The creation and enhancement of a nurse academic’s professional identity within the tertiary sector

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To all of you and to me...thank you!
Declaration

I declare that this thesis is my own account of my research and contains as its main content work which has not previously been submitted for a degree at any tertiary institution.

Kamaree Berry
PhD Candidate, MEd Stds (Hons), PGDip Clinical Nursing (Perioperative), RN BN, MACN, RAA

Date: 05 December 2016
### Abbreviations used throughout the thesis

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<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACN</td>
<td>Australian College of Nursing (formally RCNA)</td>
</tr>
<tr>
<td>ACT</td>
<td>Australian Capital Territory</td>
</tr>
<tr>
<td>AIN</td>
<td>Assistant in Nursing</td>
</tr>
<tr>
<td>AMA</td>
<td>Australian Medical Association</td>
</tr>
<tr>
<td>ANMAC</td>
<td>Australian Nursing and Midwifery Accreditation Council (formerly ANMC)</td>
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<td>ANMC</td>
<td>Australian Nursing and Midwifery Council</td>
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<td>ANRAC</td>
<td>Australasian Nurse Registering Authorities Conference</td>
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<tr>
<td>ATN</td>
<td>Australian Technology Network</td>
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<tr>
<td>BN / BNurs</td>
<td>Bachelor of Nursing</td>
</tr>
<tr>
<td>CAE</td>
<td>College of Advanced Education</td>
</tr>
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<td>CNA</td>
<td>College of Nursing Australia (formally RCNA)</td>
</tr>
<tr>
<td>CNC / CNS</td>
<td>Clinical Nurse Consultant / Clinical Nurse Specialist</td>
</tr>
<tr>
<td>CoP</td>
<td>Communities of Practice</td>
</tr>
<tr>
<td>DDON / DON</td>
<td>Deputy Director of Nursing / Director of Nursing</td>
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<tr>
<td>EBA</td>
<td>Enterprise Bargaining Agreement</td>
</tr>
<tr>
<td>EN</td>
<td>Enrolled Nurse</td>
</tr>
<tr>
<td>Go8</td>
<td>Group of Eight Universities (Australia)</td>
</tr>
<tr>
<td>HoS</td>
<td>Head of School</td>
</tr>
<tr>
<td>ICN</td>
<td>International Council of Nurses</td>
</tr>
<tr>
<td>IRU</td>
<td>Innovative Research Universities (Australia)</td>
</tr>
<tr>
<td>LA / L1</td>
<td>Lecturer A (Australia) (equivalent to Assistant Professor under the North American model)</td>
</tr>
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<td>LB / L2</td>
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<tr>
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</tr>
<tr>
<td>LD / L4</td>
<td>Lecturer D – Associate Professor (Australia and North American model)</td>
</tr>
<tr>
<td>LE / L5</td>
<td>Lecturer E – Professor (Australia and North American model)</td>
</tr>
<tr>
<td>NGU</td>
<td>New Generation Universities (Australia) - former</td>
</tr>
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<td>NHMRC</td>
<td>National Health and Medical Research Council Australia</td>
</tr>
<tr>
<td>NMBA</td>
<td>Nursing and Midwifery Board of Australia</td>
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Abbreviations used throughout the thesis cont.

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<th>Abbreviation</th>
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<tbody>
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<td>Nurse Practitioners</td>
</tr>
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<td>New South Wales (Australia)</td>
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<tr>
<td>NT</td>
<td>Northern Territory (Australia)</td>
</tr>
<tr>
<td>NUM</td>
<td>Nursing Unit Manager</td>
</tr>
<tr>
<td>QLD</td>
<td>Queensland (Australia)</td>
</tr>
<tr>
<td>PD</td>
<td>Professional Doctorate</td>
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<td>RCNA</td>
<td>Royal College of Nursing Australia (formally CNA)</td>
</tr>
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<td>RN</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>SA</td>
<td>South Australia</td>
</tr>
<tr>
<td>SL</td>
<td>Senior Lecturer (Australia) (equivalent to Associate Professor as per North American model)</td>
</tr>
<tr>
<td>SON</td>
<td>School of Nursing</td>
</tr>
<tr>
<td>SONM</td>
<td>School of Nursing and Midwifery</td>
</tr>
<tr>
<td>TAFE</td>
<td>Technical and Further Education</td>
</tr>
<tr>
<td>TAS</td>
<td>Tasmania (Australia)</td>
</tr>
<tr>
<td>USA / US</td>
<td>United States of America</td>
</tr>
<tr>
<td>VET</td>
<td>Vocational Education and Training</td>
</tr>
<tr>
<td>VIC</td>
<td>Victoria (Australia)</td>
</tr>
<tr>
<td>WA</td>
<td>Western Australia</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
<tr>
<td>WWI</td>
<td>World War One</td>
</tr>
<tr>
<td>WWII</td>
<td>World War Two</td>
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Abstract

What constitutes the professional identity of a nurse academic is ambiguous at best as there is little, if any, guidance for those who seek to be employed or are employed in the tertiary sector. The importance of specific accounts of experiences of nurse academics in Australia including their successes, disappointments and the influences of the social and political contexts in which they work provide the basis for this study to explore the tensions and challenges facing academics in order to acknowledge and support their professional identity.

This PhD study analyses how the creation and enhancement of a nurse academic’s professional identity is understood and promoted by tertiary institutions, the profession and most importantly nurse academics who are either engaged in undergraduate and postgraduate nursing programs or those nurses seeking an academic career. A mixed method approach is used in this study in which 24 participants employed as nurse academics from Lecturer A to Lecturer E from five Australian universities were interviewed in person over 21 months¹ (September 2007 to July 2009) using one hour interviews and a university profile questionnaire.

The analysis of the questionnaires and participant interviews challenged the understanding of what constitutes the professional identity of nurse academics. The thesis highlights that professional identity is complex to define and understand and draws attention to the influences and key elements that create and enhance the professional identity of a nurse academic. The production and dissemination of this knowledge will seek to inform the profession, tertiary and clinical sector, current academics and those seeking to enter the nurse academic specialty in order to promote the professional identity of a nurse academic in the tertiary sector.

¹As the data was collected over a period of 21 months (September 2007-July 2009), it must be acknowledged that there may have been changes in the academic structure, SONM workforce and course offerings of the participating universities and SONM. Where possible, I continued to monitor academic vacancies, review the selection criteria, position descriptions and professional / regulatory standards throughout the duration of the study to ensure the validity, currency and applicability of the information collected.
Chapter One
Introducing the study

Chapter insight

The nursing profession is being challenged to identify and adopt solutions that provide, maintain and extend both its workforce (through education, recruitment and retention) and scope of practice in order to meet the needs of consumers and the demands of the healthcare industry. In Australia, tertiary institutions seek to employ academic staff with the necessary knowledge, expertise, experience and qualifications to educate graduates who in turn become professionals in their own right. However, the shortage of Registered Nurses (RNs) has contributed to the challenge of identifying appropriately qualified staff to become part of this sector, as academics.

What constitutes the professional identity of a nurse academic is ambiguous at best as there is little, if any, guidance for those who seek to be employed or are employed in the tertiary sector. Nurse academics continue to struggle to meet the expectations of nursing’s dual identity profile of the academy and nursing practice; with neither group apparently willing to make concessions. This has contributed to the belief that nurse academics working in the academic arena are in some way less credible than those working in the clinical sector (Andrew, 2012) as they do not work at the bedside, while those working in the clinical arena as nurse educators are considered less credible than those working in the academic sector as they are seen to only focus on technical skill development and application (Andrew, 2012).

The concept of identity is central to my research and draws on Basil Bernstein’s (1971) sociological approach to an understanding of identity formation (explained later in this chapter) and from conversations with the participants about the creation and
enhancement of their professional identity as nurse academics in the tertiary sector. My thesis contributes to original knowledge and seeks to uncover and explore the professional identity of nurse academics as they juggle the roles, expectations and goals of an academic, while at the same time maintaining clinical competence, credibility and respectability in both the tertiary and clinical worlds. In doing so, this study examines whether the professional identity of nurse academics is being created and enhanced.

This mixed method study focuses on a gap in evidence regarding what constitutes the professional identity of a nurse academic and how it is understood and promoted in the Australian tertiary sector. To do this, a sample of Australian nurse academics were interviewed and offered the opportunity to tell their stories through the lived experiences of their success, disappointments and the influences of the social, historical, cultural and political contexts in which they work, their pathway to academia and their personal views and suggestions on the research questions:

a) What constitutes a nurse academic’s professional identity in the tertiary sector?

b) Does the concept of a nurse academic’s professional identity exist?

c) If so, what elements does it include?

These question stemmed from my own practice and experience as an academic at the time of the study. They serve as the platform for my thesis to unravel what contributes and influences this complex issue in order to identify the elements and create a framework or model for nurse academics’ professional identity in a way that “...has practical relevance [and] depends not just, or even primarily, in finding ‘technological’ solutions to discrete problems, but rather forging new perspectives, new ways of looking at things” (Glesne, 2006, p. 213).
In this chapter, I will provide a summary of the literature search process, define key terms used throughout the thesis and the pathway of nursing education and its educators into the tertiary sector. I will then provide a brief introduction to Basil Bernstein’s sociological approach to professional identity formation and finally, this chapter will conclude with an overview of the thesis.

**Literature search process**

The literature review, which is embedded throughout the thesis, extended from 1955 to 2015, sourcing information from various databases (CINAHL Plus, Medline, Health and Medical Complete – Proquest, Proquest 5000 International, ERIC, Academic Research Library, Google, Google Scholar) and across a number of disciplines (eg. education, nursing, medicine, human services). The search also included journal articles from nursing, higher education, leadership, healthcare management, sociology, social research and inquiry, Australian government reports into nursing, a variety of textbooks and university and School of Nursing and Midwifery (SONMs) websites across Australia. The websites were monitored throughout the duration of my study for academic vacancies and selection criteria across all academic levels from Lecturer A (L1) through to Lecturer E (L5).

In order to gain a broader perspective, my literature review was initially based on the nursing profession as a whole. It then became focused on my research topic on what constitutes the creation and enhancement of a nurse academic’s professional identity in the tertiary sector. Inconsistencies in terminology and language led to the extensive list of key words used both individually and in combination in order to refine my search and focus on my research topic. Terms included academia, tertiary sector, nurse educator, nurse academic, nursing education, nurse training, nursing knowledge, nursing discipline / profession, academic competency, academic profile, professional
identity, academic workforce, clinical competence, clinical credibility, scholarly practice / productivity, faculty effectiveness / evaluation, scholarship, professionalism, autonomy, empowerment and emancipation.

**Defining the terms**

There were four key terms that informed my study on the creation and enhancement of a nurse academic’s professional identity in the tertiary sector; which are used throughout my thesis. These were ‘identity’, ‘tertiary sector’, ‘academic’ and ‘profession’. Researching the literature proved to be difficult as the search revealed a number of variations, the use of interchangeable terms and changing terminology. In addition, there were no distinct elements, framework or model that acknowledged and / or indicated what constitutes a nurse academic and how this professional group can create and enhance a professional identity for itself within the tertiary sector. Given the wide variety of terms that exist within the literature reviewed, for the purpose of this study I have unpacked the definitions of the four key terms from a broader overarching perspective for consistency.

Starting with ‘identity’, the origin of the term stems from the 16th century Latin term “identitas” with the Oxford Dictionary ([www.oxforddictionaries.com](http://www.oxforddictionaries.com)) defining identity as the characteristics that determine who or what a person or thing is. Identity is a resource that can be strategically deployed in order to achieve personal, institutional and social goals. A number of variables impact on professional identity within the context of a person’s chosen career ([Abbas & McLean, 2001; Keith, 2006](#)). [Hodkinson and Sparkes](#) (cited in Abbas & McLean, 2001, p. 343) believe that “career decisions can only be understood in terms of the life histories of those who make them, wherein identity has evolved through interactions with significant others and with the culture in which the subject has lived and is living”. For example, Abbas...
and McLean (2001) would direct this to a particular individual’s experience and positioning in relation to work. In the context of my study, it included the occupation of premises/ offices (in this case the university), curriculum writing and delivery, contractual arrangements and opportunities for an experience of university service. This in turn provided the nurse academic the opportunity and ability to develop a sense of belonging, autonomy and ultimately to begin establishing their professional identity within their chosen career and working environment.

Moving onto the nurse academic’s professional work environment, Kenner and Pressler (2006) define ‘academia’ as a “collective term of the community engaged in higher education and the cultural accumulation of knowledge development and subsequent transmission across generations through its practitioners” (p.139). Broome (2006), Gibbs, Angelides and Michaelides, (2004) and Winter and Sarros (2002) agreed with this definition suggesting that higher education needs to provide a community of engagement that would essentially promote and sustain the excitement and vibrancy of learning for students and identify distinct pathways of professionalism for academics. The term ‘tertiary sector’ is also synonymous with higher education and academic sector and will be used interchangeably throughout my thesis.

The third key term is academic. Kenner and Pressler (2006, p. 139) provide a very clear definition which is “a highly educated person who works as a researcher and usually teaches at a university”. From the literature reviewed, I found that the term academic and/or nurse academic were used interchangeably with terms such as university or academic teacher, academic educator, professional educator and finally higher education lecturer. These were also found to be synonymous with the ranking of an assistant, associate or full professor used in North America and the UK. These terms have since been adopted in Australia in recent years, creating another variable
that also contributed to the difficulty experienced during my literature search.

Throughout my literature search, I found that these terms were also used interchangeably depending on the context of the research undertaken. For example, Pennington (1986), Raff and Arnold (2001) and Roberts and Turnbull (2003), used nurse academic and academic interchangeably within the context of teaching being the central aspect of academic scholarship and service (with scholarship described as the creative and intellectual activity that generates, integrates and evaluates theory, practice and research for the advancement of knowledge). The authors in these studies concluded that each of the three elements (teaching, scholarship and service) formed the basis of the roles and responsibilities of an academic across all levels, which while it did not directly contribute to identity formation were certainly found to influence professional identity. The terms academic and nurse academic are used interchangeably throughout the thesis.

The final key term surrounding my topic is profession which is defined by Carr-Saunders and Wilson (1964) as:

The practitioners, by virtue of prolonged and specialized intellectual training, have acquired a technique which enables them to render a specialized service to the community. This service they perform for a fixed remuneration whether by way of fee or salary. They develop a sense of responsibility for the techniques which they manifest in their concern for the competence and honour of the practitioners as a whole (p. 284).

While this definition is concise and all encompassing, Crisp and Taylor (2009) usefully separated out five fundamental characteristics of what constitutes a profession. These were (a) a significant theoretical body of knowledge that leads to defined skills, abilities and norms within the context of the discipline, (b) extended educational requirements, (c) a focus on the provision of a specific service, (d) a code of ethics associated to its practice and (e) autonomy in the decision making process and practice
Creating identity

Introducing Bernstein

Identities...are what they are, and are what they will become, as a consequence of the projection of...knowledge as a practice in some context...The future of the context will regulate identity and the volatility of the context will control the nature of the regionalisation and thus projected identity (Bernstein, 2000, p.55).

In this section, I will introduce Basil Bernstein’s sociological work on identity formation and Martin McNamara who developed and applied Bernstein’s work to the legitimisation of nursing into the tertiary sector in Ireland in 2006. Basil Bernstein’s primary area of research was in education and educational systems and extended from 1958 to 2000. While much of his work focuses on the relationship between knowledge and professional identity (Beck & Young, 2005), Bernstein also developed and linked the theoretical principles of educational knowledge, sociology, pedagogic discourse and identity across a number of disciplines including psychology, linguistics, anthropology and epistemology which is why his theory has been - and continues to be - widely used. Part of the greatness of Bernstein’s theory was the power of description, explanation, diagnosis, prediction and transferability (Morais, 2006). Five principles that I will be using to support the analysis of my research.

Bernstein first introduced the concept of identity in 1971 and it is explicitly grounded on selected and inventively remolded elements of modern social theory critically incorporating features of more recent currents of thought (Bernstein & Solomon, 1999, p. 265). Considered a sociologist of knowledge, Bernstein “studied the social organisation and status hierarchies of subjects or disciplines and their participants” such as teachers and researchers (Middleton, 2008, p. 126). His theory is
Pedagogic communication is any sustained process where someone gains or develops new forms of conduct, knowledge, practice and criteria from another deemed to be an appropriate provider and evaluator such as an academic (Middleton, 2008).

Defined by Maton (2000) as “the claims made by actors for carving out and maintaining intellectual and institutional spaces within education” (p. 149) such as “the claims to possess and profess legitimate knowledge and bids for limited status and resources” in academia found to be “embedded in these discursive performances” (McNamara, 2010b, p. 768).

Bernstein’s approach provides the “means of conceptualising the structure of educational knowledge” (Maton, 2000, p. 149) into what he considers sacred and profane features (discussed later in this chapter). The former refers to the relation of knowledge formation and the latter refers to the contextual demands of economic constraints (Bernstein & Solomon, 1999). As a result, identity could be threatened or changed if any of these elements were compromised or altered in any way.

McNamara (2007, 2008, 2009, 2010) has utilised and explored Bernstein’s line of enquiry into identity to inform and frame the number of studies he has undertaken related to the legitimisation of nursing within the tertiary sector in Ireland. In particular, he relied on this to examine the legitimacy of nursing that transferred into the Irish tertiary sector in 2006. While the legitimacy of nursing itself is not central to my research, it will be used to provide a broader understanding of the ways in which my research participants constructed their identities as academics and how they viewed nursing as a discipline within the academic boundaries. As Fealy and McNamara (2007a) state:
...as identity is a function of how we see and express ourselves and how others see and talk about us, then clearly academic identity will be constituted in and through language as we interact, as nursing academics, with other academics and with our clinical nursing colleagues (p. 1394).

The concepts of professional habitus, boundaries, sacred and profane knowledge are considered key conceptual resources in Bernstein’s sociological approach to professional identity. I will be discussing these in the following sections and throughout the thesis to illustrate how these concepts may have enabled and/or constrained the participants’ views within the context of the research topic.

**Professional habitus and boundaries**

One of Bernstein’s key elements related to the social construction of a professional identity is the importance placed on creating a professional habitus. The concept of a habitus is seen as a “mediation between the subjective and objective dimensions of the social world (Rezende, 2011, 118). Providing truly professional education involves imparting specialised knowledge, skills and expertise within a professional habitus. This involves the “intensive socialization into the values of a professional community and its standards of professional integrity, judgement, and loyalty” (Beck & Young, 2005, p. 188).

Based on this, I recognised that nurse academics are part of two distinct yet equally important professional habitus; that of the nursing profession (within the clinical context) and the tertiary sector (within the educational and research context) (see Figure 1.1). Each habitus includes moral and ethical codes, a sense of purpose and the development of a strong professional identity determined through one’s loyalty to their chosen code or profession. Members in each of these habitus were bound together as a collective in order to understand what their community, or discipline in this instance, is about (O’Connor, 2007; Wenger, 2000). In this case nurse academics
have to bridge between two professional habitus – academia and clinical practice which also included the difficult social position of the academic (and indeed their students) and their ability:

...to think, see, and act in different situations. Considering the university is a cell of the academic field, the structure of the academic’s identities could be seen as their habitus, which structures social, epistemological and pedagogical views that are refracted in their thinking, discourse and action (Rezende (2011, p. 118).

If successful, the professional habitus and the academics who have built it, will have an impact on the formation of not only the students’ identities (who will form part of the future structure and habitus), but of other current and new academics who will follow (Rezende, 2011, p. 118). McNamara (2007, 2008, 2009, 2010) in particular, relied on the concept of the professional habitus to examine the legitimacy of nurse academics that transferred into the Irish tertiary sector in 2006. Richards (2006, p.3) used Bernstein’s idea that “identity, whether group or individual, is never merely a matter of assuming or assigning a label; it is something that is formed and shaped through action” within a professional habitus.

This raised a number of questions for me in so far as how do professional groups, such as nurses and academics, define, construct, reaffirm and maintain their own identities? What happens when established and seemingly unproblematic identities cross over into a different professional habitus? Is it possible to create a hybrid habitus and what would that look like? Is it simply a matter of creating a new name? Could it be as simple as a single word, title or even action that can represent a specific identity? As Richards (2006) notes, the danger of making straightforward assumptions regarding role definition and assigning a specific identity, is that it does not take into account the “myriad of variables that influence, impact and contribute to the assumed identity label” (p. 5).
I also recognised that each of the two habitus (clinical and academic) have their own boundaries. This concept was derived from “more general cultural activities of background and boundary construction that has an impact on the profession considering its historical occupation origins” (Bernstein, 2000, p. 5) in which nursing has had “for many years, very real boundaries (including history, power, knowledge, gender and class) [that] separated nursing education from the academy to which many nurses aspired to be” (McNamara, 2008, p. 461).

When seeking to review and define the notion of boundaries, Bernstein (2000) explained that while they are “primarily symbolic and refer to how social structures and enduring practices operate to keep certain social groups, domains of knowledge and experiences apart” (McNamara, 2006, p. 461); secure academic identities exist in the strong boundaries between disciplines and between the field of education and work. Bernstein examined identity formation within the academic and education context by describing “the organisational, discursive and transmission practices in all pedagogic agencies” and “shows[ing] the process whereby selective acquisition of knowledge takes place” (p. 5). McNamara (2009) and Yang (2008) showed how, in academia, disciplinary boundaries have a role in shaping and influencing professional and academic identities. This occurred by belonging and working in the two professional habitus (tertiary sector and clinical practice) that my research participants found themselves in, but also at the foundation of the discipline where the development of professional practice curriculum and pedagogy are undertaken in order to pass on the discipline’s knowledge base. These academic identities are then maintained and sustained through processes and practices of identity legitimisation (explored by McNamara, 2009) that related to meeting established academic standards and requirements along with having a sense of belonging within the sector.
McNamara (2010b) believed that nursing as a profession along with its academics was formed around a number of all-inclusive organisational boundaries and practices (eg. resources, sacred and profane knowledge, relationships within and between disciplines) that aimed to provide the right to be autonomous both socially and intellectually. These have “certainly had an impact on the profession considering its historical background and occupation origins; hence the premise to remain within a silo in their hope that they would optimise and increase their academic identity and profile (McNamara, 2006, p. 461). While these all-inclusive boundaries can determine a discipline’s status and a professional’s position and trajectory, this has not always proven to be successful as “…pulling off being an academic, involves putting together relevant language, actions, values, beliefs, practices that ensures recognition to others in the same world, of the academic’s identity and status” (p. 768).

Bernstein recognised that concerns arose over the weakening and / or dissolution of boundaries between the two habitus; that can also show a variation in the development of sacred and profane knowledge within the concepts of classification (the strength of a boundary between educational contents) and framing (the strength of the boundary between what may / may not be transmitted in the pedagogical relationship) (McNamara, 2008, p. 461-462).

**Knowledge: Sacred and profane**

In addition to managing a discipline’s organisational boundaries there are two other variables that determine the foundation of constructing identity – sacred and profane knowledge. Whilst the habitus and boundaries are important to facilitate identity, Bernstein argued that the lynchpin of professional identity lies in the practical workings of what is considered, a ‘canon’ (principle / standard) or ‘corpus’ of professional knowledge, which is founded in the sacred and profane. As McNamara
states about Bernstein:

The symbolic partition of the **sacred** from the **profane** (original emphasis) is a recurring theme in Bernstein’s sociology, derived in part from his heightened sensitivity to relationships of inclusion and exclusion (due to his Jewish identity). Etymologically, sacred refers to that which is dedicated or set apart, devoted exclusively to one use, worthy of reverence and respect, or highly valued and important. While profane, literally beyond the temple, refers to that which, she / he who, is impure, defiling of the sacred, uninitiated, or lacking esoteric or expert knowledge (2008, p. 461).

While this statement related to Bernstein’s sacred and profane knowledge appears to be quite complex, it has been applied by McNamara as one of the elements related to the creation of a nurse academic’s professional identity. It essentially implies that nursing education and its academics are considered profane as they lack the reverence, respect and highly valuable knowledge that is identified as sacred. This is despite the fact that nursing education has had a number of important successes, including the most notable being the development of the continuum of academic programmes at both undergraduate and postgraduate levels.

Although the profane and the sacred are two separate entities, there appears to be an integration and “mutual contamination” between them, as “key to moving towards becoming a profession is the criteria of providing the disciplines’ body of knowledge” (McNamara, 2009a, p. 1598). The themes emerging from my research participants’ responses acknowledge and follow this two-fold division of knowledge which contributes to their dual identity (academic and clinical). This confirms that for many years very real boundaries, have existed and to some degree continue to do so, separating academics across the two sectors (McNamara 2008; 2010c, p. 461).

“Academic identity is grounded in the sacred... [and it is in the] epistemic communities [where] canonical works are produced, academic identity is forged...” and “...a sense of purpose and strong professional identity that are determined”
(McNamara, 2008, p. 461; O’Connor, 2007, p. 749). McNamara (2008) believes that the move of nursing education into the tertiary sector and nurse academics’ attempts to articulate a nursing-discipline specific knowledge base can be understood in these terms. However, in essence this has created the premise to remain within the nursing silo and creating boundaries in the hope that they would optimise and increase its academic identity and profile. Professional identity is both constructed internally and directed externally; the former facilitating the individual (in this case the nurse academic) to develop a sense of professional or moral autonomy, whilst the latter provides the knowledge base (O’Connor, 2007, p. 749).

Dickinson (2005, p. 32) agrees that although nursing education’s claim as a distinctive discipline is based on its holistic approach to care, the creation of its sacred and profane knowledge base has been influenced by what other disciplines perceive as, the “continued extensive borrowing”. While taking this inter and multidisciplinary approach (that cross a number of habiti and boundaries) has contributed to the profession of nursing and its academics struggle to establish its intellectual and professional integrity (influencing identity) and habitus, it has to a certain degree managed to increase and strengthen scholarship and research. Based on this, McNamara (2008, p. 471) agreed that the nursing discipline “seeks recognition that they possess the key requisites of” not only an academic discipline but a profession that has “a clear and distinctive focus, a coherent theoretical base, defined research methodologies and clearly articulated epistemic criteria for judging the worth of their scholarly output”. Moreover, Thibault (2011) would argue that although boundaries and silos found in healthcare are in themselves problematic there is a place for them in that:

... each profession is taught its own language, procedures culture and
boundaries, never having ventured out to collaborate or work with another, which makes it difficult to understand the differences and common ground that exist between them. Each profession prizes its own identity and its own way of doing things. Whilst individual professional identity formation is important, it can and does create barriers by reinforcing stereotypes and emphasising differences versus commonalities and collaboration (p. 314).

While the work of McNamara and Bernstein clearly recognises the issues facing nurse academics, they do not offer solutions. From the outset, Bernstein’s (1971, p.212) work strongly advocated the conviction that the academic’s “socialisation into a distinct discipline habitus imparts a strong sense of loyalty and, consequently any attempt to weaken or change...may be felt as a threat to one’s identity”. Although relatively strong boundaries and siloing continue to exist between university disciplines and their curriculum subjects this notion is being challenged in order to accommodate the flexibility that will allow for “interdisciplinary integration” and collaboration as seen in nursing (McNamara, 2010b, p. 767).

A deficit or possible erosion of essential educational requirements that underpin the nursing profession (eg. minimal university entry scores) will inevitably diminish the type of student the profession will attract and the subsequent capacity of nurses that will enter and educate the future workforce as academics. Beck and Young (2005, p. 188) clearly argue, it is not just about imparting knowledge, expertise and professional education; but the intense socialisation and integration of the values associated with the disciplines (that are now professions) standards, integrity, judgement and loyalty that ultimately leads to the creation of a professional habitus and professional identity. It is this socialisation that creates the concept of “…insiders and outsiders whose identities are defined in opposition to one another…” which although “…primarily symbolic…refer to how enduring practices operate to keep certain social groups, domains of knowledge and experiences apart” (Atkinson, 1985;
It is no secret that there was significant opposition from the medical profession dominant social structures and even nurses themselves that impacted on nursing achieving entry into academia. Although Bernstein (1971, p. 213) considers that “all disciplines have a social as well as an epistemic aspect...that is “intrinsic to all knowledge claims”, McNamara (2009b, p. 1168) pointed out that “the contradicting element here is that nursing theories have been developed...existed and [been] taught for over 50 years as the basis and framework of nursing”. So the opposition and turmoil may in fact lie in the change in location from which the information is being disseminated “along with the profile of personnel delivering the information”. This has subsequently threatened the “...cherished academic identities of members of the more established and strongly bounded tribes who still believe in the handmaiden ideal” of nursing (McNamara, 2009, p. 1170). Furthermore,

Whilst introducing ‘nursing science’ as a premise to solidify, and provide a basis of justification for the discipline’s move to the academic sector and to satisfy the ‘epistemological’ requirements related to knowledge base; ‘the large and expanding volume of knowledge requires academics to carve out their own niche of expertise while status and reputation depend on making precise contributions to their discipline (McNamara, 2009, p. 1170).

If in fact Bernstein and McNamara are right, this is a particular challenge for nursing academics for two reasons as it will see (a) the emergence of nursing as a distinctive academic discipline that is independent from medicine; and (b) the interdisciplinary nature of nursing knowledge becoming more permeable and dynamic. However, there are additional challenges that are not just about the emergence of canon and pedagogy which legitimates nursing as a tertiary education discipline. As previously mentioned, while the concept of legitimisation is not central to my research the problem of the discipline’s reputation in the clinical and academic worlds is, and this is
where talking to the academics who live the life and struggle is useful.

**Elements of professional identity**

It is important to note that this is not just about the habitus, socialisation or sacred and profane knowledge; it is also about what elements are considered fundamental in creating and enhancing a nurse academics professional identity in the tertiary sector; elements which are central to this study.

Bernstein combined “sociological analysis of identity within institutional levels...and the analysis of projected official identities” that are proposed by the use of “statutes, regulations, handbooks, templates, contracts and job descriptions” (Bernstein, 2000, p. 204; Middleton, 2008, p. 126). However “professional identities are constructed by us for us” and is considered “continuous and reflexive process” (Middleton, 2008, 126) combining both internal (self-definition) and external (by others) elements of one’s identity (Middleton, 2008, 126). Bernstein and McNamara identified and described a number of these internal and external elements that play a part in identity formation some of which I have summarised in Table 1.1. While these elements contribute and are inextricably bound up with professional identity I considered that central to my study was the need to identify which of these were common and to identify others that may not have been considered or are part of or recognised within the tertiary and clinical habitus.

**Table 1.1: Key concepts and elements**

<table>
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<th>Element</th>
<th>Definition / Description</th>
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| Autonomy | - Refers to the degree of differentiation between field - two types:  
  a) Relational: referring to independence from other value systems  
  b) Positional: refers to academic freedom in so far as distance from external controls by state, market and even industry  
  - Lower status is characterised by lower positional autonomy, direct control by external agencies and lower relational autonomy |
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<th>Element</th>
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<tr>
<td>Discourse</td>
<td>Ways of using language of thinking valuing, acting and interacting that is recognised as legitimate in relevant communities</td>
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| Genericism    | Refers to a situation in which the balance of power and control has shifted decidedly outwards, away from the professional and academic specialists towards the regulatory mechanisms of the state / territory and market  
- Refers to all legislative, professional, academic and organisational requirements that guide and direct compliance internally and externally  
- Closely associated with regionalisation, qualifications and linked with power                                                                                                                                                                                                              |
| Knowledge     | Entails systematic structures of thought at various levels of abstraction from the concrete world of practice  
- Must have the capacity to gain a conceptual purchase on practice for the purpose of corroboration and theory building  
- Linked closely with specialisation, profane and sacred knowledge                                                                                                                                                                                                                       |
| Profane       | Defiling of the sacred, impure, uninitiated  
- Lacking in esoteric or expert knowledge  
- Linked closely with the sacred to form ‘a whole’                                                                                                                                                                                                                                          |
| Regionalisation | A dominant principle for structuring higher education curriculum  
- Driven by ‘demand led’ calculations to maximise take up of courses in institutions  
- Promotes the progressive loss of academic autonomy and authority across higher education across not only different subject areas but higher and lower status institutions  
- Closely associated with genericism                                                                                                                                                                                                                                                  |
| Sacred        | That which is dedicated, devoted exclusively, set apart, worthy of reverence and respect or is important and highly valuable - knowledge is identified as sacred                                                                                                                                                                                                  |
| Socialisation | the process of learning the culture of a society (its language and customs), which shows us how to behave and communicate  
- The way academics and their discourse are constructed as specialised and distinctive  
- Emphasis is placed on who they are and what they know  
- Closely linked with knowledge; sacred and profane                                                                                                                                                                                                |
| Temporality   | The discipline’s orientation in time, the extent to which past practices and identities inform the present and the relative status attached to them (eg. nursing constant reinvention of itself)  
- Linked with history, culture, politics and economics                                                                                                                                                                                                                                 |

Adapted From:  
In summary, I will use Bernstein’s five principles to describe and explain what the professional identity of a nurse academic is in the tertiary sector, recognise and identify (diagnose) the knowledge gap that exists in this area, analyse (predict), discuss (transfer) my findings and provide recommendations. Bernstein’s sociological approach (and McNamara’s application of this) encompasses a number of areas relevant to my study. It draws on “…the role of disciplinary boundaries in shaping academic and professional identifies, establishing and sustaining specialist communities of practice and enquiry, informing the knowledge base of the professional practice curriculum and guiding pedagogy” (Yang, 2008 cited in McNamara 2009) that will ultimately lead to safe, quality patient care.

I will also use Bernstein’s approach to interpret my data and literature reviewed in the form of a conceptual framework for my study. The process of creating an overarching framework includes key elements and terms along with my own research findings. Chapter Four, Chapter Five and Chapter Six will present and link the elements that contribute to the knowledge base in what constitutes the creation and enhancement of a nurse academic’s professional identity in the tertiary sector.

The pathway of nursing education

As previously indicated the literature review surrounding this topic is embedded throughout the thesis. A summary of the historical evolution of nursing’s education from inception to academia is however discussed in this section. It will provide an overview of the how, why where and when the discipline and subsequent profession came about, the rationale and implications behind its progress to-date; and how this influences and contributes to the lack of what constitutes the professional identity of the nurse academic. This will be further expanded in Chapter Two with a particular focus on the nurse educator and subsequent nurse academic.
Richards (2006) believed that “nothing happens of itself; somewhere there is a history, somehow there are consequences” (p. 12). Nursing’s need to constantly reinvent itself is an example of what Beck and Young (2005), Bernstein (1971, 2000), McNamara (2008, 2009, 2010a, 2010b, 2010c) described as temporality. In particular, the extent of how past practices, such as history, culture, politics, social forces and economics (Rodgers & Scott, 2008), have contributed to the discipline’s orientation in time and shaped the identities that inform and influence the present and relative status of the profession and its practitioners.

The practice of nursing carries the imprint of a very ancient and essential occupation which can be traced far back into history to a period predating the early Christian era (AD 1-500) and it has evolved over the centuries. The era of reform for the discipline worldwide was marked by Florence Nightingale during the Crimean War (1854-56). Nightingale’s reforms were influential in establishing the foundation of contemporary nursing and brought about significant changes in the discipline and its education of students. Graduating students became the pioneers of Nightingale’s vision and carried her model of care to the rest of the world (Russell, 1990; Wood, 1990). While the Nightingale system brought about changes within the hospital labour market worldwide, the formal education of nurses continued to be provided by the medical profession. From there, nursing education was followed up by the informal teachings from senior students and other nurses whilst working on-the-job (Grindle & Dallat, 2000; Smith 1999).

Previous research carried out into the public image of nurses has them represented archetypically as handmaidens. Fealy and McNamara (2007) describe nurses as “doctor’s assistants and of women undertaking their natural caring role; bringing to the fore the implicit understanding that nurses do not require the kind of
academic professional education like other learned professions such as medicine” (p. 1187). Just like other professions (such as medicine), the education of nurses is fundamental in defining them as professionals. Until the 1970s nurse educators taught nursing students using the hospital-based apprenticeship model. Nurse educators were highly skilled, experienced bedside nurses who were seeking promotion and career challenges by selecting the education stream, rather than opportunities offered by remaining in clinical nursing or hospital administration. The transfer of nursing education into the tertiary sector was delayed by the nurses and educators themselves as they feared a loss of control of nurse education to non-nurses (Smith, 1999). In 1975 nursing education changed in Australia when basic training moved into the higher education sector with the advent of the nursing diploma and subsequent university degree. In the early 1990’s all undergraduate nurse education was undertaken in the tertiary sector which established nursing as an academic discipline and facilitated students’ effective use of theory and knowledge base in a variety of clinical areas that they practiced (Gassner, Wotton, Clare, Hofmeyer, & Buckman, 1999; Meissner, 1999).

The transfer of nursing education into the tertiary sector in Australia proved to be a significant contributor and influenced the disconnection between the clinical and academic worlds which impacted on the educators themselves. As the move happened there was no clear directive regarding what would be expected of the nurse educators transitioning from a hospital based apprenticeship system into the higher education sector. Although these senior nurse educators were competent and experienced practitioners, very few possessed the attributes required for career progression in the tertiary sector which included a higher degree and a research and publication profile (Meissner, 1999).
The transfer has generated and continues to generate, significant debate in the nursing literature and amongst the profession in general for over 20 years. The move from the hospitals to the Colleges of Advanced Education (CAEs) / Technical Colleges (TCs) (in the early 1980s through to 1994) and subsequently universities was not just defined by the physical relocation, but the social, cultural and intellectual status that came with entering the tertiary arena. The move saw the educators shift from one all-encompassing environment to one where both initial and subsequent education and clinical practice occurred to two distinct environments; where education and practice were separated as seen in Figure 1.1. This will be used as the basis to form the model for the study.

**Figure 1.1:** The habit

The transfer was expected to encourage the nursing profession to not only attain professional status, but allow the nurse educators, now considered academics, to gain the opportunity to create and take responsibility for its own specific body of knowledge (Gibbs & Rush, 1987). Unfortunately, the transfer increased the uncertainty surrounding the hospital based nurse educators’ role, responsibility and identity in this new world. The importance of being introduced and socialised into “learning the culture of a society (its language and customs), which shows us how to
behave and communicate” (Belcher, 2005, p. 284), also proved to be an issue as neither the clinical or academic group were prepared to make concessions or take responsibility to socialise the new academic (former nurse educator) into not only their new work environment but their new identity as an academic. Essentially the transfer revealed that while the nurse academic’s clinical expertise was not in doubt or disputed, their profile and credibility as an academic related to their qualifications, scholarship in teaching, research and publications was. Considered expert clinicians with very few holding formal educational and / or academic qualifications, these nurse educators entered this new society of academia as novices, which proved to be a humbling experience (Bavier, 2008; McDonald, 2010) for many.

There is no doubt that nursing was significantly influenced by its history, culture and the continuing public taskforces and commissions / reports (discussed in Chapter Two) that examined all aspects of the profession, its education system, clinical practice, scope of practice and boundaries, workforce capacity and relationship between society and interprofessional collaboration. Numerous research studies (Fairman & Okoye, 2011, McNamara, 2008, 2009a, 2009b, 2010a, 2010b, 2010c; O’Connor, 2007; Roberts, 1996, 1997; Roberts & Turnbull, 2002, 2003, 2004, 2005) and government reports from 1943 to 2011 (discussed further in Chapter Two) have been undertaken in relation to what constitutes nursing, its education, its professional status, knowledge base, skills and competencies and the transition of a clinician into the academic arena. However, most of these reports have been written from a government, industry, educator within the clinical environment and / or student perspective. Little information exists about the experience and reaction of the former nurse educator, now nurse academic, involved in the transfer from the hospital based apprenticeship system to the institutions of higher education. Investigations into their
actual experience and impact of what constitutes their professional identity in the academic arena has had minimal, if any, scrutiny.

The academic arena has had a long-held ideal as being a liberal and scholarly community that promotes independent thought and critical enquiry (Richards, 2006; Thompson, 2009). The long struggle of nurse education and its academics to establish and develop their position and knowledge base in this arena is ongoing which has contributed to the issue of what constitutes professional identity. While historically nursing has “moved to a point where even the process of constructing identity is laid bare for public dissection” (Richards, 2006, p.1) as seen through the numerous reviews; “public acceptance of an occupation as a profession is based upon the occupation’s assertion that its education and training make it uniquely suitable to provide a specific service” (Glen, 1995, p. 2). Twenty years on, there is no unequivocal acceptance within the profession itself that nurse education should be in the tertiary sector (Thompson, 2006). A lack of solidarity within the profession and amongst its educators, together with allegations of academic elitism, public ignorance (and to some degree disinterest); the dominance of the medical profession, political distrust along with the economic implications for the hospital workforce, challenged and conspired against the entry of nursing into the tertiary education sector from the outset (Thompson, 2006).

The move of nurse educators into the tertiary sector created uncertainty and conflict for nurse academics which the profession is not helping to resolve. This is primarily centred on the continual expectation of duality; to be both a credible clinician registered nurse and a credible academic and how to best manage these two identities and roles. The successful management of these two roles would support the academic to be able to confidently educate nurses and be at the cutting edge of
research relevant to improving nursing practice without being undermined because they are not practicing nursing at the bedside. With neither the hospital nor tertiary institution willing to make concessions as to what was (and continues to be) expected, in essence, it showed that the nurse academics themselves were in fact the victims/casualties in this conflict.

It is decades since the move of nursing education into the universities, yet there continues to be a lack of certainty of professional identity as nurse educators (in the hospitals) and indeed the clinical arena as a whole has failed to let go and fully acknowledge the role and work that their academic colleagues are undertaking. This has contributed to the ongoing debate surrounding the profession of nursing, its academics, its education, its research and location in the tertiary sector. Nevertheless, accountability and responsibility, as Duffield et al. (2011) rightly states:

...does not only lie with the tertiary sector, industry also needs to be seen to actively encourage and support staff to enter the sector. This in turn will lead to increased collaboration and the distinct view that both sectors are true partners which will increase the profile of the individual, the profession and reintroduce staff to the sector that is responsible for delivering their future staff (p. 21).

The issue of this duality in clinical and academic credibility, the participants’ views on this and their attempts to confidently establish themselves as individual professionals and ultimately as a collective within the tertiary sector is discussed in subsequent chapters. While the cultural expectations in both environments presented their own challenges (including heavy workloads, attainment of qualifications, research and publication imperatives and organisational/institutional service); issues surrounding recruitment, orientation, periods of adjustment (Earle Reybold, 2008) and retention of academics also continue. The option or pathway on how to become an academic in the nursing profession was not and is not listed as one of the many specialities on offer
Graduating students were and continue to be encouraged and expected to consolidate their learning within the clinical arena before pursuing further education if any further weakening the professional identity and the role of the academic (Duffield, Gardner, Chang, Fry, & Stasa, 2011). Nonetheless, while transitioning into this new working environment brings about changes in one’s role and responsibilities and subsequent professional identity; it does not abandon “practitioner identity and related ideology” as it is intrinsically linked and “woven throughout talk about being an academic” (Earle Reybold, 2008, p. 146).

Duffield, et al., (2011) believed that changes in function, role or job title that better reflects new responsibilities of a Registered Nurse (RN) could potentially alter an individual’s perceptions and expectations of their position resulting in consequences to their professional identity. In 2010 the introduction of a national regulation of the nursing profession in Australia, provided an opportunity to debate and determine consistency in position titles within the confines of nursing registration and practice. Whilst this had an impact in the clinical context, it had no consequences or impact within academia as structured criteria, boundaries surrounding the titles and descriptions for each academic level (which do not alter regardless of discipline) already existed. Granted, while it could be argued that universities drive the nomenclature and appointment criteria of their employees, the ambiguous positioning of hospital based educators transitioning into this structured environment added to the confusion in so far as how academics teaching nursing, identified themselves and the way they were and are perceived by others within the sector (Duffield, et al., 2011).

The notion of role legitimacy is linked to professional identity through “the recognition of competencies and the right to practice a particular healthcare role that
is conferred by the profession, educational institution, regulatory authorities and speciality organisations” (Brown, 1998, p. 163). While the move of nurse education into the academy in Australia was being contested at all levels, Gibbs and Rush (1987) assert that no one had seriously challenged the academic competence, credibility and teaching capabilities of occupational therapists, physiotherapists, social workers and any other healthcare professionals who along with their students, made the move into higher education some time ago. From this perspective there appears to be no reason why nursing academics should not demand and expect the same status and respect within this environment (p. 668). However, Duffield, Gardner et al (2011, p. 46) believe that to-date the nursing profession in Australia has not recognised the concept of identity itself; and go onto question the profession’s role and responsibility to act within the best interest of its academics and practitioners. The need to develop a model that recognises what elements create and enhance the academics’ professional identity therefore has merit.

Thesis overview

The chapters

This chapter *Introduces the study* by providing the opening statements, the research questions, the literature search process and defining the key terms used throughout the thesis along with a summary of the pathway of nursing education. It will introduce the concept of identity based on Basil Bernstein’s sociological approach to professional identity formation before concluding with an overview of the thesis chapters.

*Chapter Two, Building the picture* focuses on the historical context for nurse education, its educators and the path it took towards tertiary education. In particular,
it will review Australian nursing history, the education and training of nurses and the development of the educator’s role within the hospital-based apprenticeship system to the move into the tertiary sector and the emergence of the nurse academic. The chapter establishes that this history forms the basis of my research study and moves forward to explore not only the participants’ own background and pathway into academia but the overall concept of whether in fact there has been a shift in the creation and enhancement of a nurse academics’ professional identity in the tertiary sector.

Chapter Three, titled Presenting the research methodology, will present the mixed method qualitative approach and the theoretical framework used in my study along with the ethical considerations experienced during the data collection. The process of preparation, collection and analysis is described in this chapter along with my role as the researcher. The chapter ends with the introduction and outline of the findings and discussion chapters.

Chapter Four analyses the findings around the first theme titled Setting the scene. It presents findings that demonstrate the participants’ backgrounds, pathways into the nursing discipline and their entry and employment in the tertiary sector. The information provides a foundation on which I begin exploring the key elements and links surrounding the creation and enhancement of a nurse academic’s professional identity in the tertiary sector.

Chapter Five continues the analysis of the findings under the second theme titled Creating academic identity. This chapter explores the definition of a nurse academic; considers what constitutes a profession versus a vocation; examines the concept of professional competence related to dual professionalism; and discusses the creation and enhancement of a nexus between the two.
Chapter Six concludes the findings section with an overarching discussion of the key themes and elements that suggests that a disparity is still present. This chapter will also draw from the data and literature to support and illustrate the aspirational model surrounding the creation and enhancement of a nurse academic’s professional identity within the tertiary sector.

Chapter Seven will conclude the study by summarising the findings, outlines recommendations aimed at the creation and enhancement of a nurse academic’s professional identity within the tertiary sector, it notes the limitations of the study and opportunities for further research.

Conclusion

The importance of creating and enhancing the academic’s professional identity will not only cement their place in the tertiary sector but it will confirm the importance of their contribution to nursing’s current and future trajectory. So then, the question to be asked is “...should they [nurses] be nurtured like the endangered species they were or left to sink or swim in an academic version of survival of the fittest...?” (McNamara, 2008, p. 460) or will the creation and enhancement of a nurse academic’s professional identity in the tertiary sector be critical in the profession’s future trajectory.

What constitutes the professional identity of a nurse academic is ambiguous at best as there is little, if any, guidance for those who seek to be employed or are employed in the tertiary sector. “The power of stories and storytelling is universally recognised and if storytelling is a means by which humans organise and understand the world and feel connected to each other...” (Tannen, 1989, p. 102), then telling one’s own story is a crucial opportunity to make sense of oneself. In this study,
participants have the opportunity to tell their story and provide their views, opinions, emotions and possible solutions regarding the creation and enhancement of a nurse academic’s professional identity in the tertiary sector. “Still, in the end, it is the meanings we produce, that matter” (Wenger, 1999, p. 51).
Chapter Two
Building the picture

Chapter insight

This chapter offers an historical overview of the profession of nursing and more specifically how nurse education came about and the implications this has for the professional profile of nurse academics. Beginning with a very brief overview of the development of nursing through the Nightingale era and the subsequent influence and spread of her approach and methods worldwide, the chapter primarily focuses on the Australian experience. It looks at the changes to the education and training of nurses together with the career pathways offered to and undertaken by, registered nurses (RNs). Finally, it will discuss the development of the educator’s role within the hospital-based training system and the subsequent move into the academic sector.

Nursing history: a brief overview

The history of nursing is well documented. In 2010, the International Council of Nurses (ICN) provided the following definition of nursing:

Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of the ill, disabled and dying people. Advocacy, promotion of safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles.

However, such definition has a long history during which the care of the sick transformed into an occupation and then into a profession. The practice of nursing carries the imprint of a very ancient and essential occupation which can be traced far back into history, even before the early Christian period (AD 1-500). By the middle ages in Europe, religious orders were responsible for providing nursing functions as
part of their activities, with the Augustinian Sisters being the first recorded as having a particular reputation for caring for the sick (Innis, 1970; Kozier, Erb & Olivieri, 1991; Schultz, 1991, Valentine, 1996).

Prior to the 16th century, management of hospital facilities of the time was governed by the Roman Catholic Church. However, the dissolution of monasteries under Henry VIII during this time and the Protestant Reformation in 1517 saw a decline in societal support for the church and religion as a whole leading to a decline in this management. During the 17th and 18th centuries, religious communities such as the French Sisters of Charity, Order of the Irish Sisters of Charity and Catherine McAuley’s Sisters of Mercy were predominately concerned with caring for the sick and providing shelter for the destitute. No formal training was ever received for any of these nurses (Schultz, 1991). This period also saw the emergence of barber surgeons. A male dominated medical practice began to organise the hospitals and nursing began to emerge as a female dominated occupation. Religious sisters, bound by their vows of “poverty, obedience and chastity were joined by the secular nurses who came from the lowest level of servants” (Valentine, 1996, p. 99). These secular nurses contributed to what has been termed the “dark period” of nursing, with women providing care in hospitals described as “drunk, heartless and immoral” (Kozier, et al. 1991, p. 5).

The worldwide reform of nursing commenced in the mid-19th century with Florence Nightingale’s activities during the Crimean War (1854-56). The instigation and implementation of sanitary measures, the importance of patient comfort and mobility, provision of medications, self-caring activities, public health and more importantly nurse education initiated by Nightingale decreased deaths amongst the wounded soldiers from 42% to 2.2% during this time (Gruendemann & Fernsebner, 1995; Kozier et al. 1999; Valentine, 1996, p. 100). Nightingale’s reforms brought about
significant changes: they included a training school established under her auspices at St Thomas’ Hospital in London. Graduating students became the pioneers of Nightingale’s vision and were responsible for carrying her model of care to the rest of the world (Russell, 1990; Wood, 1990).

Across the Atlantic, in North America nursing was progressing very slowly with the only recorded nursing organisation being the Nurse Society of Philadelphia, providing women obstetric training in order to provide maternity services at home. During the American civil war (1861-1865), however, nursing reforms, especially related to the effective training of nurses, became increasingly important. The late 1800’s in North America saw the establishment of Schools of Nursing with planned training programs based on the Nightingale model. A number of the graduates from these schools emerged as the early leaders of the American nursing profession (Innis, 1970; Kozier et al. 1999).

In the period from the end of the civil war to the end of World War 1 (WWI), a rapid expansion of hospitals increased the demand for trained nurses from nursing schools for their workforce. The World Fair in Chicago (1893) marked an important step in reform during this period, providing an opportunity for 18 superintendents from leading training schools in North America to establish the International Council of Nurses (ICN) in 1899 (Innis, 1970) with discussions focused on the legal registration of nurses. At the time, Nightingale was opposed to nursing registration as she stated that the profession was “too young, too unorganised and contained divergences too great for a standard to be applied”. Her belief was that reforms should be brought about by example and not by regulation (Innis, 1970, p. 20).

In the early 1920s, after the Rockefeller Survey study on nursing education, it was proposed that nursing schools become independent and move away from the
hospital based apprenticeship system into what is known in North America as, the college level. It was not long after this time that nursing education was embedded in partnerships between North American universities and affiliated hospitals. During this same period, the enactment in Canada of the Nursing Legislation and Registration Act began increasing the professional profile of nursing in that country, leading to college and / or hospital based trained nurses being employed across all healthcare sectors (Innis, 1970; Kozier et al., 1991).

The 1940s and the advent of World War Two (WWII) saw an increasing redeployment of manpower and resources with a significant contribution being made by professional nurses who served within military and civilian hospitals. Unfortunately, the impact of the war resulted in a significant civilian nursing shortage and by 1944, 23% of USA hospitals were forced to close wards and operating rooms. During this time a nationwide training program for nurse’s aides (unregulated workers) emerged to cover this acute domestic shortage – an intervention that in later years proved to have significant implications for nursing practice and education (Haase, 1990). In 1945, President Roosevelt called for an unprecedented nursing draft from the military to fill the shortages. Even after the end of the war and with the release of several thousand military nurses back into the civilian hospitals, the shortage continued until the end of 1970 by which time American nurse education was and continues to be firmly established in the higher education sector (Haase, 1990).

Nursing education and training

Following her experience in the Crimean War, Nightingale’s reforms increased the profile of nursing as a respectable profession and most importantly acknowledged the need for education and training for nurses (Kozier et al., 1999). The establishment of the Nightingale School of Nurses at St Thomas’ Hospital in London in 1860 was the
A first public planned educational institution for nurses. The training was hospital based and involved the transmission of policies, procedures, practices and standards from experienced nurses to would-be nurses. According to Bail, Cook, Gardner and Grealish (2009):

The policy documents were used by the Sisters (senior nurses) to prepare probationers (nursing students) for nursing practice as part of hospital-based vocational education. The Sisters working with Nurse Educators would have prepared these documents with the probationer as a learner in mind (p. 1458).

The Nightingale school demonstrated the value of providing an educational foundation to nurses and led to the Nightingale model being replicated worldwide (Berry & Langridge, 2000; Grindle, & Dallat, 2000; Gruendemann & Fernsebner, 1995). Both North America and Australia took their cues from the innovations in training occurring in the UK, although the implementation across North America was more rapid than in Australia (Wood, 1990).

As the Nightingale system brought about changes within the hospital labour market worldwide, economic and political agendas began to emerge. The formal education of nurses continued to be overseen and provided by the medical profession, which ensured the power remained with them; with senior nurses providing informal ‘on the job’ training to new students. No formal education in teaching was provided to the senior nurses and / or those who became educators by default (Grindle & Dallat, 2000).

Nursing students and their educators provided a large proportion of the workforce in the hospital and for that reason, despite the value of training, the learning needs of new nurses in an apprenticeship style hospital based education were always subordinate to that of the labour requirements. Little, if any, attempt was made to ensure that the clinical experience corresponded with the theory being
taught, as these programs were solely focused on meeting hospital staffing needs. Perhaps the most significant aspect of this apprenticeship was that a nurse continued to be inscribed with an embodied understanding of inferiority (Elgie, 2007; Russell, 1990; Walker, 1997). Nurses understood very early in their history, that if the profession was to grow and survive, they needed to look at alternative options as to who would deliver, how and where it would be delivered and what their education and training would include (Walker, 1997).

Nursing schools began to open as early as 1870 in the US and in the 1890s in Canada (AAHN, 2006). In 1923, Yale University established the first school within academia, independent of a hospital that prepared nurses outside the apprenticeship model (Thompson, 2009). The vision of the Dean at the time was that “students came to Yale to learn a highly skilled profession rather than to provide extra hands to already trained nurses”. This was not only revolutionary for that era but helped to redefine the nursing profession through ground-breaking research and the emergence of new leaders (Yale University School of Nursing, 2009). This in turn provided a platform for the recognition of professional identity within the sector.

In the early part of the 20th century, nursing in North America took the lead in nursing education across the world through the establishment of the first standard curriculum for schools of nursing. However, following WWI and WWII, economic circumstances began to change the demands on nursing not only due to the obvious nurse shortages but also to the continued domination of the medical profession in nursing education (Grindle & Dallat, 2000).

In 1965 the American Nurses Association (ANA) published its first position on nursing education advocating changes to the entry level and educational requirements of nurses at a time when up to 85% of nurses were hospital trained. The authors of
this document argued that:

...all nursing education [be] based in colleges or universities and the effect of this document over time was to wrest control of nursing education away from hospitals and physicians. With hospitals no longer controlling a free nurse supply in the form of student nurse to manage ward staffing needs, national demand for graduate nurses increased (Elgie, 2007, p. 289).

By the turn of the 21st century, nursing education in North America had been firmly embedded in the tertiary sector in the form of college diplomas and degrees with the latter continuing to be the standard (Australian Government: Department of Education, Science and Training, 2001b). Today, a nurse is “a person who has completed a program of basic education and is qualified and authorised in his / her country to practice nursing” (ICN, 2010; Smith, 1999). The quality of education of nurses is fundamental in defining them as professionals and determines the respect that the profession can command (Smith 1999). Various factors such as socioeconomic, cultural, technological and teaching competence can influence the quality of this education as regards the depth and scope of knowledge provided, or lack thereof (Modly & Springer, cited in Modly, Poletti, Zanotti & Fitzpatrick, 1995; Smith, 1999).

**Nursing evolution in Australia**

In Australia healthcare services for the new colony were initially provided by a doctor who arrived with the First Fleet in 1788. Two years later in 1790, the first portable hospital was established which was staffed by self-taught or untrained personnel caring for the sick and injured (Wood, 1990). This cohort of staff continued to provide the primary care in such facilities until 1868, when Australia saw the arrival of five Nightingale trained nurses to establish nurse training programs and improve standards of care in the new colony. The Nightingale model dominated the training of
nurses for the next 100 years.

The Nightingale model of care was adapted across Victoria (VIC), Western Australia (WA), Tasmania (TAS) and South Australia (SA) from 1870 to 1897. Nursing registration came into effect with the passing of the *Nurses’ Registration Act* in 1924 in NSW; however discussions regarding standardised nursing training began as early as 1899. It was not until 1930 that the first official training schools emerged in VIC and NSW hospitals (Kozier et al, 1999; Russell, 1990; Schultz, 1991; Smith, 1999).

Australia was significantly influenced by the issues and events occurring in the UK and North America with one such issue being the end of WWI. This signalled a sociological upheaval due to the deaths of a generation of young men leading to the increasing reality of women in the workforce. Nursing became the career of choice for women during this time, as it provided overseas travel and working opportunities in addition to experiencing firsthand the educational developments being undertaken in other countries. It also heightened the desire of Australian nurses to pursue professional status and recognition (Smith, 1999; Wood, 1990).

In 1949, the CNA (now known as the Australian College of Nursing established in 2012, formally known as the Royal College of Nursing – RCNA, was established as the national nursing organisation and professional educational institution. It offered post-training nursing courses, at diploma level, in ward management, administration and education. Its role was to offer nurses a substantial opportunity to enhance their careers as educators and leaders and enhance the reputation and professional standing of nursing by ensuring that those individuals who taught nursing were highly educated and competent (Cerasa, 2009; Smith, 1999). Moreover, the college also represented the nursing profession in the public and private healthcare sector and with policy makers. Although still closely controlled by the medical profession, the
college gave nursing the attributes of a profession with an organised system of training and a registration system at state and territory level (Smith, 1999).

Working conditions for nurses began to improve in the 1960s as a result of changes occurring in the political arena in recognising women’s rights in the workforce along with professional recognition. This included salary increases, annual and sick leave allocations plus the introduction of the 40 hour working week. In addition to this, the role of the nurse was being affected by the “changing role of women in society, advances in science, technology, consumer awareness, economic constraints, the trend towards adopting a multicultural society and the increased number of an ageing population” (Smith, 1999, p. 18). This brought into focus the need for significant changes to nursing education in order to accommodate the new, emerging healthcare society. This ongoing commitment to change was seen again in the 1980s when thousands of uniformed nurses engaged in industrial action across Australia marching in the streets for better recognition, working conditions and pay (Smith, 1999).

Nursing leaders lobbied and fought for a four year degree program, however, the federal government only agreed to fund a three year bachelor degree program (Williams, Chaboyer & Patterson, 2008). The transfer of nursing education, from the hospital based apprenticeship system commenced in 1984 and by the mid-1990s the transfer of nursing education into the tertiary sector (CAEs and TCs) was complete. It was during this time the RCNA shifted its focus from an educational organisation to a professional entity highlighting the need for nursing leadership and representation in the political arena and establishing itself as the peak nursing body at both national and international levels. The impact of the transfer was emerging as the hospitals were experiencing a significant decrease in their workforce along with a shift in government
funding towards the tertiary sector.

Between 1943 and 2002 a number of commissions of inquiry reviewed nursing education (see Table 2.1). While each of these addressed issues such as the importance of nursing education, prerequisites and standards for students, workforce and economic implications, none of these included or gave any consideration to the impact on the educators and their professional identity as they moved into a new working environment and took on a new identity as nurse academics.

The profession is now represented at both national and international levels by the government appointed Chief Nursing and Midwifery Officer (GCNMO). In July 2010 the Australian Health Practitioner Regulation Agency was officially established whose role and responsibility was to establish and implement the National Registration and Accreditation Scheme across Australia for the national boards of 14 healthcare professions (Aboriginal and Torres Strait Islander Health Practice, Chinese Medicine, Chiropractic, Dental, Medical, Medical Radiation Practice, Nursing and Midwifery, Occupational Therapy, Optometry, Osteopathy, Pharmacy, Physiotherapy, Podiatry and Psychology), which included, for the first time, the registration of undergraduate students for clinical practice purposes.
### Major Reports in Nursing Education and Training in Australia

<table>
<thead>
<tr>
<th>Year</th>
<th>Report Title</th>
<th>Summary</th>
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| 1943 | The Kelly Report | - Primary purpose of the review was to improve the training and status of nurses.
- Recommendations included a long range policy to completely reconstruct nursing and training and safeguarding of trained nurses in the future.
- Recommendations implemented included a block system of study, the appointment of ‘sister tutors and instructors’ to all schools, postgraduate training and the establishment of a college of nursing. |
| 1967 | The Institute of Hospital Matrons of NSW and ACT Committee – Part 1 | - Emphasis had been placed during training on nursing procedures in order to prepare a nurse as quickly as possible for ward duties without providing the necessary correlated theoretical instruction.
- The result was “the production of a nurse who was restricted in outlook, resistant to change, and unable to cope confidently with the scientific and technical advances in medicine and the social problems of nurses” (Sax, 1978, p. 9). |
- Comments made included that nursing education is considered a trade with a very narrow and restrictive method of education. |
| 1969 | The Institute of Hospital Matrons of NSW and ACT Committee – Part 2 | - Dealt with the education of the general nurse and it stated that “it is widely held that the education of the general nurse has not kept pace with the advances in medicine and the population and social changes which have taken place in the community” (Sax, 1978, p. 9).
- Recommendations included that training should no longer be the responsibility of hospitals and that SoN should be established, combined university and nursing courses should be further encouraged, students should not be required to undertake duties other than nursing.
- The program should be developed to a standard, which would enable the interest of the intelligent student to be maintained. |
<table>
<thead>
<tr>
<th>Year</th>
<th>Report</th>
<th>Recommendations and Actions</th>
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<tbody>
<tr>
<td>1970</td>
<td>The Truskett Interim Report</td>
<td>- Nursing education to fall within the responsibility of the minister for education</td>
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<td></td>
<td></td>
<td>- Recommendations included: standard entry into the CAEs or SONs would be Year 12 high school certificate, scholarships and financial support was to be offered during nursing education, combined university degree/nurse registration courses should be extended and that small hospitals should no longer undertake training.</td>
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<td></td>
<td>Victoria</td>
<td>- Victoria recommended a pilot project, for the education of general nurses as full time students should be conducted under the aegis of the Victoria Institute of Colleges.</td>
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<td></td>
<td></td>
<td>- A basic university course for a limited number of student nurses introduced on an experimental basis.</td>
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<td></td>
<td></td>
<td>- Attention was given to the high rate of student wastage suggesting that studies on this should be undertaken.</td>
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<tr>
<td>1970</td>
<td>The Truskett Interim Report</td>
<td>ACT recommended that a Central School of Nursing should be established which would be an educational institution, in close proximity to other educational institutions.</td>
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<td></td>
<td>cont.</td>
<td>- A tertiary level basic nursing course as well as post-graduate courses in nursing should be established at the Canberra College of Advanced Education.</td>
</tr>
<tr>
<td>1973</td>
<td>South Australia Major Inquiry</td>
<td>Recommendations included that &quot;the statutory body responsible for nurse education should ensure projections are made... of numbers required... and should carry out constant curriculum review&quot; (Sax, 1978, p. 12).</td>
</tr>
<tr>
<td>1974</td>
<td>The Noble Report</td>
<td>- The NSW Board of Education looked at the future development of nurse education in NSW.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- It commented that the lack of nursing programmes in educational institutions contributed to the isolation of nursing education from the mainstream of educational thought and expertise.</td>
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<tr>
<td></td>
<td></td>
<td>- Other recommendations were that the range of educational institutions in which student nurses undertook courses leading to registration should be increased and that student nurses should be given full student status.</td>
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<td>- Educational programmes conducted in educational institutions, where the student was regarded as a student rather than a trainee, where an atmosphere of learning prevailed, and where learning could occur more readily.</td>
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Table 2.1: Major Reports in Nursing Education and Training in Australia cont.

<table>
<thead>
<tr>
<th>Year</th>
<th>Report Title</th>
<th>Key Points</th>
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</table>
| 1975 | "Nurse Education - What Future?" Goals in Nursing Education Report on a Conference in the ACT | - A conference to consider the goals in nursing education report
- "...sounded a cautionary note about the placement of nurse education in academic institutions as nurse education had traditionally been squeezed and deprived by service requirements so there were understandable pressures to take it out of hospitals and into exclusively educational institutions"
- It noted that "academic and professional courses in tertiary institutions were under increasing criticism as being impractical, remote and esoteric" and that a possible option was to "locate more of formal education in the workplace rather than away on college campuses"
|
| 1978 | The Sax Report | - The largest and most comprehensive inquiry into nursing education
- Recommendations included: continuation of hospital-based training, minimal offerings of undergraduate diplomas in nursing, the use of retired educators, overseas recruitment and international training opportunities
- The conservative principle finding was: "there is no reason in principle why the preparation of nurses should be carried out in a different setting from that of other health personnel. However, the logical educational and financial problems which would accompany a departure from present arrangements suggest that change should be cautious, evaluated step by step and taken forward only after validation justifies each change"
|
| 1994 | National Review of Nursing Education | - The first national evaluation conducted since the transfer of nursing education into the tertiary sector was completed in 1994
- Recommendations included: principles underlying theoretical and clinical education, competence assessment, first year articulation
- Key objective was to ascertain if the transfer had resulted in wider professional preparation and career choices / options for nurses
- The results of the study revealed that (a) professional preparation had been achieved however, tensions remained between the educational preparation and the institutions and (b) the career options were not even
|
| 2001 | National Review of Nursing Education and Training | The Review has the following terms of reference:
- The effectiveness of current arrangements for the education and training of nurses encompassing enrolled, registered and specialist nurses; |
Table 2.1: Major Reports in Nursing Education and Training in Australia cont.

<table>
<thead>
<tr>
<th>Year</th>
<th>Report Title</th>
<th>Findings</th>
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| 2001 | National Review of Nursing Education and Training cont. | - factors in the labour market that affect the employment of nurses and the choice of nursing as an occupation; and  
- the key factors governing the demand for, and supply of nursing education and training |
| 2002 | “Our duty of care” - National Review of Nursing Education and Training | - Seven themes were reviewed that formed the basis for the recommendations which included:  
  - healthcare as a national issue along with the provision of effective and efficient healthcare  
  - nursing as a profession, that is inclusive  
  - capability development to build on current expertise and promote continuous improvement, planning and quality  
  - nursing is a practice discipline, education and industry partnerships  
- 36 all-encompassing recommendations were developed that included:  
  - establishment of an implementation taskforce that would monitor and report on the progress of the recommendation implementation  
  - establish a national nursing council of Australia and nursing education and workforce forums  
  - establish national consistent scope of practice, standards for nurse practitioners, principles to underpin nursing legislation and regulation  
  - image and information on nursing  
  - research training for nurses and maximising education pathways and student employment opportunities  
  - continuing professional development for clinical nurses and nurses in aged care  
  - clinical education funding, HECS access and lifelong learning  
  - models of preparation  
  - encouragement of inter-disciplinary and cross-professional approaches to education and practice  
  - workforce planning, culture and organisation  
  - nursing leadership and management |

Adapted from:  
Nursing education and training in Australia

In Australia, individual hospitals began hospital based training in 1868. In 1899 the establishment of the Australasian Trained Nurses Association began coordinating improved and standardised training and registration of nurses across the country as a matter of priority (Smith, 1999). Despite these moves, hospital based training continued to be isolated from the tertiary institutions and remained firmly entrenched within the healthcare systems governed by each state Minister for Health until the late 1980s (Russell, 1990, p. 59).

Although there were earlier attempts made to transfer nursing education into the tertiary sector during this period, these applications were rejected amidst concerns about inappropriate course, subject and unit content (sacred and profane); university entry requirements and most importantly funding issues and financial support from both state and federal governments of the time (Smith, 1999). Further attempts continued in Australia in the state of Victoria, through the 1920s, 1930s and 1940s but were again rejected by the University of Melbourne due to the elitist approach that the universities took towards nursing at the time and the influence and dominance exerted by the medical profession (Department of Education, Science and Training, 2002a, Russell, 1990; Smith, 1999; Wood, 1990).

Thwarted in those early attempts, Schools of Nursing (SoN) were established in hospitals in the 1930s, when the first official training school emerged in the states of Victoria and NSW. Australian nurses, predominately female and aged in their late teens, were trained mainly in these schools that were located within the large public teaching hospitals. The Australian training hospitals maintained links to international developments for example the Royal College of Nursing (RCN) in London offered the Diploma in Nursing at the University of Leeds in 1921 and in 1926 at the University of...
London where numerous Australian nurses undertook these courses (some of whom later became staff at the Royal College of Nursing (RCNA) when it was established in 1949).

In 1943, it was acknowledged by the government that nursing education needed to be reviewed (the Kelly Report see Table 2.1). The then Health Minister Mr Kelly set up a committee to undertake the review. It was identified that there was an issue not only with the education and training but also with the recruitment and retention of nurses due to an increased demand for nurses in WWII and in the loss of trained personnel because nurses were not permitted to continue working in the profession once they were married. The recommendations from this report included a long range policy to completely reconstruct the education and training around a block system of study requiring the appointment of sister tutors and instructors within the hospitals. The report also recommended the establishment of a college of nursing (the RCNA was established in 1949). While these recommendations were insightful for their time nurse education remained hospital based for another 40 years before educational justice for nursing and its educators was achieved and established (Smith, 1999; Wood, 1990).

Post WWII the country expanded politically and economically through the engagement of new links to Asia and the Pacific regions. In 1948, Australia was one of the foundation members of the World Health Organisation (WHO) and participated in a number of health initiatives including improving the training for nurses. This saw the profession approach the federal government to fund a new college of nursing, but the proposal was rejected (Department of Education, Science and Training, 2002a).
However, rapid population growth, immigration and the subsequent expansion of the healthcare system in Australia kept the importance of nursing and nurse education at
the forefront of government agendas during the 1950s and 1960s (Russell, 1990).

The decade of 1949-1959 saw nursing education firmly established in the College of Nursing Australia (CNA) providing a clear progression towards increased professionalism even though they still lacked support from the universities (Kozier et al, 1999; Russell, 1990; Schultz, 1991; Smith, 1999). There were however difficulties with recruitment, as qualified educators capable of teaching within the college were scarce in Australia and the notion of further education for nurses in order to produce qualified educators was non-existent (Cerasa, 2009).

In 1950 for the first time a nurse (known as the Matron) was appointed as senior advisor to the Minister for the Commonwealth Department of Health on nursing issues and government policies (Wood, 1990, p. 76). The Matron was awarded a WHO fellowship and began a collaborative study with the USA, Canada and UK on the role of nursing in the healthcare system. This opportunity had a significant impact on the thinking and direction of Australian nursing at the time. Amongst other concerns with nurse education, Part One of the Matron’s Report released in 1967 argued that:

...emphasis had been placed during training on nursing procedures in order to prepare a nurse as quickly as possible for ward duties without providing the necessary correlated theoretical instruction. This had resulted in the production of a nurse who was restricted in outlook, resistant to change, and unable to cope confidently with the scientific and technical advances in medicine and the social problems of nurses (Sax, 1978, p. 9).

The report led to the introduction of a three-year training program for hospital based nursing which commenced in July 1968 (Russell, 1990). However, when Part Two of the report was released in 1969, it continued to develop an argument about the inadequacy of the apprenticeship system, leading the committee to recommend (a) the responsibility for training nurses to no longer reside with hospitals, (b) separate schools of nursing from the hospital needed to be established, (c) combined courses
offered by the schools and universities needed to be encouraged and (d) the nursing syllabus needed to be developed to a certain standard in order to continually maintain the interest of intelligent students (Australian Government: Department of Education, Science and Training, n.d.). Comments received by Dr Rae Chittick (WHO consultant) in 1968, after reviewing a nursing program offered in NSW, very pertinently stated that:

...nursing education at the basic level remains a trade which students learn over a period of three or four years in a very limited environment. Perhaps no other group of young people in modern society receives such a narrow restricted and unimaginative type of education (Sax, 1978, p. 10).

It is important to note that reports, conferences and inquiries generated by the states and territories over subsequent years echoed the recommendations of previous reports. However, they also highlighted associated problems that would arise with the transfer, including but not limited to, the lack of appropriately qualified nurse educators and most importantly, a budget for nursing education. Subsequent reports and studies into nursing outlined in Table 2.1, such as the Truskett Interim Report (1970), the Noble Report (1974) and the Sax Report (1978) reiterated concerns about nursing education albeit cautiously. For example the principle findings from the Sax committee, one of the largest and most comprehensive enquiries into nursing education, was very conservative in their statements and asserted:

There is no reason in principle why the preparation of nurses should be carried out in a different setting from that of other health personnel. However, the logical educational and financial problems which would accompany a departure from present arrangements suggest that change should be cautious, evaluated step by step and taken forward only after validation justifies each change (Sax, 1978; Smith, 1999, p. 176).

The federal government did not respond to the recommendations of the Sax Report into nursing education until 1980 at which time they determined that the education of nurses would remain in the hospitals. In 1984 however, the Commonwealth Tertiary Education Commission report revealed that the rationale for this decision was
predominately based on the financial costs associated with the transfer from hospitals to the higher education sector and the subsequent workforce issues that would emerge (Australian Government: Department of Education, Science and Training, 2003; Smith, 1999). At this time, with the universities still disinclined to accept nursing education, the proposal was to move nurse education into the Colleges of Advanced Education (CAEs) and the Technical Colleges (TCs).

Although Australia may be geographically isolated, it is certainly not isolated from the trends and changes occurring to the nursing profession within the global arena whereby the transfer of nursing education was moving into the university sector. The emergence of the commercialisation of programmes relating to comparable standards of preparation for nurses domestically and the provision for the articulation of international standards for incoming nurses in Australia began and continued to be an issue (Australian Government: Department of Education, Science and Training, 2001a).

In a later review the National Review of Nursing Education – Discussion Paper released by the Department of Education, Science and Training (2001a), the Australian Tertiary Education Commission Committee of Inquiry into Nurse Education and Training attributed the transfer of nursing education to the tertiary sector to the following factors:

a) the changing needs of healthcare and systems supplying relevant health services along with the increased and rapid expansion of knowledge and associated technology;

b) perceived inadequacies related to hospital based nurse training in meeting societal needs and students educational requirements;

c) claims that a multidisciplinary educational environment provides advantages
for staff and students;

d) the significant attrition rate related to hospital based training;

e) the importance of developing an increased professional approach and profile to nursing that would provide increases in status and pay.

The eventual move of nursing education into the universities was by default and came about due to the restructuring of the higher education sector in the late 1980s by the then Federal Minister John Dawkins. This restructuring saw institutional amalgamations and the repositioning of CAEs and the Institutions of Technology as universities. The move led to the emergence of nursing as a fully-fledged discipline. It consolidated an approach to nursing education that incorporated theory and an expanded knowledge base that underpinned the clinical practice of its graduates (Gassner, Wotton, Clare, Hofmeyer, & Buckman, 1999; Meissner, 1999).

A further feature of the university curriculum in nursing was the emphasis placed on critical reflection on one’s professional practice. This however, exposed one of the differences between the critical pedagogical traditions in universities and the pragmatic work cultures of health care facilities, which has contributed to students’ difficulties in transferring and applying their theoretical knowledge and skills upon graduation (Clarke, 1986; Dumas, Villeneuve, & Chevrier, 2000; Gassner et al., 1999; Whyte & Sellick, 2000).

A significant legacy that remains of the hospital based apprenticeship education model is that it influenced nursing culture with anti-intellectualism through the aversion to and distaste for theoretically based knowledge. However, the idea and argument that intellectual work is purely the province of academics and scholars and not of the actual practitioner, has finally become less convincing (Kozier, Erb & Olivieri, 1991; Oermann, Truesdell, & Ziolkowski, 2000). Nonetheless these tensions are also
evidence that the vision of early nurse educators and leaders of the profession was correct; and that university education was necessary to transform the professional status of nursing. Furthermore, intellectual academic work and leadership which are part of clinical life have led the profession into the future more easily than the apprenticeship model had made possible. The continuation of these traits and future vision propelled the nursing profession into the next 50 years in an ever changing global market (Walker, 1997; Walker, 2003).

Developing the educator’s role

Nightingale’s nursing vision not only included the training of nurses but the importance of training the trainers of nurses. The selection process was as follows:

Students were carefully selected by the matron on the basis of both their educational and moral standards. Vocational training, board, lodging and uniforms were provided without charge and the students received a minimal wage. In return for their training, students were expected to provide for the service needs of the hospital. Students were rotated through specific clinical areas to gain experience under the direct supervision of the ‘ward sister’ in each area. It was considered essential that the ward sisters should themselves be trained nurses who were qualified and both able and willing to teach and supervise the student nurse (Grindle & Dallat, 2000 p. 208).

Once these students completed their initial training, a number of them were identified and groomed towards this educational role in order to promulgate the Nightingale system. If a nurse was selected to become a trainer, instruction on administration and ward management were provide. However, no instruction was provided on how to teach (Grindle & Dallat, 2000 p. 208). As noted earlier, the Nightingale model remained unchanged in Australia for 100 years. As the leaders of the profession began to conceive of a more independent and more equal standing for nurses and advocate for the education and training of nurses to be separated from the hospitals, the career of nurse educators began to emerge as offering a more distinctive role. Keeping in
mind the key changes that occurred in nursing education over the past 40 years, a graduate’s career could take one of three pathways: administration, clinical or education. As with any career, the first phase was associated with the initial education and/or training received by a person intending to enter the nursing profession under the hospital based system (see Figure 2.1). In the traditional hospital based apprenticeship system, a nurse’s career would typically involve entering a female dominated profession, as young as 17 years of age, and only rarely from having achieved any other post-secondary qualifications. The students undertook a residential training course in a particular healthcare facility and were employed as part of the workforce throughout their entire training. This specific training promoted a sense of belonging, identity and pride in that hospital and a strong sense of collegiality with others trained in that place (Richardson, 1996; Roberts, 1996).

The transfer of nursing education to the tertiary sector had a significant impact on the nature of nursing education and the nurse educator worldwide. The separation from hospitals stimulated the reconstruction of the nursing curriculum triggering a pseudo-emancipatory process as nurse educators progressed from the hospital based system to the tertiary institutions (Richardson, 1996; Roberts, 1996).

While traditionally, nurse educators did not require higher education qualifications to choose the education specialisation in order to integrate and transform into a university academic it was necessary that their qualifications were upgraded; all this at the same time that teaching obligations and heavy workloads continued (Roberts, 2002). This integration into the higher education sector saw nurse academics challenged to meet standard academic requirements (a postgraduate degree and eventually a PhD) to gain credibility as an educator within the academic as well as the nursing profession (Berry & Langridge, 2000).
Figure 2.1: Career staging: Hospital based apprenticeship system
The expectation was that nurse educators not only defined nursing practice and curriculum and developed them to meet the needs of the nursing profession; but in the tertiary setting they created an academic discipline with its own substantive body of knowledge (Borbasi, & Gaston, 2002; Hessler & Ritchie, 2006; Mooney & Nolan, 2006). This saw the beginning of the process of creating and establishing their identity within the tertiary sector.

Since the implementation of the original Nightingale system, there has been a significant change in the role of the nurse educator. Until the 1950s, senior nurses taught junior nursing staff, trainees and each other, utilising the same ad hoc structure and methods that were used to teach them. No formal qualifications equipped them for this teaching role as instructing the next generation of nurses was part of the job. However, once the RCNA was established in 1949 its focus was to offer further education to RNs; as prior to this the only other option involved travelling overseas to the USA and UK to gain additional qualifications. Focusing on further education, the RCNA developed the pathways seen in Figure 2.2.

There was a strong conviction that in order to be considered for an educator role, additional qualifications would be required. Thus establishing and confirming the identity of the RN undertaking this role, which is unfortunately not the case today. This trend continued into the late 1960s, even though in 1961 the College of Nursing began offering three 40 week diploma courses that attracted federal scholarships and recognition of tertiary qualifications: Diploma of Nursing Administration, Nursing Education and Nursing Education (Midwifery). Even though many nurses and nurse educators completed these qualifications, a clear disparity began to emerge between theory and practice as upon their return they were not permitted to move away from the embedded didactic teaching styles of their hospitals.
This along with the increasing ratio of students to educator (100:1) indicated that the hospital based training model was becoming inadequate (Smith, 1999). Despite these concerns the transfer and integration of the professional education of nursing and its educators within the higher education sector was not universally supported by the profession. Moule (1999) states that:

[This was] fuelled by concerns that professional skill development would be overshadowed by academic agendas. The issue compounded by the implementation of the nurse lecturer role, which wrestles with addressing the relationship between maintaining clinical competency and scholarly activity (p. 165).

Diekelmann and Scheckel (2004, p. 385) agreed that, “...educators must depart from the safe harbors of conventional thinking to grow, develop and adapt to rapidly changing environments”. Nursing educators coming from the clinical setting had to
adjust to new organisations with a different culture working in the academic sector. They struggled to recognise and adapt the value of their previous knowledge and experience to this new working environment (Garrow & Tawse, 2009). It appeared that “unlike medicine, which thoroughly integrates practice and education, nursing has constantly had difficulties in spanning the organizational boundaries of academic and [clinical] operations” (Curran, 1999, p. 193). McNamara (2009, p. 492) reiterated that hospital based nursing schools were the “…safe homes for nurse educators. The identities, practices and forms of capital that enable many of them to live comfortable and secure lives there are not serving them well in the unfamiliar and challenging place that is academia”.

A further concern was that the public perception of nursing as a “trade for girls”, alienated “…potential nurses who may feel university education was beyond their reach, thus reducing the pool of possible recruits” (Moule, 1999, p. 167). Against these critics of the move was the firm stance that the leaders in nursing education took in that “…their belief that nursing must develop through nursing philosophy and not adopt a medico-nursing role, which relegates nurses to performing a series of tasks or procedures” (Moule, 1999, p. 169). Butler et al (2006) and Standish (2002) (cited in Andrew, Ferguson, Wilkie, Corcoran and Simpson, 2009) echo these sentiments stating that:

“…nursing does not always appear on the academic radar because of its lack of specialists discourse, uniqueness and constant borrowing from other disciplines such as medicine…nursing should maintain disciplinary boarders, cross them of course, but ultimately seek to preserve a discreet body of work that both underpins and expands the discipline”.

From the perspective of hindsight, it was clear that the transfer of nursing education had a profound effect on the clinical educators as they were now required to focus on their academic qualifications and on building an academic profile with many believing
that they were risking their clinical credibility (McNamara, 2009). During the transition there was a measure of recruitment into senior appointments of nurses who had completed the relevant teaching qualifications in the UK. This saw qualified staff bring their expertise in and knowledge of curriculum development and training in the tertiary arena as suitably qualified senior staff were difficult to find because they were not used to teaching outside the hospital environment (Smith, 1999).

In the late 1970s of the 648 educators employed in the NSW CAEs only 296 (46%) had formal educational qualifications. The move to the tertiary sector saw these experienced staff appointed at lecturer level or below and under-represented in senior academic ranks as they were under qualified compared to standard academic appointments (Roberts, 2002; Smith, 1999).

In 1994, the Reid Review into Nursing Education in Australia had over 100 recommendations including Chapter 15.1 on staffing. It recommended that specific professional development programmes for nurse academics need to be implemented to ensure that the educational standards for academic staff were met – stipulating that 70% would possess higher degree qualifications with the remaining 30% to have PhDs (Smith, 1999). Sellers and Deans (1999, p. 54), in the only published account of nurse academics in Australia, cited Roberts (1996) as reporting that only:

...7% of nurse academics in Australia hold doctoral qualifications, as compared to 41% of all other disciplines combined...nurse academics are underrepresented in senior academic positions, that merely 27% hold memberships in professional nursing organizations and that, although only 8% of the overall workforce is male, 17% of nurse academics are male (p.54).

A follow up profile study of Australian nurse academics conducted four years later again by Roberts in 2002, found that a master’s degree was standard for a Lecturer B (L2) and a doctorate was required for a Lecturer D / Associate Professor (L4). A further shift has been seen in recent times to align with the established standard in
universities with a professional doctorate or PhD being considered a minimum for any academic from L2 upwards. However, academic qualifications were only part of the equation. Clinical expertise, according to McNamara (2009, p. 486) is a “taken for granted prerequisite” for all nursing academics. The presumption of clinical expertise for all nursing educators (which is in fact a requirement embedded in accreditation and registration requirements) provides an avenue for the teaching methods of the old hospital based model to reappear in the new environment. Academic qualifications, themselves were and are not necessarily teaching qualifications so do not inevitably displace the “natural disposition of nursing faculty to cover content” based on their own clinical expertise, with an emphasis on student learning, engagement and critical thinking more common in the tertiary sector (Pardue, Tagliareni & Valiga, 2005, p.55). The basis of these teaching methods was “dominated by the attention to measurable and behavioural outcomes”. The nurse educators attempted to continue to teach the way that they were taught via a passive teaching method “that relied heavily on memorization and recitation” with a strong focus on skills and tasks. Nursing leaders of the time regarded this method as inadequate in the preparation and education of nursing students to meet the challenges of the 21st century; as it “minimizes student involvement and is not appropriate for learning many of the complex mental processes for competent practice”. It also does not meet the “overarching goal...to develop a science of nursing education upon which all practicing teachers can draw” (Pardue, Tagliareni & Valiga, 2005, p. 55; Robinson, 2009). The general consensus and rationale behind this was that members of the faculty and / or the schools were not prepared for the academic role. They lacked risk taking that is an essential element for innovation and were resistant to change (Pardue, Tagliareni & Valiga, 2005, p.56)

Whilst nurses are considered experts in their respective areas of clinical
practice, they often come into the tertiary sector with no formal preparation as an educator and/or academic. The complexity of practice, the level of decision making in implementing new healthcare approaches as well as the evaluation of effectiveness, all warrant health care practitioners and especially nurses, being educated to an advanced level. The consensus remains that nursing education must be research based: the preparation of its academics therefore needs to include qualifications at Master’s and PhD levels along with competence in the multiple components of the role. Nursing is in constant and continuing need of both academic and clinical leaders who have competence as investigators, collaborators, communicators and disseminators of knowledge (Rossetti & Fox, 2009, p. 11; Wilkes & Morton, 2008, p. 135).

**Travelling the path to academia**

What needs to be recognised are the considerable complex notions, ideals and ambiguous understandings in what is considered to be a university and indeed a university education and how they have evolved and transformed the sector over a long period of time (Glen, 1995). Of the present era, Thompson (2009, p. 694) states that:

> Universities have traditionally protected the free and open expression of a diversity of ideas, beliefs, and opinions, though this has been less evident recently with pressures for political correctness, external funding, and cultural conformity. Indeed, according to Reading (1996) the university has lost its way, its role and its function.

It has been very well documented that the fundamental role of a university is to “teach their students to think” or “cultivate, a philosophical habit of the mind”. Moreover, creating, preserving, transmitting and identifying new avenues and application of knowledge is certainly the most effective and efficient method of conserving “the
variation of ideas” and knowledge (Furedi, 2004 and Bowen & Schwartz, 2005, cited in Thompson, 2009, p. 694). It is indeed, this notion of higher order thinking (within the context of professional knowledge and practice through formal and informal thought and reasoning) upon which higher education is based.

The academic community provides the platform for the cultural accumulation of this knowledge and ensures its continual development, transmission and implementation across generations through its practitioners (Glen, 1995, p. 91; Kenner & Pressler, 2006, p.139). In addition, the necessary community engagement promotes and sustains the excitement and vibrancy of learning for students and provides distinct pathways of professionalism for academics (Broome, 2006; Gibbs, Angelides and Michaelides, 2004; Winter & Sarros, 2002).

In Australia, the long held belief and standing of the universities as the home for elite disciplines, students and scholars began to change in the 1960s and 1970s. By 1981, 30 specific colleges of advanced education that were engaged largely in teacher education were advised that they would no longer receive federal funding unless they amalgamated with other higher education institutions. These amalgamations led to the expansion of the tertiary sector that saw the conversion and mergers of the CAEs and Institutes of Technology into universities in the late 1980s (Harman, 1986; Harman, 2002).

The mergers and conversions in the sector caused significant upheaval during 1987-1991 that attracted major scholarly interest as mergers were used by the federal government to effect systemic changes and view the reaction of the affected institutions and the associated pressures that they brought about. However, little attention was paid to the sociocultural impact that these mergers and conversions had on the educators (Harman, 2002). The nursing discipline including its educators found
itself embroiled in these significant changes and controversies during its entry into academia. Issues associated with student and staff recruitment, admission requirements, the socio-political and economic trends and impacts, role and knowledge erosion, external regulatory influences and the changes associated with the identity of its students, educators and practitioners began to emerge (Glen, 1995).

During the transfer a number of changes transpired as healthcare facilities had to relinquish their schools of nursing to the CAEs and Institutes of Technology, which were then subsequently amalgamated into universities. These changes had implications with State / Territory and federal funding of the programs that included costs associated with clinical practice and student fees. Tertiary sector regulations were imposed on students (entry scores / alternative pathways, successful completion of necessary number of units and / or points) to meet the necessary academic standards for both students and staff (qualifications, publications, management, curriculum design and development) and these created significant challenges and tensions.

Changes were also seen with the external regulatory bodies associated with standards of practice and accreditation requirements. These included the Australian Nurses and Midwives Council (ANMC) that was responsible:

- for identifying and working in conjunction with the State and Territory Registration Boards on issues which impact on or are relevant to statutory nurse regulation;
- setting national nursing practice and education standards (Code of Ethics, Code of Practice, Competency Standards, National Accreditation Requirements for educational facilities);
- fostering cooperation, consulting and providing advice to government bodies,
professional and other organisations that included international nursing regulatory authorities;

- undertaking assessments of overseas qualified nurses consistent with Australian standards and guidelines; and the

- State and Territory registration boards (in July 2010 the Australian national registration board was established), the independent statutory bodies that regulate nursing and midwifery and are responsible for protecting the community by ensuring safe standards of nursing and midwifery practice, by setting the standards in education, registration and professional conduct (NMBWA, 2009).

Changes to legislation related specifically to the Nurses and Midwives Act and Regulations (formally the Nurses Act and Rules) were also required. This also saw consequential amendments made to a number of other Acts (across all States and Territories in Australia) including but not limited to Blood Donation, Civil Liability, Commonwealth Mutual Recognition Act, Constitution Acts Amendment, Corruption and Crime Commission, Court Security and Custodial Services, Criminal Code, Criminal Investigation, Firearms, Health Act, Health Professionals, Health Services, Juries, Medical Act, Mental Health, Misuse of Drugs, Pharmacy 1964, Poisons Act, Prostitution Act, Radiation Safety, Road Traffic and State Administrative Tribunal.

The transfer of nursing education saw significant changes in the career staging of graduate nurses in comparison to the hospital based apprenticeship system (see Figure 2.3 and Figure 2.4). The tertiary sector where nurse education is now located, is a mass education system involving students of various ages and educational backgrounds. It does not offer the same kind of opportunities for student nurses to develop collegiality, a sense of belonging, identity and pride in one’s place of training.
that the hospital based system did. However, what became evident was that the tertiary education model does produced graduates with a significant theoretical foundation, critical thinking skills and a sense of empowerment not previously seen in graduates of the former apprenticeship model.

What is not in contention and has not altered, regardless of the pathway taken (hospital or tertiary), is the mandatory registration requirements for nurses. Initial registration during the hospital based apprenticeship system was a state board requirement where students were expected to sit an examination prior to being eligible to register. Today, under the tertiary educational model, the responsibility for graduating students eligible for registration rests with the university itself and is achieved by having their courses and curricula accredited by the respective State or Territory Nurses and Midwives Registration Board (as of July 2010 this responsibility rests with AHPRA and NMBA).

Part of the accreditation requirements is that academics teaching nurses must themselves be registered nurses and thus this has become an essential criterion for anyone applying for any nursing academic position at any level and mode of employment (full-time, part-time and / or sessional). In addition to mandatory registration, all graduates were and continue to be expected to consolidate their education within the clinical environment. This ultimately lead to the coveted achievement of clinical competence and the anticipated move towards specialisation within each nurses’ chosen field (some of who default into these choices) (Whitehead, 2005). The pathway of the graduate then moves into the clinical career stage as seen in Figure 2.4.
Figure 2.3: Career staging: Tertiary based educational system
Figure 2.4: Clinical career

- **Registered Nurse**
  - includes graduate year and specialisation
  - achieved 1-9 years post registration

- **Clinical Nurse**
  - Clinical Specialisation
  - achieved 3-9 years post registration
  - (application and promotion)

- **Clinical Nurse**
  - Manager / Specialist / Consultant / Nurse Practitioner
  - achieved 5-10 + years post registration
  - (application and promotion)

- **Senior Management**
  - Deputy / Directors of Nursing / Executives / Department Directors
  - achieved 15+ years post registration
  - (application and promotion)
Movement towards senior management is dependent on position availability, healthcare facility criteria regarding additional qualifications / experience and successful application. Individuals can opt to remain at any level for their entire career. What is missing from this clinically focused career staging is the option and clear pathway to becoming a nurse academic. Travelling this path were the participants of this study and although each participant’s account of their career choice into nursing and subsequently the tertiary sector can be viewed as a case study in itself their narrative begins with their recollection of events of their admission into the profession (further discussed in Chapter Four).

Conclusion

The debate on the question of whether nursing education should reside predominately in practice or in the academic setting continues today despite the worldwide shift to universities. Even though the transfer occurred over two decades ago in Australia, the danger remains that the traditional view of a nurse educator’s role and responsibilities has not changed. Unfortunately the consequences of these views led to the notion that “...nurse educators are solely there as passive implementers of nurse education [which] will...curtail academic advancement, to the detriment of both the profession and the institution” (McNamara, 2009, p. 610).

A number of potential challenges continue to lie ahead for nursing and most certainly for the academics who educate its future clinicians if they are to meet the demands associated with the ever changing and increasingly complex healthcare environment. These include: contemporary curriculum development; socioeconomic factors associated with globalisation; patient profiles; government funding and workforce issues; policy changes and the drive for professional advancement of
nursing (Hegarty, Walsh, Coddon, Sweeney, 2009).

The academics engaged in educating future RNs, find themselves faced with a number of issues in a period where governments worry about costs and the increasing demand to produce more nursing graduates, while healthcare facilities are questioning their own commitment to students along with the ever increasing academic workloads (Hall, 2008). These issues have in one way or another been identified as concerns that have impacted on the nurse academics’ professional identity within the tertiary sector and discussed in a number of contexts throughout each of the participants’ interviews. Finally:

            History is not just about the past – it is also the foundation on which we can continue to build the stories that define us. History is a point we look back to in order to measure how far we have come, and a pilot light that helps guide our decisions for the future as we apply the benefit of hindsight to the outcomes and impact of the decisions made before us (Cerasa, 2009, p. 164).

Out of all the research that has been conducted around nursing, it appears that there is little, if any, that has addressed the educator’s now academic’s, point of view and insight into the implications of the transfer. The information in this chapter provided the first three key elements and links surrounding professional identity of a nurse academic: (a) temporality (an all-encompassing title that includes history, culture, politics and economics), (b) knowledge (sacred and profane); and (c) policy and compliance. It is from this basis that my research study now moves forward to explore not only the participants’ own career history, background and pathway into academia; but the overall concept of whether in fact there has been a shift towards a professional identity for nurse academics in the tertiary sector.
Chapter Three
Presenting the research methodology

Chapter insight

This chapter will describe the methodology and design process taken in my study to investigate my research question (see Figure 3.1). It is divided into four parts: (a) the design process where it describes my study’s methodology, mixed method approach and ethical considerations; (b) data collection including the coordination, planning and development phases for the questionnaire and interview process; (c) data analysis which will discuss how the data was analysed, coded and provide the data from the questionnaire and (d) my role as the researcher in this study. Overall, this chapter describes the process of how my study was undertaken and achieved.

Figure 3.1: Planning and investigation process
The design process

Methodology

This section will describe the methodology I chose for my study by providing a summary of the pathway that led me to my selection. Choosing my methodology provided me with the theoretical perspective to link my research with my chosen method (Hesse-Biber, 2010). It also supported the design and development of my research questions that evolved from my literature review and explains how my ontological [what is true] and epistemological [the methods of figuring out the truth] position guided my choice to select a mixed method approach to this study.

The analysis of the literature that I reviewed led me to conclude that obtaining background information from the Deans / HoS of the SONMs in the universities and academics insights and views would provide a clear picture and identify what would constitute the professional identify of a nurse academic. However, it was evident that there was a limited body of research that discussed the content of this topic from the academic’s perspective. Essentially, the literature review revealed that what constitutes the professional identity of a nurse academic is ambiguous at best as there is little, if any, guidance or modelling for those who seek to be employed or are employed in the tertiary sector. Overall, the review of existing literature confirmed that there was an absence of research that examined what constituted the creation and enhancement of the professional identity and how it was understood and acknowledged by nurse academics in the tertiary sector. I realised that in order to study this gap, significant importance needed to be placed on the experiences of nurse academics in Australia, their successes, disappointments and any other factors that may have contributed and / or influenced their professional identity in their working
environment.

The rationale for my research derived from the ongoing noticeable shift in what can best be termed the goalposts for prospective nurse academics: that is the essential criteria for academic appointments in nursing. As an academic at the time of this study, I had noticed that advertisements for such positions had shifted in so far as what qualifications were required for Lecturer A (L1), Lecturer B (L2) and Lecturer C (L3). These ranged from a generic statement of ‘relevant postgraduate qualifications’ to a completed or nearing completion PhD for each of the levels. This raised a number of questions for me including (a) why and should, this be occurring (b) was, there a perceived difference between academics teaching nursing and academics in other disciplines / professions, (c) what, if any, were the differences between disciplines and / or institutions and the possible reasons behind any such differences, (d) how, did the shift come about and was this also occurring in other practice disciplines and / or professions and (e) who, if anyone, believed it prudent to sanction this shift.

Essentially what it raised was how, was the concept of professional identity viewed and understood by the nurse academics themselves as the literature reviewed did not provide a clear picture on this topic. However, what was clear to me was that nurse academic’s understanding of this concept would vary and that I would need to take into consideration their role as a whole in order to undertake a thorough examination of this topic. Thus, the decision to undertake a qualitative approach was underpinned by the exploratory nature of my research question.

Choosing Bernstein’s sociological approach to identity formation (discussed in Chapter One) was central to my research as my aim was to ensure that nurse academics had a model / guide of what constitutes, creates and enhances their professional identity with the tertiary sector. Bernstein’s approach recognised that
identity formation was found in a professional habitus that has distinct boundaries, its own unique knowledge base and key elements that make up the professional identity of an individual. The use of the Bernstein’s five principles provided me with a structured approach that described and explained the professional identity of a nurse academic, recognised and identified (diagnose) the knowledge gap that exists, analysed (predict) my data and discussed (transfer) my findings that supported my subsequent recommendations.

**Mixed method approach**

“Mixed methods research is increasingly being used today in many disciplines such as sociology, psychology, health, and education” (Bentahar & Cameron, 2015, p. 3). There are several definitions of mixed methods research. For my study I have chosen to use the definition by Johnson, Onwuegubuzie’s and Turner (2007, p. 120) in Bentahar and Cameron (2015, p. 5) that states: “Mixed methods research is the class of research where the researcher mixes or combines quantitative and qualitative research techniques, methods, approaches, concepts or language into a single study or set of related studies”. In choosing this definition, I recognise that a mixed method approach provides me with the ability to draw on and integrate the strengths of both qualitative and quantitative research methodological approaches (Mehdi Riazi, 2016). The data can be simultaneously collected, analysed and interpreted through the use of different types of research instruments (Zohrabi, 2013) such as the questionnaire and participant interviews used in this study.

As the researcher, my choice of methods (quantitative and qualitative) is driven by ontological and epistemological philosophical assumptions that frame the study (Brannen, 2005). Although the two methods are in themselves based on different philosophical principals and assumptions the combination of the two
(mixed method) “is legitimized” as “methodology [is viewed] as a connexion centre of abstract levels of epistemology and mechanical levels of methods and motivated by a hybrid exploration of complex phenomena and process” (Bentahar & Cameron, 2009, p. 5). On the one hand, the quantitative approach can help to: “provide large, representative samples of cultural communities (in this case the SONMs), reliably assert cause-and-effect relationships among constructs as well as confirm or disconfirm theoretical hypotheses; and summarize numerical data in a” (Fassinger & Morrow, 2013, p. 70) clear and persuasive manner. On the other hand, qualitative approaches help to:

...enhance relationship and dialogue between researchers and participants in their communities; minimize the imposition of researcher assumptions on diverse others; empower participants by helping them to voice their stories and by honoring their strengths, needs, and values; stimulate collaborative social change efforts by researchers and participants; catalyze theory development; and frame communication and dissemination of research outcomes in ways that are immediately useful to communities (Fassinger & Morrow, 2013, p. 69-70).

Using the mixed method approach (quantitative and qualitative) of gathering data can “supplement each other and hence boost the validity and dependability of the data” (Zohrabi, 2013, p. 254) and “offer researchers maximum flexibility” (Fassinger & Morrow, 2013, p. 70). In addition, one of the main objectives of this approach, is the triangulation of the data (combination of methodologies studying the same phenomenon) that is achieved by integrating the data during the analysis phase (Bentahar & Cameron, 2015. As the researcher, this provided me with the ability “to corroborate and to support the results relative to the same phenomenon with different methods and to ameliorate internal and external validity” (Bentahar & Cameron, 2015, p. 6).

In my study, the use of mixed methods included a questionnaire and
participant interviews. The use of a questionnaire as my first source of data collection (quantitative) was based on the nature and purpose of this study (outlined in Appendix B); the research questions (see Appendix E) (Zohrabi, 2013); and the fact that questionnaires are considered a well-established and fundamental tool for acquiring information from participants (Bird, 2009). The format of the two-part questionnaire (see Appendix A) included a combination of tick boxes and open / closed questions each with its own role and purpose (further discussed in Data Collection: University profile questionnaire). These precise and unambiguous questions were provided in a logical and sequential manner to ensure that the person completing the document (SONM Dean / HoS or their nominee) understood the purpose behind the research and carefully considered and responded to each of the questions to completion (Bird, 2009; Sarantakos, 2005).

The use of participant interviews (further discussed in Data Collection: Interview question sets and pilot study and Interviews) was my second source of data collection (qualitative). Qualitative research is concerned with the nature, explanation and understanding of phenomena and aims to understand how individuals make sense of their social world and likely to uncover new information (Bird, 2009; Hesse-Biber, 2010; Ryan, Coughlan, & Cronin, 2009). Qualitative evidence is distinctive as the experiential and behavioural nature of the context in which it occurs, is dependent on the nature of the relationship being developed between researcher and participant (Holloway & Biley, 2011, p. 970; Morse, 2006). This type of enquiry depends on two key factors, the quality of my role as the researcher to support the interaction and establish rapport with the participant along with the quality of my subjectivity, especially my self-awareness about the potential effects of self on the research (Glesne, 2006).
The reflective approach of qualitative research enabled me to explore the specific details relevant to an individual’s life story, behaviours, opinions, perceptions, social and professional interactions and organisational functioning as well as looking for continuities and discontinuities between the individual’s experiences and that of others. As a result, qualitative research offers a richer account of the topic under investigation. Interviews form an essential part of data collection in qualitative research as they are considered a key source of extracting meaningful information from the participants (Sorrell & Raymond, 1995; Strauss & Corbin, 1990).

After reviewing and considering a number of different approaches, I chose to base my study on a mixed method approach that included a questionnaire (quantitative and qualitative) and interviews (specific and qualitative) with nurse academics as the key stakeholders in my study. Each data set was reviewed, analysed independently and sequentially as the information provided in the questionnaire informed and explained the selection of the School of Nursing and Midwifery (SONM) and subsequent participant interviews. The questionnaire was used to gain an overview of the SONM within Australian academic institutions and how they compared with each other across a number of variables; and the interviews (further discussed in Data Collection: Interview question sets and pilot study and Interviews) were used to obtain the individual academic’s perspective, experiences and responsiveness (Mertens, & Hesse-Biber, 2013) on the creation and enhancement of a nurse academics professional identity in the tertiary sector.

The two methods in this approach captured the contextual complexity and the synergies between quantitative and qualitative data collection and analysis techniques (Hall, 2013, p.33) for this particular topic and group. It also provided a fuller understanding and strengthened the findings of the topic being researched (Creswell &
Plano Clark, 2011, p. 139; Mertens, & Hesse-Biber, 2013). However, as with any method potential limitations do exist. They were not so much related to the use or ‘mixing’ of the different methods (questionnaire and interviews) and data (qualitative and quantitative), but rather how this approach may be understood and applied without the perceived tendency to assume that a methodological hierarchy exists; and where it is claimed that often multi (or mixed) methods is merely a quantitative study of qualitative data (Fitzpatrick 2011). Despite this, I believe that the use of this mixed method approach provided a strategy that added the “rigor, breadth, complexity, richness, and depth (Flick 2002, p. 229, in Denzin & Lincoln 2005, p.5) required to address the fundamental issue of what constitutes the professional identity of a nurse academic.

**Ethical considerations**

The aim of obtaining ethics approval is to ensure that the participants in my study are not put at risk and / or disadvantaged in anyway if they decide not to participate and / or withdraw from the study. Ethics approval was sought from my educational institution prior to the commencement of my study to ensure that the study met all ethical standards and requirements. Due to the low-risk nature of my study, an expedited approach was undertaken by the university ethics committee and the study commenced within a few months of the application submission, with outright approval. Although ethics approval had been received from my university prior to the commencement of the study, one of the institutions selected required an additional application to be made to their own ethics committee prior to confirming their participation which was successfully obtained.

The application included an institutional information letter and participant information letter describing the study, a consent form and interview question sets
which were presented to my supervisor to ensure accuracy and that all relevant information was included. At the commencement of the study, each university with a SONM was sent the institutional letter as a means of introduction and each participant was sent their information letter and consent form prior to their interview. The interviews were recorded and transcribed verbatim at the completion of the interviews at their respective academic institutions. The hardcopy and audio files of the transcribed participant interviews utilised to undertake the data analysis will be subsequently destroyed as outlined in the original participants’ information letter (five years). In order to assure the participants’ privacy and anonymity, codes were assigned and used throughout my study.

In regards to my role as the researcher, even in the best of qualitative studies, as Potter (2004) cited in McNamara (2009a) believes, the researcher cannot be considered a “neutral, passive and uninvolved” participant. This is particularly the case for me in this study as I have worked as an academic in two schools of nursing and midwifery (SONM) and was interviewing participants whom I considered to be colleagues. As a result there will be an impact on the collection and interpretation of data (Burns & Grove, 2003, p. 375). For example, being a nurse academic made it easier for me to establish rapport and credibility with the participants, but it also heightened the importance of establishing and maintaining their support, confidence and trust due to the professional relationships shared within the academic arena (the role of the researcher is discussed at the end of this chapter).

In addition to ensuring the participants’ privacy and confidentiality along with establishing my credibility and trust with them my study needed to make sure it was trustworthy. While “trustworthiness is considered the most widely used global standard” in qualitative studies, the burden of proof was on me as “the
researcher to ensure that the study [was] carried out as rigorously as possible”; and in a manner that provided an accurate account of what happened and that represented “as closely as possible the experiences of the participants” (Padgett, 2009, p. 102). In order to support and achieve this, information related to my background as an academic along with methods used in collecting, analysing and interpreting data was provided to ensure transparency and trustworthiness that the study was carried out ethically.

**Data collection**

This section describes how the data in my study was collected focusing on the two main sources of data collection in my study: first the university profile questionnaire (see Appendix A) and second the participant interviews. In order to conduct my research using a qualitative approach it was essential to develop the appropriate instruments that would meet the needs of my study.

**University profile questionnaire**

The study commenced by developing and sending via email a two part questionnaire to the Head of School (HoS) / School Dean of the 33 universities across Australia who offered a nursing program. The reason for this was to gain an overview of the School of Nursing and Midwifery (SONM) within these institutions and how they compared with each other across a number of variables (details are outlined in the following subsection). In addition, the following process was implemented:

a) design and development of a two part questionnaire that would encompass foundational information regarding the relevant school;

b) HoS / School Dean of each SONM was provided with an introductory letter giving an overview of the project, a request for them to provide the information required
along with submission dates (see Appendix B);
c) a follow up reminder was sent via email to the HoS / School Dean and / or individual participants;
d) data from submitted questionnaires were collated, coded and analysed.

Following ethics approval, the questionnaire was the first data collection strategy used to collect specific background information from the SONMs in Australian universities. It was divided into two parts: Part A was divided into five sections that covered details regarding the SONM and courses as follows:

1. *Organisational demographics* that included the school’s management structure, number of campuses, number of students in the undergraduate and postgraduate intakes and number of graduating students. The management titles and length of appointment were determined by the overarching university organisational structure at the time the data was collected. The number of student intakes was dependant on the size of the SONM and university course intakes – annual, semester or trimester based;

2. *Course information* included when the school’s programme commenced, the length of time it has been in place, initial and current undergraduate and postgraduate awards offered. This was determined by the size of the SONM, the capacity and available expertise in offering the course;

3. *Academic staff information* included staff teaching and non-teaching workload profile along with the nominated KPI workload allocation system (eg. points, hours). The number of staff was determined by the size of the SONM and the overarching university KPI structures at the time;

4. *Qualifications and promotion* included information on academic appointments, use of generic and discipline specific selection criteria along with academic
promotion requirements. While discipline and academic specific criteria were outlined (eg. nursing registration and relevant postgraduate qualifications – that altered depending on the position) educational qualifications did not feature in any of the selection criteria reviewed. Despite this, a number of the participants did state that their particular university expected them to complete a Graduate Certificate in Tertiary Teaching / Studies as part of their appointment regardless of their teaching experience.

5. Titled Further comments this section provided further / additional comments under the banner of “What do you perceive as the key pressures facing your staff in terms of” the following four headings: (a) approach to nursing education, (b) being an academic, (c) professional development and (d) performance management.

At the end of Part A, a statement of thanks was included along with two additional questions confirming their participation if selected, and promoting the study to their staff as another point of invitation to be part of the study.

Part B of the questionnaire listed the number of staff employed in the school along with their highest qualification. Where possible information was pre-completed by navigating the university and school websites to locate the relevant data and HoS / Dean asked to confirm that it was correct. The information was relatively easy to access and consisted of current undergraduate and postgraduate course titles and offerings, requirements for academic appointments (eg. selection criteria, job descriptions across all levels and staff lists) and requirements for academic promotion (eg. generic and discipline specific criteria).

The sections of the questionnaires required to be completed by the HoS / Dean of each school, were related to the actual annual number of their student intake and
graduating students; the number of staff with and without a teaching profile such as research staff along with their employment classification (part-time, full-time and sessional) and type of workload allocation KPIs were used for workload allocation.

At this point, it is important to address the different university groups that exist in Australia. This information was included in the study to determine if there was any difference in the perception and opinions among the academics working within each of these academic groups. Australia has 39 public universities each of which is considered to be part of a collective grouping based on their profile, purpose and ethos towards higher education. These groupings were self-nominated and were formed following the Dawkins reforms and in response to the Group of Eight (Go8) forming themselves into an alliance to act as a lobby group within and independently of Universities Australia, the sector’s peak body for negotiating with the federal government. The Go8 consists of seven original state universities (known as the sandstone universities) and Monash University. Table 3.1 provides a description of the groupings and the list of universities that belong to each (at the time that the research was undertaken), in addition to highlighting the institutions with schools of nursing. It is important to note that the universities in the New Generation Universities (NGU) and ones nominated as ‘Other’ were grouped together for the sample selection as the former group was disbanded. In addition, certain institutions have withdrawn from or been accepted into different groups since the initial data was collected although none of the universities that were selected for interviews have changed their status and / or grouping.
Table 3.1: Australian university groups

<table>
<thead>
<tr>
<th>Australian Technology Network (ATN)</th>
<th>Member Institutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Established more than a decade ago, the group shares a 30 year history of working in partnership</td>
<td></td>
</tr>
<tr>
<td>They provide a commitment to forging partnerships with industry and government to deliver practical results through focused research, dedication to the pursuit of knowledge and building future sustainable societies</td>
<td></td>
</tr>
<tr>
<td>The group educates approximately 20% (180,000 students) of Australia’s student population and are possibly the largest provider of international education</td>
<td></td>
</tr>
<tr>
<td>The overarching aim of this group is to:</td>
<td></td>
</tr>
<tr>
<td>a) assist in securing Australia’s reputation as the clever country</td>
<td></td>
</tr>
<tr>
<td>b) contribute to local economic wealth</td>
<td></td>
</tr>
<tr>
<td>c) become a student’s first choice by championing the principles of access and equity</td>
<td></td>
</tr>
<tr>
<td>Curtin University of Technology</td>
<td></td>
</tr>
<tr>
<td>Queensland University of Technology</td>
<td></td>
</tr>
<tr>
<td>RMIT University</td>
<td></td>
</tr>
<tr>
<td>University of South Australia</td>
<td></td>
</tr>
<tr>
<td>University of Technology Sydney</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group of Eight (Go8)</th>
<th>Member Institutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>A coalition of leading Australian universities that has been operating since 1994 as part of the vice-chancellors informal network, until its incorporation in 1999</td>
<td></td>
</tr>
<tr>
<td>Research intensive universities that provide general and professional comprehensive education</td>
<td></td>
</tr>
<tr>
<td>The overarching aims of this group is to:</td>
<td></td>
</tr>
<tr>
<td>a) Enhance members contribution to the national economic, cultural, social and environmental well-being and prosperity</td>
<td></td>
</tr>
<tr>
<td>b) Extend members contribution to the generation and preservation of world knowledge</td>
<td></td>
</tr>
<tr>
<td>c) Strengthen the nation’s capacity to engage, benefit and respond to global and local developments and challenges</td>
<td></td>
</tr>
<tr>
<td>d) Expand the opportunities for Australian students within a world class higher education environment regardless of their background</td>
<td></td>
</tr>
<tr>
<td>Monash University</td>
<td></td>
</tr>
<tr>
<td>The Australian National University*</td>
<td></td>
</tr>
<tr>
<td>University of Adelaide</td>
<td></td>
</tr>
<tr>
<td>University of Melbourne</td>
<td></td>
</tr>
<tr>
<td>University of New South Wales</td>
<td></td>
</tr>
<tr>
<td>University of Sydney</td>
<td></td>
</tr>
<tr>
<td>University of Queensland</td>
<td></td>
</tr>
<tr>
<td>University of Western Australia</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Innovative Research Universities (IRU)</th>
<th>Member Institutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Established in 2003, this network of seven comprehensive universities commitment is to conduct research of national and international standing and apply collective expert knowledge, capabilities and resources in order to enhance the outcomes of higher education</td>
<td></td>
</tr>
<tr>
<td>The overarching aims of this group is to:</td>
<td></td>
</tr>
<tr>
<td>a) Build and provide a strong profile and voice within government in addition to other influential bodies</td>
<td></td>
</tr>
<tr>
<td>b) Enhance quality by sharing policy and practice</td>
<td></td>
</tr>
<tr>
<td>c) Create opportunities through partnership and collaboration for their student body and stakeholders</td>
<td></td>
</tr>
<tr>
<td>Charles Darwin University</td>
<td></td>
</tr>
<tr>
<td>Flinders University</td>
<td></td>
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<tr>
<td>Griffith University</td>
<td></td>
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<tr>
<td>James Cook University</td>
<td></td>
</tr>
<tr>
<td>La Trobe University</td>
<td></td>
</tr>
<tr>
<td>Murdoch University</td>
<td></td>
</tr>
<tr>
<td>University of Newcastle</td>
<td></td>
</tr>
</tbody>
</table>
### Table 3.1: Australian university groups cont.

<table>
<thead>
<tr>
<th>New Generation Universities (former)</th>
<th>Member Institutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Although this group had met on a number of occasions, up until 2006 the</td>
<td>Australian Catholic University</td>
</tr>
<tr>
<td>NGU had not formally established themselves and now no longer exist as a</td>
<td>Edith Cowan University</td>
</tr>
<tr>
<td>group</td>
<td>Central Queensland University</td>
</tr>
<tr>
<td></td>
<td>Southern Cross University</td>
</tr>
<tr>
<td></td>
<td>Southern Queensland University</td>
</tr>
<tr>
<td></td>
<td>University of Ballarat</td>
</tr>
<tr>
<td></td>
<td>University of Canberra</td>
</tr>
<tr>
<td></td>
<td>University of the Sunshine Coast</td>
</tr>
<tr>
<td></td>
<td>Victoria University</td>
</tr>
<tr>
<td></td>
<td>Western Sydney</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other</th>
<th>Member Institutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universities that opted not to align and / or identify themselves with</td>
<td>Bond University**</td>
</tr>
<tr>
<td>any of the sub-groups above</td>
<td>Charles Sturt University</td>
</tr>
<tr>
<td></td>
<td>Deakin University</td>
</tr>
<tr>
<td></td>
<td>Macquarie University *</td>
</tr>
<tr>
<td></td>
<td>Notre Dame University **</td>
</tr>
<tr>
<td></td>
<td>Swinburne University*</td>
</tr>
<tr>
<td></td>
<td>University of New England</td>
</tr>
<tr>
<td></td>
<td>University of Tasmania</td>
</tr>
<tr>
<td></td>
<td>University of Wollongong*</td>
</tr>
</tbody>
</table>

*Universities with no school of nursing  **Private university (not included in the study)

Adapted from:
Interview question sets and pilot study

My rationale for my research question design derived from the noticeable shift in the essential criteria required for academic appointments in nursing for prospective academics. As previously indicated, I had noticed that advertisements for such positions had shifted in so far as what qualifications were required for Lecturer A (L1), Lecturer B (L2) and Lecturer C (L3). These ranged from a generic statement of relevant postgraduate qualifications to a competed or nearing completion of a PhD for each of the levels. This raised a number of questions for me including (a) why, this was occurring in the profession and should it be (b) was, there a perceived or actual difference between academics teaching nursing and academics in other disciplines / professions, (c) what, if any, were the differences between disciplines and / or institutions and the possible reasons behind any such differences, (d) how, did the shift come about and was this also occurring in other practice disciplines and / or professions and (e) who, if anyone, believed it prudent to sanction this shift.

These questions raised the broader research questions of what is a nurse academic and what constitutes their professional identity. The use of language and the wording of the questions was also important for creating “sharedness of meaning” (Fontana & Frey, 1994, p. 371) where both myself as the interviewer and the participant understood “the context and nature of the interview” (Fontana & Frey, 1994, p. 371; Ryan, Coughlin & Cronin, 2009). The questions (eight in total) were developed in conjunction with the headings from the university profile questionnaire (see Appendix A) and were designed to follow a sequence of events. They were listed under four broad themes (as follows) each of which had a series of focused questions with sub questions and cues that would allow the participant to elaborate on a particular issue and / or “re-engage with the interview process if they lose their train of
thought” (Ryan, Coughlan, Cronin, 2009, p. 3) (see Appendix E):

a) Setting the scene focused on gaining background information on each participant and how her / his career pathway led to their current position in academia;

b) Exploring the possibilities looked for insights into how the participants identified themselves, their role and responsibilities within the tertiary sector;

c) Defining the path focused on gaining an insight into the participants views of the profession’s cultural, historical, political and economic background and influences in addition to their views on professionalism; and

d) Acknowledging the direction looked at obtaining an overarching picture of the participants’ views as to the educational trajectory of the profession, clinicians and academics along with their own plans for a career pathway.

The selection of questions was designed to gain the participants’ insights and opinions into their experience of being a nurse academic along with their views on nursing’s professional identity in the tertiary sector. The combination and use of open, closed and probing questioning techniques was designed to maintain a semi-structured and timely passage through the interview and to allow for the possibility to be open to new and unexpected data that may have arisen during this time.

Once the interview questions were confirmed, a pilot study with three nurse academics from within my academic network at the time, was conducted (the data was not included in my study). This was done to test the validity, reliability, relevance and length of time taken to answer the research questions prior to embarking on the actual participant interviews. The pilot study included two Lecturer B (L2) and one Lecturer C (L3) with a longevity of experience within academia ranging from three weeks (this participant was a sessional staff member prior to their appointment) to over 20 years. The interviews were audio-taped with an average length of 75 minutes,
with the shortest one timed at 57 minutes and the longest at 105 minutes. The significant and rich data obtained from the pilot confirmed that the interview questions were appropriate for my research topic and emphasised the need to explore this topic further. Furthermore, the pilot also identified a number of repetitive and somewhat irrelevant questions (see Table 3.2: Set 3 - Question 3a and Question 4a, 4c and 4d).

**Interviews**

The second source that I chose for my data collection was interviews. This method would allow me to understand and focus on the views and insights of the participating nurse academics on the creation and enhancement of a professional identity in the tertiary sector. The information obtained from the interviews would then be transcribed, reviewed and finally analysed.

Academics understand and acknowledge that interviewing (structured or semi-structured) is one of the more commonly used modes of research (Ryan, Couglan, & Cronin, 2009; Whiting, 2008). Interviewing and in particular “the individual interview is a valuable method of gaining insight into people’s perception, understandings and experiences and can contribute to in-depth data collection” (Ryan, Couglan, & Cronin, 2009, p. 309) which provided me with the appropriate and relevant strategy for answering the questions in my study. In-person semi-structured interviews, used in my study, are particularly valuable in providing the opportunity to observe and interpret non-verbal cues (eg. body language, facial expressions). In addition, they provide the flexibility for the interviewer to adapt their questioning approach which would permit clarification and / or the exploration of spontaneous issues (Ryan, Couglan, & Cronin, 2009) that may arise. The use of semi-structured interviews led to the collection of rich in-depth responses from the participants, while at the same time
remaining congruent and focused on the research questions and objectives (Clarke, 2006) across the number of interviews undertaken during my study.

The role of the researcher as the interviewer and the participant as the interviewee are also critical in this method of data collection. While this process may be seen as a conversation between two people, it is important to note that the relationship between the interviewer and interviewee is not equal (Kvale, 1996); as it is designed with the “distinct purpose that is constructed to derive meaning for a particular purpose” (Ryan, Couglan, & Cronin, 2009, p. 313). Therefore, establishing “rapport and trust from the outset” (Ryan, Couglan, & Cronin, 2009, p. 311) between the two parties is of the utmost importance (I discuss the role of the researcher further at the end of this chapter).

Notwithstanding the advantages of flexibility and relevance for “collecting information on participants’ experiences beliefs and behaviours”, interviewing can prove to be “time consuming, costly and have the potential for assumptions and bias” (Ryan, Couglan, & Cronin, 2009, 313). It was at this point that I realised that I needed to take into consideration any assumptions and biases that I may have. Based on my experience as an academic, I assumed that while the participants would be able to describe their career pathway into nursing and subsequently the tertiary sector I also assumed that there would be answers forthcoming to the remaining interview questions. I particularly focused on the outcome that I would be provided with a definition or description of a nurse academic including what constituted their professional identity as my belief of a nurse academic’s professional identity had been influenced by my own experiences of working and studying within the sector which may not have been the same for the participants. These issues were discussed with my supervisor at the time, as it was important that any of my potential biases were
minimised to support the study’s credibility and trustworthiness.

**Participant recruitment**

Once ethics approval was confirmed, recruiting my participants was undertaken via email sent through to the 33 SONM HoS / School Dean. My research participants were recruited from the sample tertiary institutions who returned the completed university profile questionnaire and confirmed their participation in my study. In addition to the invitation letter sent to the HoS / School Dean confirming their school’s selection, a participant’s information sheet (see Appendix C) and consent form (see Appendix D) and interview schedule was provided. The HoS / School Deans were requested to forward the information to her / his staff as a means of advertising for voluntary self-selected participants to be part of my study.

Interviews both in-person and / or via teleconference were offered. This was done in order to capture and maximise the number of participants and accommodate travel dates around the demanding workload and academic commitments of the participating academics. Participants who opted to have their interview via teleconference were requested to email their consent form prior to the scheduled interview. All the other participants signed their consent forms at the commencement of her / his interview. Each individual interview was carried out at the participant’s university office ensuring both privacy and a setting that was familiar and comfortable for the participant. Each interview was scheduled for one hour, with the option of a follow up interview if insufficient data was collected or any other unanticipated problems, such as a failed recording occurred. Only three participants opted for a telephone interview which were scheduled outside the assigned interview dates.

The demanding workload and academic commitments of staff created several difficulties for this study, including the withdrawal of universities along with
participants. Travel dates and interview times were altered on a number of occasions to maximise staff availability and participation at a number of locations. Finally, only one interview had to be re-recorded due to the recorder malfunctioning. Unfortunately, both the participant and I acknowledged the lack of richness in the information and data provided in the subsequent interview.

The interviews were carried out over a period of 21 months (September 2007-July 2009). Each of the 24 participant interviews were audio taped with a hand held recorder. Most interviews took the full hour allocated with the shortest being 45 minutes and the longest taking 75 minutes. Each interview commenced with introductions, an overview of the participant information letter and consent form including confirmation that the participant was happy to be recorded and clarification and /or questions, if any, they may have had prior to commencing the interview.

Once all the interviews at each institution were completed the audio-taped interviews were transcribed verbatim, initially by me (five interviews). However, due to time constraints and my own work commitments as a fulltime academic at the time, I employed a research assistant to assist and complete this task. A statutory declaration was signed between myself and the research assistant to ensure the security, privacy and confidentiality of all the participant information. Upon completion, I reviewed and checked each transcribed interview with the original audio recording for clarity and accuracy in transcription (Braun & Clarke, 2006). This was then returned to the participant for their review. However, it was at this stage that a delay of 6-12 weeks was experienced in emailing the transcriptions back to the individual participants for verification. While this proved to be a significant limitation, as certain participants could not accurately recall the context of the conversation, they all reviewed their respected transcripts which were returned with no amendments.
The data continues to be held within a secure location and will be destroyed within the time specified in my university ethics application.

**Data analysis**

While the processes of data collection are important, the interpretation of this information is essential to the construction of credible interpretive knowledge (Denzin & Lincoln, 2005, p. 205). As mentioned earlier the data in my study began with the university profile questionnaire followed by the participant interviews. This section describes how the data in my study was analysed; specifically, the university profile questionnaire process and the interview analysis including the coding process. Data from the questionnaire has been included in this section.

**University profile questionnaire**

As described earlier, the questionnaire was divided into two parts. Part A was divided into five sections: (1) organisational demographics, (2) course information, (3) academic staff information, (4) qualifications and promotion and (5) further comments. Table 3.2 provides the results from Part A of the questionnaire collated from the publically available information found on the 33 university websites and then sent to the 33 SONMs HoS / School Deans for verification and completion.

Part B sourced and listed the number of staff employed in the school and included their highest qualification. Once again, this information was obtained through the SONMs publically accessible website and was entered into the pre-completed questionnaire for verification by the HoS / Dean of the school. In this section the academic staff were listed in alphabetical order along with their highest qualification achieved as listed on the website. If no qualifications were listed, then a question mark (?) was placed next to the staff member’s name for clarification and
completion by the SNOMs contact person. Additional space was provided in the event that staff profiles were incomplete or more staff had been employed since the questionnaire had been posted. The results from this section showed that staff numbers ranged from a low of only six to 55; with qualifications varying from Registered Nurse (RN) hospital based training and / or bachelor degree only through to a PD or PhD.

Table 3.2: Part A: University profile questionnaire results

<table>
<thead>
<tr>
<th>Part A Criteria</th>
<th>Description</th>
</tr>
</thead>
</table>
| Organisational Demographics | ▪ Management structure included:  
  a) 42% identified themselves as a HoS appointment period: 3 years  
  b) 58% were identified as School Dean appointment period: 3–5 years  
  ▪ Number of campuses where the course was being delivered: 1–4 (domestic and international)  
  ▪ Undergraduate student intakes per year: 1–2 (each semester or trimester)  
  ▪ Postgraduate student intake per year: 2–3 (semester and trimester)  
  ▪ Undergraduate Annual Student Intake: 50–700+  
  ▪ Postgraduate Annual Student Intake: 60–200  
  ▪ Undergraduate Annual Graduating Students: 40–500  
  ▪ Postgraduate Annual Graduating Students: 60–170 |
| Course Information | ▪ Program commenced: 1974–2006  
  ▪ Length of time program in place: 2–33 years  
  ▪ Initial award offered:  
    a) Diploma of Applied Science  
    b) Diploma of Applied Science (Nursing)  
    c) Bachelor of Nursing  
  ▪ Current undergraduate course(s) offered (see Table 3.4)  
  ▪ Postgraduate courses offered (see Table 3.4)  

*Note: Due to the volume of information, the data for undergraduate and postgraduate courses have been collated separately and listed in Table 3.3. The table provides a comparison between all 33 universities, followed by the 15 questionnaires returned and the sample universities selected as part of the study.*
### Table 3.2: Part A: University profile questionnaire results cont.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Academic Staff Information</strong></td>
<td>• Staff Teaching Profile:</td>
</tr>
<tr>
<td></td>
<td>a) Undergraduate only: 3–46</td>
</tr>
<tr>
<td></td>
<td>b) Postgraduate only: 1–11</td>
</tr>
<tr>
<td></td>
<td>c) Both undergraduate and postgraduate: 5–50</td>
</tr>
<tr>
<td></td>
<td>d) Sessionals: 2–199</td>
</tr>
<tr>
<td></td>
<td>• Number of staff without a teaching profile: 0–24 from Level B to Level E</td>
</tr>
<tr>
<td></td>
<td>• Workload profile included:</td>
</tr>
<tr>
<td></td>
<td>a) contact hours: 5–35 per week</td>
</tr>
<tr>
<td></td>
<td>b) workload points: 50–336 per year</td>
</tr>
<tr>
<td></td>
<td>c) combination: contact hours and workload points</td>
</tr>
<tr>
<td></td>
<td>d) other: KPI’s related to research, by percentage and individual negotiation of contact hours related to teaching</td>
</tr>
<tr>
<td><strong>Qualifications and Promotion</strong></td>
<td>• Academic Appointment: 100% of all universities / schools required that staff:</td>
</tr>
<tr>
<td></td>
<td>a) address generic and</td>
</tr>
<tr>
<td></td>
<td>b) discipline specific selection criteria</td>
</tr>
<tr>
<td></td>
<td>c) criteria include nurses board registration, possess nursing undergraduate and postgraduate qualifications, teaching experience, interpersonal and conflict resolution skills, research profile and publications</td>
</tr>
<tr>
<td></td>
<td>• Academic Promotion</td>
</tr>
<tr>
<td></td>
<td>a) 90% of universities the generic criteria were readily available and accessible via the websites</td>
</tr>
<tr>
<td></td>
<td>b) 10% universities website access to this information was not permitted</td>
</tr>
<tr>
<td><strong>Further Comments</strong></td>
<td>• What do you perceive as they key pressures facing your staff in terms of:</td>
</tr>
<tr>
<td></td>
<td>a) Approach to nursing education</td>
</tr>
<tr>
<td></td>
<td>b) Being an academic</td>
</tr>
<tr>
<td></td>
<td>c) Professional development</td>
</tr>
<tr>
<td></td>
<td>d) Performance management</td>
</tr>
</tbody>
</table>

*Note: Due to the volume of information, the results for this section have been collated separately and are listed in Table 3.5*
Table 3.3: Course information

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Description (n = 33)</th>
<th>Questionnaires Returned (n = 15)</th>
<th>Sample University Participants (n = 5)</th>
</tr>
</thead>
</table>
| Current Undergraduate Courses                | ▪ 82% offered a Bachelor of Nursing
▪ 6% offered a Bachelor of Nursing Science
▪ 6% offered a Bachelor of Science (Nursing)
▪ 6% offered no undergraduate nursing course |
|                                              | ▪ Bachelor of Nursing
▪ Bachelor of Nursing in addition to double degrees
▪ Bachelor of Science (Nursing)
▪ Master of Nursing (Initial registration)   |
|                                              | ▪ Bachelor of Nursing
▪ Bachelor of Science (Nursing)
▪ Master of Nursing (Initial registration)   |
| Postgraduate courses – coursework*           | ▪ 42.4 % offered a Graduate Certificate in Nursing
▪ 85% offered a Graduate Certificate in nursing specialties
▪ 57.5% offered a Graduate Diploma in Nursing
▪ 78% offered a Graduate Diploma in nursing specialties
▪ 82% offered a Master of Nursing
▪ 82% offered a Master in nursing specialties
▪ 57.5% offered a Master by Coursework
▪ 3% no information was readily available |
|                                              | ▪ Variations of offerings within the postgraduate courses list                     |
|                                              | ▪ Variations of offerings within the postgraduate courses list                     |
| Postgraduate courses - research              | ▪ 76% offered a Master by Research
▪ 45.4% offered a Professional Doctorate in Nursing
▪ 97% offered a PhD                           |
|                                              | ▪ Master by Research
▪ Professional Doctorate
▪ PhD                                         |
|                                              | ▪ Master by Research
▪ Professional Doctorate
▪ PhD                                         |

*Most institutions offered more than one postgraduate award

Initial data collected November 2008 – Data reviewed November 2010 and February 2011 for currency

\(^1\) one of these also offered double degrees – Nursing with Human Movement or Public Health or Human Services Management

\(^2\) one had changed from a Bachelor of Nursing in 2008

\(^3\) one had previously offered a Bachelor of Nursing Science in 2008

\(^4\) one of these also offered double degrees – Nursing with Human Movement or Public Health or Human Services Management
In addition to the information in Table 3.3, a range of qualitative data was also provided by the school contact person under the final section of Part A of the questionnaire; “What do you perceive as the key pressures facing your staff in terms of” the following four subheadings: (a) approach to nursing education, (b) being an academic, (c) professional development and (d) performance management. Table 3.4 lists the comments collated from the 15 questionnaires that were returned.

Table 3.4: Part A: University profile questionnaire results – further comments

<table>
<thead>
<tr>
<th>Approach to nursing education</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Increasing students, class sizes and decreasing availability of clinical placements</td>
</tr>
<tr>
<td>• Maintaining knowledge base and clinical competence / workload at undergraduate and postgraduate level(s)</td>
</tr>
<tr>
<td>• Importance of incorporating a ‘research rich’ and ‘contemporary’ teaching and learning approach / assessments and achieving generic competencies towards registration</td>
</tr>
<tr>
<td>• Increasing changes occurring within the profession, healthcare and tertiary education</td>
</tr>
<tr>
<td>• Increasing competition to be unique / contemporary and meet accreditation</td>
</tr>
<tr>
<td>• Application, appropriateness and integration of technologies and flexible media to nursing education (eg. simulation, Web CT, online learning)</td>
</tr>
<tr>
<td>• Balancing required content (acute, complex and preventative) into a three years</td>
</tr>
<tr>
<td>• Importance to educate for the future (sustainability / retention) not just for current needs (‘we are teaching nurses not units’ and ‘emphasis should be placed on holistic nursing philosophy not on science’)</td>
</tr>
<tr>
<td>• Increasing importance to provide ‘ready to work litigious students’ in an multidimensional, increasing specialised nursing (and healthcare) environment</td>
</tr>
<tr>
<td>• Change in focus (‘the increasing medicalisation of nursing as a practice discipline and focus on providing physical labour at a time when a generation of IP is the main game’)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Being an academic</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The expectation to meet both scholarly (research), publication, university service, teaching loads / profiles and productivity in an increasingly competitive working environment</td>
</tr>
<tr>
<td>• Changing and increasing of workload allocations</td>
</tr>
<tr>
<td>• Increasing in staff age and salary gap between clinicians and academic educators</td>
</tr>
<tr>
<td>• Increasing in additional administrative duties</td>
</tr>
<tr>
<td>• Budget allocations, fluctuations and restrictions</td>
</tr>
<tr>
<td>• Increasing student numbers and class sizes</td>
</tr>
<tr>
<td>• Importance of attracting and maintaining high achieving staff and students alike</td>
</tr>
<tr>
<td>• Importance of evidence based practice and its application to teaching and learning</td>
</tr>
<tr>
<td>• Importance of currency in teaching, learning and clinical practice trends</td>
</tr>
</tbody>
</table>
Table 3.4: Part A: University profile questionnaire results – further comments cont.

<table>
<thead>
<tr>
<th>Professional development</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Allocation of time (‘time poverty’) and financial resources</td>
</tr>
<tr>
<td>▪ Importance of access to services and opportunities due to isolation of campus location</td>
</tr>
<tr>
<td>▪ Increasing importance of mentoring (‘not enough good academic role modelling as distinct from nurse educator behaviour’)</td>
</tr>
<tr>
<td>▪ Focus on community / industry engagement to increase staff clinical credibility as opportunities for staff to engage in clinical work is decreasing</td>
</tr>
<tr>
<td>▪ Increasing the opportunity for research and teaching development and expertise</td>
</tr>
<tr>
<td>▪ Increasing importance of leadership and management skills and expertise</td>
</tr>
<tr>
<td>▪ Rapidly changing teaching and learning technologies and trends (flexible delivery), their application and implementation</td>
</tr>
<tr>
<td>▪ Appropriate and relevant qualifications commensurate with academic position</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Performance management</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Increase and sustain staff research development profile</td>
</tr>
<tr>
<td>▪ Additional time and support for teaching and research</td>
</tr>
<tr>
<td>▪ To maintain workload within designated KPIs</td>
</tr>
<tr>
<td>▪ Development of an accurate workload policy to reflect actual work undertaken versus just hours allocated to activities</td>
</tr>
<tr>
<td>▪ The provision of evidence and recognition of good teaching</td>
</tr>
<tr>
<td>▪ Development of a sustainable and supportive system for managing poor performance</td>
</tr>
<tr>
<td>▪ Decreasing and monitoring the ever changing increasing responsibilities and expectations of staff (‘changing the goalposts’)</td>
</tr>
</tbody>
</table>

The questionnaire identified a number of similarities and differences between the participating universities. In Part A similarities included that each university offered both undergraduate and postgraduate awards, staff were allocated either a teaching and / or a non-teaching profile depending on their appointment, they had a predetermined workload KPI profile; and the qualification and promotion criteria, staff applying for academic appointments were required to address both generic and discipline specific selection criteria. The final section in Part A saw additional qualitative comments provided by the SONMs (see Table 3.4). These were reviewed and summarised as key issues under each of the four headings highlighting a number of similarities. The differences were mainly related to the size of the SONM which consequently determined the number of students, annual intakes and number of staff
employed (subsequent reviews of these numbers over the duration of my study showed fluctuations in staff numbers which appeared to be related to changes in the overall university structure and increases and / or decreases in student numbers).

Table 3.4 highlights a number of variations in the nomenclature of what is essentially the foundational undergraduate nursing degree. No rationale could be determined as to why each of the 33 SONMs chose to have varying baccalaureate award titles when the course content is the same as it is determined by ANMAC as the governing and regulatory body. All of this data was also used in developing the questions and cues used during the participant interviews.

**Sample selection: University**

The approach to selecting the participating universities allowed for geographical and group representation. While it was important to ensure all groups along with State / Territory were represented, the sample selection for both the university and participant was based entirely on the returns from the university profile questionnaires.

Out of the 33 Australian universities with SONMs, a total of 15 (45.5%) returned their completed questionnaires and 12 confirmed their willingness to participate in the interviews, two did not respond to the request for participation and one declined to participate. In addition, one university / school replied that although their preference was to participate, they were unable due to staffing and workload issues. From the 12 questionnaires returned, seven universities were selected for the second phase of the research with the intention that there was at least one from each grouping and that all states were represented. Although invited and despite a number of follow up emails, neither of the Australian Territories (Northern Territory and Australian Capital Territory) responded and / or returned the questionnaire and
therefore could not be selected to participate. Furthermore, after a number of reminders were sent to all 33 SONMs, no additional institutions replied confirming their participation. Once this was completed, an invitation letter (see Appendix B) and a travel schedule were sent to the HoS / School Dean of each participating school. Five out of the seven invited universities accepted the invitation providing a spread across all groups and States, except South Australia as they withdrew their participation, due to staff shortages. Once the selection process was finalised an invitation letter was sent to each participating university and SONM advising of the interview times and dates.

**Sample selection: Participant**

Once each self-nominated participant confirmed their willingness to participate, a consent form and a letter of introduction that provided the background and rationale for my research was sent to them. A total of 36 fulltime academic staff were confirmed with Tasmania having the majority of participants (10), followed by Queensland (6), Victoria (5), New South Wales (5) and Western Australia (5). However, several participants had to withdraw prior to their scheduled interview due to workload and teaching commitments. Follow up requests to reschedule interviews both in-person and / or teleconference, were declined for the same reasons bringing the final sample size to 24 participants across all academic levels.

The telephone and in-person interviews were scheduled and confirmed with each participant with a follow up email two weeks prior to the scheduled date. All interviews were audio taped, then transcribed verbatim and coded. To ensure the comprehensiveness and integrity the coded data was then grouped according to each of the question sets and by academic levels and then analysed for emerging and overarching themes. All interviews were scheduled, anticipating a maximum of six
interviews per site (equalling 30 interviews), encompassing a cross section of academic levels, inclusive of the HoS / School Dean or their representative / nominee. A representative sample from Level A (L1) to Level E (L5), including the HoS / School Dean and / or Deputy Dean was interviewed. While the demographic was predominately female (n = 21), three male participants were also interviewed (see Table 3.5).

**Table 3.5: Participant academic levels**

<table>
<thead>
<tr>
<th>Level</th>
<th>Percentage participation</th>
<th>Number of participants</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lecturer A</td>
<td>4.16%</td>
<td>n = 1</td>
<td>1 female</td>
</tr>
<tr>
<td>Lecturer B</td>
<td>33.33%</td>
<td>n = 8</td>
<td>8 female</td>
</tr>
<tr>
<td>Lecturer C</td>
<td>25%</td>
<td>n = 6</td>
<td>4 female and 2 male</td>
</tr>
<tr>
<td>Lecturer D</td>
<td>20.83%</td>
<td>n = 5</td>
<td>4 female and 1 male</td>
</tr>
<tr>
<td>Lecturer E</td>
<td>16.68%</td>
<td>n = 4</td>
<td>4 female</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>24</td>
<td>21 females and 3 males</td>
</tr>
</tbody>
</table>

Participants’ ages ranged from 37-65 years of age of which these had a wide span of experience from six months to over 20 years in the academic sector. In regards to qualifications, 54.2% (n = 13) were PhD qualified, 4.2% (n = 1) had a Professional Doctorate in Nursing and 4.2% (n = 1) was enrolled in a PhD. Of the remainder 21% (n = 5) were Master’s qualified, 8.3% (n = 2) were enrolled in a Master’s degree and 8.3% (n = 2) only had a Bachelor’s Degree in Nursing.

Total staff numbers (based on the university profile questionnaire), academic levels and gender were reviewed for each institution to establish a baseline and ensure that a representative sample across these variables was participating in the study (see Table 3.6. It was found that the sample size was not representative of the size of the SONM at each institution because of (a) the self-selection of staff participation and (b) the need to ensure representation across academic position levels.
Table 3.6: Representative participant sample

<table>
<thead>
<tr>
<th>University</th>
<th>Total Staff Number</th>
<th>Academic Staff</th>
<th>Participants interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>U1</td>
<td>51*</td>
<td>48</td>
<td>3</td>
</tr>
<tr>
<td>U2</td>
<td>30*</td>
<td>25</td>
<td>5</td>
</tr>
<tr>
<td>U3</td>
<td>45*</td>
<td>36</td>
<td>9</td>
</tr>
<tr>
<td>U4</td>
<td>24*</td>
<td>21</td>
<td>3</td>
</tr>
<tr>
<td>U5</td>
<td>44**</td>
<td>41</td>
<td>3</td>
</tr>
<tr>
<td>Total number</td>
<td>194</td>
<td>171</td>
<td>23</td>
</tr>
<tr>
<td>Total percentage</td>
<td>100%</td>
<td>88.1%</td>
<td>11.9%</td>
</tr>
</tbody>
</table>

*Staffing levels in 2008 at time of interviews  
**Staffing levels in 2009 at time of interviews

Interview question sets

I commenced each interview with introductions, an overview of the participant information letter and consent form including confirmation that the participant was happy to be recorded and clarification and/or questions, if any, they may have had prior to commencing the interview. I then reiterated that the purpose and structure of the interview and emphasised my interest in the participant’s views, insights and experiences (whatever that was) on the topic. By providing the outline of the interview question sets (see Appendix E) and highlighting the use of “open-ended questions” and cues, it allowed for transparency in the process and maintained the focus on allowing each participant “to tell his / her own story rather than answer a series of questions” (Ryan, Couglan, & Cronin, 2009, p. 310).

In order to “break the ice” (Fontana & Frey, 1994, p. 371) and set the scene, my first question set invited the participant to recollect and describe the sequence of events of their career pathway into nursing and subsequently into the tertiary sector
as an academic. This was followed up by more specific questions on the topic (and in line with the four overarching headings) and questions that intended to reflect and check the veracity of the statements (Fontana & Frey, 1994, p. 371) made by each of the participants’ generating a narrative account of their experiences.

Despite the structured approach of the interviews most, if not all, participants steered towards a more conversational approach. In some instances, this interview style allowed the participants to reveal additional information and insights related to the question; others however, tended to wander and veer off topic. A consequence of this approach was that sometimes a question was inadvertently missed. However, once the interview was transcribed and reviewed, I found that on most occasions the participants had actually answered the particular question elsewhere in the conversation as it was prompted by another. In addition, other than the obvious descriptive information provided by the participants through each of the question sets, I was seeking to identify any underlying inferences or nuances in what the participants were actually saying or possibly attempting to put forward. While the obvious disadvantage of the conversational approach was that participants sometimes veered off topic, nonetheless the interview question sets provided rich and in-depth descriptions and valuable insights concerning the professional identity of nurse academics by revealing the participants’ frustrations, disappointments, influences goals and achievements; and allowed them to foreground matters of importance to them and as a result additional areas of interest were revealed. These included critique on their perception of professional isolation, other colleagues’ academic practice, the academic system regarding recruitment of both staff and students, clinical colleagues’ views on academia and the siloing attitude held by nursing versus the possibility of multidisciplinary integration of its education and academics.
Each interview concluded in an appropriately friendly manner continuing the rapport and trust that had been developed and established during this process. Thus, the final question set was designed to not only signal the conclusion of the interviews but to offer the opportunity for the participants’ to provide their views on the ideal relationship between the academic and clinical habit, any specific recommendations and any additional information they may have wanted to add.

**Coding the data**

The next stage in my analysis process was to code the data. Once the interviews were transcribed, the participants and the interview question sets were allocated an identification and colour code. The universities and participants were numbered 1-5 and 1-6 respectively, in the order that they were interviewed. Each academic level was also numbered from Level 1 (L1) for Lecturer A through to Level 5 (L5) for Lecturer E. Each participant was allocated a three part code that identified the university (U), participant (P) and their academic level (L); for example U1:P2:L3 (see Table 3.7).

<table>
<thead>
<tr>
<th>University</th>
<th>Participant</th>
<th>Academic level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number 1 = U1</td>
<td>Number 1 = P1</td>
<td>Level 1 = L1 (Lecturer A)</td>
</tr>
<tr>
<td>Number 2 = U2</td>
<td>Number 2 = P2</td>
<td>Level 2 = L2 (Lecturer B)</td>
</tr>
<tr>
<td>Number 3 = U3</td>
<td>Number 3 = P3</td>
<td>Level 3 = L3 (Lecturer C)</td>
</tr>
<tr>
<td>Number 4 = U4</td>
<td>Number 4 = P4</td>
<td>Level 4 = L4 (Lecturer D)</td>
</tr>
<tr>
<td>Number 5 = U5</td>
<td>Number 5 = P5</td>
<td>Level 5 = L5 (Lecturer E)</td>
</tr>
<tr>
<td></td>
<td>Number 6 = P6</td>
<td></td>
</tr>
</tbody>
</table>

As mentioned earlier, the interview questions were divided in four sets and the responses to these questions were coded in the same manner as the participants. Each of the four question sets was allocated a two part code that identified the set (S),
the main question it was referring to in that set (Q) and a sub-question (a); for example S2Q2(a). Due to the conversational nature of the interviews, I carefully reviewed each transcript a number of times and manually colour coded each question for ease of extracting the participants’ information and to ensure that I had captured all responses that represented the same or similar viewpoint (see Table 3.8).

Table 3.8: Coding of interview question sets

<table>
<thead>
<tr>
<th>Set</th>
<th>Questions in each set</th>
<th>Coding</th>
<th>Colour</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Setting the Scene</td>
<td>1</td>
<td>Code</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Colour</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Exploring the possibilities</td>
<td>2</td>
<td>Code</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Colour</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Defining the path</td>
<td>2</td>
<td>Code</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Colour</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Acknowledging the direction</td>
<td>3</td>
<td>Code</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Colour</td>
</tr>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Interview analysis process

Once the coding of the participants and the question sets was completed, the transcription and initial proofreading of each participant’s interview commenced.

Before I began my analysis of the information from the interviews, I first read through and examined the transcripts in their entirety from each academic level (L1-L5) within each participating university. The transcripts were then collated, clustered and cross-referenced with each respective academic level across all five participating universities. These were then colour coded and re-read within this structure to confirm that all the interview questions had been answered, that I had captured all responses that represented the same or similar viewpoint and to start searching for any possible overarching themes that emerged.
Initially my analysis was driven by the headings of each of the four question
sets (setting the scene, exploring the possibilities, defining the path, acknowledging
the direction) where I was looking to ‘capture something important about the data in
relation to the research question’ that I believed represented “some level of patterned
response or meaning within the data set” (Braun & Clarke, 2006, p. 83.). This approach
led to identifying themes within that particular question set only with minimal
“analytic work done to identify themes across the entire data set” (Braun & Clarke,
2006, p. 85). Therefore, before I began the analysis of my participants’ interviews, a
review of what process would suit and subsequently be used for my study was
required. My decision on using theoretical, thematic analysis described by Bowen
(2009) and Braun and Clarke (2006) as a form of pattern recognition identified from
within my data, leading to emerging themes that are subsequently analysed allowed
me to identify, analyse and report the patterns or themes within my transcripts.

Specifically, I used Braun and Clarke’s (2006) six step process as outlined in Table 3.9:

<table>
<thead>
<tr>
<th>Phase</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Data familiarisation</td>
<td>Transcribing, reading, re-reading data and noting down initial ideas</td>
</tr>
<tr>
<td>2 Code generation</td>
<td>Coding interesting features in a systematic fashion across the entire data set then collating data relevant to each code</td>
</tr>
<tr>
<td>3 Searching for themes</td>
<td>Collating codes into potential themes and gathering all data relevant to each potential theme</td>
</tr>
<tr>
<td>4 Reviewing themes</td>
<td>Checking that the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2) that generates a thematic map of the analysis</td>
</tr>
<tr>
<td>5 Naming and defining themes</td>
<td>Ongoing analysis to refine the specifics of each theme and overall story the analysis tells; generating clear names and definitions for each theme</td>
</tr>
<tr>
<td>6 Reporting</td>
<td>Final opportunity for analysis, selection of vivid and compelling extract examples and analysis of these Relating back of analysis to research question and literature and producing a scholarly report</td>
</tr>
</tbody>
</table>

Thematic analysis has the benefit of flexibility to be used across a number of theoretical and epistemological positions that can “potentially provide a rich and detailed, yet complex account of data patterns” (Braun & Clarke, 2006, p. 78). Using a more structured approach and with further analysis by immersing myself in my data through the repeated reading of the participant transcripts in an “active way” where I was searching for meaning and patterns (Braun & Clarke, 2006, p. 99) proved to be the best option in identifying and condensing the themes that represented and shaped my study. By continually remaining open to what my participants were trying to convey and, at the same time, relating my data to the research questions and also reflecting on my own interpretations I uncovered that there was repetitious and overlapping of information in the data. This led to a restructure of the findings and discussion chapters and the themes being condensed down from 11 (across the four question sets) to two, namely Setting the scene (Chapter Four) and Creating academic identity (Chapter Five) with a number of subthemes and concepts to support these.

**The role of the researcher**

Accurately reflecting the participant’s story until meaning can be extracted is why my role as the researcher is a critical element in this study. The significance of being immersed in this study and having been part of the group as an academic cannot be under-estimated. Being one of the crowd, finding, transforming and writing the story that the participants’ created and conveyed, added to the knowledge base of my topic.

The self is always present in fieldwork. When researchers have experience in the topic or the phenomenon which they are researching (such as myself having been an academic), they have the ability to share the language of the participants and add
data from their own experiences, knowledge and background. Conversely, this background also has the ability to influence the interpretation of results and the data presented which may in turn create bias. However, researchers cannot exclude themselves from the data collection, analysis and reporting of the study (Holloway & Biley, 2011, p. 971). Walshaw (2010) calls this performing the self and writing oneself into the research. Finlay (2002, p. 971) believes that researchers become involved by being both reflective and reflexive; reflectivity meaning that the researcher takes a critical stance to their work once it has been completed whilst reflexivity is defined as “showing awareness of the importance of the research on the researcher and vice versa; recognising how values, assumptions and presence of the researcher (like myself) may impact on the data” (Spencer et al., 2003 cited in Clarke, 2006 p. 20); including their own reactions to the study, their position and location in the study and the relationships encountered.

The researcher can certainly become an important resource for the enquiry as they understand the feelings of their participants share a sense of camaraderie and indeed may and can draw from their own experiences to understand what message or information is being expressed / conveyed. The relationship between the researcher and the participants needs to be critically analysed as it can be difficult to have both a truly emic (insider) as well as an etic (outsider) perspective. In a sense, being a qualitative researcher means being both (Holloway & Biley, 2011, p. 972). In this study, my identity within the context of the interviews was collaboratively and contextually established from the outset as emic (insider). It was for this reason that I chose to use first person as the most appropriate approach for my study as it will allow the reader to understand the reason, setting and viewpoint I have assumed.

Whilst at the time of my study I was an academic, it was clearly established that
there were no formal or informal roles or relationships with any of the universities, schools or participants. Having been an academic at two SONM and during that time having undertaken a range of roles including teaching, administrative and management responsibilities gave both myself as the researcher and the study kudos and credibility. The participants recognised that I could identify with and relate to the issues they raised and the stories they told. Tannen (1989) believes that the power of storytelling is universally recognised as a “means by which humans organise and understand the world and feel connected to each other...” (p. 102-103). This was certainly a key element in providing the participants the opportunity to tell their story; as even though it was me in my role as the researcher who guided the study, it is also the researcher who is privileged to be offered the information by the participants. It was on this basis that I hoped that a mutually acceptable relationship would be established that would then encourage participants to volunteer information freely and ask questions, which would contribute to an open and candid dialogue.

As an insider, I acknowledged the need to be readily accessible and flexible due to the participants’ workloads and locations around Australia. The interview time and dates were negotiated and the option of telephone interviews was also offered as an alternative to meeting in person. This provided the opportunity for participants to be able to accommodate the designated interview times or reschedule any previous commitments that may have been in place in order to participate in the research. I ensured that the interview questions were readily available for participants to review, consider their responses and prepare prior to their interview. Only two L5s requested that the interview questions be emailed to them closer to their interview date; of which one stated that they were ‘...actually reading [the] questions...’ prior to the interview and made a point of saying that because of this, they “...must listen a bit
more and just see in what context [the] terms [academic and nurse academic] are used
[in my school by the staff] U5:P2:L5

Each account or report needs a good story. During my study an integral component of understanding the context and culture was the explicit use of dialogue in mutual storytelling held in a safe environment. As the researcher (and an academic at the time) I had the ability to share experiences and tell the participants’ story by providing a forum to not only highlight their desire to improve their professional identity (Holloway & Biley, 2011, p. 969). As some participants stated:

‘I feel that this is such an important subject and you have made me think about my perception, my job and academics. Your study is certainly worthwhile [as] it is an area that needs to be reviewed...’ U1:P1:L3

‘It will be fantastic to see your research, to see how academics perceive themselves in this area...’ U4:P1:L2

‘We could talk for days! I really look forward to seeing what you come up with’ U2:P1:L4

‘I’d be very interested to know whether there is a difference between academics who have come up through the hospital system and academics who have come up through the university system...being in the university system is a real privilege, I love it, I can’t believe I’m here’ U4:P4:L4

Conversely, the sharing of negative experiences diminished their sense of isolation (Glass, 2003); as one participant stated ‘it’s been a great opportunity to have a little vent’ U1:P3:L2

Writing the story

Writing gives form to the researcher’s clumps of carefully categorised and organised data as it links together thoughts that have been developing throughout the research process. The act of writing invites new ideas and concepts, stimulates new inspirations, creates new connections and provides the constructs for the meanings discovered through the research endeavour (Glesne, 2006, p. 171).

The structure of my thesis altered a number of times, particularly during the
data collection and analysis phase. Establishing professional identity as a key determinant for participants led to seeking out and selecting Bernstein’s work for the theoretical framework for the thesis. The structure was divided into two constructs; the first-order, being the participants’ own practically oriented interpretations of their reality and the second-order construct that consists of the more abstract, theoretical ideas, along with facts, where the researcher translates and transforms everyday meanings into scientific knowledge (Holloway & Biley, 2011, p. 972).

My role as the researcher is critical in the design, development and setting the tone for writing the participants’ story by transforming their words into something that is meaningfully connected to other participants’ stories. It is through the analysis of their stories that allows for the opportunity to not only understand the determinants of their experience but consider what might be done about it. As one participant stated, ‘I think it will be interesting to see what you’ve got at the end’ U2:P3:L3. ...and so the scene is set and the study commences...

...one hopes that one’s case will touch others. But how to connect?...One may merely know that one is not alone and hope that a singular story, as every true story is singular, will in the magic way of some things apply, connect, resonate, touch a major chord (Pachter, 1981, p.72 cited in Glesne, 2006, p. 173).

Where to from here

Findings and discussion chapters

Chapter Four and Chapter Five represent the two overarching themes and ensuing subthemes and concepts interpreted from the participant interviews. I chose to combine the findings along with their related discussion in these two chapters as I deemed it was fundamental that the information remain together. Included in each of these two chapters is a chapter insight by way of introducing the theme and the
analysis then goes on to present the findings through subsequent subthemes and concepts that include supporting comments from the participants’ interviews along with literature that supports and/or challenges the themes on the creation and enhancement of a nurse academic’s professional identity within the tertiary sector (see Table 3.10 and Table 3.11). The tables will be featured in each respective chapter and each section will be shaded to highlight the section being addressed. Chapter Six will discuss these findings further.

Table 3.10: Chapter Four outline

<table>
<thead>
<tr>
<th>Chapter Four: Setting the scene</th>
<th>Concept</th>
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<tbody>
<tr>
<td>Entering the tertiary sector</td>
<td>Participant background&lt;br&gt;The application process&lt;br&gt;Qualifications&lt;br&gt;Remuneration&lt;br&gt;Performance and promotion</td>
</tr>
<tr>
<td>Working in the tertiary sector</td>
<td>Experiencing the cultural shift&lt;br&gt;Deciphering roles and responsibilities&lt;br&gt;Academic preparedness&lt;br&gt;Academic leadership</td>
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Table 3.11: Chapter Five outline

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<th>Chapter Five: Enhancing academic identity</th>
<th>Concept</th>
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<tr>
<td>Defining a nurse academic</td>
<td>Confusion reigns&lt;br&gt;Self-description</td>
</tr>
<tr>
<td>Nursing: A profession or vocation</td>
<td>Discipline of nursing&lt;br&gt;Nursing academics</td>
</tr>
<tr>
<td>A matter of competence and credibility</td>
<td>Competence versus credibility&lt;br&gt;Dual professionalism, is it possible&lt;br&gt;Creating and enhancing a nexus</td>
</tr>
</tbody>
</table>
Conclusion

This chapter has presented the mixed method qualitative approach used in my study which included a two-part university questionnaire and participant interviews. The process of preparation, collection and analysis was described in this chapter along with the ethical considerations, the introduction and framework of the findings and discussion chapters and my role as the researcher.

Overall, the data from the questionnaire revealed a number of similarities and differences across all 33 universities related to course offerings at both undergraduate and postgraduate levels, the number of student intakes, graduations and staffing levels varied depending on the size of the SONM. My role as the researcher and academic at the time, proved to be invaluable as it provided me with kudos and established my credibility with the participants from the outset. They recognised that I identified with and related to the stories and issues raised throughout their interview which led to the establishment of a mutually acceptable relationship that encouraged the participants to volunteer information freely and ask questions which contributed to the open and candid dialogue seen throughout the following two findings and discussion chapters.
Chapter Four
Setting the scene

Chapter insight

This chapter considers the first theme *setting the scene* and will provide an account of the participants’ experiences, diversity and complexity of their career trajectory and pathways into nursing and subsequently the tertiary sector. This theme is divided into two subthemes: (1) entering the tertiary sector (2) working in the tertiary sector. The findings under each subtheme include a discussion which is substantiated by the participant’s comments along with the literature that supports the exploration of key elements and links surrounding the creation and enhancement of a nurse academic’s professional identity in the tertiary sector.

**Entering the tertiary sector**

The first subtheme presents the participants recollection of their initial education and training and entry into the tertiary sector as follows:

<table>
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<th>Sub-theme</th>
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<td>Entering the tertiary sector</td>
<td>Participant background</td>
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<td>The application process</td>
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<th>Sub-theme</th>
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<td>Academic preparedness</td>
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<td>Academic leadership</td>
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Participant background

Common to all my participants and central to building the broader picture and argument of my thesis was that they all trained to become nurses. Even though each participant’s account of their career choice and pathway into the tertiary sector varied, the common point was established by mandatory registration requirements for nurses post their initial training and/or education. Each of the 24 participants entered nursing either through the hospital based apprenticeship system or the tertiary sector. The majority 58% (n = 14) entered via the former system commencing their career at 17 years of age; while the remaining 42% (n = 10) of the participants selected nursing as their career path at university.

The decision by the majority of the participants (58%, n = 14) to become a registered nurse (RN) was taken for very practical reasons including the prospect of being remunerated whilst training, the limited options available to women at the time (eg. teaching, secretarial, bank clerk, nursing), tradition (where another female member of the family was a nurse), altruism and the sense of caring for another person. Another participant described how his entry into nursing came about by sheer chance, a career path that he had not previously contemplated:

‘I actually went to teachers college...I left high school with the intention of becoming a teacher...so I’ve always been interested in teaching...a friend suggested nursing...and I got into it without knowing anything about it’ U3-P3:L3

For the group of hospital trained participants, entering nursing having completed a previous degree was a rare event (although today this is common). Three participants however, did exactly that as they held degrees in arts, science and pharmacy with the most unusual being a degree in English Philosophy. These participants stated that the experience of completing a previous degree shaped their decision for choosing a
career in nursing education, whether in the clinical and/or tertiary environment.

While these 14 participants chose to enter the nursing discipline, they could not conclusively offer a rationale as to why they opted to do this (even for the participant who had a practical need to earn a living while pursuing other interests). However, when I analysed these interviews in their entirety it was revealed that the common theme of altruism, the need to care and help people featured at the forefront of their decision. Other themes and motivating factors included respect for the discipline itself, its impact on the wider community and the fact that each participant believed they could make a significant contribution through their expertise, knowledge and background. As this participant commented:

‘...I came to that after 15 years as a clinician...my driving force to science was my fury at the way nurses were not being taught and were being limited in their knowledge by statements like ‘well you don’t need to know that’. My perception at that time was that nurses were receiving science information in a way that ensured that they could not advance with their practice in those areas, they could only do what they were told...so I took myself off to do science degrees...so I could merge both things...’ U2:P1:L4

The remaining 10 participants completed their nursing degree by enrolling directly into the tertiary sector (whether it was a CAE or technical college (TC) that had merged or converted into a university). Their responses demonstrated their awareness and understanding of the differences between the hospital based apprenticeship system (training) and the tertiary based education model; and although they considered themselves ‘...lucky to be educated in the current [academic] system...’ U1:P1:L3 it did not stop, as this participant stated experiencing:

‘...some really horrible biases...from nurses who felt quite strongly that university training was not as good as the current ‘awesome’ training that was going through [the hospital system]’ U3:P2:L2

Following graduation from either the hospital based system or the tertiary sector, it was, and continues to be, expected that graduates will remain in the clinical arena in
order to consolidate theory to practice. This was then followed by the subsequent specialisation in a particular clinical setting along with the option and / or choice of promotion into middle and upper management levels after a period of time as previously discussed in Chapter Two (see Figure 2.1 and Figure 2.3). Regardless of the mode of entry into the nursing arena, once registration had been achieved, all participants worked in the clinical arena for a period of time from five to over 20 years (intrastate, interstate and / or overseas) before entering the academic sector. Each participant worked across a number of specialties including medical, surgical, burns, aged care, emergency, intensive care, maternity, orthopaedics, research, paediatrics, perioperative, mental health, community, humanitarian, middle and senior management and staff development.

Despite the different motivating factors and rationales on the participants’ decision to enter nursing, the main theme that began to emerge was the common interest in teaching. The participants viewed entering academia as an opportunity to further explore this interest outside the hospital environment. The majority of participants (n = 18), stated that at one time in their career (some as early as two years after graduation) they held a staff development educator and / or a clinical facilitator position. This came about through ‘a desire to teach’, ‘by chance’, ‘gravitated towards educational activities’, they ‘enjoyed and loved teaching’ or because they ‘actually enjoyed working with students’ and ‘found it rewarding’ that students could benefit from their clinical experience and expertise. The following participant had a more atypical approach to the attainment of their role as they were as they stated ‘leant on heavily to go into the school because the Head of School noticed that I was teaching...’

U2:PL:15. While another participant came into the role through chance due to their personal circumstances where they were ‘unwell [and] on light duties and was given
an opportunity to work down at [the] staff development [office]' U1:P1:L3. Overall, the
foremost reason identified by the participants for specialising as an educator was the
perceived inadequacy of the hospital based apprenticeship system‘; with participants
offering comments such as:

‘...I started nursing when I was 17 [years old] straight into the hospital system
and basically always felt that education was the key to everything. One of the
things that kept jumping out at me when I was dealing with a lot of the issues
was their [students] lack of knowledge and their lack of education...’ U1:P4:L1

‘...I knew that the education I’d had at the [hospital name] whilst it was held to
be the best available at the time, was appalling in terms of any notion of
education in theory or any link of theory to practice or any education
underpinnings...’ U2:P4:L5

This lack of knowledge base and application of theory to practice consolidation
provided an insight into some of the flaws associated with the hospital based
apprenticeship model of nursing education where the focus was on skills and tasks
versus an all-encompassing educational model. As these participants stated:

‘[I was] a clinical instructor for hospital based students and I found that very
rewarding in the sense [that] I encouraged the students to ‘understand’, why
you were doing what you were doing. There was more to this than just the
actual skill...’ U2:P4:L5

‘...I wanted to teach in nursing and I wanted to be able to meld clinical teaching
and research [because] at the end of my hospital training I felt inadequately
prepared for what the health work place faced me with...’ U4:P4:L4

Another participant (also hospital based trained but holding a previous degree in
science) highlighted a key interest in providing a solid foundation in the sciences in
that ‘...my connection was to science in nursing rather than nursing practice [which
appeared to be lacking]...’ U1:P5:L4. These comments suggest that, for the participants, it
was not simply a preference for teaching but a vision of the kind of education required
for nursing that drove them towards educational roles and subsequently into a career
as a nurse academic. As one participant stated:

‘...I was a hospital trained nurse and at the end of my hospital training I felt
inadequately prepared for...the health workplace [that] faced me. I asked to act as a clinical facilitator...I loved clinical facilitation, I really enjoyed the students...I wanted to develop further in the education field so I went to do my Master’s degree. I was working as a general nurse educator and then a clinical educator. Both of these jobs irritated me because of the thinking around them was...‘a good nurse does as she is told’ and I was teaching that...’ U4:P4:L4

For those participants who worked as nurse educators in the hospital setting, the end of the hospital based apprenticeship system meant a change to their role. However, the recollection from the following two participants was that there was no clear direction as to how and what this meant, stating that:

‘[The transfer] probably had more to do with the politics [and] the way this faculty was moved into the tertiary sector. It was picked up holus bolus from a CAE and dumped...we had a whole lot of refugees from teaching who had nowhere to go, had no great affinity, love or connection to nursing, but thought it was a good way forward. I ended up in a department like that and a group of us fought long and hard about nursing issues...’ U2:P1:L4

‘[I] picketed on the first picket line to get the transfer of [nursing] education into the tertiary sector. I was young and silly then, it seemed like a romantic thing to do probably...I was a charge nurse on a medical ward at the time and I remembered how I felt as a student and I saw I had lots of students on ward and I could see that it wasn’t an ideal system [hospital based] that they were experiencing and thought ‘yes this [tertiary education] would have to be better for them...’ U4:P2:L4

During the interviews, an additional career stage was identified (to those described in Chapter Two) which was the option to hold a joint appointment (employment) in both the clinical and academic arenas with either a clinical (eg. critical care, perioperative) or a purely research focus. The significant advantage of these kinds of initiatives has been to bring clinical expertise into the academic environment whilst simultaneously infusing research and academic rigor into clinical practice and vice versa. In a number of situations it has seen ‘clinicians and academics able to move in and out of each other’s domains and have shared domains’ U4:P4:L4 and provide academics with a link to the clinical arena in order to build a better relationship between the academic and clinical sectors which are consistent with nursing being a practice based profession.
However, this proved to be a point of contention with the participants attributing the lack of opportunity to engage in these positions due to the increased workload carried by nurse academics and the compromises being made in order to recruit staff (addressed further in this chapter). While joint appointments generally have a great deal of autonomy in determining their roles and research priorities (Holmes, 2011; Williams, Chaboyer, & Patterson, 2000); it cannot be limited (as some participants commented) to the perceived increase of the nurse academics’ clinical credibility as registered nurses with industry. The most important advantage of joint appointments would be to support dual credibility across both sectors and as this participant stated:

‘...create a nurse academic in its best possible sense [utopia]; to say [that] I’m a clinician and...an academic and I move within these spheres competently; [so] what I am learning in clinical practice and what I am learning in academia, I’m passing on to the people I teach. That would be a very exciting place to be and it would certainly I think that would be pretty exciting, if we could achieve it’

It is no secret that tensions still exist between the educational values of university based nurse education and the practice and workforce needs of hospitals. Promoting collaboration between industry and the tertiary sector has taken on a number of forms over the years, such as joint appointments and shared approaches to decision making and power, there continues to be the need to strengthen relationships between the two in order to bridge the gap. More nurses in the clinical setting need to be made aware of and actively encouraged to seek the opportunity to increase their qualifications and be part of a joint appointment that would enable them to become true partners in the education of nurses.

**The application process**

Intrinsic to the participants’ entering academia was the requirement to address essential selection criteria about academic as well as discipline specific qualifications.
The lack of suitably qualified applicants for academic positions in the early stages of the transfer meant that concessions on qualifications were a feature of the system and this was also evident amongst the participants in my study. A review and comparison of over 300 academic vacancies advertised by SONMs across Australia throughout the duration of my study confirmed that the level of expected academic selection criteria and preparedness has shifted since the earlier days.

Whilst the essential requirement to be a RN with current registration remained constant across all positions; the minimum qualifications required for a Lecturer A (L1), ranged from a completed postgraduate diploma, to a master’s degree; with some academic institutions requiring a completed PhD or equivalent for a L1 and / or Lecturer B (L2). Participants referred to this trend as ‘changing the goalposts’ and it was especially evident at L1 and L2 although this shift was also noted in various instances at Lecturer C (L3). Despite the evidence of these trends in the qualifications required for academic positions participant accounts suggest that nurse academic recruitment requirements are not always met or adhered to. During the interviews participants reported being headhunted for and appointed into particular positions despite not having ‘enough qualifications for the position...’ U2:P2:L2.

Another participant was initially employed as clinical educator / facilitator to supervise students in the clinical setting when they were approached to be an academic as they were ‘perceived as someone obviously interested in furthering themselves academically...’ U3:P2:L2. A number of participants commented that despite not having or meeting the qualifications required, they were advised in advance of potential positions being advertised and encouraged to apply; indicating that they would be a good candidate and / or that positions appeared to be ‘tailor made’ for them. Others explained their appointments were made by waiving the essential qualification criteria
and ‘...just got given it [the job] or basing it solely on their experience stating that ‘they didn’t seem to worry too much about [the fact] that I [only] had a BN and not a Masters...’ In contrast to this, there were participants who commented on how qualifications did matter at some academic institutions and SONMs as they underwent very rigorous and extensive application and interview processes with the lack of qualifications impacting on the level of appointment. Despite this, there were participants who were appointed into positions and academic levels without appropriate qualifications; while others were given a lower academic level until the successful completion of the required qualification and only appointed into the applied position when it became available.

This ‘changing the goalposts’ as the participants labelled it, brought into question the value of not only academic qualifications deemed necessary for particular levels but the recruitment process. What should also be noted is that no advertised academic vacancy that I reviewed throughout the duration of my study included the need for academics to have any educational / teaching qualifications. The participants’ responses to this suggested that this was regularly seen in nursing in order to, in some instances, ‘just’ fill vacancies or to appoint applicants that had the potential to achieve the necessary qualifications while employed at the lower academic levels. This has proven to have a historical basis as nursing was placed in this position as the majority of educators who transferred across from the hospitals came into the tertiary sector with no formal degree level qualifications. Employing and appointing staff to fill vacancies (without meeting the academic selection criteria) placed the profession in a significant predicament from the outset. As seen by the participants’ responses earlier, it appears that this practice continues to exist.

The expectation was that university education would be used “as a strategy to
elevate the professional status of nursing” and that the graduates produced would have “a broader base of skills and knowledge that would prepare them for employment other than in large institutions” (Happell, 2005, p. 1220). That the academics did not possess and as my study identified a number of them still do not possess the necessary qualifications brought about significant pressure by the tertiary sector to ensure that the advancement of teaching and research was occurring within a scholarly framework (Andrew et al, 2009). In addition, the ongoing nursing shortage continues to drive a decline in the number of clinical staff enrolling into higher degrees and this in turn will continue to adversely impact the recruitment pool for new academics.

Upon completion of the transfer of nursing into the tertiary sector in the early 1990’s a significant push was made to ensure that all nurse educators immediately enrolled in and attained academic qualifications at Master’s and PhD levels, in order to validate and legitimise the academic positions that they were appointed into and held. As discussed earlier, while participants stated that they were appointed into their position prior to completing the relevant qualification for their academic level (eg. Master’s degree a minimal requirement to be appointed into a L1 position while the minimum qualifications for appointment to a L2 is a completed master’s and substantial progress towards completion of a PhD and more recently a PD), an additional explanation for this was provided by one of the HoS / School Deans who pointed to the poor alignment between academic and industry levels of qualification and remuneration. In contrast to the lower academic levels, the application process, selection criteria and requirements at Lecturer D and E (L4 and L5) were consistent across all institutions and no accommodations or variations were noted by the participants at these levels or indeed in the academic vacancies reviewed throughout.
the duration of my study. The common elements included meeting university requirements related to experience in teaching, research and service in addition to criteria identified by the participants that included academic qualifications at PhD level, professional credibility, a publication and research profile, administrative and management experience, expertise in teaching at undergraduate and postgraduate levels, supervision of honours, Master’s, PhD and PD students along with a record of publications and successful grant applications.

The clear dilemma that emerged from accommodating concessions, the ongoing manipulation and adjustment of academic selection criteria and required qualifications at L1 and L2, have proven to be a disadvantage to early career academics. The appointment of underqualified nursing academics and the difficulties associated with nurturing their development poses a risk for nursing foothold in the universities. As the participants highlighted, identifying staff that possess the potential and the necessary attributes to be groomed as academics was occurring; this concept of ‘growing your own’ has still not been explored to its full potential. This concept could have significant merit and may resolve the issue associated with the recruitment of appropriately qualified staff. However, in order meet the mandate imposed by practice consolidation, the academic will need to be committed to undertake studies whilst working full-time in the clinical arena in their first year as an RN, in order to establish their practice consolidation and subsequent so called clinical competence and practice credibility. The option of encouraging the enrolment into Honours degrees and subsequently PhD particularly for increasing research capacity and capabilities could prove to be beneficial. Alternatively, supporting staff to enrol into a Master’s programme could also provide them with what would be considered a more grounded and structured approach to further education whilst consolidating practice.
In August 2009, the first Bachelor of Nursing at a Technical and Further Education institution (TAFE) intake was approved in the state of Victoria in Australia. Since making the move to the tertiary sector, Australia had been the only country where nursing education was only offered at university level. Nursing academics and the profession as a whole were appalled by the Victorian Government and the State Registration Board of the time. Strong protests against the decision by the RCNA and the Australia Nursing Federation (ANF) were made as the move was described as a backward step not only for nursing but its academics. “Many nurses were outraged, seeing this as yet another ‘nail in the coffin’ of education standards, and a ‘slippery slope’ to substandard clinical care (Shields, Purcell, & Watson, 2011, p. 315). Like the participants and the literature reviewed the conclusion was that, if a degree level preparation is a requirement for all other healthcare professions, it should also be a requirement for nursing. Nursing education should be conducted at the highest level of academia, delivered by highly qualified academics who are experts in their field, be underpinned by critical thinking, science and evidence based research; foundational requirements that have never been a part of the TAFE ethos (Andrew, 2012; Shields, Purcell & Watson, 2011; Watson & Thompson, 2008). While there may be valid transitional and developmental reasons for ‘changing the goalposts’, the participants’ responses from this particular question set revealed an undercurrent of annoyance and frustration in what can best be described as, disappointment that these compromises continue to challenge their own sense of integrity and professionalism.

The participants’ background and application process emphasised issues surrounding qualifications required to become an academic as part of their journey into the tertiary sector. With a focus on this, the next section will continue with their narrative and challenges they faced in relation to this issue.
Qualifications

...it’s evident that a paradigm shift from skills training to academic learning is necessary for nurses to remain current with new delivery systems, translation of evidence-based care into practice and the implementation of appropriate treatment modalities (Hader, 2011, p. 27).

The debate has raged for decades regarding what is considered the required level of education for professional nurses. In most disciplines, the pathway towards an academic career and scholarship begins with a discipline specific degree, progresses through to Honours or Master’s and finally doctoral level study (PhD). The traditional doctorate is widely considered to provide the entry qualification and criteria for the professional scholar (Allen & Lynne, 2006, p. 5).

For many nurses, including the participants, it was no secret that this was compounded by the difficulty of attracting appropriately qualified staff during the transfer of nursing education into the academic sector as senior nurses and educators were not used to teaching outside the confines of the hospital environment (Smith, 1999). For the large numbers of educators and tutors from the hospital based apprenticeship system now occupying nurse academic positions, the immediate attainment of academic qualifications that were recognised within the tertiary sector became necessary in order to consolidate and legitimise their positions. This was no different for the participants in this study who understood that in their academic positions and for their future careers they were expected and in some instances mandated to undertake and complete further academic qualifications. The majority of the participants fell into this category and they began enrolling into courses to obtain their academic qualifications once they secured their appointment within the sector.

The data revealed that the highest qualifications attained by the participants at the time of the interviews were as follows:
• 54.2% (n = 13) of L4 and L5 were PhD qualified
• 4.2% (n = 1) L3 had a Professional Doctorate in nursing
• 21% (n = 5) of the L2 were Master’s qualified; one was enrolled in a PhD
• 8.3% (n = 2) of the L1 and L2 were enrolled in a Master’s degree and
• 8.3% (n = 3) of the L1 and L2 only had a Bachelor’s degree in nursing

Studies conducted by Roberts and Turnbull (1996; 2002; 2003; 2005) go some way towards showing how academics in nursing measure up against this view. Of the 901 nurse academics employed across Australia in 1999, half reported having mainly clinical qualifications (in specialities such as midwifery, high dependency and mental health). Of these, 33% held a graduate diploma and 25% a Master’s degree in nursing and/or health as their highest qualification. This highlighted that most nurse academics were considered relatively underqualified even for appointments at L1 and L2. Furthermore, only one fifth of the total number held doctorates (PhD) leading to the under representation of nurse academics at senior levels and limited research/scholarly track records or publications (Roberts & Turnbull, 2002).

Rolfe (2007, p. 125) agreed that whilst obtaining qualifications that will meet academic criteria is important, he suggests that an academic with “a PhD but no Master’s degree has a less-balanced education, than one with a Master’s but no PhD”. While this could be considered in itself a relevant debate and research study in Australia; when applying this statement to the participants in my study it was revealed that of the 54.2% (n = 13) who were PhD qualified (a) nine had completed a Master’s degree (L3-L5), (b) two had completed an Honours degree only (L4-L5), (c) one had completed degrees in a different discipline (L5) with no Honours or Master’s qualifications and (d) one did not disclose any previous qualifications (L3). Only one L3 participant (4.2%) had a Professional Doctorate in Nursing and had not completed a
Master’s degree. One L2 participant had already completed a Master’s and was enrolled in their PhD (which was subsequently completed). While the majority of participants did meet the premise suggested by Rolfe (2007), their responses only related to addressing the academic selection criteria and requirements for a particular level and did not include their views or discuss the notion of a balanced education.

The relevance of these qualifications and in particular the importance of a PhD to the nurse academic is the starting point to explore their professional identity. The term doctor originally derived from the Latin docere, meaning to show or to teach and was based on, doctrina, a body of teachings and knowledge. In Australia the PhD has only been available since the late 1940s, with the first degree awarded at the University of Melbourne in 1948 and at Sydney University in 1951. Historically the degree was introduced to provide an education for the future staff of Australian universities and government research institutions and it was a wholly research qualification modelled on the English tradition (Ketefian & McKenna, 2005).

In the USA doctorates were a combination of coursework and research degree. In 1975 a case was made for a professional doctorate by coursework that “prepared nurses for practice”; as distinct from an academic doctorate or PhD that “prepared nurses to advance and teach the knowledge of the field” (Ketefian & McKenna, 2005, p. 3). The trend in Australia had been to steer away from coursework doctorates and remain with the PhD because of its clear focus on research training. However, the late 1990s saw the introduction of the professional doctorates in fields such as education, psychology, business and health science areas. Nursing in Australia remained with the research PhD for a number of reasons as it (a) met the economic imperative which was supported by the university funding model, (b) followed general trends with criteria that covered contemporary knowledge and practice, consequent changes to
healthcare, globalisation and the professional response, (c) was charged with preparing leaders who can think outside the square, stimulate creative problem solving in others, (d) provided the profession with a voice (and credibility) to claim and deliver a vision of healthcare, both inside and outside the confines of organisational and institutional boundaries, that recognises the essentialness of nursing (Ketefian & McKenna, 2005, p. 57), (e) provided an internal compass that created meaning to their work along with creating and (f) context, reflection on actions and willingness to engage in scholarship; as teaching in higher education is without a doubt a scholarly business and it requires scholarship by all who are employed within the academic sector (Harris, Farrell, Bell, Devlin, & James, 2008; Ketefian & McKenna, 2005).

The Roberts and Turnbull studies conducted in 2003 and 2005, showed that the trend towards gaining a PhD was increasing. Amongst the participants 54.2% held a PhD, which by design were not a representative sample. Possessing a higher degree is not only a key requirement for employment as a nurse academic but is also required for subsequent promotions and thus the possibility of becoming a leader within the discipline as a whole. While the data revealed that obtaining the necessary qualifications added to the burden of meeting university requirements of teaching, research and service; the participants perceived that the lack of educational achievement in so far as academic qualifications contributed not only in the difficulty attracting and / or promoting qualified academic staff but in their academic status and identity. As discussed in Chapter One, Bernstein argued that the lynchpin of professional identity lies in the practical workings of professional knowledge within the epistemic communities of the academy and as this participant stated:

‘If we’re serious about a body of knowledge...we need to honour the ideal from which the university has stemmed and that takes in hundreds of years of tradition...nursing schools need to be extremely careful that they do not
promote people into academic positions of clout when they are not academics...no-one should ever be appointed to senior lecturer position or above without some kind of research degree [as they have] not yet been transformed by the university experience...’ U4:P5:L3

However the nurse academics are not alone in this. There are a number of other practice based disciplines that also require that their academics to be qualified to practice and maintain their registration in their designated profession (including physiotherapists, occupational therapists and medical professionals). These are also disciplines less likely to have the qualifications expected of traditional academics. Unlike nursing however, disciplines such as law, medicine and engineering (to name a few), are less apologetic about it and more accepting of the difference. One participant believed that ‘...qualifications [and]...experience and intellectual capacity...’ U4:P2:L4 continued to be considered key factors for success in the tertiary sector. While another believed that

‘...being a nurse...you’re often three or four years behind because you haven’t had that single focus all the time...so we don’t see 26-27 year olds with PhDs in nursing...a career academic could and would and it’s possible in nursing but most people who enter nursing don’t enter nursing to become an academic, a researcher...in nursing most people come in to be nurses and really it’s not until they start nursing that they then probably consider where in nursing am I going to go...’ U3:P4:L4

Another participant echoed this view and provided an additional dimension stating:

‘...a lot of nurses come into academia to teach and they are not prepared to research, they don’t know how to publish, they may not know [how] to present...it’s very much the teaching that drives them...in that case I’d say they were ‘nurse educators’ rather than ‘nurse academics’... a lot of schools with nursing particularly the newer level Bs are ‘teaching slaves’, they don’t have time to pursue their own research or if they are pursuing it, it’s their PhD. So a nurse academic without a PhD is already behind the eight ball because they haven’t got what most academics will start with. A PhD is your gate opener for academia...’ U4:P4:L4

Whilst the theme of academic status and credibility (related to qualifications) resonated with the participants, the nursing profession, its academics and clinicians
also need to acknowledge and take responsibility for the fact that ‘historical baggage’ that continues to be carried has contributed to this outcome. One participant believed that:

‘...I think nurses have...dragged with them a portmanteau of baggage of inferiority...so I think lose the hang ups and just become academics...if they could just relax a little bit and accept that some of the research that has actually been done in the nursing discipline is as valid and in many ways, more valid than other disciplines that we’re just contributing to the great body of knowledge...there is no one who seriously doubts that nursing doesn’t have a place in the university ideal, simply because it is a discipline which is legitimate and in fact it’s able to...apprehend a whole range of methodologies and prevue’s and concepts...and clinical hands on stuff...which is more than enough to sustain any discipline...’

This suggests that there is room to create a somewhat different account of a nurse academic; one which does not overburden them with the need to be ‘all and more’ than what is expected of an academic generally (academic roles and responsibilities are discussed further in the next section). Notwithstanding the importance placed on qualifications (and practice based registration), remuneration was another key consideration and incentive by the participants, towards entering the tertiary sector.

**Remuneration**

When reviewing nursing’s past it is easy to be beguiled by the vision of lowly paid nurses motivated by a sense of vocation as they were considered part of the ‘cheap’ hospital labour workforce (Godden & Helmstadter, 2009, p. 2693). One immediate consequence of the lack of qualifications is remuneration and the lack of parity with salaries within and between the tertiary and clinical habitus.

A review of tertiary salaries across the academic institutions was readily accessible. The pay steps within each level were similar where all institutions had eight levels for Lecturer A, six levels for both Lecturer B and Lecturer C, four levels at Lecturer D and one level for Lecturer E. Each differentiated and had separate pay
scales for academic, research and sessional / casual staff with all disciplines using the same pay scale for Lecturer A through to Lecturer E; although the rates of pay for each level varied across each institution (in some levels as much as $20,000 at L5).

Academic salaries are all inclusive and unlike the salary for RNs does not have provisions for any additional allowances such as overtime, shift allowances, weekend / public holiday loading and salary packaging to name a few. Table 4.1 outlines the number of steps and salary range for each academic level along with an average salary across each level.

Table 4.1: Academic levels / steps and salary range

<table>
<thead>
<tr>
<th>Lecturer</th>
<th>Number of levels / steps</th>
<th>Salary range*</th>
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<tbody>
<tr>
<td></td>
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<td>(*Based on current 2014 / 2015 salary scales and rounded to nearest dollar and excludes 17% superannuation)</td>
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<tr>
<td>A</td>
<td>8</td>
<td>$59,000 - $89,000</td>
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<td>L1</td>
<td></td>
<td>Average: $74,000</td>
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<td></td>
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<td>The minimum entry level for a staff member with a PhD was at Step 6 across all institutions (range $73,000-$75,000)</td>
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<tr>
<td>B</td>
<td>6</td>
<td>$84,000 - $111,000</td>
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<tr>
<td>L2</td>
<td></td>
<td>Average: $98,000</td>
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<tr>
<td>C</td>
<td>6</td>
<td>$103,000 - $132,000</td>
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<tr>
<td>L3</td>
<td></td>
<td>Average: $118,000</td>
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<tr>
<td>D</td>
<td>4</td>
<td>$123,000 - $152,000</td>
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<tr>
<td>L4</td>
<td></td>
<td>Average: $137,000</td>
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<tr>
<td>E</td>
<td>1</td>
<td>$138,000 - $190,000</td>
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<tr>
<td>L5</td>
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<td>Average: $165,000</td>
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<td></td>
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<td>Additional allowance allocated to the staff member who held a HoS / School Dean position (range $17,000-$26,000)</td>
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</table>

Adapted from: Information correct as of April 2015

In the clinical domain, nursing salaries and conditions of employment have traditionally been and continue to be industrially driven and negotiated between the respective nursing union and individual employers both public and private (part of Enterprise Bargaining Agreements – EBA) within each Australian State or Territory. As a result, position titles, levels / grades classifications, salaries, additional allowances (eg. higher duties, in-charge, overtime, on call, shift allowances, weekend / public holiday loading, district, qualification, meal, uniform and laundry, salary packaging, bed capacity) along with the respective roles and responsibilities are determined without input from and collaboration with the profession to ensure consistency (see Table 4.2). Therefore, each State and Territory (along with individual jurisdictions) possess considerable freedom and flexibility in not only determining but creating positions, grades / levels (eg. Queensland has the RN (entry level) at Grade 5 while all other States and Territories have their RN (entry level at Grade / Level 1) and associated responsibilities without any reference to other jurisdictions; once again highlighting that industry drives economic imperatives (Duffield, Gardner, Chang, Fry, & Stasa, 2011, p. 46).

A review of nursing salaries across Australia was readily accessible: however, the classifications, number of pay steps / scales, salaries and position titles varied significantly across each State and Territory. These differences proved to be difficult to separate and table, unlike the academic levels / steps and salary range in Table 4.1.

Each State and Territory EBA differentiated their pay scales using two distinct classification terms: ‘level’ (ACT, NSW, NT, SA, WA) and ‘grade’ (QLD, TAS, VIC), with a number of these using both terms together along with additional ones such as ‘year’ (ACT, TAS, VIC), ‘category’ (SA), ‘increment’ (SA) ‘senior RN’ (WA) to further define and divide each level / grade.
The rates of pay for each level / grade varied across each State and Territory with one example being as much as $20,000 for an entry level / grade 1 RN between SA ($43,976) and WA ($63,770). Although differences were noted in Table 4.1 regarding academic salaries, the titles and levels were consistent nationally. However, this consistency was not seen in the nursing salaries in Table 4.2. Adding to the difficulty and indeed confusion, was that each classification (grade / level) had its own position title that did not correlate and / or correspond across Australia. While the differences in nursing classifications and salaries between the States and Territories was evident, this was not the focus of the study. The information was included to highlight the variations in remuneration and is indicative of the difficulties experienced and expressed by the participants in remuneration equivalence when transferring from one sector to the other.

Table 4.2 outlines the classification and base salary range for each nursing level and excludes superannuation, allowances (which would inevitably increase the salary across each level) and individual salary contracts for various senior staff outside the scope of the EBA. Furthermore, except for Queensland each State and Territory differentiated and had separate pay scales and classifications for Assistant in Nursing (AIN), Enrolled Nurses (ENs), Student RN / RM, Nurse Practitioner and research staff. As a means of comparison, and where possible, I have included the relevant information and a position title for each level for additional clarification.
Table 4.2: Nursing classification and salary range across Australia

(*Based on current 2015 salary scales in EBAs, rounded to nearest dollar, excludes superannuation and all allowances)

<table>
<thead>
<tr>
<th>Australian Capital Territory</th>
<th>Northern Territory</th>
<th>New South Wales</th>
<th>Queensland</th>
<th>South Australia</th>
<th>Tasmania</th>
<th>Victoria</th>
<th>Western Australia</th>
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<tbody>
<tr>
<td><strong>Level 1</strong></td>
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<tr>
<td>Year 1-8</td>
<td>$60,772-$81,180</td>
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<tr>
<td>Level 1 1-5</td>
<td>$55,766-$63,039</td>
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<tr>
<td>Level 1 1-4</td>
<td>$58,394-$59,447</td>
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<tr>
<td><strong>Assistant in Nursing</strong></td>
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<td><strong>Level 2</strong></td>
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<tr>
<td>Year 1-4</td>
<td>$109,381</td>
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<tr>
<td>Level 2 2.1-2.7</td>
<td>$63,039-$83,401</td>
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<td><strong>Student RN / RM</strong></td>
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<tr>
<td>Grade 1 Year 1-3</td>
<td>$96,756-$100,737</td>
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<tr>
<td>Grade 1 1-3</td>
<td>$86,882-$92,828</td>
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<tr>
<td><strong>Enrolled Nurse</strong></td>
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<td><strong>Level 4</strong></td>
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<tr>
<td>Grade 1 1-3</td>
<td>$106,466</td>
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<tr>
<td>Grade 1 1-2</td>
<td>$106,466-$110,937</td>
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<tr>
<td><strong>Advanced Practice EN</strong></td>
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<td><strong>Level 5</strong></td>
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<td>Grade 1 1-3</td>
<td>$86,689</td>
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<td>Grade 1 1-2</td>
<td>$106,466-$110,937</td>
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<td><strong>Grade 5</strong></td>
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<tr>
<td>Grade 5 Year 1-7</td>
<td>$64,052-$82,158</td>
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<tr>
<td>Grade 5 Category A-E</td>
<td>$72,850-$89,530</td>
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<tr>
<td>Grade 5 Year 1-4</td>
<td>$82,839-$86,689</td>
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<tr>
<td>Grade 5 4-6</td>
<td>$82,208-$99,325</td>
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<tr>
<td><strong>Nurse Unit Manager</strong></td>
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<tr>
<td>Grade 1 1-6</td>
<td>$109,381-$164,753</td>
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<tr>
<td>Grade 1 1-2</td>
<td>$117,039-$121,721</td>
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<tr>
<td>Grade 1 1-4 Clinical Nurse</td>
<td>$83,564-$89,481</td>
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<td><strong>Grade 7</strong></td>
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<td>Grade 7 1-2</td>
<td>$131,481-$136,195</td>
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<tr>
<td>Grade 7 1-2 Advanced Practice Role</td>
<td>$99,325</td>
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<tr>
<td>Grade 7 1-2 CNC, NUM, Nurse Educator, Nurse Researcher, NP Candidate</td>
<td>$102,609-$111,399</td>
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<tr>
<td>Grade 8 1.2 Nurse Practitioner (NP)</td>
<td>$115,531-$118,404</td>
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<tr>
<td>Grade 9 1-4 Assistant DON / DON</td>
<td>$120,613-$148,592</td>
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<tr>
<td>Grade 10 1-4 Director of Nursing (DON)</td>
<td>$117,924-$148,592</td>
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<tr>
<td>Grade 11 1-4 District DON</td>
<td>$120,613-$159,066</td>
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<tr>
<td>Grade 12 Executive Director of Nursing</td>
<td>$193,387</td>
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</table>

Northern Territory Public Sector Nurses And Midwives’ 2014–2017 Enterprise Agreement.
Nurses (South Australian Public Sector) Award 2002.
Nurses and Midwives (Victorian Public Health Sector) (Single Interest Employers) Enterprise Agreement 2012-2016.

Public Health System Nurses’ and Midwives’ (State) Award 2015.
WA Health – Australian Nursing Federation – Registered Nurses, Midwives, Enrolled (Mental Health) and Enrolled (Mothercraft) Nurses – Industrial Agreement 2013.

Information current as of December 2015.
In view of the salary differences, attempting to attract staff from the clinical arena into academia has proven and continues to prove to be a significant challenge. Remuneration equivalence and position recognition do not correspond (from the clinical into the academic) due to the essential qualification criteria required by the academic sector for each level. Whilst this chapter provides an insight into the participants’ rationale for entering the academic sector, the challenge and tensions associated with remuneration equivalence, along with qualifications, continues to be a major deterrent in attracting and retaining expert staff. In most cases, individuals who moved into academic positions came from senior clinical positions with an expectation that their salary will be commensurate to the previous clinical position held. However, they were confronted with the reality that this was indeed not the case; a reality that these participants’ found themselves in, commenting that:

’...to get told [that] if you don’t have a PhD you can’t even get beyond a Level A, so the salary drops...that is a challenge in both attracting people, keeping them and motivating them.’ \textsuperscript{1}\textsubscript{U1:P2:L5}

’It’s actually a phenomenal issue for me because my main goal for coming here was to get my Masters and to understand what goes on from a research and academic perspective. I dropped $40,000 in pay, so this year makes it $120,000 [as I have been here for three years]...so I will be thinking long and hard this year as to whether I’ll stay... academia just doesn’t pay very well and you’re not getting any overtime...so when you’re comparing what someone gets paid in industry versus what someone gets paid in the university, I don’t know how attractive it is for people to cross over...I feel like a bit of a fool for dropping that income to come here...hopefully I can make it worth my while, but I don’t know how...’ \textsuperscript{5}\textsubscript{U5:P3:L2}

’People come in expecting to be at very high levels in academia without any academic background and that’s a challenge for me as a HoS to employ staff who have got clinical credibility and expertise in positions that in some way equate to their clinical expertise but they no way equate to an academic background. I have struggled with that over the years but in the end I suppose I have walked a bit of a middle ground. I think you can match salary but in fact you’re not a senior lecturer or an associate professor if you don’t have the educational qualifications.’ \textsuperscript{5}\textsubscript{U5:P2:L5}

Another participant reported taking a deliberate and strategic approach in order to
gain what they perceived to be the appropriate level of remuneration without the necessary qualifications by accepting coordinator leadership roles and:

‘...argued for that and there was a precedent set by a previous staff member who hadn’t got a PhD but still got a LB, so they gave me the LB based on leadership... I had six months to go to do my PhD... and then applied for a job at [university name] as a LC and I got the position... I came back and said ‘hey I’ve been appointed as a LC, if you don’t match it I’m leaving’ and basically they said ‘we’ll match it on completion, not examination of the PhD’, so the day it [the PhD] was completed they promoted me. But you know in all honesty it’s the dirty way of getting it...’ U1:P1:L3

The issue of comparative remuneration between the clinical and academic sectors continues to be an ongoing debate. However, the key issue here is that the academic recruitment pool relies heavily on the clinical sector for its new academics. While, clinicians moving into academia recognise that they are moving into a very different working environment that has different criteria and qualification requirements; they hope and expect to be remunerated based on their clinical expertise and length of service (a common thread highlighted by the participants when interviewed). The role requirements and expectations may not, and in most cases do not, correlate with their skills. However, from a management perspective it is not considered unreasonable or uncommon that the remuneration should be commensurate with the number of years as an RN post initial qualification, in addition to clinical competence, expertise and recency of practice. Whilst this strategy would secure appointments in a tight labour market; it would need to be managed appropriately as it could be misconstrued as a way to manipulate a system that is clear on the standards required for an academic appointment just to fill vacancies. As this participant stated:

‘...to sustain academics... we certainly need to look at that’s it’s important to have a PhD to teach these subjects... [and] I don’t think we are being paid enough for what we are expected to do... I feel as a senior lecturer I am now at an equivalent level at what I was being paid five years ago as a nurse... so to attract new people into this [academic] profession we are pushing, pardon the pun, uphill to get people into these jobs. They don’t want to leave their 80
grand a year that they are sitting happily in with their shift work, to come back and earn 58 grand as a Level A year 8 academic! So the financial benefits of these jobs are certainly not equivalent as a clinical nurse and that is something that they need to address if they want to attract people into it...’ U1:P1:L3

Recognition in the form of professional rewards and remuneration that are commensurate with qualifications and experience are being sought outside the tertiary sector by nurse academics as a more lucrative alternative because ‘...you don’t have a job for life anymore [as] people are on contracts and they need to perform...’ U1:P2:L5.

Although the participants were aware of the possibility of salary matching, it needed to be negotiated on a number of levels as ‘walking the middle ground of rewarding people for their practice experience with a salary based that’s commensurate with what they were earning...’ can be done ‘... by appointing them at levels that academically they are not fit for...’ U5:P2:L5 was not. Remuneration will continue to be an ongoing issue given the dichotomy that has been created between increased value placed on practical expertise and experience versus meeting academic requirements.

As these participants’ commented:

‘...it’s already impacting as we can’t find staff as the dollar is the greatest draw card...I would like to be paid for what I actually do [and] my professional development portfolio will actually reflect that this year and every year hence forth...’ U1:P3:L2

‘...we’ve got to pay more...I mean there are some incentives...but [don’t] seem to be [in line] with the salary changes in the real world...I’m not sure that management [has] quite got the message yet...people aren’t fighting to come and work at universities...if you are getting paid a lot more out there, that’s [going to] immediately impact [here]...I think it’s going to be a huge challenge...’ U3:P1:L5

This issue could prove to be a catalyst to the erosion rather than the creation and enhancement of a nurse academic’s professional identity as it offers no incentive to articulate, enact and affirm their academic credibility particularly when they find themselves living in, across and / or between the two habitu; which in turn is also linked to performance and promotion requirements.
Performance and promotion

The participants working in the higher education sector worried about the impact of national and global forces on academic work. Much has been written about the likely effects of increasing competition, changing policy paradigms, funding mechanisms, quality assurance and similar regulatory regimes, the rise and changes of information and communication technology, along with additional workload expectations placed on academics by the universities themselves. The importance of human resource development was considered in this study within the context of how to create and enhance the nurse academics’ professional identity.

As mentioned earlier the participants steered their responses away from performance management to academic promotion. At the commencement of my study all 33 university websites were reviewed for their particular academic promotion requirements and criteria. Out of these, 30 required staff to have a minimum of three years in their position prior to being eligible to apply for promotion; one required a minimum of two years; whilst the remaining two did not stipulate a service period.

The selection criteria for initial appointments and promotions were found to be both generic and discipline specific; and they included professional registration eligibility and currency, research and grant profiles, relevant academic qualifications for the position level being applied for and / or promoted into, experience and expertise in teaching within nursing and a specialty to name a few.

In order to gain information on this issue, I reviewed the data provided from the final section of Part A of the university questionnaire, titled further comments (provided in Chapter Three) on performance management and found a link with what the participants were saying. Comments from the questionnaire included: (a) additional time and support for teaching and research to sustain staff research profile,
(b) maintain workload within designated KPIs, (c) development of an accurate workload policy to reflect actual work undertaken versus just hours allocated to activities, (d) the provision of evidence for and recognition of good teaching, (e) development of a sustainable and supportive system to manage poor performance; and (f) decreasing and monitoring the ever changing and increasing responsibilities and expectations of staff. Effective and efficient academic structures were found to be vital in assisting staff towards achieving their academic promotional objectives. Critical to the success of these structures was leadership where HoS / School Deans saw it as their responsibility to facilitate and drive the development of conducive academic environments so that when:

‘...you need to bring people in...[you can] help them to get their higher degrees and learn how to manage in an academic environment and help them get there quicker than [I did]’ \( ^{\text{U5:P2:LS}} \)

Very few responses were provided by the participants regarding performance reviews and / or appraisals. While I attempted to draw out information on this topic during the first question set (S1: Setting the scene); the participants steered the conversation and were more interested in providing information on academic promotion. Nonetheless, the responses received by the participants showed that staff did complete formal performance reviews and / or appraisals on an annual basis. However, participants at the L1 and L2 levels all agreed that it was a very confusing process to complete when compared to what they were familiar with in the clinical sector as they had no ‘support and direction’ found it ‘very egocentric and...still struggle with that three years later...’ and expressed frustration stating that:

‘...I hate them because someone comes down from [name of university’s main campus] puts their values on what is important when our values and perhaps our collective values [are not taken into consideration] we know that for a school of our size to stay afloat we [have to] work together, we never talk about this...’ \( ^{\text{U5:P4:L2}} \)
Equity and procedural fairness issues were also raised by the participants in the promotion process. There were only three participants who agreed (two L4 and one L5, two of which were HoS / Dean of their SONM) who regarded the process as objective with set criteria and promotion panels that recommended and approved academic promotions based on teaching, research and service performance. While there was sense of, what was described as, ‘game playing’ where staff were seen to be ‘groomed by some senior staff in the way to present themselves’ and others found it ‘quicker to threaten’ to leave in order to gain an ‘out of round promotion’, overall this ‘hugely complex’ process (that in some instances resulted in the loss of ‘good people’) had what was best described by this participant as:

‘...rules of the game...and the rules of the game are that there are very fair and open and democratically arrived at criteria for promotion...the same as every other discipline...’ U2:P4:L5

Responses of frustration, disappointment, discouragement from senior academics and shock were expressed by the participants over this process. They found that applying for advertised positions was a much quicker and certainly easier way to move up the academic ladder than going through the promotion process; as they were all aware of and unwilling, to complete the arduous and substantial application process. The data revealed that only one participant had gone through the formal promotion process and was successful by ‘working the system’. Two were not interested in academic promotion at that stage, one stating philosophical feminist reasons that ‘education has very much a masculine framework even in the titles of the programmes’ U3:P6:L2 and was content with their current role; the other believing that they ‘need to put in the time now and build up my research credentials and papers’ U4:P5:L3 expressing their belief and respect in the university ideal; while all but one of the L5 participants gained promotions or progressed rapidly through the ranks to the level of professor
because of the transfer of nursing education into the tertiary sector as there was a limited pool of qualified staff applying for positions at the time. The one L5 that had not come into the tertiary sector as part of the transfer applied and was successfully appointed into new positions rather than undertaking the promotional process to move up through the ranks. On the whole, it appeared that the L5s were not well placed to assist the lower academic levels to manage their promotion requirements as they themselves were less experienced in the process, considering their individual career trajectories. In addition, the lengthy process along with the attainment of relevant qualifications, teaching workloads and a substantial research profile have contributed to nurse academics, including the participants, opting out of being part of the academic promotion rounds.

**In summary**

There is no doubt that Florence Nightingale was universally regarded as the model agent for establishing nursing as an important element of the healthcare profession. Thousands of nurse educators in hospitals and subsequently academic leaders carried her legacy forward to consolidate nursing’s professional standing and ultimately, to position it as an independent and peer profession to medicine. Not unlike their predecessors, all the participants in my study considered themselves ‘change agents’ and ‘gatekeepers’. Wanting to further enhance the profession, its clinicians and academics, was the primary reason most of them opted to become educators within the clinical setting and then academics in the tertiary sector.

This section brought to the forefront the diversity and complexity of the participants’ backgrounds related to how and why they chose to enter the nursing discipline along with their subsequent career trajectories into the tertiary sector that led to their academic appointment. The participants’ entry into the tertiary sector
emphasised an undercurrent of annoyance, frustration and a level of disappointment surrounding the challenges to becoming an academic. The continual shift related to academic selection criteria including qualifications, subsequent appointments and remuneration, performance and promotion issues compromised and impacted on the integrity, professionalism and identity of these academics. Following on from Chapter Two, the information in this section identified qualifications and remuneration as key elements that contribute to the professional identity of a nurse academic. The next section continues with the participants’ narrative and will discuss the challenges they faced while working in the sector.

**Working in the tertiary sector**

The second subtheme in this chapter, presents the participants insights into working within the tertiary sector highlighted below:

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<td>Participant background</td>
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<td>Working in the tertiary sector</td>
<td>Experiencing the cultural shift</td>
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**Experiencing the cultural shift**

The transfer of nursing education into the tertiary sector produced new expectations, roles and responsibilities, accountability and additional stress for the educators moving into this new habit (Ioannides, 1999; Roberts & Turnbull, 2002). New academics entering the tertiary sector experience a role transition as many are
changing from clinical experts to novice academics. For those who have enjoyed years of expert status this change can be difficult to grasp. The task of combining teaching, research and university service is a daunting undertaking for those individuals who had primarily clinical nursing responsibilities in the previous roles. Hessler and Richie (2006) found that the significant levels of commitment and additional responsibilities of teaching and research requirements, for which they are not prepared, drove many nurses away from seeking an academic role.

As seen in the previous section, the participants entered the tertiary sector at various stages during the actual transfer. Some came from CAEs and some direct from hospital-based training with a minority having had prior experience of the university culture. Consequently, their initiation into the academic culture involved not only changes to their roles and responsibilities but significant adjustments to the educational ideals, values, standards and qualifications held by universities. As nursing education was no longer intrinsically linked to a particular healthcare facility, a shift in professional identity (from nursing educator/teacher to academic) and their sense of belonging to academia (and its associated traits of pride, loyalty and unique individuality to name a few) began to emerge.

The participants’ decision to move from the clinical environment into the academic sector was spurred on by their attraction to or aptitude for teaching as well as their commitment to becoming as they stated a change agent and gatekeeper in the profession. Their desire to work towards a common goal of graduating clinicians that held the discipline in high esteem and to provide the grounding and opportunity to alter the culture of nursing through accountability and professionalism, featured significantly throughout the interviews (the concept of a profession will be discussed in Chapter Five). As one participant stated:
‘We are jumping to the tune of a big workforce agenda. We are pumping students through who maybe, shouldn’t actually be getting into nursing. We are letting the tail wag the dog and we need to actually fight back on that...that comes back to that gate keeping thing...it’s not only saying to the students you are good enough to come into my profession, it’s also saying to the university these students, these applications aren’t good enough to learn to be in my profession...’

A key element related to the social construction of a professional identity is the importance placed on creating and working within a professional habitus. Nurse academics are part of two distinct yet equally important professional habitus; that of the nursing profession (within the clinical context) and the tertiary sector (within the educational and research context) (see Figure 1.1 in Chapter One). Entering or being a part of any organisation / profession / group requires a degree of socialisation into the culture, language, customs, required behaviours and communication styles of the group. Belcher (2005) defines socialisation into a new arena as “the process of learning the culture of a society (its language and customs), which shows us how to behave and communicate” (p. 284). The actual depth and complexity of being a nurse academic was reflected by the participants’ responses related to the socialisation requirements of working within the tertiary sector.

Professional socialisation is viewed as a method of controlling practice through professional education and training into a person’s chosen discipline; whilst at the same time inducting its students and practitioners into the discipline, culture and social norms (Germov, 2005). The move from the hospitals to the universities was not just defined by the physical relocation, but the social, cultural and intellectual status that came with entering the tertiary arena. Unfortunately, the transfer increased the uncertainty surrounding the hospital based nurse educators’ role and responsibility into this new world. No defined criteria or requirements were offered so the now new academics could establish themselves in this new working environment; challenges
that were experienced by the participant’s in my study when they moved from one habitus into the other.

Organisational culture and socialisation of its members is considered “one of the major determinants to an organisation’s effectiveness and success” (Kantek & Baykal, 2009, p. 306). Just like any organisation, nursing developed their specific culture as it encompasses and transmits to its students, graduates, practitioners and academics, assumptions, values, norms, beliefs, practices (both internal and external) and guidelines for behaviour that contribute to its effectiveness and professional profile (Kantek & Baykal, 2009). A strong organisational culture maintains social influences, moral and performance control, however the associated risks of embedded relationships, past-decision making and view of other professions can contribute towards resistance to change (Kantek & Baykal, 2009, p. 307); not unlike what was seen between medicine and nursing and the reaction towards the transfer into higher education. However, limited research has been carried out on the nursing profession and the academic’s identity within the context of SONMs (in the university setting) and factors influencing this particular organisational structure.

While the cultural expectations in both environments presented their own challenges (such as heavy workloads, attainment of qualifications, research and publication imperatives and organisational / institutional service as previously discussed); issues related to a change in the work environment also brings about changes in one’s role and responsibilities and subsequently establishing professional identity continues to be a challenge. Academics form the core of the SONM’s university organisational workforce, they are influenced by both internal and external stakeholders that ultimately, drive and direct the academic discipline. This is clearly the case in nursing which is regulated by external professional bodies that dictate
course content, accreditation requirements (eg. ANMAC) and registration (eg. AHPRA and NMBA) including the registration of those who become nurse academics. In addition, the dependence of universities on the clinical setting for student placements, also ties the new educational location to the old hospital-based apprenticeship system; highlighting that nursing is not completely free of its past. However, the specific culture of one’s hospital training has been replaced by the specific culture of one’s university. Amongst the defining features of university culture, was the group that the university was affiliated with (eg. Go8, ATN, IRU discussed in Chapter Three). As one participant commented:

‘One of the problems of working in Go8 is you have to meet Go8 standards. So to get a professorial appointment here is really hard work and to get any sort of promotion is really, really difficult because you are competing with leading lights, it all lines up [with] the established disciplines. When nursing landed in university we all had to scramble incredibly fast to get our degrees but...not all our staff have got PhD’s but if you had started this job with [a] PhD under your belt, what you would have been doing now would be quite different to what you’re trying to do [now, which is] an immense thing, teach, PhD all the rest of it...it has to impact...you have the runs on the board and you’ve still got to have the million bucks [in funding and grants] in your pocket and we [nursing] can’t get it’ U2:P1:14

Secondly, nursing was part of a broader healthcare faculty where medicine joined an existing faculty that led to the faculty changing its name ‘...now we are Faculty of Health, Medicine, Nursing and Behavioural Sciences so that was a testament to the size of the school and the importance of the school and the faculty’ U5:P2:15. Finally, only one of the SONMs was in a stand-alone nursing faculty that stemmed from political and economic reasons; where this particular university ‘was very property acquisitive’ and the property that nursing occupied at the time became a ‘bargaining chip’ to negotiate ‘a single faculty within [university name] only in the very late 90s U2:P1:14.

Research outputs (being measured against disciplines within the broader faculties and individual ones) were also considered significant to the success of the
discipline’s credibility and its professional identity within the university environment; along with the importance of title recognition through academic qualifications that related to credibility and status (as discussed in the previous section: Entering the tertiary sector).

Nurse academics continued to experience rising tensions between conventional university goals and industry priorities as the emphasis continued to be placed on academics to provide a more skill based approach (technical knowledge) versus increasing intellectual work through research (Andrew et al., 2009, p. 608). Part of the tension arose because nurses still considered nursing work as “sacred” (that which is dedicated, devoted exclusively, set apart, worthy of reverence and respect or is important and highly valuable; such as knowledge) and were concerned that the entire “essence” of this “sacred” work was being “corroded by the drive to academicise, what some disciplines (particularly medicine) perceived as “the non-academic” (McNamara, 2008, p. 465). This had also detracted from “the creation of a strong blueprint for the development” of nursing academia and its academics. While research has shown that nursing needs to maintain disciplinary boundaries (which can be crossed), the discipline needs to preserve a discreet body of knowledge that both underpins and allows for the profession’s expansion (Andrew et al., 2009, p. 608). Historical, cultural, political and most importantly economic influences have and continue to impact on this development.

The current culture, predominant structure and expectations within nursing education continue to encourage students that on graduation, they consolidate their learning within the clinical arena before pursuing further education. Becoming an academic is not provided as an option or a pathway at the undergraduate level; therefore the professional identity is lost as an integral part of the profession. This
creates a barrier to returning to the tertiary sector as limitations such as the cost associated with studying and loss and / or decrease in income can pose a significant challenge (Duffield et, al, 2011, p. 21). However, accountability does not only lie with the tertiary sector, industry also needs to be seen to actively encourage and support staff to enter academia. This in turn will lead to increased collaboration and the distinct view that both sectors are true partners which will increase the profile of the individual, the profession and introduce staff to the sector (as academics) that is responsible for delivering their future staff.

**Deciphering roles and responsibilities**

In this section, the participants’ responses conveyed their view on what they considered a nurse academic’s roles and responsibilities. Their comments covered the breadth of these roles and responsibilities such as ‘...an expert in your field...’, ‘...a leader within the profession...’, ‘...develops curriculum...’ and a ‘...body of knowledge...’, along with ‘...professional engagement within the discipline...[and] clinical credibility...’, ‘...a role model in the hospital of what an academic does...’ and ‘...the development and preparation of nurses at...registration...specialisation, research and beyond’. As one participant summarised well:

‘...it’s all encompassing; it’s not just about teaching theory or even teaching clinical practice. We have a responsibility...to attract people to the profession. A lot of it is self-promotion of what a wonderful profession we have...’

Not surprisingly, the responses provided by the senior academics at L4 and L5 were framed more generally and emphasised the larger purpose or vision of nurse education and academics. They related it back to having the ‘responsibility to research areas of concern in nursing and develop that side of themselves’ as this participant stated: ‘...as an academic we’re automatically leaders of our profession and we are automatically gatekeepers...we have got to be worthy leaders and we’ve got to be
worthy gatekeepers’...’ U4:P4:L4. Others attested that stimulating, facilitating and imparting knowledge formed part of the role and responsibilities of academics but also about ‘developing people who are going to be able to take on the challenges of healthcare into the future...not just producing students who can regurgitate knowledge’ U4:P2:L4. Significant emphasis was placed on the continued professional outlook to lifelong learning and ensuring that the graduates had the knowledge, skill sets and attitude moving forward as ‘we are not doing anyone any favours if we think let’s teach them a skill set and get them registered...’ U1:P2:L5

In contrast, the majority of the L3 and all those at L1 and L2 offered information that pertained directly to their specific academic teaching duties. Staff in the lower academic levels focused on the job rather than the reason for their actual job. They referred back to and focused on their teaching roles whether in the clinical laboratories or lectures and tutorials (on-campus or online) and ‘re-working the curriculum...developing the units as the particular units are studied...’ U2:P3:L3. These participants included unit / course coordinators (on campus and / or online) whose responsibilities included content and assessment development within each of their respected specialities, lecturing and tutoring and clinical placement coordinators. Only one L2 participant shared the L4 and L5 vision that part of their role and responsibility was to provide succession planning by educating the future clinicians and leaders worthy of the profession.

The emphasis on teaching amongst the Lecturer A and B was matched by the lack of emphasis on research and the focus on a maximum of two profiles, clinical and teaching due to the workload required in these areas. Only one participant chose to view their role as being more in line with a ‘project manager’ suggesting that the academic’s role and responsibility extends to more than teach nursing specific
knowledge and practical skills sets (such as communication, leadership and management, law and ethics to name a few). Advocating this view would avoid the belief that ‘stigmatises their thought process by always putting them within just a health / science model...’ and would enhance the professional identity of that of an academic.

While the participants at L1-L3 recognised that the higher the academic level, the more responsibilities and output was required, very few had a clear understanding or could articulate the differences between the roles and responsibilities for each of the different levels as they focused on issues closer to their own position and workload challenges. Information related to this also proved difficult to find during the literature search and what was located was limiting. Other than the individual position descriptions (which were reviewed by looking at advertised academic positions throughout the duration of my study) that offered details regarding that particular position; only one article by Vardi and Quinn (2011) discussing the promotion and scholarship of teaching and learning in higher education and two university websites had readily available information. A summary of this information is outlined in Table 4.3.

Vardi and Quinn (2011) advocated that one of the core principles underlying the position classification standards on which merits and promotions are based, is that as one progresses through the hierarchy of levels the scope of influence and responsibility increases as to the nature of the outputs expected. For example at L1 and L2, the outputs include appropriate teaching materials, assessment tasks and tools along with the provision of timely feedback and so forth. At L3, outputs include increasing levels of research and research products in the form of textbook(s) and journal article publications. At L4 and L5, outputs in relation to research, leadership
publications, grants and international work are expected to be increasingly more significant along with the added leadership roles (Vardi & Quin, 2011, p. 43) which was in line with the participants’ responses.

What I noted to be absent (in this limited information) was the inclusion and / or need for the academic to have clinical practice credibility as part of their role and responsibilities. Whilst Table 4.3 provides an extensive summary of the roles and responsibilities required by each academic level, that emphasised the workload issues identified by the participants; there was no indication to suggest that certain areas could be replaced with others, such as clinical practice or teaching being replaced by research and vice versa.

Table 4.3: Academic roles and responsibilities

<table>
<thead>
<tr>
<th>Lecturer</th>
<th>Roles and responsibilities</th>
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<tbody>
<tr>
<td>A L1</td>
<td>Undergraduate lecturing, tutoring, demonstrating, clinical supervision, fieldwork and associated activities</td>
</tr>
<tr>
<td></td>
<td>Subject / unit coordination</td>
</tr>
<tr>
<td></td>
<td>Development of own teaching and professional expertise</td>
</tr>
<tr>
<td></td>
<td>Service to own areas of teaching and research</td>
</tr>
<tr>
<td>B L2</td>
<td>Undergraduate and postgraduate unit / course co-ordination;</td>
</tr>
<tr>
<td></td>
<td>Honours / postgraduate lecturing, tutoring, demonstrating, clinical supervision, fieldwork and associated activities</td>
</tr>
<tr>
<td></td>
<td>Management / leadership of teaching units and sessional staff</td>
</tr>
<tr>
<td></td>
<td>Beginner research and / or publications</td>
</tr>
<tr>
<td></td>
<td>Capacity to contribute to the scholarship of teaching in relevant discipline</td>
</tr>
<tr>
<td></td>
<td>Service to the academic unit and its functioning and service at the school level</td>
</tr>
<tr>
<td>C L3</td>
<td>Course / Unit / Year / Program co-ordination; scholarship in teaching and learning</td>
</tr>
<tr>
<td></td>
<td>Development of curriculum / programs of study</td>
</tr>
<tr>
<td></td>
<td>Team management / leadership, a school wide initiative, a course, a year group</td>
</tr>
<tr>
<td></td>
<td>Teach effectively at all levels, including higher degree supervision</td>
</tr>
<tr>
<td></td>
<td>Mentoring of students</td>
</tr>
<tr>
<td></td>
<td>Service to the profession and the faculty</td>
</tr>
<tr>
<td></td>
<td>Research and publications and have the capacity to lead and manage small research teams</td>
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Table 4.3: Academic roles and responsibilities cont.

<table>
<thead>
<tr>
<th>Lecturer</th>
<th>Roles and responsibilities</th>
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</table>
| D L4     |   Development of curriculum / programs of study  
          |   Significant scholarship in teaching and learning locally or nationally  
          |   Management / leadership of an organisational unit, a large team, a faculty wide initiative; mentoring of colleagues  
          |   Research, publications and significant service to the university, profession and discipline |
| E L5     |   Distinguished scholarship and contribution in teaching and learning at all levels, nationally or internationally; maintenance of academic standards  
          |   Management / leadership of a large organisational unit, a university wide initiative, policy development, community affairs, excellence in teaching and research  
          |   International recognition; capacity building  
          |   Research, publications, grants and significant service to both the University and the community |

Adapted from:  

The participants all agreed that teaching, research and practice are intrinsically linked in that ‘...research and teaching are part and parcel of being a nurse academic...’ U2:P2:L2, ‘...research is very much involved in clinical teaching...’ U1:P3:L2 and that ‘...the research you are doing should be impacting upon the teaching and vice versa...’ U4:P1:L2 as it is evidenced based’ U5:P3:L2; as it is ‘only when we start questioning can we get better practices [and] outcomes...’ U5:P4:L2.

McNamara (2010c) believed that clinical practice and academic education are central to both educational and research activities stating that if this does not occur, the relevance of the profession’s future trajectory as a distinct academic discipline and its academics will always be questioned. Participants reflected their agreement, highlighting that there is ‘...not just a relationship [between these entities] but [an] embodiment...’ U4:P5:L3; and that a direct relationship exists between the two areas as ‘good teaching is based hopefully on sound research that informs how teachers should
**teach and link critical thinking decision making and the intent to practice safely...**’

Furthermore, in any academic role ‘the research arm should feed your teaching arm [and they both should feed] your service arm...’ This encapsulated the direct correlation between the three entities (teaching, research, and service) and emphasised the multiple roles and responsibilities (including the concept of a gatekeeper and change agent) that nurse academics undertake along with the tensions and challenges that these bring.

Overall, while the participants were clear in describing their roles and responsibilities related to teaching, research and university service; there was a notable tension regarding the relationship between them. This tension was found to be both intrinsically and extrinsically linked as the pressure of trying to balance their roles and responsibilities which had a domino effect and impacted on their academic workload, as this participant offered:

‘I am very keen on research and the nursing academics role in progressing the profession because...that is why we are at a university, otherwise we might as well be working at TAFE if we are not driving knowledge in our discipline...that is our responsibility...sometimes it is easy with all the teaching workloads to forget if we don’t do the research...who is going to do the research. Trying to do the research ourselves but trying to inspire our students to do honours and consider research as a pathway for them as well is very important...’

From the participants’ responses, while teaching was considered a central aspect of their role and responsibilities (Pennington, 1986), it was found that academics overall valued research over teaching that led to an increased separation rather than integration of the two roles. The major challenge to the ongoing evolution of the academic’s professional identity continued to be the need to find the optimal balance between research / scholarship and clinical practice and credibility as it differentiates between vocational and professional status (Andrew, 2012; McNamara, 2010c). The ongoing debate for professional academic achievement; “has been overlooked in the
pursuit to achieve technical competence” (Andrew, 2012, p. 846). Unfortunately, the difficulties that nurse academics face in balancing the four-fold demands of the academic role – clinical, administrative, research and teaching are not easily resolved (Dickinson, 2005, p. 61) leading to the underlying premise of expecting these professionals to be competent in two distinct roles, academic and clinician (this will be further discussed in Chapter Five).

Rose and Glass’s (2009) research into the emotional wellbeing and its relationship to contemporary nursing practice admit that the practice environment for nursing worldwide is characterised by a work more for less phenomena. They found that limited human and material resources along with time constraints, teaching and administrative demands, student needs, office interruptions and lack of collegiality are common place. The same is seen in education as these services are affected by increasing corporatisation leading to a connection between the stress amongst nursing academics associated with increased workloads and outcomes for practice and productivity (Cumbie, Weinert, Luparell, Conley, & Smith, 2005, p. 289; Rose & Glass, 2009). Therefore, it was not surprising that the participants expressed similar concerns related to the workload requirements and expectations placed upon them that came with no additional recognition, remuneration and / or any other reward or benefit; such as paid overtime as seen in the clinical sector or a planned workload across semesters to accommodate and achieve academic expectations (eg. research, management and operational requirements dependant on position).

Nurse academics have an important responsibility in preparing future nurses for the profession and improving the quality of patient care; balancing their interests in teaching, practice, research, publication and professional interests in order to sufficiently develop their expertise and profile. However, it is evident that a number of
roles and responsibilities expected from nurse academics are sometimes outside their scope as an educator and/or their nursing expertise. While many (including the participants) are endeavouring to meet these expectations by working excessive hours and carrying heavy workloads (Gromely, 2003; Worrall-Carter & Snell, 2004) it is not conducive to maintaining their professional and personal development. Subsequently, this then impacts and skews their views on professional identity and as seen by the participants’ responses, resulted overall in a decrease in job satisfaction (Gromely, 2003; Worrall-Carter & Snell, 2004). Research conducted by Gromley (2003) on factors/predictors on this issue amongst nursing academics included professional autonomy, expectations, considerations and behaviours by leaders, role conflict and ambiguity along with organisational climate, culture and characteristics. The nursing profession needs motivated, qualified and well prepared academics as satisfaction with educating future nurses and being involved in local, state and international scholarly activities are important factors in recruiting and retaining nursing academics.

**Academic preparedness**

Critical to undertaking the roles and responsibilities associated with a nurse academic is the notion of being adequately prepared. Hashem (2007) believed that the “lack of academic readiness, while it does not and will not prevent the establishment of a discipline in the tertiary sector [it] will most certainly adversely contribute to the effects of its trajectory and subsequent development” (p. 382).

Being prepared to work within the tertiary sector brings with it designated workloads and the additional pressure of practice credibility (discussed further in Chapter Five). Therefore, nursing academics need to stop looking, comparing and contrasting themselves to nurses within the clinical context and begin identifying themselves as professionals that need to fulfil academic requirements just like other
disciplines in the sector. Mosel-Williams (2000) suggests that whilst the notion of “mirroring others” (p. 19) to meet necessary requirements and criteria was initially used as a basis to support equivalence of academic profile for nurse academics, this continues to be an ongoing issue. Both the literature reviewed and the evidence seen in the participant responses (discussed in the previous subtheme) highlighted disparities associated with the minimal qualifications required by nurse academics. Studies showed that students believed that teaching students from a clinical perspective was more important than gaining academic qualifications, in readiness to enter and indeed the capacity of preparedness within the academic realm. The focus on academic credibility was overshadowed by the need to maintain clinical credibility even though this was fast becoming detrimental to attracting well prepared and qualified academics (Mosel-Williams, 2000).

Critical to academic preparedness is acknowledging the difference between educating future clinicians and training (in the vocational sense seen as part of the hospital-based apprenticeship system). The transfer saw nurse educators having to not only work in this new environment that expected them to conduct themselves as academics, a concept that was foreign to the majority of the participants in this study on their entrance to it (and continues to be for new academics); but also shift into a new way of educating, future RNs. Dearden (1986, p. 71) succinctly stated that education is “...a matter of coming by principles, conceptual schemes, awareness of the reasons why of things, understanding in breadth and depth” (p. 71); and that the concept of “education” emphasised awareness and understanding, whilst “training” referred to the acquisition of skills and behaviours designed to establish competence in performing certain roles and tasks (Happell, 2005, p. 1219). This distinction was a critical point that participants identified stating that:
‘We educate...not train the neophytes into the profession and contribute to their professional development...contribute to the knowledge or applying knowledge in the clinical area. It’s both research and education...and also supporting clinicians along the way...’  

‘I’m not an apologist for academia. I’m clearly a believer in a rigorous education that is not training’

The education of RNs in the universities aimed to provide them with the skills and knowledge to work from an evidence base in a professional manner. Therefore, the change of emphasis from training to education was viewed as significant and the academics were able to encourage the students to become change agents in their own right (Happell, 2005, p. 1219; Heath, 2001, p. 109). Many participants reported a degree of reality shock as the gulf between their perceived expectations of academia and actual reality began to become apparent. Moving from an area of clinical expertise into the tertiary sector added further pressure as it challenged the academic’s self-esteem and self-confidence in so far as their professional credibility as they no longer actively nursed or taught within a hospital environment. The perceived ‘flexible, wonderful life’ of an academic was thought to be ‘a lot easier than their current life as a clinician, doing shift work [and] hard physical labour’.

The impact of these expectations on the academics cannot be ignored. While all participants looked for a supportive environment and mentoring that would socialise, nurture and guide them into this new working environment, this was rarely offered or provided. Instead, what they were faced with was that they would ‘hit the ground running’ and that they would find their own way. The result was confusion and isolation in what was described by this participant as a ‘chaotic system’.

McNamara (2010c) asserts that established academic leaders in nursing need to ask themselves why it is that so many of their undergraduate and postgraduate students and nurse educators “are judged ill prepared to pursue academic careers” (p.
Whilst it is expected and in some instances required that “individual nurse academics must take responsibility for their own intellectual formation, the problems confronting many novice” and even current academics are also likely to be compounded by “structural and personal” deficits related to “their own educational preparation; along with the weak academic infrastructures of the universities” and the schools they have joined (McNamara, 2010c, 383).

**Academic leadership**

...identifying individuals with the ‘right stuff’ to be leaders is more art than science as personal styles of superb leaders vary with some being subdued and analytical whilst others shout their manifestos from the mountain tops...suffice to say that different situations call for different types of leadership (Goleman, 1998, p. 93).

Within the context of academia, Kerfoot (2003) believed that “the leader who is the teacher can inspire and motivate people to crave knowledge and to grow into a better person” therefore “...if you can’t teach you can’t lead” (p. 149). The participants discussed this issue within the context of the tertiary arena and academic levels. They believed that in order to be appointed or promoted at the higher levels, a certain level of expertise, including qualifications, research experience, publications, leadership skills and commitment would be required. The importance placed on qualifications was seen to determine professional leadership and identity amongst academics and clinicians alike and avoided the label that nursing was ‘considered to be [just] a bunch of skills’ (U4: P3: L3). The completion of higher degrees was also linked to future academic standing and credibility and the need to, as this participant stated:

‘...bring people in who’ve got sufficient practice expertise to be credible [and] at the same time have an academic background that is acceptable and can stand without apology with other academics...’ (U5: P2: L5)

Academic leadership was also linked to teaching and research as it was ‘important that one teaches [and] has an opportunity to use one’s research [in] one’s teaching...’ (U2: P4: L5)
and that as this participant stated:

‘...the ideal of the university by the time you reach an Associate Professor or Professor level is that you ought to be primarily doing research...some hands-on teaching which is beneficial to all, but predominately you are the leaders...and by leading I mean, you transverse a pathway that is adding substantially to the body of knowledge and that is going the necessarily entail extra research work...’

It would be argued that “as universities increasingly recognise the value of diversity in the roles of academic staff” (Vardia & Quin, 2011, p. 40); selection criteria will become more flexible to accommodate the recruitment and retention of staff. However, “there is also the risk that, in an era where issues about staff productivity are high on the agenda, university management might be failing to make its expectations clear to potential staff and its academics” (Vardia & Quin, 2011, p. 40) as discussed in Chapter Four and seen in the section on roles and responsibilities. The sections on qualifications, performance and promotion identified differences and inconsistencies amongst academics and as Thompson (2006) asserted the impact of this is that if the academic leadership (professoriate) “is not rigorously appointed (as many do not fit the usual criteria for these positions) and those that are, deny their nursing roots, then they are simply watering the seeds of professional destruction” (p. 125); and ultimately professional identity.

All of these issues have implications that have impacted and could continue to impact on academic staff reaching the more senior academic levels and becoming future academic leaders. The difficulty in recruiting and retaining ‘people in [and] at [each of] those levels with those sorts of skills is not easy...’ The participants viewed that mentoring and role modelling as a form of academic leadership (seen to be lacking in their view) could prove to be “a successful strategy for fostering a collegial, caring environment” for current academics. It could also prove valuable and
assist new academics regardless of level and/or clinical expertise, enter a conducive environment where they can “raise concerns about their lack of understanding of the hierarchy of the organisation, lack of clarity about their new role, and whether they are undertaking it effectively” (McArthur-Rouse, 2008, p. 402).

Mentoring and role modelling was seen by the participants as a critical element in the recruitment, retention and development of qualified academic staff so that effective succession planning for future leaders could take place. Although “the majority of staff recruited were experienced practitioners in their field” they “may have limited experience in education” and “clinical expertise alone is not a qualification for being an educator” (McArthur-Rouse, 2008, p. 402; Wilson, 2007). The need for mentors and leaders that would assist both new and current nurse academics in regards to ‘their pathways and how they plan and manage their career that is maybe something we could improve on [and] encourage bright students to make sensible choices on how to become academics...’ was seen by this participant as a starting point that would enhance the professional identity of the nurse academic as this is not offered as a career option. During this study, it was found that academics continue to perpetrate the idea that clinical consolidation is critical upon graduation. However, the participants agreed that while it was important to work in the clinical environment, it was also important to provide graduates with the context of a potential academic career as they believed that it would increase the professional identity of the nurse academic and lead to future academic leaders. Although having successful academic leaders and leadership brought about a sense of empowerment that is needed to propel the profession and its academics into the future; overall there was a sense amongst the participants that nursing as a whole lacked leadership (across a number of levels) and therefore, empowerment. Leadership positions at the highest
levels are being eroded, as these participants suggested:

‘...we have got a Chief Nurse in Canberra but she doesn’t even have direct access to the Minister for Health, her key into the government is through some underling...we [nursing] don’t actually have a voice at the high levels of government...’ U3:P3:L3

‘I think we are being policy led. I think industry is being policy led too...and in that relationship with industry and the university we would do well to get a position together to lead the policy makers. Because at the moment policy runs well ahead of any evidence from here [the tertiary sector]’ U4:P4:L4

‘It’s been an absolute international embarrassment that at the World Health Assembly [where] most other countries have their Chief Nurse there, we were represented by the Chief Medical Officer or by a bureaucrat that wasn’t a nurse...’ U2:P4:L5

It is the lack of empowerment and autonomy that pervaded the nursing identity of many who trained prior to the introduction of nursing education in the tertiary sector that is one of the most important reasons that leaders in nursing continue to spend time and energy on the issues of nursing as a profession (discussed in Chapter Five). The continuing evolution towards professionalisation and autonomy that sustains and enhances empowerment is the most effective strategy for leadership professional socialisation, recruitment and retention strategy available (Cooper, 2001, p. 202; Huston, 2010). In order to achieve this it is important that ‘the nursing profession needs to think very carefully about what it wants from academy...’ U3:P5:L2 and that ‘the real power base [in] nursing exists with those nurses directly involved in nursing practice’ U3:P5:L2. What must be emphasised here is that all the participants vehemently agreed that the education of nurses needs to remain in the universities as the role of the nurse is changing and indeed expanding to accommodate improved healthcare technology and associated knowledge base and skills required to deliver safe quality care by clinicians. Therefore, the importance placed on leadership, empowerment and autonomy cannot be viewed in isolation from what is considered “the elusive concept
of power” (Huston, 2010, p. 327). The word is derived from the Latin verb *potere*, meaning to be able and allowed individuals or a collective group to accomplish their goals. While there have been numerous factors that have contributed to nursing powerlessness there are just as many driving forces that have contributed towards empowerment, including: (a) increased recognition as an educated profession with evidence based research and practice, (b) interdisciplinary and multidisciplinary partnerships and collaboration, (c) the profession’s ability to be more proactive rather than reactive, (d) becoming better informed and increasing involvement and presence in the political arena; as academics are being placed in positions that influence public policy and (e) mentoring future academics and leaders along with succession planning (Huston, 2010).

In order to continue to promote and maintain these traits (that will ultimately contribute to increasing professional identity); the nursing profession must produce leaders at every level of the system. Therefore, the profession needs to ensure “that the potential for leadership capacity is advanced through incorporation of leadership development at every level of nursing education and practice in both the academic and clinical environments”. It is important that nurses “assume primary responsibility for personal and professional growth through efforts that continue individual education and opportunities; that develop and advance the exercise of leadership skills, the profession and ultimately professional identity” (Porter-Grady, 2011, p. 34).

As one participant stated:

‘What I think the academic does, is provide leadership. Hospitals don’t provide leadership; they provide management of nursing staff and patients. So [the] key difference between working there [clinical] and working here [academia] is that you can actually show leadership here. There is no glass ceiling...as most of the innovations of nursing...all come from nurse academics. When you speak to them [nurses] individually, they don’t seem to have the political clout or skills to really drive things forward and interestingly our experience in partnerships, is
This leads to what O’Hagan and Persaud (2009) describe as the notion of “culture of accountability” that “…would contain a set of common elements wherein the common belief is continuous learning and improvement at the individual, unit or department, and organizational levels” (p. 124). It would involve the willingness to lift standards and be the gatekeepers and change agents as nurse academics are seen to have a critical role in promoting and maintaining professional nursing as leaders and expert teachers. They are responsible for creating and building the art and science of nursing education; to mentor, inspire and transform new academics; and guide others in transforming and re-visioning professional nursing education (Young, Pearsall, Stiles, Nelson & Horton-Deutsch, 2011). Having these leadership roles readily available would assist and guide academics during the transition process from one habitus to another (in both structure and culture); it would provide “astute insight into the political processes of the institution” and a benchmark to strive and achieve professional excellence and identity (Gardiner, Tiggemann, Kearns, & Marshall, 2007).

In summary

The academic sector remains a tough climate in which to work irrespective of discipline area (Glass, 2003). The assumption that entering and working in the sector may be a promising and exciting career filled with the challenges and rewards of educating nurses and where the notion of research informs practice is perhaps an overly rosy one. Many nurses, including the participants in my study, enter academia with somewhat naive and optimistic expectations. Working within the tertiary sector brought to the fore new expectations, roles and responsibilities and accountability. While the participants were clear in describing their roles and responsibilities related
to teaching, research and university service there was, nonetheless, a notable tension regarding the relationship between them which was linked to the notion of academic preparedness and the importance placed on academic leadership that would in turn support professional identity. Following on from the previous section and in line with forming the study’s framework, the information in this section identified socialisation and leadership as key elements in the professional identity of a nurse academic.

**Conclusion**

It cannot be ignored that the transfer of nursing education from the hospital based system into the tertiary sector was a monumental shift for a discipline that for the last 100 years had remained relatively unchanged in an environment where all of its practitioners and educators were hospital based trained and were then charged with making the shift across to the tertiary sector.

The transfer expected these educators (which included the majority of the participants) to immediately shift into a new way of educating (not training) and to work in a new environment that expected them to conduct themselves as academics: a shift that was met with sentiments of scepticism, hesitation, fear and uncertainty.

This chapter set the scene by demonstrating the diverse and complex career trajectory of academics into the tertiary sector. It featured two subthemes; the first titled entering the tertiary sector reflected the participants account and their reasons why they chose to enter nursing and subsequently the tertiary sector. The findings from the second subtheme working in the tertiary sector focused on their insights and experiences surrounding their employment. Each of these subthemes had a number of concepts that explained the participants’ understandings associated with their application process, meeting necessary qualifications, concerns with remuneration
equivalence, performance and promotion along with sentiments experienced with the cultural shift from one habit to another, role expectations and responsibilities in what constitutes an academic; the significance placed on the individual’s academic preparedness and leadership. The findings from this chapter suggest that as a whole the participants believed in being part of the bigger picture that would see the increase in the academic profile and identity of those who teach nursing and the provision of better educated nurses. It is also suggested the importance of the fact that “nurse academics need to be recognised and measured alongside their academic peers” (Glass, 2005, p. 115). This in turn would allow them to be part of a “level playing field and provide explicit acknowledgment” (Glass, 2005, p. 115) in their leadership capacity and ability, political astuteness and claim its right as an equal player in the tertiary sector; all key elements as Glass (2005) acknowledges that contribute towards creating professional identity.
Chapter Five
Enhancing academic identity

Chapter insight

To be a nurse requires a commitment to lifelong learning with an emphasis placed on learning required to become proficient and expert clinicians (Bowers Lanier, 2009). Furthermore “...decades old argument about technical and professional education, which degree prepares which learners for what types of patient care or even which is best for entry into practice is out of step with reality. The reality is dynamic and includes a partnership between those who practice and those who teach” (Bowers Lanier, 2009, p. 235).

In this chapter, the narrative continues with the second theme creating academic identity. It is divided into three subthemes: (1) defining a nurse academic (2) nursing: a profession or vocation and (3) a matter of competence and credibility. The findings under each of the subthemes, draws from the data and literature reviewed to explore the participants understanding of how academic identity is understood and created by defining the term itself, providing their views on the dichotomy between nursing and the academics as a profession or vocation; and finally, offer their insight into concept of competence, credibility, dual professionalism and enhancing the nexus between the two.

Defining a nurse academic

The first subtheme presents the participants’ definition or description of what they considered a nurse academic under the following concepts:
The definition of a nurse academic provided the basis of the second question set (S2: Exploring the possibilities) and was intended to extract a definition from the participants. However, what it actually did was elicit a number of different types of responses which ranged from literal/definitive answers as invited by the question through to challenges to the question itself. There were also participants whose responses demonstrated a degree of indecisiveness about how they would define a nurse academic; indicating that confusion reigns. In analysing the participants’ responses, I noted that belonging to a particular university, university group, state or territory did not have any influence or consequence on how they answered the question or defined the term.

Kenner and Pressler (2006) defined an academic as “a highly educated person who works as a researcher and usually teaches at a university” (p. 139). Conversely, MacDonald (2001) described an academic as a university teacher and compared them to secondary high school teachers with the notion that teaching was devalued and not considered a workload priority for an academic. However, Dall’Alba (2005) argued that reducing teaching to a skill or competency overlooks the engagement, commitment and scholarship embedded into the academic role.

It was clear that the higher the participant’s academic level, years of experience
and length of service in the tertiary sector the more confident and definitive were the
participants’ views on what constituted a nurse academic and the more likely the
participant was to dispute the question. Comments from the L5 participants included:

‘...I think that we are either academics or we’re not...I don’t see an academic in
pharmacy or medicine or physio or OT denigrates their profession anyway by
not introducing themselves as a physio academic...’ U2:P4:L5

Other L5 participants saw no value in providing a definition as they considered it a
‘non-event’ because they would not ‘...define them[elves] any differently than any
other academic...’ Only one L5 participant gave a more conventional response by
merely stating what appeared to be the obvious, that a nurse academic is ‘...someone
working [as a] university employee...working in a school of nursing or has a nursing
background or is using it in their work...’ U1:P2:L5. These participants were the leaders
within their respective SONMs and certainly within the nursing community (as
identified by their academic level) and yet their responses were out of step with those
provided at L1 and L2; and arguably with the expectations of the profession as a
whole. Out of the four L5 interviewed, two held the leadership position of HoS /
School Dean. The following three L4 responses were provided by one HoS / School
Dean and two Deputy Deans and begin to reveal a more descriptive response to the
question, one that highlighted both terms, that of a nurse and an academic:

‘...somebody who helps to develop and test...nursing knowledge and
practice...and disseminate that knowledge...through teaching, publications and
things like that and they also testing knowledge...applied in the field...’ U1:P5:L4

‘...obviously someone who is registered as a nurse and who...their first
preparation for employment or vocation or whatever you want to call it is as a
nurse...entering the workforce they make a decision at a certain point that they
want to be involved in education and or research and...embark upon a career
which sees them move into their primary employer being an academic
organisation and then they develop that either a research or teaching career or
teaching and research career...’ U3:P4:L4

The third response linked into the definition offered by Kenner and Pressler (2006) and
also challenged academics about the use of the title:

‘...I personally don’t think it’s just a person who works in a university....it’s a person that has the intellectual ability to be analytical and reflective and critical thinking and all those things that...you can get regardless of where you work...you could work in a university and certainly not [be] what I would consider a true academic...’  U4:P2:L4

While the L4 and L5 represented the leaders within their respective schools and the nursing community, their responses were different from those provided from the L1, L2 and L3 participants. At the L3 level an undercurrent of indecisiveness began to emerge in participants’ responses. Whilst they were aware of the difficulties and subtle implications of the nurse academic title their somewhat self-conscious answers suggest some uncertainty and a struggle to offer a definition and / or description related to them. As one participant stated:

‘...I struggle with the whole nursing educators / academics...[although] I must admit it’s interesting...[as] we focus very much on the academic world and the research and for me that’s a deflection from the clinical aspect. It’s the sort of core values of nursing; I think that we’re in danger of losing to some extent...’  U3:P3:L3

For the most part, participants at the L1-L3 used their own job description and the university requirements of teaching, research and service (also mentioned was scholarship, professional engagement, expertise and clinical credibility) as a point of reference to answer the question. Their responses varied from ‘Jack of all trades, master of none...’  U1:P1:L3 and

‘...someone who’s...not thrown in the deep end, but has leapt in of their own choice, their own volition into the deep end of education often without much experience...’  U4:P6:L2

‘...very much misunderstood by society, in nursing circles and that there is this pervasive idea that...academics...sit around all day and drink coffee...we are not ‘real nurses’ because we do not wipe backsides, wipe snotty noses and deal with vulnerable sick people in society...we are looked down upon by our colleagues...’  U4:P6:L2

As the analysis continued, comments from the L1 and L2 participants were found to be
considerably more descriptive in content; and much less concerned with the politics of
titles. The question of “How would you define a nurse academic” attracted discipline
focused remarks such as the need to be ‘passionate about nursing’, ‘enthusiastic about
teaching nursing’, ‘competent in nursing skills’, ‘have the background and experience in
nursing’, ‘a communicator of theory and clinical practice skills’, ‘an expert in their area
of practice’ and ‘a leader in the field of research in which they are employed by the
university...at state...nationally and internationally’. Their responses included
additional comments related to work overload and the difficulty of being able to meet
the requirements of what they perceived to be two different roles, in order to then
achieve the clinical and academic expectations of their role. Featuring strongly
continued to be the undercurrents of frustration and disillusionment related to the
validity and credibility of their academic positions.

The participants saw it as an imperative that being an RN is an essential
prerequisite for a nurse academic as it provided, what they perceived to be, a
necessary link to the profession, justification of their role and credibility. Maintaining
this credibility legitimised each participant’s academic position by ensuring (on their
part) that what they were teaching was current and in line with what was being carried
out in the clinical environment. However, overall what they provided by way of
definition of a nurse academic was merely a position and role description. This
confusion in defining a nurse academic is an important finding as it brought to the
forefront the differences that exist between the academic levels and raised a question
about why their description differs and how and will their views change as they
progress to become the new nurse academic leaders or will it remain as an individual
interpretation of the term.
Self-description

Whilst sourcing the definition of a nurse academic provided the basis of this question set (S2: Exploring the possibilities) a self-description on how each participant perceived and viewed themselves began to emphasise the struggle between acknowledging and subsequently embracing their academic identity. Out of the 24 participants, only one L3 participant did not see the purpose of the actual question and commented:

‘...we’re in for a penny or we’re out for a pound and I think we just need to lose the hang ups and preconceptions we have about any concept of identity...if the last body of 100 years of...philosophical work has counted for anything it is that the politics of identity are fraught with difficulty and just endlessly circle itself. So what we can do I suspect is discard concepts of identity and just begin lines of enquiry. We are a valid discipline in the university context and we just get on with it’ U4:P5:L3

The responses to the multiple choice question within this question set of “How would you describe yourself (nurse, nurse academic, nurse educator, academic who teaches nursing)” reflected each participant’s current job description and / or the situation they were in (eg. professor of nursing, teacher, educator, administrator, nurse academic). Given the discussion in the previous section, what is most interesting about their responses was whether they were willing to use nurse or nursing in their description of themselves or not. Overall:

- 37.5% (n = 9) of the L2-L5 participants clearly and decisively stated that they were academics and would not use either word. Only two of these participants described themselves as a lecturer, commenting that they no longer considered themselves a RN as their university employment contract stipulates that they are a lecturer in a SONM.
- 33.33% (n = 8) of the L2-L5 participants described themselves as a nurse academic. Several made direct reference to their clinical practice: ‘...I’m a nurse
academic because I have a joint appointment’ U3:P4:L4 and ‘I am a] nurse academic because my area of expertise is nursing and I’m working as an academic though I still practice clinically’ U5:P3:L2. One L5 described herself as ‘...I am a professor of nursing, that is what I am, that is my job...’ U1:P2:L5. While another L3 stated they were a nurse because: ‘...when somebody asks me what I am I always say I’m a nurse...just for ease...because...if someone asks you what you do they just want...a one word answer...so I find it fascinating...a nurse academic...nurse first...academic second as opposed to you are an academic’ U4:P3L3

- The remainder 29.2% (n = 7) of the participants identified themselves as educators as they believed that being acknowledged and identified as an academic required additional qualifications such as a PhD, in addition to research and publications which they did not have. Two participants from this group (L2 and L5) believed that they were teachers as their understanding of what constitutes an academic and / or scholar did not necessarily reside and / or work in the university environment only. Finally, one L2 and one L4 identified themselves as academic administrators while they still maintained a teaching profile; finally the L1 could not comment as ‘...I am learning about academia at this point in time, I am six months into this...’ U1:P4:L1

The question of why these variations in definition and self-description exist cannot be overlooked. However, before exploring the distinction between nurse academic and academic more closely; there is another dimension of this self-definition that is worth drawing out of the participants responses. This is the extent to which nurse academics are considered real academics whose doctorate qualifications, scholarly work of research and publications, their employment in an institution of higher education and learning, teaching subjects that are not vocational and / or technical in origin and most
importantly, are intrinsically linked to upholding standards, traditions, philosophies, activities and attitudes of academia.

So is there a difference between a nurse academic and an academic? ‘Why? Get over it! I have been an academic from the bottom up I can tell you!’ U2:P4:L5. This response brought to the fore, the ‘artificial constructs’ U1:P2:L5 underpinning the question; what are the differences, if any, between a nurse academic and an academic.

These artificial constructs are most apparent to those who challenged the distinction between the two as ‘...a tautology, if you are an academic; you’re an academic, just working in a different discipline...’ U4:P5:L3. Despite the conviction of the participants who said that there was but should not be a difference between the two issues of credibility, the notion of an inferiority complex and subordinate status came into focus during the interviews highlighted by these comments:

‘...I think people are pulling at straws to be really honest...we are funny creatures and I love it and I am passionate about our profession but I know the transition for me to get into academia and I watch it with other people, the sacrifice of wanting to still be a “real nurse” and being an academic is really hard because we are so ingrained...it’s a pride thing...and we talk about that a lot, about being validated, like we validate ourselves as nurses because [we] still actually get our hands dirty...’ U1:P113

‘I think we are becoming more academic...my husband has a PhD...I see him working as an academic...I think nursing still has a way to go for the recognition that people are doing. I think people outside nursing still think of nursing as sort of the hands on you know wiping the brow...and I have difficulty with coming to terms with it and I think other academics...are still struggling with why would a nurse be an academic...’ U5:P4:L2

Is it possible then that the nursing discipline itself has perceived and therefore possibly created a difference due to its significant practice based component versus taking up sole residence in academia? The argument can be made that there are a number practice disciplines within the sector with similar expectations placed on their academics such as physiotherapy, occupational therapy, engineering and medicine to
name a few. Perhaps it is time as Shields et al., (2011) believe, to ask if in fact they do experience this issue, what is it that the academics in these disciplines do differently (if anything) in order to achieve the balance between these roles; in order to establish their academic identity.

In summary

The critical, higher order thinking world of academia that the nursing discipline ventured into over 40 years ago, brought into question and challenged abilities, qualifications and identity of its current and future clinicians and academics within the profession. This section highlighted the continual ‘changing of the goalposts’ and the variations in relation to the participants’ definition of nurse academic, their self-description and the concept that although overwhelmingly differences do not exist between a nurse academic and an academic; the continual reference surrounding their concerns on these issues, may have contributed towards a perceived notion that nurse academics professional identity could be somewhat different.

Nursing: Profession or vocation

The second subtheme presents the participants’ insights into their views on nursing as a profession or vocation as highlighted below:

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The discipline

It was no secret that there was significant opposition voiced by the medical profession related to the transfer of nursing education from the hospitals to the tertiary sector and in particular to the numerous symbolic boundaries related to the dichotomies of nursing-medicine, caring-curing, vocation-profession. However, additional opposition continued to come from a number of fronts underpinned by the premise that (a) nursing was constructed as “essentially dirty work, a profane, menial activity... polluting influences into academia, in the form of the wrong kinds of teachers, learners, practices and values” (McNamara, 2010, p. 169), (b) the “virtue script” that stemmed back to the era when nursing was symbolised by veil and vow emphasising the devotion and calling towards a vocation and (c) nursing lacked in their approach and bid to become an autonomous academic and professional discipline (McNamara, 2010; Ridge, 2011). All these issues appeared to “give rise to a discourse of opposition which works to exclude nursing from a place at a high table of the academy”. This in turn constituted the challenge and real boundaries that faced nurse academics “to articulate the basis of the epistemic (academic) identities”; which Bernstein believed is founded in “the sacred” that “resides in strong insulations between disciplines, and between spheres of education and work” and “that the socialisation into a distinct discipline imparts a strong sense of loyalty” (McNamara, 2008, p. 459).

Over the years, nursing leaders (including a number of the participants) have invested a significant amount of time and energy pursuing the vision of nursing as a profession. This was in order that nurses would be fully recognised and supported by the profession and the community as a whole for their unique contribution to health and wellbeing; thus freeing themselves from the shackles of their subservient roles as
handmaidens to the medical profession (Gordon & Nelson, 2006; Nelson, 2000).

Although there has been research that has addressed the legitimisation of the discipline within society and standing amongst other healthcare professions; little literature was found to address the standing and professional profile and identity of its academics. Providing a legitimate basis to claim professional status cannot be based on the mere calling to serve a greater purpose in society but needs to be defined. In 1964, Carr-Saunders and Wilson concluded that what makes a profession is:

The practitioners, by virtue of prolonged and specialized intellectual training, have acquired a technique which enables them to render a specialized service to the community. This service they perform for a fixed remuneration whether by way of fee or salary. They develop a sense of responsibility for the techniques which they manifest in their concern for the competence and honour of the practitioners as a whole... (p. 284).

As mentioned in Chapter One, Crisp and Taylor (2009) provided five characteristics considered to be fundamental in what constitutes a profession. Each of which were identified by the participants as being part of the nursing profession: (a) a significant theoretical body of knowledge that leads to defined skills, abilities and norms within the context of the discipline, (b) extended educational requirements, (c) a focus on the provision of a specific service, (d) a code of ethics associated to its practice and (e) autonomy in the decision making process and practice (Crisp & Taylor, 2009). The existence of professional associations and governing bodies such as the ANMAC and NMBA are also central components to the establishment of a profession as they provide nurses with standards and guidelines that determine the expectations of all practitioners, both clinical and academic across all levels. These peak industry bodies in collaboration with key stakeholders acknowledge that a profession needs to operate within a framework and state that:

A profession’s scope of practice is the full spectrum of roles, responsibilities, activities and decision making capacity that individuals within that profession
are educated, competent and authorised to perform. Some functions within the scope of practice of any profession may be shared with other professions or other individuals or groups. The scope of practice of all health professions is influenced by the wider environment, the specific setting, legislation, policy, education, standards and the health needs of the population (ANMC, 2007, p. 2).

The majority of participants (across academic levels) offered definite and unequivocal answers supporting nursing as a profession; with comments such as:

‘Compared to what? Professional of course! There are people within the profession who are only working at vocational level [however] that would be true in any industry. I think the debate is long over’ U1:P2:L5

‘...a profession...with an extremely long tale of trade constructed work...I wouldn’t go anywhere near the idea of a vocation, that was a very long time ago...’ U2:P1:L4

‘Completely a profession; because professions have certain criteria that need to be met [and] competencies that can be looked at. A vocation to me is a calling; a vocation is something that people can feel as though they have to do...’ U4:P1:L2

‘It’s a profession because we have an education structure that can take us from a Bachelor to a PhD level and post doc. It’s a profession because of the level of responsibility we have for society. It’s a profession because it’s certainly developing its own knowledge base. It’s a profession because it has multiple career pathways and it is driven by a very strong bioethical framework’ U4:P4:L4

‘...nursing is possibly more professional now than it’s ever been and in some ways is more professional than other groups...in terms of the way it’s willing to organise itself and govern itself...’ U4:P4:L4

Other participants sought to define, describe and / or clarify the terms profession and vocation, in order to put their responses in context with one participant basing their answer on the notion that ‘if we’re responsible for lives and that as a discipline we have a legitimate place in the greater body of knowledge that is out there, then there is nothing constructed or otherwise that can stop us from being professional, nothing!’ U4:P5:L3. The responses demonstrate that displaying the appropriate attitudes and behaviours represented a professional approach by its members and increased not only their profile but the discipline’s profile. Nursing professionalism reflects the
manner in which nurses view their work and is a guide to nursing behaviours in practice to assure patient safety and quality care. Professionalism contributes to professional identification (of a nurse and nurse academic) and broader knowledge leads to an increase in job satisfaction and retention (Hwang, Lou, Han, Cao, Kim, & Li, 2009). However, a number of participants, regardless of academic level and whether they were hospital based trained, tertiary educated or both struggled to give up the vocational tag. Although they agreed that ‘it should be a profession by name; we are not a profession by nature…as nurses will not be taken seriously until they behave like professionals…’ and continued to acknowledge the underlying vocation stating that for ‘the vast majority of nurses, it’s treated as a vocation it’s treated as a trade…clock in clock out, no responsibilities past 3.30’ even though ‘we have fought to make it a profession…just changing the venue the location of where it was taught didn’t necessarily make it a profession with the status attached to a profession. Having said that...if you measure community views on nursing...it is a profession. It is a very trusted profession or occupation’

The responses to the question of “how do you view nursing – as a vocation or a profession”, suggest that I may have inadvertently provided some of the responses received relating to vocation by the way it was phrased. Providing definitions from the outset, as to what constitutes a vocation along with the inclusion of the term occupation, gave the clear impression that it was desirable for nursing to be a profession and that there was a stigma attached to vocational training. That said, as discussed in Chapter Two, nursing education for RNs moved back into the Vocational Education and Training sector (VET), in August 2009 in the state of Victoria only. Until then, Australia was the only country where nursing education was only offered at university level. Nursing academics and the profession as a whole were outraged by
this decision, strongly protesting and fighting to override this decision in what they
described as a backward step for nursing. However, it still remains in the vocational
sector to-date; which contributes to the ongoing vocational tag. Nurse academics have
a critical role to play in the continuing promotion of the profession and its members,
through the use of empowering teaching and collaborative behaviours that will
ultimately lead to professional practitioners (Hokanson & Hawkes, 1999, p. 67); one L5
participant emphasised this point by commenting that:

‘...it is our job to make sure that they go out the other end with the sorts of
understandings about what it is to be a professional in the discipline of nursing,
that’s important. If they go out with those skills and attributes, then what does
it matter what they come in with’ U5:P2:L5

Acknowledging and identifying themselves as professionals is a key element in the
creation and enhancement of a nurse academics’ professional identity.

The academics

‘...if they see it as a vocation they shouldn’t be calling themselves an academic
quite frankly...’ U2:P4:L5

The closed question about whether nursing academics are seen as a vocation or a
profession was intended to extract a one-word definitive response from the
participants (vocation or profession). Most of which went back to the discussion in the
previous section in defining an academic and that led the participants to reflect on
whether or not they themselves could be considered professional. In many respects it
was easier to see nurse academics as a professional, than it was to see nursing itself as
a profession. A number of the L2 participants were unsure if they considered
themselves academics or even nurse academics as they continued to grapple with the
title itself. However, others were definitive in their responses and identified
themselves as professionals. At the other end of the academic hierarchy, the L5
participants were very clear and distinct with their responses. Overwhelmingly, the
mere fact that they were working in the university sector determined their responses.

The L4 participants agreed with their L5 colleagues and linked their responses back to the importance of qualifications as this participant stated:

‘...there is not that many disciplines now who are preparing their professionals with using staff who don’t have PhD’s and we are one of them if your staff don’t construct the world of academia effectively, [you] can’t expect the students to... but doing [a] PhD changes your view of yourself, academia, the greater world of intellectual activity, knowledge generation and all of those things. That’s what constructs for me the solid understanding of academia’ U2:P1:L4

Emphasis was also placed on the individual and the profession’s status, profile and credibility within the sector and the importance of adhering to the selection criteria and qualifications when employing nurse academics as while there majority of new academics are tertiary educated, there are ‘still a lot of people that we employ as academics later in life, who come from hospital based training find it hard to make that transition and still think in terms of nursing as a vocation only’ U1:P5:L4

The L3 group had very similar views as the L4 and L5; emphasising the importance of qualifications and experience in the academic sector and the dichotomy that exists between the clinical and tertiary sector related to roles and professional identity. As this participant commented:

‘It’s probably easier for academics to view themselves as professionals, but the question is, do they think of themselves as professional nursing educators, or nursing academics, or professional nurses...maybe nursing academic is a different profession because my knowledge base is different to a registered nurse on a surgical ward...we are doing different jobs and there aren’t many commonalities between them. I work at a desk with my computer, my interaction and communication skills are probably on par but other than that my average day are radically different to what a qualified nurse would do in their average day...’ U3:P3:L3

As seen throughout my thesis, a number of factors have influenced and continue to have an impact on the nursing profession and its academics. If a comparison was to be made with medicine, it is clear that they still have both a significant academic and
vocational aspect to their profile; yet medicine continues to criticise nursing for not remaining vocational when in reality the profession is following the same educational model.

Nurse education is constantly evolving as it develops as a profession alongside the proliferation of health policies determined to resolve ongoing problems experienced in the healthcare system. The transfer of nursing education opened the possibilities for professional interdisciplinary teaching breaking the siloed and exclusive approach of nurses teaching nurses (Dickinson, 2005, p. 31); thus creating a sense of empowerment as one participant stated that links back to the importance of leadership discussed in Chapter Four:

‘I wanted nurses empowered and I got absorbed by [organisational name] because I could empower nurses by teaching them, these are your rights and how you can educate yourself further. To me the university was the answer to a lot of it. It empowered nurses and it made them stand there and say ‘hang on a minute’’

In summary

Nursing moved “into an arena that traditionally values theoretical and propositional knowledge rather than vocational and interpersonal skills” (Andrew, Ferguson, Wilkie, Corcoran, & Simpson, 2009, p. 607). Although it has been over 20 years since the transfer, there is a continuing reluctance within nursing to embrace the academic agenda including the nomenclature. This could be viewed as a defensive reaction against a culture; that by its vocational nature and defined practical activity, regarded as “inferior to abstract thinking skills” (Andrew, et al, 2009, p. 607). The question of whether or not nursing should be considered an academic discipline and the preparedness of nurses to enter the higher education sector is fundamental to the question of how nurses manage their transition from practice to education and subsequently how they perceive their own professional standing and identity within
both (Andrew, Ferguson, Wilkie, Corcoran, & Simpson, 2009, p. 607). In this section, the participants clearly considered the discipline as a profession and its academics as professionals; however the complexity underpinning the responses provided, indicated the need for the development of a distinct approach towards, not only meeting, but maintaining this status. In line with forming the study’s framework; the information in this section adds *language (nomenclature)* to the key elements and links identified as the professional identity of a nurse academic.

**A matter of competence and credibility**

The final subtheme in this chapter presents the issue of competence under the following concepts highlighted below:

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**Competence versus credibility**

One of the issues that has emerged in Chapter Four as part of a nurse academic’s role and responsibility was the concept of practice competence and credibility. Nurse academics (including my participants) have been challenged to maintain both their academic and clinical competence and credibility within two habitus. The concept of credibility is open to interpretation and is associated with the perception of competence. Nursing registration demands that its practitioners comply with professional competency standards and guidelines (Ross & Glass, 2009) which
ensures consolidation of theory to practice in order to maintain professional registration. Amongst nurse academics there is little consensus as to what it really means to maintain practice credibility in the form of clinical contact and competence (Ioannides, 1999, p. 207). While competence denotes the action and capacity to perform an allocated function, skill or task (Sellers & Deans, 1999, p. 14) “it can be argued that clinical competence includes an awareness of factors influencing practice in the short and the long term, such as socioeconomic changes, professional image and legal aspects...” (Ioannides, 1999, p. 208). The degree of competence needed for credibility however, is open to interpretation as credibility is more related to qualities of being trusted and believed; showing no correlation with competence. One L5 participant believed that while:

‘...a nurse academic needs to have practice credibility... practice credibility is not the same as recent practice experience. This is something that practitioners perhaps do not appreciate that you can actually be very up-to-date, very aware of best practice...without doing it every day. That’s not all that well appreciated by some of my own staff who see our clinical professors perhaps [as] not experts in practice, whereas I would argue that they are probably more expert than anybody else in the field. They are actually in clinical most of the time, they may not be actually laying their hands on patients, but they are there with the practitioners everyday they know the issues, the problems, they are the ones developing the guidelines for practice, they’re the ones developing the evidence’ U5:P2:L5

Another participant viewed that an academic’s clinical competence and ultimately credibility, was received better by the students and clinical colleagues as they were seen as ‘real [and]...the ones that really do know that they are talking about...’ U4:P6:L2 based on the fact that they were ‘seen in the clinical area’ as the perception was that there is a real disconnect between what nurses (including educators) at the beside think of ‘people being clinically credible and the reality of what clinical credibility is [all about]’ U2:P3:L3. For the nurse academic, the debate surrounding competence and credibility is very one-sided and limited to clinical matters. The competence and
credibility of nurse academics whose main recruitment pool is the clinical setting is not something that carries the same level of anxiety or concern. Those academics that were not clinically current appeared to lose credibility in the eyes of their clinical colleagues (and even students); whilst many RNs appeared not to have embraced the educational reasons for the transfer (even though it has been over 20 years since the move) and continued to accept and expect the apprenticeship model of nurse education to be preserved within universities. Even though industry has been saturated with degree qualified nurses, the pressure exerted by practice requirements in industry continues to influence the new tertiary educated graduates as to the perceived flaws of the current tertiary education system. From the participants’ point of view, there is a clear delineation between a clinical and academic role (as they are considered two different roles) and they would prefer a partnership between the two based on mutual respect and collaboration. Their experience however, is that this view is not shared by clinicians who expect nurse academics to be clinically competent in order to be credible. According to Middleton, Walker and Leigh (2009):

Peer recognition is an issue for the professions which argue that their claim to a perceived (and real) higher status in the hierarchy of work and occupations is forged from the individual and collective status and human capital generated in the process of becoming a member of a particular occupational group (p. 178).

In contrast, while peer recognition, from clinical colleagues was considered desirable, the participants were more focused on collaboration and partnership between the clinical and academic arena, as expressed earlier in this chapter. At the time of the interviews, only one participant continued as an active clinical nurse. The remainder of the participants had been out of clinical practice since being employed as an academic (3-20 years); although they did maintain their links with industry, either through a joint research appointment or their role as a clinical placement coordinator.
The Australian Nursing and Midwifery Accreditation Council (ANMAC, formally ANMC) in the NMBA National Competency Standards for the Registered Nurse (2014) described the term competence as the combination of knowledge, skills, attitudes, values and abilities that underpin effective and / or superior performance in a profession / occupational area; that encompass confidence and capability. There are a number of theories and tools that have been and are used to determine competence. Starting from a practice based approach one of the most noteworthy leaders in providing a structured approach for achieving competence has been Patricia Benner’s (1984) ‘Novice to Expert model. Benner provided a framework on how knowledge and associated skills are obtained and developed along with the application of these to nursing whether it being in education, research, practice or administration. Based on the Dreyfus five levels of competency (novice / beginner, advanced beginner, competent, proficient, expert) the person progressively moves through each of these levels based upon their education, clinical knowledge, experience and career progression (Altman, 2007). Altman (2007) contends that while the individual is acquiring and developing skills they pass through five levels of proficiency. This in turn reflects changes across three levels of skilled performance whereby there is a move from relying on abstract principles to actively applying them within the context of past concrete experiences, viewing a situation as a more holistic picture instead of multiple fragments and shifting from being a detached observer to an active participant and performer. Altman (2007) goes on to say that “a move from novice to expert is characterised by the transition from explicit rule-governed behaviour to intuitive, contextually determinate behaviour. Progression from novice to expert is not guaranteed; not every nurse becomes an expert” (p. 115). Benner’s work is very much structured and focused around skill acquisition in the clinical practice setting; and
although the principles are transferrable into other working environments including academia, it is not a theory or a philosophy that is readily referred to or used outside the clinical context.

In the US, the National League of Nurses (NLN) accredits any level of nursing program (community college two-year Associate Degree through higher levels of education). The Commission on Collegiate Nursing Education (CCNE) only accredits the baccalaureate and high levels of nursing education. In regards to the tertiary sector, in the US, the NLN (2005) articulated eight core competencies specific to nursing faculty educators that ensure balance across a number of different areas. These include the facilitation of learning, development and socialisation, use of assessment and evaluation strategies, curriculum design, program outcomes, a leader and change agent, the pursuit of continuous improvement in an educational capacity and scholarship within the tertiary environment. In Australia, the NMBA National Competency Standards for the Registered Nurse (2014) are “broad and principle-based so that they are sufficiently dynamic for practising nurses and the nurse regulators to use as a benchmark to assess competence to practise in a range of settings” (p.1). This tool can be and is broadly applied and used as the standard to determine competence for RNs including academics who maintain their professional registration. This comes into effect particularly if individuals were audited by the NMBA as a framework to evidence competency within the scope of practice that will enable them to maintain their registration. Competence is achieved under the four domains listed below each with a number of elements (see Figure 5.1). What the tool does have under Domain 2: Critical thinking and analysis, is an element that reflects the requirement for ongoing professional development and the integration of teaching as part of the role of an RN T(see Appendix F). These standards were recently reviewed and updated now titled
Registered Nurse standards of practice they came into effect as of 01 June 2016. The standards (previously identified as ‘domains’) have increased from four to seven. Each standard has detailed descriptive criteria that specify how the standard can be demonstrated which are interconnected with each other and are applicable across all areas of practice and roles including education and research. The new standards have been outlined in Figure 5.2 and as an appendix (see Appendix H) as a means of comparison.
### Domain 1: Professional Practice
Relates to the professional, legal and ethical responsibilities which require demonstration of a satisfactory knowledge base, accountability for practice, functioning in accordance with legislation affecting nursing and health care, and the protection of individual and group rights

- Practises in accordance with legislation affecting nursing practice and health care
- Practises within a professional and ethical nursing framework

### Domain 2: Critical Thinking and Analysis
Relates to self-appraisal, professional development and the value of evidence and research for practice. Reflecting on practice, feelings and beliefs and the consequences of these for individuals/groups is an important professional benchmark

- Practises within an evidence-based framework
- Participates in ongoing professional development of self and others

### Domain 3: Provision and Coordination of Care
Relates to the coordination, organisation and provision of nursing care that includes the assessment of individuals/groups, planning, implementation and evaluation of care

- Conducts a comprehensive and systematic nursing assessment
- Plans nursing care in consultation with individuals/groups, significant others and the interdisciplinary health care team
- Provides comprehensive, safe and effective evidence-based nursing care to achieve identified individual/group health outcomes
- Evaluates progress towards expected individual/group health outcomes in consultation with individuals/groups, significant others and interdisciplinary health care team

### Domain 4: Collaborative and Therapeutic Practice
Relates to establishing, sustaining and concluding professional relationships with individuals/groups. This also contains those competencies that relate to nurses understanding their contribution to the interdisciplinary health care team

- Establishes, maintains and appropriately concludes therapeutic relationships
- Collaborates with the interdisciplinary health care team to provide comprehensive nursing care
Figure 5.2: Summary NMBA Registered Nurse standards of practice

| Standard 1: Thinks critically and analyses nursing practice | ▪ Accesses, analyses, and uses the best available evidence, that includes research findings, for safe, quality practice  
▪ Develops practice through reflection on experiences, knowledge, actions, feelings and beliefs to identify how these shape practice  
▪ Respects all cultures and experiences, which includes responding to the role of family and community that underpin the health of Aboriginal and Torres Strait Islander peoples and people of other cultures  
▪ Complies with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions  
▪ Uses ethical frameworks when making decisions  
▪ Maintains accurate, comprehensive and timely documentation of assessments, planning, decision making, actions and evaluations  
▪ Contributes to quality improvement and relevant research  
RNs use a variety of thinking strategies and the best available evidence in making decisions and providing safe, quality nursing practice within person-centred and evidence-based framework  

| Standard 2: Engages in therapeutic and professional relationships | ▪ Establishes, sustains and concludes relationships in a way that differentiates the boundaries between professional and personal relationships  
▪ Communicates effectively, and is respectful of a person’s dignity, culture, values, beliefs and rights  
▪ Recognises that people are the experts in the experience of their life  
▪ Provides support and directs people to resources to optimise health-related decisions  
▪ Advocates on behalf of people in a manner that respects the person’s autonomy and legal capacity  
▪ Uses delegation, supervision, coordination, consultation and referrals in professional relationships to achieve improved health outcomes  
▪ Actively fosters a culture of safety and learning that includes engaging with health professionals and others, to share knowledge and practice that supports person-centred care  
▪ Participates in and/or leads collaborative practice, and  
▪ Reports notifiable conduct of health professionals, health workers and others  
RNs practice is based on purposefully engaging in effective therapeutic and professional relationships. This includes collegial generosity in the context of mutual trust and respect in professional relationships  

| Standard 3: Maintains the capability for practice | ▪ Considers and responds in a timely manner to the health and wellbeing of self and others in relation to the capability for practice  
▪ Provides the information and education required to enhance people’s control over health  
▪ Uses a lifelong learning approach for continuing professional development of self and others  
▪ Accepts accountability for decisions, actions, behaviours and responsibilities inherent in their role and for the actions of others to whom they have delegated responsibilities  
▪ Seeks and responds to practice review and feedback  
▪ Actively engages with the profession  
▪ Identifies and promotes the integral role of nursing practice and the profession in influencing better health outcomes for people  
RNs, as regulated health professionals, are responsible and accountable for ensuring they are safe and have the capability for practice. This includes ongoing self-management and responding when there is concern about other health professionals’ capability for practice. RNs are responsible for their professional development and contribute to the development of others and for providing information and education to enable people to make decisions and take action in relation to their health  

| Standard 4: Comprehensively conducts assessments | ▪ Conducts assessments that are holistic as well as culturally appropriate  
▪ Works in partnership to determine factors that affect/potentially affect, the health & wellbeing of people and populations to determine priorities for action and / or for referral  
▪ Uses a range of assessment techniques to systematically collect relevant and accurate information and data to inform practice  
▪ Assesses the resources available to inform planning  
RNs accurately conduct comprehensive and systematic assessments. They analyse information and data and communicate outcomes as the basis for practice  

| Standard 5: Develops a plan for nursing practice | ▪ Uses assessment data and best available evidence to develop a plan  
▪ Collaboratively constructs nursing practice plans until contingencies, options priorities, goals, actions, outcomes and timeframes are agreed with the relevant persons  
▪ Documents, evaluates and modifies plans accordingly to facilitate the agreed outcomes  
▪ Plans and negotiates how practice will be evaluated and the time frame of engagement,  
▪ Coordinates resources effectively and efficiently for planned actions  
RNs are responsible for the planning and communication of nursing practice. Agreed plans are developed in partnership and are based on the RNs appraisal of comprehensive, relevant information, and evidence that is documented and communicated  

| Standard 6: Provides safe, appropriate and responsive quality care | ▪ Provides comprehensive safe, quality practice to achieve agreed goals and outcomes that are responsive to the nursing needs of people  
▪ Practises within their scope of practice  
▪ Appropriately delegates aspects of practice to enrolled nurses and others, according to enrolled nurse’s scope of practice or others’ clinical or non-clinical roles  
▪ Provides effective timely direction and supervision to ensure that delegated practice is safe and correct  
▪ Practises in accordance with relevant policies, guidelines, standards, regulations and legislation, and  
▪ Uses the appropriate processes to identify and report potential and actual risk related system issues and where practice may be below the expected standards  
RNs provide and may delegate, quality and ethical goal-directed actions, based on comprehensive and systematic assessment and the best available evidence to achieve planned and agreed outcome  

| Standard 7: Evaluates outcomes to inform nursing practice | ▪ Evaluates and monitors progress towards the expected goals and outcomes  
▪ Revises the plan based on the evaluation  
▪ Determines, documents and communicates further priorities, goals and outcomes with relevant persons  
RNs take responsibility for the evaluation of practice based on agreed priorities, goals, plans and outcomes and revises practice accordingly  

The only other professional organisation found during my research was the Australian Nurse Teacher Society (ANTS) (although when I questioned the participants about this society, they were not aware of it, nor is it well known in academic circles or indeed to clinical educators in industry). The society was established as one of the few not-for-profit autonomous organisations that cater specifically for the professional interests of nurse teachers along with providing reports on policy documents and curricula (ANTS, 2010).

The objective of ANTS is to: (a) promote the advancement of all aspects of nurse education and encourage the free exchange of educational and professional ideas within the Society; (b) establish effective communications and relationships between the Society and other educational bodies and other groups involved in nursing and nurse education; (c) evaluate research from all sources in nurse education, recommend areas of research to appropriate persons and other groups and assist with research where practicable; (d) formulate policies on nurse education; evaluate the policies formulated by other bodies and communicate these policies and evaluations to interested parties, including government, the instrumentalities and other policy-making bodies; and (e) confidently reflect and express the opinions and policies of those engaged in nurse education and all its contexts (ANTS, 2010). ANTS has also developed and published competencies that are considered to be core requirements for any nurse that undertakes a teaching role regardless of setting (see Appendix G). While ANTS is a separate entity to NMBA and ANMAC, both sets of competencies provided by these organisations, along with the key performance indicators of teaching-research-service provided by the tertiary sector feed into the concept of dual professionalism and roles undertaken by a nurse academic. What is most interesting about both these sets of competencies and in particular NMBA, is that
they are used extensively to assess undergraduate nursing students while on clinical practice. However, they are not actively referred to or integrated into annual performance development models, frameworks or tools used by individual institutions to assess nurses, clinical educators or nurse academics as to their competence; negating the design of yet another set of competencies that would be specifically created to address requirements for nurse academics. Furthermore, while competencies are based on the capacity and ability to perform a skill, task and / or function applicable to nurses in clinical practice, they do not apply to nurse academics as they are not undertaking a particular skill or task. Academics seen by the National League of Nurses (2005) in the US promotes that they: facilitate learning, development and socialisation, use of assessment and evaluation strategies, curriculum design, program outcomes, a leader and change agent, the pursuit of continuous improvement in an educational capacity and scholarship within the tertiary environment.

Sellers and Deans (1999) agree that competency indicates the action and capacity to perform an allocated function, skill or task; however they also go on to include the term credibility which is related to qualities of being trusted and believed; which in fact show no correlation with competence. Although the literal definitions may not correspond, they are certainly linked, as the participants believed that competence leads to credibility, therefore if a nurse or academic has credibility they are competent. The ongoing debate for professional achievement and credibility “has been overlooked in the pursuit to achieve technical competence” (Andrew, 2010, p. 486.). Academics “are expected to display their academic credibility “through the creation of knowledge (not just recontextualising) through research and publications. However, more often than not, the academics “find themselves represented in
professional and popular discourse as a doubly profane presence in academia” (Fealy & McNamara 2007a, 1394). This is first due to the discipline’s origin “in an occupation which is concerned with the intimate bodily care of patients”; and second attempting to attain “...academic ambitions that are depicted as vain and self-serving, directed at the pursuit of status and material reward rather than knowledge to improve nursing practice” (O’Connor, 2007, p. 749). Disciplines such as medicine, physiotherapy and pharmacy are confident and secure “in their disciplinary” and professional identity along with their academic credibility; something that “still remains a significant challenge for nursing and its academics” (Kitson, 2006; McNamara 2006).

Another dimension related to competence and credibility that needs to be considered is the RNs expectations of student competence and whether they are realistic, considering how the training of nurses was managed during the period of the hospital based system (Astin, Newton, McKenna, & Moore-Coulson, 2005, p. 289). In a 2001 national review of nursing education (Heath, 2001), the discussion paper states that “complaints that the new graduates are not able to hit the ground running” (p. 17) are not only unrealistic; they appear to continue to be based on a model of nurse preparation that is an apprenticeship. This was not the case in the past (as unqualified staff in the form of students were always part of the workforce) and is not realistic for the future. What needs to be clarified is that:

...the nursing profession needs to decide if nurses are to be educated as beginning practitioners with a wide range of nursing skills such as critical thinking skills and a professional identity; or as practitioners, clinically competent in pre-registration nursing skills as well as particular more specific skills (The New Zealand Council of Nurses, 2001, p. 38).

The concept of industry ready / work ready graduates was explored and dismissed by all the participants as ‘rubbish’, ‘not what we prepare’, ‘an oxymoron’, and that ‘industry [also] has a responsibility...’ and need to contribute to their part in the
education equation to develop new graduates; bringing into focus the need to link both sectors. The same principle could be applied to neophyte academics some of whom are initially employed as sessional staff due to the shortage of appropriately qualified nurse academics. Many of these staff are employed on the basis of their clinical knowledge expecting that this skill alone will make them good nurse educators (not academics). Possessing extensive clinical expertise in a specialty area as Robinson (2009) asserts does not always mean that they have the knowledge and skills required in the academic setting to ‘hit the ground running’. From the outset this leads them to be underqualified and ill prepared to meet the educational expectations of the tertiary sector. However, it is not until they are working in this new habitus that they discover that they are lacking in competence and credibility and begin to doubt themselves and question their ability as educators; even though they continue to be employed to teach, facilitate and assess students without the necessary knowledge, skills and experience (Robinson, 2009).

**Dual professionalism, is it possible**

The concept of dual professionalism became clearer with the shift “in identity towards embracing higher education pedagogical research and disciplinary educational knowledge” (Hurst, 2010, p. 240) that would underpin professionalisation. It involved “an expectation that higher education lecturers were knowledgeable, research active and [took] responsibility for their continuing professional development” in addition to, having the “knowledge base in both their subject area and in education methods of teaching and learning theories” (Hurst, 2010, p. 240).

Exploring the options as to how, why, what (is used) and who shows the new academic, or even the current ones for that matter, how to gain the skills necessary for them to transform and establish their professional identity as successful academics is
considered as Scully (2011) asserts an essential component to appropriate professional nursing practice. Determining competence was one way raised by the participants during the interviews. Although it is clear that the tertiary sector has key indicators for performance in so far as teaching, research and service; competency is not determined by these. The question “can you be a competent clinician and competent academic or researcher” gauged the participants’ responses and confirmed the emerging concept of dual (or even triple in some instances) professionalism undertaken by nurse academics. The participants responded by stating that competence is ‘...showing practice leadership in their area of expertise...’ U2:P4:L5, the ability ‘...to make a statement about contemporary professional engagement...’ U2:P4:L5 and ‘...if we are contributing to the body of knowledge which constitutes what is informed practice, then in order to be competent, they need to be well informed...’ U4:P5:L3. The L2 participants believed that academics who were not engaged in the clinical area made them ‘less of a nurse’ as competence was measured against registration requirements: ‘if you are not competent, then you cannot register...it’s all linked to registration’ U3:P2:L2, which in itself is not the case (registration requirements are not based on competency but on five areas found on the statutory declaration that each RN needs to answer every year). The notion of the dual professionalism between clinical and academic was once again highlighted as an important issue by the participants as they continued to be viewed as separate entities, as the participants found that ‘the majority of clinicians have absolutely no idea of academia [and] it’s only when they come back to [do] postgrad that...you start to get the chance to work with them about what might be academia...’ U2:P1:L4. There was a firm belief by the L4 and L5 participants that additional consideration needs to be given to the expectation of maintaining currency and competency in two roles and the implications that comes
with this. This was viewed as a barrier and not helpful in enhancing the professional identity of the academic and moving the profession forward. While the ‘the important thing is that we have people doing the work that improves the working life and career for nurses as for patient outcomes’ U1:P2:L5, it was also recognised that ‘being a researcher in nursing is legitimate or is in fact part of the descriptor of nurse academics [however]... it is hard to have all three [teaching, research and clinical]...’ U3:P4:14

The perceived requirement to maintain dual professionalism, competency and credibility continued to be compared by the participants with the structure of joint appointments in medicine as oppose to nursing. While participants did concede the medical model continues to work in the form of the apprenticeship type education, there were differences in so far as the variation in student numbers between the two professions (much less in medicine), remuneration equivalence offered to medical practitioners at Lecturer D / associate professor (L4) or Lecturer E / professor level (L5) which is not reciprocated for nurse academics; and finally the ability to practice as an autonomous practitioner and establish their own business practice something that nurses cannot do. As one participant stated:

‘...I think this is where medicine can teach us some lessons because they’re seamlessly involved in hospitals. Hospitals would not function without people who have academic positions in universities. Almost all of the senior clinicians...belong to a university and have a university position. I don’t see that at all impossible for nurses...’ U2:P4:15

Since the structure works successfully for medicine, the same should apply to nursing; however, this is not the case due to significantly large student numbers, the workload carried by nurse academics and the compromises being made in order to recruit staff.

The notion of dual professionalism has long been and continues to be debated. Although they are inherently linked, they are also a remnant of the dominant role that the clinical sector still displays. The profession and its academics need to acknowledge
the direction that they see would propel forward both the profession and their own identity. The nurse academic role is more than a specialisation within the nursing profession; it is a fundamental element in producing future nursing professionals and enhancing the professional identity of academics. Without it, as one participant emphasised earlier, ‘*hospitals would not function without people who have academic positions...*’ U2:P4:L5.

The emphasis and importance placed on the education of nurses was one of the main reasons that led to the transfer to the tertiary sector. Aside from the relevance of technical skills and abilities required by nurses as a practice based profession, the same value and credibility needs to be placed on the nurse academic who is responsible for the design, development and quality of education delivered. There is a clear imperative that needs to return to the professional identity and profile of a nurse academic that cannot be governed or achieved merely by a set of competencies; they need to include the academics’ ongoing contribution and credibility through teaching, research, service and practice to the profession. To achieve this, collaboration between the clinical and tertiary habitus needs to be established to recognise the critical contribution that each sector has to the education of future nurses and the integrity and standing that this will bring to the professional identity of the academics and clinicians, current and future.

The participants placed significant emphasis on the duality of their role due to the expectation to maintain credibility and competence in both the academic and clinical habitus. Though it is essential that flexibility and support needs to continue for academics to maintain their clinical expertise, it is important that one role is not traded for the other. Guidance, both formal and informal, from more experienced academic members is imperative to ensure personal and professional transition into the role,
along with socialisation into the culture and the sector (Hessler & Richie, 2006, p. 151). Nursing education and nursing practice were one and the same, during the hospital based apprenticeship system. However, the move into the tertiary sector contributed to the “polarisation of the relationship between university and the hospital” and “whilst the transfer did greatly advance the discipline as a profession; too often nurses academics became divorced from practice and at the same time, nurses did not utilise research and best practice findings to enhance their practice. The priority to move the profession forward; means that both “clinicians and academics need to leave the history of the apprenticeship model behind and lay to rest the debate of the theory to practice gap”, if collaboration and partnership between the two sectors is to succeed (Campbell & Taylor, 2000, p. 218; Grealish & Trevitt, 2005; Ousey & Johnston, 2006, p. 151).

Creating and enhancing a nexus

Central to the merger between the two habitus and the possibility of dual professionalism was the continued focus related to the modifications in the participants’ educational ideals, values and standards held by the tertiary sector, along with the initiation into the academic culture and the subsequent changes to their roles and responsibilities which became of paramount importance. As nursing education was no longer intrinsically linked to a particular healthcare facility, a shift in professional identity began to emerge.

A number of possible explanations as to why this struggle occurs can be attributed as Bernstein (2000) suggests to the notion of “power and control [which] are embedded in each other...” (p. 19). Power relations create, legitimise and reproduce boundaries between groups; and control establishes legitimate forms of communication forward in order to socialise people into the framework (or habitus) that
has been created. Both power and control contribute and form one of the many components of identity (Bernstein, 2000). The imperative to re-engineer and refocus the profession in order to identify common goals and core values, across both industry and the tertiary sector, is of vital importance. Many Australian nurses and their educators held high expectations for the profession as a result of the transfer. Knowledge advancement, as symbolised by the shift of educational venue into the universities, was predicted to ensure that its academics and practitioners would achieve parity with other healthcare disciplines, become part of the global marketplace and attain and maintain high standards through research. However, unacceptably low standards of entry into university programs along with funding inadequacies continue to plague the professional profile of nursing (Sellers, 2000, p. 18) (although a recent review in 2016 of a number of SONMs show a shift in the requirement for an indicative ATAR score of 60 while others continue not have ATAR scores as an entry requirement).

Devitt (2007) and Fealy and McNamara (2007) recognised that while the debate surrounding the beliefs, expectations and purpose of the initial education of nurses has been ongoing, this study has identified that the same debate now needs to extend to nurse academics. Even through this was identified as an issue during early stages of the transfer of nursing education (Luker, 2006), the focus was centred on the profession spending too much time being concerned with educating the rank and file and making sure everyone is on board and too little time on nurturing (creating) and encouraging (enhancing) the knowledge creators and producers (the educators); of today’s and tomorrow’s academics, leaders and research stars. In order for this to succeed, the critical elements are the academics, as they are strategically positioned within the tertiary sector, to drive and instil empowering behaviours and educational
imperatives to not only the students, but also their academic and clinical colleagues (Hokanson Hawkes, 1999).

The participants in the study were clearly committed to both their role and the discipline. However, the belief was that as a collective, the profession and its profile have a long way to go to achieve the status and maturity sought by its current and future practitioners and indeed its academics. Therefore, providing an avenue for debate that will include the nurse academics themselves, relevant professional bodies, policy makers, industry and the tertiary sector, will offer the opportunity to plan and deliver on expectations that will make it possible to meet the current and future nurse academics’ needs in order to create and enhance their professional identity. For this to be achieved, the profession needs to be promoted in a way that would attract both students and nurse academics. The option of ‘trying to encourage people early on to think about an academic pathway, a research pathway rather than just a clinical pathway...’ U1:P5:l4 by encouraging them ‘to do their honours’ U1:P3:l2 were some of the suggestions offered by the participants.

As the tertiary sector moves towards adopting a more business orientated model, the institution of academia and the premise of education are being viewed differently. Where once it was thought that it was a privilege and honour to attend a university as they were held in high regard, now the tertiary sector and the ‘faculties are going to have to rethink what they deliver in terms of flexibility and meeting the needs of the next generation...’ U4:P3:l3. This in itself has also contributed to the self-imposed boundaries and the continued siloing validating Bernstein’s insider-outsider concept between the two sectors (clinical and tertiary). While it was identified that a weakening of these boundaries was occurring in contemporary educational systems, it appears that nursing continues to experience the notion of the insider- outsider
mentality through the belief of the “sacred” (Bernstein & Solomon, 1999, p. 461; McNamara, 2006). The participants identified with this principle, particularly when relating this to the clinical sector, their credibility and the premise of dual professionalism (clinical and academic). However, they also identified their role from a broader perspective as a change agent and gatekeeper that acknowledged academia as a key determinant to the status of the profession and themselves as academics along with the opportunity to make their mark and contribute to the future direction of nursing.

Tensions continue to exist between educational values of university based nurse education and the practice needs of hospitals. Promoting collaboration between industry and academia has taken on a number of forms over the years (eg. joint appointment, shared approaches to decision making and leadership). However, there continues to be the need to strengthen relationships between the two in order to bridge the gap. Collaboration and partnership are not simply about determining best practice; it is about an obligation to ensure that the two sectors see each other as essential parts of the profession. Despite the encumbrances of increased workloads with staff in both sectors, industry cannot afford to construct professional practice without academic input. At the same time, academics cannot afford to stand outside and merely theorise on professional nursing discourse and practices without immersing themselves into the realities of the practice arena (Campbell & Taylor, 2000, p. 212; Forbes & Strother, 2004); as ‘...industry doesn’t determine scholarly achievement, scholarly achievement determines practice...[as] if you look at the tradition of the university across the discipline spectrum...better knowledge often leads to better practical outcomes’ and that:

‘...we need to be partners...[with] nursing organisations and the leadership of...
those lobby groups need to be at the table... trying to negotiate commonwealth / state [territory] agreements so there is funding included in both the tertiary and healthcare models to allow for industry based PhDs, honours students, research fellows, more clinical chairs that are actually set up properly so that they achieve some good outcomes...it is all of our responsibility...’

Although most participants agreed that industry continues to oversee nursing education there needs to be a clear structure for partnership and collaboration developed in order to move forward. Hence the agreement that joint appointments (the employment in both the clinical and academic arenas with either a clinical or a purely research focus discussed in Chapter Four) was seen as a viable option to build a better relationship between the two sectors, one consistent with nursing being a practice based profession. Therefore, the assertion made by the L4 and L5 group that the tertiary sector and industry is policy led (more often than not, is reactive versus proactive) rather than profession led, has merit.

How does this then impact on the creation and enhancement of a nurse academic’s professional identity in the tertiary sector, if innovation and creativity in evidence based research and knowledge creation are being predetermined? It is important to note that this does not in any way dismiss, reject or ignore the necessary legislative requirements that govern practice and the criteria that determine what constitutes a profession. What it is attempting to establish is whether these formal, fixed structured boundaries are contributing to the creation of silos (Bernstein’s insider-outsider concept) whereby identities are defined in opposition to one another and dominant social structures along with enduring practices operate to keep apart certain social groups, domains of knowledge and experiences (Bernstein & Solomon, 1999; McNamara, 2006).

In recent years, government interventions and initiatives have impacted on issues related to autonomy, education, practice, claims on specialised knowledge along
with political and economic position to name a few. Nursing academics considered these challenges a crisis that assaulted their profession, their commitment to their chosen discipline and have contributed to their loss of identity (Beck & Young, 2005, p. 184). McNamara (2009a, p. 485) maintains that central to an academic’s identity is the involvement of “putting language, action, interaction, values, beliefs, symbols, objects, tools and places, together in such a way that others recognise you” as an academic engaged in academic activity and as a nurse contributing to the discipline and profession. The term academic nursing, was introduced by McNamara (2009a) to differentiate between the hospital based system and nursing within the academic sector as the constructs of academic nursing are not only lacking but are failing in their ambitions and attempts to become a distinctive academic and professional discipline. Furthermore, the inclusion of nursing science within the constructs of academic nursing, may have possibly contributed to the profession’s “invisibility and inaudibility” both within the healthcare sector and within academia itself, once again distorting professional identity. The implications of these issues have contributed to the ongoing challenge of recognising the importance of nursing’s identity, its clinicians and academics (McNamara, 2009a). One participant commented that in order to achieve this:

‘I think we must get our terminology right. I risk offending some people but I have believed passionately for over a decade we should get rid of the term ‘nurse educator’. It’s a ridiculous term, it’s just confusing. If you work in a university you’re an academic, if you teach in a hospital you’re likely to be a clinical resource person’ U2:P4:L5

Another participant referred back to the importance placed on having the appropriate qualifications in order to be employed as an academic, commenting that:

‘The first thing to come when there is a problem [with students] is always education. We are back on the cycle here in [state name] at the moment there are educators everywhere, completely untrained [with] no qualifications, no
idea really what they are doing, but they’re educators running around reinforcing this concrete thinking’

The move to the tertiary sector saw the hospital sector release themselves from any responsibility for their educators, bringing about considerable pressure on university management to ensure that the profession’s academics met the necessary selection criteria and requirements across the three domains of teaching, service and research (Gethering & Leelarthaepin, 2000, p. 148). Underpinning the move was both an assumption and expectation that a joint partnership between clinicians and academics would emerge. However, the strong cultural differences between the two habitus, has proven to be an impediment in achieving a successful outcome. In essence, the relationship was guillotined by both sectors and what was created in its wake was a two-fold approach to nursing education whereby the universities established the SONMs (initially based on the hospital based apprenticeship framework) and the remnants of the hospital based system continued on in the form of education units / departments in industry: “Insufficient attention devoted to the fundamental cultural differences between the academic and clinical fields has been suggested as a major underlying reason for the existence of the academic-clinical divide…” (Happell, 2005, p. 1224). One participant attributed this to management and political bureaucracy whereby:

‘...the difference in the industry sector [is that] everything has to be done quicker, the timeframes are shorter, people don’t want to discuss things as much [and] just want a clear decision with confidence. In the university system it’s considered quite acceptable to have long periods of meetings and consultation the hospital setting...its very stressful and very political and [there is a] hierarchical distinction the industry sector as a whole and the university sector as a whole, do not always work well together and the silos in those areas is an issue for nursing education, clinical placements and academia’

Despite the fact that nursing has been in the tertiary sector for over 20 years, remnants of profound effect that it had on the educators and the notion of the loss of
clinical credibility still lingers. There is no doubt that becoming an academic involved a socialisation process that takes the individual on a path that crosses over two cultures. Professional competence and credibility for academics required (and continues to require) not only attaining the relevant level of qualifications but the life-long participation in the creation of new knowledge and its application to theory and practice. The most challenging aspect in maintaining dual professionalism is having input and active participation in both a clinical and academic context (Andrew, Ferguson, Wilkie, Corcoran, & Simpson, 2009; Happell, 2005). However, this is not reciprocated from a clinical view even though the overarching definition of an RN, “includes the responsibility to examine nursing practice critically and to incorporate the results of personal action research or the research findings of others” (NHMRC, 1991, p. 4). The question then remains as to why the clinical sector expects nurse academics to continue to justify their professional credibility and tertiary based education when clearly the roles (academic and clinical) not only cross sectors but coincide, something that the participants maintained throughout the study:

‘...nursing is actually starting to get the picture that they can’t be isolated in a hospital or isolated in a university...both...are at fault if there is no nexus!’ U5:P1:L3

‘...it’s more than the fact that we are just a practice based discipline...look at the ones who have got it right and where it works well, use it! I am not an apologist for academia. I’m clearly a believer in a rigorous education that is not training!’ U5:P5:L2

The participants have talked about the importance of collaboration and partnership between the two sectors. However, the problem is that this collaboration has not been realised as academics feel that the level of clinical credibility they need is overstated. Adding to this is that they do not feel that their academic credibility is respected by the profession ‘out there’. As one participant commented:

‘One of the difficulties is that we can idealise things around evidence based
practice and you need to be independent decisions makers and you need to have a level of enquiry... But the reality is that the way the healthcare system is set up sends a completely different message. It is set up with all the talk that says we want nurses to do this, but all the structures that are put in place are such that it sends a very clear message that you are not to be thinking on your own. You follow this policy and if you deviate from that policy then you are in trouble [so] what’s the point of enquiry’ U2:P3:L3

For nurse academics the change of emphasis from training to education (discussed earlier) was viewed as highly significant and was a key point of tension between them and the clinical world which persisted in wanting a competent but not necessarily academically intelligent workforce. The differences of teaching between the two sectors were aspects that all the participants commented on as ‘...it was like coming to another planet really; I called it planet academia...’ U5:P3:L2, as teaching in the clinical environment was ‘aimed at the specific needs of first all of the organisation’ U3:P4:L4 which was ‘very much skill based’ U4:P6:L2 whereas it was ‘very different to the way you teach in a classroom situation’ U3:P3:L3. Key to these insights, were issues surrounding the body of knowledge and research undertaken and developed by the discipline along with the contribution participants had made themselves. Creating a nexus would require significant collaboration between the sectors as these two participants said:

‘...[we] are trying to bridge the gap and move up, but recognise that they need to be in this [academic] environment to be able to have the relevance of their work [recognised and] I need to be in that [clinical] environment to make sure that my work has relevance’ U2:P3:L3

‘...good work has been done about nursing, outside nursing. Surely we can be professionally strong enough, safe enough [and] confident enough to say welcome...’ U3:P4:L4

From the perspective of hindsight, the starting point to enhance this should have been the review and use of the three distinct pathways offered in nursing - administration, clinical and education (discussed in Chapter Two), paying particular attention to education. Prior to the transfer to the tertiary sector there was a strong
conviction that an educator required additional qualifications in order to be considered for the position leading to an increased professional identity of the RN undertaking this role. However, the requirement for educational qualifications no longer exists, adding to the already diminished professional identity. The importance of returning the emphasis on higher educational qualifications to hold these education positions would be a way of increasing the pool of qualified nurses to once again increase their professional identity and link both sectors together. Taking into consideration that the main recruitment pool for nurse academics is the clinical arena, it stands to reason that the middle ground and link for the roles are the education units / departments within the hospitals. While not dismissing the value that these departments have brought to clinical staff in continuing professional development, graduate programmes and research, they are the remnants of the hospital based education system and continue to remain isolated from the academic sector. Altering the titles (as one participant suggested earlier) of the staff development nurses, to reflect their role as ‘clinical educators’ on a ward / unit (who would have the opportunity to rotate into the education unit) and retaining the current structure of an education unit (known as the ‘academic and professional education unit / department) that is staffed by academics who also teach in the SONMs as joint appointments would see both sectors and the roles merge. It was the education of nurses that was transferred into the tertiary sector, therefore it is the academics, who educate the nurses that need to return to the forefront of change which will create and enhance the nurse academics’ professional identity in the tertiary sector.

The nexus could be as simple as changing a single word, title or even action that can represent a specific identity. The focus on creating and enhancing a nurse academic’s professional identity is underpinned with what I believe and what
academic medicine has been founded on: the three pillars of research-teaching-clinical practice and the interrelationships between them (Kumar, et al., 2011). Although the participants did not readily agree with the notion and title of nurse academic nor did they believe that any other healthcare profession chose to identify themselves in this manner, additional research into this concept (which was neither the aim nor part of the focus of the study) has revealed that this in fact does exist in medicine (Tulinius, & Hølge-Hazelton, 2010). Longitudinal and retrospective studies of doctors suggest that academic career choices are related to personality, learning environment, long-term participation in research, intellectual stimulation, achievement, content of specialty and influence of mentors and role models (Kumar, Roberts, & Thistlewaite, 2011; O’Sullivan, Niehaus, Lockspeiser, & Irby, 2009, p. 336), not unlike what this study has revealed. What is highlighted here is the notion of the three pillars research, teaching and clinical practice in comparison to nursing academic’s foundations of teaching, research and university service. Shifting the focus of the nurse academic from the current structure of teaching-research-service and creating a new nexus of teaching-research-practice would encompass a career trajectory that will span across the two sectors, increasing their professional identity. It is a nexus that would require the review of current academic and industry structures to accommodate the changes.

In summary

At the core of nursing is safe practice and quality patient care built on a rich combination of education and practice. “In industry, skill acquisition is considered an essential component of gaining clinical competence, along with knowledge, attributes, values, beliefs and behaviours appropriate to professional nursing practice” (Scully, 2011, p. 18). Although credibility and competence are linked to relevant qualifications, expertise and experience, it could be claimed that nurse academics have a more
rigorous job to maintain dual professionalism in both the clinical and academic habiti
in order to establish their credibility and professional identity. In this section the
participants clearly believed that nursing and its academics are professional and have a
legitimate place in the tertiary sector. However they continue to experience
challenges within both the tertiary and clinical habiti. Notwithstanding this evidence,
the data provided the basis for the development of a framework to illustrate elements
that would support the current and future professional identity of nurse academics
within the tertiary sector. In line with forming the study’s framework, the information
in this section adds power and autonomy to the key elements and links identified as
the professional identity of a nurse academic.

Conclusion

This chapter titled Creating academic identity demonstrated the diverse and
multi-faceted views on the three subthemes. The first, defining a nurse academic,
reflected the participants’ responses of what they considered defined and / or
described this concept. The findings from the second subtheme, nursing: profession or
vocation, focused on their views surrounding the dichotomy between the two
concepts for the discipline and its academics. Finally, the third subtheme, a matter of
competence and credibility, explained the participants’ understanding of the
differences between competence and credibility, the opportunity to make dual
professionalism a possibility and how a nexus can be created to enhance this between
the clinical and academic habiti.

The findings from this chapter suggest that the participants deemed nursing
and its academics to be professional and that there are no differences between a
nurse academic and an academic, despite their continual reference and concerns that
this may contribute towards the perceived notion that nurse academics could be somewhat different. It is also suggested that in order to create and enhance a nexus “industry cannot afford to construct professional practice without academic input. At the same time, academics cannot afford to stand outside and merely theorise on professional nursing discourse and practices without immersing themselves into the realities of the practice arena” (Campbell & Taylor, 2000, p. 212; Forbes & Strother, 2004) all of which contribute towards professional identity.
Chapter Six
Discussing the findings

Chapter insight

There is no doubt that education is foundational to how a discipline manifests itself and a how a profession defines itself throughout the course of a career trajectory (Bleich, 2011). The transfer of nursing education into the tertiary sector contributed to its professional status and credibility as an academic discipline. Therefore it is important that nurse academics find their voice to convey and advocate the complex and dynamic involvement needed in this context that will support their professional identity in the tertiary sector.

The study provided valuable insights into the participant’s understanding of the topic through a series of questions posed during their individual interviews that identified their views and provided suggestions that they believed would successfully improve and see nurse academics (including themselves) achieve a professional identity within the tertiary sector and also one that would be reflected within the healthcare industry and society. The importance placed on moving the profession and its academics forward in this context was a clear indication of the value placed on this study, the future directions and options that would enable it to expand its scope.

After reviewing the literature and analysing the data it was revealed that tensions and challenges continue to exist with acknowledging professional identity. Contributing to these are the ongoing historical, cultural, economic and political influences and the subsequent impact on the status (related to the qualifications, remuneration equivalence and recognition), validity and credibility within the two habitus that the academics find themselves being a part of. In addition factors such as
the importance placed on academic and professional leadership; the dichotomy that exists between profession and vocation, issues of competence, credibility, dual professionalism and creating and enhancing a nexus between the two habiti that provide the platform for the academics to move forward in order to create and enhance their professional identity were also found to contribute to these tensions and challenges. This chapter will add to the discussion under the concept of identity, followed by the two key themes represented in Chapter Four Setting the scene and Chapter Five Creating academic identity, their ensuing subthemes and concepts interpreted from the participant interviews. Finally, this chapter will provide the study’s framework related to the creation and enhancement of a nurse academic’s professional identity.

Creating identity

When looking at professional identity within the context of this study it was found to be intrinsically linked to the practical workings, the projection of professional knowledge and to the expectation that nurse academics would “display their academic credibility” by creating this knowledge (not just recontextualising) through research and publications. This ensured that academic identity would be constituted in and through language and interactions with other academics and with clinical nursing colleagues (Fealy and McNamara 2007a, 1394). However, more often than not, the academics found “themselves represented in professional and popular discourse as a doubly profane presence in academia”. First, due to the discipline’s origin “in an occupation which was viewed to be concerned with the intimate bodily care of patients” and second, attempting to attain “academic ambitions that are depicted as vain and self-serving, directed at the pursuit of status and material reward rather than
knowledge to improve nursing practice” (O’Connor, 2007, p. 749).

While historical events were not the main concern of my study, the information was used to prove the trustworthiness of how the present came to be and how it has dominated the shaping of nursing’s professional development and the professional profile of its academics. The elements of temporality, namely history, culture, politics and economics, have plagued and played a significant part in the discipline’s and academic’s progression and expansion. Learning from the profession’s rich history can be used as an advantage to move forward. Despite this history, the political inquiries that examined all aspects of the profession (eg. its education system, clinical practice, scope of practice and boundaries, workforce capacity and relationship between society and interprofessional collaboration), including the impact and subsequent follow on effect that the transfer to the university has had on educators who are now working within the tertiary sector (Fairman & Okoye, 2011) as nursing academics, was found to be sadly absent.

The data demonstrated that the profession has the capacity to actively increase their profile and involvement in the political arena through leadership at the highest level. However, these political and social changes will impact on how current and future academics view the profession and particularly how they see themselves in the context of their professional identity. Nursing’s future as a profession depends upon the extent to which it can create space to manoeuvre in both the clinical and academic environments. Thus nursing’s freedom to expand intellectually by crossing disciplinary along with political borders “hinges upon its power relations with other kindred healthcare disciplines” (Fealy & McNamara, 2007a; Rafferty, 1996, p. 188). The profession needs to acknowledge the path it has travelled to-date to achieve its position in the academic sector and the success of achieving well educated clinicians
and academics that will contribute to and meet national and global mandates. The growing evidence base confirms that these professionals have a critical and positive impact on healthcare (Daly, Macleod Clark, Lancaster, Orchard, & Bednash, 2008b; Shorr, 2000). In order to successfully achieve this goal, the clinicians need to return as academics and the option to become an academic needs to target those clinicians and graduates who have an affinity with teaching, research and / or do not wish to consolidate their clinical skills (specific to new graduates) needs to be created and offered that will further create and enhance the nurse academic’s professional identity in the tertiary sector and propel the profession forward.

Although past historical, cultural, political and economic influences have contributed towards the profession’s decline in image, profile and identity, significant changes have been seen within Australia. The federal government demonstrated its commitment to reform in health and education as a number of key strategic policy initiatives were released opening new possibilities for nurses’ (and midwives’) contribution to a new healthcare landscape (eg. Health Workforce Australia (disbanded in November 2014); and the appointment of the National Chief Nursing Advisor). However, political involvement and progress cannot just be isolated to Australia. In the current world of globalisation and internationalisation meeting the demands related to socioeconomic factors, technological advancements, the changing patient profile, will undoubtedly affect the practice and identity of nursing in the future. Furthermore, policy changes as well as the drive for professional advancement will continue to impact nursing education and its academics (Hegarty, Walsh, Condon, & Sweeney, 2009, p. 1; Law & Muir, 2005, p. 150; White, 2009).

The expectations associated with the roles of professionals, includes participation in policy making along with what actually constitutes this action at the
grass roots in order to have any influence within the political arena. Political action is integral to the profession’s role as advocates for clients and each other in order to maintain solidarity through professional organisations (McMurray, 2010, p. 114).

Although the participants agreed that the discipline needed to acknowledge that the political agenda does influence nursing quite markedly as health is a major political issue and will continue to be as today’s consumer is more informed regarding their health, the discipline as a whole (including its academics) needs to become more politically astute and active. Being selective, insular and operating in a silo related to practice, education and research leads to a failure to clearly and distinctively view the role within a socio-political context that “subjugate[s] good health to political relationships” In addition, the failure to see how the political economy of healthcare can be a vehicle for professional development leads to the profession and its practitioners under-valuing their work (McMurray, 2010, p. 115).

The drive for professional advancement will continue to impact nursing education and will undoubtedly affect the practice and identity of nursing and its academics. While significant work is being carried out in the international arena by Australian nurse academics at the highest levels (eg. WHO, ICN, GANES); White (2009) asserts this will “begin a multi country initiative to enhance nurses and midwives access, input and influence in health policy” (p. 100). However, this needs to be extended into the tertiary sector with measures that will increase the profile of the profession and its academics, and as such, influence policy on entrance requirements and promote nursing as a career of choice and an essential partner the provision and delivery of healthcare. Whilst this is a time of change for the profession, the importance of promoting the profession’s achievements and maturity in both national and international arenas will have significant influence in the creation and
enhancement of a nurse academic’s professional identity in the tertiary sector. This can only be achieved through leadership and empowerment of its current and future academics.

**Setting the scene**

Entering and working in the “critical, higher order thinking” (Thompson, 2009, p. 694) of the tertiary sector challenged the abilities, capabilities and qualifications of individual academics and brought into question their notion and sense of identity that would allow them to operate in this new environment. These changes contributed to how academics are viewed and how they view themselves (Abbas & McLean, 2001; Beck & Young, 2005; McNamara, 2009a). Unfortunately, a sense of loss was experienced which was seen to not only attack the individual’s academic identity but their professionalism as well (Beck & Young, 2005).

Chapter Four *set the scene* by demonstrating the diverse and complex career trajectory of academics into the tertiary sector. The findings focused on the participants’ reasons why they chose to enter nursing and subsequently the tertiary sector. It concerned their insights and experiences that surrounded their employment and explained the participants’ understandings associated with their application process. The meeting of necessary qualifications, concerns with remuneration equivalence, performance and promotion along with sentiments experienced with the cultural shift from one habitus to another, role expectations and responsibilities in what constitutes an academic, the significance placed on the individual’s academic preparedness and leadership.

The data from the first subtheme (*entering the tertiary sector*) revealed the importance placed on a standardised application process for the recruitment of nurse
academics. It included the use of consistent selection criteria (not ‘changing the goalposts’) recognising the need for appropriate academic qualifications and remuneration for each particular academic position and level; in order to recruit and retain academics in what was identified as, a fundamental nursing specialty.

The pressure placed on staff to attain (if they do not already have) and / or increase their qualifications to meet academic mandates would need to take into consideration the workload placed on academics and create increased opportunities for academic promotion once the requirements have been met. The review of SONM workplace structure in so far as the efficiency, effectiveness and use of resources and staff, would also need to be taken into account. Comments extracted from the university profile questionnaire along with the majority of the participants in this study coupled with what was found in the literature reviewed, reinforced that this would need to include a culture that supports and encourages staff to undertake further studies and academic promotion. The nomination of mentors to support and assist staff through the process (Brown, 1999; Huston, 2010; Kerfoot, 2003; McArthur-Rose, 2008; Vardi & Quinn, 2011; Wilson, 2007; Young, Pearsall, Stiles, Nelson & Horton-Deutsch, 2011), along with the availability and flexibility within the structure to accommodate staff promotions would provide them with the opportunity to undertake a role commensurate with their qualifications, expertise, experience and the academic promotion level that they successfully achieved.

While consideration was given to the review of academic salary structures that would reflect industry equivalence, this was outside the scope of the study and would not be appropriate due to the differences in industry remuneration between disciplines and would cause significant implications across the entire tertiary sector. Therefore, attention will need to be given to the dichotomy that could be (and to a
degree already has been) created between the increased value placed on practical experience versus academic qualifications and requirements (eg. higher degrees, publications). The offer of remuneration equivalence without imposing conditions could be a catalyst for the erosion, rather than the creation and enhancement of nurse academics’ professional identity, as it offers no incentive to articulate, enact and affirm their academic credibility.

Nursing education has been in the tertiary sector in Australia for over 20 years now, however, the cultural life of these large institutions continues to present challenges for the nurse academics. This has been attributed to the roles and responsibilities, academic preparedness (eg. workloads, attainment of additional qualifications), the need to meet research (Jackson, 2008) and university service imperatives, along with the added pressure to maintain dual professionalism which were discussed in the second subtheme - working in the tertiary sector.

The participants’ decision to move into the academic sector was spurred on by their attraction to or aptitude for teaching as well as their commitment to becoming a change agent and gatekeepers of the profession. When giving their account of working in academia, they focused on the lack of socialisation into their new habitus, and lack of clarity surrounding their new identity as an academic. They sought to understand their roles and responsibilities through their individual position description and associated workload attributed by the university mandates (teaching, research and university service) and clinical practice expectations rather than in terms of their primary role of academics to “enable, facilitate and support practicing nurses” and students within their own environment in order to meet “their own educational, research and practice agendas” (Rolf, 2006, p. 124). This would ensure the integration of scholarship into practice and give rise to the argument that education, practice
development and research are the primary roles of all academics regardless of level (Rolfe, 2006). The implication of these findings has an impact on how academics are identified and characterised across the two habitus. Without a clear framework of what constitutes the professional identity of a nurse academic, the role has the potential to remain siloed between the two sectors.

Successful leadership was seen to be instrumental in empowering and enhancing the link between the two habitus which in turn will increase the professional identity of the academics and be a contributing factor in nursing’s future trajectory. The challenge for leadership would involve a two-fold collaborative approach in so far as: (a) “contemporary policy leaders must now see nurses (academics and clinicians) as essential and equal partners in policy decisions at the national, regional, local, institutional and practice levels” and (b) “nurses (academics and clinicians) must see themselves as essential policy leaders responsible for identifying roles and opportunities for policy leadership in their own commitment to be personally engaged in policy across all levels” (Hader, 2011, p. 35; Huston, 2010, p. 332). This, confirmed the importance of increasing the professional identity of nurse academics through collaboration across the two habitus. The project needs to begin with claiming the language / nomenclature and discourse that clearly reflects and represents the profession as individuals and as a collective group. Relinquishing this, as seen in the UK and now in Australia where a number of nursing departments or faculties have replaced nursing with the broader term of health or health science whereas disciplines such as “medicine...for instance, have never done this” (Thompson, 2009, p. 695) has implications for the identity of not only the profession as a whole but its clinicians and most certainly its academics. It has the potential to support a continued subordinate view and status within the academic and healthcare sectors that is far removed from
the profession’s profile as a self-regulated and autonomous discipline.

Enhancing academic identity

In Chapter Five, the narrative continued with the second theme creating academic identity. The first subtheme of defining a nurse academic driven by the particular question set (S2: Exploring the possibilities) as discussed in Chapter Three asked the participants about their personal definition and / or description on how they would define a nurse academic, how they view themselves and if a difference existed between an academic and a nurse academic. As discussed in Chapter Five, these questions were not something that the participants had considered or that they identified as one or both which demonstrated a degree of indecisiveness and a sense of confusion surrounding this term.

Creating and establishing a sense of identity proved to be a challenge as the majority of the literature reviewed provided a number of titles and descriptions for nurse academics. The numerous titles were used interchangeably with other terms (eg. academic educator, professional teacher, higher education lecturer) further compounding and complicating professional academic identity, something that was not seen in other healthcare discipline (Billings, 2003; Cowan, Norman, & Coopamah, 2005; Davis, Stunddenbarger, Dearman, & Kelley, 2005; Young & Diekelmann, 2002). This was supported by the variations in the participants’ responses, showing that there does not appear to be a clear consensus on this term. To added to the confusion, as part of this question set I asked the same participants if there was a difference between a nurse academic as opposed to an academic. Certainly from the participants’ point of view, there was a need to emphasise the term ‘nurse’ when discussing this term. Overall, the participants did not view this as a point of contention
as it was seen as one and the same; however, they continued to refer back to
describing their roles and responsibilities to justify their responses.

Regardless of which definition and / or description is used, it is significant to
acknowledge that defining a nurse academic impacts on how professional identity is
portrayed and created. I would agree that the definition provided by Kenner and
Pressler (2006) who defined an academic as “a highly educated person who works as a
researcher and usually teaches at a university” (p. 139) is the only definition that
offered a clear description of this term that did not add a descriptor to differentiate
between professions.

The second subtheme discussed the notion of nursing: a vocation or profession
which included the participants’ views on not only how they saw the profession but
themselves. Nursing has been intrinsically and extrinsically (Nelson, 2000) influenced
and shaped by its history and the control exercised by the medical profession and it is
this, more than any other factor which has caused nursing to be regarded as a
vocation, with a subordinate status within the healthcare and academic sectors.
Questions associated with how the nursing and the profession is defined and what in
actual fact constitutes this, have been explored since the 1950s and are replete with
vocational descriptions (Henderson & Nite, 1955; Carr-Saunders & Wilson, 1964) and
are in sharp contrast to the ones offered today by the professional peak bodies
(Guerrieri, 2011; Middleton et al. 2009) such as the ICN and NMBA that use and
emphasise the language of a profession versus a vocation.

The move from the hospital based apprenticeship system “into an arena that
traditionally values theoretical and propositional knowledge rather than vocational
and interpersonal skills” (Andrew, Ferguson, Wilkie, Corcoran, & Simpson, 2009, p. 607) has also contributed to the continuing reluctance within nursing itself to
embrace the academic agenda. I would view this as a reaction against a culture that would have regarded nursing’s vocational nature and defined practical activity, as “inferior to abstract thinking skills” sectors (Andrew, et al, 2009, p. 607). The question of whether or not nursing and its academics should be considered a professional academic discipline is not up for debate (Budden, 1994), as it has been firmly established in the tertiary sector for over 20 years. However, the preparedness of nurse academics to continue embracing the higher education sector is fundamental to the question of how they manage their transition from vocation (practice) to profession (education) and subsequently how they perceive their own standing and identity within both sectors (Andrew, et al, 2009). This was compounded and continues to be compounded by the difficulty of attracting appropriately qualified staff into academic sector; as senior clinicians and indeed educators were not used to teaching outside the confines of the hospital environment (Smith, 1999).

Although research has addressed the legitimisation of the discipline within society and its standing amongst other healthcare professions, little literature was found to address the professional profile and identity of its academics. Providing a legitimate basis to claim professional status cannot be based on the mere calling to serve a greater purpose in society but needs to be defined. Despite the clear preference and conviction amongst the participants that the nursing discipline is a profession and its academics are professionals, it continues to cross from one boundary to another.

The final subtheme in enhancing professional academic identity was the matter of competence versus credibility. Participants were found to be divided on this issue, as some did not believe that competence across the three areas of teaching, research, and service was achievable; while others linked the roles together in that research
creates knowledge, which in turn is taught and put into practice. Although it could be argued that they are intrinsically linked, it could also be said that it is a remnant of the dominant role that industry still displays. This is very much due to the application of theories and prescribed tools developed by the regulatory bodies that are extensively used in this setting. Whilst these were discussed during the interviews, the participants made no mention or connection when the question of competence was asked which raised the issue of relevance within the academic context, role and connection to professional identity. What is of note, is that one of the main essential selection criteria to be employed as a nurse academic in a SONM continues to be based on the individual being an RN as it is seen to contribute to professional credibility, bringing once again to the forefront the two distinct roles and professions, the academic and the clinical. The notion of dual professionalism became clear with the shift “in identity towards embracing higher education pedagogical research and disciplinary educational knowledge that would underpin professionalisation” (Hurst, 2010, p. 240). This meant that academics were knowledgeable in their specialty area along with education methods of teaching and learning theories and practices; they were research active and took responsibility for their continuing professional development. The participants agreed that these two distinct roles brought with them the importance of competence as it showed practice leadership in their area of expertise, the ability to make a statement about contemporary professional engagement and it demonstrated that academics are contributing to the body of knowledge (sacred and profane) that constitutes informed practice. However, this also meant that there was an expectation that academics would maintain their competence across both sectors, even though they were no longer employed in or by the hospitals. This continues to challenge nurse academics as the expectation to be competent in
two distinct roles, across two distinct professions and in two distinct working environments has further widened the gap between the two sectors.

Amongst nurse academics there is little consensus as to what it really means to maintain clinical practice credibility and competence (Ioannides, 1999, p. 207). As discussed in previous chapters, the nursing registration pathway, demands that its practitioners comply with not only registration requirements but also meet professional competency standards and guidelines which ensure consolidation of theory to practice (Rose & Glass, 2009). The participants agreed that having clinical (practice) credibility is important, however, it does not mean that they need to be at the bedside to achieve this. Linking the two roles and merging the boundaries between the two habitus would enhance and achieve “it’s full potential” (McNamara, 2010c, p. 383) towards their professional identity in the tertiary sector.

**Nurse academic professional identity model**

The evidence extracted from the data provided the basis for the development of a framework to illustrate, what I propose to be the eight fundamental elements that would support current and future professional identity of nurse academics within the tertiary sector. These elements are central to this study and are based on the theoretical approach of Bernstein’s sociological model, McNamara’s application of Bernstein’s work and the findings from my study. Furthermore, they support the design and analysis of my findings but also confirm the participants’ experiences who validated the development of this framework.

I have used Figure 1.1 introduced in Chapter One as the basis to form the framework for this study. It illustrates how the nurse educator moved from one all-encompassing habitus where both training and practice existed; to two distinct ones
where education and practice crossover and co-exist in two separate habiti (nursing and academic profession).

Figure 1.1: The habiti

While the framework (see Figure 6.1) appears simplistic in its design in what was a dynamic and complex process, it proved to be useful in illustrating the relationship between the components and key elements that form the professional identity of a nurse academic.

The framework looks at the professional habitus of the tertiary sector that recognises that the academic belongs to two equally important habiti, nursing and the academy (illustrated by two circles) each with their own distinct boundaries (identified by the arrows). The boundaries (identified as the edges of each circle) show that while each habitus has its own boundaries they do intersect as the academic is required to form and exist in a strong and inclusive relationship between the two habiti.

Intersecting the two habiti and central to the framework are the academics themselves as they are strategically positioned within the two habiti to portray, promote and instil the elements (and associated behaviours and educational imperatives) that will increase professional identity. Surrounding the professional habitus of the tertiary sector (nursing and the academy) are the eight elements that form the professional identity of a nurse academic namely:
Figure 6.1: Nurse academic professional identity model
1. **Temporality** which is linked with the profession’s history, culture, politics and economics and the extent to which past practices and identities have informed the present and relative status attached to them; both for the profession (nursing and academic) and individual academic;

2. **Knowledge** which emphasises and respects the importance placed on the creation and development of the highly valuable and specialised body of knowledge which in turn supports the status and professional identity of the academic;

3. The **Policy and Compliance** element is connected to the importance placed on the legislative, professional, academic and organisational requirements in which academics work within; and the external peak bodies that govern institutional and organisational accreditation and individual practice registration;

4. **Qualifications and remuneration** emphasises the value given to the extended education, scholarship and appropriate remuneration of academics, which in turn gives rise to the integrity, credibility and professionalism and identity of the academic;

5. The **Socialisation** element is linked to a smoother transition that provides clarity and understanding into the culture, structure, language, behaviours, values, responsibilities, norms, beliefs and practices that shape the academic role and environment;

6. The **Leadership** element showcases the importance placed on shaping and empowering current and future academics leaders (regardless of level), that will promote and support a sense of autonomy and maturity in the academic’s professional identity;

7. The element of **Language** reflects the significance attributed to the use of nomenclature that recognises, values, frames and promotes the professional
identity of the academic within their professional habitus; and finally

8. **Power and autonomy** which is linked to the element of **leadership**, ensures that academics recognise that as individuals or a collective group they are able and allowed to accomplish their goals, possess the autonomy in their decision making process and practice and ultimately establish their professional identity within their chosen career and working environment.

**Moving forward**

Many potential challenges lie ahead for the profession of nursing and consequently (Hegarty et al, 2009, p. 1) its academics that will undoubtedly affect nursing practice in the future. Whilst the participants were clearly committed to their role and the discipline, the overarching belief was that as a collective, the profession, its profile and professional academic identity has a long way to go to achieve the status and maturity sought by its current and future academics and clinicians. The contention that there are nurse academics who do not wish to be in the academic habitus and/or are unwilling or unable to play ‘the academic game’ raises important questions related to, as McNamara (2006) asserts, their professional identities, career trajectories and the quality of the educational programmes in which they are involved, their research output along with the status and future of nursing as a scholarly and academic discipline.

Notwithstanding the tensions, challenges and influences experienced over the years (identified and discussed in this study), the nursing profession and its academics need to continue to address the rapidly changing contexts of healthcare and education requirements needed within Australia; whilst at the same time recognising the increasing importance of their contribution as members in what is now a global
community and the effects on their professional identity. Nursing as a profession along with its academics have “the dual right to be socially and intellectually inclusive whilst at the same time [being] separate and autonomous” (McNamara, 2010b, p. 768) as part of the global marketplace and continuing to attain and maintain high standards through research. In a world of globalisation and internationalisation, academics need to take into consideration these perspectives when creating knowledge and delivering the education. Not acknowledging this will become the catalyst, at the macro (national and international levels), meso (professional expectations including increase in professional identity) and micro levels (ultimately improvement of positive outcomes related to client care) (Law & Muir, 2005, p. 150; White, 2009). The ability to provide high-quality care is to a great extent dependent on the availability of well-educated (Luker, 2006), credible and competent academics and clinical professionals.

In Australia, as has been indicated above nursing education has been in the tertiary sector now for over 20 years and high expectations continue to be held to achieve and maintain parity with other academic disciplines. The education of nurses is fundamental in defining them as professionals as the drive for professional advancement will continue to impact nursing education and will undoubtedly affect the practice and identity of nursing and its academics. The promotion of the academic as its own distinct specialty (as a change agent and gatekeeper) and a model that acknowledges this particular role will raise the status of the profession and the professional profile of the individual academic which will provide the opportunity to make their mark and contribute to the future direction of nursing.

Innovative leadership is needed in academic institutions in order to meet and deliver on the increasing demands of what needs to be, high quality education (Chen, Beck, & Amos, 2005, p. 374). Academics as leaders must recognise the need to
become both politically astute and active participants at local, national and international levels in order to address any inadequacies that may exist in the profession’s development. Issues such as unacceptably low standards of entry into university programs along with funding inadequacies, weak infrastructure, low morale and attitudes of apathy and inertia cause the term ‘professional nursing’ to be an abstraction rather than a reality (Sellers, 2000, p. 18). This in turn will serve to design and develop of a trajectory discourse that will increase and shape the identity of the profession, its academics and clinicians not just within the milieu of its blend of art and science and referent power of high degree of trust and credibility but also as profession that displays a sense of maturity across a number of contexts, academic levels (Huston, 2019; Parker & McMillan, 2007 p.128) and within a “robust but flexible academic infrastructure” which will be “responsive to the needs of the profession” (McNamara, 2010c, p. 384) rather than being shaped by the practices of the past.

**Conclusion**

This chapter added to the discussion by revisiting the concept of identity and the two key themes represented in Chapter Four Setting the scene and Chapter Five Creating academic identity.

The findings support the premise that the professional identity has been challenged by a number of barriers that have influenced and contributed to the profession and the academics trajectory to-date. In particular, they reveal the impact of nursing history and culture, the transfer of nursing education into the tertiary sector, the educational mandates and imperatives required by the academic sector and in no small amount what appears to be the ongoing reluctance to recognise that the academic belongs to two equally important habiti (nursing and academic) and that
they are central to promoting their specialty area considered fundamental in the professional identity of academic within the tertiary sector.

The data suggest that a greater understanding and exploration of what constitutes professional identity from the academics themselves (something that the participants had not considered) would be useful in demystifying the demonstrated degree of indecisiveness and sense of confusion surrounding this concept. The themes, subthemes and concepts discussed in Chapter Four and Chapter Five, reinforced and validated the design of the study’s framework and highlighted the significant role that the eight elements I proposed (temporality, knowledge, policy and compliance, qualifications and remuneration, socialisation, leadership, language and power and autonomy) play in the creation and enhancement of a nurse academic’s professional identity within the context of the tertiary sector.

The next chapter will conclude my study. In this final chapter, I will revisit the thesis chapters where I will provide a summary of the findings and recommendations, discuss the study’s limitations and identify opportunities for further research.
Chapter Seven
Concluding the study

Chapter insight

My study investigated the creation and enhancement of a nurse academic’s professional identity in the tertiary sector and what happens to their professional identity as the academic tries to create the reality of a distinctive nursing discipline reputationally strong in both the clinical and academic worlds in which they find themselves. The study was underpinned by the key concept of professional identity and drew on the works of Bernstein’s sociology on identity formation within the broader academic and educational context. In addition the university profile questionnaire and the interview data from my participants provided a platform for dialogue and debate regarding the creation and enhancement of a nurse academic’s professional identity in the tertiary sector.

The study recruited Australian nurse academics from five tertiary institutions across Australia. Overall, 24 nurse academics across all academic levels (Lecturer A to Lecturer E) were interviewed for their views and understating of the professional identity of a nurse academic. The completion of the university profile questionnaire provided an overview of SONM within these institutions and how they compared with each other across a number of variables. The aim of the study was to analyse and substantiate the gap in evidence related to what constitutes the creation and enhancement of the professional identity of nurse academics. The study highlighted a number of difficulties in what is considered the professional identity of a nurse academic which reinforced that additional work is required to support the interests of nurse academics in developing, articulating and promoting their professional identity.
In this final chapter, I will revisit the chapters where I will provide a summary of the findings and recommendations, discuss the study’s limitations, identify opportunities for the future direction of the study and conclude the study with some final remarks.

### Thesis overview

The chapters revisited

**Chapter One** titled *introducing the study* provided the opening statements, where I claimed that there is significant ambiguity and fundamental lack of information, direction and guidance in what constitutes professional identity of nurse academics. The literature reviewed that from 1955-2015 across a number of disciplines, was found to be deficient on this topic. Investigations into the actual nursing academic experience and the issues attached to establishing their professional identity in the academic arena proved to have had minimal, if any, scrutiny. However, the literature did serve as a platform for my study as it identified and confirmed that a number of influences and challenges have and continue to impact on the identity of academics who teach nursing. The chapter introduced the work of Bernstein’s sociological approach and McNamara’s application of this work on identity formation. It formed the basis and subsequent framework of my study which was useful in unravelling this complex issue in order to provide recommendations that would serve in creating and establishing the nurse academic’s professional identity within the tertiary sector. The chapter concluded with an overview of the each of the chapters in my thesis.

Historical and cultural influences contributed to the inception and development of the nursing discipline into the profession it is today. **Chapter Two** titled
building the picture reviewed the literature and provided the historical backdrop on the emergence of nurse education, its educators and the direction they took towards the move into the tertiary sector. With a focus on nursing in Australia, it highlighted the impact and influence of the hospital based apprenticeship model of education that saw its student demographic immediately considered part of the hospital workforce; their education continued to be dominated by the medical profession and their limited career pathways upon graduation (administration, clinical and education). The pathways illustrated in this chapter (see Figure 2.3 and 2.4) highlighted that role delineation was restricted to within the hospital context with a clear clinical focus and did not include academic opportunities; which proved to have contributed to the shift in the educator’s professional identity. The move into this new academic habitus along with requirements that were not previously considered important and / or relevant, were now found to be imperative which has and continues to impact on the credibility of nurse academics.

This chapter concluded that nursing education must be research based and for this to be achieved the preparation of its academics needs to include qualifications at PhD level and extend across the multiple components of the role (teaching, research, clinical, scholarship and university service). While academic qualifications only form part of what is required to achieve a research based profession, it was also identified that what continues to be missing from the career pathway of those who are currently working in the healthcare seeking to enter and for those in the tertiary sector, is a framework on how to become an academic and create a professional identity.

It was in this chapter that the recommendation for the first three key elements of professional identity were identified as:

- temporality associated with history, culture, politics and economics;
knowledge related to specialisation both sacred and profane; and

- policy and compliance (eg. legislative, professional, academic and organisational).

Chapter Three, titled Presenting the research methodology, provided the integrated approach taken to explore my research topic describing the design process, data collection, data analysis and my role as the researcher in this study. It provided a description of the chosen methodology (Bernstein’s sociological approach to identity formation) and described the preparation, collection and analysis of the data the study’s ethical considerations. The design process included a multi method qualitative approach using a two part pre-completed university profile questionnaire and participant interviews. Overall, the findings from the questionnaires revealed that:

- the number of student intakes, graduations and staffing levels varied depending on the size of the SONM (results outlined in Table 3.2);
- similarities were seen in course offerings at both undergraduate and postgraduate levels across all 33 universities (see Table 3.3 for results);
- all position descriptions and selection criteria required staff to meet both academic and discipline specific qualifications criteria, however the level of what was required varied across academic levels and in particular at L1-L3; and
- common themes emerged as the key pressures under the headings of: (a) approach to nursing education, (b) being an academic, (c) professional development and (d) performance management (see Table 3.5 for results).

The returned questionnaires formed the basis to select the sample universities and participants; whereby:

- five universities and their SONMs participated in the study;
- a total of 24 full time academic staff members (21 females (87.5%) and three
males (12.5%) that included a representative sample from L1 (n=1), L2 (n=8), L3 (n=6), L4 (n=5) and L5 (n=4) inclusive of the HoS or Dean and / or deputy dean that formed part of the study’s objective; and where

- the interview analysis process identified the two emerging themes, subsequent subthemes and concepts discussed in Chapter Four and Chapter Five; gained from the qualitative data from the participant interviews;

Finally, my role as the researcher and an academic at the time, proved to be invaluable as it provided me with kudos and credibility with the participants from the outset. They recognised that I identified and related to their stories and issues raised throughout their interview; which in turn encouraged them to volunteer information and ask questions freely, which contributed to the open and candid dialogue.

**Chapter Four** titled *Setting the scene* was the first theme of the study and included ensuing subthemes and concepts interpreted from the participant interviews. This chapter brought to the forefront the diversity and complexity of the participants’ background related to how and their reasons why they chose to enter the nursing discipline along with their career trajectory and subsequent employment in the tertiary sector. The data from the first subtheme, titled *entering the tertiary sector* which had five concepts (participant background, the application process, qualifications, remuneration and performance and promotion) revealed:

- that 58% (n = 14) of the participants entered nursing via the traditional hospital based apprenticeship system commencing their career at 17 years of age, 21% (n = 5) entered the same system having completed a previous degree was a rare event during that time; with the final 21% (n = 5) enrolled into the tertiary based education system and completed their nursing degree;

- all participants were employed as clinicians across a number of clinical specialities
with the majority (n = 18), at one time holding a staff development educator and / or clinical facilitator position;

- the majority of the participants transferred across from the hospitals and directly appointed or promoted to fill vacancies without meeting the university selection criteria;

- discrepancies in the participants’ application process, qualifications, remuneration and performance and promotion experiences; resulting in undercurrents of annoyance, frustration and disappointment that compromised and challenged the participants’ integrity and professionalism;

- the emergence of the gatekeeper and change agent concept; which was seen as being part of the academic’s (including the participants) responsibility in order to protect, promote, prepare and propel the profession in the future.

The data from the second subtheme working in the tertiary sector which had four concepts (experiencing the cultural shift, deciphering roles and responsibilities, academic preparedness and academic leadership) revealed that working within the tertiary sector brought to the fore new expectations, roles and responsibilities and accountability. It demonstrated:

- the notable tensions that exist and experienced with the cultural shift from one habit to another;

- there was no clarity surrounding the myriad of role and responsibilities in what an academic is expected to undertake;

- the significance placed on the individual’s lack of academic preparedness that brought about a degree of reality shock between perceived expectations of academia and actual reality (eg. lack of academic qualifications and teaching experience) and;
the importance placed on academic leadership in the form of mentors and role models and implications to future leaders and professional identity.

**Recommendations**

- Consideration needs to be given to the review of human resource management systems; that would establish, confirm and adhere to consistent essential selection criteria for minimum academic entry requirements along with the dichotomy that continues to exist between the increased value placed on practical experience versus academic requirements and its impact on subsequent remuneration;

- Nurses need to create their own identity within the academy and one that is appropriate for a practice discipline (Smith, 2000) that integrates the two habitus to create and enhance the nurse academic’s professional identity by what I believe is the change from the current university mandates of teaching, research and service, to the three pillars (Kumar, et al., 2011) of research, teaching and clinical practice and the interrelationships between them. One avenue to this may be through extensive collaboration between the two habitus to accommodate applications of research to practice consolidation and vice versa (such as an increase in joint appointments);

- The development of research and teaching teams where academic staff have the opportunity to be mentored for a designated period of time. One option may be that the academic spends half of their three year probation period in research and the other half in academic teaching under the direction and leadership of senior staff and mentors. This would see academics gain experience in teaching, along with time to complete required higher degrees and publish which would support and assist in their academic preparedness; and
• Identifying individuals with leadership and management capacity and capabilities through promotion and succession planning by mentoring and fostering current and future academic leaders.

Chapter Five, titled creating academic identity was the second theme of the study and included three subthemes each with its own concepts. This theme proved to be a challenge as first it sourced the participants’ view on how the participants defined a nurse academic; which also included their perception of their own identity. The findings from this subtheme (with two concepts: confusion reigns and self-description) offered:

• a variety of descriptions ranging from academic, teacher, educator and even administrator. The overarching consensus saw the struggle to use or related to the dual title displaying the continued siloing approach by academics in their quest to be recognised in two sectors; which in turn supported the confusion that continues to exist;

• the variation in definition and self-description was found to lie across a number of variables that was related to doctorate qualifications, scholarly work of research and publications, being an university employee, studies being undertaken and / or taught in a scholarly institution are not vocational and / or technical in origin;

• that most importantly the academic’s identity was intrinsically linked to standards, traditions, philosophies, activities and attitudes of what constituted a profession.

This led into the second subtheme of this chapter titled nursing: a profession or vocation which analysed the data under two concepts: (a) discipline of nursing and (b) nursing academics. The data revealed:

• a dichotomy exists between the notion of a profession and vocation and;

• there was a clear consensus acknowledging that nursing was now firmly
embedded in the tertiary sector and considered a profession and its academics as professionals, despite the complexity underpinning the findings indicating the need for this notion to be acknowledged and clarified across the two habitus.

The findings from the third and final subtheme a matter of competence and credibility (with three concepts: (a) competence versus credibility, (b) dual professionalism, is it possible and (c) creating and enhancing a nexus) recognised that:

- the notion of credibility is open to interpretation, is associated with the perception of competence and is linked to qualifications, expertise and experience;
- academics continue to be challenged to maintain both academic and clinical competence and credibility within two habitus; which led to
- the concept of dual professionalism, clinical and academic; and
- the importance placed on creating and enhancing a nexus between the two habitus; where this concept needs to be reviewed to acknowledge the value and credibility of the academic and remove what appears to be, a remnant of the dominant role that clinical sector still displays.

Recommendations

- A simple definition that clarifies the term ‘academic’ be discussed by the profession and the academics themselves and a consensus term that reflects professional identity be agreed upon and placed at the forefront of the role to avoid the confusion that continues to exist;
- The pathway to becoming an academic be recognised as a fundamental specialty by the profession as a whole; where well educated academics educate neophyte and current RNs can return as professional academics and leaders themselves. While this will require the collaboration between the two habitus, it may help to remove the siloed approach that currently exists and provide the necessary nexus
to bridge the gap; which in turn will create and continue to enhance professional identity in the tertiary sector and propel the role and the profession forward.

**Chapter Six**, added to the discussion by providing the link between the chapters that would see academics professional role and identity take centre stage in their professional habitus. Overall, the findings discussed under the three headings of *creating identity*, *setting the scene* (theme for Chapter Four) and *enhancing academic identity* (theme for Chapter Five) reinforced:

- that further work is required to support academics articulate, develop and promote their professional identity and would involve addressing the tensions and challenges that continue to be present between the two habiti;
- the study’s aim to identify key elements, propose and create a new framework around the professional identity of a nurse academic; an area where ambiguity and lack of clarity continues to exist; and
- the design of the framework (see Figure 6.1) established the discipline’s foundation in the ethos and philosophy of the academic (based in a university setting) and the clinical practice arena; and
- central to the framework is the strategically positioned academic providing the essential link within the two habiti to portray, promote and instil the eight elements (temporality, knowledge, policy and compliance, qualifications and remuneration, socialization, leadership, language and power and autonomy), associated behaviours and educational imperatives that present their distinct professional identity.

**Recommendations**

- Adopt the proposed framework in order to assess and refine how indeed professional identity may be more fully realised in practice through the actual
involvement and use by key stakeholders.

Finally this chapter, Chapter Seven concludes the study by revising the chapters, summarising the finding and providing recommendations on how the creation and enhancement of a nurse academics professional identity within the tertiary sector can be achieved. This chapter concludes by outlining some of the potential limitations of the study, opportunities for future research and some final remarks.

**Future direction for the study**

This section provides some potential limitations of my study, identifies opportunities for future research, concludes the study and offers some final remarks.

**Limitations**

The study revealed a number of limitations. As a qualitative study, it relied on the participants’ involvement and responses. The coordination of interviews with participants within a specified timeframe that coincided with semester breaks, additional expenses related to travel costs (as dates were altered due to cancellations and/or rescheduling of interviews), the employment of a research assistant to transcribe the interviews and equipment failure where one interview had to be repeated. Unfortunately, both the participants and I acknowledged the lack of richness in the information and data provided in the subsequent interview. Time constraints and increased workloads also proved to be an issue as it led to the withdrawal of a number of SONM participation and cancellation of interviews, which in turn decreased the number of anticipated participants from 36 to 24. While it was a smaller than expected sample size; it was random and included a cross section of academic levels, inclusive of the HoS / School Dean or their representative / nominee.

As the data was collected over a period of 21 months (September 2007-
July 2009), it must be acknowledged that there may have been changes in the academic structure, SONM workforce and course offerings of the participating universities and SONM. This was despite efforts to continue to monitor academic vacancies, review the selection criteria and position descriptions throughout the duration of the study to ensure the validity, currency and applicability of the information collected. However, where possible these were included in the thesis.

Further research

The original intent of my study was to gain an international perspective regarding the creation and enhancement of a nurse academic’s professional identity in the tertiary sector. This idea developed during the research phase of Chapter Two and while it lent itself to a comparative study between nursing academics in Australia, Canada and the USA this was not undertaken. I found that the importance of gaining the insights and understanding of what constitutes the professional identity of nurse academics in Australia was required in the first instance. A comparative review of international models in so far as the university and school structures (eg. Canada, US) could be beneficial in providing further insight into similarities and / or differences and possible applications in the Australian context.

Another area that the study also identified was the continued debate on the dichotomy between nursing and medicine related to status, autonomy and role recognition. Although it was found that the participants did not readily agree with the notion and title of nurse academic nor did they believe that any other healthcare profession chose to identify themselves in this manner, additional research into this concept (which was neither the aim nor part of the focus of the study) has revealed that this in fact does exist. Conducting a study that compares and contrasts academic medicine and academic nursing’s professional identity in the tertiary sector, could
reveal more similarities than differences between the two. Similar questions could be asked in so far as what attracts doctors to academic careers and how they create and enhance their professional identity.

**Concluding the study**

“The power of stories and storytelling is universally recognised and if storytelling is “a means by which humans organise and understand the world and feel connected to each other...” (Tannen, 1989, p. 102-103) this was certainly a key determinant in affording the participants the opportunity to tell their story which included their final comments, additional insights or topics that may have been omitted from the study. The participants took the chance to reiterate their commitment to the profession and their role as academics:

‘...nursing is worth saving but we have got to make nurses realise it...’ U5:P4:L2

‘...we have to stop punishing ourselves, we are big people now, so push your shoulders back, stop trying to reinvent yourselves, stop trying to play with the big boys [because] we are with the big boys now, we are a profession’ U4:P1:L2.

‘...it’s a great career...there are so many facets, so many opportunities in it, people have got to be willing to take their opportunities...’ U3:P4:L4

‘...there is no glass ceiling for nursing; it’s what we allow ourselves to do...’ U5:P1:L3.

Comments were also provided on the importance of the study, as participants expressed their interest in the results and what the study would reveal:

‘I feel that this is such an important subject and you have made me think about my perception, my job and academics. Your study is certainly worthwhile [as] it is an area that needs to be reviewed...’ U1:P1:L3

‘It will be fantastic to see your research, to see how academics perceive themselves in this area...’ U4:P1:L2

‘It would be very interesting to see what you get from people around the country. I think it’s a really interesting set of questions...’ U3:P3:L3

‘I’d be very interested to know whether there is a difference between academics
who have come up through the hospital system and academics who have come up through the university system...being in the university system is a real privilege, I love it, I can’t believe I’m here’

The transfer of nursing education into the tertiary sector contributed to its professional status and credibility as an academic discipline. There is no doubt that education is foundational to how a discipline manifests itself and how a profession defines itself throughout the course of a career trajectory (Bleich, 2011). While there is a public and industry expectation that nursing education will continue to produce effective graduates who will meet healthcare demands, there is also an equal expectation that the nurse academics teaching the graduates “are competent, reality orientated and collectively committed to create more highly educated and competent professionals” (Bliech, 2011, p. 303). However, what also needs to be acknowledged and made public is the extensive profile of both nurses and academics which has been driven predominately by the design and development of a trajectory discourse shaped through contemporary research and practices, rather than its past history (Bleich, 2011; Chen, Beck, & Amos, 2005; McNamara, 2010c). Therefore, it is important that nurse academics find their voice to convey and advocate the complex and dynamic involvement needed to create and enhance their professional identity. Increased understanding of this is vital if the findings and recommendations from this study are to be used effectively. This study contributes to original knowledge and will also serve to strengthen current knowledge on the importance of what constitutes the creation and enhancement of the professional identity of a nurse academic in the tertiary sector.

Final remarks

...one hopes that one’s case will touch others. But how to connect?...One may merely know that one is alone and hope that a singular story, as every true
story is singular, will in the magic way of some things apply, connect, resonate, touch a major cord (Pachter, 1981, p.72 cited in Glesne, 2006, p. 173).

This study sought to establish the knowledge base of what constitutes the creation and enhancement of a nurse academic’s professional identity in the tertiary sector. Introducing, building, investigating, setting, creating, discussing and concluding this study has created the platform for further research and recommendations that will now add to this knowledge base. So the study concludes with one final poignant participant comment:

‘...the creation is here, it’s now...the enhancement of a professional identity and the creation of quite a different academic professional...the best thing about nursing is the fact that you can create...’ U5:P11L3


*ACT Public Service Nursing and Midwifery Enterprise Agreement 2013-2017.*


Australian Nursing Federation. (2002). *ANF response to ‘higher education at the crossroads’. Kingston, ACT: ANF.*


Health Practitioner Regulation National Law Act 2009

Health Practitioner Regulation National Law Bill 2009

Health Practitioner Regulation National Law Regulation 2010


Hokanson Hawks, J. (1999). Organizational culture and faculty use of empowering teaching behaviours in selected schools of nursing. *Nursing Outlook, 47*(2), 67-73.


Northern Territory Public Sector Nurses and Midwives’ 2014–2017 Enterprise Agreement.

Nurses (South Australian Public Sector) Award 2002.

Nurses and Midwives Act (2006). Western Australia.

Nurses & Midwives Board of Western Australia. (2009). retrieved 03 April, 2009 from: www.nmbwa.org.au

Nurses and Midwives Regulations (2007). Western Australia.

Nurses and Midwives (Victoria Public Health Sector) (Single Interest Employers) Enterprise Agreement 2012-2016.

Nurses and Midwives Work Value Agreement 2015 – Nurses and Midwives (Tasmanian State Service) Award.


*Public Health System Nurses’ and Midwives’ (State) Award 2015.*


Risling, T., & Ferguson, L. (2013). Communities of practice in nursing academia: A growing need to practice what we teach. *International Journal of Nursing Education Scholarship, 10*(1), 1-8 doi 10.155/ijnes-2012-0013


Schriner, C.L. (2007). The influence of culture on clinical nurses transitioning into the faculty role. *Nursing Education Perspectives, 28*, 145-149.


Schriner, C.L. (2007). The influence of culture on clinical nurses transitioning into the faculty role. *Nursing Education Perspectives, 28*, 145-149.


WA Health – Australian Nursing Federation – Registered Nurses, Midwives, Enrolled (Mental Health) and Enrolled (Mothercraft Nurses – Industrial Agreement 2013.


Profile Questionnaire

**Faculty / School Contact Person** (if further details required)

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<th>Name</th>
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**PART A**

**Organisational Demographics**

<table>
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<tr>
<th>Management Structure</th>
<th>Senior Administrative Title</th>
<th>Academic Title</th>
<th>☐ Dean (appointed) – Term: ___________</th>
<th>☐ Head of School (appointed) – Term: ___________</th>
<th>☐ Dean (elected) – Term: ___________</th>
<th>☐ Head of School (elected) – Term: ___________</th>
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**Number of Campuses across which Nursing is taught**

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<th>Locations</th>
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<th>Estimated Annual Student Intake</th>
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<td>Undergraduate:</td>
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<tr>
<td>☐ One ☐ Two ☐ Other __________</td>
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<tr>
<td>☐ Not Applicable</td>
</tr>
<tr>
<td>Postgraduate:</td>
</tr>
<tr>
<td>☐ One ☐ Two ☐ Other __________</td>
</tr>
<tr>
<td>☐ Not Applicable</td>
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</tbody>
</table>

| Is the annual intake:          |
| ☐ Increasing ☐ Decreasing ☐ Steady ☐ Quota |
| ☐ Not Applicable                |

<table>
<thead>
<tr>
<th>Estimated Annual Graduating Students</th>
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<tr>
<td>Undergraduate:</td>
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<tr>
<td>☐ Increasing ☐ Decreasing ☐ Steady</td>
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<tr>
<td>Is the graduating number:</td>
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<tr>
<td>☐ Increasing ☐ Decreasing ☐ Steady</td>
</tr>
<tr>
<td>Postgraduate:</td>
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<tr>
<td>☐ Increasing ☐ Decreasing ☐ Steady</td>
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**Course Information**

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<th>Length of time program has been in place</th>
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<tr>
<td>Date of first intake:</td>
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<td>Qualification awarded at this date:</td>
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**Current Undergraduate Course Title**

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<tr>
<th>☐ Graduate Certificate – Nursing</th>
<th>☐ Graduate Diploma – Nursing</th>
<th>☐ Masters – Nursing</th>
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<tbody>
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<td>☐ Graduate Certificate – Specialty</td>
<td>☐ Graduate Diploma – Specialty</td>
<td>☐ Masters – Specialty</td>
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<tr>
<td>☐ Masters by Coursework</td>
<td>☐ Masters by Research</td>
<td>☐ Professional Doctorate</td>
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<tr>
<td>☐ PhD</td>
<td>☐ Other</td>
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</tbody>
</table>

**Postgraduate Course Titles**

**Academic Staff Information**

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<tr>
<th>Staff Teaching Profile</th>
<th>Please insert the number of staff teaching in 2007</th>
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<tr>
<td>Level A (Associate Lecturer)</td>
<td>Ongoing</td>
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<td>Level B (Lecturer)</td>
<td>UG</td>
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<tr>
<td>Level C (Senior Lecturer)</td>
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<tr>
<td>Level D (Associate Professor)</td>
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<tr>
<td>Level E (Professor)</td>
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</tr>
<tr>
<td>Other / Not Applicable</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff without a Teaching Profile</th>
<th>Please insert relevant profile for 2007 (i.e. research only / on leave etc)</th>
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<tbody>
<tr>
<td>Level A (Associate Lecturer)</td>
<td>Number of Staff</td>
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<td>Level B (Lecturer)</td>
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<tr>
<td>Level C (Senior Lecturer)</td>
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<tr>
<td>Level D (Associate Professor)</td>
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<tr>
<td>Level E (Professor)</td>
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<th>Workload Profile</th>
<th>Monitoring Method: ☐ Contact Hours ☐ Points System ☐ Other (please state) ☐ Not applicable</th>
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<td>Please insert estimated contact time for a typical appointee</td>
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<tr>
<td>Level A (Associate Lecturer):</td>
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<tr>
<td>Level B (Lecturer)</td>
<td>Points</td>
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<td>Level C (Senior Lecturer)</td>
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<tr>
<td>Level D (Associate Professor)</td>
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<td>Level E (Professor)</td>
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## Qualifications / Promotion

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<thead>
<tr>
<th>Academic Appointment</th>
<th>Criteria staff must address: □ Generic Academic □ Discipline Specific □ Both □ Not applicable</th>
<th>Please attach a copy or complete the table below:</th>
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<tbody>
<tr>
<td>Level A</td>
<td>Professional Engagement</td>
<td>Qualifications</td>
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<td>Registration</td>
<td>Memberships</td>
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<td>Level B</td>
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<td>Level C</td>
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<td>Level E</td>
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Please tick (✓) relevant criteria for each level:

- Generic Academic
- Discipline Specific
- Both
- Not applicable

Generic requirements found at:

Are there any additional discipline specific criteria required:

- No
- Yes (please attach a copy or complete the table below)

<table>
<thead>
<tr>
<th>Academic Promotion</th>
<th>Criteria staff must address □ Generic Academic □ Discipline Specific □ Both □ Not applicable</th>
<th>Please tick (✓) relevant criteria for each level</th>
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<td>Qualifications</td>
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Further Comments (attach extra pages if required)

What do you perceive as the key pressures facing your staff in terms of:

- Approach to nursing education
- Being an academic
- Professional development
- Performance management

Thank you for your participation and information you have provided.

If your school is selected to participate in this study would you be prepared to:

a) be interviewed: □ Yes □ No

b) promote and support your staff’s participation in interviews: □ Yes □ No
PART B

Academic Staff Highest Qualifications *(enter university name)*

This data has been collated from information provided on your university / faculty and / or school website. Please amend only if an error / missing data has been noted (indicated by a question mark (?))

Space has been provided if additional staff have been employed since the information was collated.

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Additional Staff (if required)

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Research Project: The creation and enhancement of a nurse academic’s professional identity within the tertiary sector.

Researcher: Kamaree Berry
PhD Candidate, MEd Stds (Hons) UWA, PGDip Clinical Nursing (Perioperative), RN BN, MRCNA, MACORN, RAA
Contact Details: 040 911 6907
Email: k.berry@ecu.edu.au

Supervisor: Associate Professor Bev Thiele
Contact Details: (08) 9360 2269
Email: B.Thiele@murdoch.edu.au

10 December 2007

Dear <Head of School Name>

I am currently studying for my PhD and would like to extend an invitation for you to participate in the above mentioned research project. As a registered nurse, nurse educator and academic I have worked in both private and public healthcare organisations and have developed a keen interest in the issue of the professional identity of a nurse academic within the tertiary sector in a number of contexts.

Background
- The nursing profession is being challenged to identify and adopt solutions that provide, maintain and extend both its workforce (through education, recruitment and retention) and scope of practice in order to meet the needs of consumers and the demands of the healthcare industry.
- Tertiary institutions employ academic staff with the necessary knowledge, expertise, experience and qualifications to educate graduates who in turn will become professionals in their own right. The shortage of registered nurses has contributed to the challenge of identifying appropriately qualified staff to become part of this sector as nurse academics.

Nature and purpose of study
- What constitutes the professional identity of a nurse academic is ambiguous at best as there is little, if any, guidance for those who seek to be employed or are employed in the tertiary sector. The importance of specific accounts of experiences of nurse academics in Australia including their successes, disappointments and the influences of the social and political contexts in which they work will be a key feature of this project.

Your participation
- It is important that you understand that your involvement is this study is voluntary. While I would be pleased to have you participate, I respect your right to decline.
- You are free, at any time, to withdraw your consent and terminate your participation in this research study, without any penalty, consequences, discrimination or prejudice.
- All information you provide will be treated in a confidential manner, and your name will not be used, unless you have consented, in any publication arising out of the research.
- The research will be kept in a locked cabinet for five (5) years following the completion of the research and then destroyed.

Study involves
- A questionnaire, which has been partly completed from data / information obtained from your university / school website. In such cases you need only complete / alter if incorrect.
- It is anticipated that completion of this questionnaire should take approximately 30 minutes.
- All information will be confidential they will be held in a secure location and only accessed by the researcher.
Follow up and Return

- A return envelope has been provided for your convenience to return the questionnaire (Part A & B).
- **Follow up:** Monday 14 January 2008
- **Return Date:** Monday 21 January 2008
- It would be appreciated if you could email me an alternative return date, if you cannot meet the above deadline.

Benefits of study

- While it is possible that there may be no direct benefit to you, the knowledge gained from your participation in this study may assist future colleagues and the profession.

Contact

- My supervisor and I will be happy to discuss any concerns or answer any questions you may have regarding this study.
- If you wish to talk to an independent person about your concerns you can contact Murdoch University’s Human Research Ethics Committee on 9360 6677 or email ethics@murdoch.edu.au

I would like to thank you in advance for your assistance and participation with this research project. I look forward to hearing from you soon.

This study has been approved by the Murdoch University Human Research Ethics Committee (Approval No. 2007/271)
Research Project: The creation and enhancement of a nurse academic’s professional identity within the tertiary sector.

Researcher: Kamaree Berry  
PhD Candidate, MEd Stds (Hons) UWA, PGDip Clinical Nursing (Perioperative), RN BN, MRCNA, MACORN, RAA  
Contact Details: 040 911 6907  
Email: k.berry@ecu.edu.au

Supervisor: Associate Professor Bev Thiele  
Contact Details: (08) 9360 2269  
Email: B.Thiele@murdoch.edu.au

Dear Valued Colleague,

I am currently studying for my PhD and would like to extend an invitation for you to participate in the above mentioned research project. As a registered nurse, nurse educator and academic I have worked in both private and public healthcare organisations and have developed a keen interest in the issue of the professional identity of a nurse academic within the tertiary sector in a number of contexts.

Background
- The nursing profession is being challenged to identify and adopt solutions that provide, maintain and extend both its workforce (through education, recruitment and retention) and scope of practice in order to meet the needs of consumers and the demands of the healthcare industry.
- Tertiary institutions employ academic staff with the necessary knowledge, expertise, experience and qualifications to educate graduates who in turn will become professionals in their own right. The shortage of registered nurses has contributed to the challenge of identifying appropriately qualified staff to become part of this sector as nurse academics.

Nature and purpose of study
- What constitutes the professional identity of a nurse academic is ambiguous at best as there is little, if any, guidance for those who seek to be employed or are employed in the tertiary sector. The importance of specific accounts of experiences of nurse academics in Australia including their successes, disappointments and the influences of the social and political contexts in which they work will be a key feature of this project.

Your participation
- It is important that you understand that your involvement in this study is voluntary. While I would be pleased to have you participate, I respect your right to decline.
- You are free, at any time, to withdraw your consent and terminate your participation in this research study, without any penalty, consequences, discrimination or prejudice.
- All information you provide will be treated in a confidential manner, and your name will not be used, unless you have consented, in any publication arising out of the research.
- The research will be kept in a locked cabinet for five (5) years following the completion of the research and then destroyed.

Study involves
- A one-on-one taped informal interview lasting approximately one (1) hour.
- All transcripts of this interview will be confidential they will be held in a secure location and only accessed by the researcher.

Benefits of study
- While it is possible that there may be no direct benefit to you, the knowledge gained from your participation in this study may assist future colleagues and the profession.

Contact
- My supervisor and I will be happy to discuss any concerns or answer any questions you may have regarding this study.
- If you wish to talk to an independent person about your concerns you can contact Murdoch University's Human Research Ethics Committee on 9360 6677 or email ethics@murdoch.edu.au

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The creation and enhancement of a nurse academic’s professional identity within the tertiary sector.

This is to certify that I, ________________________________, agree to participate as a volunteer in this interview for the abovementioned research study.

The information about this study has been given to me, I have received satisfactory answers to all my questions and my concerns have been addressed.

I agree to be interviewed for / participate in this study. I know that I can choose not to answer any question, or stop / withdraw at any time. I understand that all information provided by me is treated as confidential and will not be released by the researcher unless required to do so by law.

☐ I am happy for this interview to be audio taped.
☐ I am not willing for this interview to be audio taped.

☐ I am happy for my name to be used in any publications arising out of this study.
☐ I am not willing for my name to be used in any publications arising out of this study.

☐ I would like to receive a copy of any comments attributed to me for verification / or amendment.
☐ I am happy for my comments to be used without being contacted again.

☐ Please tick if you would like a summary of the major findings of this research at its conclusion.

Participant Name: ________________________________
Title: ________________________________

Participant Signature: ________________________________
Date: ________________________________

Researcher Name: Kamaree Berry
Title: PhD Candidate

Signature: ________________________________
Date: ________________________________

This study has been approved by the Murdoch University Human Research Ethics Committee (Approval No. 2007/271)
**Research Project:** The creation and enhancement of a nurse academic’s professional identity within the tertiary sector.

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**Interview Format & Questions**

<table>
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<tr>
<th>Introduction</th>
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<tbody>
<tr>
<td>• Welcome from researcher / overview of topic</td>
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<tr>
<td>• Thanking participant for their time and information</td>
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<tr>
<td>• Confirmation of participation / consent form signed / any concerns addressed</td>
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<tr>
<td>• Overview of interview format - time frame, audiotaped, series of questions</td>
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<table>
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<tr>
<th>Setting the scene</th>
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<tr>
<td>1. Why did you choose to become a nurse academic?</td>
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<tr>
<td>a) Overview of career pathway</td>
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<td>b) Description of application process to appointment</td>
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<td>c) Description of performance management / academic promotion</td>
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<tr>
<th>Exploring the possibilities</th>
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<tr>
<td>2. In your opinion, how would you “define” a nurse academic?</td>
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<td>3. What do you perceive to be the roles and responsibilities of a nurse academic?</td>
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<tr>
<td>a) Current role(s) and responsibilities</td>
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<td>b) Challenges / tensions faced at particular level of responsibility (Level A-E)</td>
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<th>Questions</th>
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<tr>
<td>4. How do you view:</td>
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<td>a) Nursing - vocation or profession</td>
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<td>b) Nurse academics – vocation or professional</td>
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<td>5. What do you see as the major factors influencing nursing / nursing education and nurse academics in the tertiary sector?</td>
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<tr>
<td>a) History and culture</td>
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<td>b) Politics and economics</td>
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<th>Acknowledging the direction</th>
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<tr>
<td>6. What do you believe is the appropriate (ideal) relationship / role between academics and industry in regards to nurse education?</td>
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<td>7. In your opinion what do you believe are the future direction / career trajectory of a nurse academic?</td>
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<tr>
<td>a) Overview of own career / goals / aspirations</td>
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<td>b) Overview of nursing / nursing education</td>
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<td>8. Anything else you would care to comment on / we have omitted?</td>
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<th>Conclusion</th>
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<tr>
<td>• Final remarks / overview</td>
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<td>• Thanking participant for their time and information</td>
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<td>• Final questions / concerns addressed</td>
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National competency standards for registered nurses were first adopted by the Australian Nursing and Midwifery Council (ANMC) in the early 1990s. The ANMC was a peak national and midwifery organisation established in 1992 to develop a national approach to nursing and midwifery regulation. The ANMC worked in conjunction with the state and territory nursing and midwifery authorities (NMRAs) to produce national standards – an integral component of the regulatory framework – to help nurses and midwives deliver safe and competent care.

The ANMC officially became the Australian Nursing and Midwifery Accreditation Council (ANMAC) on 24 November 2010. The name change reflected ANMC’s appointment as the independent accrediting authority for the nursing and midwifery professions under the new National Registration and Accreditation Scheme (the National Scheme) that came into effect on 1 July 2010 (18 October 2010 in Western Australia).

With the onset of the National Scheme, the Nursing and Midwifery Board of Australia (National Board), took responsibility for the regulation of nurses and midwives in Australia, thus taking ownership of the national competency standards for registered nurses.

Since creation, these national competency standards have undergone periodic review and revision, which included extensive consultation with nurses around Australia. This helped to make sure the competency standards remained contemporary and congruent with legislative requirements.

The resulting standards, while different in some areas from the previous competency standards, remain broad and principle-based so that they are sufficiently dynamic for practising nurses and the nurse regulators to use as a benchmark to assess competence to practise in a range of settings.

What are the standards used for?

The national competency standards for the registered nurse are the core competency standards by which your performance is assessed to obtain and retain your registration as a registered nurse in Australia.

As a registered nurse, these core competency standards provide you with the framework for assessing your competence, and are used by the National Board to assess competence as part of the annual renewal of registration, to assess nurses:

- educated overseas seeking to work in Australia
- returning to work after breaks in service, or
• involved in professional conduct matters.

The National Board may also apply the competency standards in order to communicate to consumers the standards that they can expect from nurses.

Universities also use the standards when developing nursing curricula, and to assess student and new graduate performance.

These are YOUR standards — developed using the best possible evidence, and using information and feedback provided by nurses in a variety of settings. Included also are the principles of assessment to help you understand how these standards may be used to assess performance. We believe you will find them user-friendly and easy to understand.

Description of the registered nurse on entry to practice

The registered nurse demonstrates competence in the provision of nursing care as specified by registration requirements, National Board standards and codes, educational preparation, relevant legislation and context of care. The registered nurse practises independently and interdependently, assuming accountability and responsibility for their own actions and delegation of care to enrolled nurses and health care workers. Delegation takes into consideration the education and training of enrolled nurses and health care workers and the context of care.

The registered nurse provides evidence-based nursing care to people of all ages and cultural groups, including individuals, families and communities. The role of the registered nurse includes promotion and maintenance of health and prevention of illness for individuals with physical or mental illness, disabilities and/or rehabilitation needs, as well as alleviation of pain and suffering at the end stage of life.

The registered nurse assesses, plans, implements and evaluates nursing care in collaboration with individuals and the multidisciplinary health care team so as to achieve goals and health outcomes. The registered nurse recognises that ethnicity, culture, gender, spiritual values, sexuality, age, disability and economic and social factors have an impact on an individual’s responses to, and beliefs about, health and illness, and plans and modifies nursing care appropriately.

The registered nurse provides care in a range of settings that may include acute, community, residential and extended care settings, homes, educational institutions or other work settings and modifies practice according to the model/s of care delivery.

The registered nurse takes a leadership role in the coordination of nursing and health care within and across different care contexts to facilitate optimal health outcomes. This includes appropriate referral to, and consultation with, other relevant health professionals, service providers, and community and support services.

The registered nurse contributes to quality health care through lifelong learning and professional development of herself/himself and others, research data generation, clinical supervision and development of policy and clinical practice guidelines. The registered nurse develops their professional practice in accordance with the health needs of the population/society and changing patterns of disease and illness.

Domains

The competencies which make up the National Board National competency standards for the registered nurse are organised into domains.

Professional practice
This relates to the professional, legal and ethical responsibilities which require demonstration of a satisfactory knowledge base, accountability for practice, functioning in accordance with legislation affecting nursing and health care, and the protection of individual and group rights. Critical thinking and analysis

This relates to self-appraisal, professional development and the value of evidence and research for practice. Reflecting on practice, feelings and beliefs and the consequences of these for individuals/groups is an important professional benchmark.

Provision and coordination of care

This domain relates to the coordination, organisation and provision of nursing care that includes the assessment of individuals/groups, planning, implementation and evaluation of care.

Collaborative and therapeutic practice

This relates to establishing, sustaining and concluding professional relationships with individuals/groups. This also contains those competencies that relate to nurses understanding their contribution to the interdisciplinary health care team.

National competency standards for the registered nurse

Professional practice

Relates to the professional, legal and ethical responsibilities which require demonstration of a satisfactory knowledge base, accountability for practice, functioning in accordance with legislation affecting nursing and health care, and the protection of individual and group rights.

1. Practises in accordance with legislation affecting nursing practice and health care

1.1 Complies with relevant legislation and common law:

- identifies legislation governing nursing practice
- describes nursing practice within the requirements of common law
- describes and adheres to legal requirements for medications
- identifies legal implications of nursing interventions
- actions demonstrate awareness of legal implications of nursing practice
- identifies and explains effects of legislation on the care of individuals/groups
- identifies and explains effects of legislation in the area of health, and
- identifies unprofessional practice as it relates to confidentiality and privacy legislation.

1.2 Fulfils the duty of care:

- performs nursing interventions in accordance with recognised standards of practice
- clarifies responsibility for aspects of care with other members of the health team
- recognises the responsibility to prevent harm, and
- performs nursing interventions following comprehensive and accurate assessments.

1.3 Recognises and responds appropriately to unsafe or unprofessional practice:
• identifies interventions which prevent care being compromised and/or law contravened
• identifies appropriate action to be taken in specified circumstances
• identifies and explains alternative strategies for intervention and their likely outcomes
• identifies behaviour that is detrimental to achieving optimal care, and
• follows up incidents of unsafe practice to prevent recurrence.

2. Practises within a professional and ethical nursing framework

2.1 Practises in accordance with the nursing profession’s codes of ethics and conduct:
• accepts individuals/groups regardless of race, culture, religion, age, gender, sexual preference, physical or mental state
• ensures that personal values and attitudes are not imposed on others
• conducts assessments that are sensitive to the needs of individuals/groups
• recognises and accepts the rights of others
• maintains an effective process of care when confronted by differing values, beliefs and biases
• seeks assistance to resolve situations involving moral conflict, and
• identifies and attempts to overcome factors which may constrain ethical decisions, in consultation with the health care team.

2.2 Integrates organisational policies and guidelines with professional standards:
• maintains current knowledge of and incorporates relevant professional standards into practice
• maintains current knowledge of and incorporates organisational policies and guidelines into practice
• reviews and provides feedback on the relevance of organisational policies and professional standards procedures to practice
• demonstrates awareness and understanding of developments in nursing that have an impact on the individual’s capacity to practise nursing, and
• considers individual health and wellbeing in relation to being fit for practice.

2.3 Practises in a way that acknowledges the dignity, culture, values, beliefs and rights of individuals/groups:
• demonstrates respect for individual/group common and legal rights in relation to health care
• identifies and adheres to strategies to promote and protect individual/group rights
• considers individual/group preferences when providing care
• clarifies individual/group requests to change and/or refuse care with relevant members of the health care team
• advocates for individuals/groups when rights are overlooked and/or compromised
• accepts individuals/groups to whom care is provided regardless of race, culture, religion, age, gender, sexual preference, physical or mental state
• ensures that personal values and attitudes are not imposed on others
• undertakes assessments which are sensitive to the needs of individuals/groups
• recognises and accepts the rights of others
National competency standards for the registered nurse

- maintains an effective process of care when confronted by differing values, beliefs and biases
- provides appropriate information within the nurse’s scope of practice to individuals/groups
- consults relevant members of the health care team when required
- questions and/or clarifies orders and decisions that are unclear, not understood or questionable, and
- questions and/or clarifies interventions that appear inappropriate with relevant members of the health care team.

2.4 Advocates for individuals/groups and their rights for nursing and health care within organisational and management structures:
- identifies when resources are insufficient to meet care needs of individuals/groups
- communicates skill mix requirements to meet care needs of individuals/groups to management
- protects the rights of individuals and groups and facilitates informed decisions
- identifies and explains policies/practices which infringe on the rights of individuals or groups
- clarifies policies, procedures and guidelines when rights of individuals or groups are compromised, and
- recommends changes to policies, procedures and guidelines when rights are compromised.

2.5 Understands and practises within own scope of practice:
- seeks clarification when questions, directions and decisions are unclear or not understood
- undertakes decisions about care that are within scope of competence without consulting senior staff
- raises concerns about inappropriate delegation with the appropriate registered nurse
- demonstrates accountability and responsibility for own actions within nursing practice
- assesses consequences of various outcomes of decision making
- consults relevant members of the health care team when required, and
- questions and/or clarifies interventions which appear inappropriate with relevant members of the health care team.

2.6 Integrates nursing and health care knowledge, skills and attitudes to provide safe and effective nursing care:
- maintains a current knowledge base
- considers ethical responsibilities in all aspects of practice
- ensures privacy and confidentiality when providing care, and
- questions and/or clarifies interventions which appear inappropriate with relevant members of the health care team.

2.7 Recognises the differences in accountability and responsibility between registered nurses, enrolled nurses and unlicensed care workers:
- understands requirements of statutory and professionally regulated practice
- understands requirements for delegation and supervision of practice, and
- raises concerns about inappropriate delegation with the relevant organisational or regulatory personnel.

Critical thinking and analysis
Relates to self-appraisal, professional development and the value of evidence and research for practice.
Reflecting on practice, feelings and beliefs and the consequences of these for individuals/groups is an important professional benchmark.

3. Practises within an evidence-based framework

3.1 Identifies the relevance of research to improving individual/group health outcomes:
- identifies problems/issues in nursing practice that may be investigated through research
- considers potential for improvement in reviewing the outcomes of nursing activities and individual/group care
- discusses implications of research with colleagues participates in research, and
- demonstrates awareness of current research in own field of practice.

3.2 Uses best available evidence, nursing expertise and respect for the values and beliefs of individuals/groups in the provision of nursing care:
- uses relevant literature and research findings to improve current practice
- participates in review of policies, procedures and guidelines based on relevant research
- identifies and disseminates relevant changes in practice or new information to colleagues
- recognises that judgements and decisions are aspects of nursing care, and
- recognises that nursing expertise varies with education, experience and context of practice.

3.3 Demonstrates analytical skills in accessing and evaluating health information and research evidence:
- demonstrates understanding of the registered nurse role in contributing to nursing research
- undertakes critical analysis of research findings in considering their application to practice
- maintains accurate documentation of information which could be used in nursing research, and
- clarifies when resources are not understood or their application is questionable.

3.4 Supports and contributes to nursing and health care research:
- participates in research, and
- identifies problems suitable for research.

3.5 Participates in quality improvement activities:
- recognises that quality improvement involves ongoing consideration, use and review of practice in relation to practice outcomes, standards and guidelines and new developments
- seeks feedback from a wide range of sources to improve the quality of nursing care
- participates in case review activities, and
- participates in clinical audits.

4. Participates in ongoing professional development of self and others

4.1 Uses best available evidence, standards and guidelines to evaluate nursing performance:
- undertakes regular self-evaluation of own nursing practice
4.2 Participates in professional development to enhance nursing practice:
- reflects on own practice to identify professional development needs
- seeks additional knowledge and/or information when presented with unfamiliar situations
- seeks support from colleagues in identifying learning needs
- participates actively in ongoing professional development, and
- maintains records of involvement in professional development which includes both formal and informal activities.

4.3 Contributes to the professional development of others:
- demonstrates an increasing responsibility to share knowledge with colleagues
- supports health care students to meet their learning objectives in cooperation with other members of the health care team
- facilitates mutual sharing of knowledge and experience with colleagues relating to individual/group/unit problems
- contributes to orientation and ongoing education programs
- acts as a role model to other members of the health care team
- participates where possible in preceptorship, coaching and mentoring to assist and develop colleagues
- participates where appropriate in teaching others including students of nursing and other health disciplines, and inexperienced nurses, and
- contributes to formal and informal professional development.

4.4 Uses appropriate strategies to manage own responses to the professional work environment:
- identifies and uses support networks
- shares experiences related to professional issues with colleagues, and
- uses reflective practice to identify personal needs and seek appropriate support.

Provision and coordination of care

Relates to the coordination, organisation and provision of nursing care that includes the assessment of individuals/groups, planning, implementation and evaluation of care.

5. Conducts a comprehensive and systematic nursing assessment

5.1 Uses a relevant evidence-based assessment framework to collect data about the physical socio-cultural and mental health of the individual/group:
- approaches and organises assessment in a structured way
- uses all available evidence sources, including individuals/groups/significant others, health care team, records, reports, and own knowledge and experience
- collects data that relate to physiological, psychological, spiritual, socio-economic and cultural variables on an ongoing basis
- understands the role of research-based, and other forms of evidence
National competency standards for the registered nurse

5.2 Uses a range of assessment techniques to collect relevant and accurate data:
- uses a range of data-gathering techniques, including observation, interview, physical examination and measurement in obtaining a nursing history and assessment
- collaboratively identifies actual and potential health problems through accurate interpretation of data
- accurately uses health care technologies in accordance with manufacturer’s specification and organisational policy
- identifies deviations from normal, or improvements, in the individual’s/group’s health status, and
- identifies and incorporates the needs and preferences of the individual/group into a plan of care.

5.3 Analyses and interprets assessment data accurately:
- recognises that clinical judgements involve consideration of conflicting information and evidence
- identifies types and sources of supplementary information for nursing assessment
- describes the role of supplementary information in nursing assessment, and
- demonstrates knowledge of quantitative and qualitative data to assess individual/group needs.

6. Plans nursing care in consultation with individuals/groups, significant others and the interdisciplinary health care team

6.1 Determines agreed priorities for resolving health needs of individuals/groups:
- incorporates relevant assessment data in developing a plan for care
- determines priorities for care, based on nursing assessment of an individual’s/group’s needs for intervention, current nursing knowledge and research, and
- considers individual/group preferences when determining priorities for care in performance review processes.

6.2 Identifies expected and agreed individual/group health outcomes including a time frame for achievement:
- establishes realistic short- and long-term goals that identify individual/group health outcomes and specify condition for achievement
- identifies goals that are measurable, achievable, and congruent with values and beliefs of the individual/group and/or significant others
- uses resources to support the achievement of outcomes, and
- identifies criteria for evaluation of expected outcomes.

6.3 Documents a plan of care to achieve expected outcomes:
- ensures that plans of care are based on an ongoing analysis of assessment data
- plans care that is consistent with current nursing knowledge and research, and
6.4 Plans for continuity of care to achieve expected outcomes:

- collaboratively supports the therapeutic interventions of other health team members
- maintains and documents information necessary for continuity of the plan of care
- responds to individual/group or carer’s educational needs
- provides or facilitates provision of an individual’s/ group’s or carer’s resources and aids as required
- identifies and recommends appropriate agency, government and community resources to ensure continuity of care
- initiates necessary contacts and referrals to external agencies, and
- forwards all information needed for continuity of care when an individual/group is transferred to another facility or discharged.

7. Provides comprehensive, safe and effective evidence-based nursing care to achieve identified individual/group health outcomes

7.1 Effectively manages the nursing care of individuals/groups:

- uses resources effectively and efficiently in providing care
- performs actions in a manner consistent with relevant nursing principles
- performs procedures confidently and safely
- monitors responses of individuals/groups throughout each intervention and adjusts care accordingly, and

- provides education and support to assist development and maintenance of independent living skills

7.2 Provides nursing care according to the documented care or treatment plan:

- acts consistently with the predetermined plan of care
- uses a range of appropriate strategies to facilitate the individual/group’s achievement of short and long term expected goals

7.3 Prioritises workload based on the individual/group’s needs, acuity and optimal time for intervention:

- determines priorities for care, based on nursing assessment of an individual/group’s needs for intervention, current nursing knowledge and research
- considers the individual/group’s preferences when determining priorities for care

7.4 Responds effectively to unexpected or rapidly changing situations:

- responds effectively to emergencies
- maintains self-control in the clinical setting and under stress conditions
- implements crisis interventions and emergency routines as necessary
- maintains current knowledge of emergency plans and procedures to maximise effectiveness in crisis situations, and
- participates in emergency management practices and drills according to agency policy

7.5 Delegates aspects of care to others according to their competence and scope of practice:
National competency standards for the registered nurse

• delegates aspects of care according to role, functions, capabilities and learning needs
• monitors aspects of care delegated to others and provides clarification/assistance as required
• recognises own accountabilities and responsibilities when delegating aspects of care to others, and
• delegates to and supervises others consistent with legislation and organisational policy.

7.6 Provides effective and timely direction and supervision to ensure that delegated care is provided safely and accurately:
• supervises and evaluates nursing care provided by others
• uses a range of direct and indirect techniques such as instructing, coaching, mentoring, and collaborating in the supervision and support of others
• provides support with documentation to nurses being supervised or to whom care has been delegated, and
• delegates activities consistent with scope of practice/competence

7.7 Educates individuals/groups to promote independence and control over their health
• identifies and documents specific educational requirements and requests of individuals/groups undertakes formal and informal education sessions with individuals/groups as necessary, and
• identifies appropriate educational resources, including other health professionals.

7.8 Uses health care resources effectively and efficiently to promote optimal nursing and health care
• recognises when nursing resources are insufficient to meet an individual’s/group’s needs
• demonstrates flexibility in providing care where resources are limited, and
• recognises the responsibility to report to relevant persons when level of resources risks compromising the quality of care

8. Evaluates progress towards expected individual/group health outcomes in consultation with individuals/groups, significant others and interdisciplinary health care team

8.1 Determines progress of individuals/groups toward planned outcomes:
• recognises when individual’s/group’s progress and expected progress differ and modifies plans and actions accordingly
• discusses progress with the individual/group
• evaluates individual/group responses to interventions, and
• assesses the effectiveness of the plan of care in achieving planned outcomes

8.2 Revises the plan of care and determines further outcomes in accordance with evaluation data:
• revises expected outcomes, nursing interventions and priorities with any change in an individual’s/group’s condition, needs or situational variations
• communicates new information and revisions to members of the health care team as required

Collaborative and therapeutic practice

Relates to establishing, sustaining and concluding professional relationships with individuals/groups. This also contains those competencies that relate to
nurses understanding their contribution to the interdisciplinary health care team.

9. Establishes, maintains and appropriately concludes therapeutic relationships

9.1 Establishes therapeutic relationships that are goal directed and recognises professional boundaries:

- demonstrates empathy, trust and respect for the dignity and potential of the individual/group
- interacts with individuals/groups in a supportive manner
- effectively initiates, maintains and concludes interpersonal interactions
- establishes rapport with individuals/groups that enhances their ability to express feelings, and fosters an appropriate context for expression of feeling
- understands the potential benefits of partnership approaches on nurse individual/group relationships, and
- demonstrates an understanding of standards and practices of professional boundaries and therapeutic relationships.

9.2 Communicates effectively with individuals/groups to facilitate provision of care:

- uses a range of effective communication techniques
- uses language appropriate to the context
- uses written and spoken communication skills appropriate to the needs of individuals/groups
- uses an interpreter where appropriate
- provides adequate time for discussion
- establishes, where possible, alternative communication methods for individuals/groups who are unable to verbalise, and
- uses open/closed questions appropriately.

9.3 Uses appropriate strategies to promote an individual’s/ group’s self-esteem, dignity, integrity and comfort:

- identifies and uses strategies which encourage independence
- identifies and uses strategies which affirm individuality
- uses strategies which involve the family/significant others in care
- identifies and recommends appropriate support networks to individuals/groups
- identifies situations which may threaten the dignity/ integrity of an individual/group
- implements measures to maintain dignity of individuals/groups during periods of self-care deficit implements measures to support individuals/ groups experiencing emotional distress, and
- information is provided to individuals/groups to enhance their control over their own health care.

9.4 Assists and supports individuals/groups to make informed health care decisions:

- facilitates and encourages individual/group decision-making
- maintains and supports respect for an individual/ group’s decision through communication with other members of the interdisciplinary health care team, and
- arranges consultation to support individuals/ groups to make informed decisions regarding health care
9.5 Facilitates a physical, psychosocial, cultural and spiritual environment that promotes individual/group safety and security:

- demonstrates sensitivity, awareness and respect for cultural identity as part of an individual’s/group’s perceptions of security
- demonstrates sensitivity, awareness and respect in regard to an individual’s/group’s spiritual needs
- involves family and others in ensuring that cultural and spiritual needs are met
- identifies, eliminates or prevents environmental hazards where possible
- applies relevant principles to ensure the safe administration of therapeutic substances
- maintains standards for infection control
- applies ergonomic principles to prevent injury to individual/group and self
- prioritises safety problems
- adheres to occupational health and safety legislation
- modifies environmental factors to meet an individual/group’s comfort needs where possible
- promotes individual/group comfort throughout interventions, and
- uses ergonomic principles and appropriate aids to promote the individual/group’s comfort

10. Collaborates with the interdisciplinary health care team to provide comprehensive nursing care

10.1 Recognises that the membership and roles of health care teams and service providers will vary depending on an individual’s/group’s needs and health care setting:

- recognises the impact and role of population, primary health and partnership health care models
- recognises when to negotiate with, or refer to, other health care or service providers
- establishes positive and productive working relationships with colleagues, and
- recognises and understands the separate and interdependent roles and functions of health care team members.

10.2 Communicates nursing assessments and decisions to the interdisciplinary health care team and other relevant service providers:

- explains the nursing role to the interdisciplinary team and service providers
- maintains confidentiality in discussions about an individual/group’s needs and progress
- discusses individual/group care requirements with relevant members of the health care team
- collaborates with members of the health care team in decision making about care of individuals/groups
- demonstrates skills in written, verbal and electronic communication, and
- documents, as soon possible, forms of communication, nursing interventions and individual/group responses

10.3 Facilitates coordination of care to achieve agreed health outcomes:

- adopts and implements a collaborative approach to practice
- participates in health care team activities
- demonstrates the necessary communication skills to manage avoidance, confusion and confrontation
• demonstrates the necessary communication skills to enable negotiation
• demonstrates an understanding of how collaboration has an impact on the safe and effective provision of comprehensive care
• establishes and maintains effective and collaborative working relationships with other members of the health care team

consults with relevant health care professionals and service providers to facilitate continuity of care
• recognises the contribution of, and liaises with, relevant community and support services
• records information systematically in an accessible and retrievable form
• ensures that written communication is comprehensive, logical, legible, clear and concise, spelling is accurate and only acceptable abbreviations are used, and
• establishes and maintains documentation according to organisational guidelines and procedures.

10.4 Collaborates with the health care team to inform policy and guideline development:
• regularly consults policies and guidelines
• demonstrates awareness of changes to policies and guidelines
• attends meetings and participates in practice reviews and audits, and
• demonstrates understanding of the implications of national health strategies for nursing and health care practice.
Glossary

ANMAC
The Australian Nursing and Midwifery Accreditation Council, which is the new name for the ANMC

ANMC
Australian Nursing and Midwifery Council

Appropriate
Matching the circumstances, meeting needs of the individual, group or situation

Attributes
Characteristics which underpin competent performance

Competence
The combination of skills, knowledge, attitudes, values and abilities that underpin effective and/or superior performance in a profession/occupational area

Competency element
Represents a sub-section of a competency unit, and contains examples of competent performance known as cues

Competency standards
Consist of competency units and competency elements

Competency unit
Represents a stand-alone function or functional area underlying some aspect of professional performance

Competent
The person has competence across all the domains of competencies applicable to the nurse, at a level that is judged to be appropriate for the level of nurse being assessed

Contexts
The setting/environment where competence can be demonstrated or applied

Core competency standards
Essential competency standards for registration

Cues
Generic examples of competent performance. They are neither comprehensive nor exhaustive. They assist in assessment, selfreflection and curriculum development

Domains
An organised cluster of competencies in nursing practice

Enrolled nurse (EN)
A person registered to provide nursing care under the supervision of a registered nurse

Exemplars
Concrete examples typical of competence. They are not the standard but are indicative of the standard

National Board
The Nursing and Midwifery Board of Australia
National Scheme
The National Registration and Accreditation Scheme that commenced on 1 July 2010

NMRAs
Nursing and midwifery regulatory authorities (states and territories)

Nursing and Midwifery Board of Australia
The national body responsible for the regulation of nurses and midwives

Registered nurse (RN)
A person registered to practise nursing in Australia

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## Australian Nurse Teacher Competencies 2010

### DOMAIN 1 - Teaching and Learning

The core role of the educator is to facilitate learning. Educators may work in a variety of context tertiary educational facilities, hospitals, community. Learners may be students, clinical staff, clients or other staff members.

C1.1 Plans quality learning experiences and programmes which support education and nursing practice

- assesses needs of the individual learner in collaboration with the learner
- values diversity of learners
- acknowledges cultural factors affecting learning
- ensures that learner centred principles are applied
- considers current and future needs of stakeholders when planning programmes
- evaluates learning environment to support needs of the learner

C1.2 Plans effective teaching strategies which facilitate learning

- designs appropriate and realistic learning outcomes
- plans education programs/learning experiences based on adult learning principles
- utilises a variety of teaching resources to support educational practice
- recognises workplace opportunities and constraints incorporates emerging information technology to enhance learning
- provides opportunities for co-learning

C1.3 Implements facilitation strategies to support learners

- contributes to supporting a positive learning environment
- teaches content which reflects current practice
- applies evidence-based teaching practice
- adapts to contextual environmental challenges in a flexible manner
- motivates learners and demonstrates enthusiasm for teaching
- acts in capacity of mentor, coach, role model
- supervises nursing practice effectively within a clinical context
- fosters critical thinking, reflective practice and problem-solving

C1.4 Evaluates learning experiences and programmes in relation to learner needs and nursing outcomes

- monitors progress of the learner in relation to planned learning outcomes
- utilises briefing and debriefing strategies on a continuum throughout the learning experience
- provides constructive and timely feedback to the learner
- provides opportunities and support for reflective practice
- facilitates engagement of learners in self-assessment of professional competencies.
- evaluates educational programmes in conjunction with stakeholders
- utilises valid and reliable measures for evaluation
- uses programme evaluation findings to ensure currency and applicability of programmes according to professional needs
**DOMAIN 2 – Communication**

Educators need to be effective communicators in all areas of educational practice

| C2.1 Demonstrates effective communication and interpersonal skills at an advanced level | ▪ respects and values learners, staff and patients in all aspects of communication  
▪ develops teams and partnerships with health professionals and associated organisations  
▪ fosters team relationships with health professionals within the organisational unit of practice  
▪ uses formal and informal communication strategies to facilitate a trusting environment conducive to learning  
▪ teaches and supervises informatics competencies related to their area of practice  
▪ displays competence in use of technology for communication in all facets of their role as educators  
▪ demonstrates health literacy in regards to their teaching and professional roles  
▪ maintains currency of knowledge and usage of information technology programmes relevant to their role  
▪ utilises e-learning strategies to deliver programmes and support learning |

**DOMAIN 3 – Professional Practice**

Educators are required to demonstrate advanced professional practice competencies dependent on their context of educational practice

| C3.1 Demonstrates advanced nursing knowledge and expertise in the context of teaching | ▪ engages in self-reflection and reflective practice in nursing and education practice  
▪ maintains a professional portfolio which demonstrates nursing and teaching competence in the area of practice  
▪ identifies and engages in professional development activities as required for education and nursing competence  
▪ fosters critical inquiry in self and others to develop, maintain and promote the discipline of nursing  
▪ demonstrates cultural competence in both educational and nursing practice  
▪ embodies the Nursing Code of Conduct and Ethics in all aspect of education and practice |

| C3.2 Displays management and leadership skills in shaping and implementing change | ▪ participates actively in professional organisations  
▪ is cognisant of global trends in nursing education  
▪ acts as a change agent in response to policies and procedures affecting nursing and educational practice.  
▪ manages the organisation of learning experiences and programmes  
▪ monitors resources required for educational programmes  
▪ provides mentoring for clinical supervision where required |

| C3.3 Demonstrates a commitment to research and scholarship | ▪ shares knowledge and expertise within the wider nursing/allied health community  
▪ participates in research activities  
▪ models commitment to on-going learning  
▪ demonstrates the ability to use deductive and inductive reasoning |

Registered nurse standards for practice

Effective date 1 June 2016

Introduction
Registered nurse (RN) practice is person-centred and evidence-based with preventative, curative, formative, supportive, restorative and palliative elements. RNs work in therapeutic and professional relationships with individuals, as well as with families, groups and communities. These people may be healthy and with a range of abilities, or have health issues related to physical or mental illness and/or health challenges. These challenges may be posed by physical, psychiatric, developmental and/or intellectual disabilities.

The Australian community has a rich mixture of cultural and linguistic diversity, and the Registered nurse standards for practice are to be read in this context. RNs recognise the importance of history and culture to health and wellbeing. This practice reflects particular understanding of the impact of colonisation on the cultural, social and spiritual lives of Aboriginal and Torres Strait Islander peoples, which has contributed to significant health inequity in Australia.

As regulated health professionals, RNs are responsible and accountable to the Nursing and Midwifery Board of Australia (NMBA). These are the national Registered nurse standards for practice for all RNs. Together with NMBA standards, codes and guidelines, these Registered nurse standards for practice should be evident in current practice, and inform the development of the scopes of practice and aspirations of RNs.

RN practice, as a professional endeavour, requires continuous thinking and analysis in the context of thoughtful development and maintenance of constructive relationships. To engage in this work, RNs need to continue to develop professionally and maintain their capability for professional practice. RNs determine, coordinate and provide safe, quality nursing. This practice includes comprehensive assessment, development of a plan, implementation and evaluation of outcomes. As part of practice, RNs are responsible and accountable for supervision and the delegation of nursing activity to enrolled nurses (ENs) and others.

Practice is not restricted to the provision of direct clinical care. Nursing practice extends to any paid or unpaid role where the nurse uses their nursing skills and knowledge. This practice includes working in a direct non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory, policy development roles or other roles that impact on safe, effective delivery of services in the profession and/or use of the nurse’s professional skills. RNs are responsible for autonomous practice within dynamic systems, and in relationships with other health care professionals.
How to use these standards

The Registered nurse standards for practice consist of the following seven standards:

1. Thinks critically and analyses nursing practice.
2. Engages in therapeutic and professional relationships.
3. Maintains the capability for practice.
4. Comprehensively conducts assessments.
5. Develops a plan for nursing practice.
6. Provides safe, appropriate and responsive quality nursing practice.
7. Evaluates outcomes to inform nursing practice.

The above standards are all interconnected (see Figure 1). Standards one, two and three relate to each other, as well as to each dimension of practice in standards four, five, six and seven. Figure 1: Registered nurse standards

Each standard has criteria that specify how that standard is demonstrated. The criteria are to be interpreted in the context of each RN’s practice. For example, all RNs will, at various times, work in partnerships and delegate responsibilities, however not every RN will delegate clinical practice to enrolled nurses. The criteria are not exhaustive and enable rather than limit the development of individual registered nurse scopes of practice.

The Registered nurse standards for practice are for all RNs across all areas of practice. They are to be read in conjunction with the applicable NMBA companion documents such as the standards, codes and guidelines, including the Code of professional conduct for nurses, Code of ethics for nurses, National framework for the development of decision-making tools for nursing and midwifery practice, Supervision guidelines for nursing and midwifery, and Guidelines for mandatory notifications. The glossary is also important for understanding how key terms are used in these standards.
Registered nurse standards for practice

Standard 1: Thinks critically and analyses nursing practice

RNs use a variety of thinking strategies and the best available evidence in making decisions and providing safe, quality nursing practice within person-centred and evidence-based frameworks.

The registered nurse:

1.1 accesses, analyses, and uses the best available evidence, that includes research findings, for safe, quality practice

1.2 develops practice through reflection on experiences, knowledge, actions, feelings and beliefs to identify how these shape practice

1.3 respects all cultures and experiences, which includes responding to the role of family and community that underpin the health of Aboriginal and Torres Strait Islander peoples and people of other cultures

1.4 complies with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions

1.5 uses ethical frameworks when making decisions

1.6 maintains accurate, comprehensive and timely documentation of assessments, planning, decision-making, actions and evaluations, and

1.7 contributes to quality improvement and relevant research.

Standard 2: Engages in therapeutic and professional relationships

RN practice is based on purposefully engaging in effective therapeutic and professional relationships. This includes collegial generosity in the context of mutual trust and respect in professional relationships.

The registered nurse:

2.1 establishes, sustains and concludes relationships in a way that differentiates the boundaries between professional and personal relationships

2.2 communicates effectively, and is respectful of a person’s dignity, culture, values, beliefs and rights

2.3 recognises that people are the experts in the experience of their life

2.4 provides support and directs people to resources to optimise health-related decisions

2.5 advocates on behalf of people in a manner that respects the person’s autonomy and legal capacity

2.6 uses delegation, supervision, coordination, consultation and referrals in professional relationships to achieve improved health outcomes

2.7 actively fosters a culture of safety and learning that includes engaging with health professionals and others, to share knowledge and practice that supports person-centred care
2.8 participates in and/or leads collaborative practice, and

2.9 reports notifiable conduct of health professionals, health workers and others.

Standard 3: Maintains the capability for practice

RNs, as regulated health professionals, are responsible and accountable for ensuring they are safe, and have the capability for practice. This includes ongoing self-management and responding when there is concern about other health professionals’ capability for practice. RNs are responsible for their professional development and contribute to the development of others. They are also responsible for providing information and education to enable people to make decisions and take action in relation to their health.

The registered nurse:

3.1 considers and responds in a timely manner to the health and wellbeing of self and others in relation to the capability for practice

3.2 provides the information and education required to enhance people’s control over health

3.3 uses a lifelong learning approach for continuing professional development of self and others

3.4 accepts accountability for decisions, actions, behaviours and responsibilities inherent in their role, and for the actions of others to whom they have delegated responsibilities

3.5 seeks and responds to practice review and feedback

3.6 actively engages with the profession, and

3.7 identifies and promotes the integral role of nursing practice and the profession in influencing better health outcomes for people.

Standard 4: Comprehensively conducts assessments

RNs accurately conduct comprehensive and systematic assessments. They analyse information and data and communicate outcomes as the basis for practice.

The registered nurse:

4.1 conducts assessments that are holistic as well as culturally appropriate

4.2 uses a range of assessment techniques to systematically collect relevant and accurate information and data to inform practice

4.3 works in partnership to determine factors that affect, or potentially affect, the health and wellbeing of people and populations to determine priorities for action and/or for referral, and

4.4 assesses the resources available to inform planning.

Standard 5: Develops a plan for nursing practice

RNs are responsible for the planning and communication of nursing practice. Agreed plans are developed in partnership. They are based on the RNs appraisal of comprehensive, relevant information, and evidence that is documented and communicated.
The registered nurse:

5.1 uses assessment data and best available evidence to develop a plan

5.2 collaboratively constructs nursing practice plans until contingencies, options priorities, goals, actions, outcomes and timeframes are agreed with the relevant persons

5.3 documents, evaluates and modifies plans accordingly to facilitate the agreed outcomes 5.4 plans and negotiates how practice will be evaluated and the time frame of engagement, and

5.5 coordinates resources effectively and efficiently for planned actions.

Standard 6: Provides safe, appropriate and responsive quality nursing practice

RNs provide and may delegate, quality and ethical goal-directed actions. These are based on comprehensive and systematic assessment, and the best available evidence to achieve planned and agreed outcomes.

The registered nurse:

6.1 provides comprehensive safe, quality practice to achieve agreed goals and outcomes that are responsive to the nursing needs of people

6.2 practises within their scope of practice

6.3 appropriately delegates aspects of practice to enrolled nurses and others, according to enrolled nurse’s scope of practice or others’ clinical or non-clinical roles

6.4 provides effective timely direction and supervision to ensure that delegated practice is safe and correct

6.5 practises in accordance with relevant policies, guidelines, standards, regulations and legislation, and

6.6 uses the appropriate processes to identify and report potential and actual risk related system issues and where practice may be below the expected standards.

Standard 7: Evaluates outcomes to inform nursing practice

RNs take responsibility for the evaluation of practice based on agreed priorities, goals, plans and outcomes and revises practice accordingly.

The registered nurse:

7.1 evaluates and monitors progress towards the expected goals and outcomes

7.2 revises the plan based on the evaluation, and

7.3 determines, documents and communicates further priorities, goals and outcomes with the relevant persons.
Glossary

These definitions relate to the use of terms in the *Registered nurse standards for practice*.

**Accountability** means that nurses answer to the people in their care, the nursing regulatory authority, their employers and the public. Nurses are accountable for their decisions, actions, behaviours and the responsibilities that are inherent in their nursing roles including documentation. Accountability cannot be delegated. The registered nurse who delegates activities to be undertaken by another person remains accountable for the decision to delegate, for monitoring the level of performance by the other person, and for evaluating the outcomes of what has been delegated (Nursing and Midwifery Board of Australia 2013). See below for the related definition of 'Delegation'.

**Criteria** in this document means the actions and behaviours of the RN that demonstrate these standards for practice.

**Delegation** is the relationship that exists when a RN delegates aspects of their nursing practice to another person such as an enrolled nurse, a student nurse or a person who is not a nurse. Delegations are made to meet peoples’ needs and to enable access to health care services, that is, the right person is available at the right time to provide the right service. The RN who is delegating retains accountability for the decision to delegate. They are also accountable for monitoring of the communication of the delegation to the relevant persons and for the practice outcomes. Both parties share the responsibility of making the delegation decision, which includes assessment of the risks and capabilities. In some instances delegation may be preceded by teaching and competence assessment. For further details see the NMBA’s National framework for the development of decision-making tools for nursing and midwifery practice (2013).

**Enrolled nurse** is a person who provides nursing care under the direct or indirect supervision of a registered nurse. They have completed the prescribed education preparation, and demonstrate competence to practise under the Health Practitioner Regulation National Law as an enrolled nurse in Australia. Enrolled nurses are accountable for their own practice and remain responsible to a registered nurse for the delegated care.

**Evidence-based practice** is accessing and making judgements to translate the best available evidence, which includes the most current, valid, and available research findings into practice.

**Person or people** is used in these standards to refer to those individuals who have entered into a therapeutic and/or professional relationship with a registered nurse. These individuals will sometimes be health care consumers, at other times they may be colleagues or students, this will vary depending on who is the focus of practice at the time. Therefore, the words person or people include all the patients, clients, consumers, families, carers, groups and/or communities that are within the registered nurse scope and context of practice. The registered nurse has professional relationships in health care related teams.

**Person-centred practice** is collaborative and respectful partnership built on mutual trust and understanding through good communication. Each person is treated as an individual with the aim of respecting people’s ownership of their health information, rights and preferences while protecting their dignity and empowering choice. Person-centred practice recognises the role of family and community with respect to cultural and religious diversity.

**Registered nurse** is a person who has completed the prescribed education preparation, demonstrates competence to practise and is registered under the Health Practitioner Regulation National Law as a registered nurse in Australia.

**Scope of practice** is that in which nurses are educated, competent to perform and permitted by law. The actual scope of practice is influenced by the context in which the nurse practises, the health needs of
people, the level of competence and confidence of the nurse and the policy requirements of the service provider.

**Standards for practice** in this document are the expectations of registered nurse practice. They inform the education standards for registered nurses, the regulation of nurses and determination of the nurse’s capability for practice, and guide consumers, employers and other stakeholders on what to reasonably expect from a registered nurse regardless of the area of nursing practice or years of nursing experience. They replace the previous *National competency standards for the registered nurse* (2010).

**Supervision** includes managerial supervision, professional supervision and clinically focused supervision. For further details see the NMBA’s, *Supervision guidelines for nursing and midwifery* (2015).

**Therapeutic relationships** are different to personal relationships. In a therapeutic relationship the nurse is sensitive to a person’s situation and purposefully engages with them using knowledge and skills in respect, compassion and kindness. In the relationship the person’s rights and dignity are recognised and respected. The professional nature of the relationship involves recognition of professional boundaries and issues of unequal power. For further details see the NMBA’s *A nurse’s guide to professional boundaries* (2010).

References

