purpose of this thesis, I have considered the influence of Peirce and the Chicago and Columbian schools of sociology and my understanding of these philosophical traditions. I acknowledged that Glaser was adamant in his view; that “GT is a simple method for figuring out what the latent patterns are in any data. It doesn’t have a particular perspective or epistemology or ontology. It is just a simple method which can apply to anything” (Glaser 2010). However in exploring the methodological basis and the underpinning philosophies I clarified my perspective and understanding of the nature of reality, of what is known and how this influenced the decisions that I made. It enabled me to recognise my perspective and my position with the data, as being just one of many perspectives; as such my findings will reflect this stance. Others exploring the same data may commence from a different perspective and as such their understanding of the central concerns may be framed in a different way.

The influence of these differing philosophical perspectives, as described in the literature, are considered to be just a few of many perspectives in the development of grounded theory, and are summarised in the diagram below (Figure 3.1).
Diagram 3.1 – Theoretical influence in the discovery of grounded theory.
3.2 The Researcher in Grounded Theory

In embarking on this study an early tension that arose was my position within the research process and the philosophical debate between objectivity and subjectivity. This research emerged from my sense of the concerns that were raised when colleagues discussed disability and nursing students. I was also aware that my decision to embark on the study might have been influenced by my role as a lecturer working with disabled students in higher education and my role as a mother of an adult with Asperger's Syndrome. Whilst none of these factors may have contributed to the desire to pursue this research, each may have contributed to being sensitised to the area being studied, and had the potential to distort the data and the subsequent findings through the application of preconceptions and ideas.

In CGT ascribed to Glaser and the underpinning philosophical stance of Peirce, the researcher enters the field with few preconceptions in both the data collection and in the data analysis (Glaser 1978, 1992). The aim of the research methodology is not explanatory, but to provide a conceptual hypothesis that is systematically generated to produce an inductive theory about a substantive area (Glaser 2004).

The debate between objectivity, subjectivity, being objective and being reflexive, reflect differing epistemological beliefs within the differing grounded theorists. Charmaz’s view of grounded theory (2009) is influenced by the relativist ontological position of constructivism; which recognises multiple realities and rejects the notion of the researcher being separate from the participants in data collection and data analysis. In doing so, she acknowledges the subjectivity of the researcher, arguing that mutual construction of the data occurs through the interaction between participants and researchers. Although constructivist grounded theorist, have positioned themselves as rooted in pragmatism (Charmaz 2007), the co-construction of data, as the inevitable consequence of the relationship between the researcher and the participants is strongly contested by Glaser (2002, 2004, 2008) as being a distortion of the
original methodology. However, Berger and Luckman (1967), who were influential in the development of constructionism, believed that society exists as an objective reality that is produced by human interaction and is real at the subjective level of the individual. In doing so, they argued that Society has an objective and subjective reality. Thus, society can be viewed as composing of objective rules and structures and subjective concepts that give rise to shared meanings and understanding. These shared meanings and understanding come together to form common understanding, which no longer requires underpinning concepts to be defined, and as such the behaviours of the individual will reflect these concepts. It is in methods of CGT that these sub-conscious behaviours and concepts are then lifted and abstracted to emerge as the grounded theory.

Critics of the objectivist perspective often associate it with the positivist methodology of experimentation, and the manipulation of variables when seeking to uncover knowledge or to verify a hypothesis (Annels 1994). Glaser in contrast argued that in being objective within CGT, it is merely in the ‘suspension of beliefs’ that conceptual ideas are allowed to emerge from the data. Through researcher objectivity, these conceptual ideas then have the flexibility and rigour to transcend the immediate substantive area and be applicable to other contexts, and grounded theory becomes apparent (Glaser 2014). The objectivity of the researcher in this process facilitates the process of abduction, as a researcher is not constrained by conceptual pre-conception and remains open to new concepts that can be subsequently grounded in the data. Charmaz (2007) argued that in assuming this position within CGT, the researcher is adopting a positivist and objectivist stance that fails to account for the relationship between the researcher, the data and the emergent findings. Glaser (2005) addressed this issue by acknowledging that it is difficult in being truly objective as the researcher will often embark on a study with ‘latent concepts.’ He argued that in embarking on a study, the researcher ‘suspend(s) their knowledge of the literature and the research field … to stay in control of perceptions and to remain open’ (Glaser 2005, page 6). These latent concepts are then seen as data and contribute to the theory.
development. This is supported by the research procedures that underpin the concept that CGT is about ‘discovering, conceptualising and explaining patterned subjective realities’ (Simmons 2013 page 25) and in embarking on a study, the objectivity enables the researcher to remain ‘open’ to see what is within the data.

Glaser (1998) provided some guidance on how the researcher remained objective by arguing that grounded theory can use any data and that it is the researcher who determine what data they are collecting (Glaser and Holton 2004). In this study I addressed the issue of objectivity and the potential influence of my professional role within HEI; my professional and personal experiences of working with people with disabilities in the context of professional education; and my lived experiences of disability in my private life, by not negating my ‘latent understanding but by actively ‘objectifying my understandings’ and subjecting them to rigorous analysis through the research procedures.

Aherne (1999) suggested to achieve objectivity the researcher adopted a reflexive stance. Although being reflexive is not described by Glaser and Strauss (1967), and reflexivity was explicitly rejected by Glaser (2001), mechanisms for acknowledging the role of the researcher are often described within qualitative research. In considering this element, I recognised that Glaser (2001) considered reflection to be a distraction from the data. He argued that through the CGT process of constant comparative analysis, the effect of the researcher and latent concepts would emerge as data and that any emergent concepts would then be checked out against other concepts as the data analysis progressed. In this manner, latent concepts through the research methods either earn their way into the emergent theory or are rejected. Thus, as Glaser acknowledged, the study began with the possession of ‘latent concepts’ and in adopting a CGT methodology, I actively set aside and objectified my own ‘latent’ concepts and understanding of the area being explored. Charmaz (2007) would argue that my position within the research process could be considered as ‘mutually constructing’, but this did not fit with my intention to theorise how others, as nurse educators, worked when considering disabled nursing students.
However, as a novice in the use of CGT, and the need for some guidance in the early stages of the research process, I drew on the grounded theory procedures to memo my thinking and used the artefact of ‘bracketing’ in a conscious way to capture my subjective understanding of, and relationship with the research being undertaken. The act of bracketing in the early stages of the research enabled me to consider my experiences and understandings as data that through theoretical sampling and constant comparison, provided theoretical sensitivity to the research process (Glaser 2005). Bracketing is described in qualitative research as the process that enabled the researcher to remain open and objective to the research (Tufford and Newman 2010). It originated from the work of Husserl (1913-31) and phenomenology, whereby he argued for the importance of direct seeing and looked beyond ‘constructions, preconceptions and assumptions’ during the research. The act of bracketing is not explicit within grounded theory, but as a mechanism it arguably makes the researcher’s position clear and unambiguous. It is seen as the explicit acknowledgment of the researcher’s position and preconceptions which in turn legitimises the research process (Beech 1999). Tufford and Newman (2010) suggest that bracketing can be seen as a multi-layered process that is meant to access various levels of consciousness, such as beliefs and values (Beech 1999); biases (Creswell and Miller 2000); preconceptions (Glaser 1968); presuppositions (Crotty 1998) and assumptions (Charmaz 2006). Rennie and Fergus (2006) argued that Glaser and Straus incorporated into their method ‘the phenomenological technique of bracketing without addressing the complex question as to the extent to which such activity can be carried out successfully’ (p 485).

As the research progressed, and I continued to read about the methods of CGT (a strategy advocated by Glaser) the need to engage in the active act of bracketing lessened as I began to trust in the research methods, and the emergent concepts from ‘all’ the data were simply captured in memos. These memos were then subjected to comparative analysis and subsequently rejected, parked or considered as central to the emergent theory. This approach whilst not explicit in the early works of Glaser
(1967, 1968) is inferred by Glaser in 2002 who stated that “the data is what it is, and the researcher collects, codes, analyses exactly what he has whether baseline data, ‘proper line’ data, interpreted data or vague data. There is no such thing for GT as bias data or subjective or objective data or misinterpreted data. It is what the researcher is receiving as a pattern, and as a human being (which is inescapable)” Glaser 2002 page 1.

3.2.1 All is data

As my skills as a researcher developed I shifted towards the process of self-interview (Glaser 1998) to extensively capture my thoughts and from which a series of memos emerged (this is explored in greater detail in chapter 4). In this manner, I captured my working role with disabled nursing students and within the wider university in the development of support for students in general and my personal experiences. In this manner the axiom that ‘all is data’ (Glaser 2008) and the GT procedures allowed for my understanding to become objective and treated as data that through the research procedures could be scrutinised, and emergent concepts compared with concepts derived from field data analysis. In approaching the field of research with the notion that ‘all is data’ supported the position of Glaser (1998, 2002) who argued that the purpose of GT is not accurate description but ‘transcending abstraction.’ Abstraction as a philosophical concept is the thought process whereby ideas are distanced from objects, and the emergent concepts become central. In this way, the researcher is freed from the ‘data worry and data doubts and puts the focus on concepts that fit and are relevant’ (Glaser 2002 page 1). In this manner, I put aside the concern that the research findings might not be true to the data, a concern Glaser attributes to issues within qualitative data analysis, as with CGT the focus is not accuracy, but conceptualisation that occurs as the researcher listens to the participants’ accounts. Glaser advocates that in completing a CGT, the researcher needs simply to ‘get on with the research’ and to trust in the application of the research methods (Glaser 2004).
As a classic grounded theorist, I ascribe to the view that the researcher is not separate from the research as a researcher is embedded within the research process through the decisions made by the act of data collection and analysis. However, through researcher objectivity and the application of the grounded theory procedures the data is analysed in an objective manner.

Thus by considering my experiences as data, they were rendered transparent and subjected to conceptual and critical analysis. The research, therefore, commenced not with an ‘empty head’ but with what Duchscher and Morgan (2004) described as ‘abstract wonderment,’ a curiosity to know what was causing concern and complete uncertainty about the social processes that were being enacted.

3.3 Literature review in classic grounded theory

A key concept in CGT is the Glaserian dictum of ‘no preconception,’ ‘no forcing the data,’ extends to delaying the literature review so that the researcher has ‘no extant concepts of the field by reading the literature in the field of study before the emergence of a substantive theory’ (Glaser 2012 page ). Glaser argues that the researcher will not know what literature to review until the substantive theory emerges. Allowing the theory to emerge from the data and not to force the data with extant theories, enables the researcher to remain open to all possibilities. Once the theory has emerged then, a literature review will be completed, and emergent concepts compared with the field data to contribute to the grounding of the theory. What is allowed is an understanding of the general area of interest, having curiosity, but a lack of knowledge of the problems associated with the substantive area to be explored (Glaser 2012).

Whilst the background literature, as part of the requirements for completing this doctoral thesis, has been included within this write-up (Chapter 2) this simply captured what I, as the researcher already knew and situated the thesis within the broad areas of disability and education. Those aspects associated with nurse education simply rendered
transparent my underpinning knowledge of nurse education and the support of students that formed my latent understanding, by virtue of my job role. These were treated as data and as with all CGT methods the emergent concepts were subsequently compared with the field data.

Once the core category has emerged a subsequent literature review becomes a source of secondary data, and through the process of constant comparative analysis, the emergent theory and extant theory are woven back together (Glaser 2014). Glaser (2004) uses the term 'fracturing' to describe the CGT process of coding, with the grounded theory emerging from this fractured data as the core category, that accounts for how participants resolved their main concerns, becoming evident. This process enables the grounded theorist to generate a theory that both transcends the literature and synthesises it at the same time (Glaser 1998), in doing, so a theory emerges that has relevance and is fit for the context (Elliot and Higgins 2012).

3.4 Summary

In this chapter, the methodology of grounded theory is explored, and this study is positioned within the Glaserian, CGT methodology with its logical objectivist stance and discovery methodology. In using this approach, I am seeking to understand ‘what is going on’ as nurse educators work with diverse students in nurse education. Unlike other versions of grounded theory (and qualitative data analysis), CGT offers the flexibility and creativity through which serendipitous observations (Deady 2011) are not side-lined but add to the rich vein of data that ultimately leads to theoretical completeness. The field is entered with abstract wonderment, with no intention to ‘prove’ a hypothesis but to characterise the participants’ main concern and how it was resolved. CGT provides a methodology whereby I can position myself above the data, to identify the latent patterns and behaviours undertaken by the participants, and how they address their main concerns to emerge. As concepts emerged, these were not shared or checked out with the participants based on the
Glaserian premise that the participants were simply resolving their everyday concerns. As a researcher, I was able through the process of abstraction explore theoretical concepts that accounted for how they resolved these concerns. In adopting this logical objective stance I remained cognisant of my prior understanding and beliefs, and through the research methods ensured that the emergent theoretical concepts were grounded in the data.

In keeping with a Glaserian argument that CGT is a generative and emergent methodology (Holton 2007), I recognised as I engaged in the research that I would develop an ever increasing understanding of the research process. Glaser (2008) recommends that continued reading of literature related to the research methodology help the novice grounded theorist develop insight into the process of grounded theory, and as grounded theory emerges, an understanding of the main concerns of the participants.
Chapter 4 Applying the grounded theory procedures

4.0 Introduction

GT as a research method must possess several key features which differentiate it from other qualitative research methods and reflect the purpose of grounded theory, to identify substantive or formal theories that emerge from the main concern of the participants. It is in the application of the research procedures that CGT can be distinguished from generic qualitative data analysis. Many of the elements are commonly seen in all research, such as data collection and data analysis, but unlike many methods, the research process in grounded theory is not linear but concurrent. Both data collection and data analysis occurring simultaneously and as concepts emerge they are continually grounded in the data (Glaser 2008).

In this chapter, the key research procedures used are outlined and how they substantiate the use classical grounded theory demonstrated. This chapter is written in a linear fashion, and this does not capture how the procedures were followed. The writing of memos and coding procedures, for example, were cyclical, with many elements occurring concurrently.

4.1 Ethics approval

Ethics approval from the University of Brighton Research Ethics and Governance Committee was obtained prior to commencing this study. Researching the responses of nurse educators to the subject of disability could be considered a ‘sensitive’ research area as participants may inadvertently disclose discriminatory attitudes or behaviours towards disabled people. In addition, the presence of the potential of a political threat may emerge as the study area explores an area subject to controversy or social conflict (Lee 1993). Following ethics approval from the University of Brighton, permission was obtained from the two host HEI, for recruitment of participants to the study. In doing so the
participating HEI’s stipulated the process through which I as the researcher could obtain advice and guidance from a neutral third party (identified by the participating HEI) in the event a participant disclosed discriminatory attitudes and behaviours towards disabled people. In such an eventuality support would be made available to any participant through the host HEI’s equality and diversity units.

During the recruitment process, participants were provided with an information sheet outlining the nature of the research and the type of data that would be collected. Participants were fully informed that within the interview process the issue of disability and nurse education would be explored. Their anonymity within the documentation would be maintained through the use of a pseudonym, and neither they nor the host HEI would be identified in any written documentation. If a participant chose to leave the study, the data collected up until the point of their withdrawal would inform the study but no direct reference to them or direct quotes from their interviews would be used. All data was stored in a password protected file on a computer only accessed by the researcher. A consent form was signed by each of the participants. Within the consent form information was provided that in the event that potentially ‘discriminatory attitudes or behaviours’ were expressed that this would be discussed with a neutral third party and details of their host HEI’s equality and diversity units would be provided.

Throughout the study, the participants spoke freely about their views of disability, disabled nursing students and disabled registered nurses. Although they held strong views the participants voiced the need to ensure they were not discriminatory, and the need to not be discriminatory emerged as a concept within the data analysis as they considered the differences between ‘normal’ and ‘disabled students’ (section 5.2)
4.2 Recruiting participants

Participants for this study were recruited from two Schools of Nursing based within HEI in England. Recruitment occurred following an informal presentation of the proposed study held at each HEI. A total of 18 participants took part in this study. The importance of recruiting from outside of the researcher’s workplace was to limit the impact of having a 'working relationship with participants' and to limit their understanding of the researcher's working role in developing inclusive work practices. In keeping with the Glaser's dictum of entering the research with 'objectivity' and openness, so as not to force the data with preconceived ideas, recruiting participants in other workplaces helped me to remain open and to be aware of my pre-conceptions about the area being studied. Being in a strange and unfamiliar setting provided a sense of being 'unsettled' which encouraged me to attend to, and reflect on my beliefs, as I adopted the role of student and researcher within the research process; without the distractions of a familiar working environment. The decision to recruit from settings in which I was unknown also reflected a desire to see the data with 'open eyes,' without the familiarity of an organisational structure and culture that might constrain conceptual thinking.

4.3 Constant comparison

Constant comparison ties each of the research procedures\(^7\) together and is a key element of CGT. It refers to the process through which all the data is interrogated to see if the emerging concepts support and continues to support the emergent grounded theory (Glaser and Holton 2004). As such, it is relevant in the context of this study to discuss constant comparison prior to discussions about the research procedures in general. As a process, it begins with the first interview as the emergence of the first codes, derived from the coding process, and the writing of memos, which

\(^7\) Although the term research methods is commonly used to describe the research process, for the purpose of this thesis the term research procedures will be utilised to differentiate generic qualitative research methods from the methods of grounded theory.
provided narratives about incidents, are compared with subsequent interviews. As coding begins with the first interview, the process of constant comparison is immediately evident, as thoughts and ideas emerged. In this way, conceptualised codes begin to form concepts/categories (Glaser 1978). The constant comparison between codes and categories at this early stage of the process leads to further refinement in data collection and the process of data analysis. As categories emerge, questions are continually asked of the data to conceptualise what is happening.

Glaser and Holton (2004) suggest that this comparative process moves the research through open to selective coding (Section 4.5) and in doing so involves three types of comparison:

1. Incidents are compared to other incidents to establish underlying conformity and varying conditions
2. Emerging concepts are compared with more incidents to generate new-theoretical properties
3. Emergent concepts are compared with each other to establish the best fit between potential concepts and a set of indicators. In doing so the conceptual levels between concepts that refer to the same set of indicators and their integration become the substantive theory (Glaser and Holton 2004)

In applying this process, new-conceptual categories were developed which were compared with new incidents as they emerged from the interviews (Box 4.1).
<table>
<thead>
<tr>
<th>Disabled Students</th>
<th>As a problem</th>
<th>Not a problem</th>
<th>Conceptual categories emerging from the comparison with data</th>
</tr>
</thead>
<tbody>
<tr>
<td>001</td>
<td>Working harder</td>
<td></td>
<td>In thinking about disabled students as a problem, being a problem was related to the Additional effort – Category feeling burdened by the workload. When not a burden, then able to fit in</td>
</tr>
<tr>
<td>002</td>
<td>Takes more time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>003</td>
<td></td>
<td>Everyone was experienced with the condition so fitted in</td>
<td></td>
</tr>
<tr>
<td>005</td>
<td>Needs resources</td>
<td></td>
<td></td>
</tr>
<tr>
<td>009</td>
<td>Uncertainty about what it means</td>
<td></td>
<td></td>
</tr>
<tr>
<td>016</td>
<td>Practice has no time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>011</td>
<td></td>
<td>It was awful and could have happened to us all, so the clinical area was very accommodating</td>
<td></td>
</tr>
</tbody>
</table>

Box 4.1 Example of constant comparison of code disability as a problem and emergence of new-conceptual categories
As the research progressed concepts that arose throughout this period from all aspects of the research process, were captured through memos. Any emergent concepts were then subjected to the constant comparative procedure. These concepts included those derived from my ‘self-interview’ (section 3.3.1), and memos that were written during the data collection period, but not directly related to the interview process.

The constant comparative process of data analysis is captured in the diagram (4.1). This demonstrates how the concept of ‘time famine’ that emerged from the interview data, was refined through the comparative process eventually to become a sub-category of the concept ‘negotiating a temporary pass.’ Time famine had initially appeared as a central category that was influential in how nurse educators engaged in supporting disabled students, but through constant comparison it was re-categorised as only one element within the process of ‘negotiating a temporary pass.’ In this manner, it emerged as one of the three sub-categories that together formed ‘negotiating a temporary pass.’
Nurse educators believe that time is a finite commodity.

As a finite commodity, Nurse Educators are reluctant to ‘use’ time wastefully. If a student is to fail anyway then, the use of time is wasted.

However feel obliged to consider a student in order they can demonstrate ‘inclusive practices.’

Time expenditure for a short period might be possible under certain conditions. Nurse educators need to balance how they use their time. In supporting a student in clinical practice, the time for the student should not encroach on caring time for patients. Need to be able to make a case for the student being in practice. Time is a component of enabling a disabled student to have full access to the clinical environment.

Time famine is re-labelled as a subcategory of the category - Negotiating a temporary pass.
4.4 Interviews

In this thesis data collection primarily took the form of interviews, based at the participant’s place of work. In embarking on the interview process, I had hoped that the participants would talk freely about the concept of disability and its relationship to nursing practice. However, my concern that the participants might be reluctant to talk about issues related to ‘disability,’ had led to the formulation of a loose framework to guide the interview process. This framework is outlined in the box 4.2.

<table>
<thead>
<tr>
<th>Interview plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Introduction to study, question on understanding of disability</td>
</tr>
<tr>
<td>2) What are the participants’ experiences of disability in higher education?</td>
</tr>
<tr>
<td>3) What are the experiences of disability in nursing?</td>
</tr>
</tbody>
</table>

Box 4.2 Loose framework for interviews

These opening questions set the scene for the interview and commenced with a simple question as to what the participant understood about the term disability. In hindsight, I had set out to find out what I assumed be the area of concern – that being disabled was difficult to discuss and would be the major concern of the participants. My pre-conceptions were forcing the direction of the interview. Glaser (2002) recognised that novice grounded theorists are often inadvertently guided by their pre-conceptions, and concerns that the data may not be ‘accurate’ or ‘true’. However, after the first interview, it became apparent that the participants welcomed the opportunity simply to talk, and their discussions covered a broad range of issues. In keeping with CGT, the interviews soon took the format of a simple conversation (Scott 2012, Glaser 2003). Including the word ‘disability’, and inviting people to talk about disability encouraged the participants to talk freely, and Glaser referred to this as providing a spill to allow the participants to vent (Glaser 1998). As a consequence,
participants shared complex stories of not only professional experiences of disability (with students and themselves), but also their personal experiences of being disabled or of having a family member with a disability. At this stage, I actively listened to their narratives, and through repeating phrases and words encourage the participant to expand and clarify what they were saying. The enthusiastic participation by the participants stimulated many thoughts and ideas that were captured in field notes during and after the first interview, and subsequent interviews and enabled the interviews to remain flexible and discursive. From these notes, memos were developed as initial theoretical ideas emerged. As a result of the first interview, the interviews became increasingly discursive, as initial thoughts and ideas generated, guided my focus within subsequent interviews. The first interview provided me with the confidence to enable the interviews to run at a pace and speed dictated by the participants, as their readiness to talk became apparent, and I focussed on capturing their concerns.

4.5 Field notes and Memo writing

Throughout the research process field notes and memos were developed, and contextual information such as time and place recorded. The field notes written during and at the end of the first interview started the process of data analysis, as thoughts and ideas about the interview and its content were captured (Box 4.3). In CGT, the concurrent data collection and data analysis facilitates the early emergence of themes and concepts, which inform subsequent interviews as ideas and thoughts are checked out. In this way, the emergent findings are constantly grounded in the data. The subsequent memo writing is an essential component of grounded theory, as Glaser describes ‘memo writing on the field note provides an immediate illustration for an idea’ (1967.page 108) Memo writing allowed me to capture immediate ideas and to conceptualise the data in a narrative form. Following the field note one (Box 4.3) the following memo explored the concept of ‘problem’ (Box 4.4).
Field Note one, November 30, 2010. The interview with 001 began much easier than I thought. I was expecting 001 to be reluctant to discuss the issue of disability as it always seems to be such a contentious issue, and people find it difficult to talk about it. I had planned some questions but, in fact, never got past the first one, as soon as I asked about disability, 001 shared not only professional experiences of disability, but her story about being disabled and nursing. Having a disability seems such a problem to her, and she seems to have struggled and is still struggling. There were so many things she wanted to share.

Box 4.3 Field note generated following completion of the first interview November 30, 2010

Memo following field note December 1, 2010

Disability as a problem. The physical problem of not being able to walk easily and to have to work hard to be ‘fit’ in practice. The problem seemed to be how she saw herself as compared to others that stemmed from the initial view of her doctor at the time. The Dr told her she was not disabled she just had to get on with things; the problem was not real but was imagined. Having to ‘not have a problem’ led her to hide her difficulties and to be constantly proving how able she was. The story about the ski boots and how much she loved skiing but didn’t get any special boots because that would mark her out as different. So for years she skied in pain...last year she got special ski boots. She experienced personal conflict in both hiding and feeling obligated to disclose the problem. This conflict was most evident at this time as she was changing her job role and was debating whether she should disclose to the Occupational Health Dept. Disclosing seemed to change her view of herself, and she saw herself as being less able, the extent of the problem is influenced by the context, in some contexts having a disability is more problematic than others. 

The problem associated with the riskiness, currently most problematic as she feels her job is at risk if she does not disclose but is also problematic if she does. Her concerns seem to be about being disabled and being able to work – or being judged as not able to work.

Box 4.4 memo based on first interview and field notes recorded at the same time.
These early memos were often descriptive but gave rise to ideas and thoughts that were through constant comparison with the data, developed through data analysis. In the first interview, the link between being disabled and being employed was a central concern to the individual participant, but initially, this was ‘parked’ as it seemed at the time not relevant to the issues of student nurses. At this stage, my pre-conceptions were still guiding my thought processes, and I was still waiting for the participants to talk in depth about disabled nursing students. I had noted the concerns associated with being able to work, but it was only later through the constant comparative process that it was revisited, as concerns about employability and being able to work continually featured in the interviews. As it was checked out in subsequent interviews, its centrality to the main concern of the participants became more evident. Later memos considered the importance of being able to work and to be employed (box 4.5, 4.6)
Memo December 2010 Participant 001

I was quite surprised by the speed at which the participant during the first interview moved the discussion from disability and inclusion in the context of students to her personal experiences. She had expressed very strong emotions when talking and sounded very cynical that having a disability is something that is 1) not seen as being positive in society. Her discussion about her GP telling her she was not disabled even though she had clearly struggled, and 2) that as a person with a disability she had to be seen to be normal, and to not cause difficulties. 3) She had struggled with the idea that she ‘ought’ to disclose her disability in case her employed status was jeopardised – did she think that by non-disclosure she could lose her job? She had also spent time justifying her position to the Occup Health including checking it out with her colleagues 4) that nurses were expected just to do things and that the workplace could only function if everybody fitted a view of being normal. As such the workplace is inflexible, doesn’t like change and that the additional effort of permanently adjusting is problematic. 5) that the workplace needed to be safe and as such this was keeping patients safe and also keeping students’ safe. During the interview, it was interesting that when discussing her disability there was much emotion expressed through the use of words such as ‘battling’ ‘agonised,’ ‘paranoia’ as a personal experience was described. When considering students having a disability although there was some discussion about the student needing to be aware of their impact on the working environment – the tone was different, the emotion was missing and the language was considered and cautious. The responsibility was placed on the person who was disabled at minimising their impact in clinical practice, of not causing difficulties or placing additional demands on the workplace. Taking personal responsibility and knowing your limitations was seen as important. The discussions about others with disability seemed to reflect a normalised view of nursing, of nurses, should be able to do certain things and to fit in with the normal way of working that reflects the personal experience of ‘having to not be disabled’ and having to ‘prove ability.’ When discussing the disabilities associated with students she spoke to a professional and her concerns were about the delivery of care. Having a disability was also seen as being less able to make decisions this was linked to ideas of being safe, the importance of keeping patients safe and the lecturer making decisions about whether the disabled person could maintain their safety, as well as that of their patients. I wonder whether the same concerns are raised with other students. Do we assume people without a disability will be safe but assume somebody with a disability will not be able to recognise the impact their disability will have as they are inherently less able to monitor themselves because of their disability? The disabled student is more vulnerable because they lack insight into their impact on clinical practice. The lecturer is aware of the potential difficulties because they have worked in practice and considered the environment to be inhospitable to people who present with differences. Being vulnerable is not surely inherent with the disability but because of the response of others

Box 4.5 Memo following interview 001
In thinking about the concerns of the participants that keep referring to the importance of being able to work do jobs and be efficient. The focus on being able to work is task orientated and focusses on the 'occupational role and values' of being a nurse and not the professional roles and values. The importance of workability, fitting into the workplace, seems to be at odds with their educational values, and this challenges their personal values and beliefs. The tensions they are experiencing rest on how they can balance their concerns without appearing to be judgemental or discriminatory. The social model considers the individual’s capability and how social structures are disabling. Nurse educators are aware of the social model of disability, but this is not translated into nurse educators’ actions or feeling that they able to change the workplace. They rationalise this by alluding to the guidance from the NMC and the requirements for core skills, but more importantly they are emphasising the need for the health care organisation to have a stable, normal and ordinary workplace which maintains patient safety.

Box 4.6 Later memo on workability

The written memos formed a trail through the data collection and its analysis. Later, it was in the sorting of memos that concepts were grounded in the date and ‘earned’ their way into the emergent theory. Glaser considered memo sorting as a key process in grounded theory, as it facilitated the emergence of a theoretical outline and articulation of the theory (Glaser and Holton 2004). In sorting the memos the ‘fractured’ data is reassembled, and the ‘nitty gritty’ (Glaser and Holton 2004 page 11) of making theoretical discrete discriminations allows the researcher to consider how and where, each part fits with the emerging theory.

At the end of each day of interviews, a shorter field note (Box 4.7) captured my thoughts about the process of the interview(s) and summarised my thinking at that time.
Three interviews completed today and feeling exhausted. Each interview lasted about one hour. Participants very keen to talk about disability. Thought I might be leading the conversation but listening to recordings it is clear that there was a lot people wanted to say. Still surprised by the personal declarations of their positions, and experiences related to ‘being disabled.’ Two out of the three shared very personal stories and felt very emotional, 3rd participant did not share a personal story but strong professional story about being inclusive, the experience of being supportive of people who had disabilities, on the face of it, it sounds inclusive but have a niggle that it is not. Must listen to recordings again. Digital recorder is excellent but must remember to note file number down as it will record everything as a new file so no stopping and starting.

Will explore these ideas later

Field note December 2010

Box 4.7 Field note following first day of interviews

Although the interviews were recorded and transcribed, in keeping with grounded theory the verbatim transcription was later omitted, as emergent ideas and concepts were captured extensively using field notes and memos. The initial verbatim transcription did sensitise the researcher into the way participants spoke, the words used and the emphasis and emotions they placed on words, but as these were captured in the field notes and in memos the need for verbatim transcription lessened. As the research progressed, it was in listening to the tapes and reading of memos and field notes that conceptual ideas were clarified. This emphasis on memo writing, as opposed to verbatim transcription, is advocated by Holton (2007) and is considered an essential component of CGT by Glaser (2004), as memos run parallel to the coding process to capture the researcher’s ideas and develop conceptualisation. The conceptualisation supports a central concept of GT, which is not solely concerned with an accurate description, but about the development of
emergent ideas that are grounded in the data by the use of illustrative incidents.

During the early data analysis quotes taken from the transcription, to capture incidents, were also initially verbatim. However, as concepts emerged then, the quotations became edited, focussing on the essence of what participants were describing (Box 4.8). Critics of this argue that in doing so the voice of the participant becomes lost, and the accuracy of the data questioned. However, in CGT it is uncovering the latent patterns which are subconsciously displayed by the participants and the development of conceptual ideas and not descriptive accuracy, that are central to the grounded theory. The words of the participants generated conceptual ideas that are compared with the data. The edited quotation is then used as a discrete incident to illustrate the emergence of a category that can then through comparison, be compared with other incidents within the data (Box 4.9)

009 “When I was in practice I suppose the patient was my main concern. Whilst we all have to accommodate people my concern was that in practice, the shift would work, the patient was safe, and care was given. Now I am in education the student is my concern, and I think I am more tolerant now because I am not in practice and it, practice is not my first concern?”

This verbatim quote was edited in the memos and as an incident

009 “Moving from practice to education made it easier to be tolerant as my responsibility had shifted from patients to students.”

Box 4.8 Moving from verbatim to selected quotes from the data

As the research process progressed, the field notes and memo writing led to the emergence of codes. Through the process of constant comparison and identification these emergent codes guided the interview conversations. In this way, the direction and content of the conversations were guided by the participants as they laid out the issues they considered to be important (Box 4.9).
Interview 005  We are very busy and having to do extra things is difficult
(participant 005)

Code        Short of time

Interview 006

It means we have to sort out things first, so I need to know the student is
there, and then I need to get things together, so it all takes extra time and
resources. We do not have extra time. (Participant 006)

Category       Time famine

Memo: Lecturers are taking responsibility for making sure that the
student has what they need. They are trying to make sure it will be ok and
that it will work. However, this is at some cost as they are fitted it into their
existing time. Feeling short of time and believing that a disabled student
will need extra time burdens the participants as they allocate time to
different aspects of their work.

Interview 10 the workplace is very busy, and staff are so short of time as it
is, they cannot spare the time for students

Interview 16 it worked at first when they had plenty of staff, but then it
became difficult as the workload increased, and eventually they just said
they could not cope.

Memo;

Time is a finite resource a commodity that has to be rationed and
budgeted for; time famine captured this – suggest there are times when
time is more plentiful the idea of experiencing a time famine

Box 4.9 Relationship between interviews, codes and memos as they guide the
interviews and data analysis

In the research process interviewing continued until saturation occurred.
Glaser argued that in the process of completing grounded theory the
concurrent data collection and data analysis allowed the theory to emerge
as each category becomes saturated (Glaser 1978, 1992). Knowing when to stop data collection is difficult but Seldén (2005) suggested that “one keeps on collecting data until one receives only already known statements” (page 124). Using this approach data collection ceased when it became evident that no new categories or ideas were emerging, common themes were being repeated, and these underpinned the conceptual ideas that were being developed.

4.6 Theoretical and analytical memos.

The production of memos is an essential process in grounded theory as the literal transcription of the interview is omitted. Each of the memos I produced captured the thinking that occurred during the interview, and it was in the writing that the emergence of conceptual ideas became evident. These memos were revisited and refined to become theoretical memos.

The terms theoretical memos and analytical memos are often used interchangeably in the literature (Montgomery and Bailey 2007). In CGT, analytical memos drive the direction of the analysis, and theoretical memos identify the significance of the concepts and how they can be used to gain further insights. The analytical memo allows the researcher to explicate underlying processes and takes the form of a private conversation between the researcher and their data (Lempert 2011) Box 4.10

Analytical memo, January 2011 – Being normal.

Being normal and being seen as normal is very important for 001. There is a specific way of being against which she is constantly comparing herself. There is a sense that in needing to be normal she has to deny her disability and difficulties. I will use code being normal to see if others make reference to being normal as a denial of self. There is something about identity and about how people are judged to be in a particular category.

Box 4.10 Analytical memo following coding of interview 001
For Glaser (1998), a theoretical memo simply captures the ‘meaning and ideas for one’s growing theory at the moment they occur’ (page 178). In writing memos, the focus is on the process, rather than the form of theoretical memos, as they increase the researcher’s sensitivity to the meaning ‘behind the words’ as concurrent data collection and analysis continues. In this manner theoretical memos are revisited and revised over time as new ideas form, new codes emerge and analytical depth develops. Each memo is dated, and ultimately it is the sorting and ordering of memos that give rise to the emergence of categories until the main concern of the participants is visible.

The analysis of field notes, memos and other materials collected concurrently with the interviews helped to refine and delimit the emergent codes (Holton 2007). From the examples above (Box 4.9 Box 4.10) and following coding of the first interview the following theoretical memo was written (Box 4.11).

Theoretical memo ‘disability as less than’ 1 January 2011

Participant 001 used powerful words such as ‘battling’ to describe her personal experiences of disability. She described a working life that relied on her denying her impairment existed, and as such proving to others that she was not disabled. She felt that it was very important that she was not seen as being disabled by her impairment, denying her disability and being ‘normal’ suggests a belief that disability is less than. As a person with a disability, she would be perceived as being less than her colleagues and as such she went to extraordinary lengths for this not to occur, she worked harder, longer and referred to having to battle. Disability is associated with the individual model; the disability is within her, it is her responsibility and not as a consequence of the external environment or situation. Disability as being less than, the negative association of disability being equated with being more problematic and creating more difficulties. She seems to have accepted that in her working life, ‘permission to be present in the workplace’ is conditional on her assuming an ordinary and normal identity. As a disabled person, she is not fully present in the workplace.

Box 4.11 Theoretical memo one participant 1 January 2011

From the theoretical memo ‘disability as less than’ and through constant comparison with the data, a theoretical memo on ‘being present’ was written (Box 4.12).
Having an impairment is seen as the personal responsibility of the individual, with the individual having to control their altered state to fit the normalised view of health care and nursing. There is a focus on the individual identifying how they can adjust to meet the course requirements; the individual has to make up the differences to achieve the pre-set standards of how things are. This is very much linked to skills and skills achievement. The kind, supportive and benevolent lecturer (P007) supporting the student with achieving this by helping the student practice the skills, and providing an opportunity for these skills to be demonstrated to others, proving that an individual can achieve and perform the skill in a pre-set manner. This affirms the normalcy through which nurse competence is measured, which is defined by an ablest perspective of what society, employers (NHS) and patients expect of a nurse. Disability then becomes problematic for health care, as it challenges perceptions of what is possible. A student with a disability also lacks the capacity for insight, and to be able to judge for themselves the impact of their impairment on their performance because 1) they do not know how they should be 2) they are less able than other students who are not disabled. Because of this the student needs to be protected from harm, and the lecturer assumes responsibility for their safety and of the safety of those people with whom the student will have contact – vulnerable student unable to care for vulnerable patients. The concept of vulnerability is linked to concerns about safety, safety for the student, safety for the patient and safety for the clinical environment. Nurse Lecturers (NL) were very concerned about keeping people safe and assumed a fiduciary relationship. In a fiduciary relationship, one person, in a position of vulnerability, justifiably vests confidence, reliance and trust in another whose aid, advice or protection is sought in some matter. In such a relationship, good conscience requires the fiduciary to act at all times for the sole benefit and interest of the one who trusts. In this case, the NL perceives the patient, the clinical environment (staff) and the student as having had a claim on them for support. Can a fiduciary relation be between an individual and group? Is this an implied ethical relationship? Although the participants can describe when disabled students and others have been in practice, there is an assumption that they will be ‘normal.’ A disabled person is not given permission to be ‘fully’ present in the workplace. As being fully present, might be more problematic.

Ideas emerging from the data 1) There is an accepted ‘ordinary and normal’ way to be a nurse, 2) Disabled student as vulnerable other, lack ability to be self-determined. Nurse educators must act on their behalf, 3) Differing impairments are seen differently creating a greater or lesser problem; 4) Nurse Educators have a fiduciary relationship with the student, patients, and clinical environment. Students need to trust the nurse educator that the nurse educator is acting in their best interests, 5) Inclusion of disabled people as student nurses are dependent on the individual being given ‘permission to be ‘present in the workplace.’ Most-disabled people hide their difficulties in the workplace because they are not ‘fully present in the workplace.’
This theoretical memo explored the ideas around disability as less than and in doing so three new-conceptual ideas emerged: -

- Ordinary and normal
- Fiduciary relationship between nurse educator and the student
- Permission to be fully present in the workplace.

These conceptual ideas became categories through which the data could be further interrogated to see how they compared with existing categories and incidents.

This analytical process of writing theoretical memos, to develop conceptual ideas, continued throughout the research process and as each new-conceptual category emerged they were grounded in the data through the constant comparative processes and theoretical sampling.

4.6.1 Theoretical sensitivity

Glaser and Strauss (1967) consider theoretical sensitivity as being a two-part process. Firstly, it reflects the researcher’s insight of themselves and their awareness of their subject and secondly their intellectual development and how this influences everyday thought. Developing theoretical sensitivity occurs alongside data collection, data analysis and memo writing as theoretical ideas are used as conceptual levers. The process of developing theoretical sensitivity reflects the way in which emergent codes are refined by theoretical ideas and knowledge which develop the conceptual nature of the category, which can then be compared with the data. In this process, the subsequent shifting of perspectives lifts the finding from a descriptive to conceptual theory (Ng and Hase 2008).

The initial concepts emerged from the very data analysis itself as the writing of memos constantly compared emergent ideas with concepts grounded in the data. As this process continued, the use extant literature (Giske and Artinian 2007) added to the developing theoretical sensitivity and led to increasingly focussed interviews and revision of previously identified conceptual categories. The literature review (section 3.4)
became secondary data and in this manner the cycle of data analysis, emergent codes, memo writing and constant comparison continued until emergent categories were saturated and grounded in the data. Categories that did not fit the data were ‘side-lined’ or ‘rejected’ as not being significant in the context of this study and did not then contribute to the emerging theory. In this way, categories and concepts become delimited, and I was left with a series of categories that had emerged from the data and are focussed on the main concern of the participants.

4.7 Coding

From the beginning of the research process, the amount of data that emerged was at times overwhelming as coding began immediately following the first interview, and as a novice grounded theorist, the process often felt ‘uncertain.’ In completing a grounded theory, Glaser (1998), cautions researchers that they need to be tolerant of uncertainty, as they embark on a process that is not guided by a previous hypothesis. Through perseverance, the grounded theory will emerge from the data. Critics of CGT argue that ‘trusting in the emergence of the grounded theory’ is only made more certain when the researcher has a wealth of knowledge to support their theoretical sensitivity (Fram 2013). In contrast, Glaser (1978, 2002, and 2004) argues that it is through the application of grounded theory procedures, which the emergent theory will become evident.

The process of coding attempts to order the vast amount of data that is collected. Glaser (2008) makes reference to different types of coding: -

- substantive coding that includes both open and selective coding that conceptualises the empirical substance of the area of research;
- theoretical coding that conceptualises how substantive categories relate to each other in the emergence of the grounded theory (Glaser 2008).
4.7.1 Substantive coding

Holton (2007) described substantive coding as ‘the process of conceptualising the empirical substance of the area under study: the data in which the theory is grounded’ (page 275). This process began with initial open coding to identify incidents\(^8\) and the comparison of these incidents to each other.

In engaging with substantive coding, I asked the following key questions of the data.

- What is the data a study of?
- What category does this incident indicate?
- What is happening in the data?
- What is the main concern being faced by the participants?
- What accounts for the continual resolution of this concern? (Glaser 1998, page 240)

As I began the coding immediately following the first interview, I was able to capture everything that appeared to be significant, and whilst this initially felt overwhelming, it enabled me to identify a range of categories that could be used as conceptual ideas for subsequent interviews. Questioning and challenging the emergent categories encouraged me to focus on the patterns of the differing incidents which then give rise to emergent codes. To remain objective, word clouds, the use of Thesaurus and simple Google search terms also assisted in the visualisation of emergent categories and codes. These artefacts focussed my attention and allowed me to rise above the data to imagine concepts that through the process of constant comparison facilitated conceptual thinking and abduction allowing categories to emerge. As concepts, these provided me with the opportunity to see the data with new and different eyes, to consider data in unfamiliar and new ways and in doing so maintain objectivity and openness to the emergent theory. The emergent\(^8\) Incidents refer to the empirical data, the indicators of a category or concept, from which grounded theory is generated.

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8 Incidents refer to the empirical data, the indicators of a category or concept, from which grounded theory is generated.
categories then formed the coded, condensed and abstract view of the data. The initial coding of the first interview (Box 4.13) is below.

Box 4.13 – excerpt from interview 001, with coding to identify emergent categories
During the data analysis, there were so many areas that seemed to cause concern that I found it difficult to get a sense of the main concerns being raised. It was at this stage that memo writing, use of word clouds and ‘free writing’ were important to capture emerging ideas and conceptual codes to illuminate the patterns that were evolving (Diagram 4.2).
4.7.2 Theoretical coding

Substantive coding leads to the emergence of categories and sub-categories, but it is in the process of theoretical coding that the underpinning pattern that describes the actions of the participants as they resolved their concerns emerge.

The aim of identifying conceptual categories and the process of constant comparison (Section 4.2) is for the emergence of a core variable. The core variable is what Glaser (2002) described as being the theoretical code that explained how the participant’s main concern was processed or resolved. It was the theoretical coding which conceptualised how substantive categories related to each other in the emergence of the grounded theory. The final theoretical code is the grounded theory (Hernandez 2009) and must be central and relate to as many other categories and their properties as is possible whilst simultaneously accounting for the variation of behaviour. In doing CGT, it is the development of the theoretical code upon which the grounded theory will develop that is considered an essential component of completing a grounded theory. Although theoretical coding can be confused with substantive coding, it is the conceptual elaboration of the emergent patterns that signifies its relationship with the data. As the substantive codes became increasingly conceptual, the theoretical codes begin to emerge that implicitly demonstrate how the substantive codes related to each other. Glaser (2005) refers to these theoretical codes as a ‘modelled, interrelated and multivariate set of hypotheses that account for the resolving the main concern’ (Glaser 2005 page 11). The identification of the theoretical code, then allowed for selective coding and further literature review (Holton 2007). In selective coding, data collection and analysis, including memo writing, is delimited to that which is relevant only to the emerging theoretical concept.

Glaser, 1978, clustered together theoretical codes derived from epistemology and sociology in the form of coding families that made basic claims about how the social world was organised. Examples of coding
families include basic social processes (concepts include stages, phases, transitions, passages, careers, chains and sequences) and the ‘six C’s’ (concepts include causes, context, contingencies, consequences, covariance’s and conditions). Kelle (2005) argued that this simply provided a ‘hotchpotch’ (Kelle 2005 page 4) of concepts that aided in the development of theoretical sensitivity. However, Glaser argued that in the absence of a theoretical code ‘theory tends to be a mundane conceptual theory’ (Glaser 2013). The coding families are important to sensitise the researcher (Glaser 1998) to the array of behavioural patterns that enabled the researcher to link the fractured data back together in a parsimonious grounded theory (Ng and Hase 2008). In selecting a coding family, only the variables that are related to the core will be included (Glaser 2005). In any study, there may be more than one core category but it is in the delimiting analytical processes and constant comparison that enables the researcher to ‘see’ the theoretical code that ‘resolves, processes or solves the main concern of the participants’ and allows the development of theoretical completeness (Glaser 2005 page 8). In this thesis, through constant comparison during the coding process it was the emergence of different stages, and the sense of ‘action’ and ‘movement’ that was evident as the emergent core category was ‘processed out.’

Theoretical saturation is achieved when no new properties emerge from the data, and the interrelated categories have a theoretical completeness. This process continues as a means of abstract modelling of ‘latent structural patterns that integrate and explain the emerging theory’ (Holton 2007 page 284).

4.8 Personal reflection on professional and personal experiences

During the data analysis, the Glaserian dictum that ‘all is data’ led to a review of not only the interviews, but also contextual information gained during the interview process and reflection on my position as a researcher.
Glaser (1998) argued that whilst he advocated that the researcher should be objective to the research to avoid forcing the data; he acknowledged that researchers often entered the field with an interest or curiosity about something. By actively attending to my responses through the process of ‘self-interviewing’ (section 3.3.1), Interviewing oneself, is a strategy advocated by Glaser (2012) and in using self as data it enabled me to make transparent preconceptions and the potential for me to be ‘closed’ to ideas that might inhibit creativity and force the data. I became another source of data that led to the identification of new concepts, through which constant comparison with the data led to enhanced theoretical sensitivity (section 4.4.1). It was in this way that it became evident that my concerns were not those of my participants and whilst this was initially disconcerting it provided an exciting opportunity to explore what was the main concerns of my participants as I felt ‘freed’ from the constraints of my preconceptions. The process of being critically reflective, seeing oneself as data, was also facilitated by the process of research supervision, which served to challenge developing ideas of GT and illuminated emotional experiences, reactions, and cognitive biases that had the potential to obfuscate and distort data collection and analysis.

Theoretical sensitivity was enhanced by exploring my personal responses to disability, and to the emergent categories. These periods of critical reflection occurred throughout the research process, but it was at key junctures, when the research appeared to stall, or the confusion and chaos that shrouded the data appeared to be impenetrable that they helped to provide the clarity to explore data from a shifting perspective. For example following an emotional Ph.D. supervision meeting, the Ph.D. supervisors challenged me to consider whether this emotion was as a result of being a mother of an adult with disabilities, my concerns about her experiences in the workplace or as a result of my work experiences? This question provided the impetus for critical exploration of ‘self’ through the probing and questioning of personal and professional responses to people with disabilities. Glaser argued that in this manner, ‘interviewing yourself’ and treating yourself as data can provide conceptual insights that can further enhance the data analysis (Glaser 1978)
Seeing self as data was achieved through a series of memos, conversations with myself, and diary accounts of incidents that occurred, both professionally and personally, during the research process (Box 4.14)

Memo on self - Distancing January 2012

I believe I need to be able to see the data in an objective way but feel challenged that being objective might be false, when on a daily basis I address the issues associated with disability. Normally I distance and compartmentalise my life but distancing seems to be increasingly difficult for me to articulate.

Participants appear to distance themselves from disability in a range of different ways – time, place, role, but I cannot seem to get past what or why. Feeling very emotional today and not sure why I seem to be stuck with the data, and I am feeling very frustrated.

Memo on self – Distancing Feb 12

Difficult supervision but seems to be going nowhere. I can feel something is there but cannot seem to get past what is happening and am concerned that I am forcing the data, making it fit my preconceived ideas … always a fear when XXX says I sound quite strident in my views, so now I avoid personal views. Deep breath…maybe I need to think of myself and my responses. The idea of being distant keeps resurfacing within my thoughts Distancing – is this something I do. I think I do it all the time. When my D….rings and she can ring many times a day sometimes, I feel I cannot cope with her needs, so I do not answer the phone. Dealing with her difficulties, all seems so difficult. In fact, I think this is a strategy to avoid trying to manage a situation where I do not have any answers, but I feel as if I am supposed to make it all right and the difficulties to go away, maybe this is about self-preservation, I do not think it is about abdicating responsibility as ultimately I have a responsibility for my D……as she is family. However, putting distance between me and the events helps me to consider solutions, to be objective, being objective to the situation is important to me as it helps me to analyse and to think through solutions, it is not my D…just a person as a student … maybe I need to think about distancing not in a literal sense but as a mechanism to keep me strong and resilient in uncertain times, a coping strategy for uncertainty. Feeling in control, or regaining control…

Box 4.14 Memo on self - Distancing

Following this memo on self, I then used the conceptual category of regaining control and constant comparison to see if it was evidenced by the data. Regaining control in the manner in which I had been considering it from my personal experiences was not evidenced in the
data, but distancing as means of deferring responsibility and avoiding challenges to decisions made appeared to be relevant as a means of preserving the image of a professional educator, and avoiding conflict. (Box 4.15)

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**Theoretical memo - Distancing April 2012**

– There appear to be many situations when participants put space or distance between themselves and decisions about a student. It is most evident when they are considering an applicant for the course who discloses a disability, and they are reluctant to not give them an opportunity. The fear that they are discriminatory or might be accused of being discriminatory, leading to a reliance on others to make a decision. In this case, it is Occupational Health who makes the final decision. Thus, a decision as to whether they accept or refuse a student is not theirs. Even if they disagree with the decision, they are unlikely to challenge it simply deferring to the decision as it is made. Not feeling able to challenge a decision seems to reflect the uncertainty about disability in general and a desire to avoid conflict. There is a sense of movement and action as they move away or move towards the student…moving away is most often when they have no solutions, whereas moving towards indicates they feel able to resolve the concerns.

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**Distancing May 2013 -** Distancing is also evident in the participant’s consideration of the student’s progress in clinical practice. Distancing as a term does not capture their reliance on others to make decisions 1) Occ health 2) mentors in practice 3) employers **Deferred decision making** seems a better description than **abdicating responsibility**, as outcomes are not associated with the individual, and the image of the professional nurse educator is intact. Maintaining their professional role facilitates how they will be seen in the future by their clinical colleagues and maintains ‘trust’ in how decisions are made.

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**Box 4.15 Theoretical memo on Distancing following constant comparison**

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**4.9 The literature review**

In CGT methodology, the literature review is delayed until after the emergence of the core category (Section 3.4) at which point extant theoretical concepts can be compared and contrasted with the substantive
grounded theory. Glaser argued (2004) that the literature is then treated as another source of data, which through the grounded theory procedures helps to further refine the grounded theory. In this sense, concepts from the compared literature are considered to be new “data” to compare constantly to the emergent theory. This new “data” may ‘give new perspectives on the emergent theory and its prospective role in the literature, as well as “data” that might benefit from a different perspective’ (Christianson 2011). In this study, the secondary literature review became an important element that sharpened the concepts and illuminated how the emergent grounded theory added to understanding the social processes that occurred.

4.10 Other sources of data

Whilst the prime field data was in the form of participant interviews, contextual data from the environment, and the public and professional domains were also collected. During the interview process, information gleaned from the participant’s place of work was treated as an additional source of data and helped to get a sense of the participant’s contextual working environment. This data included; -

- written material from each HEI;
- information within the public domain related to nurse education at the respective institutions;
- materials available from the professional body NMC on pre-registration nurse education;
- And diary notes of information within the public domain including published reports and government briefings.

During the time frame of this study, significant changes in government legislation, social policy and concerns about the quality of nursing care were within the public domain and frequently reported in the media. Ideas generated by this background data, ‘grey’ data, were also captured in memo writing. In this way, theoretical sensitivity was enhanced, but it was only through the process of constant comparison with the field data, that any concepts became integrated into the theory.
4.11 Judging the credibility of a grounded theory

There has been much debate as to the applicability of judging qualitative and quantitative research by the same criteria (Mays and Pope 2000); as quantitative, and qualitative research has different purposes and stems from different philosophies. The credibility of the research findings is an important consideration and in quantitative research there are many established measures of credibility, associated with reliability, validity and generalizability associated within a general positivist epistemology (Winter 2000). In quantitative research, often completed by experimental methods and quantitative measures to test the hypothesis, the outcomes are judged on their generalizability (Bashir et al. 2008). In addition, Creswell (2003) argued that in establishing reliability and validity there is an emphasis on the measurement and causal relationship between variables. Often results will be subsequently illustrated with graphs and tables, which capture the findings as they are portrayed in the research (Golafashani 2003).

In contrast, the application of reliability and credibility within qualitative research reflects the research methodology and uses terminology that reflects this position (Shenton 2004). Guba (1981) for example proposed four criteria that demonstrated the trustworthiness of the study a) credibility, b) transferability, c) dependability and d) confirmability that corresponded to the criteria used by a positivist researcher.

In CGT, the Glaser argues that a satisfactory grounded theory will have what is referred to as the ‘five pillars’: fit, grab, work, relevance, and modifiability (Glaser 1978, 1992, 1998) and in the absence of these the theory will remain unbalanced and inadequate (Chametzky 2013). Holton (2008) describes these pillars as follows:

**Fit** refers to the emergence of conceptual codes and categories from the data rather than use preconceived codes or categories from extant theory.

**Work** refers to the ability of the grounded theory to explain and interpret behaviour in a substantive area and to predict future behaviour.
Relevance refers to the theory’s focus on the core concern or process that emerges from a substantive area. Its conceptual grounding in the data indicates the significance and relevance of this core concern or process ensuring its relevance.

Modifiability refers to the theory’s ability to be continually modified as new data emerge to produce new categories, properties or dimensions of the theory. The living quality of grounded theory ensures its continuing relevance and value to the social world from which it emerged. (Holton 2008).

4.12 Summary

Although, for the purpose of this chapter, the research procedures have been discussed sequentially in reality they occurred concurrently throughout the research process as concepts emerged, and ideas developed. The research procedures used in this study are summarised in Diagram 4.3, and although this is expressed in a linear fashion, the process is inductive and cyclical as the participant’s main concern becomes more coherent and theoretical in nature.
Diagram 4.3. Diagram of the research methods in grounded theory and their relationship to each other.
Chapter 5: The findings and emergent categories

This chapter will present the research findings, grounded by excerpts from the research interviews, field notes and memos. Where phrases and words used require clarification, an explanation will be provided in footnotes.

For ease of reading and to provide a logical flow, this chapter is divided into three parts. These three parts do not reflect the sequential nature of the interview process, but how key themes, collated as concepts, coalesced together to form sub categories to account for how the participants coped, addressed and responded to their concerns associated with disabled students within nurse education. Each part guides the reader through the concepts as they were developed and ends with a summary of the emergent category. The chapter begins by exploring what participants understood by the term disability and being disabled. It then explores how the participants related being disabled with becoming a nurse, and finally, how they related this to the professional role of nursing within the NHS and private sector.

5.1 Understanding disability

Having disabled students studying in higher education was common, and each of the participants described how they had supported disabled students in nurse education. This first section, understanding disability, captured the thoughts of the participants as they explored their understanding of disability from their personal perspective within nurse education. In their discourse what emerged was a professional understanding of disability (in the context of nurse education), as they shared stories of their professional experiences (related to students who had disabilities), and personal understanding of disability (in general and in nursing). This personal understanding was, for some, influenced by their experiences as a disabled person or those of a family member with an impairment. For others, it reflected a wider view of disability as portrayed in society.
As the interviews commenced it became evident how the participants welcomed the opportunity to explore the topic area and how they considered that a person with an impairment or disability is accommodated within a nursing course, and in particular within nursing practice. For many the concerns associated with supporting students with disabilities to become nurses had remained predominantly private, or only discussed with colleagues and friends in a cursory fashion during exam boards or when general concerns were raised about students. Jo and Jack illustrated this stance in the excerpts below.

Interview 011

Jo: I think it (disability) is something we worry about as a nurse and in education but it only gets mentioned when we have difficult students

KM: is this a student with a disability?

Jo: Yes, we try not to single them out and discuss the issues but it is a problem, a big problem in (nurse) education. We do not get the opportunity to explore the issues. So it is nice just to be able to air my views. We are so PC we do not want to talk about the real issues.

Interview 018

KM: As we started our discussion you said you had many concerns, could you explain what you meant?

Jack: Well we have a bit of a reputation here at XXX for being very good with students with dyslexia, so we have many students, and I am not sure it is a good thing. Because we have never sat down and talked about what it means to us as nurses. It is good to talk about the issues, like what if they are not safe, or something goes wrong. I have huge concerns about where it will all end up. We can only make it work if we have honest and open discussions.
Several of the participants had stated that they generally avoided discussing disabled students, as simply talking about disability, and its impact did not feel ‘politically correct’, and they struggled with knowing what words to say or to use. Jo alluded to her belief that ‘political correctness’ limited in depth discussion about disabled students in order to avoid creating a situation where they would be considered discriminatory; as people would automatically focus on the disability, and not the issues that were being raised. This unwillingness to talk about the student and the impact of being disabled as a student nurse continued to marginalise any discussion of inclusion or exclusion as the discussions almost always occurred once a student was described as ‘problematic’. In the context of the research interviews, participants felt able to explore these concerns and express what they considered to be the main issues.

5.1.2 Talking about disability

The discussions about struggling students often coincided with individuals becoming aware that a student had a disability and marked a time when they questioned their assumptions about the ‘normalness’ of the student nurse. Until then it was assumed that students would, by virtue of being on the course, be ‘fit and able’, and that their capability and ability to study to become a nurse unquestioned. Once they became aware that a student was ‘disabled,’ they questioned whether it was appropriate for the disabled student to be on the course; as they explored the implications of ‘being disabled’; and how this altered the student’s capability. In managing inclusion, this marked a critical juncture⁹, where the participant's personal and professional beliefs about being a nurse were challenged, as they considered the implications associated with being disabled in a nursing context. For some of the participants, this was the first time they had actively thought about having disabled people as nursing students. Whilst for others, this was an issue that they had worried about with previous

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⁹ A critical juncture has been described as a time where things do not fit easily into existing rubrics and new decisions have to be made
students, or because of their personal experiences. However, for all the participants each episode created unique problems and issues to be considered. Jack described the following encounter with a student whilst he was teaching.

Jack: ‘Now I am thinking about it, there was one occasion when I was teaching skills, and this student came up to me and said ‘you know I have a hearing problem, so I cannot do blood pressures?’. Well, I did not know, but all I could think was well how are you going to be a nurse then, – so I spoke to my colleagues, and we began to consider just what this would mean for the student in practice. How would a student be safe and how would the patient be safe if the student were unable to hear?

When the participants became aware of a disabled student, the relationship between the student and the nurse educators shifted as the nurse educators embarked on a period of decision making as to whether an individual could be offered a place on a course (if he/she was an applicant) or the need to provide additional support (for existing students). The ‘capability’ of the student or applicant to become a nurse adding to the factors that nurse educators considered when interviewing or supporting the individual. Their concerns about an individual’s ‘capability’ had the potential to impact on future opportunities for the applicant or student concerned. Although all of the participants had an opinion about disability legislation (Box 5.1), it was only when they considered the capability of a disabled student becoming a nurse that their personal and professional beliefs about ‘disability’ emerged.
Meaning of disability and being disabled

'It means that any physical impairment that might prevent them from doing something which would be deemed to be normal activity - Or mental illness, or cognitive impairment that would prevent them from doing what we would perceive to be normal activity Leslie

I understand it (the law), and I am looking at it from the perspective of how we are managing students with a disability, coming to the programme. When we see the person, we tend to see the disability, but the law is telling us to see the person first. Louise

There are a broad range conditions or circumstances where somebody may be impaired in terms of what is … normal to their normal activities. We need to acknowledge that, and perhaps take it from a person – individual perspective?' Jo

There has always been a standard blanket approach to certain types of disability. Somebody with muscular skeletal problems would not be fit for certain types of work. I am thinking about nursing if a person has got a back problem and they should not be applying for nursing. That would be the standard sort of attitude and feeling towards it. Liam

The legislation is trying to get us to think that might be the case, but it may well not be the case. So look at that person, first Lana

Box 5.1 Participants' understanding of the term disability and being disabled.

Throughout their discussion, it soon emerged that the participants associated becoming a nurse with the ability of the individual to be 'ordinary and normal'. In using 'ordinary' as, a benchmark participants
differentiated between students that were abled and those that were disabled. It reflected a ‘common sense’ view of disability; that framed the disabled person as being less able or lacking capability. The limitations they associated with being disabled made it difficult for them to consider alternative or other ways of being as a nurse. They were also aware that this ‘ablest’ view was challenged by current disability legislation; that focussed on a social model of disability (see chapter 2 for discussion of models of disability), and the importance of being inclusive. In thinking about disabled people becoming nurses, the participants struggled to balance what they considered to be a common sense view of disability, with the legislative requirements to be inclusive and avoid what they argued was inadvertent discrimination.

5.2 The ordinary worker

In justifying their position, there was an overwhelming sense of how important it was to be ordinary, normal and accepted within the workplace. The workplace was predominantly the settings in which student nurses engaged in nursing practice to develop professional competence, but for some it also included their place of work within HEI. In both settings, it was argued that by being ordinary and normal the individual’s presence was assured. In HEI accommodating ‘difference’ was considered to be more likely, whilst being ‘other’ in the workplace was associated with being marginalised and problematic. As such, the workplace was believed to have a preference for people being ‘ordinary and normal.’

The term ordinary referred to the ‘expected’ behaviours and performance of both abled and disabled student nurses. In establishing what was expected of a student nurse they compared their professional experiences and expectations of students; and their personal experiences of working as a nurse and as a lecturer.

For some, the ability to be ordinary reflected how they had ensured their own ‘disabilities’ were managed or remained hidden, as they passed as ordinary, non-disabled/not different in the workplace. Throughout their discourse, they were clear that they believed the disabled worker had a
responsibility to demonstrate their abled-ness, and ability to conform to the normative expectations of nursing practice. In discussing nursing practice they did not explore (personally or professionally) the benefits or positive attributes that ‘being different’ could bring to nursing practice or different ways of working; but how as nurses there was a set of expected behaviours, and the efforts that are required so that disabled people are perceived as ‘normal.’

5.2.1 Being normal

In being normal nurse educators, who disclosed being disabled, described how they had compensated for being different, and this is exemplified in the manner through which Lucy had managed, as a nurse, with impaired mobility. Although walking was both painful and difficult for her, she had maintained an ‘ordinary and normal’ way of working by framing herself as an asset to the workplace. In managing her disability, she had described working hard, staying longer to complete work, and being careful not to go off sick even if she was in pain. She attempted to ensure that her effort and work efficiency was greater than most of her peers, and as such her abilities, as opposed to her disabilities, would be remembered. In this way, Lucy believed that she was not seen as a ‘problem’ and did not openly disclose being disabled to her colleague. However, she believed that being in the workplace was a constant ‘battle’ as she ensured that her disability was not a factor that limited her achievements. This need to prove her normality had continued throughout her working life, and she remarked that even now in her current role, she still had to ‘prove’ to everyone she can do the job. The need to be seen as ‘able’ to do the job, and not just being able to do the job led her to consider employment as increasingly precarious, as maintaining employment was contingent on her ability to remain ‘normal’ and ‘able’. She was very wary of disclosing the difficulties she experienced as she believed this would change people’s view of her ability.
Lucy: Occ. Health is always a difficult one; you do not want to disclose as then people will see you differently. They do not really want to know about the problems, but if you don’t disclose and something happens, you can lose your job because they will say ‘yes well you didn’t tell us’

In her desire to be seen as normal Lucy expected that there would be times when she was in extreme discomfort but was able to ‘put up with the pain’ because she was doing the job she loved. This need to be seen as normal also extended into her private life, and she recalled how on a skiing trip; she had used ‘normal’ ski boots despite the pain and discomfort they created. As she talked she disclosed that it was only in becoming a lecturer that she began to consider having support, as she believed education would be more tolerant of her disability. In this new environment, she had finally, after a period of sickness accepted having special orthopaedic shoes to improve her walking and limit her discomfort, and had asked for an office on the ground floor. She knew that this marked her out as being different but had conceded that to complete her work it was an essential adjustment. However, even in this more tolerant environment she felt ‘watched and judged’, as she believed that the tolerance was limited, and could be withdrawn, if she created any additional difficulties or problems to her employers.

For some of the participants overcoming an impairment relied on their ability to ‘re-brand’ themselves as an asset. Lucy had already described how she was ‘good at doing the extra shifts’, and had worked extra hard. Josie also described how she had engineered a situation so that what she had perceived as a ‘problem to her colleagues’, became an asset. As a nurse, she had always felt she had never achieved her full potential, but when she discovered she had dyslexia, this provided some answers to the difficulties she was experiencing. Prior to her diagnosis, she described how she had worked ‘far longer’ than her peers in preparing for lectures, and created situations to avoid writing or reading; by getting the students to write notes on flip charts. In needing to be prepared well in advance of
any taught session she believed she worked harder, but she felt that her colleagues thought she was difficult, as she was unprepared to do things suddenly, such as covering sessions. Following her diagnosis, and as she began to understand why she had found certain elements of her role more difficult, Josie described how she had set out to become the ‘champion’ for students with dyslexia in her school.

Josie: “I had a reputation for being difficult because of the way I worked. So I have started championing support for students with dyslexia. I guess I must be a pain to my colleagues, but now I have some value as they do see me as the dyslexia expert. Now, any student they have problems with they send my way! I think it is ironic that they now see me differently because the University has made it such a big thing that we are seen to be supportive. It doesn’t fundamentally change their view; they just cover it up by sending the student my way.”

In articulating the need to work harder and the need to be a champion for the students with dyslexia, she reflected a view that acceptance as an employee with dyslexia, required her to create a situation that ‘retro fitted’ her to the working environment. It supported the belief that being disabled or different, without any tangible benefits to others, was more likely to be perceived negatively by colleagues in education and default practitioners in practice.

Most of the participants commented on the ‘number of disabling conditions’ students’ experience. Lilly commented, on how the broad legal definition made her rethink her ideas of what is considered as disabling. Her ‘common sense’ understanding of disability that was predicated on having a physical impairment was challenged by what she considered to be an ever increasing list of ‘disabling conditions.’

Lilly: The law includes things such as asthma and cancer, not just the obvious disabilities such as losing a leg. So it does make you think about things more. I do wonder where it will end as we can all have things that are ‘disabling.’
Throughout the discussions about what constituted a disability was the doubt that disability as defined by current legislation truly impacted on the individual’s ability to perform. As they considered the broad definition of ‘impairment’ they retained this belief that when the disabling characteristics were not obvious there was a need for confirmation that there was a ‘real disability’. The doubt about the impact of a hidden disability on an individual’s performance reflected a historic view of disability whereby there were obvious signs to indicate an individual’s ‘lack of capability’. Arguably this stance fits comfortably with the normal working environment of health care, which clearly defines patients and service users by virtue of their health and ‘ability’ status, as ‘other’ to the health care staff. In trying to understand the nature of the disability nurse educators emphasised the need for a disability diagnosis or label. This label legitimised the disabled status and emphasized the need for the nurse educator to consider how the student would be supported. It positioned the disabled student as ‘other’ to the ordinary students.

The need to be not disabled was evident when Louise described how she had considered herself as abled, because she believed that she could function ‘normally’ as a nurse and meet the ordinary expectations of clinical practice. As a consequence, she believed she was accepted with her disability because of her ability to nurse. However, when confronted with being seen as ‘disabled’ Louise was challenged to reconsider her value to the workplace, as she tried to understand how her abilities would now be questioned. The reluctance to adopt this label reinforced the negativity she had associated with being disabled, and her inability to recognise this as a true description of herself.

The presence of a disability diagnosis or label also reinforced the problematic nature of the person concerned. Julie and Liam articulated how important it was that clinical practice was not disrupted by the presence of a ‘problematic’ student or the need to change their ordinary way of work.
Julie: The wards have enough to deal with, without having to deal with students who are disabled. So it is important that the student can be normal so as not to cause disruption in the clinical setting.

Liam: When I talk to the practitioners about having a student who needs adjustments they just tell me how difficult work is, how they are very busy and short on time and simply have no capacity to consider anything that will disrupt the workplace.

Leslie, who had previously described how he had hidden his disability, illustrated the importance of assuming an ordinary and normal image when he described his experiences with a student who was Deaf.

Leslie: She was very demanding and could be quite unpleasant about making sure we are supporting her, maybe she had to be like this, she had learnt to be like this because of society, but I cannot see with an attitude like that how she can be a nurse. There is a normal way a nurse has to be, and we have to behave in that way no matter what difficulties we face.

From this study, it was evident that nurse educators believed that the workplace in general and the health care workplace, in particular, had an ordinary and normative way of being which focussed on how able a person was to work effectively. In thinking about how disabled students can be ‘ordinary’ and ‘normal,’ they explored the impact having a disabled student would have on the functioning of the health care workplace. Nurse educators believed that the workplace environment had a preference for workers who could be assimilated or ‘retro-fitted’ into the ‘ordinary and normal’ working routine without creating problems or difficulties to their colleagues or to the organisation. Indeed the experience of participants who described their attempts at being normal was matched by the general view that it was important that a student with a disability adopted ordinary, abled workplace behaviours and performance. Central to managing inclusion was the capability of a
disabled student to pass as ordinary and normal. Passing as normal acted as a ‘covert rite of passage’ that disabled students had to achieve to demonstrate, to the nurse educator and to the clinical practitioners that they were suitable, capable and committed to becoming a nurse. In managing the inclusion of a disabled student, the normalised, retro-fitted student was considered to be unproblematic as they could complete the course with minimal support.

From the data, the concept of ‘able disability’ emerged to describe the level of disability that the participants believed would be accepted within nursing practice because the student would be able to act in the ordinary and normal fashion. Managing the expectations of the clinical environment and the acceptance of the disability reflected how those participants with an impairment, had managed their disability or sense of being different. For others, the need to be normal was based on their ‘common sense’ understanding of the nature of being disabled and their inability to believe that nursing practice can be performed in any other way. Students who presented as able-disabled met the ordinary and normal expectations of a nursing student. In doing so there would be no changes to the expectations of the student’s performance, and clinical practice would not have to consider changes to the ‘common sense’ notion of what a student nurse can do or what was required of a nurse in clinical practice.

5.2.2 Being more than normal

For some participants, the acceptance and inclusion of a student with a disability were not associated with how ordinary or able the student was to behave in a normative manner, but by the student being exceptional, and a hero in overcoming adversity. The influence of the student’s personal story was demonstrated by Jo, who discussed how a student with a physical disability, had worked extra hard to overcome her disability in order to get to the initial interview and finally to start as a student nurse. She described how the student had started her first clinical placement:
Jo: “... so she came into practice, and she was absolutely delightful. She stood there in her uniform beaming and said – I just wanted to be a nurse all my life, and I am here doing it and I never thought I would be able to. I felt very proud of her at that moment.”

Jo’s admiration of the effort the student had put in, was evident, and was echoed by Laura, who also described how much work and effort a student with a disability would have to have put in order to achieve the course requirements:

Laura: ‘Students with disabilities have to work so much harder and give up so much more than other students just to get here.’

Disabled students who put in the additional effort and were self-sacrificing were considered in a favourable light even when there were concerns about their performance. Jane described her experience of having a student with a physical disability on a course, where the personality of the student had a greater impact than her concerns about his ability to be a nurse.

Jane: “he was so enthusiastic, and he was always the first to volunteer for anything we asked, I wish we could have bottled that for other students. I thought he will be eaten alive in practice, and I could not see how he could be a nurse. There were so many difficulties, and we had responsibilities for our patients and their safety.”

Lana mirrored this stance when she discussed a student who had overcome a serious illness. She described how the clinical area managed the situation when a student who had had breast cancer, returned to clinical practice.
Lana: “she was so brave, and the ward were brilliant. They let her do as little as she needed and to come and go depending on how she was feeling. If she was able to do a couple of hours that was OK. They really went overboard on being supportive. It seemed right that we supported the student at this time; it was tragic and could happen to anyone.”

That nurse educators expressed admiration of disabled students whom they considered having been ‘self-sacrificing,’ had overcome adversity or were able to maintain work effort in difficult situations. The ability of the individual to overcome adversity reflected a heroic view of disability which influenced their belief in how supportive they, and their clinical colleagues could be. The heroic disabled student was judged as having an ‘exceptional moral fortitude,’ that positioned them as different to their abled peers. It also served to frame the student in a positive light and the individual was applauded for working hard and striving to become a nurse. The student was not at fault, or responsible for any ‘failures’, and the actions of the nurse educators reflected a positive moral position, to be supportive and non-judgemental.

Participants in general, argued that a student with a disabling condition who demonstrated how they had overcome adversity and possessed a willingness to work hard, would be accommodated in the course, as it seemed to be morally just\(^\text{10}\) to be supportive. Supporting a student was made easier if the student was seen as pleasant, and as ‘being delightful,’ and the nature of the disability was not too demanding of the people involved. This conditional support, for particular students, was reflected in the way they described the student within the interviews and their willingness, despite the doubts they had about the student being successful, to give the student an opportunity to study.

\(^{10}\) Acting ‘morally’ refers to a belief that as a nurse and as a lecturer the individual should behave in a right and proper way that is inherently good.
Lee: ‘I thought she was so brave to want to do this, to be a nurse.’

Jim: ‘it is not just coming on the course, it must be so difficult to keep on striving to do the thing you want when everything is stacked against you.’

For others, the exceptional nature of being disabled, that is epitomised by the image of the 'wheelchair athlete' challenged their ‘common sense’ notion of disability. The conflict associated with being both ‘disabled’ and ‘fit’ was explored by Jack; as he discussed whether an applicant with a physical disability could become a nurse.

Jack: you have got to have stamina. You have got to be in good health because of the nature of the work, the shift pattern - the unpredictability of some of the settings that people work in. I think that health is an advantage and being fit is an advantage. So we think that being fit is about being able – if that makes sense?

And that somebody who is disabled, therefore, can't be fit. But we know that that is not the case. We know that, you look at the wheelchair marathon; you know there are people who are far more fit than some of our student nurses! That is probably what we cannot sort out. If we think it is good to be healthy and fit, then that correlates with being able-bodied and not disabled

We haven't sorted out what the differences are. Because actually being disabled you can be very healthy and fit, and not smoke and not drink heavily. They perform much better than I would if I had to push a wheelchair for 26 miles. There is nothing that they could not get involved in. if they met the entrance criteria, in terms that they have got the qualifications and their person specification … no their personal statement showed that they had knowledge of the field of nursing, and they had the right commitment to nursing, and their references supported that, then they would get an interview, and they would probably be offered a place: it would be based on occupational health clearance, and then ….we would have to consider all the problems it will cause and the likelihood of the student being unsuccessful

The heroism associated with managing as a disabled person was evident in his discussion as Jack considered individual impairments, and the attributes that would be required to become a nurse. In his discussion he recognised that not many abled student nurses could complete
marathons but that for a disabled student to be able to use a wheelchair, as a nurse, they would need to demonstrate a level of fitness that was greater than their abled peers. The inability to reconcile the conflict between being ‘fit and able’ and being ‘fit and disabled’ remaining as a potent limiter to disabled people having the opportunity to study to become a nurse.

Jack recognised that the concept of fitness and its relationship to being able was not adequately explained by the belief that having a disability was automatically equated to being unfit. As he explored the issue, he shifted his view from one where being physically disabled automatically prohibited the applicant’s ability to nurse, to considering how with a physical disability you could nurse. However, even whilst he considered the possibility of a student using a wheelchair, he remained concerned that in the workplace having a disability was inevitably linked with being problematic.

Other participants had described how, when they considered people with disabilities applying to become nurses, that any decisions to include a disabled person would be judged, by others, as discriminatory or unrealistic. Joanne made this explicit as she described an interview, in which the candidate was being considered for starting on a BSc Nursing course.

Joanne: “We interviewed this candidate, and she was clearly not quite right especially in the group work and the way she was talking, quite awful really, and we were concerned about how she would manage. However, we talked with her, and she explained she had been diagnosed with Asperger’s, and she had worked hard to get here and she knew she would have to work hard to get communication right, she showed such insight that we decided to give her a chance. If she were just awful, we would not have taken her. Colleagues have thought we are mad as they cannot see her being successful on the course as they do not think it will work in practice. I think we have a view that we cannot discriminate against people, so we tend to take them and hope for the best.”
Despite Joanne considering it right to offer a place on a course to study nursing, she recognised that others doubted the decision made. Seeing the potential for an individual to be a nurse involved the participants being able to see the person before they saw the disability, and to feel able to take a chance and provide somebody with the opportunity to prove their abilities. Rationalising that the applicant had already demonstrated considerable effort and had shown insight convinced Joanne that offering the applicant a place on a course was appropriate. She felt that it was fair to accept the student as she had no reason not to accept the applicant. However, ‘hoping for the best’ reflected an uncertainty about whether this was the right decisions to make.

Valuing and recognising the effort that was required of a disabled person to become a nurse had been alluded to by Lucy as she described her own ‘battles.’

Lucy: “When I was nursing I would work longer and stay later to make sure my disability did not cause any difficulties in practice. It was my responsibility to put in the extra effort required so that nobody could say I was not pulling my weight.”

As Lucy accepted the responsibility for ensuring that the practice setting was able to function effectively, reflected a belief that as a disabled nurse, she had to possess the right positive attributes and be prepared to put in the additional effort. It was her responsibility to ensure that the disability did not create any additional problems within the practice setting.

Believing that people should be able to make sacrifices and to work hard in order to become a nurse was not limited to students with disabilities. However, when considering a disabled applicant or student, it was seen as a positive indicator as to how as a person they managed their disability and minimised the potential risk for problems in the future. In their general discussions of applicants and students, participants were more likely to make reference to the individual’s positive or negative, personal
characteristics if they disclosed or demonstrated a disability. When an applicant or student presented in an unexpected manner, they often explored to see whether the individual had a disability that explained the 'abnormal' behaviours they had identified. The nurse educators expected the ‘disabled’ applicant or student nurse to disclose their disability and to demonstrate a greater level of personal transparency than their ‘abled’ peers. If an applicant or a student did not disclose a ‘disability’, this was judged negatively and indicated that they were less likely to have the appropriate ‘insight’ required to be an effective nurse.

These narratives of students overcoming adversity or being ‘super fit’ led to the emergence of the concept ‘virtuous disabled,’ a view of the disabled student as possessing high moral fortitude and positive traits, and who, despite difficulties, was able to demonstrate their potential for being a nurse. The student judged as being ‘virtuous disabled,’ was seen by disabled and abled participants as being able to achieve their goal of becoming a registered nurse. As a student, the disability was not hidden but was seen as a mark, as to how hard they will have worked in order to be a student, and as a consequence the effort they would put in the future. In having a virtuous disability, a disabled student was more likely to be seen as an individual, and practitioners were more likely to consider adjustments to the practice setting. The nurse educators and clinical practitioners accepted the additional workload (identifying and implementing reasonable adjustments) as they considered it to be synonymous with being supportive as it was the ‘right’ thing to do.

5.2.3 Uncertainty

Although some of the participants related to either their own or others experiences of being disabled in the context of nursing, others in discussing disability, expressed uncertainty about what being disabled meant and how this would impact on the ability of the student to become a nurse. This uncertainty was evident in how their discussions unfolded and how they searched for words and examples to describe their position and beliefs about disability and being disabled. Participants who felt
uncertain also expressed doubts about disabled students, voicing concerns associated with the greater ‘risks’ the presence of a disability created and how this limited the student's capability to become a registered nurse. The focus was not on how as a disabled person, the student might become a nurse, but the risks to others of having a disabled person as a student nurse. This uncertainty was not universal to all ‘disabling conditions’ but was evident when participants discussed particular impairments or disabilities. Jane, for example in discussing a student with cerebral palsy commented

Jane: “he not only looks different, and walks different, but he laughs inappropriately and gets far too close to you. The staff (in practice) find it very uncomfortable to work with him. I do wonder what on earth patients must think, but they seem to be very nice to his face. Although there was one occasion when someone who was drunk thought, he was one of the patients. He did pass the course and got a job, but I think there were difficulties. The risks associated with him being in practice are huge, not just to him but to everybody else as well.”

The uncertainty associated with certain hidden disabilities increased the concerns expressed by the participants, and they felt challenged by being asked to consider a disabled student becoming a nurse, doubting the student’s ability to be successful within the course.

Liam: “Having a mental illness is risky; we could not have someone with BPD (borderline personality disorder) for example, becoming a nurse as we would not know how safe they were. They would not be aware; they might not turn up, and the lack of insight would be disruptive and cause us real concerns. We had this student who had a long history of depression, and he was really hopeless, when he turned up he would be exhausted by midday, and the ward was forever sending him home, he just was not able to function in the way that was expected.”
The ‘popular’ and ‘unpopular’ judgements made about certain disabilities reflected the values associated with differing impairments as nurse educators addressed the management of inclusion within nurse education. As a consequence, both Jo and her description of the ward area described a response to breast cancer that was qualitatively different to the account given by Liam, as he discussed mental illness. Students with hidden disabilities, fluctuating conditions, chronic illnesses or stigmatised disabilities such as mental illness, were presumed to be less capable of managing their disability or themselves and had limited insight, as such they were considered to pose a greater risk to the workplace.

For the student who had recovered from breast cancer, flexible attendance to facilitate inclusion of the student was seen as both manageable and acceptable. For the student with mental illness adjusting shift patterns was not considered as an option, and the student was expected to act as 'an ordinary student.' The unwillingness of the nurse educator to explore adjustments to the mode of attendance as a strategy to support the student was evident. The student with mental illness and their support were considered as a drain on clinical resources.

Mental illness was a particular concern of the participants as they associated being mentally ill with being disruptive, unpredictable and posing a greater risk to the clinical setting than other students, abled or disabled. Jo described the events that surrounded a nursing student who had a mental illness.

Jo: “And it was because he became a ‘famous cause’ in the sense that he went round the xxx, he walked into medical lectures and things, and started challenging the laws of relativity, and all sorts of things like that. So many people talked about it and knew about him and– xxx, which is mental health trained - had him in a Seminar when we first realised that he was seriously becoming disordered. He was doing a really bizarre presentation, and he was nearly lynched by the other students because he was making outrageous comments.”
“It often challenges people when … where do we stand? What actions can we take? At the time, the university had no real infrastructure to deal with that. However, then the next day he was admitted and that solved the problem.”

The negativity associated with mental illness was justified by referring to the case of ‘Beverley Allitt.’

Jo: “we can all think of students who have gone off the rails, like Beverly Allitt, and then we are concerned about their MH status and whether it will happen again.”

Josie: “It is like having Beverly Allitt, nobody could have foreseen that happening, so we have to be very cautious and think about keeping people safe, I think there are real dangers there when you do not know what might happen.”

As the participants discussed ‘disabilities’ that caused concern they often alluded to a cautionary tale to substantiate that having the particular impairment was inevitably associated with difficulties and problems, and increased the risk of harm and danger, situations in which people would be unsafe. In exploring these difficult situations, they used: -

- Real life experiences, examples of what has happened
- a ‘cause celebre’ as an example of what could happen

In using a cautionary tale, participants reaffirmed beliefs that having a disability was inherently problematic, and provided a common sense explanation as to why having a student with a disability on a nursing course would be difficult.

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In trying to understand why a student with a disability would want to be a nurse, some of the participants were suspicious of the student’s motives and considered that they were in reality accessing care to address their needs.

Lucas: “one of the difficulties, they have a great insight, and they can tell us a lot about it (the disability) So they really do tick that box, there might be some other things that you think and it is very difficult to then say – well do you think you are just accessing this for the right reasons’. Are you sure this is not just a surrogate support – or a surrogate care worker that you are looking for here?”

Louise: ‘One of my concerns has always been why a student is studying to be a nurse, are they looking for support,’

Others simply questioned the rationale as to why a disabled person would pursue a career in nursing.

Jack: ‘I do not understand it really why put yourself through all of this when the one thing you want to enjoy is nothing but problems and difficulties; it must make them feel even worse.’

His statement ‘it must make them feel even worse’ implying that as a disabled student the student already had negative feelings about being disabled. The assumption that disabled people aspire to be ‘normal and ordinary’ reaffirms that there is a preferred normative way of being. The inability to see the value and worth of ‘being’ marginalises the disabled person as ‘other’, and challenges the authenticity of a disabled person’s aspirations to become a nurse.

Positioning the disabled student as less capable and less independent was enhanced when they considered whether a disabled student was able to maintain the safety of patients or had insight into how their impairment impacted on their ability.
Jack: “People have a label for a reason, and you would not want somebody with dyslexia doing drug rounds would you. We don’t know enough about what it means to have a disability; it is not enough just to know they have a disability we need to know what that means.”

Julie: “If they have a skin disorder for example I think they will just stop washing their hands because their hands are sore, and they do not realise about safety.”

Participants believed that disabled students lacked many of the positive attributes required of a student nurse and as such the participants felt responsible for keeping the patient safe from potential risks.

Liam: “You would not want people like that caring for your children, well nobody would, would they. It is no good just saying oh well they have dyslexia, and it will be all right, you need to know it will be all right. You would not have a blind pilot so why would you have someone like that as a nurse. We would have to be constantly checking that they were safe.”

Feeling burdened by the responsibility of identifying the potential risks and hazards associated with a disability, and assuming responsibility for monitoring the student’s performance concerned many of the participants. In response to this, they referred to what was arguably a ‘common sense’ position, to demonstrate how having a disability is incompatible with the role being described. The uncertainty associated with having a student with dyslexia, and the potential risk of harm was reinforced by the imagery of the blind pilot.

As they articulated their concerns about the potential for the increased risk in the clinical setting that they associated with the ‘unknown’ nature of the disability, they used a ‘common sense’ explanation as to why having a disability was likely to be problematic. Providing a concrete ‘lay example’ of how having a disability impacted on the ability to complete
'skilled' work and maintain safety, enabled the participant to make a case for not having a student with a disability in practice.

Nurse educators needed to rationalise and justify decisions made to ensure that their judgements were considered to be fair and just. This process required them to satisfy their concerns based on their views of disability. The combination of doubting why a disabled person would wish to become a nurse, and the suspicion that the applicant/student was accessing the course for their support needs challenged participants’ ability to see disabled students as independent learners. It also predisposes the nurse educator to consider ‘exclusion’ as opposed to ‘inclusion’ as being a common sense outcome.

From these general discussions about being disabled and what participants expressed as the potential risks associated with a disability, emerged the concept of ‘Dis-Abled disability.’ **Dis-Abled disability** reflected the view that many disabilities were inherently risky. Including students with **‘Dis-Abled Disability’** had the potential to disrupt the clinical environment, and there was greater uncertainty about the outcomes. It also reflected a view that whilst nurse educators recognised that there were different ways of being and that being different did not in itself exclude a person from becoming a nurse, the uncertainty and the ambiguity associated with being disabled caused concern.

The discussions about different impairments and their potential impact on the individual’s ability suggested that nurse educators had developed an informal hierarchy of disability. Impairments that were difficult to understand or poorly defined caused greatest concern as they were believed to be more unpredictable and more problematic. The stigma of particular impairments was justified by rational arguments associated with increased danger and increased the risk to patients and staff in the clinical setting.
5.2.4 Being inclusive

As the participants discussed their understanding of the terms ‘disability’ and ‘being disabled,’ they painted a picture where despite recognising the value of being inclusive the deficit model, associated with a bio-medical model of disability prevailed. As they considered the different branches\(^\text{12}\) of nursing, and how a disabled nurse could be accommodated within clinical practice they explored how the expectations of how a student would perform differed between each of the fields of nursing.

Louise in her discussion of being inclusive believed that adult nursing was probably less able to accommodate disabled students and colleagues than other branches of nursing.

*Louise: “Adult nursing is probably the least tolerant; that is because we are the biggest group, the most physical, and although there are many diverse settings, they are the black and white areas. People tend to have a fixed view of what they expect from the nursing staff. So maybe there are more tensions in adult nursing than there might be in other areas I do not know.”*

This belief that the adult branch (AB) was less tolerant of disabled people was supported by Lana as she compared the adult branch to the learning disabilities branch (LD).

*Lana: “as a branch (LD) we are brought up from day one with the notion that disability is a social construct... Whereas a lot of our adult colleagues and Physio colleagues see it as a physical problem that may require fixing.”*

\(^\text{12}\) Branches refers to the different types of nurse – Mental Health, Adult, Child and Learning Disability. This term has now been largely been replaced by the phrase ‘field of nursing’
In these excerpts, the participants compared their beliefs about disability with their understanding of what nursing entailed. Adult nursing was linked to the biomedical model of care with its emphasis on completing psychomotor skills as illustrated by James and Liam.

James: “you cannot have a nurse who cannot give injections or take blood pressures.”

Liam: “Can you imagine the nurse (with a disability) doing a drug round?”

For the participants, the inability to complete psychomotor skills would be the main reason accommodating disabilities in adult nursing would be problematic. Participants also believed that patients who had a physical illness would expect their nurses to be able to perform certain skills and procedures. They believed that patients would have an expectation that nurses would be able-bodied and perform in a 'customary,' normative way.

Jim: “Patients would find it very surprising if their nurse could not do things like take blood pressures or do dressings.”

Lorna: “It’s easy for us to be inclusive, but nobody asks what the patients might think if he or she were being cared for by somebody who was disabled.”

In contrast, participants who represented learning disabilities (LD) or mental health (MH) considered themselves and their branches of nursing to be more inclusive and more accepting of students with disabilities. Nurse educators cited their professional beliefs about empowering and promoting autonomy within their client group, as evidence of this inclusive way of thinking.
Lana: “Whereas we (LD) place an emphasis on the outside world needing to change in order to accommodate a disability. So we come from a very different perspective.”

Luke: “We often take students who haven’t been successful in other branches. We have one girl, for example, who struggled opening medicine pots, but that is not an issue for us.”

For the participants their initial views on students with disabilities, and whether a disabled nurse would be accommodated within their profession, reflected their different nursing backgrounds. However as they discussed and reflected on students with disabilities; participants who had previously identified that they felt as a branch of nursing they were tolerant and most inclusive were able to give examples of disabilities that they felt were difficult and incompatible with their branch of nursing. Whilst participants who had identified themselves as being intolerant were able to describe situations where having a student with a disability had created no difficulties.

Lana LD “blindness is one that we find quite challenging. So not being able to see what is going on when, for instance, you are dealing with people who may have no verbal communication. Whereby you are totally reliant on your eyes to look at a person’s reaction as to what might be going on. So that was one thing that we found difficult.”

Jack LD “I am really thinking about the difficulties of being a lone worker, so we cannot have people with physical disabilities who, for example, would not be safe working in the community on their own.”

Josie LD “the student with speech problems, for example, was confused with the clients, and that took some explaining to the Doctors.”

Lucas MH “we cannot have vulnerable people (students with MH conditions) looking after vulnerable people.”
Lee MH ‘If they have obvious signs of self-harm that can be tricky in the clinical environment.’

Louise AD ‘I cannot see it causing any difficulties, the hospital is geared up to using lots of aids in the care now.’

Jo AD ‘Although I think about what they cannot do I can also see many benefits in having a disabled person as a nurse.’

Although participants from LD and MH backgrounds had considered themselves more inclusive than their AB colleagues, they were concerned about the inclusion of students who had disabilities similar to those of their client group. The need for clear demarcation between the student and the client was considered important in order to be able to maintain patient and student safety. Knowing who the nurse was was linked to beliefs about safety and minimising risk. Being a nurse was strongly associated with being protective and supportive of vulnerable others. As such, a disabled nursing student was more likely to blur the boundaries between the nurse and ‘others.’

In all branches of nursing the ‘common sense’ argument focused on whether the disability impeded the student’s ability to work effectively in a particular setting. Evidence of the importance of the context in which the student or nurse delivered care was present in discussions about when having a disability was not seen as a problem. Lana, for example, gave an example of how in LD they had employed students 13 who had active epilepsy.

Lana: ‘in the 1970’s we had students and nurses with active epilepsy working in special Epilepsy Centres.’

This view of conditional inclusion, whereby inclusion was made possible because being disabled was matched with a particular client group

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13 In the 1970’s student nurses had contracts of employment with local hospitals
suggests that disabled people are seen as a homogenous group, sharing common characteristics. When ‘grouped’ together the disabled people are considered to be safe and less problematic, as the context would be supportive, and the abled others could, in a fiduciary manner, ensure potential risks were limited. Although Lana had considered this to be ‘inclusive,’ inclusivity was restricted to a particular context, the student or nurse with epilepsy working at a special centre for epilepsy. The use of covert restrictions on where a nurse can work, effectively restricted the work opportunities of the individual, by limiting their employability within the wider professional arena. In effect, the disabled student or nurse was still deemed to be unsuitable and less capable of most aspects of nursing. In limiting the opportunities for the disabled student, the disabled student was segregated and distanced from their peers which limited not only what was expected of the student, but potentially also their career aspirations.

In managing the inclusion of disabled students, the participants identified some clinical areas, (notably the more acute or complex areas), as unsuitable for disabled students.

James: ‘Well they could not go to theatres or ITU, but I suppose they could work on a general ward, somewhere a bit quieter.’

Liam: ‘I think having a student in the adolescent unit, or acute admissions (MH) would be unfair and create too many problems.’

Josie: ‘If they are having problems it can change the whole environment which can be volatile at the best of times’ (discussing a dementia centre)

14 Distancing is referred to as a strategy through which individuals manage difficult situations. It can be a physical or psychological response whereby the individual puts ‘space’ between themselves and the issue they are considering.
If a disabled student were considered less able to meet the rigours of a particular setting, then one way in which it could be managed would be through identifying ‘an easier’ placement or specific branch of nursing. Judy discussed how the needs of different branches of nursing could be overcome when a student moved from one branch of nursing to another.

Judy: ‘She had real difficulties in Adult and failed her skills because she was not able to open medicine pots and do dressings and things but with us (LD) that isn’t a problem.’

Louise, when she had discussed managing epilepsy in practice, had also referred to the setting in which she had worked

Louise: ‘Well I suppose working on a neurological unit, we had many people who had seizures, so the staff was not that concerned if I did.’

Through the nurse educators, comparison of different branches of nursing and different settings within individual branches emerged a ‘hierarchy of practice’. This hierarchy of practice reflected the nurse educators occupational (work) values and their expectations of the work expectations within a given setting. This hierarchy of practice arguably considered those areas where adjustments to practice could be considered, alternatively it reflected a normalised ‘reproduction of oppression’ where in doing their work, nurse educators common sense approach to disability continued to position the disabled student as less than their abled peers.
5.2.5 Summary

The participants’ discussion about the ordinary worker and being inclusive, and thinking about students with disabilities within their different branches, suggested that the decisions made and the management of inclusion would be influenced by:

1) The type of nursing that was being undertaken
2) The type of disability that was being considered
3) The context in which nursing was taking place

How nurse educators believed being disabled impacted on the capability of students was captured in the concepts of the able disability, virtuous disability and dis-abled disability. These concepts reflected a hierarchy of disability that participants used as they considered the implication of accepting a disabled applicant, or supporting a disabled student completing a nursing course. This hierarchy of disability was supported by a hierarchy of practice (Box 5.2) as they matched the capabilities of the individual student with the expectations of the clinical environment.
<table>
<thead>
<tr>
<th>Exceptional - refers to the belief that if you were disabled but could be better than normal, the disability would be accepted</th>
<th>Virtuous disability</th>
<th>Quieter placement – able to accommodate students with a wide range of abilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accepting - Being self - open to disability through professional experiences Hiding The importance of Passing as non-disabled enough - normalising differences</td>
<td>Able disability</td>
<td>Student must pass as ‘ordinary and normal.’ Settings can support a student but this is dependent on the staff available and the workload.</td>
</tr>
<tr>
<td>Uncertainty about what the disability label means, but it must mean something The risks associated with having a disability and the uncertainty of how a disabled person might be. Student lacks insight and capability.</td>
<td>Dis-Abled Disability</td>
<td>Acute – fast paced settings where students will have minimal support. Students expected to fit into the clinical environment without disruption Patients/clients safety is questioned in the presence of the disabled student Unlikely to accept student who is different</td>
</tr>
</tbody>
</table>

Box 5.2 Hierarchy of disability and practice as described by the participants.

In supporting the inclusion or exclusion of disabled students the participants positioned an impairment within a hierarchy of ‘disability and practice’ based on the core values that they believed to be essential in order for an individual to have the capability of becoming a nurse. Some of these values such as working hard, sacrificing personal wishes, fitting
and being normal can be described as workplace or occupational values, and they are the positive attributes that the participants associated with being able to do the job. These workplace values indicated how the participants believed the disabled individual should manage their disability. Other values such as having insight, keeping people safe, knowing how the disability affects you, are intrinsic to the student and reflect the personal values held by the nurse educator. As such, they related less to being able to do the job, and more with having the right behaviours and attitude associated with being a nurse. These behaviours and values are linked to both the professional and personal values expected of a nurse in clinical practice.

Values can be considered in the context of personal, social and cultural value systems. Personal values expressed by the participants, related to how their individual beliefs and judgements about disability and being disabled were associated with what they understood about being ‘able’, and their view of how able and disabled people lived within a society. Their value systems reflected their professional and occupational values of being a nurse and of being a lecturer and how these related to their perceptions of others. Values can be prioritised, and this was evident in the discussions of the participants as they considered disability, being disabled and disabled students becoming nurses. The different values they assigned to differing impairments and disabilities; and their beliefs that some clinical areas were easier than others led to the emergence of an implied context specific hierarchy of disability. This hierarchy reflected how the participants believed the impairment would impact on the individual’s ability to become a nurse in different branches of nursing. Certain impairments, such as mental illness, were considered problematic within all branches of nursing, other impairments were accepted or not accepted according to the type of nursing that was being undertaken. How participants prioritised competing values and how these influenced their perceptions of a person with a disability becoming a nurse, influenced the participants' ability to see the student as being 'capable' as opposed to being 'unable'. The hierarchy of disability and practice guided the decision-making process that ultimately supported a disabled person to
embark on a course of study leading to registration as a nurse, or influenced decisions that led to the student’s exclusion.

The hierarchy of disability and practice informed the ‘internal’ decision-making process, as individual nurse educators rationalised the decisions that were made. Nurse educators with predominantly negative views about being disabled and fixed professional work values were more likely to consider a disabled student as being problematic. They expressed difficulties in being able to visualise a disabled student as a nurse or to identify new and different ways of working. Their professional and nursing work values mirrored a traditional view of the nurse as needing to be able to work hard, to work in any environment and to be able to give physical care. In contrast participants who held positive views about being disabled, positive professional values and flexible nursing work values could imagine a disabled student becoming a nurse in certain contexts or situations. They could envisage the nurse working in very different ways in different environments, and articulated a professional role that was not constrained by traditional images of nursing, and was not restricted to a particular way of working. (Diagram 5.1).
Diagram 5.1 Summary of the opposing positions of nurse educators as they considered being disabled and the ability of a disabled person becoming a nurse.

The nursing context and situation, the declaration of ‘fitness to practice’ from the occupational health service, and the requirements of Equality and Professional legislation provided the backdrop that underpinned the decision-making processes as nurse educators worked to manage inclusion of disabled students.

In comparing the abilities of different students and matching these with the requirements of a specific branch of nursing, the participants used a ‘hierarchy of disability’ and a ‘hierarchy of practice’ to resolve the dilemmas they experienced when creating an equality of opportunity for
disabled students. In their role of supporting disabled people becoming nurses being able to match the student with an appropriate branch, and then identifying areas where a student ‘best fit’ can be achieved, influenced their decision-making processes. Although this study had started by considering the disabled nursing student in HEI and clinical practice, it became evident that it was the practice element that caused the participants their greatest concern. In rationalising how they could or could not manage the inclusion of a disabled student, it was maintaining the safety of the clients/patients and of the student nurse that influenced their decision-making. Their discussion of being inclusive had demonstrated that despite their reservations they had accepted that an increasing number of disabled people would apply to become nurses, and it was how they made decisions that would be most difficult, as they considered themselves to be the gatekeepers of the profession. In making the decision to include or exclude a disabled person onto a course, they balanced the need to be able to accommodate a disabled student with minimising the potential risks they associated with a specific disability. The dichotomy between voicing the language of being inclusive, and the reality of the ‘real’ world reflects a position that is not in itself overtly discriminatory, but covertly pro nondisabled. This position avoids the explicit rejection of disabled people becoming nurses by rationalising through a ‘common sense’ argument’ that being disabled and being a nurse may be incompatible with the expectations of the patient and of the working environment.

The sub categories hierarchy of disability and hierarchy practice provided the framework through which they could measure the capability of a student against what they presumed would be acceptable.
5.3 Permission to be present in the workplace

As they discussed disability, ‘needing permission to be present in the workplace’ emerged as a factor that influenced how nurse educators perceived and considered ‘being disabled’ and how the disabled person might gain access to the workplace.

Although nurse educators managed nurse educational programs, they were reliant on the clinical practitioners to support the student in the clinical setting. Their understanding of the practitioner’s gate-keeping role was influenced by their personal experiences of ‘being disabled’ as a nurse, working with disabled students and their professional experiences as nurses.

Louise, for example, considered how she had managed her epilepsy, as a student and as a nurse. Initially, she had not considered that her epilepsy was disabling and did not associate having epilepsy with being disabled.

Louise: “It just never occurred to me that I was different, I was just like everybody else. I just got on with things the same way as others, and if I was not well, then I just had to make up for it later. I did not expect anything to be different for me.”

Her identity as an abled person was later challenged, and she recalled how her view of herself changed when she applied to complete a neonatal intensive care course. It was at that point that her epilepsy became labelled as a disability and her ability to be a nurse questioned. It was also at that stage that she became aware that people saw her differently because she had epilepsy, and this she found unsettling as she began to question what she had assumed to be ‘ordinary and normal’ and reframed her personal view of herself. On being challenged to reconsider her status as being a disabled person, she expressed how emotional she had felt, and remarked that on being turned down to study because her competency as a nurse was questioned, she had felt ‘livid.’

Louise “I can just remember how ‘livid’ I felt, what did they think I was going to do, drop the baby!”
The concerns over patient safety and the inherent risks associated with being disabled reaffirmed the preference of the workplace for students (and staff) to be ‘ordinary and normal’. This pre nondisabled preference had been evident in the very first interview completed in this study, when Lucy had described how she had ‘battled’ to ensure she was seen as an abled person despite the physical difficulties she was experiencing.

As a consequence, both Lucy and Louise described the strategies they employed to minimise the impact ‘being disabled’, and to maintain their normal identity. As Louise discussed her support for disabled students becoming nurses, she eloquently described how, throughout her time as a student, she had taken personal responsibility to take care of her health, and how when in practice, she had prepared the clinical area for the occasional ‘seizure’, and how ‘having a seizure’ was managed in a clinical setting. The practice area accommodated her occasional seizure by being aware of her disability, and a plan made as to how this was managed within the working environment. Planning, and taking personal responsibility to mitigate against any potential risk, had enabled her to sustain her ordinary, non-disabled identity and as a consequence she experienced feeling accepted and being able.

For Louise access to the workplace was made possible by the acceptance of the clinical setting. Louise was unconcerned that she might have a seizure in practice as she felt accepted by her colleagues in the workplace, and she reasoned they would be able to ‘cope’ if she had a seizure.

In contrast, Lucy adopted a strategy of hiding her disability, relying on her position in the workplace being sanctioned and legitimised by others. This included her strategic disclosure of her disability through a letter she had written to the Occupational Health Department to justify her entitlement for the post, and to prove that she would be able to do the work. Seeking approval for her position reflected the conflict between believing that as a disabled person she was able to do the job, and a belief that the workplace was an inhospitable environment that was un-accepting of a disabled person. Gaining permission to be present in the workplace,
without having to disclose openly being disabled was made possible when her position was legitimised by the occupational health process. The fear associated with being ‘discovered’ as disabled was clear, as Lucy strategically, and explicitly, made it known to her employers how she managed her disability so that her work output would not be affected. She considered that the offer of her new job was precarious, not because she was unable to do the job, but because she had a disability and this would be seen negatively by her future employers unless her position was legitimised.

Lucy: “although they do not say it you feel like with any excuse they would find a reason for you not to have a job, especially in the current climate. It is like insurance you have to declare it but when you do they may not cover you. If they needed to lose people, you always think, you are the first to go.”

For others such as Liam, being present in the workplace required them to act in a particular way in order that they fitted into the workplace. Liam described himself as the ‘token’ male and how as a male nurse, he had been very conscious that he was able to fit in. In being a nurse, he believed it was important that he was accepted in the work environment, and this was made possible because he ‘changed’ the way he behaved.

Liam: “…when in practice I was very conscious of being male, not because anybody said anything I just felt I was different. People often gave me a look as if to question why I was there, so I changed my way and learnt to fit in and feel more comfortable, I suppose their view was that nursing is not a job for men, especially as I really enjoyed the hands-on care. For many people, this type of work is considered to be quite effeminate.”

Liam had identified himself as being different because of his gender, in contrast Jane identified with feeling different because she was seen as an ethnic minority.
Jane: “When I worked in XXX it was very difficult because all the trained nurses were white, I felt different, and so I had to work hard to be accepted. I guess it must be the same for a student who is disabled. You only realise people find difference difficult when you have experienced the subtle negativity associated with being different. They never said anything about me or to me; it was just something I felt. They sometimes talked over me to the other nurses, and I know this made me very conscious of how I behaved. I actively set out to make sure I was very useful; I was very good at doing those extra shifts at short notice.”

In this context, permission to be present in the workplace was made possible by the sanction of other workers, and Jane’s continued usefulness in the workplace.

The need for disabled students to maintain an expected way of being mirrored these discussions of how as a disabled person the participants had been accepted in practice. Meeting the expectations of clinical practice was made clear by Jane as she described the advice she gave to students once she knew they had a disability.

Jane: “I normally advise the student to see how they can fit in and not to cause the ward staff any difficulties. I point out that the workplace is very busy, and it is not always possible to accommodate any changes. Sometimes I even go as far as suggesting they ‘choose’ their battles as they are only there for a very short period.”

Being accepted in practice not only focussed on the students’ ability to be ‘ordinary and normal’ but also the endorsement of nurse lecturers and the Occupational Health Department (OHD), both of whom acted as gatekeepers to disabled people being given the opportunity to study nursing and accessing the nursing profession. This two-stage process required the individual firstly to satisfy the nurse lecturer that they had the
academic and attitudinal ability study to become a nurse, and secondly they needed to be cleared ‘fit for practice’ by the occupational health service. If the nurse educator felt unable to make a decision, or they felt they might be discriminatory they deferred the final decision to the occupational health process of being ‘cleared fit for practice.’

The reliance on the occupational health process for a student to be cleared as ‘fit for practice’ was not unique to accepting a disabled nursing student onto a course. However, the significance of the decisions made were most evident for disabled students, as Julie explained.

Julie “We accepted her onto the course because on paper there was no reason not to, and then the occupational health doctor cleared her as fit for the course but said that she might struggle, and we would need to make some adjustments in practice. We argued to our colleagues that we had to make adjustments to practice. It didn’t work, and the student left the course.

Then she came back to the course, and we let her back on to the course because we are nice. Then the same thing happened.

I have thought about it and think, the anxiety that she experienced because we let her on the course and then let her back on the course because we felt we should because Occ Health said she could, and they make that decision because she wanted to have another go – were we being fair to her?”

In determining the ‘fitness for practice,’ the Occupational Health department was seen to have the final decision.

Louise: “we will offer a student a place on the course, based on their academic achievements and how they come over to us when we meet them. I am not in practice so I cannot make a decision about whether a student is fit, so we rely on Occupational Health to tell us. I can only talk about HEI.”

Lana: ‘students need to get their fitness to practice before they
can go into practice, and this is where we rely on Occ Health, if they are not fit for practice then they have to leave.’
Jack: ‘Occ Health will come back and say what a student can or cannot do, and we then have to look at the practice.’

Using the occupational health process to make the decisions about fitness to practice distanced the participants from having to make difficult decisions in the area in which they felt uncertain about whether their personal decisions would be considered to be ‘right and proper.’ The decision of the OHD gave permission for the disabled student to be ‘present’ in the workplace and legitimised their position as students. Seeing a disabled student as having the entry requirements for nursing, and the conflict between their beliefs about the risks associated with a disability and the need to avoid discrimination led to a reliance on this decision-making process. Moreover, decisions made by this process firmly signalled to the nurse educator that the educational process including the provision of clinical experiences needed to be supportive. In making difficult decisions, relying on the Occupational Health decision, limited the nurse educator’s responsibility for making the ‘right’ choice and enabled participants to abdicate responsibility for the decisions made. In doing so the student being given permission to be ‘present ‘in the workplace, and it enabled them to justify the inclusion of a ‘problem student’ to their clinical colleagues. As James remarked

James: ‘when practice asks me I simply say they were cleared fit by Occ Health.’

Thus, the decision to include or not to include an applicant because of the occupational health decision is not a reflection of the nurse educator’s personal beliefs or concerns, but an objective decision made by others. All of the participants voiced their concerns that if they decided not to accept an applicant they would be considered discriminatory\(^{15}\) as they had not given the disabled applicant an opportunity to try. Nurse educators’

\(^{15}\) Avoiding being discriminatory was a moral and professional issue for the nurse educator. Their personal and professional code of behaviour and ‘doing the right thing’
reliance on the occupational health process to make decisions about fitness to practice, reflected their uncertainty about how decisions about fitness to practice were made and the lack of clarity in the requirements of the equality legislation and professional standards. The divide between the rhetoric of inclusion within education and work, and the enactment of inclusion inevitable requiring some people to be excluded from nurse education. Exclusion from nurse education because an individual does not have the right entry requirements, or poor performance at interview becoming more complicated if the applicant discloses a disability. As a consequence, the nurse educators relied on the Occupational Health Department, to advise not only on students’ fitness’ to be a nurse, but also to provide advice on how support and adjustments would be possible within the clinical setting.

5.3.1 Summary

The need to for ‘permission to be present’ in the working environment, and to not standout as being different influenced how individuals behaved in the workplace, and their continued reliance on having permission, sanctioned by others, to remain present in the workplace. The emergent sub-category ‘legitimised decisions’ externalised the decision-making process. It distanced the decision from the participant as they balanced the contradictions between their beliefs about supporting inclusion or exclusion of disabled people; their beliefs that a student with a disability would be more problematic, and their professional values associated with the need to be empowering, non-discriminatory and pro inclusion. Through the ‘legitimisation of decisions’ nurse educators balanced their educational obligations outlined in equality legislation and the public sector duty, and professional aspirations to have a more diverse workforce, through the provision of an equality of opportunity for disabled students. Nurse education highlighted the potential conflict between opposing and potentially contradictory concepts as nurse educators’ work at the intersection between education and employment. The role of Occupational Health and the contractual arrangements with the NHS became contextual factors that through ‘legitimising decisions’
influenced how nurse educators managed the inclusion of disabled students on courses to become nurses. By legitimising decisions, participants resolved the conflict between their beliefs about disability, their beliefs about inclusion and their role as nurse educators supporting students within the course of study. The need to legitimise the inclusion of a disabled student resolved participants’ concerns when they considered nursing courses within the wider context of providing effective, and efficient health care service.

5.4 Category Professional Reckoning

From the participant interviews and their discussions about disability and being disabled in the context of nurse education, the following sub-categories emerged:

- Hierarchy of Disability
- Hierarchy of Practice
- Legitimising decisions

Central to each of these sub-categories was the participants’ expectations of what was required in order for an individual to become a nurse. These are expressed as expected behaviours of a student nurse and reflected the values participants held about disability, being disabled and becoming a nurse. These values are grouped into those beliefs and values associated with being able to do the job, which I refer to as occupational values, and those values associated with the expected behaviours of being a nurse, the professional values.

Nursing, like many professions, has fitness standards that initially regulate entry onto the course and subsequently fitness and competency standards for entry onto the professional register. In becoming a registered nurse students are expected to have demonstrated appropriate professional behaviours, and although not explicit, the implied appropriate work values. The course is focussed on enabling students to develop these predetermined generic skills. In becoming aware of a disabled applicant or student, participants make a judgement about whether an
individual has the attributes most likely to enable them to meet the standards required as they balanced the need to be inclusive with professional accountability. The uncertainty associated with whether a disabled person could become a nurse was an issue for the participants and led them to reflect on the ways in which they might become more inclusive to applicants with disabilities. Making decisions about somebody’s ability to become a nurse before they embark or completed a course of study was influenced by the participant’s beliefs and values associated with being able to nurse and their beliefs about the nature of being disabled. Their reliance on deferring final decisions about ‘fitness to practice’ to the occupational health service reflected their uncertainty associated with the implementation of the equality of opportunity agenda, associated with the equality legislation and social model of disability, within the professional workplace.

How the participants managed inclusion with the different branches of nursing emerged as the category of ‘professional reckoning.’ This process led to the conditional inclusion of disabled students and encompassed both internal and external processes.

The internal process, through which the participants established whether the individual would ‘fit’ the criteria for becoming a nursing student, enabled the nurse educator to consider how they would support a student. As a covert process, it relied on their ability to make a judgement about the capability of the individual to become a nurse supported by an educational and/or professional rationale. Through professional reckoning, the participants considered the capabilities required of a disabled student nurse for them to be able to ‘do the job.’ In expressing their occupational values, the primacy of the disabled student’s ability to be ‘able’ as opposed to ‘being disabled’ was evident as, they discussed that the individual needed to be able to work hard and to assume a state of being normal. Being able to work hard was common to all the different fields of nursing and reflected a profession which has strong ties to the ability of the workforce to meet the daily, routinized demands of the workplace. Recognising how the work of a nurse is contextually different within the different fields of nursing led to a recognition that clinical
settings differed in what they expected as ‘normal’ work practices. Within the hierarchy of disability and practice, they identified situations that would be more likely to offer a disabled student the opportunity to be in practice. However, in all branches the more hidden the impairment, the most uncertain the participants felt about the capability of the individual to become a nurse. They also recognised that inclusion was dependent on how the clinical staff viewed disability and that in professional reckoning they set out to match the student with an appropriate and supportive clinical environment.

The external process was reliant on the decisions made by the Occupational Health service, as a mechanism to legitimise and sanction the position of the student on the course, and to identify reasonable adjustments that would fit with clinical practice to provide opportunities for students to complete the course. The conflict between the educational ethos of providing equality of opportunity through the educational experience; and the need to ensure students completed courses and became registered nurses, being resolved by decisions made by others.

In managing inclusion, accepting disabled students, whom might be less able and less likely to complete the course was considered to be risky. Through ‘professional reckoning,’ the participants balanced the ‘risk’ using a hierarchy of disability, their understanding of the ability of a particular branch of nursing to accommodate a student in practice and how decisions are legitimised through the Occupational Health process.

The process of professional reckoning (Diagram 5.2) drew together three distinct areas:

- Hierarchy of disability - their understanding of what it means to be disabled and how different disabilities are accommodated within the different branches of nursing and
- Hierarchy of practice – what is expected by different fields of nursing and different areas of practice.
- Legitimising decisions - the primary role of the occupational health service in sanctioning the inclusion of disabled students on nursing
courses and as a consequence meet the objectives of the NHS strategic workforce planning.

Diagram 5.2 Professional Reckoning and its relationship with becoming a nurse
5.5 Supporting Students

The previous section explored what participants understood about the term disability and being disabled, and reflected both their personal and professional experiences, as they considered the possibility of a disabled person studying to become a nurse. During their discussions, they provided examples of individual situations about being disabled in education and nursing and how they perceived disability would impact on individual students. From their discussions emerged the category *professional reckoning*.

As they discussed the issue of disability and being disabled they began to move away from simply considering individual experiences and thinking about whether for a disabled person it would be possible to study a nursing course; to how a disabled person is supported *whilst studying* nursing.

Many of the participants still had reservations about whether an individual with a disability should be a student nurse but accepted this as a fait accompli. They cited the fact that a student would have met the entry requirements for the course and the fitness standards of the Occupational Health service. Once an individual had started a course, the focus of the participants was on how they met their obligations to be supportive and the reality of supporting a disabled student to complete their studies and meet the requirements to be registered as a professional nurse.

5.5.1 Providing support for a disabled student

The participants believed that as a disabled student the support that was required would be different to their abled peers. This support was identified by the participants’ University and Occupational Health Departments and took the form of recommended reasonable adjustments\(^{16}\) to the program of study. In managing the support required

\(^{16}\) A reasonable adjustment is not defined by the Equality Act 2010 but the guidance from the Equality and Human Rights Commission states that “for a further or higher education institution
by the disabled student, participants focussed on implementing these reasonable adjustments. This was influenced by their experiences in higher education, and their understanding of the reasonableness of reasonable adjustments, particularly in clinical practice.

The term reasonable adjustment was referred to in the interviews as the way that changes to practice are made. It was as they considered a disabled student working as a registered nurse that they questioned the 'reasonableness' of these adjustments in the 'real world of nursing.' Nurse educators described a range of adjustments that support disabled students.

Lee: Mostly I think it is about giving students extra time to complete things

Josie: It really applies to their studies and does not apply to the practice setting as students need to be competent.

Laura: I suppose it is meant for us to consider their abilities and look to see how they can achieve competence by doing things differently.

Liam: No idea other than giving extra time. I cannot see how we can consider a reasonable adjustment in practice. They still have to do the same amount of work. It means we have to consider how we teach, and the assessments that are required. Students may need us to do things in a different way.

Kim: We put in additional support, you know the reasonable adjustments for when a student is in practice."

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when determining what might be a reasonable adjustment is to consider how to ensure that disabled students can be involved in every aspect of student life. Often effective and practicable adjustments involve little or no cost or disruption.”
Throughout their discussions of reasonable adjustments, participants did not consider adaptations to ‘nursing activities’ as they focussed predominantly on the student being given additional time.

One participant, Luke, described how he had asked for clarification of a reasonable adjustment recommended by the Occupational Health department.

Luke: “we had a letter about a student whom Occ Health said needed reasonable adjustment in practice, and when I asked what that meant they said well as long as the student can complete about 50% of the normal workload expected of a student, then that would be seen as being reasonable. I just thought this will never work when they are qualified.”

Participants assumed that a disabled student would be problematic, and constantly referred to how they would implement reasonable adjustments ¹⁷ to overcome the difficulties that were faced. Lucas described his experience of supporting a student in practice.

¹⁷ The duty to make reasonable adjustments aims to make sure that, as far as is reasonable, a disabled worker has the same access to everything that is involved in doing and keeping a job as a non-disabled person. (EHRC accessed 2013)
Lucas: “we had this student, and she was causing real problems in the practice setting, she was so needy and required so much support. She had been here about a month and hadn't disclosed anything at her application, so I asked her whether she had any difficulties and then she said she had dyslexia, if she had told us in the beginning we could have sorted something out. Once we knew we got her to student support, and they identified the reasonable adjustment we needed to make, but it only talked about writing in exams and assignments and extra time, so nothing is written about practice. We had taken it into account at handover and things, but I am not sure that was very helpful because everything was so rushed, and there was no extra time in practice, for making sure she had got all the things that she needed, because they (mentors) were bending over backwards in practice, but she still could not do the things she had to do, she was not safe, but they did not want to fail her. Everyone was involved, and she was, it was becoming difficult.”

Lucas considered that the aim of reasonable adjustments was to correct the deficit, and, as a result, the disabled student would be normalised, and able to participate effectively in education and clinical practice. The limited impact that reasonable adjustments had on the student performance highlighted the concerns nurse educators experienced when they considered reasonable adjustments. These concerns reflected a lack of understanding about what constituted a reasonable adjustment, and how ‘reasonable adjustments’ supported a student. They questioned the transferability of adjustments between different settings. For example, having additional time in education was considered to be an acceptable solution but in practice time was finite, and additional time during ‘handover’ was considered to be impossible because of the workplace demands and resources. When a student’s performance did not improve, the assumption was made that the adjustments had failed or were not appropriate for the clinical setting. They believed that the clinical practitioners remained reluctant to fail the student as they felt that a reasonable adjustment changed what could be reasonably expected of the student, and as such, influenced how clinical mentors followed the assessment process. They were concerned that if they were unable to orchestrate a favourable outcome in practice, they would be judged as being unfair to the student. The concept of ‘unreasonable reasonable adjustment’ captured the uncertainty associated with making
adjustments in practice, and the inability of practice to accommodate different ways of working. It also illuminated the difficulties experienced by mentors and nurse educators, assessing students in practice, when the transferability of adjustments from HEI to practice is questioned. In raising these concerns, it suggested that even though they were supportive of the student; they believed that the issues created by being disabled and working in clinical practice were ‘real’, different to those experienced in HEI and as a consequence remain poorly defined. Not knowing how to be supportive of the student in the working environment, but feeling that the support required was likely to be both unrealistic and unworkable created a dilemma. To overcome the dilemma created by feeling unable to support the student, the student was subsequently characterised as being more difficult. The phrase ‘being needy’ reflected a view that the student required a level of support, which exceeded the normal support provided for student nurses in the context of nursing practice. This positioned the difficulties experienced in the workplace as being the responsibility of the student as opposed to the workplace, and reinforced the view that the problems and difficulties experienced resided with the student and not the clinical setting.

Reasonable adjustment was seen as a way of ‘managing the disability’, but not as a means of managing inclusion or adjusting practice; thus the student with a disability in receipt of adjustments was still expected to perform the same practice, in the same way as other students. As a consequence, the more encumbered a student, the less potential to become a nurse the student was perceived to have, and the harder it was for the participants to see the student as being a nurse.
5.5.2 Managing time

As the participants discussed clinical practice, knowing whether an adjustment was reasonable led the participants to consider how the normal way of working can be altered and how they supported or advised practitioners to consider different ways of delivering nursing care. The resource implications of any adjustments they suggested became a critical issue as they considered the likelihood of clinical practice implementing reasonable adjustments. Unlike their initial discussions when their views had been predominantly influenced by reflecting on ‘past’ personal beliefs and experiences with individual students, they now began to discuss current situations and the need to support disabled students as part of a student group.

Lana: ‘we have many students, and we do not have the time always to think about their individual needs, there just are not the resources for us to do it.’

Laura: ‘ When I have a group of students, even if I know of a particular student, the systems are not in place for me to do anything, and there is no extra time set aside for supporting students with extra needs.’

Their discussions revealed that although they were aware that some students might require additional support, this awareness did not always translate into feeling able to influence practice or to provide additional support within their teaching or within the course. The participants were concerned that within their working day, they would be unable to find the time to provide the additional support, and this contributed to a sense of not being able to meet the additional needs of disabled students. The resource implications associated with implementing reasonable adjustments, and their current workload limited their ability to be supportive and increased the stress experienced by the additional demands on their time. Lily described herself as ‘feeling overwhelmed’ by
the additional responsibility associated with supporting a student with additional needs.

Their belief in the difficulties associated with supporting disabled students and the need to meet the workload demands of HEI was mirrored by their beliefs about the provision of support in clinical practice.

*Lilly:* “In practice, they started very supportive, but as the days went by, and the workload in practice increased you could see them resenting the additional support. Finally they just rang us and said they did not have the time to support the student – you know when it gets to that point you have not got a leg to stand on, as they will simply refuse students in the future.”

*Jo:* “we knew this student was coming, and she went to Occ Health, and they wrote this letter saying she was fit for the course, but that we would need to provide reasonable adjustments to her placement. So they suggested flexibility in starting her shifts and to avoid certain placements as they would be too difficult for her. We discussed this and asked placement about whether ‘in principle’ they could accommodate the student. We then thought this will not work in practice if the mentors don’t know when to expect the student, or she is not there. How will they manage their workload, students need to be on shift at the same time as everyone else? Moreover, what is an easier placement she still has to do all the things that other students have to do, there was so much in their recommendations I am not sure practice can even begin to consider the adjustments.”

The limited time available to support a student, in general, was considered to be a major factor in how a clinical setting would be able to support a disabled student in practice. Reflecting on how they experienced being short of time in HEI; led Louise and Jo to consider the issues for practice. Firstly Louise considered the potential impact of experiencing being short of time, and how this related to patient care.

*Louise:* “In practice, it is different and being short of time is not just about a student it is also about not being able to give patient care and putting patients at risk.”
Whilst Jo reflected on the inevitability of experiencing being short of time in clinical practice

Jo: “practice is hectic; there is never enough time for anybody and even the most-robust students have got just to get on and do things – the student has to accept this is just the way it is, and if they cannot cope then there is not very much we can do, we can talk to the practitioners, and appeal to their better nature – but their view is that we are soft on the students, and there is a ‘real world’ out there.”

Time and the lack of time, limited the sustainability of the support required by a disabled student, as the participants met their obligations to support other students, and in practice practitioners delivered patient care. They believed that balancing the demands on their time would inevitably create difficulties in higher education and clinical practice, as they saw time as a finite commodity that was rationed between differing students; and between students and patient care. As a commodity, the concept of time was divided into working time, personal time and educational time. Working time was considered by the participants, to be essential to their personal organisation and how organisations became ordered. Feeling short of time and being unable to complete tasks or work roles impacted on the individual, and the participants expressed feeling burdened and overwhelmed when faced with challenges that stretched their available time resource. Lily described how she felt when thinking about supporting a disabled student.
Lily: “we set aside time for things such as seeing our personal students, but if a student has needs, then they get more of your time that is unfair to the others. Sometimes I just feel like I just see problem students. If I know, I have a student with a disability then my heart sinks as I just never know how I will fit in all the extra things that are required. If I feel like this, and I am paid to see the students can you imagine how practice must feel, it just becomes one problem too many. As a consequence, the disabled student is seen as a problem even before we have seen how they can work.”

Feeling burdened by increased workload and feeling short of time led to the emergence of the concept of ‘time famine’. Time famine described the participants’ perceptions that a disabled student would require additional time and resources in order for them to achieve the course requirements. This additional time would need to be accommodated within the existing time allocation which inevitably detracted from the time available for other activities. Feeling as if they were short of time reflected a working environment that was constructed using a temporal cycle that was based on the predictable throughput of students. In the University, these cycles were based on the patterns of terms and teaching hours. The curriculum was based on how the abled student as opposed to the disabled student can function within the constraints set by the NMC (the length of the course) and University setting (the educational structures and requirements). The participants experienced being short of time when supporting a disabled student in the university. The time they had allocated for the support of students was perceived to be used disproportionally in the support of disabled students.

Likewise, the participants implied that nursing practice had a cycle reflecting the twenty-four-hour need for care and the need to deliver or to receive care on a daily basis. There was a common health care cycle based on the day/night patterns within which care is delivered that maintained a balance between the patients’ need for care and the need for rest. The participants, although based in higher education, demonstrated their awareness of this temporal cycle and how the delivery of care in clinical practice was influenced by workers maintaining an
adequate workflow. In this study, the participants considered that in clinical practice, time was organised for the delivery of care (primary time allocation) and setting aside time for students (secondary time allocation) was considered, by the participants to encroach on the time that is available for patient care. Secondary time allocation (educational time) was arbitrary and subject to change depending on the workload of the clinical environment. In busy health care environments, there was an implicit expectation that the student would follow this pattern of working and commit their time towards patient care, relinquishing their educational time, or need for support. Participants considered that the additional time required by a disabled student would detract from the care given to patients, and as a consequence they colluded with their clinical colleagues, when as a result of experiencing time famine, support of students would be withdrawn.

Experiencing ‘time famine’ within HEI contributed to the participant’s feelings of low self-efficacy, which they expressed a belief that they were unable to change things, or to make a substantive difference to a disabled student’s experience. In managing their sense of not fully meeting the student’s needs, participants made reference to external factors, such as the lack of resources, or unrealistic expectations of the organisations (both HEI and clinical practice) or of the student. Experiencing time famine and attempting to accommodate the needs of a disabled student led to the participants raising concerns about how a student would be able to meet the course outcomes when ‘time’ was limited. Whilst participants had alluded to their personal experiences of time famine within the HEI setting; it was when they considered clinical practice that their concerns extended from being focussed on supporting the student - to being concerned about the delivery of care in clinical practice.
5.5.3 Student Fit

In their management of disabled students, participants raised concerns as to how a disabled student was perceived in clinical practice; and that by being disabled the boundary between the student, and the patient might be blurred. The lack of clear boundaries between the student and the patient was highlighted by Lana and Jim.

Lana: “it was really difficult we had one student whom the clinical staff kept on muddling up with the clients because she had a speech impediment.”

Jim: “the consultant just said in the meeting, why is that patient here? Pointing to the student who then left the room in tears.”

The disabled student blurred boundaries between the nurses and the patients, and the preference for the student, having no impairments or problems, was underpinned by the participants’ beliefs about being disabled, clinical practice and also their perceptions of what clinical staff would expect of a student. A student being unencumbered reflected the belief that being ‘fit to practice’ is equated with being ‘abled’ and not ‘disabled’, and how a ‘normal’ student is likely to behave.

Having a clear boundary between the student and the patient was considered to be an effective strategy, to minimise the potential risk of a disabled student compromising safety and creating harm in the clinical setting. Jane and Jo both voiced the tension they associated with vulnerable, disabled students going into clinical practice.

Jane: “it is quite simple really you just cannot have vulnerable people caring for vulnerable people, and we cannot just send any old student into the clinical environment. Not only what will they (staff) think in practice, we have to think about the patients. We know what happens out in practice, and I would always want to have a talk with practice first, they need to know what the implications are in having a student. The student might not fit the working environment, or they
may have too many things that could compromise patient care and safety”

Jo: “We have this application for MH; the candidate has Tourette’s. Can you imagine how this would affect practice, the staff would be up in arms. So if they accept him onto the course, I am going to have to do a lot of work to get them to give him a chance. It is going to cost me dearly in the long run as they (practice) will just think I am asking too much.”

Having a student with a disability in practice; challenged participants’ notions of fitness and wellness as they associated being disabled with an increase in the potential risk of additional problems and harm in the clinical setting. Disabled students were seen as less able to maintain a professional boundary between themselves and their patients, and clinical staff less able at seeing the disabled student as a nursing student. The participants felt they were responsible for both the safety of the student and by default the safety of the patients as they managed the process of inclusion. It was also evident that in managing the inclusion of the disabled student the nurse educators needed to support the practitioners to see the disabled student as a student, and not as a person who required care. In supporting and identifying a clinical experience for a disabled student, the nurse educators selected those areas where the student’s difference would be accepted.

Jo: “I look at the student and then have a look around at where I could fit the student in, where they will not be noticed or where the staff are less concerned.”

Laura: “Sometimes we just manipulate and fit the student in…in some cases, I use the ‘disability card’ and make the placement feel like they are doing me a favour. This only works in those ‘lighter areas.”
The sub-category of ‘being out of place,’ captured their concerns associated with the student being disabled and being in clinical practice, and how they ‘retro-fit’ the student to the experience.

**Being out of place** was associated with the expectation that there was a set of ordinary and normative behaviours associated with being a student nurse, which would be expected by the practitioners and the patients in a clinical setting. This ordinary way of being reflected the expectations associated with professional education and a commitment to becoming an effective and efficient member of the workforce. The participants assumed responsibility for ensuring that students behaved as expected and upheld the professional standards of a student nurse. Their doubts about the capability of the disabled student increased their concerns that problems would ensue.

Health care settings and the NHS are bureaucratic organisations that have identified roles for the people that work within it. These roles and their associated behaviours become the cultural norms that occur as a consequence of the organisation and the ‘place’ and assumed a common sense logic of what people do in particular roles. In this way, the work of an organisation can be organised through the role expectations of the people involved. In health care, workers within the environment assume a position or role, inhabit a particular ‘place’ within the setting that is framed by a professional and lay expectation of what can be expected of a student nurse and a registered nurse. Student nurse are expected to behave in a particular way that fits with the organisational structures.

5.5.4 Convincing others

The tensions associated with experiencing ‘unreasonable reasonable adjustments’, ‘time famine’, and believing the disabled student might be ‘being out of place,’ led the participants to consider what type of support was needed by a disabled student in the practice setting, and how this support was negotiated. They reflected on the situations they had come across, during their time as lecturers and expressed feeling responsible for negotiating the support and minimising the impact a
student would have in the practice setting. Feeling responsible for the student and for the impact a student might have in clinical practice, was highlighted by Liam as he outlined how students supplanted patients, as being his responsibility, once he became a lecturer.

Liam: “When I was in practice my patients and keeping my patient’s safe was my prime concern. Now I am in education; students have become my concern… I am now batting for my student and have to think about how they can be in practice, so my views have changed. Sometimes when I think ‘this just isn’t possible’ I have to stop and think, why isn’t it possible, you (the student) are my concern now not the patients so I try and work out how I can improve the student’s chances in practice, by building a case or sometimes just finding that one person whom I know will be accommodating”

In this discussion, Liam was exploring his views on disability and his views of what it meant to be a nurse, and how these views have changed, now that he worked within education. Feeling that ‘things’ would not be possible had been replaced by needing to consider how things could be possible or could be achieved in a different way. The challenge of thinking of alternative or new ways of working, and convincing clinical colleagues that different ways of working would be possible troubled many of the participants. They described that nurses needed to be caring, and maintain safety in practice, but also considered that it was important that people had opportunities to study. In managing these beliefs participants demonstrated feeling responsible, and having a fiduciary responsibility to the student and an indirect fiduciary\(^{18}\) responsibility for the safety of patients in receipt of care delivered by a disabled student. Ensuring that the presence of a disabled student would not compromise the working environment, and convincing the practitioners that adjustments would be possible was managed by the participants utilising insider knowledge about which areas, and which people might be accommodating. Once an

\(^{18}\) A *fiduciary duty* is a legal duty to act solely in another party's interests.
area of practice had been identified and to overcome concerns that the
disabled student might create additional risk in practice, several of the
participants discussed the importance of establishing how able a disabled
student was likely to be, through additional assessments of the disabled
student’s capability.

Jo: “If I know the student has a difficulty we will arrange for them to
go to the skills room and demonstrate what they can do.”

Louise: “If there is a potential for difficulty I will go to an area and
begin to cultivate a positive response, sometimes I will invite the
student, so they can demonstrate that they will not be different in
practice, or I invite the practitioners to the Uni to see what the
student can do.”

This pre-practice assessment of a disabled student emerged as a
common tactic in the management of inclusion and often occurred after a
student had commenced their course, but before a disabled student
commenced a clinical experience. Nurse educators describe how all
students had ‘skills sessions’ in the university prior to commencing clinical
placement. For a student with a disability, their initial performance in the
University setting had the potential to impact not only on their subsequent
clinical experience, but could also raise doubts as to their capability to
perform in practice. Abled students were provided with the opportunities to
practice, and irrespective of their performance were expected to become
more skilful over time as they delivered nursing care. Disabled students
were judged on their level of competence in the University setting prior to
engaging in nursing care as it was considered to be an indicator of their
capability in the future. Lucas and Lee described the specific assessment
of disabled students prior to them being able to go into clinical practice.

Lucas: “sometimes we set up some sessions in the skills room and
see what the student can do, like opening medicine bottles and
handling equipment such as needles, sphygmomanometers and
dressing packs.”
Lee: “we went to the skills room, and I invited as many people as I could think, such as the chief nurse and senior colleagues from practice, just to prove the student would be safe. I said to the student if you can prove to them; then we can get you into practice but I also wanted them (practice) to see that we were taking no chances.”

This need to make certain that a student with a disability was fit and capable to continue in practice was a covert process, in that the purpose was vague, but the outcomes influenced the student’s journey within the course. Arguably the pre-assessment provided an opportunity for observing how skills can be modified and identifying new ways of working, but in their discussions the focus was simply ‘seeing what the student could do and identifying those areas that would be difficult.’ The participants compared what the disabled student would be able to do with what they expected an abled student to be able to do. In addition, Lee described the process as a way of being able to ‘prove’ to others that having a student with a disability was a planned and thoughtful response.

This pre-assessment formed part of the negotiating strategy between the participants and the clinical practitioners, as the participants created the case for why the clinical area should accept the student in practice, and the support or adjustments required.

Laura: “when I know I have a difficult student I am very careful in how I work with my colleagues in practice, it can feel a little underhand when I am promoting their positive traits because I know it will be hard. Sometimes I will argue that if they have this student they needn't have another one…if I am honest, this can work better as they are so grateful not to have students.”

Laura considered that in enabling the student to go into practice, the pre-assessment would help to identify where there would some ‘give and take’ between herself and the clinical area, and what adjustments to practice
would be possible. In creating this positive argument for inclusion, the nurse educators looked at what leverage they had and how they could create a favourable climate for inclusion. Demonstrating the potential for a disabled student to develop the skills required of a nurse, offsetting concerns from colleagues and clinical mentors that a student would not be capable of becoming a nurse.

When pre-practice assessments were not completed the participants reiterated the need to make sure that the students,' with and without a disability, had been cleared fit by Occupational Health before they embarked on their clinical placement

Jo: “before they go into practice they have to have their fitness to practice certificate.”

Lucy: “I don’t know about practice as that is the role of Occupational Health, but if they are not cleared as fit they cannot go into practice.”

Louise: “we had this student with obvious self-harm scars, but Occ health have spoken with her and have cleared her as fit for practice.”

Pre-practice assessments almost exclusively focussed on psychomotor skills such as opening medicine pots, handling equipment; whilst Occupational Health Clearance was relied on for students with a broad range of difficulties and general concerns about capability, reaffirming an association between being ‘fit’ and being ‘able.’

In believing that disabled students would require additional support, the participants described how important it was that the practice setting was prepared and ready to support a disabled student, and their responsibility for ensuring support was in place. They discussed how they prepared the practice area for the student. Jo discussed a clinical placement which she had selected for a specific student who had a disability.
Jo: “we spent time before the placement started making sure that everything was in place. We work hard to address the areas of concern so that mentors felt they were not alone or abandoned. In one case, the mentors (supervisors of student’s practice) were at first very supportive of the student, but in practice they were unable to continue supporting the student, and it became more problematic. Finally, they resented having to give her more time and special support.”

In contrast, Louise attempted to legitimise the right of the student to be in the placement

Louise: “Sometimes I simply try the ‘disability card,’ by pointing out that they should be supportive and providing equality of opportunity. For some, they then think Oh yes, and actually come up with solutions, but for others, it was No in the beginning, and it is NO at the end, so I just have to move on and hunt for another placement.”

The tenuous nature of the support that they could expect from the clinical area, and concern that giving support was problematic for the mentors within the working environment, increased the workload of the participants as they negotiated support in clinical practice. They negotiated support and tolerance for the disabled student by enhancing the individual student’s positive attributes. In doing so, they ensured that the student was given the opportunity to enter the practice setting.

Laura made the effort to ensure the practice areas would be able to accommodate students with disabilities by discussing the issues with mentors in advance of a student being placed there.

Laura: “I went to the clinical area and talked through with them the student’s needs. I listened to their concerns and offered compromises, just to create a favourable outcome. We identified what could be done in that setting and what would not be possible. I reassured them that we were thinking of their needs and those of the students.”
Some participants had begun to discuss the issue of disability and disabled students with practice settings they were involved with at other times. Liam, for example, described how he discussed the issues associated with a disability when completing an educational audit.

*Liam: “When we are doing the audits there is a question about the DDA and supporting students with a disability. So I ask them what you would do if a student used a wheelchair or a student had a hearing impairment. I get them to think about what reasonable adjustments could be made, so we think about access and information before a student goes to placement.’ They can normally think of solutions when there isn't a student, but when you ask them for a particular student, you have to overcome resistance, remind them of these discussions and cajole them to give it a go.”*

Many of the participants in their discussions about student support focussed on being able to find a placement or mentors that would be nice to the students; the implication being that many placements and many mentors are likely to be unkind and unsupportive. Being dependent on getting the right mentor and right placement to support a disabled student added to the complexity of ensuring adjustments would be made. Lana considers the importance of identifying the right mentor

*Lana: “If we have a student with a disability we will try and find a mentor whom we know will understand and be willing to support the student, there are some for whom you just know it wouldn’t work.”*

The supporting relationship that was required was dependent on several factors and the fragility of this relationship, between the student and the mentor, was outlined by Louise.

*Louise: “In practice you cannot expect the staff to be always concerned about supporting the needs of the student. They are very busy and with staff shortages, patients are their priority, they are supporting vulnerable patients and not students. It’s at times like these that student support can be withdrawn. If I want a difficult
placement to have a student in the future, I am not going to force them for one difficult student.”

The lecturers accepted that clinical practice was challenging and that being concerned for a student would not take priority. The uncertainty associated with support in practice and the lack of control over what happened in the practice environment meant that the participants relied on ‘the good will of practitioners’ to ensure support continued. Identifying a placement that would be supportive and increase the likelihood of the students’ success balanced the concerns about the inevitability of a disabled student being unsuccessful.

The belief that support in practice was limited reflected the need for the participants to spend time in planning clinical experiences. Louise did not expect the mentors to continue to supervise the student when the clinical setting became busy. Participants believed that supporting students in practice should not compromise the time available to deliver patient care, and as such the more independent the student, the more likely they were to be seen in a positive light by both the participants and the mentors in clinical practice. The need for students with disabilities to have continued support reflected a different view of the disabled student compared with other students. The default view of the disabled student was that they would be less able and as a consequence would require more time and more support in the clinical setting.

Jo: I have to make a case for each and every student who is different and then they (the staff) turn around to me and say ‘it’s all right whilst they are a student but that never happens in practice, so they can’t be a nurse’

As nurse educators considered disability and disabled nursing students, they articulated what they justified as a ‘common sense’ view that being disabled was associated with being less able, and considered that disabled nursing students had greater needs than their abled peers.
This perspective highlighted their normative beliefs and values of what was required to be a nurse and how these became prerequisites for individuals to engage in nursing work. However, when they considered a particular student their previous concerns were challenged by the belief that once a disabled person had commenced a course, they were obligated to be enabling, and desired to be seen as non-discriminatory.

At the intersection of education and health care, seeing disability and being disabled as a deficit, in the context of nursing work, conflicted with their nursing ideology of being caring and empowering, which in turn challenged their beliefs about the importance of being able to do the work. In managing the inclusion of a student nurse educators engaged in enhancing the student’s perceived capability by stressing the un-problematicized nature of the disability and a managed approach to their inclusion. Un-problematizing, the student, centred on the ability of the nurse educator to promote the normative capabilities of the student. The normalised student had greater social capital than those who required clinical areas to consider different ways of working.

From these concerns emerged the sub-category of ‘accommodating’ which described how the participants identified clinical practice areas and mentors that would be able to support a disabled student.

5.5.5 Summary

The perceptions of the participants of the difficulties associated with students with disabilities in practice were influenced by their beliefs about disability and also their understanding of clinical practice. They considered clinical practice and the real world of nursing was pressurised and required a student nurse who could work in a timely fashion, and who behaved in the way a student nurse was expected to behave. From the data emerged four sub categories unreasonable reasonable adjustments, time famine, being out of place and accommodating which described how nurse educators managed the practical element of ensuring a disabled student was supported in clinical practice that centred on the student being accepted within the clinical setting.
For a student to be accepted within the clinical setting, they identified the need for clear boundaries between different groups of people and their respective roles in practice, to ensure the continued delivery of care. Caregivers were placed on the health and abled side of the respective ‘health/illness’ and ‘ability/disability’ divide. Thus in broad terms there is an idealistic view that care was delivered by ‘healthy able people.’

Students on courses to become nurses were expected to assume this role as the course was enabling them to provide support for others. In making this assumption, the student was also placed on the health and able side of the ‘health/illness’ and ‘ability/disability’ divide. The disabled student blurred this division, and participants had to consider that unlike abled students who, once cleared fit can embark on a course with ‘normal’ support, the student with a disability potentially required additional support in the form of reasonable adjustments.

Nursing is rooted in the need for practitioners, in all branches, to be able to perform in a particular way, and this perpetuated the roles and behaviours that are expected of a nurse. Whilst new ways of nursing practice emerge over time, the retention of old, traditional and familiar skills that had been performed over many years predominated. The participants discussed core skills that nurses required and how they underpinned the requirements of their professional body (NMC) for a student to become a registered nurse. The participants demonstrated a tacit acceptance of these normative practices, derived from their own personal and professional experiences, and this informed their expectation of what a student nurse should be able to do.

The participants’ acceptance of the able-bodied, taken-for-granted way a nurse should be was reinforced by the value given to disabled students who achieved a normative way of being that did not require practice to change. Disabled students who did not fit the environment were considered to be difficult and problematic as they challenged these normative practices. Disabled students have the potential to deviate from an expected way of being, requiring the organisation and the professionals to rethink what is nursing and what it meant to be a nurse.
The importance of the disabled student fitting in and not ‘being out of place’ affirmed the normative nature of being a nurse and of having defined occupational skills. Although the participants recognised that many nurses, with and without disabilities, might not retain competence in all occupational skills and that once qualified the relative importance of these occupational skills might diminish. Being able to demonstrate these normative occupational skills as a student confirmed their ability to be professional on registration. Being out of place and being different created discord and challenged the support available within the clinical setting.

The concepts that emerged from the participant's discussions about the issues they associated with managing inclusion of disabled students in a nursing course revealed their concerns about the nature of practice and their role in being able to make it work for a disabled student to be in practice. The four emergent sub categories: -

- ‘Unreasonable reasonable adjustment’ that focusses attention on the difficulties in assessing a student in practice
- ‘Time famine,’ where the participant is overwhelmed by the lack of time to support a student
- the student ‘being out of place’ and not fitting into the traditional role of a student nurse;
- ‘accommodating’ the additional support required for a disabled student

These sub-categories illuminated the concerns of the participants as they considered how a disabled student can be supported within the course with a particular emphasis on the practice element which they considered to be most problematic. To ensure the disabled student had an equality of opportunity, they needed to overcome any reservations that might hold and present the student in a positive light to the clinical mentors. In doing so, they negotiated a temporary pass for students to access the clinical setting, by identifying particular mentors and particular clinical settings which could accommodate the student.
5.6 Category - Negotiating a temporary pass

Negotiating a temporary pass emerged from the data to describe the way that the participant’s managed the practicalities of supporting a disabled student as they felt obliged to be supportive. They balanced the issues of ‘unreasonable reasonable adjustments’, ‘time famine’ and ‘being out of place’, and accommodating, to ensure that support would continue and that the student would be given a fair opportunity. Participant’s perception of what happens in a clinical setting was underpinned by their beliefs about disability and the ability of disabled students creating a ‘poor job fit’ in the clinical setting. This deep-seated belief that even with adjustments and support the student was unlikely to succeed in practice challenged their educational ideology that widening participation was desired. To balance these conflicting beliefs they actively engaged in supporting the student by negotiating with the clinical mentors. They also recognised that any negotiated support can be withdrawn, during periods when the clinical area is experiencing increased workload. This ambivalence towards the removal of support reflected a belief that support of a disabled student remained problematic for the clinical setting. They considered that that the needs of the disabled student were, in the long-term, incompatible with the needs of the clinical environment.

In negotiating access to the clinical setting, the participant assumed a ‘guardianship role’ towards the student to enable them to be in practice. Being a guardian for the student draws on the concept of legal guardianship whereby a person has the legal authority and corresponding duty to care for the personal interests of another person, known as a ward. Usually, the status of being a guardian is because the ward is incapable of caring for their interests, reinforcing the perception that a disabled student is a vulnerable student. In this study, being a guardian refers to the nurse educators negotiating on the student’s behalf to ensure that clinical colleagues agree to the student attending clinical practice and that reasonable adjustments are implemented.
In successfully supporting students in clinical practice, the relationship between the participants as University lecturers and the NHS as clinical practice providers was an essential component. When the participants considered the issues they associated with a disabled student being in practice, it was their occupation ‘nursing’ values that predominated as they articulated the potential problems that could occur and how these would be overcome. In resolving these concerns, they set out to demonstrate the potential for a disabled student and engaged with practitioners in discussions about reasonable adjustments and being inclusive. As they managed inclusion through ‘negotiation,’ the participants actively engaged in ‘persuading’ the clinical placements to accept a student. Being able to negotiate a student placement was more difficult when a student had a disability or required adjustments to the practice setting. In this negotiating process, they acknowledged that the primary gatekeepers to a placement were the clinical staff.

Recognising that they (the participants) and the university had limited efficacy in enabling a disabled student to have a placement they accepted that the provision of a placement was arbitrary, and as such could be withdrawn at any point in time. To increase the likelihood of success participants focussed on identifying placements where they had a personal relationship with the clinical colleagues or where a particular mentor had demonstrated an interest in supporting a student. In the absence of a named person to contact, they considered placements in clinical areas where they believed the accommodations required would be acceptable by their clinical colleagues or where the work environment was considered to less hectic and less challenging to the student. That the participants believed that some clinical areas were more suited to students with disabilities supported their ‘hierarchy of practice’ (section 5.2).

Nurse educators saw student nurses as temporary members to the clinical setting, and as such were strangers to the staff that worked there. As
strangers, they were unknown, and their social capital\textsuperscript{19} to the group uncertain. Unlike abled students they were less likely to behave in an ‘ordinary’ manner, and this required the nurse educators to act as the student advocate to enhance their value and worth. In this way the likelihood of the clinical area accommodating changes to working practices was considered to be increased, despite the additional resource expense (time and support), as a student would be visualised as an individual and as being able to contribute to the practice setting. Personalising the student through showcasing the student’s ability (section 5.5.3), made it more difficult for the clinical mentor to refuse support, as their decisions were linked to a person and not a ‘name.’

Participant’s belief in the vulnerability of the student with disabilities and the tenuous, fragile nature of the support in practice required them to manage and to organise the clinical experiences. In doing so, they ensured support was in place and encouraged the practitioners to accept the student, reassuring them that the impact on them as individuals and in clinical practice would be minimal. Despite a predominant negative view of disability, there was a belief that the inclusion of disabled students did and would occur within specific areas. This view reflected a belief that even within fraught and difficult health care organisations that the legislation made it difficult to refuse access to a disabled student without being discriminatory.

The category ‘\textit{negotiating a temporary pass}’ (diagram 5.3) described how the participants managed the inclusion of a student providing them with the opportunity for skills and professional development. In negotiating this pass the participants balanced their concerns about the nature of clinical practice, and the capability of disabled students, by focussing on their role in supporting a student within the course.

\textsuperscript{19} The relationship between normative value and social capital was described by Coleman () in his discussion of social norms and social capital in the context of how individuals gain control over ‘externalities’, external factors that influence action within groups.
Diagram 5.3 Category Negotiating a temporary pass and its sub categories

5.7 Entry onto the register

Participants had discussed their views of disability, being disabled and supporting a disabled student whilst they were on the course. During these discussions, there was a general acceptance that despite any reservations that they had, their prime role was to support the student as they progressed through a program of study.

It was at the end of a student’s course that their views about disability, being disabled, and nursing practice were once again brought into sharp focus as they considered a disabled student is finally becoming a registered nurse. This time marked the final stage of the student journey and also marked the point in time when the educational process came to
an end. Prior to this stage, the participants’ discussion had been focussed on the immediate reality of the student journey, what the students were doing and how inclusion could be managed so that they could be supported to achieve the standards required. Throughout their discussions, the participants had alluded to their values and beliefs about disability, being disabled, nursing and being a nurse, and the concerns they associated with a disabled person becoming a nurse. At this final stage, at the point when a student was about to enter the professional register, the conflict between competing and conflicting professional values re-surfaced, and the participants revisited their concerns about disabled students becoming registered practitioners. Central to the discussions at this stage was the broader issue of the purpose of a nurse education program to provide a competent workforce for the NHS, and a belief that health care practice was focussed on ‘getting the work done.’

As they explored their concerns associated with a disabled student becoming a registered nurse they articulated that the agenda for nurse education was different to that of other courses within HEI; as the ultimate goal was directly linked to employment in the future. Jo discussed what he considered to be the difference between nurse education and other non-professional courses within HEI.

Jo: ‘When we have a student on a course, we have a wide entry gate but the bottom line is that most people assume that on starting a course, the student will complete and achieve the standards required so that they are employable in the end. Studying nursing is about getting a job that makes it different to many courses in HEI, so we have to think about whether it’s fair to support a student to achieve the course when we know they will be unemployable in the end.’

The participants considered that students on nursing courses were ultimately being prepared for employment and that whilst supporting and providing reasonable adjustments in higher education was considered possible; their reservations about a disabled student as a future member of the workforce caused concern. Their reference to the ‘real world’ of nursing illuminating a ‘practice-practice gap’ between what was possible
as a student nurse and what would be possible as an employed nurse. Feeling responsible for ensuring a fit and competent workforce and not just supporting students, led the participants to reflect on their personal and professional values that they associated with being a registered nurse.

5.7.1 Assessing competence

When discussing ‘reasonable adjustment’ and the ‘real world’ of nursing the participants voiced concerns associated with the assessment of competence standards. For many of the participants having disabled nursing students, was considered to be problematic because of the need to complete specific elements within the course.

Laura: “well I suppose that nursing is so varied that there are many things a disabled person could do, and because we are often managing care and others are delivering care, we could be more creative and think differently. Once you are a nurse it is often workable, the stumbling block is always the course that is prescriptive; we cannot let go of the belief that to be a nurse you have to demonstrate you can do everything even if you end up never doing those things. If your skills are in a particular area and your weaknesses are in another there is nearly always a place for you to be able to slot into, but for the course and for your registration you need to have core generic skills.”

Assessing students, to ensure that a student, at the point of registration, can perform to the standards required, was considered an essential component of the course. They were concerned that failing students are not always failed and that the presence of a disability made the decision-making process more complex. In the following excerpts, the participants described the added difficulties if they failed a disabled student.
Jack: “It is not like we are just failing to fail a student, you know the Duffy report? It’s more complicated if they have a reason for not doing very well because of a disability or something, we need to make sure we are not discriminatory or give them grounds to appeal against a decision that has been made.”

Louise: “when you have a student with a disability they (mentors in practice) don’t want to fail the student. So they will contact us and ask ‘is there anything they need to know’ or do they need to put in reasonable adjustments, or what reasonable adjustments are needed. Sometimes they even suggest that the student should be in an easier placement where their disability will not cause them (the mentors) any difficulties in passing the student.”

Other concerns raised by participants discussing reasonable adjustments in HEI were that the nature of the reasonable adjustments created doubts as to the legitimacy of the work being completed. They were concerned that the assignment it might not be the individual’s work.

Josie: “I have this student who is completing her research, and she has about six hours of help a week because she has difficulties writing, and it makes me think well whose work will I be marking, is it hers or is it the support tutor. It’s not right as writing is essential to completing a doctorate; you have got to be able to write.”

In being inclusive, the participants were concerned that the disabled student would be assessed differently to their abled peers and that inevitably this would impact on how the registrant would be able to cope with the ‘real world.’ In being reliant on the clinical practitioners to complete the assessment process, they also believed that the mentors would be reluctant to fail a disabled student and in doing so they would lower the standards to avoid making decisions that might be ‘discriminatory.’
Their doubts about the confidence of mentors in practice to always assess and make a decision about students with and without a disability became evident as they described clinical mentors contacting them if they were concerned about a student. They described how mentors would ask about factors that they needed to take into account with regards to the student’s performance. The participants believed that the clinical mentors would be unwilling to fail a disabled student without feeling that they were being unfair to them.

In contrast, others believed that clinical mentors would simply fail the student by judging the student against pre-set normative ideals and limiting the opportunity to develop new ways of working.

Jo: “I am not sure they will give the student (student with a physical impairment) the opportunity to try new ways of working. They just want the student to be as efficient as they are.”

The conflict between lowering standards because of reasonable adjustments, or raising standards, cast doubts about the nature of the assessment and the subjectivity in the assessment process; that potentially challenged the provision of an equality of opportunity for a disabled student. Lana highlighted her concerns that the provision of additional support and reasonable adjustments changed the nature of nursing work and created tension between how different students were assessed. She questioned whether a disabled student would be assessed differently to the non-disabled student.

Lana: “If they have extra time for their OSCE’s they cannot have extra time for practice, you cannot expect practice to be constantly adjusting for staff who are not capable of doing things, it means other people will constantly working harder to make sure everything gets done. The university assessment is supposed to represent what would be expected in practice, but often that is not the case, as we have created an isolated incident. At the university having additional time is of little real consequence, but in practice, time is an issue,
and we should be expecting our students to be able to work in a time pressured environment. If a disabled student has extra time, are we simply deferring the inevitable failure when they are in practice?"

The relationship between starting a course and finishing the course, with most nursing students being expected to complete the course; and feeling that support for a student, inevitably changed the clinical experience and the learning opportunities created tensions. Nurse educators described the dilemma they experienced between the implementation of reasonable adjustment for a student to enable a disabled student an equality of opportunity to meet the course demands: and reasonable adjustments that would guarantee a disabled student can meet the course demands. Participants alluded to fairness within the assessment process through not only in deciding what is to be assessed, but also how the assessment is undertaken. They believed that the mentor assessment of a student’s performance in practice would be influenced by the presence of a disability and reasonable adjustments. Their concerns centred on: -

1) Mentors are not assessing a disabled student’s competence in an objective manner - lowering the standards required.
2) That disabled students would be expected to demonstrate a greater level of competence that their non-disabled peers – raising the standards required.

Believing their workload was substantially easier led participants to be critical of disabled students who did not then modify their behaviour or improve their performance. This critical stance placed the responsibility on the student to ensure that with reasonable adjustments, the problems they experienced would be resolved and work output would increase, and their performance would be the same as ‘ordinary’ students. The focus on improving the normative work output and not valuing what the individual was bringing to the clinical situation and the skills of the individual helped to maintain the homogeneity of the workforce.
In contrast, other participants believed that mentors made it harder for a student with a disability, by not allowing them the time to develop the competencies required or by judging their current performance against expected performance of a non-disabled student, or of a qualified nurse. In their discussions about lessening the workload, there was a consensus that this adjustment whilst possible within the University context would not be possible when employed within the NHS. Thus the expectations of the disabled and non-disabled student in the future, as an employable nurse, influenced the assessment of the student whilst on the course. Participants and the mentors needed to be able to believe that a disabled student would be able to function as a registered nurse.

Not trusting the assessment process and having students complete a course of study without having the capabilities for practice is reflected in the concerns expressed by Jo as he discussed the nature of a nursing course:

Jo: “we have a wide and open entry gate to get people onto the course and once they are on they are almost guaranteed to get off the other end with registration. We seem to hold on to this idea that failing is not an option, and this is reinforced by concerns about attrition. Education in a professional course is about getting a job. So when you have a student who is just not up to it, cannot cope with the demands of practice and you can see how much they want to be a nurse you end up both pleased and concerned that they manage to pass.”

Others such as Laura believed that students were simply passed in practice

Laura: “Students can pass their assessments in practice because they (the mentors) just sign them off as competent. I think they argue that somebody else later on will be making decisions. This applies to all students not just students with disabilities, but if they have a disability, it makes failing the student even harder.”
Some of the participants considered that their course with its focus on professional requirements did not reflect what was required as a registered nurse and was influenced by a lack of professional confidence about what it meant to be a nurse.

Lucas: “we have gone a little overboard on the professional requirements which reflects a public view of what it means to be a nurse but does not relate to having a set of attributes that enable a nurse to do a set number of task. We are trying to prove how professional we are and how we have moved away from our vocational roots. We need to think again about what does it meant to be a nurse and be a little more honest about the hard graft and physical nature of most nursing roles.”

Jim: “we want an intelligent and creative work force that does everything the same.”

The discussion reflected concerns about the assessment process and tensions between professional and work values. Professional values and standards are expressed as the need to be innovative and creative in practice that places the patient at the very centre of the process and implies a heterogenic approach to delivering individualised care. In contrast, work values reflected organisational demands where the possibility of multiple ways of working is potentially disruptive. Concerns associated with maintaining standards are easier to address when each member of the workforce can contribute equally to the organisational function. Having a workforce with a set of predetermined skills and behaviours helps to create homogeneity, practice is both standardised and cost effective. Being employable within an organisation needed the students, both disabled and abled, to demonstrate their level of competence within the framework of professional registration. In this way a student with a disability, who required adjustments to practice or who had a different way of working, created discord in the running of the
organisation; unless through reasonable adjustments homogeneity was restored.

The inability to influence the workplace and the nature of nursing work, to support different ways of working was highlighted by Jim when he argued that

*Jim: “most students will simply accept that there is one way of doing things and not expect us to change. and I am not going to advocate my clinical colleagues change. The students that don’t make the cut, should probably never have started the course, we set them up with false expectations that health care is supportive, when we know it is not.”*

By creating a homogenous workforce, the disabled student, and the disabled worker is assimilated into the working environment. Knowing that a student has the correct skills and can work effectively in the environment is a major concern for the participants, and they are reliant on their clinical colleagues for the decisions made.

From the data emerged the category of ‘unreliable assessment’ that captured the concerns associated with the variation in the support and assessment of a student in clinical practice. They acknowledged that students are assessed but that the assessment process was strongly influenced by the beliefs of individuals, and it was these beliefs about being disabled and being a worker that impacted on the decisions made.

5.7.2 The efficient worker

During the course, participants negotiated with clinical staff for the student to enter the practice setting. The temporary nature of that agreement – ‘whilst a student,’ provided opportunities for the student to learn how practice worked. Learning how practice worked included the student becoming familiar with the unwritten rules of the efficient worker. Students who achieved the skills required but were unable to meet the unwritten rules of practice were then considered to be unemployable in the future. As they considered a student becoming a registered nurse, the
participants began to question the previous decisions made and raised the spectre that the student had been ‘setup to fail.’ The need to avoid failure by ensuring that the student was not ‘set up to fail’ was identified at different points in time during a period of study. Within the course ‘setting up to fail,’ was related to the student not be able to cope with the pressure of work as is evident in the following excerpt from Lucas.

Lucas “the placements are tricky at the moment, they are short of staff and the staffs are pushed to their limit. If we have a student who is covered by the Equality Act, we avoid putting them in placement until things are easier as we are just setting them up to fail. We would put a different student in, one who could cope.”

In the previous excerpt, the difficulties associated with the workplace were resolved by manipulating the allocation of students to the practice setting. For others, concerns were resolved by bartering as they traded with the clinical practitioners to create opportunities for disabled students.

Lana: “I sat down with the mentors and we talked about how pressurised they were feeling, and I was thinking OK, if I can get you to accept this student now, and then maybe we can avoid placing a student with you next time. So I suggested that, but they still felt very uncertain, so then we agreed that the student would visit for a week, and if they still felt the same we could withdraw the student.”

At the final stages of the course, the emphasis shifted from being concerned that a student might not be able to cope, to practice not being able to accommodate the different needs of the student, as a registered nurse.

Lana: “we work hard to put in all the adjustments whilst they are on the course (in HEI) but we cannot change practice, and I just can’t see it working, we are setting him up to fail.”

Julie: “I just think we are setting them up to fail, as work will never tolerate the student.”

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Kay: “I have a student who is in the final weeks of her course and all the way through we have supported her. When she is well, she is excellent but when she has a meltdown, she is just not able to cope. Now I am worried that we have been too kind, one melt down in practice, and that will be it. I have told her that she cannot expect the same level of support once she is qualified…part of me hopes she will be failed at the final hurdle, but if that happens I will feel guilty that I set her up to fail.”

The phrase ‘setting up to fail’ was used by all of the participants when they voiced their concerns about the inclusion of students with disabilities and the requirements of clinical placements. Nurse educators cited their personal experiences of supporting students, and the level of support that is required in the HEI as evidence that failure in practice was inevitable. The term ‘setting up to fail’ reflected a view that disabled students not only lacked capacity to make decisions for themselves, but also lacked the ability to be effective nurses. Giving disabled students false hope that they could be employed as registered nurses, troubled the participants as they felt complicit in creating a situation whereby the student would inevitably struggle and remain unemployable. This paternalistic approach, whereby the participants felt responsible for the student outcomes, reinforced the view of being disabled that sees the disabled student as lacking the ability to make decisions and choices for themselves.

The two components of nurse education, one in higher education and one in clinical practice reflect a dual curriculum. The clinical practice component includes the implicit unwritten rules associated with becoming an efficient and competent registered nurse.
Jo summarised this by stating

Jo: “Our courses are not about education, but about making sure we are providing a skilful workforce. All of our students are training for a job; we have to make them fit the job because the job will not change.”

The concerns associated with a disabled student completing the course, but not becoming a skilled member of the workforce stemmed from believing that efficient workers needed to be able. Ability in the context of nursing courses was the combination being able to complete the academic course and being able to work. Lucas considered that inclusion within nurse education was inherently problematic because of the recruitment process, and what clinical practice could reasonably expect from a student nurse and ultimately a registered nurse.

Lucas: “We want people to be well educated and able to work in a specific way. We have contracts with our SHA to recruit a certain number, but practitioners always believe that we (the university) take on too many difficult students that will never make it in practice. The bottom line is that a student needs to be able to do the job in the end, and we need to be cautious about letting people in.”

Managing the agenda in higher education associated with widening participation and being inclusive, and the needs of NHS workforce planning, highlighted the conflict between meeting the demands of higher education and the requirements of an employer. This conflict illuminated a dual curriculum (one based in HEI and one based in clinical practice) that was evident as nurse educators worked between the HEI and the NHS.
Liam outlined the tensions created by this conflict when he commented:

Liam: “it is difficult for us as we are very mindful of what we are supposed to produce, which is workers for the NHS. We recruit to a contract and get fined when attrition is too high. It is not always worth taking on riskier students; we can see how they can be supported as students, but I am not convinced they are supported as practitioners so when you know they may not be successful, you feel that you are letting everybody down.”

The contractual relationship between the education providers and the NHS was identified as an issue that influenced the participants when they considered the inclusion of disabled students. In balancing these conflicting perspectives, participants looked at how the decision to include a disabled student could be endorsed to resolve their concern about whether a disabled applicant or student would be fit for practice.

One concern was how efficient the student would be in clinical practice; with efficiency being linked to the time it took to complete tasks. Being timely was referred to by the participants as being an essential work skill required for effective nursing practice. Impairments were seen as limiting the student’s ability to be successful in the clinical context because clinical practice would not be able to provide the time needed. This was most evident with hidden disabilities, fluctuating and chronic conditions where the ability to ‘fit’ in with the workplace was less predictable and uncertain. The pressure of work in clinical practice, time famine, had already identified as a significant barrier to a disabled student being supported (section 5.2.3) and now not being able to work in a timely fashion limited the disabled student’s ability to be an effective practitioner.
Kim: “It is all very well for us to think about the adjustments, but you cannot expect clinical practice to be able to do that, they just will not have the time and the resources. Nobody asks the patients what he or she think when his or her nurse clearly has difficulties with some of the basic aspects of care. The care needs to be given efficiently - It is all about being inclusive for the student, but I worry about the patients who deserve the very best, and the other staff who are struggling.”

Louise: “In practice you know everyone is very busy and with staff shortages. As a nurse, you have to be able to work at the same pace.”

Laura: “We can reduce the workload as a student, but that level of adjustment will not happen when they are qualified, as it means others will have to work harder to compensate.”

This view is verified by several of the participants who discussed concerns raised by practitioners about students completing their final placement before registration.

Lee: ‘we have students who have limped along and have been given lots of opportunities, and the wards contact us and say ‘how has this student got this far,’ ‘the level of support needed is too much for the final placement.’ We talk about reasonable adjustments, but all the clinical staff can see is a person who is adding to their workload and not contributing effectively to care.’

Louise: “in the workplace we hear of people who are ‘hot desking,’ without a computer of their own, they even have a shortage of chairs. So how can I expect the placement to support a student who finds writing difficult, they will not have the resources the student will need. I have asked for quiet places for students to write up notes and things, and the ward managers have laughed and said well we don’t have the budget for that, so they will have to cope just like everyone else.”
The harshness of the working environment and the constant pressures associated with staff ‘coping’ supported a view that clinical practitioners preferred abled students who were perceived to be already skilful and able to work efficiently, as required for practice. Disabled students are believed to require adjustments to clinical practice, but the participants remained concerned that even with adjustments, they would be unable to achieve the same level of competence or ‘slickness’ in their performance. Not being competent was linked to not being efficient in delivering care. Any factors that contributed to a delay in the efficiency of care provision are seen as incompatible with an efficient health care system. Thus, a student who required more time, takes longer to complete core ‘tasks’ or created an imbalance between the input (nursing intervention), and output (patient outcomes) was less likely to be employable within the context of the health care system.

The concerns about being efficient and being effective as part of the workforce reflected a ‘market’ view of health care, where the primary goal was measured by the ‘number’ of patients who had received care. The participants expressed contradictory views about ‘nursing practice’ and ‘nursing work.’ When discussing the professional role of ‘nursing practice’ the nurse educators articulated the need for safe and competent patient care that was situated within a professional framework. This professional stance placed the patient central to all the decisions made, and also reflected a participatory model of education whereby; the nursing student is both learner and worker as they are supported to achieve the standards required. In contrast, as they discussed ‘nursing work,’ they alluded to a market perspective that was primarily concerned with work efficiency. This market view reflected a bureaucratic model of education focussed on standards, competence and meeting the demands of the workplace, where the student (with and without a disability) needed to be an efficient member of the work force. Being an efficient worker supported the belief that being able to work is associated with ‘normal bodily performance.’ Being disabled was associated with impaired bodily function and this inevitably compromised the student’s ability to be efficient.
Previously the participants had discussed the importance of skill performance and having completed a course the assumption was that a student, at the point of registration, will be able to perform skills in the correct manner. The participants also believed that as a student moved through the course that clinical colleagues would expect that the support required would less. At the end of the course, students are expected to be able to demonstrate the professional standards for registration and work competence; the work standards for employment. Having a student with a disability, as a future registered nurse, is considered by the participants to be risky. Their concerns centred around the difference between being competent as a student with reasonable adjustments in place and being competent as a registered practitioner working in a busy health care setting. These concerns associated with being a disabled nurse are captured in the comments below

Leslie: “students are on the course, and they get all the support they need, but once they qualify they have to be able to work just the same as all the others. It’s easier for the HEI to adjust things.”

Jim: “We need to know that a student will be able to perform in practice; it’s not just enough to say they have a disability.”

Laura: “If they have times when they are not well, that cannot be accommodated easily in practice; the wards need to know they can rely on staff being there.”

Jack: “If you have a caseload of ten patients you have a case load of the patients, if we put in all this extra support, it’s unrealistic for when they qualify.”

Josie: “What GP would employ a nurse who couldn’t give injections, they would have to employ someone else.”

In expressing their concerns about a student qualifying, but not being employable, the participants are responding to the conflict and tension between the requirements of being a student, and the requirements of
being a registered nurse. In supporting students, the participants negotiated a clinical placement and how support was implemented. Once the student was in practice, they relied on the assessment process and decisions made by clinical colleagues, who judged the capabilities of the student. At the point of registration, they reconsidered these decisions as they were concerned that disabled students would remain un-employed as the support required during their time as a student were believed to be in-compatible with working as a registered nurse.

Adjusting the workload or changing the work expectations of a disabled student was, for most of the participants, considered to be an un-realistic adjustment that would be unreasonable and incompatible with clinical practice. They could see how as a student this would provide the time required for learning, but on registration they believed that a nurse would need to be as abled and work as hard as their peers. Their tacit understanding of how work was organised painted a picture of an environment where there were always staff shortages and an ever increasing workload. Their uncertainty as to how adjusting practice was achieved without compromising care delivery; and that reasonable adjustments inevitably meant that the student was slow and less efficient, challenged their beliefs about how possible it would be to be inclusive within health care. The disabled student increased the workload of the mentor as they had to spend more time planning how the student would be supported whilst managing a complex and challenging workload. They all agreed that in clinical practice, patient care would take precedence over the support of the student and that the presence of the student would slow the clinical practitioner’s ability to work.

Josie commented on the dilemma she experienced when organising a clinical experience for a disabled student.
Josie: “Organising a placement for a disabled student I feel guilty when I am asking them (staff) to include reasonable adjustments, when I know the staff are stretched. I then question whether this is unreasonable and not reasonable, as why should clinical staff have to fit this in when supporting a student as this will not be translated into support when they are working. It’s unreasonable on the staff and sets the student up with false expectations of what will happen when they qualify.”

In implementing reasonable adjustments, the participants also voiced concerns about needing to be fair to all students with and without a disability. Fairness was linked to the division of resources and work tasks. In seeing the support of a disabled student as creating an imbalance, and being unfair in the division of the workload, it was assumed that as a consequence of reasonable adjustment the disabled students contribution to the workload would be less or valued as less. This belief about the inability of a disabled student to work effectively reinforced the negative connotations associated with having a disability. The conflicting views between believing that it is important to be inclusive and believing that the nature of nursing work was incompatible with being inclusive, illustrated the belief that being a disabled person would fundamentally change what would be expected of the student nurse. As a consequence, any reasonable adjustments identified would make the work of the student easier by increasing the time allowed and reducing their workload, whilst increasing the workload of others.

This change to what would be expected of the student became evident as they discussed the implementation of adjustments to clinical skills assessments.

Lana: “If they have extra time for their OSCE’s they cannot have extra time for practice, you cannot expect practice to be constantly adjusting for staff who are not capable of doing things, it means other people will constantly working harder to make sure everything gets done.”

Ensuring fairness in the workplace was an important to the participants,
as whilst they could articulate the need for additional support, they believed that this additional support created an imbalance between what was required of disabled and abled students alike. The concept of fairness was important to the participants who believed that as all students needed support, this support needed to be equitable so that no students were advantaged or disadvantaged. Liam, for example, remarked:

\[ \text{Liam: “If we start adjusting for everything, then where would we stop, everyone has things in his or her life that can cause them difficulties, things are unfair, and that is just the way it is.”} \]

Being able to fit in as a student nurse and compensating for personal difficulties was considered the important criteria by some participants who questioned whether having a disability did impact on a student’s ability to perform. These doubts were evident when nurse educators discussed unseen conditions where the difference between the able and the disabled student was unclear with no perceptual differences between the different students.

\[ \text{James: “Dyslexia is not a disability; I think some students are just lazy, and if they can get extra support they will.”} \]

\[ \text{Louise: “It’s like a student with Asperger’s; it was creating some difficulties, and one of my colleagues suggested that the student was just putting it on and choosing when it would be difficult.”} \]

\[ \text{Josie: “We all feel low at times, but you just shrug your shoulders and get on with it; it is not a reason for being late and not attending.”} \]

Believing that the impact of disabling condition was something the individual could control within the workplace, permeated through the discussions that the participants had about how being disabled would impact on the individual, and heightened their concerns related to fairness. The feeling that additional support for a student with a disability would be unfair to other students created conflict between the participants’
belief that support was needed, whilst simultaneously believing that providing support would provide the disabled student with an unfair advantage.

Underpinning their discussions of reasonable adjustment, is the belief that there is a real world of nursing that the student has to be able to work within and that this real world is altered by the presence of reasonable adjustments. Fitting into this real world of nursing which focused on nursing ‘work’ was most often alluded when participants discussed the skills required of a nurse and standards of care.

The importance of not compromising on standards and being able to perform nursing in a familiar and known way concerned the participants when they considered a disabled student entering the workforce. Luke described a student who has had additional time to complete skills and tasks.

Luke: “...it’s all very well putting in these adjustments in HEI but when they are working there will no adjustments, and they will still have to see the same number of clients in a day. Managers will not sanction a lighter load.”

This real world view of nursing described by the participants reflected a view that the University experience for a student nurse was different to the ‘real world’ of nursing once qualified. Although the courses are about developing a professional fit for practice, the ‘real world’ context in which nursing takes place was considered to be hard and unforgiving, and this raised concerns about a disabled student being able to meet the demands of the workplace.

The differences between the University experience and the expectations of practice highlighted the participant’s concerns about how effective a disabled student might be in practice. The need for nurses and students to be able to deliver effective care in an efficient manner, and to be ‘quick’ in order to complete elements of care, is evident in the discussion
by Lana of a student with ‘slow processing speed’\(^\text{20}\) in relation to completing drug calculations;

\[\text{Lana: } “\text{in the University we were able to allow the student extra time to complete the safe medicate paper, and he got it 100% right, but you wouldn’t be able to do this in practice as it wouldn’t be possible. So I worry that we are setting the student up to fail…’ of course other students had some errors in their answers, but they were much quicker, and they will have another opportunity to retake the paper in the future. The ideal is the student who is both quick and accurate.”}\]

In this vignette, the student with slow processing speed was successful and achieved 100% in their exam, but the time it took was considered to limit the likelihood of the student being successful in clinical practice. Lana was concerned that being slow would be incompatible with being able to work as a nurse, and this led to her questioning the relationship between professional standards and work efficiency. The participants’ concerns over performance as a nurse were not limited to the considering of disabled students as they also recognised that non-disabled students, who are slow, might have difficulties in the real world of nursing.

\[\text{Luke: } “\text{we can all think of students (without a disability) who are hopeless and not up to the mark, and with luck the mentors will pick this up, and they will be failed in practice.”}\]

\[\text{Louise: } “\text{I can think of students now, who will qualify in less than six months, and I really don’t know whether they will be ready for the shock of those first few months as a qualified nurse.”}\]

From the data emerged a clear difference in what the participants believed was possible within the duration of the course and what would be possible once qualified. The differences between the participants’ expectations of how a disabled person is supported during the course (what occurred as a student) and practice (what occurred as a registered nurse) caused concern to the participants. Nurse educators recognised

\[\text{20 Slow processing speed is associated with SpLD, such as dyslexia, and refers to the longer time required for a student to take in to process information and to formulate a response or action.}\]
the increased diversity of the nursing student population and had a growing awareness of how individual’s needs are met through reasonable adjustment. However, this position created tension between participants educational beliefs about the importance of widening participation and inclusion, and their professional concerns that the health care setting are unable or unwilling to make adjustments and be supportive of students. As a consequence whilst reasonable adjustment was considered possible within a course, these same adjustments were considered unreasonable in clinical practice. From the data merged the concept of **setting up to fail**, as a disabled student embarked on a pathway with an intended goal, that would be unattainable due to the inability of the clinical settings to continue to support a disabled person, once they are registered nurses. Setting up to fail captured the differences between what was possible as a student and what was considered to be possible as a registered nurse.

### 5.7.3 Summary

Throughout the interviews, the concerns participants associated with disabled students led to the emergence of the sub-categories ‘**unreliable assessment**’ and ‘**setting up to fail**’. The participants had raised general concerns about students passing the course without achieving the appropriate level of knowledge and competence required for registration and the concept of not failing a student reflected these concerns. When they considered a disabled student they believed that the presence of the disability made failing the student even harder, and as a consequence disabled students were likely to have an unfair advantage and pass the course with a lesser level of competence.

Their reservations about a disabled student passing a course without demonstrating appropriate competence was counterbalanced by a belief that the disabled student who was successful on the course was also unlikely to be employable as a registered nurse in practice. A disabled student was more likely to be referred to as being ‘setup to fail’ irrespective of the course outcomes. The inevitability of this outcome for
students with a disability and feeling responsible for the student’s ultimate success increased the need of the participants to not set somebody up to fail. Not setting somebody up to fail meant not exposing the disabled student to the rigours of the course or the workplace, and in doing so the student would either be excluded from the course or settings identified that were considered to be easier and less demanding.

5.8 Emerging category – (Un) Employability

The concerns associated with the student failing are supported by the participants’ beliefs about clinical practice and the nature of the NHS. In this environment there is a set of expected behaviours that the participants associated with being able to nurse; a set way of being that is recognised by the practice setting, by the professionals working in practice and by the patients in receipt of care. The essential nature of these work behaviours so that the individual is recognised as a nurse are embedded within the professional beliefs of the participants. It reflected their belief that health care environments are complex and multifaceted and work orientated. To ensure nursing standards were maintained in practice, they believed that all nurses need to behave and be able to perform in a standard way. Their view of practice was that it was a busy, hard working environment characterised by mentors having a heavy workload and limited resources.21 A student entering this environment was expected to fit in, and to be able to participate in care delivery with minimal disruption to the mentor and also to the patients. The role of the student in this environment was to create as few difficulties as possible whilst contributing in an effective and timely way to the provision of care. The agency of nurse educators in managing the inclusion of disabled students was informed by their moral and ethical beliefs about ability, disability and what it means to be disabled that have been developed from their life experiences, and how these relate to their understanding of being a nurse. These underpinning beliefs and values acted as a moral

21 Hayes (2002) theoretical concept of ‘climate of opportunity’ which considers how environmental factors influence the organisations’ and individual's ability to manage diversity and inclusion within the workplace.
compass\textsuperscript{22} that guided nurse educators’ behaviour by the way it underpinned what they believed to be important and the subsequent decisions and judgements they made. This study suggests that nurse educators believe that there is a divide between the language of inclusion and the reality of the workplace. As a consequence nurse educators experienced a dilemma between competing moral perspectives which they resolved through an overarching belief that their prime responsibility was to be seen to do the ‘right thing.’ Doing the right thing included not only accepting when a student with a disability could be successful but acting in a fiduciary way, to ensure that the student came to no harm. Knowing what is best for the student-led to decisions being made whereby the student was not placed in a position where they would be ‘setup to fail.’

The ‘hostile’ nature of clinical practice\textsuperscript{23} and the personal experiences of nurse educators in supporting disabled students to become nurses (their experiences of disability and their professional experiences of working as a nurse) coalesced together and formed an organisationally driven, common sense understanding\textsuperscript{24} of what is expected of a nurse. In the context of this thesis, the conflict between nurse educators desires to promote the inclusion of disabled students, the need to maintain professional standards and patient safety and the organisations inability to accommodate difference is associated with perceptions of the organisational inflexibility and limited resources and capacity. In believing that nurses need to be able to work in hard and unforgiving environments, which had little scope or resources to consider how the work can be adjusted, limited the ability of nurse educators to promote inclusion.

\textsuperscript{22} Moral compass is defined by Cambridge dictionaries as a natural feeling that makes people know what is right and wrong and how they should behave.

\textsuperscript{23} The difficult health care climate is supported by the literature and includes:

- That the clinical culture is not conducive to learning and supporting students (Bramer 2008, Levitt-Jones 2005)
- Nurse educators recognise the conflicting agendas of education and clinical practice and experience conflict between their competing role obligations between education and practice (Kapola 1994)

\textsuperscript{24} (Schneider 1975, 1990)
In this study the category ‘(un)Employability’ emerged from the data as nurse educators managed the inclusion of disabled students in nursing courses in such a way that both the student and the practitioners were satisfied with the outcomes. The students had the opportunity to become registered nurses, and clinical practice could expect practitioners with the appropriate level of competence to work efficiently and effectively in the delivery of patient care.

The category ‘(un)Employability’ emerged from the sub-categories

1) Unreliable assessment
2) Setting up to fail

As an emergent category ‘(un)Employability’ describes why nurse educators negotiated to temper the beliefs that the disabled student was less able, and of the student’s capacity to cope and manage in complex care settings was limited. In this process they addressed their concerns that the student would be unemployable and that the assessment process was flawed as they focused on their educational role to ensure that support was identified, and in place, and thus the student was given an equality of opportunity. Balancing the risk that the student would be unemployable reflected a complicit response between the participant and the clinical setting, whereby the participant balanced their beliefs about the nature of clinical practice and that the limited availability of support would inevitably lead to failure\textsuperscript{25}; with the need to do the ‘right thing.’

\textsuperscript{25} This collective view of the health care environment supports Schneider Wheeler and Cox (1992) concept of work climate, which they defined as the “employees’ perceptions of the events, practices and end procedures as well as their perceptions of the behaviours that are rewarded, supported and expected” (page 705). However unlike Schneider, Wheeler and Cox (1992) where understanding of work climate was based on current employees perceptions; in making judgements about the health care setting, nurse educators relied on predominantly past experiences and future concerns to rationalise whether clinical areas could accommodate different workers.
This chapter presented the emergent sub-categories and categories that described how nurse educators coped, addressed and responded to disabled students; as educators engaged in delivering the knowledgeable and professional workforce of the future. Their management of inclusion within nurse education emerged as a basic social process that encompassed three categories:

1) Professional reckoning,

2) Negotiating a temporary pass and

3) (un) Employability.

These categories reflected the belief that disabled students required additional support to access nurse educational programs. As a result, there was a need for nurse educators to negotiate at the intersection between higher education and clinical practice; to establish the conditions within which inclusion of disabled students was considered to be possible.

The negotiated inclusion of disabled students was influenced by a belief that practitioners and clinical practice found it difficult to consider alternative ways of being or of working. This negotiating process was influenced by a workplace that was not overtly discriminatory but had a preference for a non-disabled workforce that did not add to an individual's workload, or require practice to consider other ways of meeting the demands of the workplace. In working at the boundaries between education and clinical practice, nurse educators needed to feel confident that they were acting in the best interest of the student, the best interest of the profession and the best interest of the organisations (higher education and health care). Moreover, these are interests that in any given time or place potentially conflict or compete or are contested. In supporting disabled students nurse educators set out to secure the ‘best deal’ that was right for the moment, and in doing so provided the student with the opportunities to develop the skills required for professional registration.

The three emergent categories, *professional reckoning, negotiating a*
temporary pass and (un)Employability described how they attempted to resolve their personal and professional concerns associated with managing inclusion and the concerns of others, as they found a solution that met the needs of all those involved. When securing a deal was deemed to be unlikely, nurse educators rationalised to themselves that they had done *the best that they could*, and framed the decisions made as in being in the best interest of the student and of the profession.

The need to consider disabled students and to manage inclusion emerged as a consequence of the increased number of students who presented with a disability on nursing courses (section 2.5). This increase was considered to be the inevitable consequence of Equality legislation that has opened up opportunities for disabled people; and Higher Education that has embraced widening participation\(^\text{26}\). With this increasingly diverse student population, *Brokering* emerged as a strategic social process through which nurse educators mediated an equality of opportunity for disabled nursing students, and in doing so the disabled student was seen as being ‘acceptable’, or exclusion could be justified, to the individual, the profession and to the organisation.

The process of brokering began with an inner dialogue; as the nurse educator rationalised the suitability of a disabled student becoming a registered nurse, within a particular branch of nursing (section 5.2 and 5.3)). In this inner dialogue, they balanced their understanding of the impact a particular impairment would have on the individual, with what they believed would reasonably be expected of the student nurse in clinical practice. Following this the nurse educator ‘checked’ out their decisions through the occupational health process. This process legitimised and sanctioned the student’s position on the course and the need to consider how inclusion within nurse education is managed. Secondly there were the external processes, where the practicalities of navigating through the educational and practice landscape became evident, as they negotiated with others to ensure that a disabled student

\(^{26}\) The widening participation agenda has focussed on social reasons for young people not accessing higher education. However, it also to a lesser extent encompasses other marginalised groups.
had the opportunity to demonstrate their capability to become a nurse (section 5.5). Finally, there was the recognition that ‘managed inclusion’ within the course was contingent, and that successful registration need not necessarily lead to successful employment in the future (section 5.7). In managing this element nurse educators needed to be satisfied that they had done the best that they could and that they were not responsible for the decisions of others in the future. It also required the nurse educator to be able to justify an alternative ending to a period of study; completion of a nursing course might not lead to a disabled student working as a registered nurse in the future.

In managing inclusion, nurse educators embarked on a period of negotiation with colleagues both in higher education and clinical practice. In this process, the student was predominantly absent unless they were 'showcased' as an exemplary example of how an individual coped with a disability, the virtuous disabled. The term negotiation is often used to describe ‘discussions that resolved the issue in a way that all parties find acceptable’ (Oxford Dictionary). However, the traditional negotiating processes that resolved ‘simple’ problems did not fully encapsulate the complex negotiating process that was undertaken in managing inclusion as nurse educators worked at the intersection between higher education and work. Neither did it capture the pragmatic nature of the solutions that focussed on securing a deal that was right for the moment, and the ambiguity and uncertainty that remained with the participants, even after they had successfully supported a disabled student to complete their course. In contrast the term broker, defined by the Oxford Dictionary as a verb to ‘arrange or negotiate (an agreement) on behalf of others,’ encapsulated a negotiating process that was responsive to the situation and to the moment. As a noun, a broker is defined as ‘a person who buys and sells goods or assets for others’ with brokerage describing the ‘business of acting as a broker.’ The business aspect of being a broker ‘distanced’ the individual from making personal, or professional decisions as brokers are guided by the concept of ‘doing the job.’ As such ‘brokering’ is focussed on securing a ‘deal’, and the broker uses the resources available, including insider knowledge of the context and
situation and the power embedded within their relationship with others. Thus brokering inclusion on behalf of disabled students became part of the ‘job role’ of educators within higher education and was not necessarily reflective of their personal and professional beliefs and values about disability and being a nurse. Moreover, as brokers their personal beliefs remained unchallenged as their role was legitimised by others and supported by the rhetoric of inclusion that was evident in legislation. In this thesis, the strategies used during negotiation influenced the relationship between the parties involved, and the mediating and balancing process that was undertaken, both within the participants (their inner dialogue) and with others, to provide an opportunity for a third party, the student.

The social process of brokering and its sub-categories are captured in the explanatory matrix (Diagram 5.4). For ease of reading each of the stages and associated categories, are shown in a linear fashion. However, it is recognised that the issues and concerns can arise concurrently and that participants can move between the different stages or become fixed or delayed in a particular stage; if they are unable to resolve the concerns to establish favourable conditions to broker an effective deal.
Diagram 5.4 The social process of brokering and its associated sub categories of professional reckoning, negotiating a temporary pass and (un)Employability.
Chapter 6 Comparison of brokering with the literature

6.1 Introduction

In the previous chapter, the core category of brokering emerged as the basic social process through which nurse educators worked with multiple challenges and contradictions as they supported disabled nursing students. In this chapter, the substantive theory of brokering will be discussed in the context of other work and the emergent theoretical concept compared and contrasted with formal extant theory. In this process, the literature is ‘discovered.’ Glaser 1998 argued that in completing a CGT thesis it is impossible to know what literature to review in advance of the substantive theory emerging. The purpose of this literature review is to integrate the theory into the extant theory through a discursive comparison of concepts, and not simply to use the literature to legitimise the findings (Christiansen 2011). Thus: the literature review and comparison will be conceptually driven and not contextually delimited. In this way, emerging concepts from the study will be gradually delimited as the comparison of substantive codes, theoretical codes, conceptual hypotheses – to pre-existent concepts and hypotheses in existing literature, will continually refine the grounded theory (Christianson 2011).

This chapter is divided into three sections, with the first part summarising the key elements of brokering in the context of nurse education. Part two will explore existing theory on brokering, and the final part will compare and contrast substantive theory of brokering with extant theory associated with inter-organisational working, and, in particular, how this relates to the resolution of the concerns raised by the participants within this thesis.
6.2 Brokering in nurse education

Being able to ‘create a deal’ that enabled the inclusion of disabled nursing students within nurse education emerged as the major concern of nurse educators as they felt obligated to support a disabled student, within a context (clinical practice), that they considered to be inhospitable and unsupportive. In part, this reflects the divide between the legislative rhetoric of the benefits of diversity and inclusion in education and work, and the realities of what nurse educators referred to as ‘working in the real world of nursing’. Nurse educators were concerned that accommodating new or different ways of working would challenge a workforce which was already feeling distressed by shortages of staff, unrealistic targets and expectations. This difficult landscape of health care and its impact on nurse education is identified within the literature:

- That practice placements suffer due to staffing difficulties and increasing workloads. The UK nursing labour force being overstretched and under-resourced. (Casteldine 2007, RCN 2012). The recent Willis report (2012) identified that the practice environments often did not create positive learning experiences due to poor funding, unwelcoming cultures, and lack of support for students and for mentors.

- That the sociological culture of clinical practice is ‘workforce orientated’ and not educationally orientated. Student nurses often express that they are simply being used as a ‘pair of hands.’ (Melia 2006, McGowan 2006). Education is seen to be based on a values-laden perspective that may be inconsistent with those of a workplace driven by rationalisation and increased productivity. The instability of the workplace due to external pressures was linked to negative patient outcomes and further focussed nursing staff on meeting patient needs as opposed to supporting student education. (Duffield et al. 2011). This difficult education and workplace environment is compounded by a lack of time and limited resource; adverse practice settings and stressed registered nurses; lack of organisational
support and conflict between educational needs and organisational, operational concerns (RCN 2012, MacPhee 2009)

The gap between policy and practice is not unique to healthcare and professional education. Tee (2008) had noted a similar gap between policy and practice in his exploration of general educational processes. In his discussion, he argued that ‘policy rhetoric was more a symbolic expression than an actual achievable reality’ (Tee 2008 page 596)\(^{27}\). Deal (2010) had commented how despite the discourse of inclusion, there was a potential conflict between the rights of the disabled person and the self-interest of the non-disabled population. This divide between policy and reality emerged as a barrier to inclusion that nurse educators set out to overcome by:

- lessening the practitioner’s perceptions of the difficulties associated with being disabled and being able to nurse;
- balancing the competing and conflicting professional and work orientated demands of education and nursing practice;
- reaching ‘a deal’ that satisfied the clinical practitioners concerns and preserved the working relationship between education and clinical practice, to ensure continued support for nursing students in the future.

Supporting disabled nursing students was considered to increase the workload of the nurse educator (sections 5.1; 5.2). Although they accepted the presence of the disabled student their common sense understanding that being disabled was synonymous with lacking capability prevailed. Moreover, they were concerned that a disabled student would not be readily accepted in clinical practice, and that support identified could not be sustained in the workplace (section 5.3). However, they conceded that considering the needs of disabled students was the inevitable consequence of Equality legislation and having an increasingly diverse student population.

\(^{27}\) The divide between the rhetoric of legislation and its enactment in practice is explored in section 6.2.1
Despite the legitimacy of disabled nursing students starting educational programs (individuals will have met the eligibility criteria to be a student nurse - section 2.5 and 2.6) nurse educators believed that full access to nurse education was conditional and contingent on issues being resolved. These included the limitations imposed by clinical practitioners’ concerns associated with maintaining patient safety and work efficiency. The uncertainty expressed about the ‘rights and wrongs’ of being inclusive within nurse education, when balancing the need for equality of opportunity and meeting the professional and workplace demands became highlighted when nurse educators considered the generic nature of nursing courses (section 5.2). Registration with the professional body, the NMC, required all nursing students (within a specific field of nursing) to achieve the same standards in generic areas of practice. As registered nurses, this made them eligible to apply for posts in all areas within their chosen field. The pre-determined professional standards provided little scope to adjust or modify a program that focussed on an individual’s potential, and their positive contribution to the different elements of nursing practice, by virtue of the individual’s physical, psychological strengths and personality traits.

The limitations imposed by the professional requirements promoted a way of being that was seen as both essential to maintaining standards in practice, and problematic in considering solutions. Professional standards created doubts about the reasonableness of reasonable adjustments, how practice can be modified or adjusted, and how innovative new ways of working are identified (sections 5.2; 5.3, 5.7). The nurse educators believed that in endorsing Equality Legislation the professional body had not explored in depth the issues of being disabled and being a nurse, and had simply supported the concept of being inclusive in order to counteract the criticism that as a profession, nurses were intolerant of disabled practitioners (Sections 2.4, 5.3, 5.7). The NMC in their guidance to HEI reminded the providers of nurse education programs the being disabled did not bar a person from becoming a nurse as long as they were able to meet the requirements for registration (NMC 2010).
Nurse educators believed that the clinical practice had a preference for a homogenous, low-risk, predictable student ‘workforce’ to contribute to the delivery of effective and efficient care (section 5.3, 5.7). As brokers, they assumed that for all clinical environments, the presence of a disabled student, whilst socially advocated, was potentially problematic. These assumed ‘difficulties’ limited their ability to make significant demands on the practitioners to consider supporting a student, or to consider alternative ways of practice. As a consequence, the temporary nature of the brokered deal (the deal applied to a single student for a specific period) was significant as it enabled nurse educators to find a solution that was right for the moment. Moreover, it did not require them to resolve professional concerns as to whether a disabled person can be employed as an effective, efficient and competent nurse or consider ‘real’ alternative and different ways of working. Instead, it created a solution that fundamentally did not change the beliefs or behaviours of the individuals or the organisations involved, but made consideration of the disabled student more likely. The temporary nature of this agreement, underpinned a pro non-disabled stance that was used as a covert bargaining chip within the process of brokering, to reassure clinical areas that any accommodation would be short lived, and only impact on the clinical setting for a relatively short period (section 5.2). The implication being that once a student had completed an experience the clinical setting could continue working in a traditional and ordinary fashion.

As they discussed nursing, the concept of the ‘ordinary and normal’ way of working became evident in both their descriptions of their personal working practices and their expectations of the students. The need to be ‘ordinary and normal’ was made explicit when, as a disabled person, the individual justified their personal right to be in employment. However, even in the absence of personal experiences all of the participants (both abled and disabled) struggled to visualise how a disabled person could meet the requirements of professional registration. How they overcame

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28 Although student nurses are supernumerary, and as such are not part of the official workforce, practice learning involves being engaged in clinical practice and as such they contribute to meeting the work load.
and balanced these professional and personal concerns about a student's capability in clinical practice; and their role as educators supporting students through the course was influenced by contextual factors and the organisational environments of education and health care (section 5.2, 5.3). The sensitivity of nurse educators towards the workplace and their understanding of the respective organisational structures, policies and processes (which together formed the organisational landscape and climate) influenced whether they were confident to act as a broker within a particular context.

As brokers nurse educators set out to negotiate a favourable ‘deal’ for inclusion on behalf of the student; or, accepted that for specific areas of clinical practice, the issues to be resolved were too great. In those circumstances, they accepted the exclusion of the student from that particular clinical experience. In the absence of clinical experience, full access to nurse educational programs is denied, and the potential for the student to have the opportunities to achieve a level of competence required for registration limited. Accepting exclusion challenged the nurse educator to reconsider their views about inclusion within education, and also their responsibility towards the student who may have worked exceptionally hard just to be accepted as a student nurse (section 5.2).

As they negotiated a ‘deal’ that was acceptable to both education and health care, they satisfied the requirements of all the principals involved (including the student who could now access clinical practice) by establishing 'conditional permission to be present in the workplace.' To guarantee a greater likelihood of brokering success nurse educators carefully selected when, where and with whom they brokered a deal, often identifying those clinical environments that they believed would be amenable to supporting a disabled student. In these ‘quieter’ areas, they believed it was easier to make case for the student to be included and that

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29 The terms landscape and climate are well documented in organisational literature to refer to the organisational infrastructure that includes the built environment, policies, legislation and work practices.
30 In this context ‘exclusion’ simply refers to the clinical placement not agreeing to have the student.
the disabled student nurse would be more likely to be granted a temporary pass into the clinical setting (section 5.2).

As brokers, working on behalf of the student, they repeatedly engaged in discussions with clinical practitioners as they setup the ‘deal’ and manoeuvred through the objections raised. When advocating the inclusion of a disabled student they legitimised their actions by stating that being inclusive was a requirement under current Equality legislation. Acting as a broker was supported by Occupational Health clearing the student as fit for the course and professional beliefs in the importance of being inclusive. Legitimising their role as brokers of inclusion enhanced the nurse educator’s authority to act without compromising their personal views or sentiments. However, in acting as a broker nurse educators recognised that they also negotiated exclusion and ‘alternative endings’ to a program of study, whereby the student was considered to be unable to successfully complete a course and register as a nurse. In brokering an alternative ending the goal, was to ensure that the student was ‘supported’ and that the decisions made were justified. In justifying the decisions made nurse educators argued that the final decision was ‘out of their hands’, and they were working in the best interests of the student or professional group.

Brokering described the negotiating, mediating and bridging processes undertaken by nurse educators when they worked at the intersection of higher education and health care. As brokers, they worked for multiple people or groups to ensure that all interests are addressed as they acknowledged the often polarised positions of the major organisations involved and the need for organisations to maintain contact. In negotiating, mediating and bridging, they balanced the institutional demands created by the differing ideologies of work and education. In doing so, they set out to manage inclusion, by resolving the concerns associated with the inclusion of disabled nursing students (chapter 5), and stretched preconceived notions of what would be possible in the context of nursing practice. The pre-disposition for exclusion by the healthcare workplace, based on an inability to cater for ‘difference’, reflected a belief that inclusion was conditional on normalising the individual. A similar
process is evident in studies on inclusionary practices within compulsory education (Evans and Lunt 2005), whereby inclusion within classrooms becomes dependent on the individual teacher and the limitations of inclusionary processes imposed by the realities of ‘classroom practice’ (Hansen 2011).

6.2.1 Inclusion of disabled students as a wicked problem

Inclusion of disabled students within nursing courses forced nurse educators to revisit their personal and professional beliefs that, despite their experiences, had almost always considered nursing to be for 'abled' people, and that being disabled was problematic for the workplace. How some of the participants had ‘hidden’ their impairment to assume an able identity reinforced this ablest perspective (section 5.1). Resolving their personal concerns and those of their professional colleagues created situations that did not follow the ordinary and normal way of working. Instead of the student simply being accepted as one of a group, who performed in the ordinary and normal way, the disabled student required the nurse educator to work in a bespoke manner to resolve concerns and to broker inclusion on an individual basis. The process of brokering inclusion shared similar characteristics to what Rittel (1969) had described in resolving a ‘wicked problem,’ when no ‘one size fits all’ solution is applicable. Wicked problems lack easy definition, with no definitive description of the problem fitting all situations, and as such a problem can be described differently depending on individual perspectives. The ‘wicked’ nature of working with disabled students in nurse education was evidenced by the multiple positions adopted by the participants. Rittel (1969) described this as the ‘interlocking issues and constraints’ with different stakeholders, each person seeing the problem from a different perspective that are influenced by differing institutional and organisational demands. In this thesis, it emerged that nurse educators believed that clinical practice viewed the ‘disabled student’ from the perspective of the working environment and as such viewed the nature of the problem more negatively when compared to education. Moreover, whilst they believed it was important to be more inclusive they struggled to resolve their
personal concerns about a disabled student’s capability with meeting the requirements of the workplace. The subsequent inclusion of disabled nursing students was influenced by these external factors, contexts and situations making simple solutions hard and unsustainable; thus, the ‘problem’ was continually being re-addressed, with many different solutions emerging. In nurse education, the desired goal was to retro-fit the disabled nursing students into pre-determined pathways of nurse education with minimal disruption to themselves or to clinical practice. However, the reality was very different and pre-conceived solutions of ‘adaptsions to the workplace’ unsatisfactory, as each disabled nursing student presented with unique challenges, requiring an individualised management approach. Using a comparative approach, the emergent concepts encapsulated in the descriptions of ‘wicked problems’ described by Rittel (1969), and in managing inclusion within nurse education are captured in the box 6.1.
<table>
<thead>
<tr>
<th>Concepts that emerge from Wicked Problems adapted from Rittel Horst 1969</th>
<th>Emergent concepts when nurse educators work with disabled students in Nurse Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding wicked problems depends upon one’s idea for solving it. System approaches to understanding the problem are not helpful as every solution gives rise to new issues.</td>
<td>Managing inclusion within nurse education requires nurse educators to be able to define the problem. But as was evident in this study different perspectives about differing disabilities, and the expectations of different people in different clinical settings led to many different beliefs about what was a disability, when was a disability disabling and how could disabled people be included within nurse education. (section 5.1)</td>
</tr>
<tr>
<td>Wicked problems have no stopping rule and it is unclear when the problem is resolved. When resolving a wicked problem individuals tend to stop when they run out of time, resources – culminating in a view that this is the best they can do</td>
<td>When managing inclusion, nurse educators sought to do the best that they could, and accept the limitations to their success. Negotiating the inclusion of a student in a single clinical placement, or period of time did not guarantee inclusion in the future as the circumstances or context were forever changing. Resolving the problem for a single episode did not resolve the problem for every episode. (section 5.2; 5.3, 5.7)</td>
</tr>
<tr>
<td>Solutions to wicked problems are not-true-or false, but-good-or-bad. There is no single right or wrong solution and many people are entitled to judge the solution. The judgements are likely to differ to accord with their group or personal interests</td>
<td>Nurse educators viewed the inclusion of disabled students within nurse education as positive as it met the demands of Equality legislation and their professional belief in empowering and enabling others to have an opportunity to succeed. In contrast they believed that practitioners may view inclusion as being detrimental to the workplace as it impacted on resources and efficiency in the delivery of nursing care. The inclusion of a disabled student would be judged according to the ‘needs’ of others at the point in time (section 5.1;5,3)</td>
</tr>
<tr>
<td>There is no immediate and no ultimate test of a solution to a wicked problem. Any solution when implemented will generate waves of consequences over an extended period of time. The repercussions may outweigh the advantages accomplished</td>
<td>In negotiating inclusion within nurse education success was determined by how well the student is able to work within an environment that was focussed on the abled-ness of the nursing workforce. The consequences of inclusion was believed to impact on patient care and on the workforce. Setting up the student to fail, is considered to outweigh the benefits of including the student. (section 5.2; 5.3, 5.7)</td>
</tr>
<tr>
<td>Concepts that emerge from Wicked Problems adapted from Rittel Horst 1969</td>
<td>Emergent concepts when nurse educators work with disabled students in Nurse Education</td>
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<tr>
<td>Every solution to a wicked problem is a ‘one shot operation’; because there is no opportunity to learn by trial-and-error, every attempt counts significantly. Every implemented solution is consequential, as many peoples’ lives will be affected.</td>
<td>Negotiating inclusion impacts on the nurse educator, the student, the clinical area and has the potential to impact on patient care. Concerns over patient safety and challenges to patient safety by taking a risk on including a student whose capability is in question, may have consequences in the delivery of care. The consequences of brokering inclusion for a disabled student may impact on the patient, the delivery of care, resource availability (time) and the student who might remain unemployable. (section 5.3, 5.7)</td>
</tr>
<tr>
<td>Wicked problems do not have an enumerable set of potential solutions. In solving a wicked problem a host of potential solutions can arise, and it is in the judgement of the individual which solution will be pursued</td>
<td>In managing inclusion, the variables associated with each student, each clinical placement and the context in which they come together created multiple ways in which the nurse educator can work. Each situation was judged by the individuals involved and as such was difficult to replicate, and the judgement of the nurse educator influenced the decisions made. (section 5.1; 5.2)</td>
</tr>
<tr>
<td>Every wicked problem is essentially unique, despite many similarities between current problems and previous problems.</td>
<td>Nurse educators were most comfortable in negotiating inclusion for those students whose disabling conditions followed predictable patterns, which were managed through ‘ordinary’ processes. However, simply working on previous solutions had the potential to fail, and when they failed they felt uncertain as to how they could move forwards. (section 5.1, 5.3, 5.7)</td>
</tr>
<tr>
<td>Every wicked problem can be considered to be a symptom of another problem. In this way problems are described as the discrepancy between the state of affairs as it is, and the state as it ought to be</td>
<td>Nurse educators believed in providing an equality of opportunity and supported the ethos underpinning Equality legislation. Yet their confidence in the ability health care settings to be inclusive and supportive of disabled nursing students or disabled workers prevailed. (section5.1; 5.2; 5.3)</td>
</tr>
<tr>
<td>The existence of a discrepancy can be explained in numerous ways. The choice of explanation determines the nature of the problem’s resolution</td>
<td>Nurse educators rationalised the exclusion or inclusion of disabled nursing students for example with arguments associated with meeting legal obligations, managing with limited resources, maintaining patient safety and meeting professional or work expectations. Thus inclusion is made possible or impossible depending on the arguments that are raised. (section 5.2, 5.7)</td>
</tr>
</tbody>
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Box 6.1 Comparison of wicked problems (Rittel 1969) and the emergent concepts of this study
6.2.2 Positioning a student within a hierarchy of disability and practice

The participants provided examples of when they had worked with disabled students to enable them to have a fair opportunity to achieve the course outcomes and, when successful, register as nurses. However, despite their actions, their doubts about the capacity for clinical practice to be inclusive, and the capability of the disabled student remained; as they considered that inclusion of health care was inevitably problematic and incompatible with efficient nursing practice. In reconciling these dilemmas, the participants rationalised and positioned themselves as ‘doing good’ both to the individual and to the wider profession and organisation. Rationalising these decisions was made easier by their use of an informal hierarchy of disability and practice (section 5.1). When a student was positioned as ‘able disabled’, and capable of completing ‘ordinary’ nursing activities (section 5.1), with no disruption to the health care setting, then inclusion was believed to be possible. As ‘able disabled’, the identity of the student was comparable to other students and met the expectations of others within the profession, creating few if any, situations that required adjustments to practice. It was at either end of their disability hierarchy (section 5.1) within which they positioned a wide spectrum of ‘conditions’; where being disabled was considered to be more problematic, and highlighted the positive or negative value of the disabled student and what they could or could not bring to the profession. It was at these opposing ends that nurse educators felt that they needed to be actively engaged in managing inclusion, as ordinary and normal processes to support students were ineffective. Using this constructed hierarchy of disability and practice, nurse educators made reasoned decisions about the potential for a disabled student to become a nurse as they framed the student in a positive or negative light according to their disability. Thus the virtuous disabled, who had overcome adversity and required reasonable adjustments in practice, were framed as being more positive and more likely to be acceptable as a nurse, and any accommodations seen as supporting the caring ideals of nursing practice. In contrast, the ‘dis-abled’ disabled were associated with negative connotations and
posed a greater risk to the profession. Managing the inclusion of the ‘disabled disabled’ nursing student challenged nurse educators as concerns associated with patient safety predominated in their thinking, and the need to minimise risk prevailed. Reasonable adjustments, in this case, were seen as more difficult to implement and less likely to reconcile the concerns raised by clinical practitioners. Underpinning these concerns was the view that the student more likely to add to the ‘real world’ workload of nursing.

The use of a ‘hierarchy of disability and practice’ created an illusion of inclusivity as disabled students were ‘retro-fitted’ into the normal and ordinary way of working. Whilst it can be argued that this gave disabled nursing students more opportunities to become nurses, the conditional nature of ‘being inclusive’ did not challenge existing practices in education or the workplace. Whitburn (2014) argued that in education (general education) the divide between the rhetoric of inclusion and reality was in itself constructed by the inclusion discourse. Inclusion requires there to be a point of exclusion to have meaning. Exclusion is viewed as the ‘otherness’ to inclusion (Hansen 2012) and as such they are two interconnected processes. Being inclusive is only possible if there are people to whom, or situations where, you are exclusive. Exploring this ‘point of exclusion’ sheds light on inclusion as it challenges people to redefine and reconsider what is impossible and how the capabilities of individuals can be seen as making things possible. Slee (2013) however, suggested that within the current political climate, that despite legislation and an overwhelming acceptance of the social model of disability, exclusion remains a ‘political predisposition’. In his discussion of inclusive educational practices, he argues that in the current economic climate, people have to ‘traverse the fragmented social and economic landscape’ and individual ‘uselessness’ marginalises those that are ‘flawed’. The rhetoric of inclusion and the neo-liberal focus on competitive individualism collectively creates a condition of exclusion for those less able to match the normal and ordinary expectations of educational and working life. The ‘normal and ordinary’ are justified by a common sense understanding of disability. In nurse educators use of the denominator ‘normal and ordinary’
reflected a pro-nondisabled stance and students who fell outside of this parameter remained marginalised. This marginalisation was reinforced by the construction of a hierarchy of disability that reaffirmed the preferred state of being 'normal'.

This thesis adds to the debate on 'exclusion' and 'inclusion' as it focusses on two distinct but connected issues – education and employment. As nurse educators work at the inter-organisational boundary and also at the intersection of 'ability/disability' and 'inclusion/exclusion', their responses to disabled nursing students become significant in how 'the point' of exclusion is determined within nurse education and professional nursing. Rationalising the 'right' for a disabled student, and justifying they were 'doing the right thing' for an individual in nurse education was essential within the process of brokering. However, they recognised that the individual self-interest within the workplace, as nurses simply got on with their jobs made the consideration of 'different ways of working' problematic. The belief that as nurse educators they were 'doing the right thing' was influenced by the decisions of the occupational health service that legitimised the 'rights of the student'. This sanctioning of the student on the course informed the nurse educators as they set out to reconcile concerns about 'rights,' 'equality,' 'fairness,' 'equality legislation,' 'competence,' 'duty of care,' 'public expectations,' 'professional expectations' 'patient safety' and 'justification of public expense.' In balancing these concerns, they concluded that having a disabled student on a nursing course was the inevitable consequence of how as a society people valued the rights of the individual to have an 'equality of opportunity' (section 5.1, 5.2). However, this right did not reflect the reality of being able to complete nursing work (section 5.5), or the needs of the health care system (section 5.7) contracted to deliver an effective and efficient service to patients. This thesis illuminated how nurse education and nursing practice continue to struggle to develop a truly authentic representation of diversity that is focussed on individual capabilities within an environment with strong, embedded beliefs that stem from a covert position that is pro non-disability.
6.2.3 Brokering and inter-organisational working

Brokering occurred at the inter-section between HEI and the NHS as a 'covert process' alongside the ‘ordinary negotiating processes’ that occurred in the support of all students. As a process, it enabled nurse educators to justify any outcome as being ‘out of their hands’ or ‘the best they could do’ at that point in time. For example, nurse educators and clinical mentors negotiated on behalf of many students, around a range of different issues (section 2.5); but when negotiating on behalf of a disabled student, an element of ‘trading’ became evident as agreements reached impacted on other activities. In this covert process, the nurse educator and clinical colleagues could reach agreement on:

- the number of students, a clinical area, will accept,
- the additional support available to the clinical area that accepted a disabled student,
- the withdrawal of the disabled student if the clinical area got ‘too busy.’
- other ‘favours’ that could be given to the clinical area in return for them accepting a disabled student (section 5.2)

Nurse educators were concerned that in their actions whilst they aimed to be supportive, support in completing a course for registration may not be translated into employment as a registered nurse (section 5.3). For many of the participants their concerns about whether a disabled student ‘should be a nurse’ centred not on the ability of the student to complete the course, but on the subsequent ability of the student to be employed. They doubted the student’s capability to be an effective and efficient member of the health care workforce, or the willingness of practice to accommodate different ways of working. These concerns reflected what they perceived to be the conflicting objectives of the two major organisations involved, Higher Education and the National Health Service. HEI being committed to widening participation, whilst health care is entrusted to provide a cost-effective, competent and flexible workforce.
For some of the participants, the inability of a disabled student to be subsequently employed confirmed their inner concern that being disabled was incompatible with becoming a nurse. They subsequently justified the decisions they had made by believing they had at least given the student the opportunity to try. They argued that the disabled student lacked the resilience to be able to function in what they perceived to be a hostile environment, and the willingness of the environment to adjust to the needs to the student. The un-employability of the student being seen as protective of the student as they are not exposed to the harsh working environment, and protective of the professional work force, which no longer had to consider adjustments to normative ‘ordinary’ ways of working. For others, this outcome was more troubling, as they felt they had been complicit in a process that would inevitably fail the student, and this challenged their professional ideology associated with being supportive and empowering; whilst upholding their responsibility to ‘do good’ and ‘not do harm.’

6.2.3.1 Creating space

Brokering was a dynamic process and reflected the need for the brokers to revisit decisions made; to find new solutions that resolved the changing concerns associated with the different nursing context, within which students gained clinical experiences. The need to ‘find new solutions’ required the brokers to distance themselves and 'step back' from their personal and professional beliefs about nursing and being disabled (section 5.2) and how they understood the health care setting to function, before 'stepping forward' to broker a deal on behalf of the student. Stepping back created the space within which they could consider the student before they 'stepped forward' to commence brokering a deal that was right for the moment. In this space they considered the requirements of Equality Legislation and professional registration, and what they believed to be possible within the institutional setting of health care influenced their decisions either to engage in brokering a deal for inclusion or to support exclusion. These pre-conceptions were evident in how they constructed a hierarchy of disability and practice within which being
disabled was measured against the capacity to become a nurse within a particular context. Although this hierarchy of disability provided no easy solutions, it guided the nurse educator through the process of brokering through which decisions to exclude or include the student were rationalised, sanctioned and legitimised.

This need to create space reflected the ‘wicked ‘nature of the problem and the lack of formal guidance or processes to resolve concerns. As a wicked problem, nurse educators were required to consider each student as they presented, either during the interview process or the course. As nurse educators, they believed they should be supportive of disabled people and that once on the course their job role was to enable the disabled student to study. However, they also believed that the health care workplace was unsupportive of any worker who was 'different.' Stepping back to create space enabled the nurse educator to distance their personal beliefs and values from their job role as they reframed themselves as brokers. As a broker, they were distanced from the 'problem' as they set out to resolve what they believed to be inter-organisational tensions. ‘Stepping back’ became an artefact that enabled the nurse educator to sever their personal beliefs and values about disability from the act of ‘doing the job.’ As a strategy for managing tension it is reminiscent of the coping mechanisms that workers employ in Lipsky's concept of 'street-level bureaucracy' (1980) to shield themselves from the tensions between what they are supposed to do and what they actually do. Lipsky (1980) argued that in situations of organisational conflict workers modify their job conceptions in order to satisfy all those involved. Finding a solution and brokering the best deal ‘for the moment’ to enable a disabled student a fair opportunity or practice to be able to 'refuse' to have a student was made possible within the nurse educator's 'modified' job role of the 'broker'.

In brokering inclusion, space was also created between the disabled student and the brokering process. In this way, the student was 'protected' from the responses of the clinical environment, and nurse educators acted on the student's behalf. Although distancing the disabled student from the process characterised and reinforced the ‘problematic’ nature of having a
disabled student, it also created an opportunity for nurse educators to engage in dialogue with their clinical colleagues as they reframed the disabled student in a positive light (section 5.3, 5.5.2). Moreover, it assisted in how they, as brokers, overcame the potential ideological conflict between the two institutions and how they were able to support disabled people. Nurse educators considered ideological conflict as a barrier to inclusion; as the educational emphasis on being inclusive was believed to conflict with the demands of the ‘real world’ of nursing work, and did not reflect what clinical mentors expected of a student nurse in clinical practice. By creating ‘space’, any discussions and concerns were less likely to be considered discriminatory as they were simply objective judgements based on factual information and not personal concerns based on beliefs about disabled people becoming nurses. Thomas (1984) identified a similar mechanism in the negotiation process within maximum security prisons, when social order is maintained by the manner in which the guards and the inmates negotiate through ‘loose coupling’ and use the policies and processes so that all parties can benefit.

In distancing the disabled student from their abled peers nurse educators, affirmed their belief that a disabled person lacked the capacity and capability to make decisions and act for themselves. This sub conscious alignment of disability with impaired ability led the nurse educator to act in a fiduciary way as they assumed responsibility to balance the needs of HEI with the demands of clinical practice and managed the potential impact that inclusion or exclusion had on the student. Moreover, as an ‘inclusionary practice’ distancing the disabled nursing student effectively ‘othered’ the disabled student through seemingly legitimised pedagogical processes.

This ‘space’ also created an informal arrangement between education and health care that was conducive to brokering and allowed the disabled student to be ‘present’ in the workplace. The informality of the process enabled nurse educators to adopt a flexible approach to negotiation as decisions made were not contractually bound, this preserved the right of those involved to reconsider decisions made. However, despite the informality involved in brokering it also became a formal process of
negotiation between the organisations, in that it culminated in decisions being agreed, and successful brokering facilitated inclusion or managed the exclusion. As a consequence, the process of brokering was enacted through a series of discretionary behaviours; the negotiator's tacit understanding of the ‘task in hand’ and the personal interactions that occurred between individual nurse educators and clinical mentors. It was these behaviours that reflected the case by case approach that epitomised brokering, as nurse educators engaged in strategies that increased the likelihood of a successful deal being agreed (section 5.1 and 5.2).

In this thesis, nurse educators as brokers, modified their ordinary way of working so that inclusion or exclusion of a disabled student could be argued as in 'the best interest of the student' or the 'best interest of the profession'. In doing so, organisational stability is maintained by the enactment of policies and practices in the daily life of the organisation. In nurse education, maintaining the social order between education and clinical practice, led to the covert separation of the disabled student from the formal educational arrangement between the two organisations as they balanced what the organisations said should be done (education and the workforce should be inclusive) and how they, as functionaries, proposed to do it.

6.2.3.2 Brokering a deal for ‘the moment.’

The need to avoid discrimination troubled the participants as they felt that the practice environment focussed on a 'traditional' and ordinary way of working; despite their belief that nursing practice was changing (section 5.3). As the participants discussed the changing nature of nursing practice, they concluded that disabled people could increasingly perform many elements of nursing practice with imaginative reasonable adjustments. However, they also conceded that whilst they could be creative, the requirements of the professional body which focussed on core competencies and essential skills, reinforced an ordinary and
normal way of working, and had no criteria or processes that considered the registration of a nurse with restrictions\(^{31}\) (sections 5.2; 5.3).

As brokers, nurse educators recognised that managing the inclusion of a disabled student challenged traditional normative\(^{32}\) views of nursing students and nursing practice. To secure a deal, they set out to form a relationship with specific clinical areas and clinical mentors; to reframe how nursing students were perceived by the health care setting. In this way, they could make the case that the presence of the student would have a minimal impact on the working environment, in the ‘real world of nursing.’ The nurse educators’ tacit understanding and insider knowledge of this ‘real world,’ provided them with insight as to what would or would not be acceptable, or within which areas of practice reasonable adjustments would be deemed possible. The decision to broker inclusion rested on the conditions, the nature of the clinical area and the support from the clinical practitioners, being conducive to securing a deal (section 5.1). If clinicians argued that having a student would be problematic; nurse educators attempted to shift the balance in favour of including the disabled student by the strategic demonstration of the student’s ability, and potential for achieving professional competence, or by appealing to the good will of the clinician (sections 5.1 and 5.2). In this manner the disabled student, who until that point had been invisible and ‘distanced’ from the process, was ‘showcased’ by the nurse educator. As a negotiating strategy, this shifted the focus from an objective discussion of disability and disabled people becoming nurses to considering a person. It focussed attention on not only the abilities of the student, but also their personal characteristics as they were framed as either ‘able disabled’ or ‘virtuously disabled’ and an ‘exceptional worker.’ The personalisation of the student, made clinical practitioner’s judgements about inclusion or exclusion more difficult, as unfavourable decisions (the exclusion of the student), might be judged as discriminatory and linked to the individual

\(^{31}\) NMC requires all students have to be competent in all elements, even if they are not part of the subsequent job role within which they will be working. There is no ‘restricted’ component of the register. Nursing and Midwifery Regulations NMC 2010

\(^{32}\) Nursing students are considered to be supernumerary to the workforce but able to contribute to effective health care delivery (NMC 2010)
involved in the decision-making processes. Favourable decisions, the inclusion of the disabled student was not without problems as the nurse educator had then to resolve the practical concerns raised by their clinical colleagues. Nurse educators believed that this influenced the brokering process as it positioned the student in a more favourable light and positioned the clinical practitioner as having a decision-making function.

As they brokered a deal, individualising and personalising a student created an opportunity for nurse educators to identify individuals whom they believed would be sympathetic to the student. The presence of the student then influenced the willingness of individuals to accept the student or to consider adjustments to the ‘ordinary’ working of clinical practice (section 5.4). It also served to validate to the clinicians that the inclusion of a disabled student was not a foregone conclusion and that they valued the clinician’s opinion within the collaborative working partnership. Showcasing the student, and gaining a positive endorsement of the student empowered the nurse educator to establish the legitimacy of their actions. However, the efficacy of this device could be counteracted by the professional argument of the clinical mentor. When presented with rational arguments about patient care and safety, nurse educators would reconsider; apply a counter argument based on the rights for inclusion or concede to the professional view that inclusion would indeed, impact on ‘patient safety’ and ‘delivery of care’ (section 5.3). The limitations imposed by practitioners and the clinical context, on the ability of the nurse educator to negotiate a ‘deal’ on behalf of the student, reinforced their uncertainty as to whether a disabled student could always become a nurse. This uncertainty led nurse educators strategically decide when, where and with whom they would engage in the process of brokering. This strategy increased their effectiveness as a broker but restricted the opportunities to be innovative and creative for the inclusion of disabled people as nursing students. The participants believed that the inclusion of a disabled student was not accepted universally within health care practice, and as such brokering occurred most commonly when individuals believed they would be successful. The ability of the nurse educator to broker deals had the potential to broaden the range of
potential clinical settings that would be accepting of a disabled student, but success was always tempered by the caveat that patient safety came first. In doing so, they justified to themselves that supporting disabled students was a managed process and that they had taken into account contextual factors. Throughout the brokering process, nurse educators set out to ensure that the student was given the opportunity to be 'present' in the workplace. This presence, however, was conditional on the student being able to assume an ‘ordinary and normal’ way of being. Not being ‘fully’ present in the workplace reflected the limited tolerance nurse educators expected of the workplace to accommodate students who presented as 'different.'

As nurse educators engaged in inter-organisational working, any brokered agreement was considered to be tenuous, with clinical practitioners retaining the ability to revoke any agreement made. To overcome this nurse educators relied on their relationship with specific practitioners or clinical settings, as they set out to maintain a relationship within the interdependent organisational structures that framed the negotiating process. In this way, inclusion was justified by the need to meet the legislative requirement, and exclusion justified on professional grounds related to patient safety and the working environment.

In mediating at the intersection between higher education and clinical practice, nurse educators worked in a collaborative manner with clinical colleagues, at the organisational boundaries through a range of mechanisms to ensure students (abled and disabled) were provided learning opportunities within clinical practice. At this intersection, nurse educators positioned themselves as ‘agents’ for HEI, the professional body and the student as they worked to provide the student with an equality of opportunity and minimise attrition, meeting the requirements of the educational contract. Throughout the process of brokering the nurse, educator had both a fiduciary and ‘agent’ relationship with the student. In this dual relationship, they simultaneously supported inclusion and ensured that the student was protected. The student was not ‘set-up to fail’ by embarking, or continuing with a course that would inevitably lead to failure due to the hostile, unsupportive nature of clinical practice (section
Nurse educators effectively working within a 'dual curriculum,' the first based within HEI which centred around producing knowledgeable, innovative and creative practitioners and the second based in clinical practice ensuring nurse were able to 'do the job' in the real world of nursing. This concept of a dual curriculum is reminiscent of the recent Francis Report (2013) in which one chief executive in giving evidence, alludes to nurses taking part in 'guerrilla warfare' whereby the hostile environment forces them to work 'below the radar', to ensure they complete the required work. Brokering inclusion or exclusion of a disabled student was predominantly a 'local' response, and as such occurred 'below the radar' as nurse educators were very conscious of the difference between the rhetoric of developing an inclusive workforce and the reality of the 'real world of nursing practice.'

6.2.4 Summary

Nurse educators expressed wide-ranging beliefs associated with being disabled and becoming a nurse as they considered inclusion from many different perspectives (section 5.1). They also believed that managing inclusion was a dynamic process, with limited guidance or processes to follow. As they addressed the problems, they worked within the constraints created by the health care environment; with its perceived lack of resources, and the political ramifications of any decisions made. In balancing the competing requirements of those involved, managing inclusion within nurse education challenged the participants' personal and professional understanding of being disabled and becoming a nurse as they endeavoured to do the 'right thing.' During their discussion, it was when circumstances and events led them to consider the issues associated with being inclusive for a specific student, and manage a process that enabled the student to have equality of opportunity, a fair chance to succeed; that their concerns became most apparent. Throughout this thesis, nurse educators had shared their general beliefs about disability and being disabled and demonstrated an awareness of
equality legislation. However, it was when they considered the inclusion of
disabled nursing students, that the implications of promoting equality and
being inclusive, within a professional nursing framework, became central
to their thinking.

The co-existence of competing and conflicting values associated with
diversity, inclusion and equality were dilemmas they set out to resolve,
when they considered the need of the health care service to have ‘fit, able
and competent’ nurses, to provide a cost effective and efficient service. In
doing so, they set out to balance the demands of equality legislation and
professional values; that recognised and respected the rights of
individuals to have equality of opportunity both in education and work. In
managing these concerns, nurse educators felt obligated, by their
professional beliefs and values as an educator and as a nurse, to be
supportive and to manage inclusion to provide the disabled student with
an equality of opportunity. They also felt constrained by the working
environment of health care which they believed to be inhospitable to the
inclusion of ‘difference,’ creating a climate that would limit their ability to
find a solution. The key concepts that emerged are represented in the
diagram below (diagram 6.1).
Diagram 6.1. The emergent categories and the background occupational (work) values, professional values and personal values.

6.3 Brokering and organisational theory

The actions of the broker and the process of brokering that emerged in this thesis can be aligned with concepts identified within organisational theory, and the interactions between individuals as they work at intersections between groups within organisations, or between organisations in inter-organisational working. Organisational theory considers multiple perspectives as organisations increasingly operate in complex, uncertain and contradictory situations, and as collaborative working becomes the norm. Clark (1991) argued that organisational theory was initially influenced by a predominant management focus and as a consequence neglected the social processes between individuals and between organisations.

More recently, in understanding the complexity of organisations and how they function, Scott (1998) addressed this shortcoming and described three levels of organisational analysis: -
1) The social psychological level which focussed on individual and interpersonal relationships,
2) The structural level that focussed on the organisations in general
3) The macro level with its focus on the organization in relation to other organisations and society.

As such, organisational theory, which initially focussed on how organisations maintained stability, is increasingly seeking to understand how organisations change and react to new contexts and new situations (Greenwood et al. 1996). Understanding the social processes within organisations has led to the development of a strand of organisational theory, known as institutional theory.

In institutional theory, organisations can be considered as comprised of many different institutional elements that provide ‘cognitive schema, normative guidance, and rules that constrain and empower social behaviours’ (Scott 2008, page 429). DiMaggio and Powell (1983) argued that the institutional order was made possible by the ‘coercive, normative and mimetic’ process of social reproduction. These concepts developed by Scott (2008), referred to institutional theory as having three key ingredients: the regulative, the cultural and cognitive processes. Regulative processes included the rules and regulations that governed institutional function. Normative elements introduced ‘a prescriptive, evaluative and obligatory dimension into social life’ (Scott 2008: 54). Whilst the cultural-cognitive element focussed on the shared meanings and values that made up the nature of social reality and the frames through which meaning is made. Scott (2008) argued that institutional, social order (and by default organisational order) are influenced by whether actions are due to expedience, moral obligation or because one cannot conceive of other ways of acting. Organisations, therefore, adopt a recognisable organisational form (DiMaggio and Powell, 1991) formed by the underpinning institutional ideas and values that provide the pattern of
organizational structures and processes. This form or template also provides a framework within which what is ‘ordinary and normal’ can be expected by those who work within the organisation and those who are in receipt of goods or services. How organisations and institutions change in response to internal and external demands can be viewed through the lens of a ‘template’, and can be defined as either convergent or radical (Greenwood and Hinings 1993). Convergent change occurring within the parameters of an existing template, whilst radical change, occurs when the organisation shifts from one template to another. DiMaggio and Powell (1983, 1991) commenting on the homogeneity of ‘like organisations,’ argued that when change is resisted, and then imposed, it can be discordant to the prevailing structure. In response organisations set out to conform to contextual expectations to regain legitimacy, as they replicate within a new template a pattern of institutional behaviour that is recognised and expected by others, accepted as normal and subsequently form a fundamental part of the organisational culture.

The ‘template’ is, therefore, constantly influenced and challenged by external and internal drivers that form the ‘technical (market driven) and institutional environments (Scott and Meyer 1991). In this model, for example, hospitals have environments that are influenced by both technical and institutional demands, whilst schools historically had environments that were predominantly influenced by institutional demands (Scott 2008). The current economic climate is arguably shifting both these positons so that both education and hospitals become responsive to technical (market) forces which conflict with traditional educational and healthcare institutional forces (education being a goal in its right and health care to be outside of the market place). In addition, Meyer and Rowan (1977) considered that organisations responded to these institutional pressures by adopting a ‘ceremonial conformity,’ whereby institutional demands were adopted but then decoupled from the actual practices, which reflected the local demands and practical realities.

Institutional theory provides a way of considering the role of the individual and how agency is influenced by contextual factors (Oliver 1991), including the resource and institutional forces (Dobbin and Sutton 1998).
Focussing on the agency of those involved in situations of institutional conflict within inter-organisational working; where the differing institutions have conflicting ideological beliefs and contextual drivers, adds to an understanding of the social processes involved in institutional theory. Using a principal-agent model, (also known as agency theory) whereby individuals (the agents) work on behalf of the principals provides a conceptual view to understanding how those who work at the intersection between organisations; where there is the potential for institutional conflict, manage processes to achieve common goals. Conventionally in the principal-agent model, one person is designated as the 'principal', and the other, in the provision of goods or services is designated as the 'agent' (Pratt and Zechouser 1985). The principal governs the agent's actions through formal or informal contractual arrangements, and in the absence of clear guidance, the agents can act in what they consider to be the best interest of the principal. In the application of agency theory to organizational work (Young et al. 2008) the agents are ‘hired’ to work on behalf of the organisation (principal) and in doing so the organisation (principal) delegates some decision-making authority, which may lead to agents acting in a self-serving manner, and not always in the interests of the organisation. In overcoming this risk, principals seek some control over the agent working and in the context of organisational and institutional theory this could be through regulatory, cultural and cognitive processes. In other words, the actions of the agent are constrained by their understanding of organisational and institutional expectations and requirements.

6.3.1 Agents with multiple principals

The principal-agent theory originated as an economic theory to understand asymmetry between a single agent and their principal (Miller 2005). However, increasingly this dyadic model is being replaced by models of multi-agency working, as organizations, and institutions increasingly operate collaboratively within complex models. This is most evident in political sciences where the combination of wicked problems inter-organisational working and the influence of inter and intra-
institutional structures and processes, creates a pattern of working that can involve multiple agents and multiple principals. Mitnick (1973) developed an institutional or regulatory principal-agent model that sought to explain the complexity of intra and inter-organisational working, where the simple dyadic relationship between a single agent and a single principal is problematic. In this model Mitnick, (1973, 1985) examined the relationship between agents in a ‘regulatory bureaucracy’ and the related legislators and interest groups (political principals). In the regulatory principal-agent model, the emergence of a single agent multiple principal roles reflected the complexity of working in an environment where different principals, hold different perspectives as to how the issues are resolved. Waterman and Meier (1998) in their exploration of the dynamic nature of the principal-agent relationship that emerged in situations of goal conflict and information asymmetry, within political science, considered an alternative relationship between the agent and the principal. They argued that the hierarchical relationship between principals and agents was replaced by political relationships between multiple agents and multiple principals. In this model, agents are not always unitary actors, but can have opposing goals within an agency. Thus at any time, the agent can act differently in response to the conflicting and competing demands of multiple principals. As such goal conflict and information asymmetry became variables that influenced the bureaucratic processes within institutional working. In the traditional principal-agent relationship, the principal must attempt to align the agent with their preferences and eliminate the likelihood of an agent acting independently for their purposes. In sustaining successful inter-organisational working, the principal must ‘give up’ some authority and allow the agent to work flexibly and take some risks (Miller and Whitford 2002). In doing so, the agent in working with multiple principals, can mediate between different institutional demands and to find solutions to seemingly irreconcilable differences. The potential for polarised positions (each organisation has its institutional belief about the issue being resolved) highlighted the importance of the agent cultivating trust, authority, knowledge and leverage. In particular these concepts are influential when, as an agent for multiple principals, the individual: -
1) Overcomes organisational barriers
2) Reaches out to decision makers
3) Sustains relationships
4) Manages without absolute power

Miller (2005) argued that within political sciences, this nuanced behaviour of the agent(s) to work cooperatively with different principal(s) through mutual collaboration, has led to an increased emphasis on the negotiation of administrative procedures as opposed to outcome-based incentives. In his discussion, he refers to the principal-agent theory as being structured as a form of a ‘game’ as it is based on prior assumptions associated with common-knowledge and ultimate bargaining. In viewing the agents and the principals as ‘game players’, as they developed a relationship within which ‘mutually beneficial negotiation’ occurs (Miller 2005, page 218), the importance of co-operation and credibility emerged, as agents and principals resolved conflict. In doing so, the agent is not seen as being passive or self-serving but as acting through a series of checks and balances to moderate and constrain the extreme or polarised position of the principal(s).

The challenges faced by the agents, within multiple principal-agent working within and between institutions, encapsulated elements of the negotiated order described by Strauss (1963) from his field work in organisations. Theoretically he argued that the organisational order is always a negotiated order, that is produced through the actions of the individual ‘actors’ involved as they go about their organisational function. The initial description of these negotiating processes focussed on the actions of the actors, to the neglect of the structural and negotiation contexts. Strauss (1993) commented that in the original concept of ‘negotiated order’ he failed to address the issues of the context within which negotiation occurred, in particular, the implicit impact of ‘power, coalition, politics, and the like’...(Strauss, 1993. Page 249-50).
Fine (1984), drawing on the work of Strauss, and in addressing the issue of context, described four key elements associated with negotiated order:

1) Strauss (1963) argued that all social order is a negotiated order and as such organization is not possible without some form of negotiation.

2) Specific negotiations are contingent on the structural conditions of the organization. Negotiations follow lines of communication and are not random.

3) Negotiations have temporal limitations, and they are renewed, revised and reconstituted over time.

4) Structural changes in the organization require a revision of the negotiated order. The structure of the organization and the micro-politics of the negotiated order are closely connected. (Fine 1984, page 241)

In negotiating an effective working relationship to bring to fruition common goals, whilst meeting the individual, organisational demands, the actions of the agent can be understood through the application of the multiple principal-agent model that was described in political sciences, in particular with policy formation with trans-national or coalition governments (Shapiro 2005, Waterman and Meier 1998). In understanding inter-organisational working, the theoretical elements from institutional theory, principal-agent theory and the concepts associated with negotiated order, coalesced together to provide a richer understanding of the complexity of the negotiating process undertaken. In comparing brokering to these theoretical positions, it can be seen as a representation of a multiple principal-agent process, not dissimilar to that evident in political processes that are influenced by the context and structure of the organisations involved; the institutions and the relationship between individuals and organisations.
6.3.2 Agents as brokers

Using a multiple principal-agent model, within inter-organisational working, brokers, as agents, can be seen as working at the intersection between differing principals (organisations and institutions). Descriptions of people who work between different organisations are common within organisational literature and are referred to by a variety of terms, including the mediator, arbitrator, boundary spanner and broker. In inter-organisational working a ‘mediator’, is identified as a third-party agent who worked within complex negotiating conditions, where conflict or negotiation failure was deemed likely (Ivanov 2010, Menkel-Meadows 2009, Astor 2007). Mediators are considered to be individuals who are associated with working between groups or individuals, with the aim of resolving conflict, by getting the negotiating parties to come to a common agreement as to how their differences will be resolved. The negotiating parties continue to negotiate in the presence of mediators who help to break down barriers and encourage dialogue and communication between the negotiators. The negotiating process occurs between the two parties with the mediator simply ‘holding’ the parties together. In doing so, the mediators manage the intense and polarised stance of each party, with the aim of bringing members, with extreme and potentially different beliefs together, by establishing common ground through which conflict is resolved.

In contrast, the role of the arbitrator is to make the final decision when negotiations have stalled. Whilst they have similar attributes to a mediator, in that they are working independently between parties, arbitrators are called upon to resolve an ‘impasse’ with their judgement being seen as final and binding on both parties (Witkin 2010). The negotiating parties look to the arbitrator to ‘hand down a solution’. Arbitrators have decision-making authority as opposed to mediators, who have no power (DiUbaldo 2008). As a consequence in areas of conflict, mediation is often attempted first and is seen as a ‘soft’ negotiating tactic, with arbitration only occurring if mediation fails (Bennett 2013)
Brokers, also work between people and organisations, but unlike mediators and arbitrators they often lack clear lines of authority over others, and yet maintain a legitimacy that enabled them to be effective in working across boundaries (Williams 2005). As brokers, individuals needed to position themselves within decision-making processes to cultivate consensus, equality and win-win\(^{34}\) situations. Brokers differ from mediators and arbitrators in that they are active within the negotiating process. The negotiation occurs through the broker, who then re-frames the stance of each ‘principal’ to make it more palatable, and more likely to be acceptable to all the parties concerned.

Brokers strategically used their relationship with all parties and the power and knowledge asymmetry and dynamics between individuals to secure a deal. Brokering differed from simple negotiation as solutions to complex problems were unique, temporal in nature and involved ‘give and take’. From a business perspective, the concept of ‘give and take’ described the way the broker made it possible for one or both of the negotiating parties to give away some aspects, for the benefit of another, to ensure a ‘deal’ is brokered. In achieving this outcome, the broker attempted to ameliorate between the different principals, by addressing the main concerns of the parties involved (Ryall and Sorenson 2007).

In inter-organisational working, Williams, 2005, made reference to brokers as people with skills fostering trust, expertise in influencing and negotiating and have a perceived ‘legitimacy’ to act objectively and openly for others. The relationship between the broker and the parties involved suggests that brokering is a sophisticated and complex process within negotiation that did not aspire to be ‘neutral’, but neither does it aspire to enforce binding decisions. Brokers set out to develop a trusting relationship with those with whom they were engaged, and this relationship was by necessity forged by the broker engaging in direct communication. Whilst negotiation can occur at a distance, brokering required the broker to have some understanding and knowledge of the

\(^{34}\) Win-win, describes a situation where both parties believe themselves to have succeeded and originated as a concept in game theory.
individuals engaged in the process. This relationship is developed by what Emerson et al. (2012) referred to as a 'principled engagement'; or face-to-face interaction between the people involved, to facilitate collaboration and agreement.

Williams (2002) argued that brokering epitomised the essence of successful working across organisational boundaries that depended on skilful brokers ‘understanding the interdependencies between problems, solutions and organisations’ (page 137). The ability to broker an effective deal to resolve complex issues required expertise in negotiating and influencing others, whilst retaining an element of legitimacy and objectivity to enable individuals (or groups) to feel that their individual needs are met. In describing these brokers, Williams (2013, 2002) used the term ‘boundary spanners,’ to outline how they worked across organisational boundaries. He outlined their role as a form of collaborative working that helped groups solve complex public policy issues such as ‘community safety, poverty, inclusion, and health inequalities’ (page 104), without themselves having a vested interest in the outcome. Others have considered the need for brokers to have authority and legitimacy as they acted between individuals and organisations. In resolving the ambiguity associated with death within health care, Timmermans (2005) referred to the physician as having cultural authority and that through ‘death brokering’ distinguished between the acceptable line of curing or letting go. In doing so, death brokering was considered a professional accomplishment that offered a cultural script about when how, with whom, and where to die. Simultaneously death brokering gives meaning to death whilst retaining its essential ambiguity and the need for continued expert guidance. In this process, the authority and legitimacy of the death broker become evident as they mediated between and within individuals to resolve potential conflict in a manner that is acceptable to all.

The role, and need for brokers working collaboratively across organisational boundaries has emerged from increasingly complex organisational and inter-organisational structures. In health care,
boundary working is a common feature of working between different health agencies and has been described by the terms ‘collaborative public management’ and ‘collaborative public managers,’ (O’Leary and Bingham 2009). These roles encapsulated key elements of the brokering process including working objectively; connecting people together to find solutions that meet the goals of those involved, and being both strategic and tactical in knowing when it was the ‘right time or the right conditions’ to negotiate. The importance of contextual factors to enable effective brokering are considered by Jezewski (1996), in her study of culture brokering within health care. In her study, she identified how ‘conditions’ such as the expectations of the clinical environments and the beliefs of the different professionals involved had a significant impact on the success in enabling marginalised groups access to paediatric clinics.

The importance of ‘trust and reciprocity’ within the process of brokering has been highlighted in studies of inter-agency working that tackle employability of disadvantaged groups (Lindsay et al. 2008). In the resolution of ‘wicked’ problems, trustworthiness and flexibility, and the continual need to review decisions made and to negotiate new decisions as a result of decisions already made; or changes to the negotiating climate and context supports the fluidity of the brokering role. A skilful broker created a negotiating environment in response to the context and situation, within which all parties believed that their demands were met.

The similarity between brokers and multiple principal-agent working in mutually beneficial negotiations is encapsulated by Jackson (2003) who defined the knowledge broker in education as the

‘proactive facilitator who connects people, networks, organizations, resources and establishes the conditions to create something new or add value to something that already exists (Jackson 2003 p. 4.)’
6.3.3 Brokering as a negotiating process in multiple principal-agent working

In the literature, the process of brokering has been documented in information technology, anthropology, health care, education and politics. It has been associated with diverse issues, such as establishing peace in war zones (Goddard 2012); maintaining power supplies in a changing economic and environmental context (Holland and Neufeld 2009); knowledge transfer within information technology systems (Conklin et al. 2013); mediating between groups in situations of power asymmetry (Hoffman, Merand and Irondelle 2011); bridging the divide in intra-professional working (Jezewski 1995), and bridging the divide between research, policy and practice (Lomaz 2007, Lawrence 2006). In those instances, the broker acts as a catalyst for bringing people together who might be of benefit to each other, by imparting knowledge and managing areas of conflict in a skilful manner, and then mediating between individuals/groups to effect change.

The concept of brokering primarily occurred when there is a perceived asymmetry between knowledge and information, (knowledge brokering) resources (resource brokering), people (culture brokering), monetary resources (financial brokering). In addition brokering is associated with resolving political discord and polarised positions within systems of government (political brokering) and between governments and nations (peace brokering). These asymmetrical and discordant relationships share some of the characteristics of ‘wicked problems’; in that solution are very dependent on external factors or individual people; solutions are subject to context and conditions. As they are resolved, the solution can in them-self create new difficulties or problems to be resolved. The importance of the ‘conditions’ and the political backdrop to the brokering process, and the subsequent impact of any deal that is brokered is highlighted in specific examples of 'brokering'.

Northern Ireland peace talks, she considered how the brokering process reframed the balance of power, the asymmetry between the opposing parties, so that neither party felt disempowered, and their respective followers believed that a negotiated outcome had met their demands. The need for brokers in territorial or political disputes becomes evident when individual positions are polarised, and legitimate decisions become increasingly difficult as norms, rules are disputed, and events contested. Goddard (2012) argued that in resolving this impasse, brokers were key to the process as they had unique access to the social and cultural resources (Archer 1989, Tilley 2001), and as such their unique ‘agency’ was a function of their position. In drawing on these resources, they had the ability to legitimate and frame settlements in a manner that resonated with the differing parties involved. Goddard (2012) considered that brokers brought with them the ‘social authority’ and the ‘rhetorical resources’ (page 506), which, when situated at the intersection between polarised parties, enabled them to legitimise solutions.

Holland and Neufeld (2009) also alluded to how the political rhetoric and increasing public debate about energy sustainability influenced how energy supply was organised to meet public expectations. The subsequent ‘deal’ resulted from the ‘shifting public debates over its (energy supply) structure and the form of its ownership’ (Holland and Neufeld 2009, page 36).

Brokering as a political process is most evident in situations of conflict where the outcomes impact on the wider social landscape within which the negotiating process was situated. Securing the peace in Northern Ireland (Goddard 2012) impacted not only on those engaged in the process of brokering but also the people who lived in the province. The political nature of brokering is also evident within and between public bodies, where any decisions agreed impact on service provision within the wider community and inter-professional working when traditional roles between individuals become challenged (Knolle 2013). Brokering involved the interdependent member’s use of power, influence and political manoeuvring to achieve their goals (Mirand, Hoffman, and Irondelle 2011), to broker effective deals. As such, brokering, unlike
negotiating, actively challenged preconceived ideas about what is possible, by manoeuvring around, and manipulating the conditions that enabled the negotiating parties to shift their position, whilst still believing their demands or needs had been met. For example, Fischer (2009) suggested that the key roles for brokers within knowledge brokering was to

- enable and maintain access to information
- make information more edible for audiences
- create a demand for information/generating cultures of information use
- support marginalised voices to be heard
- create alternative framing of issues
- connecting spheres of action
- enable accountability

In the literature, the process of brokering was often associated with power asymmetries, such as between doctors and patients, and the broker mediated to reduce the differential and ‘level’ the playing field. Jezewski (1995) identified power asymmetry in the health care interactions between doctors, nurses and patients. She reasoned that the primary consequence of the subsequent culture brokering was conflict resolution. She argued that the experienced broker anticipated areas of potential conflict and as a consequence mediated to prevent conflict situations arising and ‘facilitated access and use of health care for people seeking care.’ It is this mediating and anticipating of conflict that mirrors the discretionary actions of agents associated with the political nature of multiple agent-principal working within political science that supports the development of political coalitions and agreements.

Throughout the literature brokers acting to resolve problems associated with polarised and discordant positions are acting as agents for multiple principals, as they balanced the asymmetrical relationships, knowledge or resources to achieve a particular goal. In this thesis, the nurse educator primarily acts as an agent with multiple principals. However, within the
process of brokering they retain the ability to shift this position, selecting the most appropriate stance to secure a deal.

6.3.4 Nurse Educators as Brokers

From the extant literature that considered how individuals work within and between organisations common concepts emerged. In comparison with the substantive data, they help to delimit the theory of brokering. (Box 6.2).

<table>
<thead>
<tr>
<th>Emergent concepts from the literature review on brokering.</th>
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<tbody>
<tr>
<td>The act of brokering occurs as an intervention in areas of conflict</td>
</tr>
<tr>
<td>Brokers are acting as gatekeepers at critical junctures within interactions.</td>
</tr>
<tr>
<td>Brokering has a temporal quality and occurs best when it is 'at the right time', and when negotiators have time to negotiate</td>
</tr>
<tr>
<td>Possessing role ambiguity in the context of brokering and functioning in asymmetrical relationships</td>
</tr>
<tr>
<td>Functioning marginally in one or more systems whilst brokering between systems</td>
</tr>
<tr>
<td>Brokering has the potential for changing systems</td>
</tr>
<tr>
<td>Dealing with others positively and cultivating varied social relationships</td>
</tr>
<tr>
<td>Mediating between traditions</td>
</tr>
<tr>
<td>Innovating when traditions are inflexible</td>
</tr>
<tr>
<td>Facilitating communication by translating interests and messages between groups</td>
</tr>
<tr>
<td>Bridging value systems</td>
</tr>
<tr>
<td>Functioning as a go between</td>
</tr>
<tr>
<td>Bringing people together in the workplace</td>
</tr>
<tr>
<td>Complementing existing ways of work or doing business</td>
</tr>
<tr>
<td>Developing and maintaining public confidence and reputation</td>
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</tbody>
</table>

Box 6.2 Emergent concepts from the literature review.
Having a disabled student on a nursing course created problems that were not easily resolved through the normal day to day negotiation between nurse educators and their clinical colleagues. Participants believed that, from a practice perspective, 'the real world of nursing' would be non-negotiable as clinical practice had a set of normative work-related criteria. These criteria are influenced by institutional, managerial aims and objectives for efficient, cost-effective health service. In the process of brokering nurse educators adopted a 'third party' position as they stepped outside of their normal educational role, and the disabled student was distanced from the day to day management of nursing students (section 6.2.3). In doing, so, they assumed a relative neutrality within the negotiating process, as they sought a solution that was right for all parties concerned. Successful brokering was dependent on their ability to create a solution that matched the work beliefs of the clinical environment and the clinical mentors, with the adjustments for a student, within the ‘real world of nursing.’

In managing the complexity of brokering inclusion nurse educators, voiced tension when faced with working between two differing organisations and balancing the competing institutional expectations of education and work. Research had previously identified the moral distress\(^{35}\) experienced by nurses when working in environments that they considered to be unsupportive and where their ability to work is compromised by organisational and legislative demands outside of their control (Corley et al. 2005). Other studies have previously positively correlated job satisfaction to perceptions of work load, relationships with co-workers, job control, job security, rewards, career opportunities and the physical work environment (Cummings 2010, Li and lambert 2008, Trivellas and Dargenidou 2009). Allison (1999) in her study on organisational barriers to diversity in the workplace cited how even in public service industries the rhetoric of inclusion is often ineffectual in changing workplace culture. McDuie-Ra and Rees (2010) observed that most-professional

\(^{35}\) Moral distress is the psychological disequilibrium that occurs when a person believes he or she knows the right course of action to take, but cannot carry out that action because of some obstacle, such as institutional constraints or lack of power (Epstein and Delgado 2010)
employees would ‘shudder’ at the thought that their policies foster discrimination or exclusionary practices of any kind:

‘well motivated, highly skilled practitioners, dedicated to providing caring and competent service to clients/patients find it difficult to believe that their professional norms, or the practices of their agencies, may serve to disadvantage clients, fellow workers and minority communities’ (page 1)

Brokers in nurse education initiated a change process that increasingly made the inclusion of disabled students seemingly possible (created something new) through facilitation, and exchange of knowledge between negotiating parties. Initially, this process was clandestine (Fischer et al. 2010) unrecognized and often invisible (Meyer 2010), as they worked ‘below the radar’ to set up a deal. As a consequence, they were able to create situations where the acceptance of the disabled nursing student was met with initial enthusiasm, before the reality of the decisions made became apparent. These scenarios I have termed as ‘Yes-But’, where the principle of including disabled students was seen as reasonable to both education and to health care, but the enactment was seen as problematic. ‘Yes-but’ captured the initial support of including disabled students expressed by the nurse educators and their clinical colleagues, which was soon followed by the reasons why this would be problematic.

Brokering as a strategy to manage inclusion within nurse education, reflected the complexity of the institutions involved, and their continued need to work together to ensure that sufficient competent and professional nurses were available to meet the demands of the workplace. The asymmetrical relationship which superficially was led by education, but in reality was influenced by workplace and professional concerns are reflected in how the nurse educators, as brokers, positioned themselves as agents for multiple principals, and as principals with multiple agents in multiple principal –agent working (section 6.3.1)
Through the continuing comparative process the following core theoretical concepts emerged:

a) Brokering occurred in situations where conflict is presumed, actual or potential. Brokers attempt to resolve conflict to minimise difficulties and to enable all parties to agree on a solution. As nurse educators they presumed the presence of a disabled student is problematic for the clinical setting, and that conflict will occur between the needs of the student and the needs of the practitioners in the delivery of patient care. As a broker pre-empting difficulties to avoid conflict gave the disabled student the best opportunity to have full access to nurse education. In the process of brokering, the student is ‘distanced’ from the process as they are decoupled from the normal processes through which the student experience is managed.

b) Nurse educators only have limited authority as partial gatekeepers to the profession and were dependent on the actions of the others to legitimise the presence of a disabled student on the course and in practice. As broker’s nurse educators experienced role ambiguity, as both educators supporting inclusion of students and professionals guarding professional standards.

c) As agents, nurse educators work with multiple principals at the intersection between HEI and NHS. In a brokering process, not dissimilar to that seen in political sciences, they shift their position and act so that all principals believe their needs have been met. Nurse educators recognise that the culture of higher education and the culture of health care are different and finding common ground between the two organisations provides the pathway forward. Their capacity to frame inclusion in a manner that is acceptable to all parties, effectively marginalises doubters without forcing either themselves or others to make ‘choices’ or a commitment that a disabled person can always become a nurse.
d) The asymmetrical relationship (s) between the agent and principal are implied by the nature of the organisation (s), their relationship with each other, and their environments. The power asymmetry between nurse educators and clinical colleagues, in health care, limits the potential for changing systems. The scope for change in clinical practice is reliant on clinicians seeing the benefit of having nursing staff who are ‘different,’ as the work of a nurse is perceived to be fixed within inflexible traditions associated with health care organisations and service delivery. Having a positive relationship and developing trust is central to nurse educators identifying a positive clinical experience.

e) The presence of a disabled student initiates the need for groups to come together to discuss ways forward and bringing people together to discuss concerns and issues about individual students is a core strategy. Nurse educators act as the ‘go-between,’ as they act for the student and clinical practice. The process of brokering occurs through the nurse educator, as they represent all parties concerned. The student is not always present in these meetings, and the nurse educator assumes a fiduciary role, believing they are better able to put forward the student case.

f) The complex web of values and beliefs about having a disability, being disabled and becoming a nurse operated in different cultures – higher education and health settings. Bridging and mediating these contradictory positions is an essential element of successful brokering so that all parties believe their concerns have been addressed.

g) As brokers, the deal brokered is ‘right for the moment’ and nurtured new ways of working, the adjustment of skills that benefit the student and health care setting. Successful inclusion of a disabled student is as a result of innovation and new ways of working. These ‘shifts in practice’ ensure disabled students met the requirements of the professional body (NMC) and can fulfil their roles as student nurses without fundamentally changing how the workplace is organised. However, inclusion remained conditional on maintaining the pro non-disabled stance of ‘ordinary and normal’ and nurse education and
nursing practice has yet to truly develop an authentic representation of diversity by considering innovative and creative ways of working.

As brokers within nurse education, their portrayal of the principal-agent model is more similar to that seen in political sciences. Hence, in managing inclusion within nurse education, the brokers, act as both agents and principals dependent on the prevailing context and conditions. This is summarised in the box 6.3

<table>
<thead>
<tr>
<th>Nurse educators as Agent with multiple Principals</th>
<th>Nurse educators as Principal with multiple Agents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Higher Education - The asymmetry between the contractual provision for nurse education in HEI and the enactment of this contract by nurse educators as agents</td>
<td>Clinical Practice - the information and knowledge asymmetry related to expertise in educational practices positions the nurse educator as the principal, as they seek out opportunities and manage the inclusion of the disabled student within clinical practice.</td>
</tr>
<tr>
<td>Profession - As agents to the professional body nurse educators are entrusted to maintain standards to ensure the competence of newly qualified nurses.</td>
<td>Higher Education – Nurse educators also overcame the resistance from their peers and colleagues within HEI. In making a case for a disabled nursing student, they assumed the role of Principal to enable the student to access nurse education.</td>
</tr>
<tr>
<td>Student - The nurse educator will act in the student’s best interest, to ensure that they can succeed.</td>
<td>Clinical Practice - In response to concerns raised by clinical practice, as clinical practitioners act as the principal in managing the clinical environment, nurse educators will act to manage the 'exclusion' of the student from practice.</td>
</tr>
</tbody>
</table>

Box 6.3 Summary of Principal and Agent roles expressed by nurse educators.
Although arguably nurse educators are always agents to the profession, to higher education, to the profession, to the NHS as the commissioning organisation and to the student, their relationship with clinical practitioners, and individual colleagues within HEI is more nuanced. In working with practitioners, nurse educators can be both agents and principals. In this model, nurse educators by virtue of their perceived expertise in education and inclusion (knowledge and information asymmetry), act as the principal, in the manner in which they seek clinical experiences for the student, with the clinical practitioners acting as agents. This Principal role is also evident in how they overcame the reluctance or the concerns of peers within HEI. Simultaneously they act as agents as they recognise the prime directive of the clinical areas to provide effective and efficient care.

The information and knowledge asymmetry associated with managing inclusion within the workplace (clinical practice) supported this role. However, their role of Principal was contingent on clinical practice accepting the disabled student. When the legitimacy of the concerns raised by practice appeared to be irrefutable, nurse educators switch to become an agent. In this agent role, the nurse educators act on behalf of the clinical practice area, and of the profession as they set out to maintain work efficiency and standards, and to ensure the safety of the patients and clients in practice. As agents for the profession, the exclusionary predisposition became evident and disabled nursing students were less likely to be offered the opportunity to enter clinical practice. This dynamic principal-agent relationship reflected the politicisation and ‘wicked’ nature of the problem to be resolved, as resolving the issue to be inclusive inevitably created situations where some students are excluded.

Nurse educators, therefore, act simultaneously for all those involved to broker a deal that is right for the moment. This process of brokering within inter-organisational/inter-institutional working is captured in the diagram below in which the asymmetrical positioning of the ‘nurse educator’ as a broker is captured by the asymmetrical diagram.
6.3.5 Summary

In this study, the act of brokering between the nurse educator and the clinical setting, had two ultimate objectives. Its prime objective was to enable the student to study to become a nurse, and for the clinical area to accommodate the student. The second objective was to minimise the clinical disruption to maintain the alliance between the nurse educator and clinical colleagues and preserve the nature of working environment and the associated standards and efficiency of nursing practice. This secondary objective characterises the ‘pro-ability stance’ associated with the equality legislation, and influenced when nurse educators would
capitulate to the beliefs and wishes of their clinical colleagues and accept the exclusion of a particular student, so that other students in the future might be considered more positively.

In the process of brokering nurse educators acted as both agents and principals, and it was how nurse educators shifted their positions as agents and as principals, at different stages of the process, which became significant and facilitated multiple principal-agent working. The shifting dynamics reflected a need for collaboration and the need to maintain alliances for future brokering episodes irrespective of the outcome of any single negotiating experience.

The need to maintain alliances and for collaboration emerged as a key factor in this study, as brokering occurred at the intersection between two established organisations: each having entrenched institutional structures and processes and where the inclusion of disabled students challenged the normative way of being. Nurse educators worked within inter-organisational spaces to modulate and mediate between polarised perspectives and positions so that the outcomes were considered to be satisfactory to both organisations, and macro policies are perceived to be maintained. In this position, they acted as agents for both education and the profession, and the student became the commodity that was traded. In doing so the traditional normative way of working that, is associated with common sense understanding of nursing practice remained unchallenged. Brokerage is, therefore, deemed to have succeeded when disabled students can access the course, and can become a nurse.

As brokers, nurse educators also acted as principals, as they identified and negotiated practice experiences for disabled students. In this position, it was taken for granted that they had greater knowledge and expertise about education, the nature of being disabled and of inclusion and retained an understanding of the requirements of nursing practice. As the principal, they had the authority and legitimacy to create opportunities for the student in such a way that the student was perceived in a positive light, and full access to the course was maintained.
The agency of nurse educators reflected the two institutions, the policy drivers of inclusion and diversity, and the complex mechanisms through which the organisational and professional working, the needs of those delivering the day-to-day work, was sanctioned. Brokering inclusion of disabled students in nurse education was shrouded in uncertainty, and the ultimate goal was dependent on those engaged in the process having a willingness to put aside personal beliefs, and to work for the benefit of others; and for organisations to consider a different way of being. The political nature of this process and the fluidity with which decisions are made making the role of the broker essential, as in the absence of the broker the predisposition for exclusion within nursing practice, as the ‘common sense’ response to a disabled person, seem to be inevitable.

The need for brokers illustrated the tensions and dilemmas in enacting the disability discourse that is evident in policy and practice. Despite the legislative frameworks for inclusion that underpin education and the workplace, the language continues to position the disabled person as ‘other’ to the able-bodied and inclusive practices remain dependent on context and conditions. As such inclusion within nurse education is subject to educational and work traditions which reinforce the ‘otherness’ to the normal student and worker. As a consequence, nurse educators utilise a functionalist approach to retrofit disabled nursing students within the ‘ordinary and normal’ context of nurse education. This retrofit enables more disabled students to access nurse education but falls short of supporting diversity in education and in work that is truly authentic.

This study presented the substantive theory of brokering as a third party negotiating process, instigated by nurse educators, that reflected multiple principal-agent working, as they brokered a deal that balanced the interests and goals of those involved. Brokering was influenced by the context, the ‘climate and landscape,’ as brokers made tactical decisions that mediated between the competing demands and goals of the institutions involved. Nurse educator’s uncertainty about the ability of disabled students to function as nurses, coupled with believing they had a moral obligation to ensure that they supported diversity within healthcare, coloured the nature of the negotiating process. Throughout this thesis, it
appeared that the student was both passive and distant in the process as the nurse educator acted as their agent within the negotiating process. In this agency role, they believed they were acting in the best interest of the student, informed by an asymmetrical relationship that was based on having greater knowledge about nursing practice and the working environment.

Nurse educators took their position as brokers between the two organisations seriously feeling a moral responsibility to the student, to the profession and to the workforce. These multiple responsibilities are summarised by the thoughts of Laura when she discussed a particular student studying to become a nurse.

‘Meeting the student I was bowled over by her enthusiasm and sheer sense of joy, and yes at the time I did think this would be possible, we will all see what she can bring to the profession and will be able to overcome any difficulties. She had declared this as a disability as she needed time to attend OPD appointments in XXXXX, but I was not sure if she required any adjustments in practice or not. Her determination was quite inspiring, and I hoped she accepted this offer. She had studied at university for one year on a business studies course, but she was discontinued during her hospitalisation. It is remarkable what people will do just to have a chance.

Now she is on the course my initial enthusiasm has waned as the realities of the practical situation and the responses of my clinical colleagues have hit home. They do not want to change their way of working; they are finding it hard and difficult just keeping up with all the things they have to do. How can I champion a student and ask my colleagues to make sacrifices to support her, their concerns are the patients in their care, not the student. So I look for easier places, other areas where it might be possible but ultimately I accept the clinical areas can say No.’ I do not want to set the student up to fail by exposing her to a setting that will not provide her the support she needs. I could insist and say that you must take her, but she (the student) would suffer, and they (the staff) will be less willing to take students in the future.

So now I wonder whether she (the student) is really capable of being a nurse and am beginning to think about encouraging her to reconsider her position, so we do not have a situation where she is failed.’ Laura
Chapter 7 Reflections, limitations and implications

7.1 Introduction

This final chapter reflects on the research process as it explores the limitations of this study and how as the research process unfolded, I mitigated against these limitations. It will explore my research journey and the implications of the findings to the disability discourse within education and the workplace.

7.2 Contribution and implications of thesis findings to nurse education

This thesis has developed an understanding of the nature of the problems experienced by nurse educators as they manage inclusion within nurse education.

In exploring the interface between education and employment, and the sensitive area of disability, I was conscious that through the research process and as participants spoke freely about disability and in some cases being disabled, that practices might emerge that would be discriminatory and contravene equality legislation and the Code of Professional Conduct (NMC 2008). However, when concerns about being discriminatory were explored the participants themselves acknowledged historic practices, that in the light of current legislation might be considered discriminatory, and how practices had changed over time as they recognised their responsibilities towards enabling disabled people to have an equality of opportunity. In conceptualising how nurse educators balanced the ensuing tensions between the inclusion and exclusion of disabled people within nurse education this thesis provides insight into how concerns are resolved at the interface between education and ‘work’. In doing so this thesis adds to the body of knowledge that is emerging to understand the complexity of inter-organisational working and how
institutions manage the workplace (education and health care) to balance the rhetoric of legislation with the perceived reality of the ‘work’ to be done.

7.2.1 Managing inclusion as managing a ‘wicked problem.’

Findings from this study indicate that the management of inclusion within nurse education and by default into the profession is a complex, multi-faceted process. Nurse educators find themselves positioned between two organisations, with their respective institutional structures and processes, who consider the issue of disability and inclusion from different and often polarised perspectives. In this position nurse educators have to balance, mediate, navigate and find those elements that are conducive to creating the opportunities for disabled nursing students. In doing so, ‘inclusion’ is characterised as a ‘wicked problem’ which is never consistent or conducive to simple solutions that are replicable. In managing inclusion, the very process needs to be flexible, ‘for the moment’; and the brokers need to be resourceful, tactical and confident so that the inclusion of disabled people within nurse education would be accepted by their professional peers and standards of professional practice maintained.

The difficulties experienced by nurse educators reflect the language and rhetoric of Equality legislation that continues to position the disabled person as ‘other’ and inclusive practices as being functionalist in nature. Inclusion and inclusionary practices through reasonable adjustment are not radical in nature and as such neither nurse education nor nursing practice is challenged to change, and ‘normal and ordinary’ practices prevail. Similar findings are articulated by Whitburn (2014) in his analysis of the enactment of national and international disability legislation within education and work in Australia. The divide between policy rhetoric and inclusionary practices suggesting that more research into understanding exclusion is required to ensure a sustainable change in educational and work practices.
7.2.2 Understanding of inter-organisational working

In acting as brokers in inter-organisational working, nurse educators act as both agents and principals, and shift between these two positions, to achieve their goal of managed inclusion or exclusion of the disabled person. This development of the principal-agent model provides new insight into how individuals work at the intersection between institutions and illuminates an explanatory mechanism that describes the dynamic relationships that occur in working between organisations. Previous studies have considered how individuals work, through exploring multi-agent working and the issues that are overcome. In this thesis, it is the political nature of the relationship between principals and agents, normally associated with political sciences and resolving the conflict between nations, which is most evident. In this manner, nurse educators as agents and as principals can actively select those factors that are most conducive to resolving concerns so that the deals that are made, satisfying the concerns of all those involved. The limitations to this position are that it does not fundamentally change the underpinning beliefs or values of the negotiators, and disabled people remain predominantly marginalised in the workplace. In addressing the issue of inclusion within nurse education and the workplace, the inclusive discourse continues to see disabled people as less capable of making reasoned decisions, and as with traditional models of impairment and disability, reliant on the abled majority agreeing to ‘accommodate’ difference. Nurse educators are portrayed as wanting to be inclusive but find that the management of inclusion stretches and challenges their personal and professional understanding of how a disabled person can function as a nurse and work in what is portrayed as a hostile environment. In this environment, the discourse of disability and ability is not challenged, despite the personal experiences of some of the participants who had ‘battled’ to become nurses. The workplace climate, in general, reduced the generosity of individuals to consider reasonable adjustments and to be supportive of people who are different.
Nurse educators are well positioned as agents for higher education to act as knowledge brokers. In doing so, they can enhance understanding and tolerance towards being disabled and becoming a nurse. However, in doing so, they need to be pro-active and create a climate where dialogue about concerns can be freely articulated both within their institutions and in their collaboration with health care. This study indicated that nurse educators are well versed in their legal obligations but lack the confidence to articulate the professional possibilities or limitations to being inclusive. Instead, they were reliant on a ‘common sense’ view of disability framed within a hierarchy to guide their thinking and decision-making. The nuanced political ‘flavour’ about doing the ‘right thing’ and being ‘politically correct’ coloured this decision-making process and reflected the wider political arena. Health care and nurse education are situated in organisations with competing and conflicting equality, education and workplace ideologies. Moreover, the context is made complex by the legislation; financial and resource implications of inclusion; and professional agenda that requires nurse educators to be empowering and inclusive whilst preserving standards and the ‘status quo.’

These issues can be tackled through continued dialogue led by and with disabled people, the NHS and clinical practitioners, the NMC and the commissioners for nurse education so that the possibilities for inclusion are considered. Seeing the value of having ‘difference’ in the workplace and understanding the barriers to inclusion within nurse education highlights the impact of the ‘workplace’ in shaping what can reasonably be expected of the profession. The reluctance of nurse educators in this thesis, to consider creative and new ways of working which matches the rhetoric of inclusion with the wider health care agenda for high quality, competent and effective practice suggests that there is a need to explore this topic from the workplace perspective. Seeing the potential for disabled people to achieve their desire to become nurses and to contribute to the profession in an authentic and meaningful way may enhance not only the health care workplace for disabled people but also their abled peers.
7.2.3 Brokering

The literature on brokering has predominantly linked brokering to a specific subject such as knowledge, power or peace. In this thesis, key concepts that emerged within brokering inclusion, suggest that as a process ‘brokering’ is a particular form of negotiation that can be observed in many different context and conditions. Adding to the body of work associated with ‘negotiated order’, and inter-organisational working brokering has emerged as a specific negotiating strategy most commonly used to resolve situations of uncertainty, where the solution had the capacity to create more issues and dilemmas to be resolved. As a strategy, the brokered solution can be considered a ‘deal’ that was right for the moment.

Common elements in brokering include the ability of the broker to

1) Work in positions of ‘asymmetry’, between groups or individuals as they seek to resolve concerns or issues.
2) Mediate and bridge between polarised positions to find solutions that are right for the moment and acceptable to all those concerned.
3) To become the conduit through which the concerns and issues can be shaped and framed, so they are palatable for all those involved
4) Retain a position that is objective and considered to be trustworthy and honest by all those involved.

7.3 Limitations to the study

7.3.1 Limitations created by the research methodology and methods

Grounded theory is often criticised for lacking methodological rigour with many conflicting opinions and unresolved issues pertaining to its nature and process (Cutliffe 2000). The key areas of contention are centred on the nature of sampling, creativity and reflexivity; the use of literature and the precision with how grounded theory is developed. Bryant and
Charmaz (2007) argued that grounded theory is purported to be “epistemologically naïve,” as researchers embarked on studies with small sample sizes, a slipshod attention to data collection and hints of being unscientific. In addressing these concerns, I have attempted to extrapolate my ontological and epistemological understandings (chapter three) and address the issues related to the method that underpinned this thesis.

Although this study is limited by its focus on a single professional group, nursing, examining in depth the response of this group, provided insight into how nurse education and in particular health care practice is perceived; and how inclusion was managed. The characterisation of the health care working environment as hostile and unsupportive to workers who are different may have simply reflected the view of the nursing profession, but it illuminated an understanding of the workplace from the perspective of this professional group. Moreover, it affirms the relevance of context and conditions that make up the organisational and institutional climate and how this sits within the wider social climate, whereby the legislative rhetoric of equality and inclusion is tempered by the reality of peoples' working lives. This mitigates against the concerns that grounded theory studies tend to focus on the immediate contextual conditions without considering the wider social and political conditions that influence the actions of the individual (Heath and Cowley 2004).

This thesis was concerned with the experiences of those engaged in delivering nurse education and as a classic grounded theory offered a set of theoretical concepts as to how the participants resolved their main concerns. The findings of this study are limited to the substantive area of nurse education and as such it arguably remains at the descriptive level. Although grounded theory facilitates the abstraction of qualitative data into a conceptual theory (Glaser 2003) the methodology is arguably constrained by the ability of the novice researcher.

However, to counteract the criticism that the methodology leads to 'low-level theories based on extensive description without the ability to extend the explanation to other times and places (Urquhart 2007); the emergent
findings were compared and contrasted with the extant theoretical literature about inter-organisational working and principal-agent working (Chapter 6). In this way, inductive processes, whereby ideas and concepts are further developed, move the data from empirical generalisation and on to the theory. However, my limited research experience (see section 7.3.4), and the breadth and depth of my comprehension of multiple theoretical codes positions the theory of brokering at the descriptive end of a conceptual continuum. Although the theory presented in this thesis demonstrates the potential for conceptual generalizability as individuals resolve conflicts between ideals and realities, as it stands this theory has been generated from a single substantive area.

Arguably this one-sided perspective, which does not consider the issues from the perspective of other professionals or students within health care, will not provide a clear understanding of the totality of the issue, but it goes some way to understand the responses of those involved in making nurse education work.

Moreover, I would argue that despite the limitations of this study, the findings are applicable outside of this arena, and future studies in other professional and non-professional arenas would further develop the theory of brokering. In the current climate with new ways of collaborative organisational and intuitional working being developed, understanding how agents work, with competing and conflicting demands will develop understanding of how the barriers to inclusion can be overcome, and the limitations to inclusion imposed by institutional norms and values, understood. In addition, this thesis provides a substantive example of how the point of ‘exclusion’ is identified within the social rhetoric of inclusivity in education and work. It supports the notion that in developing authentic representations of diversity, particularly in the workplace, understanding the predisposition for exclusion within society will go some way to stretch the aspirational barriers that are experienced by disabled people.
In addition, it is arguably ‘UK’ centric and exploration of this issue within other cultures and health care settings may have revealed different outcomes.

7.3.2 Personal reflections on researching disability issues within nurse education

Throughout the study, and in my professional and personal life, I have found it difficult to know how to refer to disabled students in a manner which recognises their individual contribution to society in general and nursing as a profession in particular. In becoming a researcher, I have been made aware of how my beliefs and perceptions might ‘close my mind’ and limit the objectivity that I strived to achieve within the research process. The decision to recruit in a University where my working role was unknown and in an environment where I was simply a research student was sufficiently unsettling to enable me to attend to my thoughts and to capture these in field notes. In addition throughout the research process, I took comfort in the writings of Glaser and others, who encouraged the researcher to treat themselves as ‘data’ which, through the critical application of the research method of constant comparison could add to the emergent findings, without forcing the theory. As a novice grounded theorist, the continued reading of the research methodology and how others using a Glaserian approach addressed the complexity of the research process provided the checks and balances to ensure that findings were emergent and not forced. The constant comparative approach ensured that findings were constantly grounded in the data. During the write-up stage supervision meetings and presentations to multi-professional groups challenged me to ensure that the emergent concepts were supported by the data and had ‘fit’ and ‘grab’ that was recognisable to others. In addition, peer group support from other doctoral students and participation in discussion groups helped to maintain theoretical sensitivity as my thinking was critically challenged. As a consequence in the research journey, and as the issues was explored, many blind alleys were followed only to be rejected as they were not substantiated by the data. Other concepts that had initially been rejected
as being inconsequential or peripheral to the main concerns were later retrieved as they were seen to offer explanatory mechanisms that underpinned the participants’ main concerns.

7.3.3 Limitations due to self-reporting

The findings emerged from interviews with nurse educators who had volunteered to the research process. As such it is possible that the participants self-selected because of their interest in this area and as with other self-reported information simply gave me the information I was seeking. In addressing this issue, copious field notes and memos were collated, both before and after the interviews to capture the contextual issues. In addition, my thinking about the research and thoughts that emerged during the interview were captured and read in conjunction with the interview transcripts later. As concepts emerged, these were checked out with the interview transcripts of other participants. During the interview process, the interviews developed and took the form of a conversation, with the participants shaping the language used and selecting the issues that were explored.

7.3.4 Being an inexperienced researcher.

This study was the first substantive piece of research I had completed and as such it was challenging in many different aspects. Firstly, as a researcher, my limited research experience had always been based on subjects that have a physiological basis, as a consequence embarking on a study that would lead to an exploration of complex sociological themes and concepts was simultaneously both daunting and exciting. In the research process overcoming hesitancy and to feel comfortable with the iterative, creative research process without the support of ‘hard’ data involved a steep learning curve. It is only now in the final stages that the creativity associated with understanding sociological data can be seen as comparable to the creativity associated with physiological data, and the value of rising above the data to see its pattern, strengths and limitations are understood.
Secondly, entering the research field without a hypothesis or preconceived ideas as to what I would be finding and what would emerge as the major concern of the participants was daunting. In keeping with the Glaserian tradition, I did not complete a literature review or explore literature in the substantive area, prior to embarking on the study, although, by my professional role, I was well-versed in the general literature (Chapter 2)... As the concept of brokering emerged, it became evident that the main concern of the participants was linked to employability in the workplace. This led me to explore new and unknown extant literature that provided another source of data, which through constant comparison strengthened the theoretical basis. This new literature, provided opportunities to explore areas outside of my knowledge base, as the main concern of the participants centred less on disability and more on organisational and institutional working.

As the main concern associated with the student becoming an effective worker emerged, this opened an exciting new area of study, which had not previously featured in my understanding of how inclusion was managed within nurse education. Thus my understanding of the issues, and by default my working practices have been influenced by the research process and the findings.

Finally during the research process I too discovered that I had a SpLd, which made writing the thesis painfully slow, in contrast to the formation of conceptual ideas. My ability to adequately convey these concepts in a robust and rigorous form required a tenacity and determination to complete the task I had started.
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