Evolving Views: A Constructivist Grounded Theory Exploration of Nursing Students' Concepts of Health and Illness.

Catherine Frances Delves-Yates

UEA Registration No. 6524028/3

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Abstract

Background: Health and illness are fundamental concepts and core elements of pre-registration nursing curricula. There is limited empirical research exploring the views and perceptions of health and illness held by nursing students, how these may evolve and how they could influence the implementation of person-centred care.

Aim: To explore evolving views and perceptions of health and illness of students undertaking a full-time pre-registration BSc nursing programme in the United Kingdom.

Methodology and Methods: A concept analysis of health and illness and an empirical study, adopting a qualitative longitudinal and Constructivist Grounded Theory methodological approach. Sampling was initially purposive, progressing to theoretical. The sample comprised 21 students undertaking a full-time undergraduate (BSc) pre-registration nursing programme at either of two English universities (one urban, one semi-rural), between September 2016 - August 2021. The sample included students in all three years of study and represented all four fields of nursing. Qualitative data were collected through nine in-person focus groups and eight individual online interviews. Data were analysed inductively, developing initial and then focused coding, using the constant comparative method.

Findings: Four data categories emerged – ‘Evolving Views’, ‘Developing a Nursing Lexicon’, ‘Influencing Care’ and ‘Caring for Self’. Conceptual interpretation of the data identified that reflective processes were fundamental, as the evolution of views of health and illness were characterised by the development of meaning from experience.

Conclusion: The emergent grounded theory, The Theory of Balance in Perception of Health and Illness and Care Delivery (Theory of Balance), recognises a relationship between nursing students’ understanding of views of health and illness and person-centred care and provides an original contribution to nurse education.

Recommendations: Students’ views of health and illness should be a focus for regular guided reflection and discussion, occurring both during and after periods of placement learning and co-facilitated by clinical and academic staff.

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The impetus for this work resulted from some personal experiences with close relatives who are no longer present, individuals to whom I have delivered care, plus students and colleagues I have worked with, in several countries, over many years. They all had a key impact on this work and their influence is a golden thread running through it. Thank you.

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Glossary

Clinical placement - the term used to describe the experience of care delivery that a student undertakes as part of their pre-registration nursing education.

Expressive caring - person-centred and holistic care.

Field of study - identifies the category of persons being the focus of the study, which can be either adult, child, mental health or learning disability.

Fields of nursing - identifies the category of persons being cared for, which can be either adult, child, mental health or learning disability.

Instrumental caring - maintaining physical health and comfort in a task-oriented manner.

Lay - referring to a perspective not informed by professional knowledge or professional experience of healthcare delivery.

Participant - a nursing student who voluntarily took part in the research.

Theory - an explanatory scheme outlining how concepts are related to each other through logical patterns of connectivity.

Abbreviations

AH - Adult Health

BAME - Black, Asian and Minority Ethnic

CGT - Constructivist Grounded Theory

COVID or COVID-19 - Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2)

DSM - Diagnostic and Statistical Manual of mental disorders

GT - Grounded Theory

HCA - Health Care Assistant

ICF - International Classification of Functioning, Disability and Health

ICIDH - International Classification of Impairments, Disabilities and Handicaps

IfG - Institute for Government analysis

ITU - Intensive Therapy Unit

LD - Learning Disability

MH - Mental Health

NHS - National Health Service

NMC - Nursing and Midwifery Council

PCNF - Person-centred Nursing Framework

PCPF - Person-centre Practice Framework

PIS - Participant Information Sheet

PPIRes - Public and Patient Involvement in Research

QLR - Qualitative Longitudinal Research

SARS-CoV-2 - Severe Acute Respiratory Syndrome Coronavirus 2

UK - United Kingdom

USA - United States of America

WHO - World Health Organization

Part One – Understanding the Background

‘Research can be a very personal journey’

Reflective Journal Entry 05.06.2018

Chapter 1 Overview of the Thesis

'An exploration of experience and a development of my knowledge and understanding in so many realms'

Reflective Journal Entry 19.03.2023

1.1 Introduction

This initial chapter serves as an introduction to the thesis. It commences by identifying the impetus for undertaking a research study focusing on nursing students' concepts of health and illness, first by presenting a personal rationale to support this and second by discussing the complexity involved in defining the concepts of health and illness while contextualising the importance of their understanding in nursing and nurse education. An outline of the research approach and design is presented, including an introduction to the positionality of the researcher. To ensure clarity, key terms used throughout are explained and the rationale for the use of a personal voice within the writing is shared. The chapter ends with an overview of the layout of the thesis, providing a brief outline of the content of each of the following chapters.

1.2 Identifying the Impetus for Research

The impetus for the research originates from my experience prior to becoming a nurse, throughout my own nursing education and as a provider of care and later as a nurse educator. My interest in the concepts of health and illness has developed through a combination of personal and professional experience. Personally, I have experienced long-term and terminal illness of family members, as a child and adult. Professionally, I have studied nursing at undergraduate and postgraduate levels and delivered care as a student and Registered Nurse. More recently I have supported nursing students in their delivery of care in my role as an educator, while working in the United Kingdom (UK), the United States of America (USA), Cameroon and Nepal. This experience has helped me realise that the concepts of health and illness have a wide range of meanings, which are frequently difficult to conceptualise (Herberts and Eriksson, 1995).

My interest in differing views of health and illness became particularly focused while I was participating in the collaborative development and delivery of nursing programmes for universities in Cameroon from 2008-2015 and in Nepal from 2011-2012. The educationalists I was working with asked for assistance to develop a curriculum based on a biomedical approach to nursing, without any inclusion of the traditional medicine heritage common to both countries, reflecting the approach to nurse education I had experienced and taught. While working collaboratively to develop these programmes and later when supporting students undertaking them, I questioned the impact programmes with a biomedical approach had on the Cameroonian and Nepali students' views of health and illness; did their original interpretations alter, or did they maintain two, or more, different positions? Further to this could differing positions be held simultaneously, overcoming 'either/or thinking', or did the introduction of different approaches and positions create dissonance? At first my focus was on the differences presented within what I saw as the contrasting ideologies these students were experiencing. As my experience of working with students undertaking nursing programmes outside of the UK increased and was interspersed with working with nursing students within the UK, I came to appreciate far more similarities than differences; both ideologies had the same aim and students were experiencing similar development of their views. Thus, I recognised the naïvety of my original questioning and the assumptions I had made regarding pre-existing views. In discussions with students studying in the UK and elsewhere, it became clear that they were all being exposed to new perspectives regarding views of health and illness. While supporting students studying outside of the UK prompted me to focus on nursing students and their perspectives on health and illness, as Helman (1978) and later Leininger (1996) identify, there is actually no need to travel. Views of health and illness are individual and diverse, regardless of geographical location.

1.2.1 Concepts of health and illness have a wide range of meanings

It is widely acknowledged that concepts such as health and illness are difficult to define precisely (Mordacci, 1995) and gaining an understanding of these concepts is challenging because they embody value judgements and are imbued in metaphor (Boyd, 2000). Health and illness are both complex and abstract conditions that are experienced individually and uniquely (Kleinman, 1988, Charmaz, 1995, Blaxter, 2004, Helman, 2007). Even though it is possible to classify objective signs and symptoms of illness, there is a large degree of subjectivity in any episode of illness because the perception and experience of the person involved will be personal and variable (Helman, 1981, Kleinman, 1988, Leininger and Reynolds, 1991, Eriksson, 2007, Charmaz, 2008). Determining health as a state is just as, if not more, complex, as there is no measurable standard. Health is experienced subjectively and has been declared intangible and impossible to define (Smith, 1992), with the starting point for consideration depending upon whether a medical, pedagogical, philosophical or psychological perspective is being adopted (Skär and Söderberg, 2016). The most well-known and frequently-quoted definition, WHO (1946, p. 984),

> *'Health is a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity'*

has been described as vague, unachievable, inflexible and unrealistic (Tulloch, 2005, Jadad and O'Grady, 2008, Horton, 2009, Godlee, 2011). Later WHO-sponsored work published as the Ottawa Charter (WHO, 1986, p. 17) revisited and expanded the original definition to feature health promotion,

> *'Health promotion is the process of enabling people to increase control over and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realise aspirations, to satisfy needs and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion isn't just the responsibility of the health sector but goes beyond healthy lifestyles to well-being'*

This however has also been criticised for not fully reflecting the relationship between health promotion and health (Potvin and Jones, 2011), not being sufficiently engaging, particularly from a global perspective (Pettersson, 2011) and representing the perspective of the privileged (McPhail-Bell et al., 2013). The reflection of health as an ideal state is a particular aspect of concern with focus on the word '*complete*' in the 1946 definition seen to be absolute and difficult to measure (Seedhouse, 2001). Thus it is questioned as to whether it is possible for a person to be without physical, mental or social challenge, with Smith (2008) suggesting that the prerequisite for completeness within the WHO definitions results in most individuals being unhealthy most of the time. This is particularly pertinent regarding persons with long-term illness who would never be able to achieve the state of health identified by the WHO definitions (Huber et al., 2011).

Despite these criticisms, however, merit can be found in the emphasis the WHO definitions place on the positive qualities of health and its multiple dimensions. Later definitions of health adopt such an approach, highlighting the dimensions within which health can be considered. Last (2007, p. 95), for example, proposes two definitions outlining an ecological perspective, thus identifying health as,

> *'A sustainable state of equilibrium or harmony between humans and their physical, biological and social environments that enables them to coexist indefinitely'*
>
> *'A structural, functional and emotional state that is compatible with effective life as an individual and as a member of family and community groups'*

which provide acknowledgement of dependence on health sustainability and its interrelation with the surrounding environment. Last's work includes the multidimensional components of the earlier WHO definition, but without identifying health as a complete state and integrates a social perspective and the ability to function as an individual. This reflects that, as the concept of health has been developed over time, it has become possible to identify greater inclusion in definitions of the expression of subjectivity and aspects of quality of life and well-being (Skär and Söderberg, 2016).

The enigmatic nature of health and its fundamental role in nursing has long been recognised,

> *'We know nothing of the principle of health…except from observation and experience…which will teach us the ways to maintain or bring back the state of health'*
>
> (Nightingale, 1859, p. 133)

with definitions of health varying across the lifespan, between and within cultures, as well as amongst individuals with diverse life experience (Viner et al., 2012, Meurier, 2016). This confirms the perspective that definitions are individually determined and, due to the range of influences relevant to the specific experience of the person involved, standardisation is problematic.

Similarly, Nordby (2004) suggests that outside the healthcare professions the term 'illness' does not have a standard, uniform use, because it is a state experienced uniquely by each ill person. Nordby (2004) presents a notable perspective, not in the respect of the uniqueness of illness, but that it could be inferred from his comment that there is standard uniform use of the term illness within the healthcare professions. Applying Borton's (1970) reflective model to analyse whether my experience in clinical practice and education supported the existence of a standardised definition of illness did not provide evidence that this is the case; resulting in the conclusion that neither illness nor health has a shared meaning between healthcare professionals. There is also a further layer of complexity, healthcare professionals do not just converse about health and illness with each other, the main focus of their communication regarding these abstract concepts is on those for whom they provide care.

Freidson (1970), building on previous work such as Hughes (1968), demonstrated that there were fundamental differences in the meaning and understanding of health and illness held by the persons receiving care and those delivering it. Further support for such a perspective can be found in the identification that sophisticated lay views of health and illness, distinct from professional ones, exist (Helman, 1978, Kangas, 2001, Haidet et al., 2007). The proposed difference between a lay view and a professional one is the knowledge underpinning it (Kleinman, 1980, Good et al., 1994, Kangas, 2001, Helman, 2007). Lay views of health and illness are said to be informed by subjective anecdotal experience, combined with folklore mythology and are slow to alter, whereas professional views are underpinned by contemporary empirical evidence, so are objective and subject to rapid change (Kleinman, 1988, Bury, 2005, Helman, 2007). From this perspective therefore it could be concluded that all nurses have views of health and illness underpinned by contemporary empirical evidence that differ from the anecdotally informed views of health and illness of the lay persons they deliver care to. To arrive at such a conclusion however seems rather simplistic and reductionist, ignoring the known unique and personal perspective that characterises views.

Within the literature there is little contemporary consideration of how much views between professional healthcarers and lay persons, in reality, differ. The issue is addressed by Shaw (2002), in his consideration of the impact of the collaborative processes involved in healthcare. These ensure that, once a person is receiving care, health professionals, family members and/or significant others and sometimes also their wider social support network work together to define, contextualise and, if necessary, remedy an illness or health challenge. Throughout their lifetime only a few individuals will not experience being either a person in receipt of healthcare or a family member/significant other of a person receiving care. Hence, at the very least, indirect contact with healthcare professionals for the majority of the population will result. It is possible that this exposure to the health and illness-related knowledge and views healthcarers hold may cause an alteration in understanding of health and illness within the individual. In addition to the case presented by Shaw (2002), the potential influence of all types of public service broadcasting and social media also need to be considered, whereby the knowledge and views of healthcare professionals and persons experiencing illness or a health challenge are easily accessible, and possibly even seen when they are not explicitly solicited. It is therefore conceivable that lay views may be informed by expert professional discourse and change rapidly in response to new information. This highlights the potential for the distinct dichotomy described by the work of Hughes (1968), Freidson (1970), Helman (1978), Kangas (2001) and Haidet et al. (2007) not accurately reflecting a contemporary perspective.

1.2.2 Why is an understanding of the concepts of health and illness important in nursing?

If the declared goals of healthcare are to attain health (Godlee, 2011) and prevent illness, a detailed understanding of the abstract concepts of health and illness is necessary in order to devise nursing interventions to attain these goals and to identify when they have been achieved (Earle et al., 2007). If there is no understanding of the existence of difference in definitions of health and illness there is a potential of communication gaps between nurses and those they provide care for (Spector, 2002). In order, therefore, to provide appropriate care nurses need to have both knowledge and understanding of experiences of health and illness (Sherwood, 2011).

The personal conceptions of health and illness of both the persons receiving care and those delivering it are important because they influence health behaviour and interactions (Freidson, 1970, Kleinman et al., 1978, Armstrong, 1989, de Silva, 2011, Hibbard and Gilburt, 2014). The satisfaction and concordance of care recipients are positively influenced by integration of what they understand and feel to be important (O'Connor et al., 2004, NICE, 2009, de Silva, 2012, Berwick, 2013), with a shared definition of any health challenge being an essential element in effective care delivery, illness management or health promotion (Leventhal, 1985, Hampson et al., 1990, Eriksson, 1997, Fredriksson and Eriksson, 2003, Pollock, 2005, McCormack and McCance, 2006, Coulter and Collins, 2011, Kleinman, 2012, Cole and Bird, 2013, Carel, 2014, Kidd and Carel, 2017, Rivai et al., 2023). As definitions and perceptions of health and illness differ between those delivering care and those providing it, Skär and Söderberg (2016) identify, with specific reference to nursing students, the need to understand this so they learn to tailor the care they provide to ensure it is effective. The effectiveness of nurses working in a manner upholding the perspective of the person they are delivering care for is clearly supported within the literature, with The King's Fund (2012) also identifying that working in this way brings an increase in the morale of the care provider. Further to this, the importance of upholding the perspective of the person receiving care was supported by Darzi (2008) in his review of the UK National Health Service (NHS), is enshrined in the Health and Social Care Act (UK Government, 2012) and features in both the original NHS Constitution for England (DoH, 2012) and the updated version (DoH, 2023).

It is clear therefore that a fundamental aspect of nursing care is for the nurse and person receiving care to work collaboratively in the care process (Peplau, 1991, Gastmans, 1998, Coulter and Collins, 2011, NMC, 2018a, DoH, 2023), with an understanding of the perspective of the person receiving care (McCormack and McCance, 2016, Skär and Söderberg, 2016). Such an approach enables decision-making to be shared between persons receiving care and the nurse, which has been described as an ethical imperative (Coulter and Collins, 2011).

Nurses therefore require both the knowledge and the skills to contextualise care in order to meet the unique needs of each and every individual (Loke et al., 2015). In order to achieve this, one of the aims of nurse education, not just in the UK but also globally, is to enable students to collaborate with a person receiving care, respecting their individual view at all times in order to maximise the positive impact of any interventions (ICN, 1987, NMC, 2018a, NMC, 2018c, DoH, 2023). The nursing approach enabling care to be delivered in this way should be developed throughout pre-registration education (Skär and Söderberg, 2016). Over a number of years while pre-registration programmes have been seen as effective in enabling students to become technical experts, they do not sufficiently develop the ability to deliver compassionate nursing care that meets the unique needs of every individual (Melia, 1987, Watson et al., 1999, Mackintosh, 2006, Murphy et al., 2009, Mlinar, 2010, Loke et al., 2015, Romero-Martín et al., 2019, Reynolds, 2023). The crucial issue is that programmes can fail to cultivate the ability of students to develop and sustain a professional caring connection with the person receiving care. In pre-registration nursing programmes there can be a relocation of the focus of teaching from, for example, the importance of developing a therapeutic connection with the person receiving care, to the doing of practical care skills and application of technical expertise. While the importance of proficiency in the performance of practical care skills and the ability to correctly use technology is not disputed, the role of a nurse is more complex than this. To effectively undertake their contemporary nursing role, students need to acquire practical care skills and technological expertise in tandem with the ability to deliver effective person-centred care.

Although the importance of upholding the perspective of the person receiving care has been enshrined in the Health and Social Care Act (UK Government, 2012) and the NHS Constitution for England (DoH, 2023), and is the adopted care approach in the NHS (NHS-England, 2019a, NHS-England, 2019b), concerns relating to healthcare professionals' lack of knowledge, understanding and appreciation of the perspective of the person receiving care continue to be expressed. Thus the need for acknowledgement of the personhood of persons receiving care (Kleinman, 2015, Hennelly and O'Shea, 2019), a humanistic turn in healthcare (Kidd and Carel, 2017, Wang et al., 2020) and a fundamentally person-centred approach (McCormack and McCance, 2006, McCormack et al., 2011, Richards et al., 2015, van Belle et al., 2020) to be constantly achieved in care delivery persists (McCance et al., 2011, Seah et al., 2022, Younas et al., 2023).

At the core of person-centred nursing practice is a genuine interest in the personal beliefs and views of others, the decisions they want to make and the priorities they allocate to their health or illness. Delivering care which adopts a person-centred approach enables the focus to be on the care recipient, enabling their perspective of health and illness to guide goals, interventions and evaluation. In person-centred practice the person receiving care is placed at the centre, with the nurse upholding their dignity, providing autonomy by offering choice, control and respecting the decisions they make.

It is possible to identify three important elements in the delivery of nursing care that uphold the views of health and illness of the person receiving care: first, that nurses have an understanding of the relevant attributes, or critical characteristics of health and illness, from a range of perspectives, as this is paramount to successful communication with all involved in care. Second, that nurses respect the views of health and illness held by persons receiving care and, third, that nurses work effectively in response to the many and differing views individuals can hold, including those opposing their personal positions. As such further questions are raised regarding whether this is achieved and, if so, how. Within current nurse education there has been increased recognition of the importance of gaining an understanding of both others and self through learning to reflect on experience (NMC, 2021b). Being self-aware as a nurse, having an understanding of the impact your personal inner world has on the shared interpersonal outer world, is one of the first steps towards achieving the conscious and authentic guiding of professional behaviour necessary to deliver care reflective of the perspective of another (Peplau, 1991, Eckroth-Bucher, 2010). Strategies supporting students to develop this approach throughout their programme, enabling them to appreciate changes within their views as they develop the skills and values of their profession, have, however, been judged as not always sufficiently overt (Cheng et al., 2020).

1.2.3 Developing the existing knowledge

There is an extensive body of literature and research relating to health and illness, which considers the importance of understanding concepts of health and illness. The difference in concepts of health and illness between those being cared for and the healthcare provider features strongly within this, especially regarding cross-cultural encounters. Much of this literature, however, focuses on the perspective of the healthcare provider being a doctor; there is much less consideration of the concepts of health and illness held by allied healthcare professionals. Within the literature focusing on allied healthcare professionals there is consideration of Registered

Nurses but there is a paucity of empirical research focusing specifically on the concepts of health and illness held by nursing students.

Students commence their studies fulfilling the definition of a lay person. They are, however, individuals whose choice to study nursing is likely to signify an interest and possibly even experience in healthcare prior to starting their programme of study. The question is posed therefore as to how informed their views of health and illness may be at the start of their programme and whether they alter during a nursing programme. It is not possible to answer these questions within the currently existing accessible knowledge, but relevant issues that I wish to explore feature prominently in the work of the authors identified below. Therefore, to make an original contribution to knowledge my research seeks to combine and build on the literature of:

> Hughes (1968), Helman (1978, 2007), Freidson (1970), Kleinman (1980, 1988), Blaxter (1983, 2004), Charmaz (1990, 1991, 1994, 1995, 2002, 2006, 2008) and Skär and Söderberg (2016) focusing on perception of health and/or illness,
>
> Kitwood (1993, 1997), Kitwood and Brooker (2019), McCormack (2001a, 2001b, 2003, 2004), McCormack and McCance (2006, 2019a), McCormack et al. (2011) and McCormack and Dewing (2019) focusing on person-centred nursing practice,
>
> Herberts and Eriksson (1995), Eriksson (1997), and Fredriksson and Eriksson (2003) focusing on caring.

The findings from this research have the potential to increase understanding of the concepts of health and illness held by nursing students, and their perception of the views of health and illness held by the person they are delivering care to, including whether and how these change during their nursing education. For nursing students to learn to deliver effective care to all persons there is the need to understand that different factors promote or hinder health in each individual (Meurier, 2016). The resultant findings will enable nurse educators to enrich this aspect of knowledge development within their current pre-registration nursing curricula and will contribute to the evolution of future curricula.

1.3 Research Design

A research study exploring the understanding and perspective of participants, driven by specific research questions, fits most naturally within a qualitative methodological approach (Patton, 2014). Within the range of qualitative approaches grounded theory (GT) offers the most appropriate methodology, enabling the application of a model which is rigorous but flexible (Charmaz, 2014). This research applies a qualitative longitudinal research approach and Charmaz's version of GT, underpinned by the theoretical principles of symbolic interactionism and social constructionism. Such an approach reflects the socially constructed culture that nursing is located within and has the potential to capture the multiple and subjective realities of views of health and illness. My role as researcher within this approach is to act as the author of a co-construction of the experience identified by the participants (Charmaz, 2014).

Since GT methodology originated, in the 1967 work of Glaser and Strauss, its development has taken diverging paths, which depended on the epistemological perspective of the individual applying it (Birks and Mills, 2022). As outlined by Barchard (2019), Charmaz, in her research, adopted the Glaser and Strauss (1967) inductive, comparative and emergent approach to GT, but also emphasised the iterative logic and focus on both action and meaning highlighted by Strauss (1987). The result was an approach Charmaz identified as constructivist grounded theory (CGT), which can also be referred to as 'Charmazian grounded theory'.

To demonstrate transparency and rigour of study reporting the research reported throughout the thesis adheres to the Consolidated Criteria for Reporting Qualitative research (COREQ) (Tong et al., 2007), with the checklist presented as Appendix 1.

1.4 Explaining Key Terminology

Throughout this thesis my aim is to achieve clarity by avoiding misinterpretation and ambiguity. Thus, the sections below provide explanation of the key terms and how they have been used throughout the work. In addition, a glossary has been compiled to clarify the specific meaning I have allotted to other relevant words and concepts (see page 8).

1.4.1 Person or persons receiving care

It is not easy to identify a term covering all those who use a health service and the individuals nurses work with. Possibly the most frequently-used term is ‘patient’, which may be appropriate when an illness or specific condition has significant impact on an individual’s life and requires ongoing intervention from health professionals. To use patient on a long-term basis can, however, be an inappropriate label, so other terms such as ‘service user’, ‘client’ or ‘expert by experience’ have been adopted. Despite these terms having different connotations to that of patient, they have also been criticised. According to McLaughlin (2009) the term ‘user’ is linked to drug addiction while the danger with the term ‘service users’, even if it applies to a group of persons who use the same service, is they may have little else in common; their diversity of need and experience could be overlooked. The term ‘expert by experience’ also can be a cause of concern, for some persons receiving care dislike being labelled as experts (North, 2018).

Jackson et al. (2016) add to the debate by stating that finding an appropriate term is more than just a semantic exercise, as our use of language reflects how we view those we support and our values and intentions. Terminology can imply or lead to an imbalance of power, transmitting a message as to how the persons the label is applied to are viewed, which can influence the behaviour of others toward this group. The terms we use can also affect how the person to whom the term is applied sees themselves (Emerson and Northway, 2022).

Throughout this thesis person-first language will be promoted, using linguistic expressions relying on words that reflect awareness, a sense of dignity and positive attitudes when talking about persons with illness or disability. To reflect the fact that an individual receiving healthcare is foremost a person, I will refer to them as a person receiving care or, in plural form, as persons receiving care. While using people as the plural form of person is grammatically correct, the terms person and persons in this thesis are being used to represent more than just membership of a biological species. The terms are used to characterise the uniqueness of all persons, who each have equal value and intrinsic worth (Sullivan, 1989, McCormack, 2004).

While the thesis aims to ensure consistent use of terminology, a fundamental element of many chapters are quotes from the research participants. To remain authentic and to precisely replicate the words used by participants, in these quotes the exact expression the participant used to refer to the person or persons receiving care will be cited.

1.4.2 Nursing student

Globally the term ‘nursing student’ describes an individual enrolled on a formally recognised programme of initial nursing education which provides a broad foundation in the behavioural, life and nursing sciences for the generalised practice of nursing (ICN, 1987).

Within the UK, ‘nursing student’ refers to an individual over the age of 17 who is undertaking a Nursing and Midwifery Council (NMC) validated education programme, at an NMC-approved education institution. Successful completion of this programme results in gaining the professional qualification of Registered Nurse and an academic award of a degree in nursing. Most frequently the degree studied for is a Bachelor’s-level award, but a growing number of Master’s-level programmes are also available.

Initial nurse education programmes in the UK offer students the choice of four specialised areas (called fields) of study or nursing, which are adult, mental health, learning disability or children’s nursing. These fields of study or nursing identify the specific categories of persons with health needs that the programme of study focuses on.

From this point onwards within the thesis the term student will be used to refer to a nursing student. If it is relevant to the discussion the field of study or nursing will also be indicated.

1.4.3 Registered Nurse

Worldwide, a Registered Nurse is a person who has successfully completed a programme of initial nursing education and is authorised by an appropriate regulatory authority to practise nursing in a specific country (WHO, 2020). A Registered Nurse has been educated to provide nursing care, which includes the promotion of health and prevention of illness, plus the care of persons with physical or mental health needs in all acute healthcare and community settings. They also have the knowledge and skills to deliver healthcare teaching, function as a member of a healthcare team, lead, supervise and educate others who deliver healthcare and be involved in research (ICN, 1987). Thus Registered Nurses play a fundamental role in the organisation of healthcare as well as healthcare delivery, with half of all healthcare professionals worldwide being nurses (WHO, 2020).

In the UK while the term ‘nurse’ can be freely used, the term ‘Registered Nurse’ is protected under the 1997 Nurses, Midwives and Health Visitors Act (UK Government, 1997). In the UK, to be able to call yourself a Registered Nurse and practise as one, the person will have successfully completed an initial nursing education programme validated by the NMC and be listed on the NMC register as a Registered Nurse (NMC, 2010, NMC, 2018a, NMC, 2018b, NMC, 2018c, NMC, 2021b). As identified in the previous section, programmes of initial nurse education in the UK are specialised, focusing on specific categories of persons with health needs (referred to as the ‘field(s) of study or nursing’). Consequently, the term Registered Nurse in the UK is further classified as adult, child, mental health or learning disability.

Throughout this thesis the term ‘nurse’ is used to refer to a Registered Nurse. If it is relevant to the discussion the field of nursing will also be indicated.

1.5 Using my Personal Voice

As a nurse educator I am asked frequently by students how they should write their work: '*Can I say 'I' or is that not allowed?*' Such an apparently simple question elicits a much longer response than is often expected and it is one I now apply to my own work. Writing on any topic involves the sharing of a personal perspective and there is little more personal in research than the production of your own doctoral thesis. Reflecting on my own nursing education, I was schooled in the approach that writing should present a comprehensive exchange of ideas (Leviw, 1975) but it was impolite to use the first person (Day, 1983). More contemporary views are much more accepting of a personalised approach, especially regarding qualitative research. Such views, however, are not unanimously accepted (Smith, 2020) and I agree that there is merit in taking a cautious approach, as in academic writing the rules of scholarship still need to apply. Formal academic work should not, for example, be written in the same style as a letter to a friend or family member.

While I view writing as a craft and a pleasure and value the time, effort and patience it takes to produce the most eloquent written narrative possible, the primary function of any writing is to communicate with others. As has previously been mentioned in this introductory chapter, throughout my thesis my aim is to achieve clarity in all aspects of my work and to avoid misinterpretation and ambiguity. The use of my personal voice is an intentional approach taken to enhance accessibility and clarity, not only to prevent my thesis from becoming 'stodgy and uninspiring', but also to accept accountability and responsibility for my actions and opinions. My voice is not intended to be seen as an invisible expression of authority, but as that of a real person, with both history and interests (Harding, 2016) whose research is not free of my ideology, values and emotional foundations (Leininger, 1992, Mohr, 1999). Writing from a personal perspective, being explicitly self-aware and self-critical, is also one of the ways in which qualitative research ensures scientific rigour (Denzin and Lincoln, 2008), with Geertz (1973) advocating relevant self-disclosure in order to facilitate debate on the wider issues of research practice. In this way, therefore, I aim to enable the reader to share in all aspects of my research journey and become immersed in my work as it unfolds.

1.6 The Researcher

Charmaz (2014) advises that there is the need to understand the positionality of the researcher in order to fully engage with their findings and, from the perspective of the interpretivist/constructivist paradigm she adopts in her work, highlights that there is not one reality but many. Realities are '*articulated based on the values, standpoints and positions of the author*' (Daly, 2007, p. 33). Therefore, it is necessary to recognise that the findings identified in this research are presented as one possible co-construction of experience, which is based on my positionality as a female, middle-aged, white British, middle-class lecturer in adult nursing, registered adult nurse and PhD student.

1.7 Organisation of the Thesis

Material within the thesis has been organised into four parts. The focus in Part One of the thesis is on highlighting the background to and the context of the research and Part Two provides an overview of the research methodology and methods applied. Part Three reports the research findings and emergent theory and Part Four discusses these, concluding the thesis. Each part is divided into relevant chapters, as detailed in the following sections.

1.7.1 Part One – Understanding the background

Chapter 1 provides an overview of the thesis, outlining the impetus for the research, identifying the context and explaining key terminology. The rationale for using my personal voice is considered, the positionality of the researcher is briefly addressed and organisation of the thesis is highlighted.

Chapter 2 starts by providing the rationale for undertaking a staged approach to the literature and then focuses on sensitising concepts, concept analysis and the role they have played within the research. How the relevant sensitising concepts were distinguished is considered and the processes involved in revising a concept analysis model to devise the adaptation of Rodgers' (1989) evolutionary concept analysis model (Delves-Yates et al., 2018) are outlined. The adapted model is applied to analyse the concepts of health and illness and the chapter concludes by highlighting key points in the current understanding, identifying the gap in knowledge and presenting the research questions, aim and objectives.

1.7.2 Part Two – Considering research methodology and methods

Chapters 3 and 4 present an overview of the research methodology and methods applied within the thesis. Chapter 3 considers how a methodological choice was made and the chosen research methodology is described. Methodological issues are then further considered in discussion relating to the theoretical framework and the influencing philosophical and theoretical principles.

Chapter 4 outlines the research methods and considers ethical issues, sampling, recruitment and data collection. The process undertaken in transcription is described, the principles applied to data analysis are highlighted, how quotes from the data were selected is considered and reflexivity, trustworthiness and credibility are discussed.

1.7.3 Part Three – Reporting the research findings

The chapters in Part Three provide a comprehensive report of the research findings. Chapter 5 identifies the relevant contextual features, provides profiles of the research locations and considers the impact of the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) pandemic on theoretical sampling. The flow of research activity is outlined, as are the characteristics of the participants, and the emergent grounded theory and data categories are introduced.

Chapters 6, 7, 8 and 9 report each of the emergent data categories, detailing and discussing their properties. Using the voice of the participants there is consideration of experience, reflection, definitions and how the concepts of health and illness are wrestled with. The relationship between views of health and illness and care delivery is considered, the issue of tribalism is identified and professional boundaries and healthy working are discussed.

Chapter 10 draws the findings together by presenting, explaining and discussing the emergent grounded theory, The Theory of Balance in Perception of Health and Illness and Care Delivery (Theory of Balance).

1.7.4 Part Four – Discussing, reflecting and concluding

The final part of the thesis addresses the research questions by discussing the findings and emergent grounded theory, placing them in the context of the existing literature and emphasising new insights.

Chapter 11 deliberates the findings in respect of the existing literature and contemplates the implications for nurse education. The Theory of Balance is considered and its contribution to knowledge examined. Specific recommendations are made and the limitations of the research examined.

Chapter 12 concludes the thesis by providing a summary of the significant aspects of the research and the original contribution to knowledge provided by the thesis is outlined. The dissemination of the findings is considered and a plan for future activities is outlined.

At the beginning of each part and chapter of the thesis is a citation from my reflective journal, a participant or an author which relates to the material presented in the part or chapter. A reflexive narrative detailing the further relevance of these is presented in Appendix 2.

1.8 Conclusion

This introductory chapter has established the primary impetus and the context for engaging in the research and outlined a detailed personal rationale to support this. Key terminology has been explained with the choice to write the research using a personal voice discussed. The chapter concludes by focusing on what is to come in the thesis, briefly introducing the content of the following chapters.

While it is essential as a researcher to both justify the impetus for this research from a personal perspective and acknowledge my position, it is also important to move beyond this (Crotty, 1998). Therefore, it is necessary to consider what is already known about the topic under investigation to develop an approach which will enhance the existing knowledge. This is especially relevant to research focusing on the concepts of health and illness, which are, as previously outlined, nebulous in nature. To facilitate this the next chapter will explain how the relevant literature has been reviewed and applied to underpin the thesis and will report an analysis of the concepts of health and illness.

Chapter 2 Considering the Literature

'Overcoming the hurdle of preconceived ideas'

Reflective Journal Entry 26.09.2016

2.1 Introduction

In the previous chapter the primary impetus for the research presented in this thesis was considered, providing a personal rationale for the study, the relevant context and identification of what the work will contain. This chapter presents an explanation of how the relevant empirical, theoretical and professional literature has been applied to underpin the research, identifying how, to uphold the ethos of CGT, a staged approach was taken. The chapter commences by outlining the need for a staged approach to the literature, discussing and clarifying the rationale for this.

The focus of debate then moves to the concept analyses undertaken to investigate the sensitising concepts of health and illness, which were the first stage in the application of the staged approach. To clearly identify the relevant aspects of the processes undertaken to produce the concept analyses, the chapter provides an overview of what sensitising concepts are, followed by identification of how they were determined and used in this research. An integral aspect of the chapter is consideration of the topics of concepts, philosophical approaches to concepts and the development of rigour in models of concept analysis. The chapter is concluded by the identification of a gap in knowledge and the research questions, aim and objectives central to this inquiry.

2.2 A Staged Approach

In GT the issue of how to manage the literature review is one of a number of methodological issues frequently discussed which can, at times, be contentious and confusing (Sebastian, 2019, Birks and Mills, 2022). While across all GT methodological approaches there are agreed core principles, there is also disagreement regarding other processes and philosophical assumptions, for example, entering the field of inquiry as a clean slate or 'tabula rasa', ignoring all forms of pre-existing knowledge, theory and fact (Glaser and Strauss, 1967). Such an approach is seen to enable a researcher to conceptualise theory directly from their data without external influence (Sebastian, 2019), reflecting Glaser and Strauss' view that research practice, at that time, placed undue emphasis on verification and neglected theorizing (Timonen et al., 2018). In CGT, however, the ability to escape prior knowledge is viewed as neither practicable nor possible, with previous knowledge and experience valued for their ability to contribute to the construction of new knowledge (Charmaz, 2006, Sebastian, 2019). While there is agreement of this principle in CGT, there is a lack of agreement and contrasting approaches as to when the literature review should occur, as in a random sample of four studies applying CGT (Martin and Barnard, 2013, Rand, 2013, Kean et al., 2016, Farragher and Coogan, 2020) each study accesses the literature at a different point in the work. While each study takes a different approach, what unites them is they clearly justify the approach they adopt. Further support for working in this manner is gained from Thornberg and Dunne (2019), who suggest that the issue requiring careful consideration should not be when the literature is consulted, but how to integrate it in a manner that does not undermine the data. Charmaz (2014, 2017), who as the creator of the CGT approach occupies a position of authority, advises undertaking the literature review in the final stages of the research, because this provides a further occasion to apply the constant comparison and demonstrate why certain arguments and evidence have been favoured. While Charmaz's approach is understandable and has clear benefits, it also poses problems. Demonstration of an understanding of the relevant literature is required in an application for ethical approval and funding, to identify gaps in knowledge where further research is required. This avoids the possibility of duplicating existing research, which could be unethical, or adopting an ill-considered approach (Dunne, 2011). Thus, the development, justification and formal acceptance of a research proposal can become problematic if reference to the existing literature is not an integral element of early work.

The challenge described is one experienced within this research. I needed to be able to develop and justify the research focus while remaining congruent with the chosen research approach (CGT). I also needed to secure formal agreement from relevant individuals and bodies before commencing the research, as they needed to be assured that the research was worthwhile and would proceed ethically. Therefore, to identify the most acceptable approach I could implement to achieve this, while remaining true to the philosophy underpinning CGT, I explored the pertinent methodological literature to seek advice from those who had previously navigated this issue.

While there is extensive discussion of the issue from a theoretical perspective, sound practical advice that is comprehensible to a novice researcher is more limited. Clear guidance is offered by Elliott and Higgins (2012), with the strategy they identify later supported by Thornberg and Dunne (2019). Their suggestion is that, as a first step in the development of a research proposal applying any type of GT approach, researchers should undertake what can be described as a preliminary review of the literature which serves to provide a basic orientation to the area of inquiry. Thus, the guidance I required to ensure my study progressed in a sound fashion would be gained, but the preliminary review would be purposely limited, addressing only the information required to place the focus of investigation within the appropriate context and to provide a rationale for my exploration. Further practical advice is offered by McGhee et al. (2007), who outline the fundamental role of reflexivity in CGT to ensure perceptions of the data are not distorted by literature, theory and prior knowledge. Throughout the research process, therefore, I consistently deliberated and recorded whether and how my ideas were being influenced in the theoretical memoing, reflective journal entries and field notes.

In summary the advice within the methodological literature was not to undertake a detailed literature review until data collection and initial analysis were complete. Adopting such an approach can limit the influence of the literature on the research findings by reducing the opportunity for preconceived ideas to contaminate a researcher’s interpretation. By being immersed in the data over a lengthy period of time I would develop a detailed comprehension of the relevant issues, which would be further supported and enhanced by the development of my thinking as a result of doctoral-level study. Allowing this to occur prior to consulting the existing literature would not only ensure that the theory I developed was grounded in the data collected but also prevent me from having to constantly resist the temptation, whether it be conscious or unconscious, to focus on what had previously been described by experts in the field. To achieve this the most appropriate and practical technique to apply to consulting the literature in this research was a two-staged approach. This entailed the literature being reviewed prior to the research commencing; the first stage. Literature would not be consulted again until after data collection and initial analysis had been completed; the second stage. Working in this way, considering the literature prior to the research commencing would enable me to obtain a basic orientation to the area of inquiry. By delaying any further consultation of the literature until after data collection and initial analysis were complete I would be able to use the literature to verify, clarify and refine the conclusions that I had already made. Such an approach ensured that I constructed theory supported by the relevant literature, rather than influenced by it (Charmaz, 2017).

While the staged approach described was applied to the literature relevant to the focus of inquiry, review of the methodological literature pertinent to the research approach adopted was undertaken at the start of the study and at relevant points as work progressed. In this way it was possible to be certain that approaches appropriate to the methodology were being applied and sound decisions were being made. Detailed discussion reflecting this is presented within Part Two of the thesis, in Chapters 3 and 4.

In commencing the staged approach further clarification was sought from Charmaz's work as to how best a preliminary review of the relevant literature could be confined to just the mapping of key areas of research within the appropriate context while still providing a rationale for the inquiry. Charmaz (2014) suggests a way to achieve this is investigation of the sensitising concepts relevant to the research.

2.3 Applying the Sensitising Concepts

As has been discussed, although I accepted the value of not considering the literature until data collection and initial analysis were complete, I also recognised the need to reflexively review my existing perspective on the topics of health and illness prior to commencing the research. In addition, there was the requirement to submit a formal research proposal for ethical review and approval, for which underpinning literature was essential. I also wanted to ensure the research would generate new knowledge of value.

A strategy capable of providing what I needed, enough underpinning evidence and details to ensure that I was not going to build the research on faulty foundations, was, as outlined by Charmaz (2014), to investigate and explore the sensitising concepts relevant to the research. Sensitising concepts are words which relate to the research topic and originate from the participants' perspective (Van den Hoonaard, 1997) that can spark a researcher's thinking in order to sensitise them to possible lines of inquiry (Given, 2008). A review of the sensitising concepts can unravel the multiple meanings built into a simple word, so sensitising concepts are best captured in the exact words the research participants used to explain the focus of the research (Becker, 1993). According to Blumer (1969) sensitising concepts provide a researcher with a general sense of reference and guidance in approaching their research and can act as an appropriate starting point for inquiry (Charmaz, 2014).

I had an entry in my reflective journal describing the terms students used in a teaching session that provided further detail and enabled exploration of the sensitising concepts in this research:

> 'today during a discussion about their understanding and definitions of health and illness with the year 1 students, I kept a note of both the terms they were using to describe health and illness and the frequency of their usage'

Table 2-1. Students' terms and frequency of use

Term	**Frequency of use**
Disease	3
Fit and fitness	9
Health – including healthy and good health	72
Illness – including ill and ill health	107
Sick and sickness	22
Well and wellness	12

(Reflective Journal Entry 15.10.2015)

As identified in Table 2-1, in their discussion, which was part of a teaching session I was leading about their understanding and definitions of health and illness, the students used the words health and illness, including their related forms, such as healthiness and healthier for example, more frequently than any other terms. It could therefore be interpreted that the terms health and illness were the sensitising concepts, because the students used these terms more frequently than any others (Becker, 1993). Such an approach did, however, seem rather circular. In my aim to unravel multiple meanings by investigating the sensitising concepts as defined by the terms the students (who represented the participants I planned to recruit in my research) were using, I ended up investigating the same terms as I was using. To explore this further in order to ensure this was an accurate interpretation, I followed the advice of Bowen (2006) to ascertain whether more appropriate terms had been missed, and compared the terms the students had used with the 'keywords' applied to the journal articles of four authors on health and illness, Mildred Blaxter, Cecil Helman, Cathy Charmaz and Arthur Kleinman. My knowledge at this time made me aware that, while concepts of health and illness have been widely debated by many individuals, the work of Blaxter, Helman, Charmaz and Kleinman presented ideas of importance and lasting influence within the areas of health and illness relevant to this research, which are repeatedly referenced by others. According to Huberman and Miles (2011) their work can be seen as seminal, they can be identified as seminal authors and authorities in the field. In a sample of 12 articles written by these four authors and published in academic journals (three items for each author) the keywords health and illness were applied more frequently than any others. Thus the terms they used were also the same as the students. The work of these authors, however, included two further frequently applied keywords to their articles, 'definition' (of health and/or illness) and 'perception' (of health and/or illness). While I had not formally noted the term 'definition' in my reflective journal in relation to the student discussion during the teaching session I led, I was confident that it had featured in the words they used. I could also appreciate that gaining clarification, clarity and precise meanings of the terms health and illness (their definitions) would assist to unravel the multiple meanings built into the terms health and illness. Regarding the term 'perception', I felt able to accept that too. It clearly described what the students were discussing and is important in the focus of this investigation, as perception is personal, it is our interpretation of the world around us, is shaped by experience and relates to your individual reality, which was what I wanted to explore.

Two further measures were also taken in order to confirm my choice to accept these terms. First, a review of the words used to refer to health and illness within the published definitions of health and illness I was familiar with. I was able to conclude that the terms being used were, quite simply, health and illness. Second, further consultation of the work of Charmaz (2014), who identified sensitising concepts as provisional, so they may be disregarded as other more applicable concepts emerge. As Charmaz (2014, pp. 31-32) states, the role of sensitising concepts is to guide inquiry as *'points of departure for studying the empirical world while retaining the openness for exploring it'*. So, if further investigation of the terms identified in discussion with the students and supplemented by consultation of the work of four seminal authors did not yield the insight I required, it was acceptable to revise them. As a starting point, however, the approach I was planning to take was confirmed as appropriate, so the terms previously identified (see Table 2-2) were adopted as sensitising concepts.

Table 2-2. Sensitising concepts

Sensitising concepts of health	Sensitising concepts of illness
‘health’, ‘definition’, ‘perception’	‘illness’, definition’, ‘perception’

The next step was to decide how best to investigate and explore these terms. As Charmaz (2014, p. 31) refers to sensitising concepts as ‘*points of departure’*, the terms identified in Table 2-2 were seen as an appropriate focus for the preliminary review of the literature. As has been discussed, the approach taken to the literature within this research was staged, with the first step being a preliminary review of the literature to provide a basic orientation to the area of inquiry. I wanted to limit the preliminary review, aiming only to address the essential information required to place the focus of investigation within the appropriate context and provide a rationale for the exploration. However, because the sensitising concepts included the precise terms of health and illness, investigating them by undertaking a traditional literature review at this point in the research felt as if the work was not remaining true to GT philosophy. To further assist in limiting the remit of the preliminary review therefore I needed to consider whether the investigation could be better undertaken using concept analysis. According to Foley and Davis (2017) by applying concept analysis to investigate the sensitising concepts I could dissect them in my search for clarity, rather than expand them, and not extend the focus of the preliminary review beyond the basic orientation I desired.

Prior to progressing any further, however, an entry in my reflective journal made me aware of a need to address my personal underpinning knowledge before I could undertake any further investigation,

> 'Concept and concepts seem to be words I am thinking about and writing a great deal right now. But can I clearly define exactly what a concept is, can I talk about them in respect of their underpinning philosophical view?
>
> [.....] to answer these questions I have to say, 'not exactly sure' and 'no' [.....] and now I am thinking about this there is more! What is concept analysis and how/why is it used in research?'

Reflective Journal Entry 23.10.2015

The next stage, therefore, needed to be an investigation of a range of issues relating to the notion of a concept and its role in research plus an exploration of concept analysis. This consideration was found to be multifaceted and far more complex than I expected, involving the navigation of differing views as to the meaning of concepts and the comprehension of different ontological and epistemological stances.

2.3.1 What is a concept?

When considering the role of concepts within research, McKenna and Cutcliffe (2005) identify them as the building blocks of theory, so any attempt to build or use a theory without a clear understanding of these building blocks risks laying faulty theoretical foundations. From this perspective concepts play a fundamental role in the development of knowledge (Rodgers, 1989), but such a view is not universally accepted. Bergdahl and Berterö (2016) argue that concepts do not have any specific meaning outside the context in which they are defined. When attempting to describe concepts, Walker and Avant (2005) propose that they are not words but a mental image of a phenomenon, with Asp and Fagerberg (2005, p. 64) describing them as '*cognitive in nature and comprised of attributes abstracted from reality, expressed in some form and utilised for some common purpose*'. This perspective results in concepts solely having meaning within a specified context and only achieving pure expression in the mind of the individual using them. Also, as concepts acquire meaning through personal interpretation, the same concept can be applied by individuals in different ways (Toulmin, 1972). Thus, concepts are complex, possessing an essence that cannot be truly captured in either the spoken or written word (Beckwith et al., 2008) with the potential for a lack of clarity in application and meaning.

In order to develop this initial understanding, to obtain further guidance and ascertain a broader view, the traditional philosophical views of concepts were consulted. Within these, two differing longstanding schools of thought can be identified: the entity and the dispositional views, to which Rodgers (1989) adds a third, the evolutionary view. The principles of each of these approaches are presented in Table 2-3, which demonstrates the difference in how a concept can be regarded. In essence, depending on the philosophical approach selected, concepts can be considered to have clear boundaries and be unchanging, or be fluid and personally determined, or be subject to change, developing through time and influenced by significance, use and application.

Table 2-3. An outline of the entity, dispositional and evolutionary view of concepts
adapted from Rodgers (1989, p331)

View	Entity view	Dispositional view	Evolutionary view
Concepts	Concepts are regarded as an entity or 'thing', such as an abstract mental image or idea, a word with a specific grammatical function or an element in a system of formal logic.	Concepts are regarded as habits or abilities to perform certain behaviours or capabilities.	Concepts are regarded as an abstraction, expressed in some form.
Focus	The focus is the entity itself, regardless of the form of the concept.	The focus is on the use of the concept, behaviours or capabilities that are possible when an individual grasps the nature of the concept.	By socialisation and repeated interaction, a concept becomes associated with a set of attributes, which can be seen as the concept's definition.
Features	A concept is characterised by a rigid set of conditions necessary to identify an instance of the concept. Thus, concepts have clear and distinct boundaries or lines of division and do not change.	Focusing on the use of concepts overcomes the distinction between the private and public realms of cognition and reveals interrelationships. There is, however, considerable difficulty associated with the idea of 'use' as the term is vague and ambiguous.	Concepts are viewed to be subject to change, developing in a cyclic fashion that progresses through time and influenced by significance, use and application. Dynamism and interrelationships are valued, overcoming the limitations of the entity and dispositional views.
Foundation texts	The foundations of entity theories can be identified within the works of noted philosophers such as Aristotle (384-322 BC), Locke (1632-1704), Kant (1724-1804), Frege (1848-1925) and the earlier writings of Wittgenstein (1889-1951).	The foundations of dispositional theories are in the later writings of Wittgenstein (1889-1951) and the works of Ryle (1900-1976).	The foundations are in the work of Rodgers (1989, 2000).
Summary	In summary concepts have clear boundaries and are unchanging.	In summary concepts are fluid and personally determined by the individual applying them.	In summary concepts are subject to change, develop through time and are influenced by significance, use and application.

Re-adopting a research-based focus on concepts, the stance adopted by a researcher as to how they view a concept and which philosophical perspective they attribute to it matters, to accurately advance knowledge research needs to adhere to scientific processes based on an understanding of philosophical perspectives (Branch and Rocchi, 2015). To apply a positivistic approach in research, identifying with a reality where objects have existence and meaning independent of our consciousness of them (Crotty, 1998) while unknowingly applying a concept analysis which upholds a dispositional view, where concepts are fluid and personally determined by the individual applying them, is incompatible. Confusion such as this signifies potential weakness in the research.

2.3.2 An overview of concept analysis

The purpose of concept analysis is to analyse, define, develop and evaluate a concept. Such an approach is viewed to facilitate the development of a notional and theoretical understanding of the phenomena (Kvale, 1996) and identify a detailed operational definition (Foley and Davis, 2017). Irrespective of focus, it is therefore suggested that research studies undertaken for the purpose of developing knowledge, such as doctoral enquiries, commence with an exploration of the existing knowledge about the concept, by the application of concept analysis (Knafl and Deatrick, 2014). As concept analysis enables the researcher to use the concept effectively and evaluate its strengths, limitations and variations, it would address the information required to place the focus of investigation within the appropriate context and provide a rationale for my exploration. It, therefore, offered an appropriate approach.

One of the main aims of concept analysis is to identify the attributes of the concept, the critical characteristics which differentiate it from another related concept and therefore clarify its meaning (Walker and Avant, 2005). The easiest way to think of attributes is as the hallmarks of the concept (McKenna and Cutcliffe, 2005) or, to apply a marketing term, the unique selling point, ‘USP’, differentiating the concept from other similar notions. So, an attribute of the concept of ‘mentoring in nursing’ could be role modelling and an attribute of the concept of ‘overcoming’ could be determination to change or surmount a problem. Identification of the attributes of a concept is undertaken by considering its common use, as the words we use to talk and think about a concept are central to our understanding of it.

While concept analysis is perceived by some as an ideal tool to navigate the complex nature of concepts and ascertain the meanings associated with their common usage (Tofthagen and Fagerstrøm, 2010), its value is debated. Within the discipline of nursing opinions vary from concept analysis being the starting point for many scholarly endeavours (Knafl and Deatrick, 2014) because of the importance of defining concepts of interest as a foundation for further investigation, to it having no place (Draper, 2014) and needing to be abandoned (Bergdahl and Berterö, 2016) because it offers no additional insight. Paley (1996, p. 578), in particular, is highly critical of the process, advising that *‘conceptual clarification is an arbitrary and vacuous exercise’.* Despite concept analysis being frequently advocated and undertaken as the starting point for further study, it has been suggested that few concept analysis models provide the necessary analytical depth or have sufficient rigour or replicability to enable the theoretical development claimed (Beckwith et al., 2008). Frequently there are also weaknesses in how the models are applied with, for example, no justification of the inclusion and exclusion criteria for the choice of attributes (Risjord, 2009). More specific criticism is directed towards the simplicity of some models and their inability to determine the rich and diverse worldviews depicted by concepts (Draper, 2014). While it cannot be denied that simplicity in any method has attraction, especially for a novice nurse researcher, rigour still needs to be upheld. Such criticism of simplicity is highly relevant to many of the models of concept analysis, for example Norris (1982), Chinn and Kramer (1987), Schwartz-Barcott and Kim (2000) plus Walker and Avant (2005), all of which are adaptations of the work of Wilson (1963). The work of Wilson (1963) has been singled out as being overly simplistic because it focuses on the use of the concept alone, an approach considered unable to capture the complex nature of a concept (Beckwith et al., 2008). Exactly how focusing on the use of a concept to both infer meaning and achieve greater clarification of a phenomenon is an aspect of the concept analysis process seen to be needing much more detailed and rigorous underpinning.

The lack of clear articulation of the philosophical foundations underpinning many models of concept analysis has been evident in my exploration of the subject. This is pertinent because, while the approaches taken within differing concept analysis models may appear similar, many possess significant philosophical differences in the position they adopt as to the theoretical view of a concept (Rodgers and Knafl, 2000). This theoretical view also highlights further concern with the concept analysis process; treating an abstract concept as a tangible entity, having the ability to possess attributes, for example, can be difficult to accept.

Further consideration of the philosophical approaches to concepts (described in Table 2-3) adopted in models of concept analysis, those derived from Wilson (1963), utilise a positivistic perspective, reflecting the entity view. Notably, however, adaptations of Wilson (1963) include Rodgers (1989) which is one of the few models to contain some discussion of the philosophy underpinning the model. In this discussion Rodgers (1989) describes her model as having an evolutionary approach, underpinned by a constructivist perspective and the evolutionary view of a concept. This is despite it sharing a common ancestry with models underpinned by a positivistic perspective and therefore the entity view of a concept. It could be possible to view this as Rodgers building on and developing the existing approach, but this remains unknown, as she does not make this perspective apparent. Thus it is necessary to appreciate that there is a lack of clarity and an element of philosophical dualism, or possibly confusion, in many of the commonly-used models of concept analysis (Asp and Fagerberg, 2005). If concept analysis is being seen as a scientific process any possible confusion or lack of clarity must be viewed as weakness. The practical and pragmatic response to such an issue needs to be increase caution, highlighting the importance for those applying a model of concept analysis to both understand a model's philosophical stance and heritage and take sufficient measures to assure analytical depth, rigour and replicability.

2.3.3 Why choose concept analysis?

There is a view within the nursing research literature that concept analysis should not be undertaken because it is neither capable of providing the level of insight required (Paley, 1996, Draper, 2014, Bergdahl and Berterö, 2016) nor meets with all the methodological requirements of well-conducted academic research (Nuopponen, 2010a, 2010b, 2011) due to the lack of rigour and replicability in the approach taken by many models, leading therefore to questioning of the trustworthiness of models (Paley, 1996, Beckwith et al., 2008, Nuopponen, 2011, Draper, 2014, Bergdahl and Berterö, 2016). Also, as previously discussed, there can be a lack of identification of the relevant underpinning philosophical perspective of the model which has the potential to weaken the resulting analysis because to accurately advance knowledge research needs to adhere to scientific processes based on an understanding of philosophical perspectives (Branch and Rocchi, 2015). Finally, there is the issue that the guidance provided on how a model of concept analysis should be applied can also be limited, with Nuopponen (2010a, p. 4) reporting this to be as little as to *'use common sense'* in some models.

In view of this, the decision to undertake a concept analysis as the starting point for a research study was one requiring careful consideration. While it would have been unwise not to take note of the cautions aired by others regarding undertaking a concept analysis, they do not necessarily mean that the approach must be avoided. What they do indicate is that if the decision to undertake a concept analysis as a starting point for a research study is taken, it needs to be made with knowledge of the potential challenges and the understanding that concept analysis needs to be applied in a manner that is certain to add value. In order not to produce a poorly-executed concept analysis, it is necessary to apply the methodology from a perspective of understanding the areas where potential weakness exists and adding measures devised to strengthen them.

As identified earlier in the chapter, a reason for the prior investigation of what concept analysis is, plus how and why is it used in research, was to ascertain whether it might be appropriate for the preliminary consultation of the literature undertaken within this research to be concept analyses of health and illness. The concepts of health and illness are widely recognised to be abstract, intangible and individually determined (Kleinman, 1988, Smith, 1992, Leininger, 1996, Helman, 2007, Charmaz, 2008, Blaxter, 2010, Viner et al., 2012) so the information provided by analysing these concepts could increase my understanding of the usage of these terms, my appreciation of the range of meaning allocated to them by others and develop and refine my perspective. They could also provide guidance as to how to proceed with the research by increasing my understanding of what might be the most appropriate investigative approaches to take in research investigating these topics. Undertaking concept analyses would also enable me to map key areas of research and place the area of investigation I wanted to focus on within the appropriate context. Such an approach could enable the development of a rationale for the inquiry, justification that the research focus I was advocating was worthwhile and facilitate identification of a gap in the existing literature.

At the time this work was being undertaken, between December 2015 and June 2016, one concept analysis of health could be located within the published literature, undertaken by Simmons (1989). Literature searching did not identify any concept analyses of illness. Simmons' (1989) concept analysis of health identified the purpose of the paper as being to analyse the concept of health to promote theoretical clarity. Within the analysis there is a clear overview of definitions of health from an historical perspective, consideration of relevant theoretical perspectives and identification of the critical attributes. Case examples of health are developed, the potential operationalisation of health is considered and there is discussion of the relevance to nursing research and practice. While it is accepted that the analysis had been undertaken twenty-six years previously, what was presented was clearly relevant and informative. There were however a number of elements missing, which posed questions regarding the rigour of the work.

What had been omitted was clear identification of the processes involved in the analysis; no details of the model of concept analysis applied were included, the sample of literature reviewed in the analysis was not identified and how this sample was chosen was not outlined. The work clearly demonstrated the limitations of concept analysis previously identified, highlighting the omission of information that needed to be included to demonstrate the trustworthiness of the work. These findings supported the need for me to undertake my own concept analyses of health and illness.

There was also a further potential benefit in undertaking concept analyses. Not only would I be gaining a basic orientation to the significance of health and illness within the context of nursing and the delivery of effective care, plus exposing my perspective to scrutiny, but I would also be upholding the philosophy underpinning CGT. By focusing on the concepts of health and illness, not directly searching for existing work sharing the explicit focus of my research, I could limit my exposure to the prior conclusions of others. The approach would also adhere to the guidance of Charmaz (2014), that the existing literature should consulted in order to support the construction of the emergent grounded theory rather than influence it. Therefore, the decision to use concept analysis as a starting point for the research was made. However, as the existing concept analysis models, for the reasons previously identified, did not provide the level of trustworthiness desired, I realised there was a need for me to adapt a model to achieve this.

2.4 Adapting a Concept Analysis Model

My experience of adapting and applying a concept analysis model arose from, as has been discussed, the decision to undertake concept analyses to investigate sensitising concepts for my research. This followed the realisation that many existing and frequently-applied models would need adaptation to ensure that the concept analysis process added value to the research.

2.4.1 Adapting Rodgers' (1989) evolutionary model of concept analysis

Taking note of the issues, weaknesses and limitations identified in the previous discussion, an adaptation of Rodgers' (1989) evolutionary concept analysis model was devised (Delves-Yates et al., 2018, see Appendix 3 for publication). The Rodgers' (1989) evolutionary concept analysis model was chosen for adaptation because it included identification of the philosophy underpinning the model, the evolutionary view of concepts, although this was not discussed extensively. The model was developed by Beth Rodgers, who has worked extensively on nursing knowledge advancement and concept development. What I found particularly attractive in Rodgers' model is that it applies the evolutionary view of a concept, which resonates with the perspective I hold. Table 2-4 replicates the original presentation of Rodgers' (1989) evolutionary model of concept analysis, 7 steps without supplementary guidance.

Table 2-4. Rodgers' (1989) evolutionary model of concept analysis

The method of analysis (revised approach)
1. Identify and name the concept of interest.
2. Identify surrogate terms and relevant uses of the concept.
3. Identify and select an appropriate realm (sample) for data collection.
4. Identify the attributes of the concept.
5. Identify the references, antecedents and consequences of the concept, if possible.
6. Identify concepts that are related to the concept of interest.
7. Identify a model case of the concept.

The adaptations made to Rodgers' (1989) model involved breaking it down into a number of stages by applying Tofthagen and Fagerstrøm's (2010) phased approach to concept analysis, adding relevant measures to increase rigour and replicability, plus providing clarification as to how the model should be applied. The process informing and guiding these adaptations included application of the work of others, such as Tofthagen and Fagerstrøm (2010), to provide greater explanation of the application of the model, followed by evaluation of these measures by two research-active nursing lecturers and three post-graduate students with experience of applying concept analysis. This was followed by review of the adapted model by the research supervisors. The feedback provided by this process was integrated into the final version of the adapted model.

The adaptations made the underpinning procedures more transparent and produced clear methodological guidance for those undertaking the process and are described in Figure 2-1 and Table 2-5.

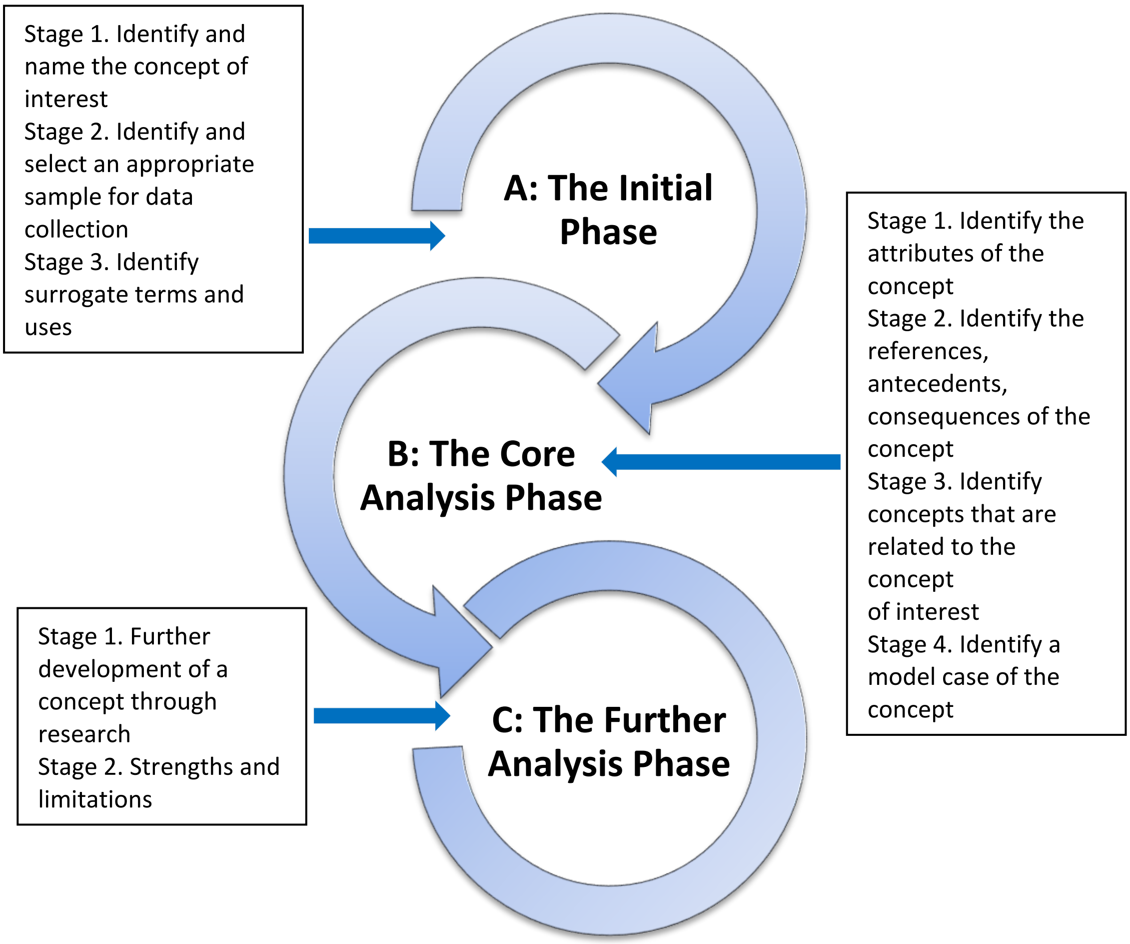


Figure 2-1. The adaptation of Rodgers' (1989) evolutionary model of concept analysis

Table 2-5. Applying the adaptation of Rodgers' (1989) evolutionary model of concept analysis
(Delves-Yates et al., 2018)

A: The initial phase	**B: The core analysis phase**	**C: The further analysis phase**
Stage 1 Identify and name the concept of interest The process commences with a brief introduction to the concept under analysis, including an outline of personal experience and interests, explaining any personal influences. This incorporates a reflexive approach, enabling meaning to be induced whilst personal influences and pre-existing knowledge are acknowledged. *Stage 2 Identify and select an appropriate sample for data collection* An extensive review of relevant literature is undertaken, selecting material from computerised databases across a wide timeframe, with exact parameters set according to seminal work. The use of computerised databases reduces the risk of selection bias and increases the prospect that the sample is representative. Considering a wide timeframe highlights the evolution of the concept and the continual emergence of knowledge. If the search strategy is further enhanced by selecting material which does not focus solely on the use of the concept but includes theoretical perspectives, research data, definitions and personal perspectives of relevant individuals, the richness of the resultant data is increased. *Stage 3 Identify surrogate terms and uses* Concepts are often discussed by differing or surrogate terms. This stage identifies these and, if relevant, locates them within their specific category of use.	*Stage 1 Identify the attributes of the concept* Relevant data is extracted and then analysed by thematic analysis, an iterative process identifying, organising and reorganising themes within the literature sampled until a 'cohesive, comprehensive and relevant system of descriptors is generated' (Rodgers and Knafl, 2000, p. 5). Specific details about the process of data extraction are included in the report of the analysis, enabling understanding of exactly how data were generated, ensuring transparency in the data extraction procedure. The attributes of the concept emerge from the thematic analysis. Transparency and integrity of the process are increased by identifying the components of each theme, outlining the underpinning raw data. Acknowledging personal/other factors influencing attribute selection further increases transparency and trustworthiness. *Stage 2 Identify the references, antecedents, consequences of the concept* Identification of the references, antecedents and consequences of the concept provides additional information and clarity in understanding what the concept is, or possibly more importantly, what it is not. References identify the range of situations, incidents, or phenomena the concept is considered within. Antecedents are events or phenomena that precede an instance of the concept and consequences are occurrences that follow the concept. *Stage 3 Identify concepts that are related to the concept of interest* Identify and discuss the main related concepts, focusing on important aspects of the relationship. *Stage 4 Identify a model case of the concept* This unites all aspects of the analysis, presenting a clear example, but may not always be possible (Rodgers, 1989).	*Stage 1 Further development of a concept through research* Rodgers (1989) does not view concept analysis as an endpoint, but as a method of increasing understanding of a concept central to further research. The clarity of understanding obtained from a concept analysis will enable greater focus in the development of the proposed research, which will be undertaken from a more informed perspective. *Stage 2 Strengths and limitations* This is a final opportunity to highlight the steps undertaken to ensure the quality and authenticity of the process, whilst accepting that there will always be limitations.

By presenting the model in three phases, as described by Tofthagen and Fagerstrøm (2010), the process moves away from the step-by-step, linear approach implicit in Rodgers' (1989) model. Removing the linear steps enables the researcher to take a more iterative approach, encouraging them, as necessary, to return to a previous stage or phase to seek clarification or confirmation, before proceeding. This aids the researcher to consider their previous actions and decisions in the light of new data, returning to previous stages or phases if they feel the need to alter or update their actions or the decisions they have taken.

To provide an exemplar of the concept analysis process the procedure described in the adaptation of Rodgers' (1989) evolutionary model is applied to the concepts of health and illness in the next section.

2.5 Concept Analyses of Health and Illness

The concept analyses apply an adaptation of Rodgers' (1989) evolutionary model of concept analysis (Delves-Yates et al., 2018) to clarify the concepts of health and illness from a nursing perspective. The adapted version of Rodgers' (1989) model was chosen for the analysis for two reasons. First, because the philosophical approach taken to a concept within the analysis, the evolutionary view, is one which I can philosophically appreciate and adopt. Such an approach also aligns with the approach taken within my research. Second, the adapted version provides additional advice as to how the model should be applied and advocates specific steps to take to increase rigour.

The purpose of the concept analyses was broadly to define the concepts I would be investigating (Paley, 1996). Considering this in greater detail, I wished to develop my notional and theoretical understanding of the research area at the start of the research process. As outlined in Section 2.2, I planned to do this as advocated by Charmaz (2014), using the sensitising concepts identified by potential participants as a departure point for the research. This would also spark my thinking and identify potential lines of inquiry for the research (Blumer, 1969, Van den Hoonaard, 1997, Given, 2008).

The two concept analyses were undertaken individually, firstly the concept of health, then the concept of illness, but to remove repetition of material from the application of the same concept analysis process, the analyses have been united in the following discussion.

The concept analysis process commences by consideration of the initial phase.

2.5.1 A: The initial phase

The first stage of the initial phase commences with a brief introduction to the concept under analysis, including an outline of personal experience and interests, explaining any personal influences. This incorporates a reflexive approach, enabling meaning to be induced whilst personal influences and pre-existing knowledge are acknowledged.

From a historical perspective, the word 'health' is derived from an Anglo-Saxon word 'hoelth' meaning whole (Hwu et al., 2001) and appeared in writing from 1000 AD (Simmons, 1989), its etymology relating to words meaning wholeness, prosperity and holiness.

The ancient Greek view of health, formulated by Hippocrates in 400 B.C., was a holistic one, with human well-being influenced by all environmental factors (Ahmed et al., 1979). Health was seen to result from harmony of the body, environment and lifestyle, a view persisting until the Cartesian revolution of the 17th century (Simmons, 1989), which brought a separation of the mind and the body and likened the body to a machine (Engel, 1977). Thus, a more restrictive idea of health emerged, equating it to a disease-free state, a view persisting into the 20th century and later.

Any introduction to the concept of health would be incomplete without consideration of the WHO definitions (WHO, 1946, WHO, 1986), however, these have been considered within earlier sections of the thesis. For accuracy in applying the adaptation of Rodgers' (1989) Evolutionary

Model of Concept Analysis (Delves-Yates et al., 2018), as described in Figure 2-1 and Table 2-5, a brief overview of the relevant information is presented. The WHO (1946) and the 1986, WHO sponsored work published as the Ottawa Charter (WHO, 1986) are the most well-known and frequently-quoted definitions of health, but have been widely criticised for being vague, unachievable, inflexible and unrealistic (Tulloch, 2005, Jadad and O'Grady, 2008, Horton, 2009, Godlee, 2011, Awofeso, 2012). Particular issue is taken with health being identified as an ideal state, with the use of the word '*complete*' in the 1946 definition identified as absolute and difficult to measure (Seedhouse, 2001). Smith (2008) suggests that the use of this word results in most individuals being unhealthy most of the time and Huber et al. (2011) outline that persons with long-term illness would never be able to achieve a state of health. Others take a different approach in their definitions of health, highlight the dimensions within which health can be considered. Last (2007), for example, integrates a social and ecological perspective with the ability to function as an individual within two related definitions of health, thereby acknowledging health sustainability and its interrelation with the surrounding environment without reference to health as a complete state. Within the many definitions of health in the literature there is identification of it varying across the lifespan, between and within cultures, as well as amongst individuals with diverse life experience (Viner et al., 2012). In summary therefore it can be concluded that definitions of health are individually determined and cannot be not standardised in order to reflect the range of influences relevant to the specific experience of the person involved.

Regarding a definition of illness, according to the Oxford English Dictionary (Brown, 1993, p. 1317), there are three. Two of the definitions relate to how the word was used up to the 18th century to mean either '*wickedness, depravity, immorality'* or '*unpleasantness, disagreeableness, hurtfulness'*. Such meanings reflect the fact that the word *'ill is a contracted form of evil'* (Boyd, 2000, p. 9), portraying the embodiment of value judgements. The identification of such a background to the word, with the link to evil, wickedness and immorality, can be further compounded by a theological perspective. For example, within Christianity, the Bible connects illness with sin; in Psalm 103:2-3 the healing of sickness is presented as God forgiving sin and Leviticus 26:14-16 directly connects sin with disease and obedience with healing. In Hinduism, suffering, which can be related to illness, can be viewed as punishment for deeds done in a previous life (Whitman, 2007). As outlined by Cole and Lejeune (1972) and Gunderman (2000), illness can be accompanied by the view the sick person has ‘brought it on themselves’: because illness occurs due to a person’s failings, illness equates to failure. When viewed from this perspective, not only can an ill person’s reluctance to seek help be fully appreciated, but so too can the origin of healthcare professionals blaming ill persons for causing their disease (Tishelman, 1997). While acceptance of personal responsibility for health can vary depending on political ideology, attribution of blame to the sick grossly oversimplifies a complex issue, with a clear lack of integration of any understanding of the social determinants of health (Gunderman, 2000).

It is Oxford English Dictionary’s third definition of illness, *‘a disease, a sickness’* (Brown, 1993, p. 1317), dating to the 17th century, that is accepted today. If an attempt to further develop understanding is made by searching for the definition of ‘sickness’, the explanation is *‘The condition of being sick or ill; illness, ill-health, disease’* (Brown, 1993, p. 2828). A circular pattern therefore emerges within the definitions, which is somewhat unhelpful. However, when considered from a medical perspective, sickness can be clarified as a social role, a status where the person termed as ‘sick’ is supported by society (Boyd, 2000).

Illness and disease have long been major traditional concepts in sociology and medical sciences (Nordenfelt, 1993). These concepts are interwoven and although they are frequently used interchangeably, they are not the same. Toombs (1987, p. 223) defines illness as

> *‘a state of disharmony, disequilibrium, disability and disease in which the individual finds himself separated from his familiar world’*,

whereas disease refers to abnormalities of the structure and function of body organs and systems (Eisenberg, 1977). It is possible to identify clear difference, as the concept of illness focuses on a person's subjective response to being unwell (Helman, 1981) or, as outlined by Cassell (1977), disease is something an organ has; illness is something persons have. Disease, however, is a term frequently used to refer to an abnormal condition affecting an organism, possibly due to infection, degeneration of tissue, injury, trauma, toxic exposure, or the development of malignancy. The term disease is also used to refer to something that needs to be cured and is therefore an objective, medicalised term (Marinker, 1975). In contrast to this illness frequently refers to the individual perspective that accompanies a disease, for example, feelings such as pain, fatigue, weakness, discomfort, distress and dysfunction, which are the reasons persons seek healthcare and are entirely personal and subjective (Hofmann, 2002a).

Such contrasting perspectives reflect the differing approaches taken by WHO (1980) in the International Classification of Impairments, Disabilities and Handicaps (ICIDH) and the later International Classification of Functioning, Disability and Health (ICF) (WHO, 2001). Although the ICIDH was developed to capture the overall health status of populations, it failed to portray the impact of the social and physical environment on function (Alford et al., 2013). The revised version, the ICF, which resulted from collaboration between government and non-government organisations, including groups representing persons with disabilities, achieved this, moving the focus from the cause of disease to its impact on functioning. The ICF considers more than the physical impairment of the individual, recognising the interplay between physical functioning and social, personal and environmental factors. Thus, not only was there a move in focus from the cause of the disease to its impact on functioning, but also there was an attempt to understand the perspective of the whole person, variation in health experience and identification of the needs of the individual beyond those evident in a diagnosis.

Further to this it has to be recognised that everyone has relevant experience, knowledge and a personal perspective of health (Kleinman, 1980). Definitions of health should not be seen as the property of experts alone. Regarding definitions of health and illness, however, the only agreement it is possible to identify is that no consensus has been reached. This clearly highlights the complexity of the concepts and the challenge for nursing. How health and illness are defined can have far-reaching practical consequences and identifies the need to accept health and illness as practical and pluralistic concepts (Helman, 1978). As nursing exists within an environment where health and illness are fundamental features, increasing nurses' understanding of these concepts is an important aspect of developing their appreciation of the subjectivity of the experience of the person receiving care. While I have previously shared my personal experience and interest in the concepts of health and illness, for accuracy in applying the adaptation of Rodgers' (1989) Evolutionary Model of Concept Analysis (Delves-Yates et al., 2018), as described in Figure 2-1 and Table 2-5, the relevant information is briefly summarised. My interest in the concepts of health and illness developed from experience gained during my original pre-registration nursing education and as a qualified practitioner working and teaching in the UK, USA, Cameroon and Nepal. Experience increased my curiosity and made me aware that the terms health and illness have a wide range of generally-accepted differing meanings, which are frequently difficult to conceptualise (Herberts and Eriksson, 1995).

2.5.1.1 Literature searching in a concept analysis

The second stage of the initial phase of the concept analysis involves identifying and selecting an appropriate sample for data collection by undertaking an extensive review of the relevant literature. As previously identified, models of concept analysis have been criticised with reference to the approach to selecting an appropriate data sample, due to lack of rigour, replicability and justification of inclusion and exclusion criteria (Beckwith et al., 2008, Risjord, 2009), as there is no recognised methodology for searching. The process undertaken within the literature searching in the concept analyses of health and illness reported later in this chapter was therefore devised to address this issue, to be systematic and comprehensive, plus described in sufficient detail so it could be reproduced. However, defining the search terms to the same degree as would be needed to achieve the level of focus and clarity expected within the search terms used in a systematic review (Higgins et al., 2019) would not accomplish the fundamental purpose of a concept analysis, which is concept clarification (Foley and Davis, 2017). To achieve this there needs to be an element of ‘ruminative speculation’ (Rogal and Young, 2008) in the approach to searching, with the application of more generalised search terms. Being open to the emergence of material, rather than commencing a search with a more constrained view as to what is expected, is more likely to facilitate an understanding of the current state of knowledge plus the identification of areas of potential development. The process of searching, however, still needs to maintain rigour, replicability and trustworthiness, so measures to achieve this need to feature within the process.

The aim of the search strategy in a concept analysis is to identify the uses of the phenomenon under study with, or without, consideration of a specific context. Thus, a search can be extensive or more focused on sources reflecting a specific context. A search without focus on a specific context of a concept is likely to return a large and potentially overwhelming number of items. A search undertaken with consideration of a specific context would return fewer items, but they would probably be more relevant. Regarding the number of items needed to provide sufficient detail for a concept analysis, Rodgers (1989) advises that the sample should be at least 30. Searches were undertaken with consideration of a specific context, as the anticipation was that the items returned by this would be more than 30, with an unfocused search likely to return so many items it could prove to be unmanageable and expand the scope of the preliminary review of the relevant literature further than the basic orientation to the area of inquiry desired.

A comprehensive search of the literature was performed between 1st–8th December 2015 for the concept of health and between 1st–5th June 2016 for the concept of illness. The data therefore from which the attributes of health and illness were defined, as identified in Tables 2-9 and 2-10, are those obtained from these searches and have not been repeated more recently to identify contemporary material. This is because the purpose of the concept analyses was to develop my notional and theoretical understanding of the research area at the start of the research process, to spark my thinking and identify potential lines of inquiry for the research.

The Cumulative Index to Nursing and Allied Health Literature (CINAHL), PsycINFO and MEDLINE complete databases were selected for the searches. This was due to their combined coverage of the subject areas of behavioural science, mental health (PsycINFO), medicine and clinical science (MEDLINE) and midwifery, nursing, occupational therapy, physiotherapy, podiatry and health education (CINAHL). This combination provided a thorough overview of relevant literature and identified the context. The use of computerised databases also increased the prospect that the sample is representative of the range of relevant literature (Thorpe et al., 2015). A date ranging from the inception of the database to the date of the search being conducted was applied, to produce an historical perspective. Considering a wide timeframe within the search was seen to highlight the evolution of the concept and the continual emergence of knowledge. All searching was undertaken independently by me.

The search strategy was further enhanced by the decision to select material which did not focus solely on the use of the concept but also included theoretical perspectives, definitions and personal perspectives of relevant individuals, thereby increasing the richness of the resultant data.

To ensure that the search returned relevant items, as was previously described, the sensitising concepts were used as search terms. To facilitate the most comprehensive search, terms were combined as outlined in Table 2-6, with the addition of 'health-definitions' for the health search and 'illness-definitions' for the illness search to maximise the hits (Cronin et al., 2010).

Table 2-6. Keywords applied in search

Concept	Keywords
Health	‘Health’ AND ‘definition’ AND ‘perception’ AND ‘health-definitions’
Illness	‘Illness’ AND ‘definition’ AND ‘perception’ AND ‘illness-definitions’

Inclusion criteria for the searches were defined, as outlined in Table 2-7, to ensure most relevant items were retrieved.

Table 2-7. Inclusion criteria

Health	Illness
Health is the primary focus of the item	Illness is the primary focus of the item
A definition of health or an individual’s perception of health is described	A definition of illness or an individual’s perception of illness is described
Health is described in a context that is healthcare-related	Illness is described in a context that is healthcare-related
The item is published since inception of database and December 2015	The item is published since inception of database and June 2016
Health is considered in relation to human subjects	Illness is considered in relation to human subjects
The item is available in full text	
The item is published in English	
The item is from a peer-reviewed, or comparable, source	

A total of 48 items were selected to be included in the concept analysis of health. Figure 2-2 outlines the process followed and provides quantitative details for each stage.

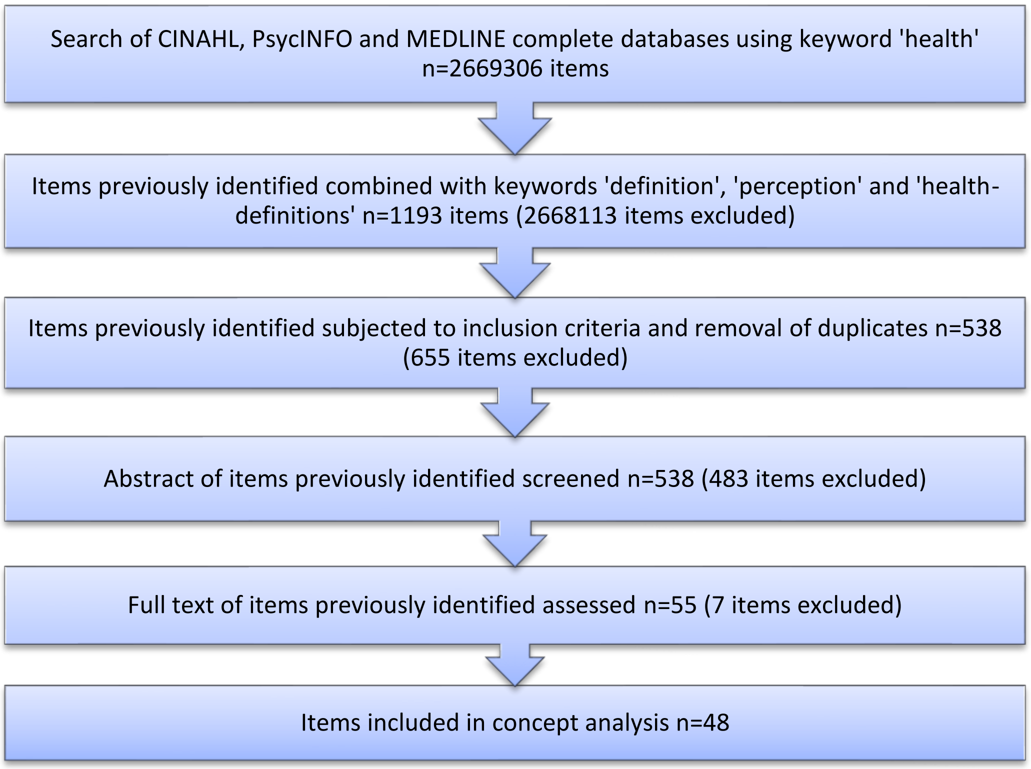


Figure 2-2. ‘Health’ search process

The search using the keyword ‘health’ was refined by combining it with the other keywords, ‘definition’, ‘perception’, ‘health-definitions’ using the term ‘AND’. Items identified without full text versions available online, through the University library existing stock or via inter-library loans were excluded, as were those that were published in non-peer-reviewed journals or comparable sources, or not written in English, or with a focus on non-human subjects and any duplicates. Items identified were screened, firstly by abstract, then in full text.

The process followed in the search of the keyword ‘health’ was precisely duplicated in the search of the keyword ‘illness’, resulting in a total of 83 items selected to be included in the concept analysis. Figure 2-3 outlines the process and provides quantitative details for each stage.

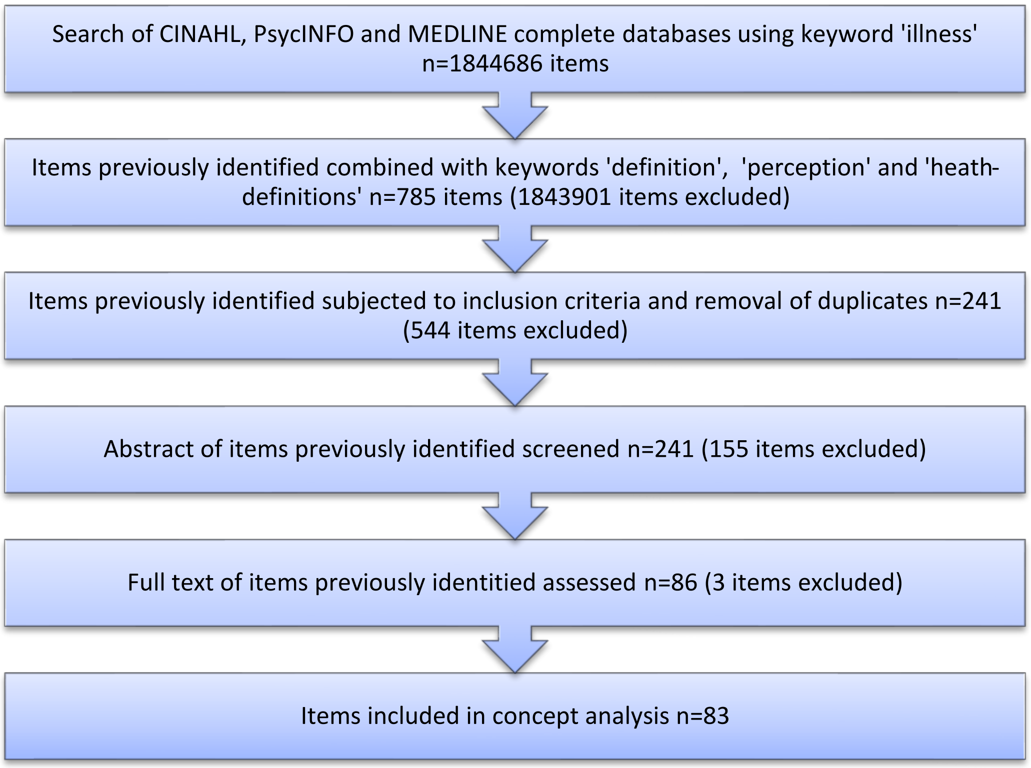


Figure 2-3. ‘Illness’ search process

This search retrieved nearly twice as many illness-related items than the health-related search. This, however, reflects that healthcare has traditionally been most frequently driven by disease diagnosis, focusing on responding to symptoms and illnesses after they arise (Ranheim and Dahlberg, 2012, Hewitt, 2023). While health and well-being are the stated outcome of healthcare, activities focused on promoting health have, for many years, accounted for a much lower percentage of activity (Schang et al., 2011, Hewitt, 2023). It is therefore to be expected that this will be reflected in the state of the literature.

During the screening of the items identified in searches, key sources/seminal authors relating to health and illness were revealed. Four key sources/seminal authors were identified relating to health (Mildred Blaxter, Cecil Helman, David Seedhouse, World Health Organization) and six relating to illness (Mildred Blaxter, Cathy Charmaz, Leon Eisenberg, Cecil Helman, Bjorn Hofmann, Arthur Kleinman). Their works were retrieved as identified by the search and the two most frequently referenced were selected. The final selection was limited to a maximum inclusion of two papers per author/source to ensure the analysis would not be overly influenced by the view of a particularly productive contributor or source (Rodgers and Knafl, 2000).

The final stage in the initial phase of the concept analysis is the identification of surrogate terms and uses. Concepts are often discussed by differing terms or synonyms, which Rodgers (1989) refers to as ‘surrogate terms’. These are identified within this final stage and, if relevant, are located within their specific category of use. This process is undertaken after the literature searching has been completed and when identified the surrogate terms are not applied as literature searching terms.

Considering the overall process of concept analysis this stage feels ineffective. It would be more appropriate to identify the surrogate terms and uses prior to the literature search and include these terms within the those applied to searching. As this search, however, was being undertaken as a preliminary review of the literature prior to the start of the research process and was purposely being restricted to using specific terms identified as sensitising concepts within the searching, the ordering of stages outlined by Rodgers in her original model was followed.

Regarding the concepts of health and illness it is possible to identify several surrogate terms and locate these within three categories of use. These are presented in Table 2-8.

Table 2-8. The surrogate terms of health and illness

Category of use	Surrogate terms applied to health	Surrogate terms applied to illness
Representing perspective of persons receiving care and public	Fitness, good condition, haleness, healthiness, physical and mental wellness, prime, robustness, shape, strength, top form, vigour, well-being, wholeness.	Ailment, debility, disability, disease, disorder, ill health, infirmity, malady, poor health, sickness, suffering, weakness.
Consideration within a traditional medical model	Disability absence, disease absence, functioning.	Ailment, debility, disability, disease, infirmity.
Considering as an aspect of whole being	Adaptability, strength, well-being, wellness, wholeness.	Lack of well-being, lack of wellness, suffering, threat, weakness.

At this point the initial phase of the concept analysis model had been completed.

2.5.2 B: The core analysis phase

The first stage of the core analysis phase is to identify the attributes of the concept. Relevant data were extracted and then analysed by thematic analysis, applying the approach described by (Braun and Clarke, 2006, 2012). Thematic analysis is an iterative process identifying, organising and reorganising themes within the literature sampled until a *’cohesive, comprehensive and relevant system of descriptors is generated’* (Rodgers and Knafl, 2000, p. 5). Data used within the concept analyses were collated manually from the items retrieved from the searches. All items were read at least twice and then codes were applied, line by line, to highlight specific sections of the data. Codes were simply a piece of text which identified important topics, ideas, or concepts within the data. Connections between codes were made to develop themes, which were collections of concepts or topics that were highlighted repeatedly throughout the literature. The process of identification of codes and the development of themes were repeated many times in order to provide a summary of the literature that uncovered their underlying meaning. This coding process was independently duplicated by two coders, me and a research-active lecturer with doctorate-level qualification, for the first ten items coded. The resulting coding was discussed and the small number of differences the process identified were debated. Agreement was reached on a combined approach to the coding and appropriate solutions to resolve the differences were identified and applied to the coding already undertaken. The combined approach to coding resulting from this experience was adopted for all further coding.

As previously described, the attributes of the concepts of health and illness were therefore generated, developed and integrated by the thematic analysis. As the transparency and integrity of the process are increased by identifying the components of each theme and the underpinning raw data, these are presented at the end of the discussion of the attributes of each concept.

As a further measure to increase transparency and trustworthiness it is also suggested that relevant personal and other factors influencing attribute selection are acknowledged. All researchers enter their research with not only an undeniable broad range of knowledge about their area of study (Birks and Mills, 2022) but also personal experience and views which have the potential to influence their decisions as to the relevance of the data. As a brief review of the discussion relevant to this that has been previously identified, the impetus for this research originates from my experience prior to becoming a nurse, throughout my own nursing education and delivery of nursing care and then later as a nurse educator. My interest in the concepts of health and illness has developed through personal and professional experience which has influenced my subjective understanding of the concepts of health and illness. Applying critical reflection to this personal and professional experience (Borton, 1970) to facilitate objective understanding of its impact reveals that I am sensitised and mindful of potential bias towards the areas of

1. impact of illness on family members
2. cultural interpretations of health and illness
3. differences between lay and professional perspectives of health and illness
4. nurse education

which will be continuously considered during this research through reflection.

2.5.2.1 Attributes of health

Throughout the data there were recognition that health was thought of in a *'myriad of different ways'* (Turner Goins et al., 2011, p. 17). The paradigm of health within nursing was viewed to be demonstrated through the approaches adopted by nurses when working with persons receiving care. Therefore, nurses' understanding of health not only determines the development of nursing practice but guides the interactions between nurses and persons receiving care (Hwu et al., 2001). The historic paradigm of health was viewed to emphasise disease, whilst the contemporary one emphasised health, functioning and well-being (Larson, 1999), with nurses and nursing leaders not having a sufficiently nuanced view of the multidimensional nature of health (Herberts and Eriksson, 1995).

The process of thematic analysis resulted in the identification of four themes, or attributes, which were:

Health as enablement
Health as dependence on/independence from healthcare
Health as a sociocultural construction
Health as personal responsibility

These attributes are discussed in greater detail below, with the components of each and the raw data underpinning them presented in Table 2-9 at the end of the discussion.

2.5.2.1.1 Health as enablement

Health is an inseparable fusion of mind, body and spirit (Piko, 1999, Blaxter, 2004), the balance of the person's whole being (Spector, 2002, Turner Goins et al., 2011), which enables them to engage and maximise their potential (Simmons, 1989). So, there is a sense that health is a resource which enables the person to realise aspirations, satisfy needs and change or adapt to the environment (WHO, 1946).

The capacity to make adaptation (Tulloch, 2005) is frequently associated with health, so the healthy individual does not have to be disease-free (Jormfeldt et al., 2007) but has the capacity to adjust, meet obligations and enjoy the associated rewards, irrespective of disease (Smith, 1992). Yurkovich and Lattergrass (2008, p. 448) highlight the importance of gaining a sense of personal well-being within one's established boundaries,

> *'Being in balance…having equilibrium and not being out of control…which includes the spiritual, cognitive, emotional and physical domains'.*

So, as long as there is balance in physical, psycho-social and spiritual factors (Seyedfatemi et al., 2014), there is no need for the absence of disease.

Within this perspective health can be viewed as strength (Williams, 1983, Song and Kong, 2015), energy (Poortaghi et al., 2015), independence (Long and Baxter, 2001, Jormfeldt et al., 2007, Song and Kong, 2015) and a commodity that enables material wealth (Seedhouse, 1986, Turner Goins et al., 2011). For a concept that has been described as a mirage (Dubos, 1965) and nebulous (Larson, 1999), such views provide an insight on how it is possible to perceive health as a tangible entity.

Health is not a static state but a process of unfolding, growing and becoming (Hwu et al., 2001, Song and Kong, 2015), which is a *'dynamic process concerning all aspects of human life'* (Herberts and Eriksson, 1995, p. 868). Within this process connectedness with others, not only others as individuals, but others as society, the environment and a belief in a deity, can be significant (Song and Kong, 2015).

2.5.2.1.2 Health as dependence on/independence from healthcare

Regarding healthcare, health may be viewed from two contrasting perspectives. It can be seen as being synonymous with access to healthcare and adherence to the prescribed treatment regimes and conversely also the lack of need to access healthcare services.

The use of healthcare services is clearly recognised as a way to provide security against poor health outcomes and adherence is a method of ensuring good health, as is described by a participant of a study undertaken by Turner Goins et al. (2011, p. 17),

> *'I'm not going to lay down sick or anything because I'm taking quite a few prescriptions.'*

Health is described not only in terms of the absence, control, management or treatment of illness-related symptoms but also as the absence of requiring medical attention and the need to access healthcare (Song and Kong, 2015). Thus, health can be characterised in terms of illness management with dependence on healthcare and illness absence with independence from healthcare.

2.5.2.1.3 Health as a sociocultural construction

The context within which a person is raised affects an individual's perceptions of health (Yurkovich and Lattergrass, 2008). Culture and society provide a filter through which persons interpret experience. Individuals assign their own meaning to health, applying an appropriate sociocultural context, as health definitions are dependent on what an individual's culture deems valuable (Turner Goins et al., 2011). Therefore, interpretations of health depend on the values and cultural background of the individual (Piko, 1999), resulting in a culturally-skewed personal version of what it means to be healthy (Secker, 1998) with all cultures having 'traditional' systems of health beliefs. Such traditional beliefs can influence how health is viewed. For example, in traditional indigenous American culture, health is the state attained when an individual lives in harmony with nature. In traditional Hispanic culture, health is achieved by living in harmony with their god and within traditional Vietnamese culture health is when the poles of hot and cold that govern bodily functioning balance (Nielsen-Bohlman et al., 2004). Such statements need to be treated with caution, as they are potentially stereotypical. Culture-bound perspectives are not confined to non-western cultures; for example, just because a medical system has science as its knowledge-base does not mean it is either morally neutral or immune to the influences of culture (Lupton, 2012). Cultures are also neither static nor homogeneous: they evolve, with views changing to reflect contemporary influences and contain a range of perspectives. It is possible to find as much variation within individuals sharing the same culture as between individuals of differing cultures (Viner et al., 2012).

2.5.2.1.4 Health as personal responsibility

Health is a matter for persons to decide themselves, where self-reliance, independence and a capacity to act without professionals mandating what is 'right' is encouraged (Long, 2000). Health means *'being empowered through knowledge of illness and honest self-awareness'* (Yurkovich and Lattergrass, 2008, p. 448). WHO (1984) recognises the link between health and personal responsibility, individuals who take active responsibility for their health are likely to benefit (Eachus, 1991) and everyone is seen to have the duty to actively seek recovery (Larson, 1999).

Within this perspective health is a reflection of a lifestyle (Stainton Rogers, 1991). Personal behaviour contributes to health, which is associated with clean living, good personal hygiene and healthy behaviours such as exercise, proper nutrition and rest (Turner Goins et al., 2011). Further to this the individual needs to adjust and accept their circumstances with optimism, knowing their limitations and coping with losses with a positive attitude and realistic optimism (Song and Kong, 2015).

This attribute includes the morally-laden perspective that individuals have the freedom to choose whether or not to be healthy, rather than choice being constrained by social and economic circumstances. Not being healthy is correlated to unhealthy behaviour and the responsibility for health is placed directly on the individual and their lifestyle choices (Ochieng, 2006).

Table 2-9. Components of each attribute of health

<table>
<tr><th>Attribute - Health as enablement</th><th>Attribute - Health as dependence on/independence from healthcare</th></tr>
<tr><td rowspan="5">Complete physical, mental and social well-being, not merely the absence of disease or infirmity (WHO, 1946).
An inseparable fusion of mind, body and spirit. Health has multiple dimensions. Health is being whole. Holism. The multidimensional nature of health reflects a complete system of beliefs and ideas (Blaxter, 2004, Turner Goins et al., 2011).
Beliefs about health emphasise the wholeness of a human being (Piko, 1999).
Recognising aspirations and safety needs in order to change or cope with the environment (WHO, 1984).
Well-being irrespective of disease (Jormfeldt et al., 2007).
A dynamic process giving life meaning (Herberts and Eriksson, 1995).
A process of growing, unfolding and becoming (Parse, 1990, Hwu et al., 2001).
Connectedness with others, including a deity (Song and Kong, 2015).
Energy (Song and Kong, 2015).
Gaining a sense of personal well-being at any moment of time within a specific context (Yurkovich and Lattergrass, 2008, Collins and Rodgers, 2009).
Physical, mental and spiritual well-being (Poortaghi et al., 2015).
Physical capabilities as well as personal and social resources (Long, 2000).
Maximising potential (Simmons, 1989).
Meeting obligations (Smith, 1992).
Adaptation (Dubos, 1965, Tulloch, 2005).
Well-being, free of disease or infirmity (Saracci, 1997, Starr and Marsden, 2008).
Functioning (Parsons and Jaco, 1958, Simmons, 1989, Long and Baxter, 2001, Blaxter, 2010, Song and Kong, 2015).
Strength (Williams, 1983).
A dynamic state of well-being, characterised by a physical, mental and social potential, which satisfies the demands of life (Bircher, 2005).
Inner and outer state (Manning and Tikhonova, 2009).
Balance (Spector, 2002, Yurkovich and Lattergrass, 2008, Seyedfatemi et al., 2014).
Engagement (DHSS, 1980).
Empowerment (Jormfeldt et al., 2007).
A resource (WHO, 1984).
An invaluable commodity that is contextually valuable (Seedhouse, 1986, Turner Goins et al., 2011).
A right (United Nations, 1948, Saracci, 1997).
Something one is, one has, one does (Bishop and Yardley, 2010).</td><td>Health as absence, control, management or treatment of illness-related symptoms (Song and Kong, 2015).
Health is the goal of healthcare (Godlee, 2011).
Synonymous with following a biomedical model of healthcare. Using healthcare services provides security against poor health outcomes (Turner Goins et al., 2011).</td></tr>
<tr><th>Attribute - Health as a sociocultural construction</th></tr>
<tr><td>The context an individual is raised within affects their perception of health (Yurkovich and Lattergrass, 2008).
Interpretation of health depends on the values and cultural background of the individual (Piko, 1999).
Individuals align their own meaning to health using an appropriate sociocultural context. Definitions of health depend on what an individual's culture deems valuable (Turner Goins et al., 2011).
Presents a culturally-skewed version of what being healthy means (Secker, 1998, Nielsen-Bohlman et al., 2004, Viner et al., 2012).
Culture-bound perspectives are not confined to non-western cultures (Lupton, 2012).</td></tr>
<tr><th>Attribute - Health as personal responsibility</th></tr>
<tr><td>Behaviours contribute to health (Turner Goins et al., 2011).
A mentally healthy person is an autonomous, self-actualising individual (Rose, 1999).
The aim to balance public and personal responsibility for health is a moral dilemma (WHO, 1984).
A positive attitude and realistic optimism – knowing one's limitations and coping with loss (Song and Kong, 2015).
Being empowered through knowledge of illness and/or honest self-awareness (Yurkovich and Lattergrass, 2008).
The concept of freedom to make choices – health is a matter for persons to decide themselves (Long, 2000).
The ability to adapt and to self-manage (Huber et al., 2011).
Reflection of a lifestyle (Stainton Rogers, 1991).
Knowing what to do and how to do it. How to cope (Blaxter, 2004).
Health as a personal commitment is a way of focusing on the human experience (Parse, 1990).
Everyone has the responsibility to actively seek recovery (Larson, 1999).
Those who can be encouraged to take active responsibility for their health are likely to benefit in terms of more rapid and successful recovery (Eachus, 1991).
Individuals are responsible for their health and lifestyle choices (Ochieng, 2006)</td></tr>
</table>

2.5.2.2 Attributes of illness

Within the data extracted there were frequent recognition that illness is a subjective concept with a myriad of meanings. Although it was possible to find general agreement that it has negative connotations, there is also the identification of hope and positivity within illness, underlining further the subjectivity of the experience.

The process of thematic analysis resulted in the identification of five attributes, or hallmarks, which were:

Illness as fundamental loss of wholeness
Illness as reality
Illness as meaning
Illness as hope and positivity
Illness as a sociocultural construction

These attributes are discussed in greater detail below, with the components of each theme and the underpinning raw data presented in Table 2-10 at the end of the discussion. One of the attributes, a sociocultural construction, was found to be common to both health and illness. Viewing this application to the concepts of health and illness from the perspective of sociocultural theory, as originally outlined in the work of Lev Vygotksy (1896-1934), our perception of the world reflects the broad social system we function within and the cultural activities we undertake. Individuals apply their personal sociocultural framework to all the situations they encounter, so the attribute of a sociocultural construction being shared by health and illness is not so surprising. What is emphasised by this shared attribute is that experience of health and illness is diverse, further supporting the previous claims that both concepts are difficult to define precisely (Mordacci, 1995) and that definitions are likely to vary between and within cultures (Viner et al., 2012).

2.5.2.2.1 Illness as fundamental loss of wholeness

Illness disrupts the fundamental unity between the body and soul, where the body can no longer be taken for granted (Toombs, 1987). The body is viewed to no longer be trusted, which is accompanied with the realisation of personal vulnerability. Such experience is identified as *'disvalued change'* (Eisenberg, 1977, p. 11) and is viewed negatively (Hofmann, 2002a). There is frequent reference to illness being bodily change and abnormality (Gillon, 1986, Toombs, 1987, Haug et al., 1998), failure of the ordinary and hopelessness (Fulford, 1989). Illness represents a very powerful *'first-person negative experience'* (Nordby, 2004, p. 30) frequently described as weakness and loss of self (Blaxter, 1983, Charmaz, 2006). This is often accompanied by stigma (Weiss et al., 2006, Kool et al., 2009, Arthur et al., 2010, Omori et al., 2014) and a loss of self that can be felt so strongly by some that illness is equated to invisible personhood (Sorrell, 2007, Kool et al., 2009).

Marginalisation and discrimination are frequently identified, from a social and psychological perspective (Charmaz, 2008, Miller et al., 2009). This is powerfully described by Murphy (1987, p. 85),

> *'I lost much more than the full use of my legs. I had also lost part of myself. It was not just that people acted differently toward me, which they did, but rather that I felt differently toward myself'*

Thus whilst illness itself is seen as a highly subjective experience (Coutu et al., 2011) there is agreement that it is generally perceived as a negative notion (Hofmann, 2002b).

2.5.2.2.2 Illness as reality

When illness becomes reality there is a reorganisation of everyday living as the illness experience is integrated into an individual's daily life (Toombs, 1987) and a new 'normal' is attained (O'Baugh et al., 2003). Priorities change with the reality of illness (Carter et al., 2004), as '*people learn what they can do and what it takes to do it'* (Charmaz, 2006, p. 30).

The reality of illness is constructed by interactions with others, which can result in the disconfirmation of the subjective experience of illness (Good et al., 1994). The result of this for the ill individual can be suffering, due to a lack of ability to access the support they require. This can be compounded by the shame of being perceived as wrong in their definition of reality (Ware, 1992) and with the language of illness being claimed by others, leaving individuals isolated and deprived of the words to describe their distress (Illich, 1976). Illness can result in individuals facing a reality heavily influenced by the negative views of others (Galvin, 2005).

A negative perspective on illness as reality is not, however, universal. Self-management programmes can result in successful adaptation to the reality of illness, with individuals reporting that they feel healthy despite the limitations they may face (Huber et al., 2011) and self-rated health scores being higher than prior to the experience of illness (Lorig et al., 2003).

2.5.2.2.3 Illness as meaning

Illness is frequently viewed to be inextricably interrelated with meaning (Thorne, 1999). Events are rendered meaningful on multiple levels (Mordacci, 1995), with this meaning being unique because individuals do not attach an identical set of meanings to illness, even when experiencing the same illness. Thus illness has an individual personal meaning (Schüssler, 1992) and experiencing illness can increase the meaningfulness of life (Moch, 1998).

Toombs (1987) contrasts the differing perspective of illness meaning between physicians and the persons they deliver care to. Physicians are trained to comprehend the meaning of illness in terms of the signs and symptoms that determine a disease state, applying an objective view of quantitative data. For those experiencing illness however, the meaning is in the effects on their everyday life, a subjective qualitative perspective. While Toombs (1987) focuses on the perspective of the physician, it is possible to see how the approach of the physician could well be adopted by other healthcare professionals who have undertaken professional education programmes underpinned by an evidence-based scientific methodology. If the difference in comprehension of meaning is considered in terms of the work of Alfred Schutz (1899–1959), specifically his phenomenological theory of finite provinces of meaning (Schutz, 1962), the meaning of illness is being constructed from a perspective of two differing worlds. The ill individual is deriving meaning from experience generated by their everyday life and functioning, while the healthcare professional is focusing on relevant scientific classifications. Illness, as an experience, generates meaning that clearly differs from scientific theoretical explanation.

2.5.2.2.4 Illness as hope and positivity

While the prevailing view is that illness generally is considered as a negative notion, there is also identification of hope and positivity. Hope is a valuable coping mechanism in illness (Reder and Serwint, 2009) and can be adopted as a generalised perspective central to the ability to contend with illness in a family member (Bland and Darlington, 2002). Hope can also be far more tangible, related to the belief in the power of medication and treatment to provide a cure (Piat et al., 2009).

For all of those involved in the experience of illness, directly or indirectly, it can be the motivation to set new priorities and alter current actions, frequently in order to *‘defeat illness and emerge victorious over death’* (Charmaz, 2006, p. 32). For some positivity can be found in taking control of the illness experience (O'Baugh et al., 2003), or in the opportunity illness can offer for spiritual growth (Tu, 2006). From such perspective the experience of illness can be seen to be transformative, offering individuals an opportunity to act in a way that enables them to lead a rewarding and valuable life, while reflecting on their experience to ascertain what they want and who they are (Scammell, 2001, Viswanathan and Lambert, 2005).

2.5.2.2.5 Illness as a sociocultural construction

According to Eisenberg (1977) illness is culturally bound and differs in relation to gender, education, place of residence, ethnicity and social class (Kleinman, 1988). Symptom patterns vary between cultures, despite the persons receiving care having objectively similar medical conditions

(Zola, 1966), cultural codes define attitudes to illness (Litva and Eyles, 1994, Emami and Torres, 2005, Takahashi et al., 2005, Yurkovich and Lattergrass, 2008, Farquharson et al., 2011) with social context creating and shaping any experience of illness (Thorne, 1999).

While there has been agreed international classification of diseases (ICD) for many years, over time societal approaches to illness have changed and diagnostic criteria have evolved. This is most clearly evident in classification systems for mental illness. For example, homosexuality was originally classified as a sexual deviation disorder in the 1952 edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-I), but by 1987 (DSM-III) all such reference to it had been removed (Surís et al., 2016). As outlined by Illich (1976), illness is classified in a manner that reflects social organisation and with the language of illness being claimed by doctors, which leaves those experiencing illness deprived of the words to describe their distress.

Table 2-10. Components of each attribute of illness

<table>
<tr>
<td rowspan="2">Attribute – Illness as fundamental loss of wholeness
Illness is primarily experienced as a fundamental loss of wholeness (Toombs, 1987).
Illness usually occurs in a man's life as a threat to his history, as a crisis in the narrative account of his life and of his identity (Mordacci, 1995).
Illnesses are experiences of discontinuities in states of being (Eisenberg, 1977).
Lack of health is a negative experience (Mordacci, 1995).
Illness is invisible personhood (Sorrell, 2007, Kool et al., 2009).
Hopelessness and helplessness (Haug et al., 1998).
Failure of the ordinary (Fulford, 1989).
Illness represents first-person negative experience (Nordby, 2004).
Illness is weakness (Blaxter, 1983).
Loss of self (Charmaz, 2006).
Marginalisation (Charmaz, 2008).
Illness affects the very fabric of your everyday existence (Thorne, 1999).
Illness as stigma (Arthur et al., 2010, Kamara and Singh, 2012, Omori et al., 2014).
Illness as challenge (Martin, 2009).
Subjectivity of illness experience and variation of response (Coutu et al., 2011).
Illness as burden (Tumiel-Berhalter and Zayas, 2006).
Illness and discrimination (Miller et al., 2009).
Illness as a negative notion (Hofmann, 2002a, Hofmann, 2002b).
Illness as abnormality (Gillon, 1986).</td>
<td>Attribute - Illness as a sociocultural construction
Illness is culture-bound (Eisenberg, 1977).
Medical care is a complete social process, embedded in the cultural matrix and laden with values (Eisenberg, 1977).
Variations in symptom patterns in Italian and Irish persons receiving care with objectively similar medical conditions (Zola, 1966).
Variations in analgesic reliance (Beecher, 1956).
A culture-based syndrome (Chodoff, 1954).
Social construction (Aronowitz, 2008).
Persons receiving care conceive illness in different ways (Nordby, 2004).
Differences in how lay persons conceive of illness (Kleinman, 1988).
Lay and medical models of illness differ (Kleinman, 1980).
Social context shapes and creates illness experience (Thorne, 1999).
Worldview impacts on illness experience (Opala and Boillot, 1996).
Illness experience is affected by lay beliefs (Webair and Ghouth, 2014).
Cultural codes shape attitudes to illness (Litva and Eyles, 1994).
Symptom presentation is culturally-based (Farquharson et al., 2011).
Societal approaches to illness change (Illich, 1976, Surís et al., 2016).</td>
</tr>
<tr>
<td>Attribute – Illness as meaning
Meaning in illness (Mordacci, 1995).
Search for explanation – meaning and illness are inextricably interrelated (Thorne, 1999).
Illness has an individual personal meaning (Schüssler, 1992).
Illness increases the meaningfulness of life (Moch, 1998).
Differing perspective on meaning (Toombs, 1987).</td>
</tr>
<tr>
<td>Attribute – Illness as reality
An individual's goals relate to immediacy as an attempt to integrate the experience into daily life and there can be multiple reality perspectives (Toombs, 1987).
Keeping it normal (O'Baugh et al., 2003).
Setting priorities – people learn what they can do and what it takes to do it (Charmaz, 2006).
Priorities change with the reality of illness (Carter et al., 2004).
Disconfirmation of the subjective experience of illness (Good et al., 1994).
Shame of being wrong in a definition of reality (Ware, 1992).
Deprived of the words to describe their distress (Illich, 1976).
Facing reality heavily influenced by the negative views of others (Galvin, 2005).
Feel healthy in illness (Huber, 2011).
Self-rated health scores can increase in illness (Lorig, 2003).</td>
<td>Attribute – Illness as hope and positivity
Taking control and being positive (O'Baugh et al., 2003).
Motivation to set new priorities (Charmaz, 2006).
Opportunity to reorient the active self (Brink et al., 2006).
Illness as a developer of family resilience (Lee et al., 2004).
Illness as an opportunity for spiritual growth (Tu, 2006).
Hope is a valuable coping mechanism (Reder and Serwint, 2009).
Hope offered by medication (Piat et al., 2009).
Illness can be seen to be transformative (Scammell, 2001, Viswanathan and Lambert, 2005).</td>
</tr>
</table>

2.5.2.1 Relevance to the nurse

Each of the four attributes of health provide acknowledgement of the important role it plays in nursing care. The nurse is alerted to the existence of difference in perception of what is health is clear, plus the identification that the choice to be healthy, or not, is one to be made by the individual, who can also be held responsible for the outcome of their choice. Thus, the need for the nurse to both understand this and ensure the care they deliver supports the perspective of the person being cared for is emphasised.

While health is recognised as being nebulous, healthcare is described as a way of achieving and maintaining health, within which nursing will be paramount. Therefore within care delivery health can be seen as a tangible resource that enables the achievement of potential. To benefit from this resource a person does not need to be disease-free, health can be attained by all through a process of adaptation resulting in personal well-being. The nurse plays a fundamental role within this process, which, as health is seen as a variable state, can be ongoing. The role of the nurse therefore involves contribution to support for the person, for whatever time it is required, by the provision of effective care that maximises connections with others, society, the environment plus a spiritual aspect if this is deemed appropriate.

Subjectivity is also a clear theme within the five attributes of illness, with sociocultural factors shaping all illness experience and the meaning of illness being personal to the individual experiencing it. The possibility of nurses and persons receiving care constructing meaning from contrasting perspectives is identified, highlighting the importance of the nurse appreciating and understanding this, echoing the need to ensure that care delivery reflects the perspective of the person receiving it. There is recognition that if this is not the case, the negative associations of illness can be magnified.

The spectrum of views of illness is clearly vast, ranging from a transformative experience that increases the meaningfulness of life to a trigger for stigma, marginalisation and discrimination, with the reality of illness involving a reorganisation of everyday living to reflect a change of priorities and a new expression of reality. Hope is identified as a valuable coping mechanism throughout this process, with a potential for positivity to result from the taking control of an illness experience. This highlights the need for the adoption of a nursing approach featuring connectedness between the nurse and the person receiving care, in order to offer effective individualised support with a clear focus on the specific needs identified by the person experiencing illness.

2.5.2.2 Identification of the references, antecedents and consequences of the concept

The second stage of the core analysis phase is to identify the references, antecedents and consequences of the concept under focus. Identification of these provides additional information and clarity in understanding what the concept is, or possibly more importantly, what it is not. References identify the range of situations, incidents or phenomena the concept is considered within, antecedents are events or phenomena that precede an instance of the concept and consequences are occurrences that follow the concept.

References to the concepts of health and illness permeate every aspect of an individual’s living. While these analyses aim to clarify the concepts of health and illness from a nursing perspective, a claim of exclusive ownership by one healthcare discipline or environment cannot be supported. To put it very simply, health is *‘a universal concern’* (Seedhouse, 1986, p. 36) with illness and references to it being evident within and outside all healthcare settings.

The antecedents of health and illness, like the references, are evident in all aspects of everyday living. If again, however, a nursing perspective is considered, the events or phenomena that usually precede a healthcare encounter relevant to both concepts under consideration are either illness, due to disease, trauma, infection, sickness, or infirmity, or health promotional activities, such as immunisation or health surveillance.

Within the literature the consequences of health and the consequences of illness can be seen to reflect many of the surrogate terms identified in Table 2-8, with the addition of happiness, achievement and empowerment for health and for illness, loss of control, failure, disempowerment and death. Table 2-11 presents a full list of consequences for each concept.

Table 2-11. The consequences of health and illness

Consequences of health		Consequences of illness	
achievement	healthiness	ailment	infirmity
adaptability	mental wellness	death	lack of well-being
disability absence	physical wellness	debility	lack of wellness
disease absence	prime robustness	depression	loss of control
empowerment	strength	disability	malady
fitness	‘top form’	disease	poor health
functioning	vigour	disempowerment	sickness
good condition	well-being	disorder	suffering
haleness	wellness	failure	threat
happiness	wholeness	ill health	weakness

2.5.2.3 Identification of concepts that are related to the concept of interest

The third stage within the core analysis phase involves the identification of concepts that are related to the concept of interest, focusing on important aspects of the relationship.

The main concepts related to health are well-being, illness and disease, with the main concepts related to illness being disease, health and well-being. The symmetry within the related concepts is unsurprising due to the close relationship between the concepts of health and illness. In consideration of the related concepts identified, well-being is frequently referred to when representing the perspective of the person receiving care, or when considering health as an aspect of whole being. The relationship between health and well-being can be traced back to the ancient Greek view of health (Ahmed et al., 1979) and well-being is a term used in the frequently-quoted definition of health, from the World Health Organization (WHO, 1946). Well-being emphasises positive qualities, *‘being in balance…having equilibrium and not being out of control’*

(Yurkovich and Lattergrass, 2008, p. 448) and has been recognised as representing a contemporary paradigm of health.

As has been previously recognised, the concepts of illness and disease have been major traditional concepts in sociology and medical sciences (Nordenfelt, 1993). They are closely interwoven and often used interchangeably, but can be individually defined: disease refers to abnormalities of the structure and function of body organs and systems (Eisenberg, 1977, WHO, 1980); illness is a subjective response to being unwell (Helman, 1981).

2.5.2.4 Identification of a model case of the concept

The final stage of the core analysis phase involves the identification of a model case of the concept, uniting all aspects of the analysis and presenting an exemplar. Rodgers (1989) does warn, however, that this stage may not always be possible to achieve.

As has been outlined, health and illness are both abstract concepts, without a universal meaning. The use one person applies to them need not be that of another. Within this context, the construction of a written model case to demonstrate the personal and individual perspective is challenging and seen to be unable to provide the clarity desired. In such a situation, Woodhouse (2012) encourages the use of visual methods of communication, as this approach not only expresses ideas that cannot be captured in words, but also conveys more than the words alone (Buckley and Waring, 2013). Hence, a more transferable and universal model case of health and illness are presented pictorially in Figures 2-4 and 2-5.

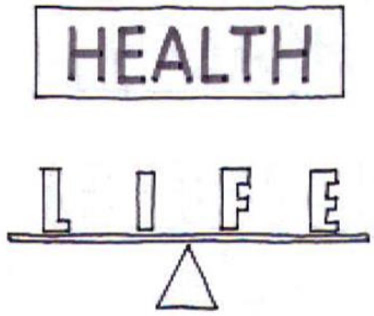


Figure 2-4. A model case of health

Figure 2-5. A model case of illness

The analogy of health to balance and equilibrium is frequently highlighted and can be linked to the equilibrium theory of health which is evident in the writing of Whitbeck (1981), Pörn (1984), Nordenfelt (1987), Spector (2002), Yurkovich and Lattergrass (2008) and Seyedfatemi et al. (2014). The marked difference between the equilibrium theory and this model case is that the equilibrium theory considered a biological basis of health and illness, with balance referred to in that context. Within the model cases presented in Figure 2-4 and 2-5, the element of balance is seen to be underpinning all aspects of life, representative of the individual in health being enabled and exerting control. In illness the loss of balance is representative of the individual's lack of control, without this necessarily being accompanied by disordered biological functioning.

At this point the core analysis phase of the concept analysis model has been completed.

2.5.3 C: The further analysis phase

The first stage in the further analysis phase is the further development of a concept through research, as in Rodgers' (1989) view that concept analysis is not an endpoint, but one method of increasing understanding of a concept prior to further research. The following chapters of this thesis therefore could be viewed as a continuation of this stage of the concept analyses.

Practically, the increased understanding obtained from the concept analyses will enable greater focus in the development of the proposed research, which will be undertaken from a more informed and objective perspective. The attributes identified by the analyses of health and illness were fundamental in the building of the vignettes shared with participants in the focus groups and are discussed in greater detail in Chapter 4. More generally, the literature considered within the concept analyses has facilitated understanding that health and illness have a fundamental role in nursing and definitions of the concepts vary, not only across the lifespan, but also between and within cultures. These factors apply to both the persons receiving care and the professionals delivering care alike.

The second stage, which is also the last in the further analysis phase, is consideration of the strengths and limitations of the process, providing a final opportunity to highlight the steps undertaken to ensure the quality and authenticity of the process, while accepting that there will always be limitations.

It is possible to identify several strengths and limitations. Regarding strengths, the approach was systematic and detailed, with a wide range of literature consulted and the potential impact of personal experience considered. Specific measures were also taken to increase the rigour, transparency, trustworthiness and replicability of the data-extraction process, plus reduce bias. The process of undertaking the concept analyses has enabled meaning to be further clarified and has facilitated recognition of the importance of nurses understanding the subjectivity of the concepts of health and illness. The process has identified that understanding the relevant attributes of these concepts is paramount to effective nursing care and the development of nursing knowledge.

Considering limitations, much of the analysis was undertaken by one individual, so while measures were instituted to ameliorate the impact of this, not all interpretations were cross-checked. Reflecting on the attributes identified, they are clearly representative of my personal perspective, signifying my interests and previous clinical, educational and personal experience. While the data retrieved by the search criteria represented a date range of 70 years (1946-2016), this was not as large as I desired. I would have liked the date range for the data collection to have started in 1910, as it was thought that the consideration of material prior to the First World War and the start of the UK National Health System (1948) might add further to the understanding of the development of the concepts. This starting date was, however, outside the limits of the databases so items from the full date range I desired were not retrieved.

At this point the further analysis phase of the concept analysis model has been completed, bringing the formal concept analysis to an end.

2.6 Reflections on Applying the Adapted Version of Rodgers' (1989) Model

Despite the concerns relating to the process of concept analysis identified and discussed in this chapter, the processes involved in adapting and applying a model of concept analysis were beneficial in facilitating my understanding of the concepts of interest and the philosophical approaches to concepts. Undertaking the work focusing on concept analysis within this thesis has been a good learning experience, summarised by a quote in my reflective journal,

> *'Even though it makes my head hurt, exploring the differing views of a concept has proved to be an excellent introduction to the wider foundations of philosophy'*
>
> Reflective Journal Entry 01.07.2016

The process also identified further potential areas for contribution to the development of relevant knowledge that had not, until undertaking the concept analyses, been explicitly appreciated. In addition to this it is positive to see that the Adaptation of Rodgers' (1989) Evolutionary Model of Concept Analysis (Delves-Yates et al., 2018) is being cited and applied by other researchers in their work (Romagon and Jabot, 2020, Smith et al., 2020, Afaneh et al., 2021, Parvaresh-Masoud et al., 2021, Smith and Mörelius, 2021, Vena and Copel, 2021, Morgan and Gazarian, 2022, Nasrawi et al., 2022, Skobba, 2023).

There are, however, concerns relating to the process of concept analysis that persist, which focus on both the practicalities of the application of the adapted Rodgers' (1989) model (Delves-Yates et al., 2018) and, much more significantly, the overall value of concept analysis.

Regarding the practicalities of the application of the adaptation of Rodgers' (1989) model, most of the stages of each of the three phases described within the model flowed effectively, enhancing the procedure and enabling iterative, bi-directional, non-linear movement, which is viewed as a positive addition. An issue, however, was identified with the final stage in the initial phase, in the identification of the surrogate terms of the concept and their uses. To undertake this aspect of the analysis at this point not only served to disrupt the process, but also did not make the greatest value of the knowledge and insight that could potentially be gained. This stage needs to be undertaken prior to the literature searching. Thus, stages two and three of the initial phase need to be reversed, enabling the surrogate terms to be identified prior to the literature search. If this was the case the surrogate terms could be used to inform the search terms for the review of the relevant literature.

Less easy to rectify are the more philosophically focused concerns relating to the overall value of concept analysis and negative perspectives previously identified by Paley (1996), Beckwith et al. (2008), Draper (2014) and Bergdahl and Berterö (2016), which were not resolved prior to the development of the adapted version of Rodgers' (1989) model (Delves-Yates et al., 2018). The areas of concern are whether

i. the usage of a concept is an appropriate tool to enable clarification of trustworthy meaning,
ii. any meaning allocated to a concept can be translated to situations outside the context an individual applies and
iii. as a mental image of a phenomenon, concepts can be accurately captured within the spoken or written word.

Progressing through the processes involved in the research and becoming increasingly immersed in the data-gathering, analysis and writing enabled time for consideration of and reflection on these issues. While they continued to feel important and relevant, they remained unresolved until the publication of further work by Paley in 2021. As was previously identified, in his 1996 work Paley was highly critical of concept analysis as a method to obtain conceptual clarification. Paley's 2021 work on concept analysis is extensive, critiquing the topic in detail, within which debate relating to whether *'there's a different way of seeing this'* (Paley, 2021, p. 5) resonated with my thinking. The concept analysis processes applied within this research have added value, but the methodological and philosophical concerns cannot be overlooked. To regard concept analysis as an objective, scientific process is overestimating its contribution. Viewing concept analysis from a different perspective more accurately indicates its worth and considering it as a way to explore the pattern of use of words you are interested in (Paley, 2021) is much more appropriate.

2.7 The Gap in Knowledge

There is a paucity of knowledge relating to nursing students' views of health and illness and it remains unknown how nursing students' views of health and illness develop throughout a nursing programme and how nursing students' perceptions of health and illness influence their views of the care they deliver.

Therefore, further empirical research is required to explore the views and perceptions of health and illness held by nursing students. This needs to explore how the perceptions of nursing students evolve throughout the course of a pre-registration BSc nursing programme and how these perceptions influence their views of the care they deliver. The findings of this research have the potential to inform the development of curricula for pre-registration nursing programmes, facilitating appropriate engagement in experiences that are known to develop nursing students' views of health and illness.

My research aims to address this identified gap, contributing original knowledge which increases the understanding of the concepts of health and illness. This relates to nursing students' perceptions and how these develop, answering the research questions and achieving the research aims and objectives identified below.

2.7.1 Research questions

1. How do nursing students perceive the concepts of health and illness?
2. How do nursing students make sense of their personal and professional experiences before and during a nursing programme, in terms of their perceptions of health and illness?
3. How do nursing students' perceptions of health and illness influence their views of the care they deliver?

2.7.2 Research aim

To develop a grounded theory which offers an original contribution to the understanding of how nursing students perceive health and illness and how this perception may influence care delivery.

2.7.3 Research objectives

1. To undertake a concept analysis of the concepts of health and illness.
2. To undertake a grounded theory study to explore nursing students' understanding of the concepts of health and illness and how they develop while they undertake a three-year undergraduate programme.
3. To develop a grounded theory of nursing students' concepts of health and illness and how this influences care delivery.

2.8 Conclusion

This second chapter outlined the staged approach taken to the literature and presented the concept analyses of health and illness. An integral part of this chapter was consideration of the topics of sensitising concepts, understanding concepts, philosophical approaches to concepts and conceptual analysis. The intention of this discussion was to clearly identify the strategies undertaken to uphold the ethos of CGT regarding the approach taken to the literature and present detailed consideration of a range of issues.

Applying the Adaptation of Rodgers' (1989) Evolutionary Model of Concept Analysis (Delves-Yates et al., 2018) to explore the pattern of use of interesting words (Paley, 2021), proved to be an effective means of identifying what was common in their usage. It was revealed that the use of both words, health and illness, could be categorised in three different ways: from the perspective of persons receiving care, within a traditional nursing or medical model and as an aspect of whole being. Further exploration identified that the words health and illness had one pattern of usage in common, that of sociocultural construction, which clearly revealed the importance of nurses having an awareness of the subjectivity and contextuality of these words.

The process of undertaking conceptual analysis, when defined as an exploration of the pattern of usage of interesting words (Paley, 2021), resulted in an increased understanding of the words health and illness, which is contemporary and contextually appropriate. Further strengths of the process were the unveiling of different directions the research project could take by identifying issues and questions that had not previously been appreciated.

Utilising the measures outlined in the Adaptation of Rodgers' (1989) Evolutionary Model of Concept Analysis (Delves-Yates et al., 2018) was found to facilitate a robust process that enhanced the quality and transparency of the data and produced more accurate and dependable findings (Mason, 2002a). To supplement this, the adapted model also encouraged reflexivity, an approach which clearly aligns with the philosophy underpinning Rodgers' (1989) model. The exploration proved to be a useful tool facilitating the development of the understanding of a phenomenon under investigation.

A gap in knowledge was identified, relating to a lack of empirical research exploring exclusively how nursing students perceive the concepts of health and illness, how their views of health and illness develop throughout a nursing programme and how they perceive care delivery to be influenced by views of health and illness. My research aims to address this knowledge gap by answering the research questions and achieving the research aims and objectives outlined.

The conclusion of this chapter marks the end of Part One of the thesis, which served to provide an understanding of the background to the research. Within this Part it has been identified that health and illness are fundamental to nursing and that definitions of health and illness vary across the lifespan, between and within cultures, with the variation applying to both the persons receiving care and the professionals delivering it. Views of health and illness are influenced by a range of factors and affect the care nurses deliver. It remains unknown, however, as to how nursing students' views of health and illness develop throughout a nursing programme and how nursing students' perceptions of health and illness influence their views of the care they deliver.

In the next part of the thesis, the focus moves to considering research methodology and methods, outlining the theoretical approach underpinning the research. To commence this discussion, the following chapter, Chapter 3, considers the process of making a choice of methodology and outlines the overarching theoretical framework supporting the research.

Part Two – Considering Research Methodology and Methods

‘Design follows purpose – but what do I want to produce?’

Reflective Journal Entry 25.09.17

Chapter 3 Selecting a Research Methodology

'How best to explore perceptions in order to gain a rich and detailed understanding?'

Reflective Journal Entry 25.10.2016

3.1 Introduction

In Part One of the thesis, my personal interest and rationale for engaging in the research were identified, with Chapter 2 reporting an analysis of the concepts of health and illness. The knowledge informing the understanding of health and illness within the context of healthcare has been explored, with a gap in the knowledge identified that this research aims to address.

The intention of this second part of the thesis is to outline the theoretical approach underpinning the research by deliberating on the concept of a paradigm, contemplating relevant philosophical and theoretical principles plus discussing of the role of a theoretical framework. This detailed consideration has been undertaken to identify the chosen research methodology and the key research methods to be applied.

To address these issues this chapter begins by considering the process of making a choice of methodology and outlining the overarching theoretical framework underpinning the research. To discern the integral elements of the theoretical framework there is discussion of the principles of interpretivism, symbolic interactionism and constructivism, all of which guide the path of the research. Throughout this chapter ontological, epistemological and axiological assumptions are debated, along with their influences on the research design and approach. The chapter concludes by reviewing the chosen research methodology.

3.2 Making a Methodological Choice

Every researcher has their own view of what constitutes truth and knowledge, plus what they perceive to be valuable. It is these notions that guide their thinking, beliefs, view of society and self (Denzin and Lincoln, 2008). Our individual views frame the world around us, constituting a paradigm (Schwandt, 2001). The work of Kuhn and his landmark book, The Structure of Scientific Revolutions, first published in 1962, is considered to be fundamental in identifying how paradigms are chosen and applied as a way to summarise a researcher's beliefs about their approach to the creation of new knowledge (Morgan, 2007). Choosing a paradigm, however, is not without complication, as the term paradigm can be used in more than one way (Shannon-Baker, 2016), with Kuhn said to apply his concept of a paradigm in more than 20 ways (Masterman, 1970).

The breadth of use of the term paradigm has a negative impact on clarity, resulting in debate as to what constitutes a paradigm and introducing complexity in its application. A paradigm, therefore, is not unanimously viewed as a helpful concept, not only due to the lack of clarity but also because its application has the potential to marginalise some beliefs or force researchers to adopt a specific philosophy (Maxwell, 2011).

There is also the view that paradigms can assist in framing an approach to a research question, offering propositions as how to address it within a framework of certain beliefs or philosophical assumptions (Shannon-Baker, 2016). In this way a paradigm can support a researcher to summarise their ideas about their efforts to create new knowledge.

3.2.1 Considering a paradigm

A paradigm outlines a belief system which influences the knowledge a researcher seeks and how they interpret the data they collect. This view presents a very broad approach to the concept of a paradigm, with the possibility of differing interpretations by individual researchers. According to Morgan (2007), while interpretations do differ, the key difference relates to the level of generality in the belief system a researcher holds. Thus, it is possible to locate their individual interpretations within one of four categories, as identified in Figure 3-1.

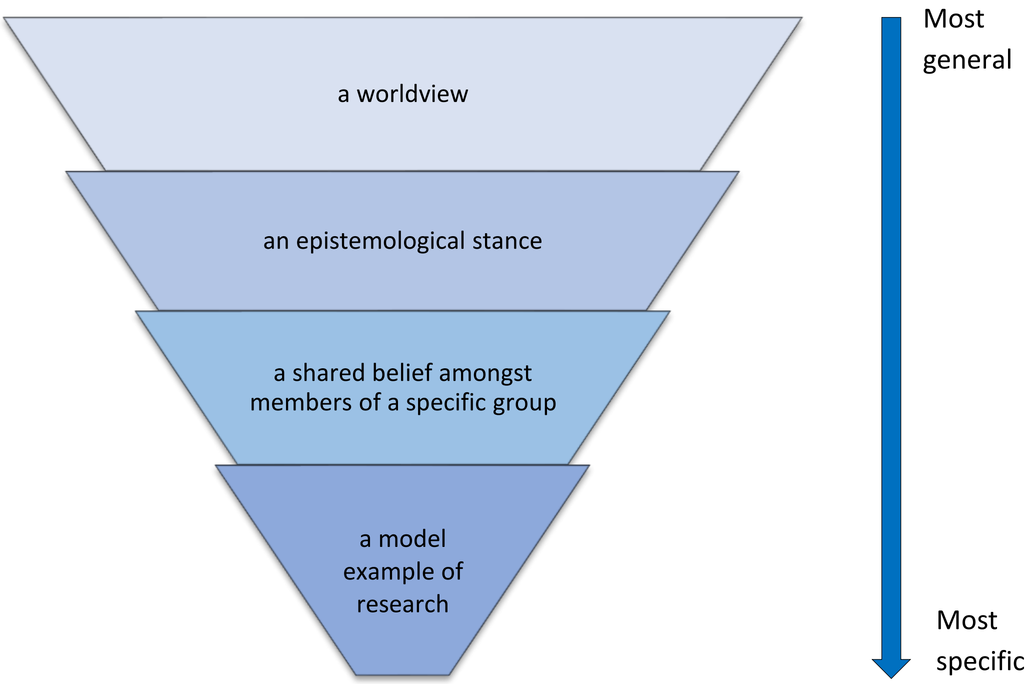


Figure 3-1. A paradigm as...
Adapted from Morgan (2007)

The first interpretation, considering a paradigm to be a worldview, has attraction regarding its brevity and simplicity. Such an approach requires some caution, as paradigms do not reflect everything a researcher believes or thinks; they are focused on thoughts about the nature of research. Considering a paradigm to be a representation of all-embracing perspectives of the world by defining it as a worldview is clearly the most generalised approach. This interpretation is common in everyday discussion and even though there is recognition of the role of personal experience and culture within this explanation, this approach is too broad to have sufficient, direct relevance to research.

The second interpretation, viewing a paradigm as an epistemological stance, is the most widely held approach in social science research methodology, where paradigms are viewed as being the philosophical underpinnings from which specific research approaches originate (Weaver and Olson, 2006). Such an approach is helpful in as much as it focuses on research inherently involving epistemological issues about the nature of truth, knowledge and value, so it is more focused and relevant than considering a paradigm to be a worldview. There is, however, a layer of complexity requiring further consideration: the perspective of researchers who apply mixed methods. In their work researchers using mixed methods apply paradigms which could be seen to have opposing epistemological stances, as they intentionally combine qualitative approaches with quantitative ones to facilitate the study of phenomena in depth and detail while applying standardised metrics. Considering a paradigm as an epistemological stance highlights Maxwell's (2011) view that this approach could force researchers to adopt just one specific philosophy in their work. Hence, the approaches available for a researcher to apply would be restricted, rather than supporting them to choose the approach which will, in their view, best answer their questions while facilitating creativity and innovation.

The third interpretation, a paradigm as a shared belief amongst members of a specific group, produces a consensus as to which questions are the most meaningful and which procedures are most appropriate for answering them. Such an approach is typically applied in some disciplines, or by groups of practitioners within a discipline, with nursing being a good example of a discipline where this approach is evident (Newman, 1992).

The fourth interpretation, a paradigm as a model example, can be used by a novice to understand how research is undertaken in a specific field. This is the most specific use of the term. Such an approach is evident within many textbooks addressing research approaches, for example Creswell et al. (2003) in their handbook of mixed methods and Charmaz (2014) in identifying her approach to GT, include research projects as case studies to illustrate the principles they are discussing.

By considering each of the four interpretations of the term paradigm independently it is possible to identify potential strengths, as well as limitations. So, the question is raised as to whether it is necessary to accept only one approach as being accurate, as it is possible that none of the previously described perspectives is either incorrect or mutually exclusive. This notion is developed by Morgan (2007), who suggests that the most effective way to view a paradigm is by thinking of the four previously described interpretations as being nested within each other, accepting all potential interpretations and forming a continuum from generality to specificity. This is how they have been purposely depicted in Figure 3-1, as considering a paradigm in this way clearly underlines that none of the perspectives is necessarily individually correct and that the boundaries between them can be fluid. Such an approach enables paradigms to be seen as tools useful to the research process (Biesta, 2010). Viewing a paradigm from this perspective means that the question a researcher needs to answer when aligning their research to a paradigm is, 'Which paradigm or paradigms provide me with the best tools for the questions I wish to answer?'

The following discussion focuses on four paradigms often applied within nursing research: Positivist/Post-positivist, Interpretive/Constructivist, Transformative/Emancipatory and Pragmatist (Weaver and Olson, 2006), each of which was considered as a potential approach for this research.

3.2.2 Positivist/Post-positivist paradigm

Auguste Comte (1798-1857) formulated the doctrine of positivism to reflect a strict empirical approach in which claims about knowledge are based on direct scientific experience, with investigation focusing on the degree to which a phenomenon can be exactly determined. Positivism applies the scientific method and is viewed as objectivist, where objects around us have existence and meaning independent of our consciousness of them (Crotty, 1998). Positivists view the scientific method as the only way to establish truth and objective reality, with science being the only foundation for true knowledge.

Post-positivism differs somewhat from positivism, emphasising probability rather than absolute certainty and focusing on theory falsification, rather than theory verification. Post-positivists, in the same way as positivists, believe that there is a reality independent of our thinking that can be studied through the scientific method. Post-positivism is influenced by the philosophy of critical realism, recognising that observation may involve error and theories can be modified, thus reality cannot be known with certainty (Chilisa and Kawulich, 2012). It is still viewed to be possible to achieve objectivity, however, through the application of multiple measures and the triangulation of data, resulting in a clear understanding of reality.

3.2.3 Interpretive/Constructivist paradigm

Both interpretivism and constructivism address understanding the world as a product of the experience of experience (Charmaz, 2014). Interpretive research aims to understand rather than predict and a constructivist approach emphasises that knowledge emerges through an individual's interaction with the environment in the course of their experience (Crotty, 1998), with the focus being at the level of the individual (Young and Collin, 2004). Constructivist approaches can be traced back to Edmund Husserl's (1859-1938) philosophy of phenomenology (the study of consciousness and self-awareness) and Wilhelm Dilthey's (1833-1911) philosophy of hermeneutics (the study of interpretation), later elaborated on by Martin Heidegger (1889-1976) and Max Weber (1864-1920) (Newman, 1992).

From the perspective of this paradigm all knowledge and therefore all meaningful reality is dependent on human practices being constructed by interactions between individuals and their world, which is developed and transmitted within a social context.

3.2.4 Transformative/Emancipatory paradigm

The transformative/emancipatory paradigm is one which has become increasingly applied within nursing research and allied disciplines (Kramer-Roy, 2015). The shared view within this paradigm is that many other paradigms are built on philosophy typically developed by white male academics who studied 'male' subjects within a Western setting (Chilisa and Kawulich, 2012), marginalising the perspective of other communities and their ways of knowing. A result of such marginalisation is not only the development of research projects and their resulting outputs that fail to be of benefit to all, but also a failure to see the value in all ways of knowing.

This paradigm is influenced by philosophies and theories which share the focus of transforming and emancipating communities by group action and social justice. Such approaches can be traced back to Karl Marx's (1818-1883) theory that the ruling class controls the production of knowledge and ideas. This perpetuates their domination, accounting for the dominance of Western research paradigms and marginalisation of knowledge produced in other cultures. Other theories relevant to this paradigm include critical theory, feminist theory and post-colonial theories. These have resulted in the application of critical social science research, participatory action research and feminist research designs, along with research designed to emancipate individuals experiencing discrimination and oppression (Chilisa and Kawulich, 2012).

3.2.5 Pragmatist paradigm

The pragmatist research paradigm has been developed from the philosophy of pragmatism (Maxcy, 2003), embracing a plurality of approaches. The underpinning proposition is that researchers should use the philosophical/methodological approach that works best for the particular research problem they intend to investigate, with the focus being on the research questions and the consequences of research not the methods employed (Kaushik and Walsh, 2019).

Pragmatism originated in the USA in the late 19th century and was developed by academics, such as John Dewey (1859-1952) and George Herbert Mead (1863-1931), and non-academics alike. The approach represents the rejection of the thought that social science inquiry can investigate reality purely by the application of a single scientific method (Maxcy, 2003). Philosophical arguments have not been dispensed with in this paradigm, but pragmatist researchers believe that the broader philosophical arguments can never be solved because meaning is inseparable from human experience and needs and alters due to context (Dillon et al., 2000). Their choice of one version of reality over another is dependent on how effectively that choice results in the outcomes desired. According to Biesta (2010), pragmatism is not a philosophical position but an assortment of philosophical tools which can be applied when problems need to be addressed. Thus, pragmatism is oriented to solving practical problems in the real world.

3.2.6 Making decisions

What is clear within the preceding brief consideration of a small number of paradigms are the difference in the underpinning philosophical assumptions. These philosophical assumptions focus on:

> ontology - the nature of social reality, whether there is one verifiable reality, or the existence of multiple, socially-constructed versions
>
> epistemology - ways of knowing, what is the source of knowledge and how do we know it is true
>
> axiology - value systems, what is valued and has meaning

all of which will result in differing perspectives on what is the appropriate methodology for and the articulation of the research. A researcher needs to commence their work by deciding how their ontological, epistemological and axiological beliefs will be expressed within their work, as the paradigm they adopt will lead to them asking certain questions and applying a specific approach within their systematic inquiry or, in other words, their methodology. Thus, the methodology is the overall approach which summarises how the research will proceed. To decide on a methodology it is necessary to first ascertain which paradigm or paradigms best inform the approach.

According to Chilisa and Kawulich (2012) in this process of making decisions a researcher’s perspective on ontology, epistemology and axiology, supported by a number of other views, can be used as a decision-making guide, as outlined in Figure 3-2.

Questions?

1. What is the reason for undertaking the research?
2. What are the ontological assumptions?
3. What are the epistemological assumptions?
4. What are the axiological assumptions?
5. What counts as truth?

Figure 3-2. Questions?
adapted from Chilisa and Kawulich (2012)

Considering these questions in relation to my research, the reason for undertaking the research is to explore the perceptions of students to gain a rich and detailed understanding which will identify how they make sense of the world from their unique perspective. I want to understand the processes involved in students' conceptions of health and illness, how they develop meaning from their experience before and while they are a student, considering how their interactions with others during their professional nursing role impacts on their perspectives. I am aware from my personal, teaching and clinical nursing experience that there is unlikely to be 'one single truth' in the data I wish to collect and the required approach needs to be able to capture how meaning emerges as individuals interact with others, plus whether and how such influences impact on attitudes and values.

Personal reflection, discussion with knowledgeable others and exploration of key texts have identified that my research should follow an interpretive/constructivist paradigm, as my view is that reality, regarding the focus of the research and more generally, is not fixed but is subjective depending on the perspective of the individual. Thus, I need to gather the meanings and interpretations of the research participants to gain the understanding I desire. I want to uncover knowledge relating to the concepts of health and illness held by students that is grounded in symbolic meaning and constantly modified by social interaction, within a world that is as an individual views, interprets and experiences it.

Applying an interpretive/constructivist paradigm will enable me to both elicit the subjective perceptions and generate the new insights and knowledge I desire and to uphold my axiological perspective that values cannot be separated from the individuals who hold them or their actions, because they are an integral aspect of their life.

While a number of qualitative methodologies, phenomenology and ethnography for example, could deliver thick descriptions and rich insights in order to *'unveil the nature, essences, characteristics and meaning of phenomena'* (Leininger, 1992, p. 403), when I discovered the work of Charmaz (1990, 2012, 2014), it quickly became clear that CGT was the specific methodology I was searching for. I desired a methodology which enabled mutual understanding of phenomena through collaborative relationships between researcher and participants to construct new knowledge in the form of theory. This is precisely what CGT offers (Charmaz, 2006, 2014). Furthermore, CGT allows an acknowledgement that my pre-existing personal and professional experiences have shaped my perceptions of health and illness and are the original motivation from which this research has developed. CGT also supports my view that individuals construct their own personal and subjective perspectives by way of ongoing interactions in their social world. As previously recognised, my prior experience and beliefs will influence the research, as I am unable to separate them from myself to enter the field without this perspective. By applying CGT, this becomes a facet of the exploration.

CGT is identified by Coşkun (2020) as having a relativist ontology and a constructivist epistemology, which further supports the view that it is the most appropriate methodology for this research, as it is possible to align these perspectives with my previously-identified positioning.

3.3 Research Methodology

The role of a methodology is to provide a set of principles and ideas which are developed from the underpinning research philosophy to inform the design of the research. The methodological framework, along with its underpinning philosophy influences how the researcher will work throughout their research. My ontological, epistemological and axiological position has led to the choice of CGT as the methodology to be applied, as it will both provide answers to the questions I am asking and align with my personal perspective. In addition, there is also a guiding framework offered for data collection and analysis (Strauss and Corbin, 1990, Glaser and Kaplan, 1996, Glaser, 2001, Bryant and Charmaz, 2010, Charmaz, 2014, Birks and Mills, 2022), which will be of clear benefit for a novice researcher.

To consider the chosen methodological approach further, discussion now moves to a brief historical overview of GT, followed by an overview of the development of CGT.

3.3.1 Emergence of Grounded Theory

The history and development of GT are closely linked with developments in social scientific inquiry, especially tensions between qualitative and quantitative research in sociology in the United States at the beginning of the 1960s (Bryant and Charmaz, 2010). The origin of these tensions were the works of sociologists at the University of Chicago at the start of the twentieth century, such as George Herbert Mead, John Dewey, W.I. Thomas, Dorothy Swaine Thomas and Florian Znaniecki. Their work inspired numerous graduate students, one of whom was Anselm Strauss, who studied at Chicago from 1939-1945, to further develop qualitative approaches. At the time Strauss was studying at Chicago, inductive qualitative inquiry in sociology involved participant observation, but neither the methodology nor the methods applied had been theorised or explained. Hence, the qualitative analytical strategies being applied were not being made widely accessible (Evans, 2013).

Barney G. Glaser (1930-2022) and Anselm L. Strauss (1916-1996) are recognised as the founders of GT. They originally worked together on a study investigating the experience of terminally ill individuals. Glaser and Strauss explored how these persons dealt with the knowledge that they were dying and the reactions of healthcare staff caring for them (Denzin and Lincoln, 2008). Throughout this collaboration, Glaser and Strauss questioned the appropriateness of using a scientific method of verification for this study (Birks and Mills, 2022). This resulted in the development of the constant comparative method, a key element of GT and Glaser and Strauss generating a theory of dying that was ‘grounded’ in qualitative data, first described in their work Awareness of Dying (Glaser and Strauss, 1965).

Glaser and Strauss subsequently wrote The Discovery of Grounded Theory: Strategies for Qualitative Research (1967). This work explained how theory could be generated from data inductively. Such an approach challenged the traditional method of testing or refining theory through deductive analysis. At a time when quantitative approaches were dominant, the emergence of GT stimulated interest in qualitative methods across the academic community, extending awareness beyond the Chicago school. GT provided an approach that questioned the prevailing view, that quantitative methodology was the only valid, unbiased way to determine truths about the world. In their work, therefore, Glaser and Strauss challenged the belief that qualitative research lacked rigour and detailed a method of comparative analysis which enables the generation of theory. After publishing The Discovery of Grounded Theory, Glaser and Strauss wrote independently from each other and expressed divergent viewpoints in the application of GT methods (Dey, 1999). Their differing views and the development of approaches by others, resulted in the generation of several types of GT. While there is variation in these types, it is possible to present some commonalities (Noble and Mitchell, 2016). GT is an inductive, comparative and interactive approach to research that offers a range of open-ended strategies for conducting emergent inquiry. It is a systematic methodology that begins with an inductive approach and involves engaging in simultaneous data collection and analysis. The aim is to make conjectures and review these as the research process continues. GT enables the study of processes, actions and interactions, providing understanding of what is happening in the field (Chun Tie et al., 2019). Essentially, GT as a research methodology has significance because it provides explicit, sequential guidelines for conducting qualitative research and legitimises qualitative research as scientific inquiry (Charmaz, 2004). GT offers specific strategies for handling the analytic phases of inquiry, streamlines and integrates data collection and analysis and advances conceptual analysis of qualitative data (Charmaz, 2014).

The research procedure followed in GT differs from many other approaches. Rather than a linear model, GT has what can be thought of as a spiral approach. Following the identification of preliminary ideas, data are collected and analysed simultaneously. The approach is much more integrated than many others, with cycles of data collection comparing new information with previous ideas, continuing until an explanatory theory emerges (Flick, 2013).

3.3.2 Constructivist Grounded Theory (CGT)

CGT originates in the work of Kathleen (Kathy) M. Charmaz (1939-2020). Her approach focuses on how researchers create their own interpretations of theory from the data. CGT challenges the view that theory can be 'discovered' from the data, recognising that theory will always be biased by the way the researcher and the participants create their own understanding of society and reality. The engagement between participants and researchers is often stated as being a key part of this approach (Charmaz, 2012, 2014, 2017).

Charmaz (2017, p. 34) described her approach as one which

> *'shifts the epistemological foundation of the original versions and integrates methodological innovations in qualitative inquiry'*

Thus, the theoretical stance underpinning CGT makes it ideal for research intending to explore the processes involved in the evolution of a student's concepts of health and illness during their pre-registration nursing programme in several ways. CGT has the potential to facilitate a rich and detailed understanding of the participant's perspective, analysing data with the level of depth and detail required to answer the research questions. Such an approach will achieve the desired purpose of the research. A number of the features of CGT are common to other types of GT, such as a focus on basic social processes (Morse, 2001), the use of symbolic interactionism (Charmaz,

2014) and the respect for the subjective interpretation of experience and processes (Charmaz, 2006). The deciding factor, however, in my choice of CGT was the ability to acknowledge that pre-existing personal and professional experiences have shaped my perceptions of health and illness and that these can be legitimately incorporated into the research to become an additional facet. While classical GT views the researcher as external to the research process, CGT acknowledges the role of the researcher and participants in constructing reality (Tie et al., 2019) where the role of the researcher is as the author of a reconstruction of experience and meaning (Mills et al., 2006). In CGT researchers co-construct data together with the participants, with the researcher's social, cultural and historical orientation, academic preparation and personal paradigm influencing these data, their analysis and the 'emergent' theory (Thornberg and Dunne, 2019). The theory constructed will depend *'on the researcher's view; it does not and cannot stand outside of it'* (Charmaz, 2014, p. 239).

Such an approach is precisely what I required to produce the results desired within this research, a co-construction shared between the researcher and the participants resulting in a narrative of our reality.

3.4 Deciding the Theoretical Framework

As the terms theory, concepts, theoretical framework and conceptual framework are common and widely used within the research literature, the degree of difficulty in ascertaining precisely what is being referred to is somewhat surprising. Regarding the term theory, throughout this thesis theory is viewed as an explanatory scheme outlining how concepts are related to each other through logical patterns of connectivity (Birks and Mills, 2022). The definitions allocated to theoretical framework and conceptual framework throughout this thesis will now be outlined.

Within the research literature there is identification and general agreement of the importance of research being guided by theory. The requirement of a theoretical framework to provide credibility, make the research meaningful and enhance rigour (Adom et al., 2018, Mensah et al.,

2020) is not, however, an unanimously-adopted view (Varpio et al., 2020). This situation is further compounded by difficulty in accurately distinguishing between theoretical and conceptual frameworks (Charmaz, 2014, Adom et al., 2018, Mensah et al., 2020), owing to vague and, at times, contradictory descriptions of the differences (Charmaz, 2014, Ravitch and Riggan, 2016, Miles et al., 2018, Varpio et al., 2020).

In an attempt to provide clarity, Mensah et al. (2020) describe the interrelatedness of theoretical and conceptual frameworks and, more helpfully, the difference. Throughout this thesis a theoretical framework is viewed as a map which guides the researcher during the entire research process by providing a specific theory or set of theories about aspects of human endeavour (Mensah et al., 2020). Thus, this theoretical framework underpins the overall theoretical approach of a research study, applies the known (accepted theory) to the unknown (research focus), representing the thoughts of leaders in the specific research field. This provides an orienting lens (Swanson and Chermack, 2013), as views of the research leaders can assist in development of a researcher's informed and specialised lens which will be evident in all aspects of their research (Mensah et al., 2020).

The role of a theoretical framework within hypothesis-testing, systematic, controlled empirical research does appear more immediately evident than in research seeking to develop theory grounded in the data collected (Mitchell, 2014) and its value is debated (Corbin and Strauss, 2008, Birks and Mills, 2022). Charmaz (1990, 2014), however, offers advice and a clear example in her research, 'Discovering chronic illness', of how a theoretical framework can underpin a CGT study. It is therefore her approach which has been followed to devise the theoretical framework applied within this research.

Within this thesis the theoretical framework is comprised of an overall interpretivist/constructivist approach, applying a symbolic interactionist perspective in combination with social constructionism. The research builds on and combines the literature of:

Hughes (1968), Helman (1978, 2007), Freidson (1970), Kleinman (1980, 1988), Blaxter (1983, 2004), Charmaz (1990, 1991, 1994, 1995, 2002, 2006, 2008) and Skär and Söderberg (2016) focusing on perception of health and illness,

Kitwood (1993, 1997), Kitwood and Brooker (2019), McCormack (2001a, 2001b, 2003, 2004), McCormack and McCance (2006, 2019a), McCormack et al. (2011) and McCormack and Dewing (2019) focusing on person-centred nursing practice, and

Herberts and Eriksson (1995), Eriksson (1997) and Fredriksson and Eriksson (2003) focusing on caring.

3.4.1 A conceptual framework?

While much of the relevant literature identifies that most research requires a theoretical framework, the same stance is not taken regarding a conceptual framework. A conceptual framework is used to present a researcher’s explanation of how the research problem will be explored as the product of their own thinking, in order to portray an integrated approach and a visual display of how ideas relate to each other (Osanloo and Grant, 2016, Mensah et al., 2020). To apply this approach, having an identified conceptual framework at the start of this specific CGT inquiry is not viewed to align with the philosophy underpinning the methodology. As Charmaz (2014) outlines, conceptions as to what course the research will follow prior to it commencing are restricted to investigation of the sensitising concepts. Therefore, the research does not have a detailed conceptual framework in addition to this.

3.5 Influencing Philosophical and Theoretical Principles

The development of this thesis has been influenced by the philosophical and theoretical principles of the interpretive/constructivist paradigm, symbolic interactionism and social constructionism. As the interpretive/constructivist paradigm was identified in Section 3.2.3, this discussion will not be repeated, but symbolic interactionism and social constructionism will be outlined and their role within the thesis considered.

3.5.1 Symbolic interactionism

Symbolic interactionism originates from the thought of pragmatist philosopher and social psychologist George Herbert Mead (1863-1931). Much of the impact of Mead's thinking is due to the endeavours of his student, Herbert Blumer (1900-1987), who was central to the posthumous publication of Mead's work which explicitly described symbolic interactionism. Blumer (1969, p. 2) identifies three basic interactionist principles, that

> *'human beings act towards things on the basis of the meaning that these things have for them'*
>
> *'the meaning of such things is derived from or arises out of, the social interaction that one has with one's fellows'*
>
> *'these meanings are handled in and modified through an interpretative process used by the person in dealing with the things he encounters'*

Symbolic interactionism emphasises meaning, the self and the ways in which the self is constructed through interaction with others, which occurs within the social world. It is impossible for individuals to be removed from the context of the social world (Handberg et al., 2015), where they are constantly engaged in a process of adaptation and change. As a response to this an individual's knowledge, insights and perceptions evolve, with Blumer (1969) referring to this process as symbolic interactionism. Through symbolic interactionism individuals constantly evaluate the symbolic meaning of the world around them and the actions of others. This evaluation results in subjective interpretations which evolve into new insights and interpretations (Bryman, 2008). This theoretical perspective is based on an epistemology focusing on the exploration of individual, subjective consciousness and the view that this reveals inner experience rather than that of the wider world (May and Perry, 2022).

As what is being investigated in this research is the personal, inner experience of students as their concepts of health and illness evolve, prior to and during their undergraduate nursing programme, such a theoretical perspective is highly relevant.

3.5.2 Social constructionism

The term social constructionism is used in this thesis to refer to the theoretical principles which acknowledge the impact of experience and interactions in the social world, plus how this can influence the construction of perception, resulting in subjective meaning and interpretation.

The interpretive/constructivist paradigm adopts the perspective that reality is dynamic, subjective and constructed by individuals within the context of their social environment. From this perspective knowledge is socially constructed, derived from the conceptualisations and interpretations of individuals from their personal experiences and actions and the actions of others and the context or situation in which this occurs (Blaikie and Priest, 2019). Similar to constructivism, social constructivism places the researcher in the role of a co-constructor of phenomena and provides a way to interpret reality (Andrews, 2012), although the focus is social rather than individual (Young and Collin, 2004). According to Charmaz (2014) social constructionism is consistent with CGT.

Although interpretivism and social constructionism have similar philosophical foundations, there is a distinction (Andrews, 2012), as interpretivism applies empiricist logic to explore human inquiry. Such approaches are also complementary to the theoretical perspective of symbolic interactionism and have clear relevance in research which aims to investigate subjective and relativist perceptions in order to generate new knowledge of a phenomenon (Gardner et al., 2012).

3.6 Conclusion

The focus of this chapter's discussion has been on presenting issues to consider when choosing which methodology to adopt within the research. This involved comprehension of not only which research paradigms had the potential to provide the best fit for the questions I was asking, but also understanding my ontological, epistemological and axiological positioning and the relationship between the two. The role of a methodology within the research process was considered, the theoretical framework for the research was introduced and the influencing philosophical and theoretical principles outlined.

The discussion will be further developed in the second chapter in this part of the thesis, Chapter 4, with the identification of and deliberation on the chosen research methods.

Chapter 4 Determining the Research Methods

'The real questions are, who to ask and how to ask them'

Reflective Journal Entry 02.03.2016

4.1 Introduction

This chapter further develops discussion from the preceding chapter, focusing on the identification of and rationale for the research methods adopted and outlining the plan for their implementation.

It opens by debating the role of research methods, discussing those frequently applied in GT. A rationale is developed to support the specific methods chosen and applied and a detailed consideration of ethical issues is given. The processes involved in participant sampling and recruitment throughout the research are outlined and the application of a qualitative longitudinal research method is discussed. The range of processes involved in data collection and analysis are described, with the topics of theoretical sensitivity and saturation explored. There is explanation of how participant quotes were selected and included within the findings, with the chapter concluding by considering reflexivity, trustworthiness and credibility.

4.2 Research Methods

Loseke (2017) likens research design to an architectural drawing: in the same way that it is unlikely a good building will result from a poor plan, a research project built on faulty foundations is unlikely to achieve results that are trustworthy. Research design therefore needs to provide a package of elements within which the methods applied are 'in harmony' with the identified methodological approach and can effectively explore the research focus.

As McCann and Clark (2003) identify, no matter which GT methodology is chosen, there are key GT methods which need to be applied. These key methods are constant comparative analysis, analytical coding techniques, theoretical sampling, theoretical memoing, theoretical diagramming, theoretical sensitivity and theoretical saturation. To ensure the research has the hallmarks of a GT methodology and to ensure credibility and enhance the rigour of the research, each of these methods needs to be implemented within the research plan (Bryant and Charmaz, 2010). Therefore, how the GT approach was applied using key GT methods is described in this chapter, outlining how the resulting theory was grounded in the data, revealing and conceptualising the relevant social patterns (Strauss and Corbin, 1998).

4.3 Ethical Issues

Ethical approaches are an essential and integral aspect of research practice, with the privacy, dignity, well-being and safety of participants paramount. It is therefore important that the researcher is aware of any possible risks in carrying out the research and that steps have been taken to ensure that best practice is followed. Within this research the potential risks were viewed to be:

pursuing a research topic that was not of value
infringing confidentiality, anonymity, or privacy
causing a data breach
re-exposing participants to memories of distressing experiences
coercion resulting from power inequality

The strategies outlined below were put in place to reduce these risks.

Early in the research the idea was informally discussed with and opinions sought from nursing students, lecturers and research-active colleagues as to whether the topic was worth pursuing and asking them for feedback on the approach I was planning to take. In healthcare research, public and patient involvement (PPIRes), where persons receiving care and the interested public are partners in the design and governance of a study, increasingly features in research design. There is great benefit in research being carried out ‘with’ or ‘by’ members of the public rather than research that is done ‘to’, ‘about’ or ‘for’ them (NIHR, 2021). Not only do members of the public bring unique experiences and perspectives, PPIRes has demonstrated multiple positive impacts, including a reduction in waste of scarce resources, increased outputs and an improved experience for all stakeholders (Maccarthy et al., 2019). While persons receiving care were not directly involved in this research, I wanted to achieve the best experience for the participants it did involve, ensuring the time they donated to the research was worth their investment and the experience they gained from taking part was felt by them to be valuable. This process of consulting nursing students, lecturers and research-active colleagues (referred to as the PPIRes group from this point) continued as the study progressed.

In response to the feedback from the PPIRes group, in combination with adhering to my professional code (NMC, 2018a), upholding The Code of Practice for Research Degrees (UEA, 2023) and the ethical principles of respect for autonomy, non-maleficence, beneficence and justice, the following approaches were adopted regarding the risks identified.

4.3.1 Access to participants

Consent to approach the students and undertake the research at each research location was granted by the relevant gatekeepers at each university who occupied the roles of Head of Programmes/Deputy Head of School at one university and were the Director of Teaching and Learning and the Director of Research at the other (see Appendix 4). They read the research proposal, felt that it had value and agreed for their School to be a research location.

4.3.2 Confidentiality, anonymity and privacy

Confidentiality, anonymity and privacy for the participants were all relevant during data collection and afterwards. While there is overlap within the meaning of each of these terms, there are also distinct differences. Confidentiality within research relates to keeping information secret or private and is a necessary element within the maintenance of trust between researcher and participant (Mason, 2017). Anonymity, however, is a method of ensuring that participant data are presented without the exact originating source being known or specified. Thus, it should not be possible to identify individuals in the write-up of the research or any associated notes.

Research participants were assured that I and the research team (research supervisors and note-taker for focus groups) would maintain confidentiality regarding all information. There were two exceptions to this, where confidentiality could not be guaranteed: first, if an issue relating to safeguarding, self-harm or security was raised. If this was the case, the protocol outlined in the Participant Information Sheet (PIS) (see Appendix 5) would be followed. It turned out that such actions were not required. Second, regarding the focus groups: although the ground rules established at the start of each focus group highlighted the importance of confidentiality, which would be maintained by me and the note-taker, it was not possible to guarantee that other focus group participants would abide by this. Again, this was outlined in the PIS.

The PIS also explained that views expressed by the participants and any other data generated would be anonymised and it would not be possible to attribute them to specific individuals. Respecting the privacy of the participants was an essential aspect of the research, especially as it was possible they would share personal information or stories that they found emotionally difficult. Participants were anonymised in the transcription of the recording and analysis of data and they were assigned pseudonyms in the findings chapters. If a participant inadvertently identified themselves during data collection the identifying features were removed and if a story shared by a participant had the potential to identify either them or other individuals, the relevant details were modified to assure anonymity.

4.3.3 Data management

All participant contact information was stored securely and separately from data collected as part of the research. All hardcopy data collected were stored in locked cabinets and transferred securely. Electronic data were stored on a password-protected, secure server with all information provided during the research stored in accordance with the Retained Regulation 2016/679

General Data Protection Regulation (GDPR UK) (European Parliament, 2016), the Data Protection Act (UK Government, 2018) and The Code of Practice For Research Degrees (UEA, 2023).

4.3.4 Safety and well-being of participants

Ensuring that safety and well-being are paramount is a primary concern of any research activity. Experiences revealed during a data collection activity can profoundly affect participants, with unexpected, upsetting or damaging thoughts being revealed (Holloway and Galvin, 2016). Such an experience is not limited to the participants alone, as the researcher can also be vulnerable (Lincoln and Guba, 2000). Therefore, during each data collection meeting, either face-to-face or online, an individual who knew the participants was available if a participant decided that they needed to leave the focus group or interview and/or required support and debrief during or following the event. If issues were raised that I felt necessitated similar support or debrief, the research supervisors were to be accessed. During the research such measures were not required.

4.3.5 Informed consent

The principle of informed consent is fundamental in ensuring that the privacy, dignity, rights, well-being and safety of all participants in a research project are upheld (Mason, 2017). It is therefore essential to ensure that all research participants are fully informed about the plan and purpose of research and that once they understand this, freely agree to participate (DH, 2018, ESRC, 2023). To ensure that participants were fully informed about the plan for the research details on the organisation of the data collection sessions were outlined in the PIS (see Appendix 6). The PIS also explained that the purpose of the research was to investigate nursing students' views of health and illness at the start of their undergraduate nursing programme and to explore whether these altered during their pre-registration education. The PIS further explained that obtaining students' views would result in better understanding that may help improve the provision of future nurse education and ultimately benefit patient care. The PIS described that taking part involved the participants talking about their views of health and illness in relation to a variety of scenarios in the focus groups and, in the interviews, how their views had developed during the nursing programme. Providing this level of information enabled participants to understand what taking part in the study involved but did not dictate precisely what data I wanted them to provide. During data collection I aimed to make it clear that there were no correct answers and that I was interested in all the participants’ views.

For participants to openly share their stories and for me to achieve the richness of data I desired, they needed to be willing to participate and do so voluntarily (Creswell and Poth, 2016). Thus, the PIS clearly outlined participants’ right to change their minds and withdraw at any point. Due to the methods of data collection and analysis, however, participants were informed that it would not be possible to remove any data once it had been provided. Disentangling and removing an individual contribution from a focus group was not feasible, as the discussion would have been influenced by the view shared. Participants who indicated they wished to participate in the study were provided with informed consent forms to read, which were completed at their first data collection meeting (see Appendix 6). When taking informed consent with the participants, I allowed sufficient time for them to ask any questions they might have and establish understanding of both the research and their involvement in it, by asking relevant questions. I did not have a pre-existing relationship with any of the study participants.

At all data collection meetings participants were reminded of their right to withdraw at any time. Providing this constant reminder and reassurance was felt necessary as it was possible neither to predict what the focus of discussion would be at each meeting nor to know the impact of this on the participant (Krueger, 2014). It could be that what might emerge during discussion may alter a participant’s willingness to continue in the study (Barchard, 2019).

According to Beauchamp and Childress (2019), ethical research is supported by the four key ethical principles of respect for autonomy, non-maleficence, beneficence and justice. These ethical principles, combined with the accountabilities outlined in my professional code (NMC, 2018a), underpinned all aspects of the research, from the development of the protocol to how I acted when collecting data. This approach ensured that the potential of harm was minimised and that participants were informed about the purpose of the research, gave informed consent to participate and were fully aware of their ability to withdraw from the study at any time, without any consequence on them. While it could be seen that in occupying the roles of researcher and lecturer I had more power than those who were in the role of research participant and student, adopting the approaches described aimed to reduce the inequality of our positions.

4.3.6 Ethical approval

The research proposal was formally submitted to the University's research ethics committee. A research ethics committee is a group of credible individuals appointed to review research proposals to assess if the research meets the required ethical principles and any legal requirements. The proposal for the research was approved by the University's ethics committee in December 2017 (see Appendix 7). An amendment to the proposal was granted in February 2021 (see Appendix 8). The rationale for this amendment is discussed in detail in Chapter 5.

Thus, formal permission to carry out the research was obtained, along with expert appraisal of the protocol and agreement that it had value in implementation. At all times research activities were only commenced after formal agreement had been secured.

4.4 Sampling and Recruitment

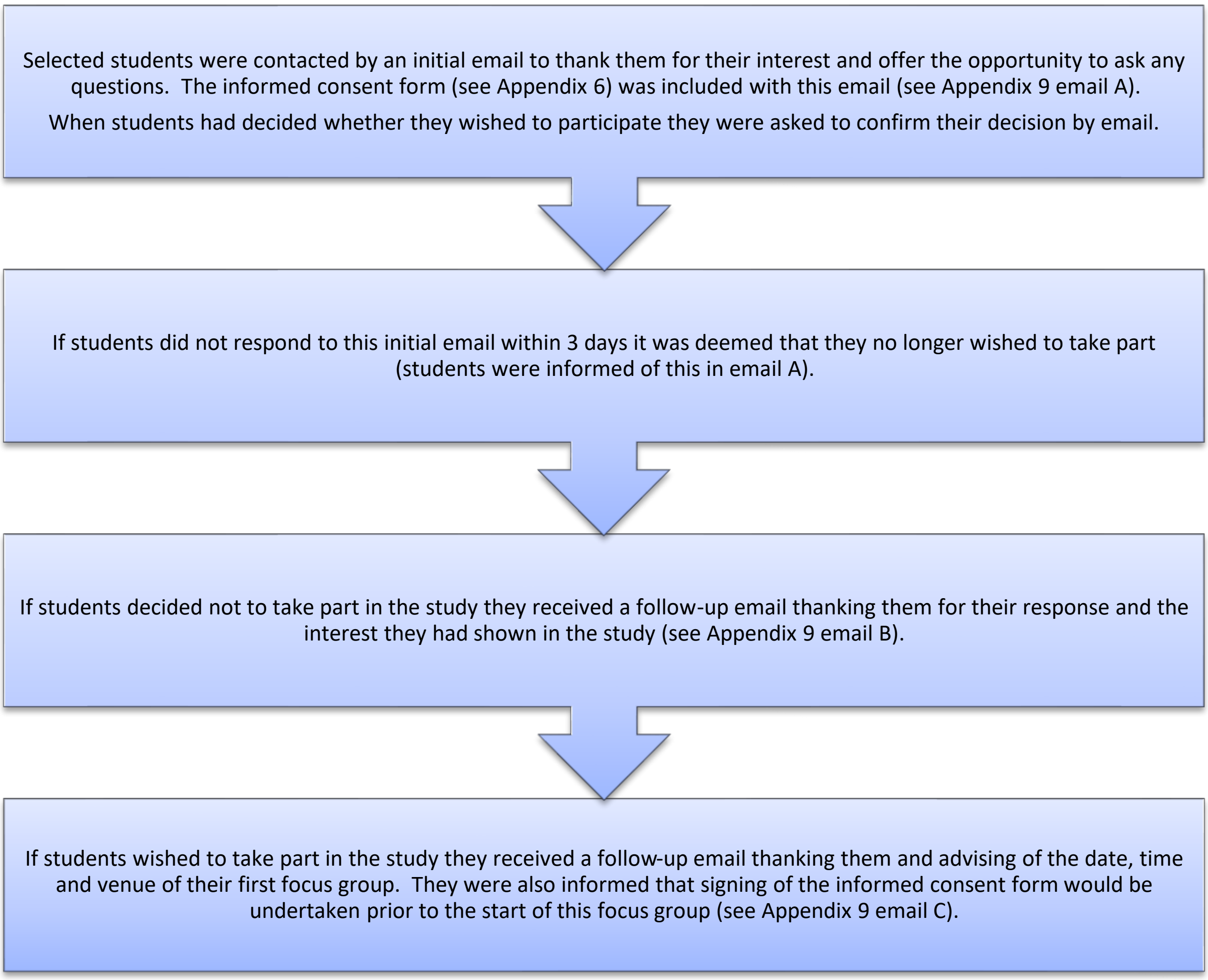
During the research sampling was initially purposive, progressing to theoretical as the research proceeded. At the start of the research participants were sought who met the inclusion criteria of being registered on a full-time undergraduate (BSc) pre-registration nursing programme at either of two English universities (one urban, one semi-rural), between September 2016 and August 2021. Potential participants could be in any of the three years of study and undertaking a programme in any of the four fields of nursing (adult, mental health, child, learning disability). No further sampling criteria were applied. While the potential of selection bias with this form of sampling is recognised, in that students who are interested in or have experience of the topic may well be more likely to volunteer, this can also be seen as a strength, as such individuals are '*information-rich cases ideal for in-depth study*' (Patton, 2014, p. 264). The sample was sought as students had not been studied before in relation to the evolution of their views of health and illness as they undertook a 3-year, full-time, BSc nursing programme.

To recruit the initial purposive sample of participants at the start of the study, the same recruitment process was followed at both research locations and was repeated a total of six times (three times at each location) to recruit individuals from each year group.

To introduce the study to potential participants I met with each student year group at both universities during the last ten minutes of a university-based theory session. During this meeting I explained the rationale for the research, provided an overview of the planned process and invited students to express an interest to participate. It was stated, verbally and in writing on the PIS (see Appendix 6), that participation in the study was entirely voluntary, not a required element of the programme and would have no bearing on the student's treatment or achievement during the programme. It was emphasised that there would not be a financial incentive to participate. Students were also informed that they had the right not to participate in the study. If they decided to take part, they were told that they could withdraw at any stage, without any form of redress or penalty and did not need to give a reason. The PIS, in hard-copy, was available for students after the introduction to the study, with an electronic version also available via the course-specific virtual learning environment (i.e., Blackboard Learn, 360Learning, Moodle) hosted by their university.

Students interested in participating were asked to email me within five working days to signify their interest. Allowing five working days after the introduction to the study was seen to enable the students to have sufficient time to fully consider whether they wished to be involved without feeling under any undue pressure or influence.

Initial recruitment was planned to progress as outlined in Figure 4-1.



Selected students were contacted by an initial email to thank them for their interest and offer the opportunity to ask any questions. The informed consent form (see Appendix 6) was included with this email (see Appendix 9 email A).

When students had decided whether they wished to participate they were asked to confirm their decision by email.

If students did not respond to this initial email within 3 days it was deemed that they no longer wished to take part (students were informed of this in email A).

If students decided not to take part in the study they received a follow-up email thanking them for their response and the interest they had shown in the study (see Appendix 9 email B).

If students wished to take part in the study they received a follow-up email thanking them and advising of the date, time and venue of their first focus group. They were also informed that signing of the informed consent form would be undertaken prior to the start of this focus group (see Appendix 9 email C).

Figure 4-1. Initial recruitment process

The process continued until either a total of eight participants had been recruited from each year group at both locations, or, if fewer than eight students had expressed an interest, until as many as wanted to participate had all been recruited. By this process the participants for the focus groups were selected and recruited. The choice to invite eight participants to each focus group was guided by consensus within the literature that an appropriate number would be between five to twelve (Gothberg et al., 2013, Browne et al., 2014, Carey, 2016, Rosenthal, 2016, Hennink et al., 2019). Eight participants were a sufficiently small number to enable exchange of views without the intimidation of talking to a large number of people while also large enough to ensure that if not all participants attended the group size would remain within the numbers advised.

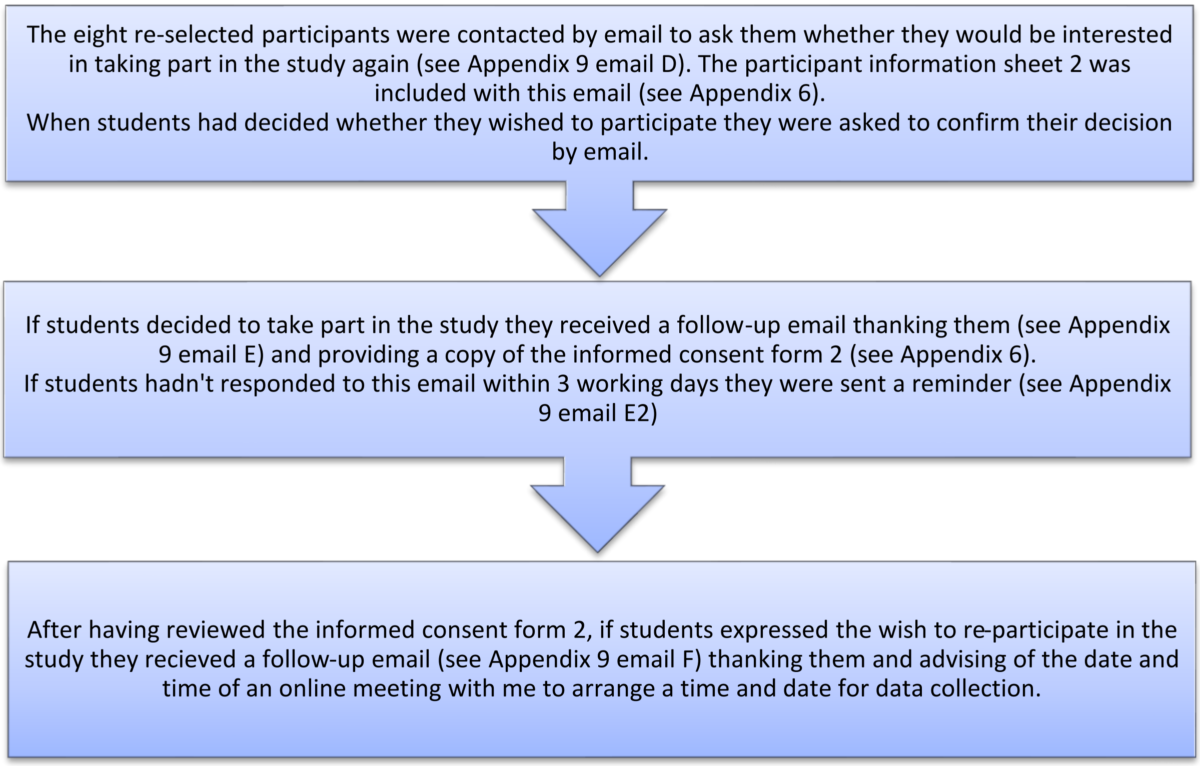
Once all the focus groups had been completed and individual experiences and understanding derived from the discussions had been combined and as the data gathered were analysed, categories emerged which needed further elaboration in the aim to achieve data saturation. Theoretical sampling is an approach applied in order to achieve this (Charmaz, 2014) as it illuminates and defines categories, assisting the development of the emerging theory (Butler et al., 2018).

Glaser and Strauss (1967) first described theoretical sampling as a process by which a researcher generates theory from data, with Stern (2007) defining it as directing the data search to advance the developing theory. This process includes collecting data, coding and analysing it, then deciding what further detail needs exploring to facilitate development of a new theory. Theoretical sampling normally takes place after several initial key concepts or categories have been identified, outlining a line of exploration which produces more data to either endorse or refute the categories that have previously been identified. Thus, an inductive-deductive interplay is realised which according to McGhee et al. (2007), is the essence of GT. Charmaz (2014) also outlines the application of inductive and deductive reasoning, describing how, when combined with abductive analysis, the most plausible theoretical account of the topic of interest is achieved. In this approach abductive analysis can be considered to be imaginative reasoning, a creative inferential approach aimed at producing new hypotheses and theories (Timmermans and Tavory, 2012). The application of abduction enables reasoned leaps to be pursued to consider possible theoretical explanations for data and categories tested to confirm or refute their properties. Within any GT approach research starts with a topic of interest, data are collected and relevant ideas develop. The initial approach is inductive, with hypotheses and tentative theories emerging from data, which are either confirmed or refuted by deductive examination and an abductive approach to theoretically sampled data.

The question I needed to answer as I moved to theoretical sampling was who were the 'key informants' in my study. These were the individuals who were best able to develop the data I had collected so far, refuting or confirming my tentative theories and would therefore compose my theoretical sample. I needed to gather data from a group of individuals who were able to answer the questions I had to further develop my categories. I felt that these individuals still needed to be immersed in their experience of being a student, so that they had not forgotten their views and experiences from this time or replaced them with views representing a different position. I realised that the key informants I was seeking were students at the end of their three-year BSc nursing programme who had participated in the previous rounds of data collection. These individuals had not only the nursing experience and knowledge required to assist in the development of emerging categories and theory but also their pre-existing familiarity with me and I hoped the trust and rapport we had already developed were likely to make them feel comfortable in an individual interview situation. Therefore, for theoretical sampling the decision was to re-recruit a total of eight previous participants. Although the complexity of assessing saturation is recognised and discussed in detail in Section 4.9, the plan was to commence theoretical sampling by undertaking eight further data collection meetings, because pragmatically eight interviews should meet the parameters generally agreed to be sufficient to enable theoretical saturation to be achieved (Carlsen and Glenton, 2011, Hennink et al., 2017, Hennink et al., 2019, Namey et al., 2020). In the interviews resulting from theoretical sampling, while continuing to listen carefully to hear anything new, I could also address the gaps I perceived in the data, to ensure they were as saturated as possible. If, after the eight individual interviews had been completed, I identified a need for further data then more interviews would be organised.

At the time when I wanted to embark on theoretical sampling, nine of the participants had completed their programme and were therefore no longer nursing students. Thus, they did not meet the selection criteria for further participation. Twelve of the participants were still undertaking their studies and were eligible to participate again.

For the theoretical sampling I needed to identify a group of participants who were information-rich (Glaser and Strauss, 1967, Charmaz, 2014). Therefore, from the twelve participants still undertaking the programme, I selected the eight who had contributed the most to discussion during the focus groups. Each of these individuals was contacted by email and invited to participate in the study again, as outlined in Figure 4-2.



The eight re-selected participants were contacted by email to ask them whether they would be interested in taking part in the study again (see Appendix 9 email D). The participant information sheet 2 was included with this email (see Appendix 6).
When students had decided whether they wished to participate they were asked to confirm their decision by email.

If students decided to take part in the study they received a follow-up email thanking them (see Appendix 9 email E) and providing a copy of the informed consent form 2 (see Appendix 6).
If students hadn't responded to this email within 3 working days they were sent a reminder (see Appendix 9 email E2)

After having reviewed the informed consent form 2, if students expressed the wish to re-participate in the study they recieved a follow-up email (see Appendix 9 email F) thanking them and advising of the date and time of an online meeting with me to arrange a time and date for data collection.

Figure 4-2. Theoretical sampling recruitment process

If it was not possible to re-recruit all eight participants identified, the remaining four previous participants would be contacted, once again in an order representing their contribution to discussion, until a total of eight had been achieved. If, after contacting all previous participants, a total of eight had not been achieved, all nursing students currently in Year three of the programme would be contacted (see Appendix 9 email D2) and the process described by Figure 4-2 continued until a total of eight participants were recruited.

4.4.1 Inclusion of a Qualitative Longitudinal Research method

Qualitative longitudinal research (QLR) is described by Neale (2016) as a method which can explore the dynamic nature of the lives of individuals by focusing on the same individuals, in real time, as their lives unfold. QLR enables the collection of empirical data reflecting transition and change (SmithBattle et al., 2018), providing insights into how people narrate, understand and shape their lives and the social world they belong to (Neale, 2016). Due to QLR developing across different research traditions, it can be included as a design element in a research study without being bound to a specified methodology (Bennett et al., 2020).

As perceptions are changing, diversify and unfold over time, Audulv et al. (2022) advise that phenomena with a developmental perspective may be better described by undertaking data collection with the same participants at differing time points. Time is an important factor in understanding the dynamic nature of lived experience, which means that exploration of experience through time can facilitate an understanding of social change, or continuity, plus the mechanisms through which this occurs (Neale, 2016).

Within this study QLR was used to observe students' views of health and illness over 31 months, aiming to understand any change in their perceptions as they described them.

4.5 Data Collection

In GT research data collection and analysis occur concurrently, with the research methods frequently including in-depth questioning approaches, such as focus groups or individual interviews (Noble and Mitchell, 2016). Focus groups and individual interviews were used in this research. Their combination enabled data collection to be an iterative process which was in accord with the philosophy of CGT, as initial insights from focus groups guided exploration of individual accounts in the interviews, resulting in the emergence of data enriching the conceptualisation of the phenomenon being researched (Lambert and Loiselle, 2008).

4.5.1 Focus groups

Focus groups were chosen because talk-based methods are one of the most widely-used empirical tools to gain an understanding of daily life while allowing new data to emerge, particularly about social meanings and the social organisation of everyday practices (Strauss and Corbin, 1998). The use of focus groups in CGT research is particularly appropriate as participants are empowered to work alongside the researcher, sharing their own perspectives and focusing the discussion on a perspective relevant to them (Kitzinger, 1995). Thus, focus groups are useful for exploring how participants think and why they think in the way they do, tapping into interpersonal communication to highlight values and group norms.

Focus groups enable data to be accessed that results from interaction among participants, accessing jokes, anecdotes, questioning and arguments, to increase the depth of inquiry (Grønkjær et al., 2011). By enabling participants to talk together about everyday practices focus groups enhance understanding of everyday life (Browne, 2016) with participants collectively constructing and making sense of specific issues (Bryman, 2008). In this study the use of focus groups was viewed likely to be acceptable to the participants because they were familiar with group discussion, an approach frequently used in nurse education (NMC, 2018c).

Focus groups were held at both research locations at the start of each academic year and were repeated at the end of the year (see Table 4-1). Repeating the focus group with the same participants at the end of the year enabled discussion as to development in the participants' concepts of health and illness. The number of focus groups undertaken, two for each category of participant, which was two for each year group in this research, is identified by Krueger (2014), as enabling the collection of adequate data to facilitate exploration of a phenomenon.

Table 4-1. Overview of focus groups

Participants*	Starting year 1		Ending year 1	
Group	A	B	A	B+
Venue	University 1	University 2	University 1	University 2
Participants*	**Starting year 2**		**Ending year 2**	
Group	C	D	C	D
Venue	University 1	University 2	University 1	University 2
Participants*	**Starting year 3**		**Ending year 3**	
Group	E#	F	E#	F
Venue	University 1	University 2	University 1	University 2

Notes
***The same participants from each year group were invited to both focus groups**
+Focus group was planned but had to be cancelled as the timing of the participants' lecture was changed and clashed with focus group
#Focus groups were planned but didn't take place because it proved impossible to schedule at a time when the participants were attending university-based teaching at the same time.

Krueger (2014) recommends that the length of time needed for a focus group varies between 45 and 120 minutes. In deciding the length of time allocated to each focus group in this study, the ethical issue of placing an unnecessary burden on participants without legitimately adding value to the data was carefully considered, so it was decided that each focus group would aim to last between 45 and 60 minutes. The location of each focus group and seating arrangement for participants were also carefully considered. Discussion in a focus group is enhanced by the location and surroundings, which can set a positive tone and provide a comfortable, relaxed and informal environment conducive to productive discussion (Hennink, 2007). Focus groups were therefore planned to be held in an appropriate classroom at the participants' university, a setting they were familiar with. Within the classroom the seats for the participants and me were arranged in a small circle, ensuring that all those taking part could see each other and were sufficiently close enough to be able to easily hear conversation, but not so close that it felt inhibiting. All focus groups were arranged at a time when participants were attending theory sessions, so they did not incur additional travel costs.

Each focus group included participants at the same stage in the nursing programme and I facilitated the exchange of views within the group rather than being central in the discussion. As recommended by Grealish and Trevitt (2005) I aimed to remain ‘outside’ the discussion, although I did encourage comment from the quieter participants. In moderating the focus groups I adopted the role of a naïve listener and sought clarification when it was required. I also used every potential opportunity to build trust and rapport by, for example, providing clear and consistent information and offering time for questions to be asked and answered.

Focus groups characteristically capitalise on the synergy arising from interactions of the members (Carey, 2016), which in turn encourages participation. Factors which prevent participants from contributing to focus groups are: feeling unable to contribute due to the presence of the researcher or because other participants are very verbose, or feeling the need to give socially desirable or expected answers (Bergen and Labonté, 2020). Participants can also be concerned about possible further contact with others in the focus group who may know more about an individual’s views than they would normally share (Krueger, 2014). Within each of the focus groups my aim was to achieve an approach which enabled the collection of rich data and made the experience interesting and as stress-free and enjoyable as possible for participants. I aimed to make the participants feel physically and mentally comfortable by being clear in my communication and approachable in my manner, promoting a supportive, inclusive atmosphere and encouraging contributions from all.

Each focus group was digitally audio-recorded, although it is recognised that this can make some people feel nervous or self-conscious so may inhibit participants’ ability to express their views. If participants are nervous or self-conscious during the focus group their discussions may not be natural or free-flowing which could negatively impact the quality of the data collected (Hennink et al., 2019). Despite this the focus groups were audio-recorded to ensure that all discussion, including silence, was accurately captured.

All focus groups followed the same format, following a focus group guide (see Appendix 10) and were moderated by me. The focus group guide was purposely developed to be a simple list of bullet points that assisted in ensuring all the required areas were addressed. The material included started with general issues concerning the running of the session and then moved to the consideration of the vignettes (discussed in detail later in this section) and ended with the participants identifying what they felt was the most important aspect of discussion and concluding remarks. My aim was that for the guide to assist me to provide sufficient structure to instigate discussion, which would then be developed by the participants. The focus group guide was devised in consultation with the PPIRes group and was modified following feedback from the participants of the pilot focus group (discussed in further detail later in this section).

A note-taker, who was one of the research supervisors, attended all focus groups. Their remit was to record any relevant non-verbal communication or actions that accompanied the discussion. Having a note-taker is a commonly-utilised strategy, which enables the focus group moderator to focus on participant interaction and to stimulate discussion, rather than being distracted by the process of note-taking (Sim and Waterfield, 2019). The note-taker did not take any part in discussion and was seated outside of the circle of chairs occupied by the participants and me. The role of the note-taker was explained to participants prior to the start of data collection.

Vignettes were used as a trigger for discussion in all focus groups (see Appendix 11). These took the form of scenarios focusing on the story of a person receiving care, in which the attributes of health and illness ascertained from the concept analyses reported in Chapter 3 were reflected. Each vignette was composed of stimuli which represented tangible and detailed descriptions of social circumstances and situations, which enabled participants to express their beliefs and values in concrete contexts rather than abstract ones (Alexander and Becker, 1978). Such an approach enabled access to the participants' own ideas in rich detail and provided an opportunity for them to speak without feeling threatened or needing to discuss their personal information (Easter et al., 2007). This also enabled participants to express their views and interact with others more effectively and, because discussing similar vignettes is a frequently-used tool in nurse education (NMC, 2018c), this is an approach participants were familiar with.

Each of the vignettes was developed following the approach outlined by Liyanapathirana et al. (2016), which included reviewing by experts, who were three research-active and clinically-credible nurse educators/practitioners and one of the research supervisors, to confirm the realness of the hypothetical situation presented, following the process detailed in Figure 4-3. The modified vignettes were then tested at the pilot focus group (discussed later in this section). The application of this process enhanced reliability and validity (Randall and Gibson, 1990).

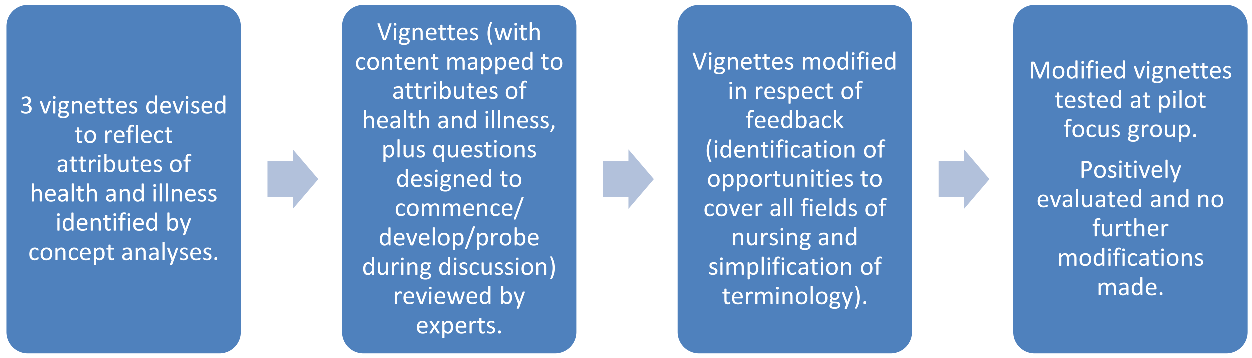


Figure 4-3. Development process for vignettes

Focus groups lasted between 25 minutes and 71 minutes, with the majority lasting between 30 and 60 minutes. After completion of each focus group, the audio-recording was transcribed verbatim by me, within 24 hours, with the transcription supplemented with the note-taker’s observations.

Prior to any focus groups being undertaken for data collection a pilot focus group was held to test the approach planned. Five participants were at the pilot focus group, all were nursing students in various years of their programme and provided useful feedback. They agreed that how the group had been run made them feel able to contribute to discussion and that their comments had been valued. They also felt that their awareness of the audio-recording, although making them feel uncomfortable at first, had soon been forgotten and did not constrain their responses. The vignettes were thought to be true to life and good for triggering discussion, enabling participants to feel comfortable with the topic and the group. Participants suggested that at the end of the session, they should be asked to identify one aspect of discussion that they felt was the most important to them, a modification which was made to the focus group guide. Having the opportunity to act as a focus group moderator prior to data collection was invaluable, allowing me to test the audio-recording technology and increase my confidence in undertaking the focus groups.

4.5.2 Interviews

Once the focus groups and their data analysis had been completed, I became aware that I needed further data. The iterative approach to data collection in GT enables researchers to be flexible, with the ongoing, cyclical nature of data collection maximising opportunities to elaborate emerging theory (Charmaz, 2014). To be able discuss issues emerging in the data and elaborate this further I wanted to talk individually with the participants.

The interview techniques applied in qualitative research are underpinned by three approaches, a structured, unstructured, or semi-structured format (Patton, 2014). In consideration of these approaches, the application of a structured interview was not considered sufficiently flexible to produce the rich data desired. Although Corbin and Strauss (2008) advise that an unstructured interview approach will produce the richest data, undertaking such a method requires a researcher highly skilled and experienced in interviewing. There is a compromise approach, however: a semi-structured interview using a flexible topic guide to aid the researcher’s focus.

Thus individual semi-structured interviews were chosen because they provided the opportunity to discuss the identified topics outlined in the semi-structured interview guide (see Appendix 12) individually with participants, to obtain in-depth responses about experience, perception, opinions, feelings and knowledge (Patton, 2014). In GT research the co-construction of meaning between the participants and researcher is fundamental in theory development (Charmaz, 2014), the depth of response was viewed as critical in developing the categories emerging from the research data already collected. The semi-structured interview guide was developed in consultation with the research supervisors to assist me to focus my discussion on the areas of the developing data categories, acting as a prompt to enable me to ask questions targeting these areas, but allowing the participant to develop the conversation in whatever manner reflected their perspective. As more data were gathered it was possible to develop the categories further, so there was corresponding modification of the focus of questions.

As the interviews were undertaken at a time when safety needed to be assured from infection risk for all involved, they were undertaken remotely, using an online platform of the participant's choice (e.g., MS Teams). Although according to Namey et al. (2020), such an approach can be applied without a reduction in the quality of findings, Abrams et al. (2015) and Woodyatt et al. (2016) identify a smaller volume of information resulting from online data collection than face-to-face. The content generated online, however, was seen to be contextually similar to that generated face-to-face (Synnot et al., 2014, Abrams et al., 2015, Woodyatt et al., 2016). Regarding the approach used by participants to describe experiences in online data collection approaches, Campbell et al. (2001) found that participants were less expansive in their use of stories and narrative, an approach which can help add context for analysis. This finding was later supported by Namey et al. (2020). While online approaches may still be able to provide the rich data I required, enabling clarification and understanding of the emerging data categories, there did seem to be differences between the type of data likely to be collected.

Collecting data online presented the challenge of being remote and that in our communication, which could possibly involve the consideration of distressing experiences, we would be physically apart. Therefore, the approach of ensuring that another individual who knew the participants was available, if need arose, was reinstituted and details of individuals and groups who could provide further sources of assistance were added to the PIS 2 (see Appendix 6). I also sought advice from the PPIRes group who felt that the approach being adopted and the additional measures taken were acceptable and had nothing further to add. The approach was also approved by the University's research ethics committee, which reviewed the plan for the online data collection and provided formal permission that it could be carried out (see Appendix 9).

All interviews were conducted by me at a time convenient to the participant. As the interview was undertaken remotely, the participant was able to choose the location from which they joined the online platform, but in the PIS 2 a quiet and private place was suggested. All participants undertook the interview from their home. All interviews were audio-visually recorded and were transcribed verbatim by me within 24 hours, with the transcription supplemented with observations from my field notes.

As discussed in Section 4.4, the choice to undertake a total of eight interviews was guided by consensus within the literature that these, in addition to the previous focus groups, should theoretically provide sufficient data to achieve saturation.

The interviews lasted between 1 hour 10 minutes and 1 hour 57 minutes, with most being between 1 hour 10 minutes and 1 hour 20 minutes, supporting the view of Jamshed (2014) that most interviews last between 30 and 90 minutes. Topping et al. (2021) advises that the interview length should be guided by the participant, with the researcher being responsive to any signs of fatigue. Within this research I was always watchful for and responsive to any cues from the participants. Regarding the interviews, not only was the focus of discussion potentially personal and emotional, but they were undertaken at a time when participants were experiencing a high level of stress due to taking part in the national SARS-CoV-2 response (NMC, 2021a, NMC, 2022c) and completing assessments at the end of their programme. Participants were frequently offered breaks and were informed that the decision on when the interview should end was theirs. While emotions were shared during the interviews, none of the participants felt it necessary to either end their interview early or access the further sources of support offered. When asked at the end of their interview, all participants said they had enjoyed the experience of being involved in the research, with five commenting that talking about their experience had been '*helpful*', '*a good way to process experiences*' and something they would like to have done more often.

Throughout the interviews an approach of discussion clarification was used to ensure meaning was understood and to gain richer data (Irvine et al., 2013). In all interviews the participant was central and did most of the talking. Prompts and probes were used to encourage and inspire elaboration and explanation, with a flexible approach to enable participants to answer questions freely (Creswell and Poth, 2016). To end the interview the participant was asked what, out of all the things discussed, they thought was the most important, bringing the interview to a natural close (Doody and Noonan, 2013). To reduce any distraction, field notes were only taken prior to and following the interview, not during it.

Similar to the focus groups, prior to any interviews being undertaken for data collection one pilot online interview was held, with a final-year nursing student not involved in the data collection, to test the approach planned. The experience provided useful feedback on the technological aspects of the online method, highlighting issues such as ability to hear questions and how to manage any drop in signal. They also echoed the views of the participants of the pilot focus group, that while knowing they were being audio-visually recorded felt uncomfortable at first, this was soon forgotten and did not constrain their responses. The semi-structured interview guide worked to support the discussion, so was not modified. Hence, similar to the pilot focus group, having the opportunity to undertake an interview prior to data collection was invaluable, enabling the testing of my approach and the technology, which increased my confidence when undertaking interviews.

4.6 Transcription

All focus groups were recorded using two digital audio-recorders, to reduce the potential of a recording being missed. Also, the chance of being able to clearly hear all participants was increased, as there would be a greater likelihood that they were close to a recording device. All interviews were audio-visually recorded.

Focus groups and interviews were transcribed verbatim by me as soon as possible after data collection, in all cases within 24 hours of the event. Easton et al. (2000) outline the need for verbatim transcription with scrupulous attention to detail to ensure the trustworthiness of findings, which logically should be best achieved by the researcher transcribing their own data, as they have accurate knowledge of the event from their involvement (Halcomb and Davidson, 2006). Personal transcription of data also immerses the researcher in the data, encouraging reflexivity and preserving rich details that could otherwise be missed (Charmaz, 2014) and assisting to orient them to any areas needing further exploration (Gale et al., 2013).

4.6.1 Participant verification

Participant verification, also known as interview transcript review, informant feedback or member checking, is a form of respondent validation and involves the sharing and checking of transcripts or findings with research participants as a means of verification (Morse et al., 2002). It is a crucial technique for establishing credibility (Lincoln and Guba, 1985) and a way of assessing research quality (Birt et al., 2016).

To apply participant verification within this research, at the end of each focus group participants were offered the opportunity to receive, by email, an overview of the themes of discussion in the form of a bullet-pointed list (see Appendix 13 for example). The approach taken was decided in consultation with the PPIRes group and the decision was made to provide an overview of the discussion themes and ask participants to comment on the accuracy of these, rather than return the entire focus group transcript to participants for consideration. This reflected the nature of data collection in focus groups, which differ from interviews in that they are a combined group discussion, rather than the specific view of an individual, so isolating the contribution of one individual from another in a focus group could be complex. Seeking agreement from participants on a wider scale, focusing on the topics discussed and any further additions to these, or corrections, was thought to be the most useful approach.

Four focus group participants requested an overview of the themes of the discussion they participated in. All four responded to this positively, commenting, '*We talked about so many things*', '*I really enjoyed our discussion*', '*Talking with the group made me realise how much we know*', '*I've thought about our discussion and am going to think more about it when I'm next on placement*'. None asked for further explanation of the discussion or for points to be added or removed.

At the time the interviews were undertaken the participants were at the final stage of their programme. In addition to focusing on ensuring they had achieved all the clinical and academic requirements of the programme, a number were also moving out of accommodation and all were preparing to commence new jobs. In consultation with the PPIRes group, the decision was made not to add further to the demands on the participants' time, so offering participants an interview transcript or the themes of discussion to review was not undertaken.

4.7 Data Analysis

In CGT data analysis commences with initial coding, which then develops into focus coding enhanced by theoretical sensitivity. Theoretical memo-writing assists in the development of conceptual categories, which are refined by abductive theoretical sampling in an aim to achieve saturation and therefore the emergence of a theory grounded in the data (Charmaz, 2014). All of these processes, underpinned by constant comparative analysis, were applied.

4.7.1 Initial and focused coding

Data were coded, firstly using initial coding and then focused coding, in combination with the constant comparative method and ongoing consideration of memos. This involved the practical steps of reading and re-reading transcripts until understanding emerged and then the data were broken down line by line and labelled (line-by-line coding). Firstly, the labels were simple words reflecting actions or processes in the form of gerunds or in vivo codes (codes using participants' terms), which were eventually further developed into conceptual codes.

The conceptual codes were read and, in combination with the process of constant comparison, grouped into categories based on shared characteristics,

> '*using the most significant and/or frequent earlier codes to sift through and analyse large amounts of data*'
>
> (Charmaz, 2014, p. 138)

Decisions were made about which initial codes made the most analytic sense to categorise data in a move to focused coding, where frequently-occurring initial codes of significance were identified and organised into a higher level of conceptualisation. These categories were then read to examine whether further links could be made to distinguish between fully formed and sub-categories. Tentative categories were therefore developed to advance the theoretical direction of the analysis (Charmaz, 2014) and highlight gaps in the data to inform theoretical sampling decisions.

Coding took place using paper copies of transcripts generated in Microsoft Word, with transcripts including observations from the note-taker in the focus groups, my observations, thoughts and comments relating to the data collection interaction, plus any other relevant information, such as non-verbal signs or communication. Initial coding was duplicated independently, for 20% of the transcripts, by either one of the research supervisors or a research-active nurse lecturer with a

PhD qualification. Relating to the focus groups, one of the nine transcripts was fully coded independently and three were partially coded independently and for the interviews two were partially coded independently. Following the duplicate coding the overall approach to coding was discussed and the rationale behind any differences considered. In each instance the differences were minor, agreement was reached on how to proceed and any changes added into the coding. Focused coding was not independently duplicated, but decisions made and the emerging categories plus the developing theory were discussed at monthly supervision meetings. This was supplemented by informal discussions with other postgraduate students, plus ongoing peer discussions with the individual who undertook the duplicate coding.

Theoretical coding was applied as a second stage of focused coding to conceptualise

> '*how the substantive codes may relate to each other as hypotheses to be integrated into a theory*'
>
> (Glaser, 1978, p. 72)

and theorise from the data.

The approach taken was iterative and dynamic, occurring simultaneously with data collection. It was also important to constantly remind myself to remain open to a wide range of possibilities, as a measure to assist the emerging theory to be fully uncovered. Coding requires constant reflexivity, as there is the need to make sound decisions from the start, recording these carefully so they can be reviewed, as they will influence future decisions. The coding process was also far from linear, with focused coding not always immediately following initial coding.

4.7.2 Constant comparative analysis

Data were analysed using the constant comparative method, a feature of GT research. Glaser and Strauss (1967) identify constant comparative analysis as a method that researchers apply to make comparisons between all data as analysis develops. Using this approach data can be compared to identify similarities, differences and variations, to construct a theory. Applying a sequential approach, comparing early data with that emerging later, enables clarification of existing codes, plus the recognition of new codes which may not have fully emerged. Theoretical sampling can then be applied to collect the additional data required for clarification (Charmaz, 2014). Thus the findings reported in this thesis are due to constant iterative data integration. The first set of focus groups provided the early data. All data collected (information from focus groups, individual interviews, observations from field notes, insights from theoretical memos, diagrams, drawings and reflective journal entries) contributed to answering the research questions and underpins the construction of the theory. This process of data addition and refining using constant comparative analysis is pictured in Figure 4-4, where the aim was, by using an interpretative approach across all elements of the data, for a grounded theory to emerge.

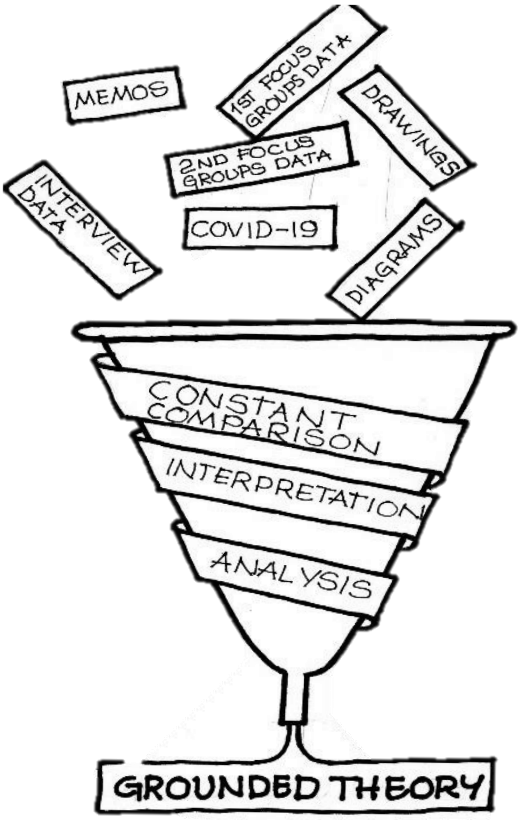


Figure 4-4. The refining process

As the analytical thinking advanced and new data were generated during this refining process, existing categories of data were adapted, rebuilt, or refined to capture the new information. Data collection activities resulted in an increasing number of codes which were used to populate, develop and define the properties of existing categories or, where relevant, create new ones. The new codes also helped to clarify which categories should be integrated, as the new codes made it evident that they shared the same properties. As the number of codes increased, it became clear that some of what had initially been viewed as independent categories were sub-categories of an overarching category.

Category grids, as shown in Table 4-2, were used as a framework to support this refinement. These grids proved to be fundamental to the process working effectively, functioning to provide a stimulus for analytical thinking and an effective audit trail of changes made. Within the grids a recording system was devised that enabled clear identification of the precise location of the original data (for example see **^** Table 4-2) plus the identification of which sub-categories had been integrated to form components of an overarching category (for example see **#** Table 4-2). Brief summaries of each of the integrated sub-categories were also included in the category grid, which served as a link between the content of the category grids and the insights gained from the theoretical memos, field notes, diagrams, drawings, or reflective journal entries. Applying this detailed level of recording not only made it simpler for the data to be viewed, developed and refined but also maintained a consistent, systematic and meticulous approach to the management of the large amounts of data collected.

Table 4-2. Example of a category grid

Category name - **Developing a Nursing Lexicon**	
Integrated sub-categories	Codes
Defining illness	The term illness has different meanings - **^** 1fg-K47
	Views of wellness and illness differ - 1fg-K24
	Poor health isn't illness - 1fg-K1
	Poor health isn't illness - 3fg-K3
	Diabetes isn't an illness - 2fg-K27
	A life-long condition isn't an illness - 5fg-K25
	Long-term conditions are not illness - P5 Int p4
	A cold is an illness - P6 Int p6
	Summary - Views of what constitutes health or illness vary.
# *Time*	
	Timescales are important in illness - 1fg-K48
	Being ill takes up lots of time - P10 Int p16
	Illness is short term - 2fg-K45
	Illness can escalate rapidly - 5fg-K36
	Long-term conditions can be illnesses at first, but this can alter with time - 3fg-K49
	Summary - The passage of time can alter the impact of illness.
Challenges	Sudden illness is traumatic for patient and family - 1fg-K42
	Illness leaves a long-term impact on a family - 1fg-K44
	Illness is a shock for the patient and family - 4fg-K38
	The uncertainty of illness is a challenge - 5fg-K60
	Summary - Illness is challenging, traumatic and the outcome is uncertain.
Defining health	Well can mean differing things - 1fg-K16
	Health can mean being well, or living healthily with illness - 2fg-K17
	Health is being able to do what you need to - 3fg-K21
	Summary – 'Health' is individually defined

^ 1fg-K47 identifies the location of this code in the original data transcript

names in italics identify sub-categories integrated in the overarching category 'Developing a Nursing Lexicon'

Charmaz (2006) acknowledges that the prior knowledge and experience of the researcher, combined with their developing theoretical sensitivity, drive this process as they seek to make analytical sense of the data they have gathered. Reflexivity is an essential element in this process to assist pre-judgements to be avoided, assisting the researcher to remain open and to attempt to view the situation through the eyes of the research participants. There is, however, inherent subjectivity in a researcher's construction and interpretation of the data, which is acknowledged by Charmaz and Mitchell (1996) and Charmaz (2000, 2017). This subjectivity also accounts for 'Charmazian grounded theory' being termed constructivist, in that it places researchers in the position of an author of the reconstruction of experience influenced by historical and cultural contexts (Mills et al., 2006).

4.7.3 Theoretical memos and diagrams

The construction of theoretical memos is an important strategy in data analysis and is fundamental in the chronology of a researcher's rationalisations of what they perceive the data to be revealing (Charmaz, 2006, 2014). Memos may need to be written at unanticipated and inconvenient moments, but if they are not recorded at this point data revelation may wane, with the theory failing to develop (Birks et al., 2008). Theoretical memo-writing is a crucial methodological link that enables a researcher to transform the data into a theory, by developing raw data to an advanced level of theoretical abstraction (Charmaz, 2014). As shown in Figure 4-5, theoretical memoing was also used to assist and develop the understanding of what was being revealed within the data. The theoretical memos were written as and when they came to mind, jotted down to capture the thinking exactly as it occurred and then reviewed, revised and advanced to provide insight into what was emerging.

Theoretical Memo: 25th June 2020

What I am seeing so far in the data are that the participants are viewing health and illness as being subjective and complex. Both health and illness are being seen as concepts that are multi-dimensional; they have significance that is individual to the participants and the data seems to be suggesting they can be context specific. There are also similarities in how health and illness are being perceived.

Participants understand that their views of health and illness will not necessarily be the same as the individuals they are caring for, or those who are also participating in the delivery of care. Factors influencing views are both intrinsic and extrinsic, responses to and learning from prior experience, these can be either personal or professional – the key issue is that the participant sees them as being of significance.

The impact of environments external to the participant are also relevant. The approach of a clinical placement to health and illness can influence participant's views. So, while a participant's perception is influenced by their personal approach, their intrinsic qualities and attributes, extrinsic factors matter too.

Figure 4-5. Example of a theoretical memo

Theoretical abstraction can also be developed by drawing theoretical diagrams, to clarify links between codes and potential categories. As Charmaz (2014) highlights, diagramming can be a visual representation of a researcher's ideas, which can be an extension of theoretical memos. Thus, diagramming strategies are flexible and can be adopted by researchers as they feel appropriate (Kennedy-Lewis, 2014), although Glaser (1992) and Charmaz (2014) recommend the researcher ensures they are not forcing the data in doing this.

To further prompt and develop analytical thinking, therefore, data were also viewed in the visual format of drawings and diagrams. According to Milani and Schoonderbeek (2010) drawings and diagrams can be subjective expressions of the inner vision of those creating them. At a time when I could not clearly verbalise my inner visions, the processes involved in developing simple drawings and diagrams enabled theoretical links and/or relationships to be recognised and allowed me to express my conceptions. The production of the visual material assisted in the recognition of precisely what it was that the participants were identifying as significant. This clarity was fundamentally important in the creation of possible ways to demonstrate how this related to their personal and professional learning and development regarding their views of health and illness during the nursing programme.

These simple drawings and diagrams have been included in the thesis, as they proved to be an excellent way to clearly present information gained in the research.

4.8 Theoretical Sensitivity

Theoretical sensitivity essentially refers to a researcher's insight, being able to give meaning to the data, understand what it says and being able to separate out what is relevant and what is not (Birks and Mills, 2022). In this way a theory that is grounded, theoretically dense and cohesive is developed (Noble and Mitchell, 2016).

A researcher develops their sensitivity from what Strauss and Corbin (1998) identify as a number of sources, including: a rich understanding of the relevant literature, understanding of the events being explored from personal and/or professional experience and the application of analytic processes, enabling insight and understanding of the phenomena. Within this research the research methodology and methods have been chosen or developed to assist me to achieve this.

4.9 Theoretical Saturation

According to Charmaz (2012), theoretical saturation is the process by which GT research can move beyond conjecture because theoretical categories are supported by robust data. Although the origins of theoretical saturation are in GT (Glaser and Strauss, 1967), it is now accepted in a range of approaches to qualitative research as being the criterion for discontinuing data collection and/or analysis (Saunders et al., 2018). Theoretical saturation is achieved when no new concepts or category properties emerge and patterns in data are explained (Charmaz, 2014, Birks and Mills, 2022). This, however, is a somewhat simplistic interpretation, as Hennink et al. (2017) present the perspective that there is a potential difference between code saturation and meaning saturation and that they may not be achieved together. In practice, while the researcher may have heard it all (code saturation), they may not have understood it all (meaning saturation). In response to this, I took a reflexive approach to my analysis, constantly questioning my understanding. This was used as a focus for discussion with the research supervisors which assisted me to appreciate, contemplate and reflect further on differing perspectives.

Theoretical saturation is a judgement and proclaiming it is challenging (Charmaz, 2012, 2014, 2017, Hennink et al., 2017, Saunders et al., 2018) as it is an imprecise measure which potentially results in categories suggested by data rather than saturated by it (Dey, 2004).

Regarding data collection for this research, no new codes or meanings were revealed in the data added after interview four. Therefore, at this stage in the research, through the process of constant comparison during the final four interviews codes were re-ordered and the development of categories continued. Throughout the final four interviews, while I remained conscious of the need to listen carefully to hearing anything new and being open to this, the focus moved to addressing perceived gaps in the data, with the use of theoretical sampling to ensure that data were as saturated as possible.

4.10 Selecting and Including Quotes from the Data

Throughout the thesis the ongoing narrative and resultant discussion are interlaced with a selection of quotes from participants taken from the data transcripts. Such an approach has been adopted for two reasons. First, using quotes in the participant's own voice presents their perspective authentically by outlining their experience and illustrating how they have been affected in their own words. This reflects a constructivist approach, with the world being understood as a product of the experience of experience (Charmaz, 2014). Second, quotes have been selected and included as a means of elucidating the analytical processes, using the participant's voice to support and illustrate interpretations and explanations of the data to deepen understanding of the topic under consideration. At all times the quotations selected have been used in a way that is respectful of the participants and maintains confidentiality. Using the voice of the participants to add their real-life experience to the thesis serves to bring the content to life and permits the reader to enter into the situation being presented (Patton, 2014). There does, however, need to be some caution with such an approach as using contentious examples of participant views anecdotally provides neither an in-depth focus for discussion nor validation of the analytical processes employed (Silverman, 2019). Quotations included throughout the thesis, therefore, have been selected not only to enhance readability, add vividness to the account and aid communication (Eldh et al., 2020) but also to include original data to enable the reader to assess the credibility of the analysis and strengthen the dependability of the findings. To reduce bias in my selection of quotes, to present an accurate presentation of reality rather than only the data I thought was relevant, a reflexive approach was maintained and my choices were discussed and debated with the research supervisors.

Methodologically in a GT study the findings are conceptual and expected to speak for themselves (Glaser and Strauss, 1967, Glaser, 1978), with the outcome of the research being a comprehensive understanding of meaning and behaviour presented as concepts (Glaser, 1978). While the aim of this research is therefore to capture the participants' perspectives as a whole (Ricoeur, 1992), the sharing of the participants' contributions in their own words in identified quotations adds clarity to and illustrates how the findings and interpretations have arisen, plus how meaning has been constructed from these. As the quotes are direct extracts from the data, they act as a source of support for the claims I am making and contribute to analytical transparency. Returning to the theme of caution, however, while it may be tempting to add drama to the narrative by focusing on controversial perspectives, if these views are 'outliers' their value in enhancing an understanding of the analysis is limited. Thus, unless identified to support an individual's view, quotations have been selected because they are representative of the entire range of the data. To enhance the clarity of the analytical processes, quotations are accompanied by an interpretative commentary. This interpretative commentary identifies either how the quote serves to support the findings or a relevant issue to demonstrate analytical transparency.

Quotations, as far as possible, have been reproduced precisely. Any modifications deemed necessary have been limited, made only to protect the confidentiality of the participant, clinical environment, or location, or to enhance understandability. Participants' words, grammar and syntax differ from mine but have been preserved to retain authenticity, replicating the participants' own words if they do not detract from the readability of the quote. To identify the source of each quotation, a consistent system of identification was devised. This system has two elements. The first element is a pseudonym, giving all participants a fictitious name. The second element is the participant's year of study when they provided the quote, indicating whether they are a 1st-, 2nd-, or 3rd-year student. This has resulted in identifiers such as 'Florence 1st year' or 'Lizzie 2nd year', for example. As some participants took part in the research in more than one year of study, some names ('Florence' as an example) contribute both as 'Florence 1st year' and

'Florence 3rd year'. In three instances the participant pseudonym was not provided to ensure confidentiality was maintained. Further details relating to participants are presented in Table 5-2.

4.11 Reflexivity, Trustworthiness and Credibility

Reflexivity involves acknowledging the researcher as the central figure who collects, interprets and constructs a representative view of the research findings and is an integral part of implementing robust research practice and, ultimately, enhancing trustworthiness (Birks et al., 2019, Birks and Mills, 2022). According to Malacrida (2007), reflexivity offers a positive contribution to research and can transform challenges a researcher may face into an opportunity for insight and learning. An important aspect of the process of reflexivity is the acknowledgement that meaning is negotiated within a particular social, historical and cultural context, where a researcher's subjectivity becomes entangled with the lives of others (Denzin, 1997). Thus, each researcher brings their own perspective to the data and others may discover alternatives (Yao and Vital, 2018).

Finlay and Gough (2003, p. 16) identify that the primary aims of reflexivity are to:

- Explore the impact of the position, perspective and presence of the researcher
- Promote insight through examining personal responses and interpersonal dynamics
- Uncover unconscious and implicit biases
- Evaluate the research process, method and outcomes
- Facilitate scrutiny of the integrity of the research to enhance trustworthiness

Focusing on the primary aims outlined by Finlay and Gough (2003), reflexivity is applied throughout this research as a tool to support decision-making and enhance trustworthiness and credibility.

At the start of the research I recognised the need to apply a reflexive approach in order to acknowledge my position within it and comprehend my influence on the study, the findings and the emergent theory. I was also aware that to maintain the trustworthiness of CGT research, a researcher should make explicit the existing knowledge, experience and insights that they bring to the research and document this for clarity (McGhee et al., 2007, Charmaz, 2014). To achieve this Archer (2007) advises that reflexivity is best attained through a series of internal conversations, giving due consideration to emotional responses, sensations and feelings. Much of the reflexive writing in this work has been developed from discussions with myself, the research supervisors and the PPIRes group. Prior to data collection I also arranged for a research-active colleague to interview me to identify my views and experiences of health and illness. This interview was recorded and enabled the revealing of my perceptions at that point and, at a later point, me to appreciate development in my perspective. These approaches made it possible to tease out my emotional reactions, sensations and feelings in response to experiences, many of which occurred some considerable time ago and explore the overall impact they had. These reflexive discussions were developed into passages of reflexive writing (see Appendix 14), in which I aimed to establish my position in this research, clarify my prior knowledge, experience and insight and consider the impact this could have on the theory emerging from this research.

Corbin and Strauss (2008) advise that researchers can fail to appreciate what the data are telling them because they cannot divorce themselves from their experience, their assumptions and the literature they have read. As it is the researcher who chooses both how the voices of the participants are represented and which transcript extracts are presented as evidence, being able to understand how personal experience and assumptions, plus other influences such as the literature, impacts data analysis is essential. I was especially sensitive not only to the impact of my previous personal and professional experiences but also to my emotions. Emotional responses shape our interpretations (Mauthner and Doucet, 2003) and in this research many of the experiences participants shared with me in the individual interviews reflecting caring for persons during the SARS-CoV-2 pandemic were emotional for us both. There were also other discussions, in the focus groups and interviews, where student experiences made me emotional. To recognise the potential influence my emotional responses could have and enable me to fully appreciate this, I applied the approach detailed by Mauthner and Doucet (1998) (see Appendix 15). In this approach the participants' words are presented in one column and researcher reactions and interpretations in an adjacent column. I was able to examine where and how my emotions, and the assumptions and views based on these, may be influencing my interpretation of what the participant is saying and how I represent the person. In this way I was able to

> '*retain some grasp over the boundary between the respondent's narrative and my interpretation*'
>
> (Mauthner and Doucet, 2003)

4.12 Conclusion

Within this chapter the research methods implemented were outlined, with a rationale for their adoption. Ethical issues, sampling, recruitment and data collection were explored in detail providing clear insight into the approach taken. A transparent account of the processes applied in data analysis has been provided and reflexivity at all stages of the research has been considered, with identification of key actions taken to illustrate this. The chapter describes a robust and rigorous approach to the CGT methods implemented. This enhanced the credibility of the research and contributed to overall trustworthiness of the research.

This chapter ends Part Two of the thesis, which considered research methodology and methods. Part Three, which follows, reports the research findings and commences with a chapter introducing the findings.

Part Three – Reporting the Research Findings

'The participants have trusted me with so much to say – so much of which needs to be said……..but how do I say it?'

Reflective Journal Entry 27.09.2021

Chapter 5 Introducing the Findings

'and some features have been surprising'

Reflective Journal Entry 23.02.2023

5.1 Introduction

In the previous part of the thesis, the methodology and methods implemented throughout the research process were outlined. Part Three of the thesis here reports the findings resulting from the research methodology and methods described.

The focus in this chapter is on introducing the findings reported in the rest of this Part and identifying contextual features relevant to them. To achieve this the chapter begins by providing an outline of the profiles of the research locations, followed by consideration of the experience of undertaking theoretical sampling during the SARS-CoV-2 pandemic. An overview of the flow of research activity is then outlined, providing a clear summary of how the research methods described in Chapter 4 were implemented with the numbers of participants recruited identified. Discussion then continues to provide further details as on the characteristics of the research participants.

The chapter concludes by identifying and introducing the emergent grounded theory and emergent data categories which will be deliberated in the subsequent chapters of this Part of the thesis.

5.2 Profiles of the Research Locations

There were two research locations, referred to throughout the research as 'University 1' and 'University 2'. Both universities were in England and offered pre-registration nurse education programmes. To become a Registered Nurse in England, in common with all countries of the UK, it is necessary to successfully complete a degree-level pre-registration programme. This programme has to be delivered by an educational institution which has been approved by the NMC (NMC, 2022a). All UK pre-registration nursing programmes are regulated by the NMC and provide professional education based on standards devised by the NMC. This results in pre-registration nursing programmes being initially validated by the NMC, which also review the institutions offering the programmes on a regular basis (NMC, 2018c). While there may be local differences in how the programmes are delivered by individual approved educational institutions, the content of the programme plus the amount of time spent in university-based learning and learning in clinical placement will be consistent.

All research participants were undertaking a pre-registration nursing degree at Bachelor's level at either University 1 or University 2. This entailed a full-time, three-year study programme, with students spending 50% of their time in academic study and 50% of their time in clinical placement. At both universities successful completion of the pre-registration nursing programme leads to

1. the opportunity to apply for professional registration with the NMC, which is essential to practise as a Registered Nurse in the UK. This professional registration identifies the nursing 'field' of study, specifying the category of persons the student has studied the care of, which can be adult, child, mental health or learning disability;
2. the academic award of a Bachelor of Science (BSc) Nursing. This academic award also recognises the nursing fields of study, so would be BSc Adult Nursing, BSc Child Nursing, BSc Mental Health Nursing or BSc Learning Disability Nursing.

University 1 and University 2 had a similar profile regarding their overall provision of nursing education, offering a comprehensive range at undergraduate and post-graduate level for all fields of nursing. A UK Registered Nurse will normally be registered in one, but sometimes more, of these fields. Differences between the universities were that University 2 had a broader provision of healthcare programmes, offering undergraduate education for a wide range of healthcare disciplines including medicine, midwifery, occupational therapy, operating department practice, paramedic science, pharmacy, physiotherapy, social work, speech and language therapy. The provision at University 1 of education for healthcare disciplines other than nursing was less extensive, offering midwifery and social work. University 2 also had a larger number of research themes under exploration than University 1, with higher numbers of research-active faculty and was a more research-intensive environment in which to study (REF, 2021).

University 1 is in an urban area on the outskirts of a large city in a metropolitan setting. The university is consistently rated as one of the top 50 institutions in the UK and has a total of 18,800 students (University 1, 2022). Within this total student population 28% travel from overseas to undertake their studies, 52.5% of all students are defined as being mature (21 years of age or over) and 66.2% of all students are Black, Asian, and Minority Ethnic (BAME). Approximately 280 students commence the full-time undergraduate BSc Nursing programme at University 1 each year, of which 87.8% are female and 12.2% male (University 1, 2022).

University 2 is in the countryside, on the outskirts of a small city within a rural county (University 2, 2022). The university is consistently rated as one of the top 25 universities in the UK and has a total of 17,000 students. Of these 54% originate from the county surrounding the university and 15% travel from overseas to undertake their studies, 76% are less than 21 years of age and 27.4% of the total students are BAME. Approximately 240 students commence the full-time undergraduate BSc Nursing programme at University 2 each year, of which 90% are female and 10% are male (University 2, 2021).

Thus, there are similarities and differences between the universities. They are similar in the respect of size of overall student population, plus they offer similar pre-registration nursing education programmes to similar numbers of students with a similar gender ratio. The marked difference is their geographical location plus the age and ethnic diversity of students. From a wider perspective there is also a difference in the possible availability of interdisciplinary healthcare learning, regarding the opportunity to study in an environment which includes students studying different healthcare professions. There is also a difference in the potential exposure of students to research-active faculty and participation in research activity.

In consideration of what these differences contribute to the research, deciding to undertake the study at just one of the locations would not have brought such diversity regarding potential research participants, their variety of experience prior to commencing a nursing programme and their range of cultural backgrounds. The contrast in the geographical locations also potentially facilitated a wider range of research participants, ranging from those who wished to study close to their existing home to those who wished to relocate to a different area of the UK, or a new country entirely. The combination of these factors is seen as strength and while they were not all explicitly explored as part of the research, they featured by increasing the richness of the resulting data and answering the research questions.

In addition to the similarities and differences in profiles of the educational institutions and the students choosing to study at each university, both research locations also contribute an individual profile regarding the persons residing in the geographical area. This profile will influence the care delivered by the students throughout their nursing programme, as the nature of the care will depend on the specific needs of the residents of the geographical area. The geographical area of each research location was composed of local authorities, as every part of England is governed by a local authority which is a layer of local government responsible for services such as housing, environmental health and rubbish collection. The area of University 1 contained a total of two local authorities and the area of University 2 contained a total of nine local authorities, which reflects the geographical area covered by University 2 being much larger than University 1. Data are available for each local authority regarding an overview of the health status of the residents (as indicated by life expectancy at birth), plus their demographic, economic and ethnic profiles. This is presented in Table 5-1, Figure 5-1, Figure 5-2 and Figure 5-3.

Table 5-1. Resident age, life expectancy and low-income family data for research locations

(ONS, 2012, Public Health England, 2016a, Public Health England, 2016b, Public Health England, 2016c, ONS, 2021, ONS, 2023)

University 1 clinical placement areas		
Local authority 1	Local authority 2	
• 12% (nationally low) of children live in low-income families. • Life expectancy higher than average. • Average age 37.4 years. • 13.3% aged 65 years or older.	• 19% (nationally high) of children live in low-income families. • Male life expectancy less than average. • Average age 34 years. • 18.4% aged 65 years or older.	
University 2 clinical placement areas		
Local authority 3	Local authority 4	Local authority 5
• 16.1% (nationally high) of children live in low-income families. • Life expectancy higher than average. • Average age 46 years. • 25% aged 65 years or older.	• 11.6% (nationally low) of children live in low-income families. • Life expectancy higher than average. • Average age 48 years. • 25.9% aged 65 years or older.	• 10.2% (nationally low) of children live in low-income families. • Life expectancy higher than average. • Average age 40 years. • 11.5% aged 65 years or older.
University 2 clinical placement areas (continued)		
Local authority 6	Local authority 7	Local authority 8
• 14.2% (nationally high) of children live in low-income families. • Life expectancy higher than average. • Average age 49 years. • 27.8% aged 65 years or older.	• 19% (nationally high) of children live in low-income families. • Life expectancy lower than average. • Average age 44 years. • 22.9% aged 65 years or older.	• 19.6% (nationally high) of children live in low-income families. • Life expectancy lower than average. • Average age 46 years. • 24% aged 65 years or older.
University 2 clinical placement areas (continued)		
Local authority 9	Local authority 10	Local authority 11
• 17.1% (nationally high) of children live in low-income families. • Life expectancy equals average. • Average age 47 years. • 25.8% aged 65 years or older.	• 11% (nationally low) of children live in low-income families. • Life expectancy higher than average. • Average age 54 years. • 33.5% aged 65 years or older.	• 17.6% (nationally high) of children live in low-income families. • Male life expectancy less than average. • Average age 34 years. • 15% aged 65 years or older.

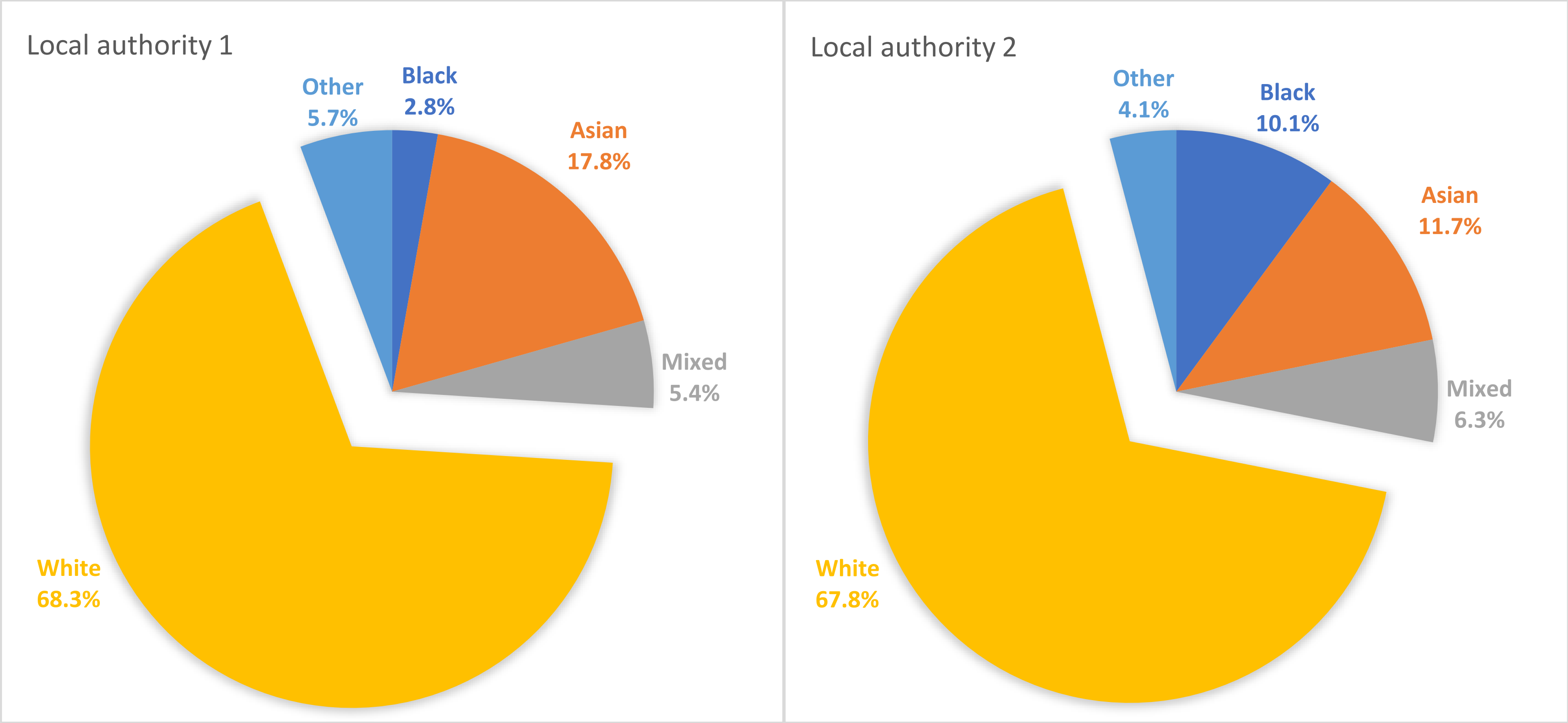


Figure 5-1. Ethnic groups of residents in University 1 local authorities
(ONS, 2023)

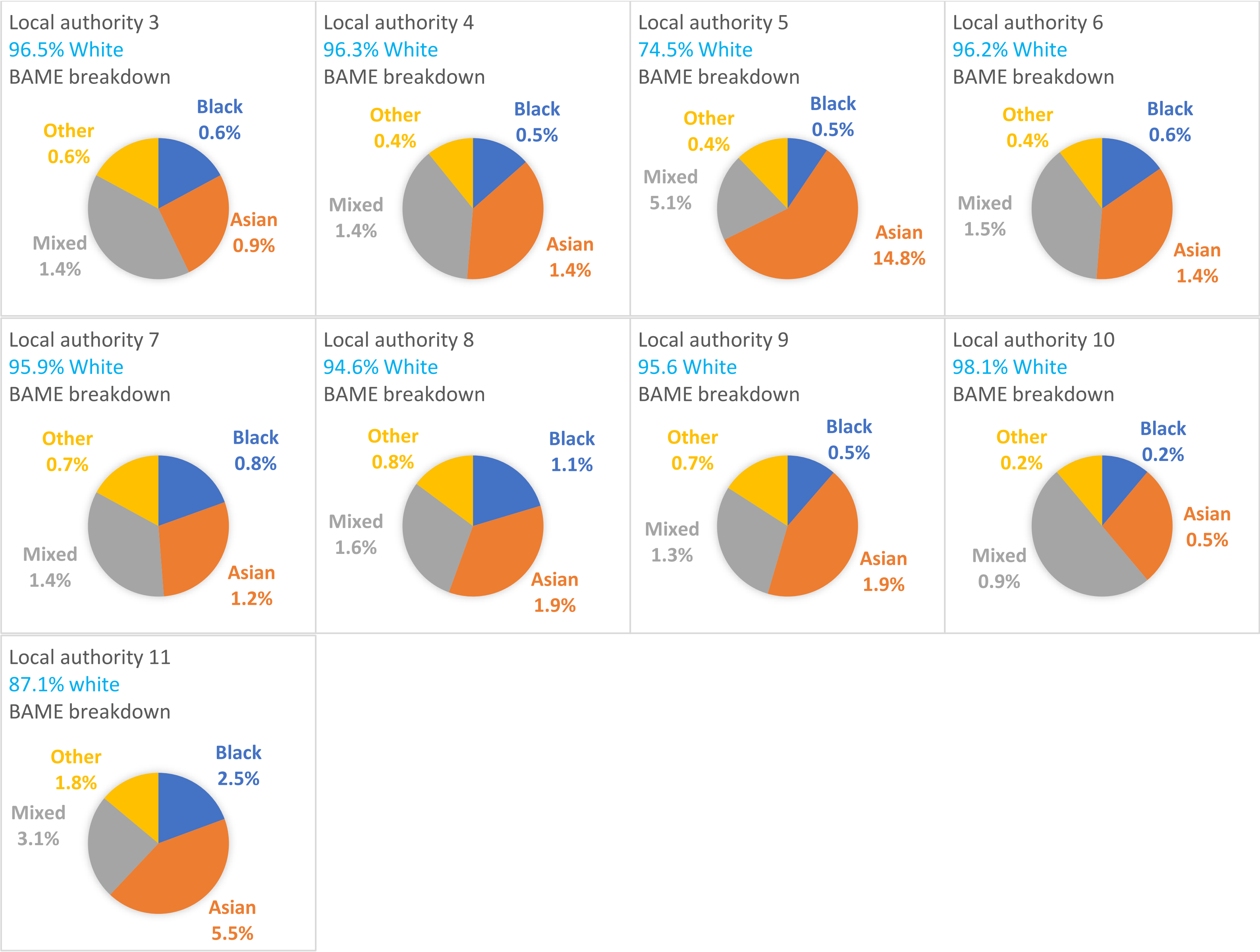


Figure 5-2. Ethnic groups of residents in University 2 local authorities (ONS, 2023)

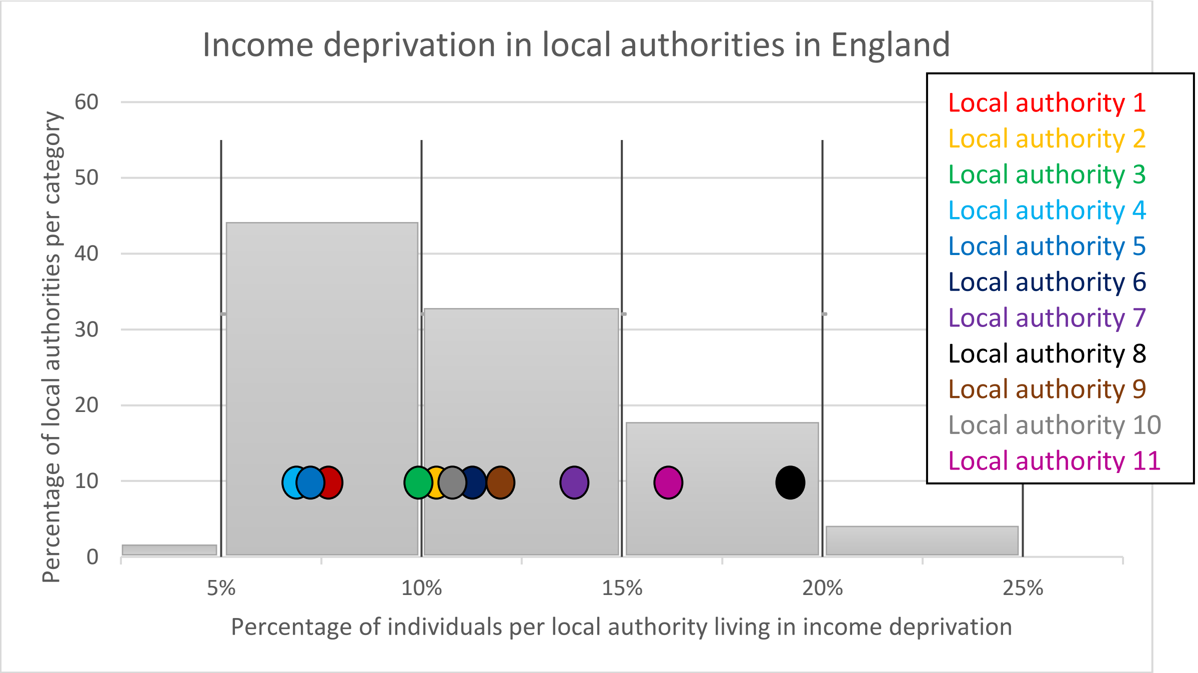


Figure 5-3. Local authorities and income deprivation
adapted from ONS (2021)

The data presented within the preceding table and figures have relevance to the research as the health status, age, income and ethnic group of residents will have an impact on the healthcare needs of the geographic areas, as discussed below. These needs, in turn, will influence the care and services the research participants are involved in delivering during their clinical placement.

While there were shared characteristics in the profiles of residents across the geographical areas, there were also differences. A clear example of difference is the older population being cared for in the clinical placement areas of University 2. The need to deliver care to individuals of older age will influence how care is being delivered to manage illness and how care delivery is organised. Generally, increasing age brings with it an increase in the complexity of health need, due to multiple underlying factors resulting in older individuals often experiencing several conditions concurrently. Care delivered to meet the needs of older individuals is more likely to be long-term and delivered within a community setting, rather than the more acute and often hospital-based services meeting the needs of younger individuals. It is likely that participants studying at University 2 will engage in a greater proportion of care delivery designed to meet the needs of older individuals, potentially in community-based settings, focusing on long-term condition management, than participants at University 1. Another difference is the ethnic diversity of the potential recipients of care residing in the geographical locations. The local authorities served by University 1 are considerably more ethnically diverse than those of University 2. Thus, it is likely that participants studying at University 1 will engage in a greater proportion of care delivery designed to meet the needs of an ethnically-diverse population than participants at University 2 and, as is highlighted in Section 5.5, the participants at University 1 are also more ethnically diverse than those at University 2.

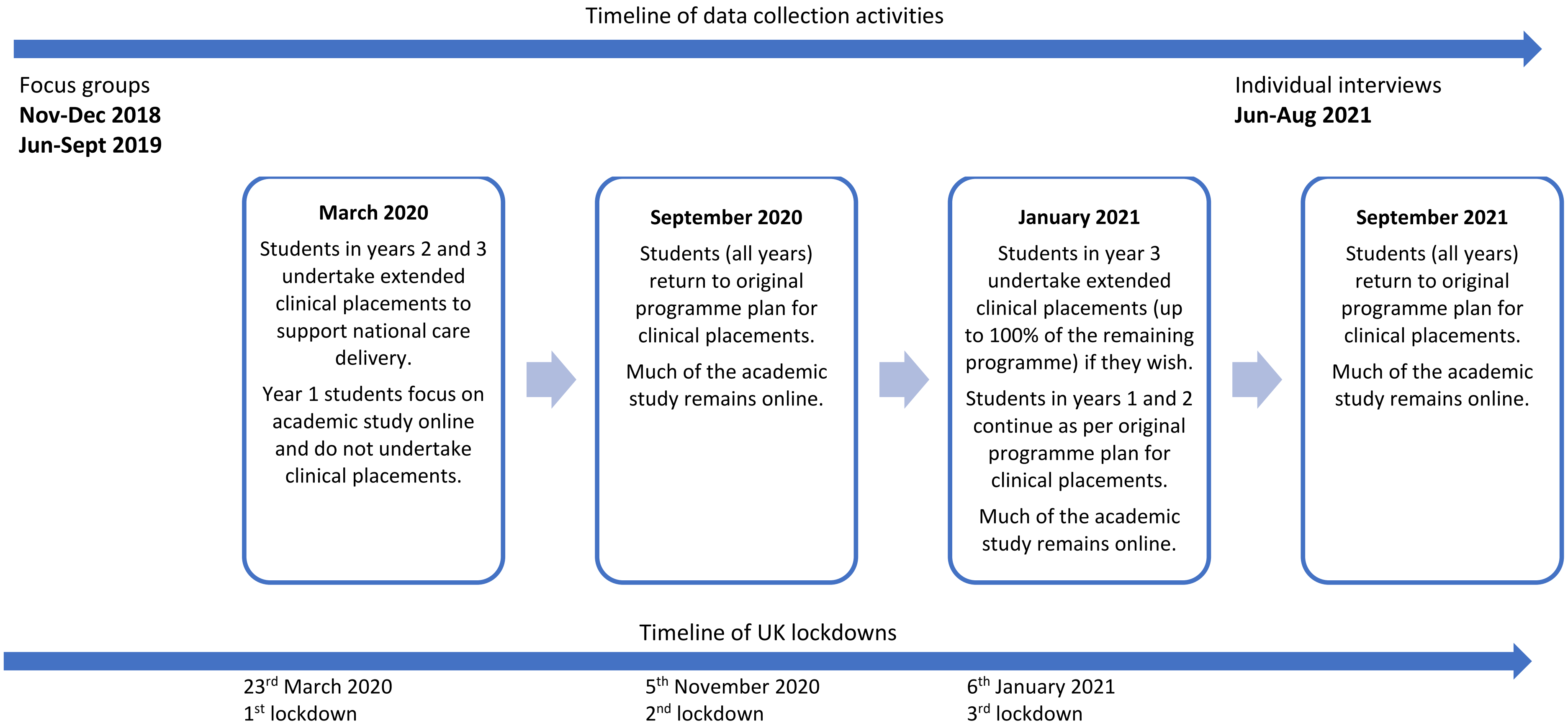
While it is accepted that there are pockets of deprivation and affluence across both geographical areas of the research locations, as no area is homogeneous, considering the areas in terms of local authorities enables some indication of difference and similarities in the economic profiles of residents. As is highlighted by Figure 5.3, the local authorities varied in levels of income deprivation, ranging from three local authorities within the 75 most affluent local authorities in England and two within the 60 most deprived. This level of data, however, needs to be treated with an element of caution, considering it represents only a very general overview regarding income deprivation, as even in local authorities with the highest average household incomes there can be some of the most income-deprived neighbourhoods (ONS, 2021). This accepted, income is known to be an important determinant of health status (WHO, 2017) and the data presented suggests that both research locations can potentially offer participants an experience of the impact of income deprivation and affluence on health and illness.

As such, the differences mentioned were seen as further benefits of having two research locations, expanding the potential for students to experience the impact that age, ethnicity and income may have on health and illness. While there was no explicit exploration of these characteristics within the research, they resulted in the participants being exposed to a variety of experience which can increase the richness of the resulting research findings and enable answering of the research questions.

5.3 Undertaking Theoretical Sampling during the SARS-CoV-2 Pandemic

While the focus group data collection and analysis had been completed prior to the start of the SARS-CoV-2 pandemic and the emerging categories had been tentatively identified, they needed further exploration. Meetings with key informants for theoretical sampling had been planned to commence in June 2021. This was at a time when, although restrictions from the third UK lockdown were lessened, with most legal limits on social contact removed (IfG, 2022), participants were still following a programme in which their final module had been altered to be comprised of clinical practice only rather than a mix of clinical practice and theory (NMC, 2021a, NMC, 2022c) (see Figure 5-4).

Students are known to experience high levels of stress and anxiety throughout their nursing programme, due to the combined effect of the need to achieve ongoing academic expectations and consistently demonstrate their proficiency in practice, while still fulfilling existing personal commitments and managing financial concerns (Li and Hasson, 2020). The SARS-CoV-2 pandemic magnified these pressures (Barrett, 2022), resulting in a disproportionate impact on nursing students, who were a *'poli-vulnerable'* group (Drach-Zahavy et al., 2022, p. 115). Thus, during the SARS-CoV-2 pandemic students' already-high levels of stress and anxiety were magnified by additional concerns not just relating to their own health, but also whether they might infect their family and friends.



Timeline of data collection activities

Focus groups
Nov-Dec 2018
Jun-Sept 2019

Individual interviews
Jun-Aug 2021

March 2020

Students in years 2 and 3 undertake extended clinical placements to support national care delivery.

Year 1 students focus on academic study online and do not undertake clinical placements.

September 2020

Students (all years) return to original programme plan for clinical placements.

Much of the academic study remains online.

January 2021

Students in year 3 undertake extended clinical placements (up to 100% of the remaining programme) if they wish.

Students in years 1 and 2 continue as per original programme plan for clinical placements.

Much of the academic study remains online.

September 2021

Students (all years) return to original programme plan for clinical placements.

Much of the academic study remains online.

Timeline of UK lockdowns

23rd March 2020
1st lockdown

5th November 2020
2nd lockdown

6th January 2021
3rd lockdown

Figure 5-4. Relationship between data collection activities and impact of SARS-CoV-2
(NMC, 2020, NMC, 2021a, IfG, 2022, NMC, 2022c)

The arrival of a global pandemic during a research study on views of health and illness shone a spotlight on the topic under focus and presented an opportunity to gather data with the potential to be enlightening. Participants had experiences of an event, a global pandemic, clearly impacting on health and illness, which was unprecedented in living memory. However, in December 2020, as discussions were taking place about how to best to manage theoretical sampling, I questioned whether the continuation of data collection was ethically acceptable, agreeable to the participants, or practically possible. At this time participants were still involved in the national care delivery in response to SARS-CoV-2 (NMC, 2021a) and there was a lack of certainty as to what still might come to be regarding the pandemic and what changes might be made to the programme the students were following. Gobat et al. (2019) identified, in work undertaken prior to the SARS-CoV-2 pandemic, that, in a hypothetical situation, there was public support for research to continue during a pandemic. The focus in the Gobat et al. (2019) study, however, was on clinical trials, which clearly differs from this research. If the research was to continue, decisions needed to be taken to ensure no individuals were placed at increased risk, with the overriding need to ensure the well-being, physical and mental, of the participants.

In February 2021 with the support of the research supervisors and following consultation with the PPIRes group, I requested an amendment to the ethical approval granted for the study (see Appendix 9). This was to alter the method of data collection used for theoretical sampling. One important reason for this was that the restrictions and requirements resulting from the SARS-CoV-2 pandemic at the time of the amendment request indicated that the most appropriate approach to data collection ensuring participant and researcher safety was to meet remotely. There was also a further reason: as the research had progressed, my understanding of the best approach for theoretical sampling had developed. The original approach had been to undertake further focus groups. This was now not seen to facilitate the detailed individual discussion I felt necessary to further develop the emerging data categories.

Therefore, a request was made to the ethics committee, and agreed, that the data collection for the theoretical sampling in this project was for semi-structured individual interviews to be undertaken via an online platform.

5.4 Overview of Flow of Research Activity

To clarify how the research methods presented in Chapter 4 were implemented, this section provides an overview of the flow of research activity, outlining details of the numbers of participants recruited and the timing of data collection.

Based on starting numbers provided by each university, the pool of students eligible to participate in the research was 840 students at University 1 and 720 students at University 2.

A total of 25 nursing students expressed an interest in being involved in the research, 11 from University 1 and 14 from University 2. Of these 25 potential participants 22 were recruited. It was not possible to organise data collection (focus group) at either the start or end of the year with three of the potential participants from University 1 as at no time were all three attending the same university-based lectures. Of the 22 individuals recruited, 21 were finally involved, as one student did not attend a focus group meeting as they had discontinued their studies. The same participants were invited to be involved in each stage of the research, so no further participants were added during the research period.

An overview of the research activity is presented in Figure 5-5.

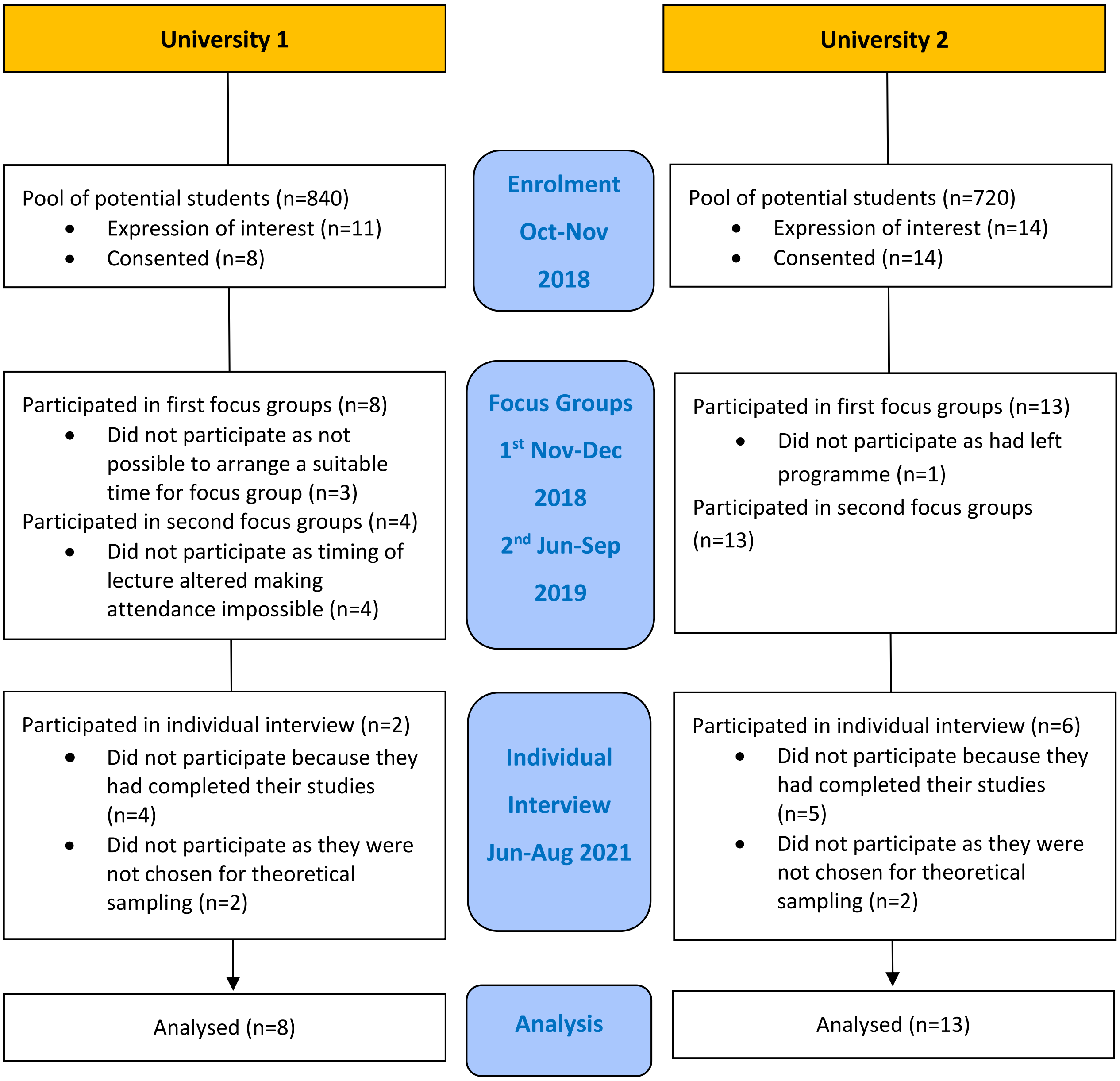


Figure 5-5. Overview of flow of research activity

5.5 Characteristics of Participants

The overall characteristics of the participants are outlined in Table 5.2. Participants came from all four fields of nursing, although there were higher numbers of students from the adult and mental health nursing fields than the child and learning disability fields. This, however, reflects the higher numbers of students studying adult and mental health nursing than child and learning disability nursing at the research locations. The gender of the participants reflected the 89.1% female and 10.9% male nursing workforce composition in the UK (NMC, 2022b). Eight of the participants were born in countries other than the UK; three in European countries and five in countries from the rest of the world. To ensure confidentiality, precise details identifying which of the participants were studying which specific fields of nursing, individual identification of participants' gender or their precise country of birth have purposely not been clarified and are not included in the participant matrix.

The ages of participants who agreed to share data on their age (two declined) ranged from 18 to 55 years at the start of the research, with fourteen of the participants meeting the classification of a mature student (21 years of age or over). Thus the majority of the participants involved in the research were in the age range of mature students.

Participants represented all three years of study in the nursing programme, with some participants contributing data in more than one year, because they participated in the focus groups and the individual interviews.

Table 5-2. Participant matrix

Participant pseudonym	Year of study			University		Age					Focus Group		Individual interview
	1	2	3	1	2	18-20	21-25	26-35	36-45	46-55	1	2	
Ada	✓		✓		✓				✓		*	*	*
Betty	✓				✓			✓			*	*	
Catherine	✓		✓		✓					✓	*	*	*
Dora	✓		✓		✓			✓			*	*	*
Ellery	✓		✓		✓		✓				*	*	*
Florence	✓		✓		✓					✓	*	*	*
Grace	✓				✓	✓					*	*	
Harriet			✓		✓		✓				*	*	
Iris			✓		✓	✓					*	*	
Joan		✓	✓		✓	✓					*	*	*
Kathleen		✓			✓	✓					*	*	
Lizzie		✓			✓			✓			*	*	
Maeve		✓			✓				✓		*	*	
Naima =		✓		✓							*	*	
Orlagh		✓		✓				✓			*	*	
Phoebe		✓		✓		✓					*	*	
Quinlan		✓		✓			✓				*	*	
Róisín	✓		✓	✓						✓	*		*
Sydney	✓			✓				✓			*		
Tatum =	✓			✓							*		
Uliana	✓		✓	✓					✓		*		*
Total	11	8	10	8	13	5	3	5	3	3	21	17	8

Key

✓- Characteristic applies	= - Declined to provide age	* - Participation

5.6 The Emergence of a Grounded Theory

Throughout all stages of data collection participants shared rich and detailed information, reflecting personal experience prior to and during the nursing programme. They also discussed experience acquired during their studies and clinical practice while undertaking the nursing programme. Experiences gained within the nursing programme had arisen from clinical placements, university-based teaching and individual study. Clinical placements were undertaken in a wide range of hospital, community and private care-home environments, with experience resulting from activities with individuals receiving care, nurses and a range of other healthcare professionals plus staff in other caring or supportive roles. Participants viewed this experience as significant and meaningful and, as a result, some were translated into their perception of health and illness. The experiences discussed included personal encounters with health and illness, interpretation of the experience of close relatives, partners and friends, or observations on the delivery of care to others, representing the significant ideas and thoughts participants felt had a role to play in understanding the phenomenon under study (Hallberg, 2006). The experiences described ranged from those the participants regarded as highly positive to those they perceived to be negative, with the majority falling somewhere between these two extremes. During the process of sharing their views, participants constantly refined their current individual and unique perceptions regarding comments made by others, demonstrating the dynamic and evolving nature of the participants' views.

The data gathered indicated that the participants' concepts of health and illness are influenced by a wide range of factors which participants individually perceive to be significant. Participants clearly recognised the complexity of health and illness and spoke about their own as well as others' diversity and subjectivity in interpreting the concepts:

> *'It's so complicated, health, illness, it's so individual. We have all spoken about it differently today and so do patients. I think someone I'm caring for is ill, but then they tell me they feel well!'*

Joan, 2nd year

The processes involved in analysing the data, in its original form and as visual interpretations, plus the recognition and development of the emerging categories, proved to be a stimulus for further analysis and a focus for conceptual interpretation. This resulted in the emergence of a theory, the Theory of Balance in Perception of Health and Illness and Care Delivery (Theory of Balance). To identify the processes underpinning the development of the theory and provide a rationale for it, the findings will be reported in the following order. First, the four emergent categories will be identified and explained; this process will start in the rest of this chapter and continue in the four subsequent ones. Second, the emergent theory, the Theory of Balance, will be reported in Chapter 10, conceptualising the discussion relating to the emergent categories.

5.7 Introducing the Emergent Data Categories

Although individuality and diversity in views of health and illness were a clear feature in the data, there were also aspects of discussion where participants were in clear agreement. The combination of this data resulted in the emergence of four categories, as represented in Figure 5-6.

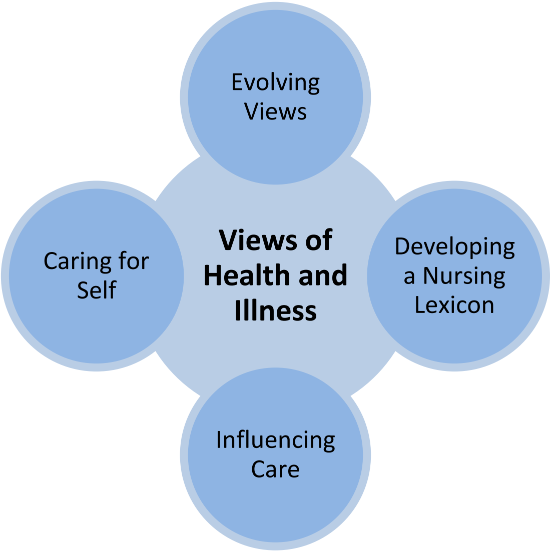


Figure 5-6. Emergent categories

While the four categories were distinct, they were also interdependent, with themes emerging from the data having the potential to impact on and be relevant to more than one category. Although the four categories are interdependent, each can be individually defined by its properties, the characteristics which give it meaning (Strauss and Corbin, 1998). An example of the coding tree facilitating the emergence of the categories is provided in Appendix 16.

According to Charmaz (2014) the identification of a core category in CGT is unnecessary, because the aim is to uncover multiple social processes. The data obtained from this research endorses Charmaz's stance, as there was no clear emergence of a core category. Multiple social processes were evident throughout the data and are represented within each of the categories, without one specific category being more clearly fundamental to the participants' perceptions of health and illness than any other. Each category, therefore, has equal value and has no greater importance than another in the emergent theory.

As highlighted above, theoretical sampling occurred during the SARS-CoV-2 pandemic. The experience of delivering care during a global pandemic, which was the experience of all the participants involved in the individual interviews, had an impact on their views of health and illness. Personal and professional experiences acquired during the SARS-CoV-2 pandemic are integral elements underpinning each of the four data categories. The impact of the experience on the participants was profound and fundamental in the evolution of their views, which was made clear by the emotions they shared during data collection.

Charmaz (2014) advocates that the credibility of research can be increased by ensuring that the individual voices of the participants are clearly reported. To not only apply this approach but also fully appreciate the value of each participant's contribution, throughout the rest of this Part of the thesis reporting of the findings will be underpinned primarily by the data collected. This will continue to be presented mainly in the form of participant quotations, although theoretical memos, field notes, reflective journal comments, diagrams and drawings will also be cited.

5.8 Conclusion

This chapter has focused on introducing the findings reported here and identifying relevant contextual features. These include the experience of a global pandemic, which resulted not only in modifications to the research protocol but also it becoming an integral aspect of each of the emergent data categories. The influence of the differing profiles of the research locations, that is, the health profiles of residents in the areas, the academic environment the participants were likely to experience during their programme and the characteristics of the participants, were also considered. Each of these was a significant feature having the potential to impact a participant's experience during their pre-registration education.

Within the chapter the emergent grounded theory and emergent data categories were named and introduced. The first of these emergent data categories, 'Evolving Views', will be the focus in the next chapter.

Chapter 6 Emergent Data Category – Evolving Views

'Views change. If they didn't change, I'd be worried, [because] *it means that you've stopped listening, you've stopped learning. Once you stop listening and learning you've stopped nursing'*

Ada, 3rd year.

6.1 Introduction

This chapter outlines and details the emergent data category of 'Evolving Views'. The category emerged early in the research, at the point of the initial focus groups, and has been further populated, developed and refined as the research progressed. As a category it incorporates the properties of experience and reflection within which the impact of the SARS-CoV-2 pandemic is integrated and contributed data relevant to the answering of all of the research questions.

6.2 Experience

When asked about their thoughts at the start of their nursing programme participants described their views of health and illness using terms such as 'simple' or 'naïve'. This was a consistent opinion, also shared by participants with experience of delivering care to others, either through a paid role or by providing care to a family member as an unpaid carer, saying that their view at this point was *'only reflecting my own experience, just my perspective'* (Ellery, 3rd year) and lacking reference to a holistic framework:

> *'Starting the programme, after 18 years of being an HCA* [Health Care Assistant] *I'd think about health as in what, you know, you eat, fitness, exercise. An illness was obviously, being poorly, poorliness, you know, cancers, whatever. But now* [at the end of the programme] *I think, it's kind of, I think of it mentally, physically, social, you know, like the World Health Organization, their definition of it being physical, mental and social well-*

> *being.* [.....] *It's all the learning from class, studies, placement coming to my head! So, yeah, it's completely changed.'*
>
> Róisín, 3rd year

Over the course of the programme all of the participants reported that their views of health and illness evolved, representing a '*deeper understanding across a broader spectrum'* (Uliana, 3rd year), which was linked to experience, by which they were referring to '*things I've seen and done'* (Ada, 3rd year), '*theory we have studied'* (Róisín, 1st year) and '*talking to patients, relatives, other students and lecturers'* (Florence, 3rd year). Participants also spoke of their personal experience, focusing on challenges they had encountered to their mental and physical health during the time they were studying.

> Interviewer – *'If you defined health and illness now, would it differ from what you said before the nursing programme?'*
>
> Ada, 3rd year – *'Yes, because, I think, before, it was a very simplified view and with all the stuff that I've read, been told, been part of, seen.* [5-second pause] *Now, I know there is a correlation between mental and physical health, they are together, you know. The difference between then and now is that I've seen it in motion. I've experienced it. I've experienced it myself with my own physical and mental health, through just the ups and downs of stress, through being a nursing student. So, it has brought more of an awareness of the experiences of others, so also, when I'm not looking after my physical health, the impact that it has on my mental health and then vice versa. So, it* [view of health and illness] *has matured.'*
>
> Interviewer – *'With your experience of working with other nursing students, do you think that is a general feeling?'*

> Ada, 3rd year – *'I think we have all moved forward, but, umm, at the same time, yes, everything is more individual! So* [7-second pause] *Sorry, I need to think about this, I think that, umm, I think that we* [nursing students] *all started at different points and we are all finishing differently,* [3-second pause] *but we have all changed.'*

When looking back on their experience, all participants reported that their views had progressed, even those who were mature students and started the programme with life as well as caring experience,

> *'I thought I knew about it* [before the nursing programme] *but actually, I didn't have a clue!'*

Florence, 3rd year.

Much of the participants' experience related to delivering care to others during their nursing programme, including experience gained while being part of the healthcare team throughout a global pandemic, but also prior experience such as pre-existing or newly diagnosed personal illness, or that of a family member also featured:

> *'My mum had cancer, so, I've always thought I had a good understanding of it.* […..] *I've always been aware of illness and the importance of health. But even after that, my version of health was very superficial, now, as nearly a Registered Nurse, it's so much more in depth. It has matured!'*

Uliana, 3rd year

The need to juggle academic study and clinical placements while still meeting the requirements of everyday life, which often involved paid work and family/caring roles, also provided a focus of discussion and identified understanding of the impact the wide range of roles an individual holds can have on the challenge of remaining physically and mentally healthy. By the end of the programme participants all stated that they felt their views had 'matured', 'evolved', 'developed further' or become 'more complex', again with this view being shared by those who entered the programme with caring experience.

It is possible to identify three chronological stages regarding the experience participants highlighted as having influence or thought would have future influence on the evolution of their views of health and illness. These were 'pre-programme', 'programme-related' and 'post-programme' experience and are discussed below.

6.2.1 Pre-programme experience

Participants outlined that personal experience of health and illness prior to commencing their nursing programme had influenced their views of health and illness,

> *'I think it was through that I had my own difficulties with mental health.* [.....] *It is that what kind of, made me think. Things I experienced in my life, have seen. They made me think about illness, mental health, in a new way. I struggled with my mental health, I experienced it, so that made mental health patients less,* [5-second pause] *seem less scary is I think what I'm trying to say. Struggling with mental health it just happens.'*
>
> Ada, 3rd year

> *'…my personal experiences before I started the course* [nursing programme]*, had a massive impact on my views'*
>
> Florence, 3rd year

Experience of health and illness that had been gained while either delivering care to others during previous paid employment or caring for family members was also an influence:

> *'I used to work with children who had learning disabilities, learning difficulties, both. And then, my experience within my family, a person being autistic, was a huge influence and*

> *started the passion for me, probably those were the main experiences and yes, they did influence my views.'*

Catherine, 3rd year

> *'For many years* [before the nursing programme] *I worked supporting people and their families through all kinds of problems. It made me think about health, the value of it and the huge impact of illness, across the whole family.'*

Ada, 3rd year

Participants also mentioned that prior to starting the nursing programme their views of health and illness were influenced by the approach originating within their family, as Catherine, 3rd year, reported: *'experiences coming from my family, they've given me a rich insight'.* Others named their mothers as being fundamental to the development of their perception,

> Tatum, 1st year – *'my mum, yes, she has influenced my views, how I think about illness and being healthy'*
>
> Róisín, 1st year – *'Yes, me, mine too!'* [General agreement]
>
> Sydney, 1st year – *'Yes! My mum was the person who I asked questions, she was the one who kept us healthy and told us when we were not…'*
>
> Róisín, 1st year – *'Umm…* [laughs] *and sent me to school even though I said I was ill!'* [General laughter]
>
> Sydney, 1st year – *'Was she a nurse?'*
>
> Róisín, 1st year – *'She was! Yes!'* [General laughter]
>
> Tatum, 1st year – *'She taught me about it, the whole family really……,* [3-second pause] *not really in words, but in how she acted when I was young. We, me, my brothers, we*

> *really do similar things to stay healthy and to treat illness, to get better. I think we have similar views on what health is, so, yes, that's her influence'*

> Uliana, 1st year – *'I think it's the same for my family…'* [General agreement]

Cultural perspectives were also identified as being influential. Ellery (3rd year) clearly contrasted differing influence from experience in what they referred to as their 'home country' and the UK:

> *'Culturally, there's, that's an impact, an influence as well. Because back home, lack of support from your family* [when people are ill] *is very rare. Our approach, it's, it's more like a group thing, than individualism, in the UK, like, Western wise. Here, I find that, as a very common thing, people 'disown' family members, leave them to cope with illness, to do things on their own, rather than as a group thing. Even if family members are difficult* (laughs), *they still belong to you.* [5-second pause] *Illness is something to be shared and belonging is important.'*

Ellery, 3rd year

It was noticeable that participants started their nursing programme with a wide spectrum of experience of health and illness. This ranged from participants who had been in paid or unpaid caring roles for a number of years or had personal experience of long-term illness, so felt that they had a wealth of experience,

> '*I looked after a family member,* […..] *who became unwell and actually needed lots of physical support,* […..] *and I've had a lot of personal health issues'*

Florence, 3rd year

to participants who felt their experience was

> ‘*very limited.*[…..] *ill people were those you met in the doctor’s surgery. I didn’t think about them living a life or anything’*

Iris, 3rd year

6.2.2 Programme-related experience

Participants highlighted different experiences which influenced their views once they had commenced the programme, recognising lots of influences occurring at the start of their first year of study, *‘I’m only 3 months into the programme, but what we have been taught already has really changed my view about it’* (Sydney, 1st year). At this early point in their nursing programme none of the participants had been exposed to clinical placements, the change had resulted from influences during university-based sessions. Regarding this, not just at the start of the programme but throughout its entire duration, specific aspects of the delivery of theory were seen by participants to be the most effective in facilitating change in views of health and illness. General reading of topics relating to nursing theory was identified as being effective in ‘*making me think differently about health and illness things…’* (Quinlan, 2nd year), as was the work required to produce a specific assignment which focused on the topic of health and illness, *‘…that assignment really expanded my thinking about health and illness’* (Iris, 3rd year), or the processes required to produce their dissertation which enabled them to realise the existence of a broader perspective:

> ‘*Writing my dissertation,* […..] *because I focused on the whole issue of homelessness, so that made me expand my views of health and illness greatly’*

Ellery, 3rd year

There was also agreement that talks delivered by persons receiving care were highly influential and thought-provoking regarding the evolution of views. Participants reported that, in university-based sessions, discussing their experiences of health and illness at all stages of the programme, with other students and lecturers, had value in making them aware of differing perspectives and enabled a review of their own:

> Interviewer – *‘What, when you were in theory was fundamental in what you described as your change of views of health and illness?’*
>
> Róisín, 3rd year – *‘We had an amazing lecturer. And you'd sit together* [the student group and the lecturer] *and you could, you’d bounce things off each other.* […..] *That's where it kind of started and snowballed. We spent a lot of time talking with the lecturer, sharing all our own opinions, talking about things relating to health and illness. And yeah, it's good.’*
>
> Interviewer – *‘So, talking about experiences, your views, with the lecturer and your group, that's made you really think about your views and develop them?’*
>
> Róisín, 3rd year – *‘Yeah, yeah. Being able to ask the lecturer, talking about things as a group, listening to others sharing what they had seen and done, thinking about the theory, talking through the theory and other things. That was the best.’*

Although theory and discussion with others were viewed to have an influence on views of health and illness, practice-based experience was, by contrast, judged to be of greater impact, providing ‘*the real light bulb moments,* […..] *understanding people’s views,* […..] *thinking about mine’* (Uliana, 3rd year). Greater learning gained from practice was also stressed: *‘placement was where I really got to see things, learning things, think about them’* (Maeve, 2nd year), by being involved physically and mentally in care delivery: ‘*actually doing the care, that’s when I get to see what a patient thinks about health and illness’* (Naima, 2nd year), ‘*I really did learn by practice!’* (Betty, 1st year). Thus, experience from placement was identified as the key factor:

> *'I don't think I could say like a single event* […..] *there have been lots of different things, influences* […..] *a gradual developing, of understanding. But, in hindsight, over three years I can see how sessions complemented each other* […..] *and the things I've taken from each lecture. But probably, practice has been the biggest factor. Because I've never really been around poorly people I've never been in hospital.* […..] *Seeing it with my own eyes, the practical side of it, being with the patients was the biggest factor, because you've got to have experience to look back on it. You must go through it.'*

Dora, 3rd year

> *'practice is a lot more important than theory. I understand the reason for theory, but the hands on, the talking to patients and being there is a lot more important than doing the assignment is. Yeah, it's* [practice] *the important bit, finding strategies for health and illness that work with people's views that you can deliver. Yeah. And realising not all strategies work for everybody'*

Joan, 3rd year

Practice experience was fundamental in assisting participants to either develop new knowledge and views or question their previous influences, knowledge and views, resulting in the appreciation of their perspective and realisation of difference,

> *'It made me question things I've seen and heard and I've read and what I thought, you know, it makes a major difference. I can see that being person-centred in care is important as we all have different perspectives'*

Florence, 3rd year

There was clear recognition of the links between influences, experience and views of health and illness, from the perspective of both the person receiving care and the individual providing care,

> *'Not just the patient's views differ but a mental health nurse, a child nurse, people from all different fields of nursing and students from different fields and others who care for patients, they'll have their different experiences, views from situations that they've been in.* [.....] *I'd like to think we're all on the same page and want to do the best for patients, for ourselves to progress patients' outcomes and health. But it's individual, isn't it? All different views from, you know, different experiences.'*

Róisín, 3rd year

Participants acknowledged that, because of the diversity in views, there was the need to be able to appreciate issues from the perspective of another,

> *'We can all have a different perception; we need to appreciate that, but globally we would agree on promoting health and preventing illness. I think we will all have a different approach linked to our experiences'*

Florence, 3rd year

Role models were seen to be an important aspect in assisting participants to understand how to act in a range of circumstances and were highlighted by participants as key features in their experiences of care delivery and academia. Role models were described as both positive and negative, not associated exclusively with positive experiences but were seen as those whose actions provided a template that could potentially be adopted, or rejected, by the participants. This was common to experiences that occurred in placement and at university which, according to participants, did or did not support the perspective of the individual they are working with:

> *'role modelling is extremely important. That's, that's the most powerful way of delivering education. I've seen good role modelling, nurses who really put the patient at the centre of their care, from every perspective think about what they can do to manage their illness, being truly person-centred in what they do. They've shown me how to do it. But I've seen*

> *appalling role modelling too, not giving person-focused care to the patient, not thinking about what they're doing, not thinking about the individual. That taught me how not to do it.'*
>
> Florence, 3rd year

> *'At one point I struggled with my mental health. My university tutor was amazing. Her approach changed my whole attitude to my health and my view of health in others. She was such a good role model* [.....] *and now I use her approach, it's her attitude I've got with patients.'*
>
> Joan, 3rd year

Thus, participants spoke about how they would apply an approach they had seen modelled by a specific individual during their programme, or how they aimed to implement a more eclectic approach, replicating what they viewed to be the best practice modelled by a range of others:

> *'I've seen lots of good nurses,* [3-second pause] *and other professionals.* [.....] *The way I approach situations, how I work with patients* [.....] *is a 'pick and mix' sort of thing!* [laughs] *I use what I think are the best bits, the approaches, to work with patients in a way that supports their view of health and illness, developing a therapeutic relationship, I think.* [.....] *A mix of the best I've seen, some of those ways were ones learnt from lecturers too.'*
>
> Róisín, 3rd year

The experiences participants highlighted from their involvement in care delivery during the SARS-CoV-2 pandemic related particularly to the actions of others, sometimes as negative role models and how this had impacted on their future aspirations,

> *'in COVID and the pandemic, I've seen compassion fatigue, burnout.* [.....] *Now I want to get a healthy work-life balance.* [.....] *I want to go to work and enjoy what I do whilst I'm at work, but I don't want to bring work home with me.'*

Ada, 3rd year

the recognition of factors that resulted in evolution of their professional views,

> *'I realised that in caring for people health and illness or especially health, is in every aspect of what we do.'*

Dora, 3rd year

> *'I realised the psychological side is the most important part of health and illness.* [.....] *COVID was hard, so sad and I saw that it isn't doing physical things, it's helping patients and relatives manage emotions. That's the most important.'*

Joan, 3rd year

as well as more personal ones,

> *'In respect of my health I realised my time could be up, that puts things sharply into focus'*

Uliana, 3rd year

> *'When what was happening, about the health of the nurses and doctors, really hit me, was when, on Facebook, there were the pictures of the healthcare staff who had died. It was twenty-three at that time. One was a student nurse. That could have been me.'*

Catherine, 3rd year

which included recognition that their actions could have a negative influence on the health of their family,

> *'I was so scared, not so much for myself, but I could have brought it home to my family. I could have been a cause of illness for them. Never have I done so much washing, cleaning, bathing in hand sanitizer!* [laughs] [10-second pause, controlling emotions] *It really wasn't funny'*

Ellery, 3rd year

6.2.3 The potential for post-programme experience

Participants clearly recognised the role of experience in the progression of their views of health and illness, regarding future, ongoing change following their nursing programme and that their views were dynamic,

> *'My views of health and illness are going to change more when I am Staff Nurse, just like they've changed from the last time we spoke.* [.....] *If I came back in three years' time we'd have a whole completely different conversation* [.....] *My views are going to evolve and further experience will make me a better nurse.'*

Joan, 3rd year

> *'I'll have more experience in my new role* [as a Registered Nurse]. *And I know I'll know personally, even more about what is important regarding health and illness and I'll use it to do the best I can do for my patients to improve their outcomes'*

Róisín, 3rd year

Views progressing between simple (an inductively-derived term used by students) and more complex, due to increasing experience and knowledge, were linked with a potential impact on care delivery, which could result in care becoming more person-centred.

6.2.4 Influences

Within their discussions participants frequently used the terms, ‘influences’ and ‘experiences’. There was differentiation, however, in how the terms were used. Experiences were seen as events which resulted in reconsideration of a perspective, whereas influences were seen to be more sustained behaviours, frequently which the participants had previously been unaware of. The catalyst for becoming aware of an influence could be a specific experience,

> *‘I had lots of experiences when my mum was ill,* [.….] *in looking after her I experienced lots of things my friends didn’t. It wasn’t until I started nursing and saw other things, had another experience, that I realised my mum’s illness had been an influence on my views’*
>
> Uliana, 3rd year

It was possible to categorise the influences the nursing students described as personal, professional, or societal/organisational, although there was overlap between the items included within these groupings (see Table 6-1).

Table 6-1. Influences on views of health and illness

Influences		
Personal	Professional	Societal/organisational
Personal experience, role models, education, professional experience, personal values	Professional experience, role models, programme curriculum, NMC Code, personal experience, personal values, professional values	Family perspective, sociocultural perspective, nursing programme team perspective, role models, clinical practice area/organisation perspective

6.3 Reflection

Experience was a necessary factor to provide a stimulus for development. However, even though the participants were exposed to a broadly similar experience throughout their programme, there were differences in their ability to identify and deliberate their perspective when discussing health and illness. Some participants seemed very able to articulate their views, while others were not.

Participants used a storytelling approach to describe their experience and then highlighted how their views evolved, frequently likening what they experienced to '*one step forward and two steps back'* (Joan, 3rd year), in an approach where they would

> *'Return to my previous views and think them through, just in my head* [.....] *comparing them to what I see or what we are learning'*
>
> Quinlan, 2nd year

Thus, it was a reflective process being described by participants. That this reflective process was triggered by participants noticing what they viewed to be a significant experience was a constant theme in the data, not just in focus groups and interviews, but also in field notes, including *'there is a reflective approach in discussion, but the term reflection is not being used'* (Field Notes 01.08.2018), and

> *'6 weeks in* [to their programme] *participants are talking about 'looking back on things' after a lecture, to 'put what they are being told into perspective'. Ada, 1st year and Florence, 1st year, mentioned this and it was met with unanimous agreement from the rest of the group'*
>
> Field Notes 25.10.2019

When theoretical memos were used to map what was developing, and how it occurred across all instances of data collection, it clearly emerged that, although the ways differed, participants were applying a reflective process to compare current new experience and knowledge with previous experience and existing knowledge and perspectives.

> *'Apart from Grace there are common threads in what the participants are describing and the processes they are using in response to an experience, be this in practice or in class, or even in their personal life. These common threads are*

> *1. They have an experience they perceive to be significant, or they notice something which becomes a trigger for further consideration.*
>
> *2. They question their experience, viewing it from a new perspective.*
>
> *3. An action or insight results from this consideration.*
>
> *and they are often recounting their experience in the form of a story*
>
> […..] *Grace however is very accepting of what she is experiencing and does not seem to be considering it any further'*
>
> Theoretical Memo 31.07.2021

As previously mentioned, the term reflection was rarely used by participants: they used elements of a reflective framework to structure what they were saying without explicitly labelling it. The use of stories, the telling of their experience, or in some cases the experience of others they either were involved in or had observed, from a reflective perspective, was how this information was shared. In this approach they created a context within which the experience was explained and through the process they shared more about themselves. When the stories were shared within the focus groups the storyteller clearly captured the interest of other participants, as they brought the experience to life in their description of personal scenarios. Key to the reflective process underpinning the participant's story was the 'noticing' of a specific trigger, with the story told by the participant providing a narrative constructed around what had been noticed and describing an outcome resulting from this.

In their stories, participants presented their experience by describing and reviewing it, focusing on their learning from it, and then applying the learning to future actions. This occurred in two slightly different ways, which I describe as follows:

> The Eutheos Approach - A one-stage process (which I have named using the Greek word, ‘eutheos’, which means immediately) where learning is derived from an experience either as it is happening or sometime soon after and translating this into actions or insight that could be implemented immediately.
>
> The Janus Approach - A two-stage process (which I have named after the Roman god of transitions and duality, ‘Janus’, usually depicted with two faces, he looks both ways) where learning is derived by reframing prior experience, re-evaluating existing views and appreciating these from a new perspective, looking backward and moving forward.

While enacting these processes the participants were seen to be replicating the moves undertaken by a player as they progress across the board in a game of ‘Snakes and Ladders’. In this analogy The Eutheos Approach imitates the climbing of a ladder, moving immediately to a new level. The Janus Approach replicates the sliding down a snake prior to the climbing of a ladder, where, although the first move is backwards, in reviewing prior learning, there is an eventual move to a new level.

Figure 6-1 visually depicts the processes being enacted by participants, including four specific examples; ‘The Case of Translation’ (described in Figure 6-2), ‘The Case of Difference’ (Figure 6-3), ‘The Case of Confusion’ (Figure 6-4) and ‘The Case of Being Authentic’ (Figure 6-5).

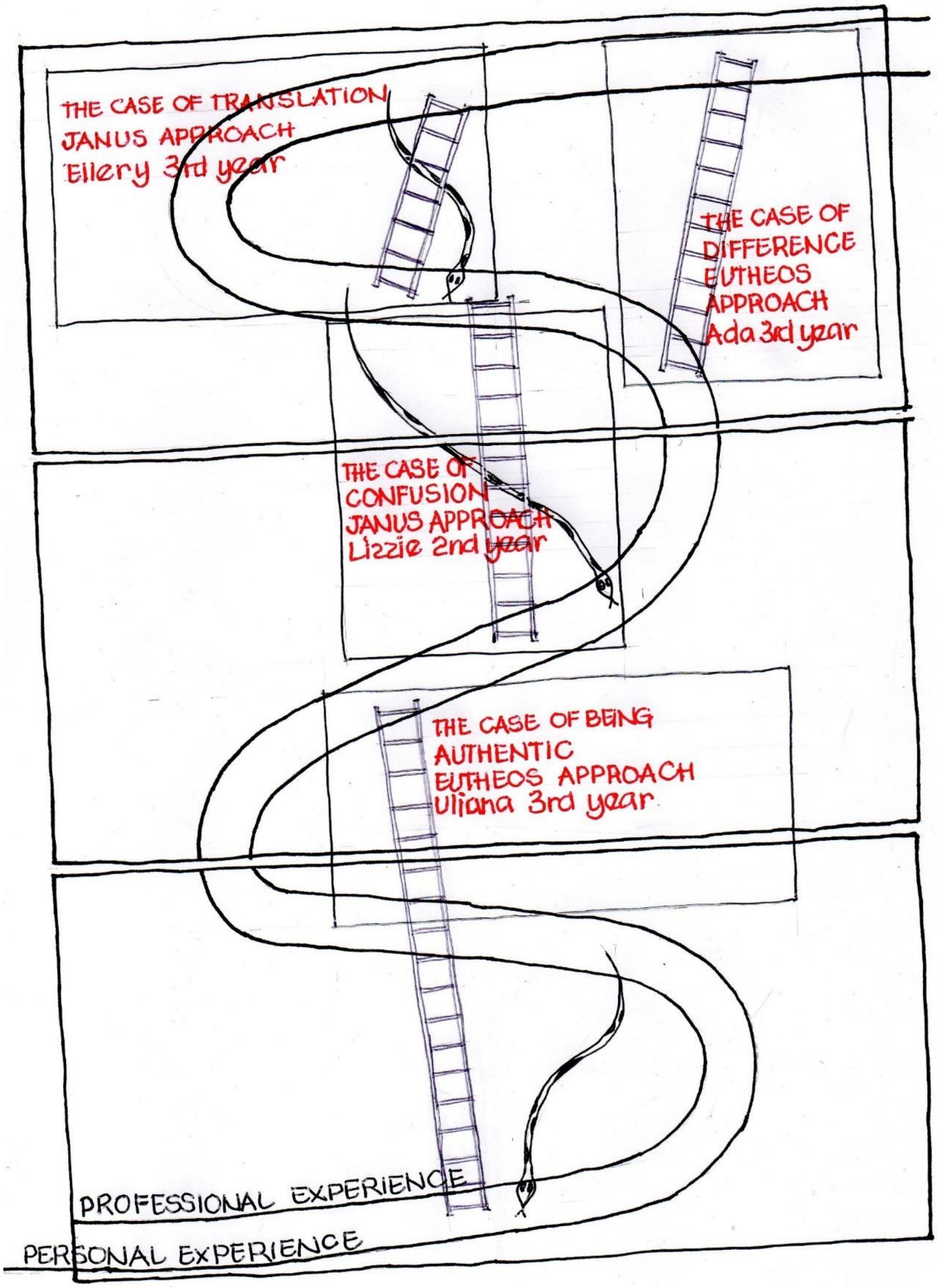


Figure 6-1. The snakes and ladders of a three-year nursing programme

The Case of Translation – Ellery, 3rd year – The Janus Approach

This case is so called because it outlines how a participant shared their story of the challenges they experienced regarding understanding mental health while delivering nursing care within a culture that was not native to them. Thus, they were translating views across cultures.

The process followed by the student is indicated in the presentation of the case below. First, they notice an experience which was of significance. Second, their experience is viewed from a different perspective. Third, a plan of action is produced and implemented.

> Noticing an experience which was of significance
> ‘W*hen I started* [the nursing programme] *I had some areas I realised I was ignorant about, like mental health.’*
> Viewing from a different perspective
> *‘Back in my home country we don't talk about it, don’t admit it exists, like I now know is the case in the UK.’*
> Producing and implementing an action plan or insight into practice
> *‘So, I did extra learning, found more ways of being exposed to it, to understand more about mental health, why they happen, what are they like, what's like the reasoning and the rationality of how people with them behave.* [.....] *I need to know more because I didn’t grow up with it. I see it as, it's my problem and I needed extra learning’*

The Case of Translation is an example of the application of The Janus Approach: the participant derived learning by reframing their prior experience, re-evaluated their existing views and took actions that enabled them to appreciate these from a new perspective. In terms of progress across a ‘Snakes and Ladders’ board, their first move was a slide down a snake which was then followed by ascending a ladder.

Figure 6-2. The case of translation

The Case of Difference – Ada, 3rd year – The Eutheos Approach

This case is so called because it outlines how a participant shared their story of how they considered their prior experience and were able to recognise individuality in the approaches of other people, thus they were able to appreciate difference.

The process followed by the student is indicated in the presentation of the case below. First, they notice an experience which was of significance. Second, their experience is viewed from a different perspective. Third, a plan of action is produced and implemented.

> Noticing an experience which was of significance
> *'My experience, before coming to nursing to, to learn so many different therapeutic models of working with people.* [.....] *I've been trained in how to work with perpetrators of domestic violence, taught solution focused brief therapy, I'm a trained hypnotherapist. All this stuff that I bring, plus my experiences from my previous working worlds, plus now the experiences from being a student nurse lets me to see health and illness from lots of differing perspectives.*
> Viewing from a different perspective
> *'My previous and new knowledge intermingle and makes me do what I do in the way I do. What I do is done in a different way to others, no one else can do it in quite the same way as me.'*
> Producing and implementing an action plan or insight into practice
> *'…and that's good for patients, you know, we – students, nurses, all, bring different approaches, different ways of seeing health and illness and different ways of relating that to care. That must be a win for patients! They come in all shapes and sizes, they have difference, so it's good that we do too, because we can find a fit.'*

The case of 'difference' is an example of The Eutheos Approach, deriving learning from an experience either as it is happening or sometime soon after and translating this insight into practice that is immediately applicable. In terms of progress across a 'Snakes and Ladders' board, the participant is ascending a ladder.

Figure 6-3. The case of difference

The Case of Confusion – Lizzie, 2nd year – The Janus Approach

This case is so called because it outlines how a participant shared their story of how they realised that states of health and illness are complex in response to being asked whether a person with a diagnosed illness is always ill. The participant identified that this caused them confusion.

The process followed by the student is indicated in the presentation of the case below. First, they notice an experience which was of significance. Second, their experience is viewed from a different perspective. Third, a plan of action is produced and implemented.

> Noticing an experience which was of significance
> *'I had an experience, it made me confused! I would previously have said that a person with a diagnosed illness is always ill, but after my experience I want to say yes and no! I was on the chemotherapy day unit, a patient came in and we talked about him being a trainer for triathlons and running ultramarathons, I assumed before he was diagnosed. But, when I got the bus home that evening he was sitting opposite me and he had his running gear on. He was going to the track to run! Himself! He was training for an ultramarathon.'*
> Viewing from a different perspective
> *'I assumed his sport had stopped when he was diagnosed. I just made that assumption, I hadn't seen people living a life with cancer, I thought of it as a sentence of death. People live with it and some of them are physically fitter than us! Sometimes you can't tell they're ill. So, are they ill? Can you do an ultramarathon and be ill?'*
> Producing and implementing an action plan or insight into practice
> *'This experience really made me go back to do more reading and think about the assumption I had made. It really stumped me for a while, not what I was expecting at all and I'm not sure I've really got it properly understood yet – it's mind boggling!!'*

The Case of Confusion is an example of The Janus Approach: the participant derived learning by reframing their prior experience, re-evaluated their existing views and took actions that enabled them to gain insight into practice. This was a two-stage process, their experience of significance triggered the realisation that they needed further knowledge and understanding which, once gained, enabled them to appreciate their experience from a new perspective and apply this knowledge to their nursing practice. In terms of progress across a 'Snakes and Ladders' board, their first move was a slide down a snake which was then followed by ascending a ladder.

Figure 6-4. The case of confusion

The Case of Being Authentic - Uliana, 3rd year – The Eutheos Approach

This case is so called because it outlines how a participant shared their story of how their experience of health and illness has influenced their approach to coping and how they apply this to their nursing care delivery. Thus, the participant identified that they were being authentic.

The process followed by the student is indicated in the presentation of the case below. First, they notice an experience which was of significance. Second, their experience is viewed from a different perspective. Third, a plan of action is produced and implemented.

> Noticing an experience which was of significance
> *'My nursing approach is. Umm, it's my overall approach, not just with patients.* [5-second pause] *It's my approach to health and illness, how I deal with it and help others to. Well, I can best explain it in that I've got my song - like a country western 12 bar blues song!* [laughs] [Sings] *I lost my dad to a heart attack, my brother in a motorbike accident, nursed my mum through cancer, I've had so, so much.'* [Singing stops]
> Viewing from a different perspective
> *'And so, I'm always prepared for the worse and I know that sounds weird. Positive thinking is advocated, everyone should think that way. But noooooo, not me, I've always prepared myself for the worst. I'm being real - bad things happen. They've happened to me in the past, so they can and will happen again, to me and others. I don't dwell on the worst things possible, but I'm ready for it. If I'm preparing, prepping myself so that when something does happen, I'm able to cope.'*
> Producing and implementing an action plan or insight into practice
> *'I always use it when I'm working with patients and talking with relatives. And maybe I've done that because of what I had to cope with as a child, as a safety mechanism, which enabled me to, to function as a normal human, I've created this approach, so that I can say, okay, this could happen. If it does happen things will get to be OK again. It will be hard at the time, but you can manage, you can cope. You can get through it. It's about resilience, nursing resilience and in everyday life, that's what I do coping with the down turns, because not everything is going to be great.*
> *So, I have that view of health and illness, it may work out, or it may not and it's how I nurse. Prepare for the not working out, prepare for the bad, prepare patients for bad, prepare relatives for bad, but nicely and kindly. And then work on making it as good as possible.'*

The Case of Being Authentic is an example of The Eutheos Approach, deriving learning from an experience either as it is happening or sometime soon after and translating this into insight into practice that is immediately applicable. In terms of progress across a 'Snakes and Ladders' board, the participant is ascending a ladder.

Figure 6-5. The case of being authentic

6.4 Category Summary

The progression between a simple (an inductively-derived term used by students) view of health and illness to a more complex, multifactorial and multi-perspective one revolved around influences and experiences. The terms influences and experiences were used by the participants to describe differing processes: influences were sustained behaviours, often which the participants had previously been unaware of; experiences were events resulting in reconsideration of a perspective. The influences described could be personal, professional, or societal/organisational, although there was overlap between the items included within these groupings. The catalyst for becoming aware of an influence could be a specific experience.

Noticing and interpreting significant experience was highly important. Significant experience could have been either personal or professional in origin and could have occurred either prior to or during the time the programme was being undertaken. Once a significant experience had been noticed, the processes applied to it were reflective and included viewing experience from a different perspective, which resulted in the production and implementation of an action plan and gaining a new insight into nursing practice.

The reflective processes applied by the participants could be differentiated into two slightly differing approaches, either as a

> one-stage process, named The Eutheos Approach, deriving learning from an experience of significance either as it is happening or sometime soon after and translating this insight into nursing practice that is immediately applicable – or as a
>
> two-stage process, named The Janus Approach, deriving learning from an experience of significance which triggered the realisation that further knowledge and understanding were needed which, once gained, were applied to nursing practice.

Views of health and illness were seen to be dynamic rather than fixed, with participants anticipating that, as they continue to develop their experience and subject this to the reflective processes described, their views are likely to continue to evolve.

6.5 Conclusion

This chapter has detailed the emergent data category, ‘Evolving Views’, the first of four data categories to be reported and has identified and discussed its properties. Experience and influences were considered and defined, with the reflective processes applied following the noticing of experience being named and described. Examples were considered to characterise how these processes were observed, with a potential link being made between the development of views of health and illness and an influence on nursing practice. Thus the category contributed data relevant to the answering of all of the research questions.

The following chapter will present the emergent data category, ‘Developing a Nursing Lexicon’.

Chapter 7 Emergent Data Category – Developing a Nursing Lexicon

'Never could I have anticipated the depth of understanding and the profound insight the participants would share'

Reflective Journal Entry 18.06.2019

7.1 Introduction

Within this chapter the details of the emergent data category, 'Developing a Nursing Lexicon', are presented. The category emerged in embryonic form early in the research at the point of the initial focus groups, where participants discussed the struggles they experienced when attempting to define the concepts of health and illness. Ongoing data collection using constant comparative enabled the category to be fully populated, developed and refined, incorporating the properties of defining health, defining illness and wrestling with the concepts of health and illness. Similar to other categories, experience resulting from the SARS-CoV-2 pandemic is an integral element. Data from this category underpinned the answering of the first and third research questions.

In naming the category 'Developing a Nursing Lexicon' the term lexicon was specifically chosen to signify that there were values underpinning the personal definitions of health and illness participants shared, some of which had been developed due to the challenges students experienced when wrestling with these concepts. As is identified by Brown (1993), a lexicon is the vocabulary of a language, in this case the language of health and illness, which acts as the internalised dictionary the speaker of the language applies. The lexicon the participants utilised was imbued with both their personal and professional values. There is a strong link between discussion in this category and that of the category 'Influencing Care', which is where there will be consideration as to how values underpinning students' definitions can be applied to care delivery.

7.2 Defining Health

Participants' definitions of health referred constantly to their personalised perceptions. In the words they used when sharing their own definitions, participants frequently prefaced their comments with, for example, '*this is only my view, other people's might differ*' (Betty, 1st year) and '*I have a view, but it's not that I think I'm right and others are wrong*' (Florence, 3rd year). Similarly, participants recognised individuality when considering the perspective of the person receiving care:

> *'What patients say* [about health] *can be very different. Their view is based on what they've experienced and it isn't possible to be certain what it is without talking to them and getting to know them'*
>
> Maeve, 2nd year

The uniqueness of definitions of health was a topic considered in each of the focus groups which, in every instance, was met with agreement and confirmation from the other participants present. This view was consistent across the focus groups held with participants in all years of their programme and as clearly identified by participants at the start of their nursing programme, '*We all have unique views of health, influenced by our personal and cultural values'* (Sydney, 1st year), as it was at the end, *'Health is unique to each individual'* (Iris, 3rd year). This view was accompanied by participants' recognition of the importance when delivering care of supporting the perspective of the person receiving care rather than their own, '*Always view health from the patient's perspective, not yours'* (Kathleen, 2nd year).

Another area of clear agreement within the participants' definitions of health was the importance of mental well-being, which was highlighted as a vital element of physical healthcare. Participants saw strong links between mental and physical health, *'The mental health aspect of physical health* *is very important. They both are needed'* (Sydney, 1st year), with agreement between participants from all fields of nursing that,

> '*Unless you are supporting patients to remain or become mentally healthy, you aren't doing a good job, certainly not being holistic'*
>
> Harriet, 3rd year

Experience of care delivery during the SARS-CoV-2 pandemic was seen by participants to underline the importance of health. This was because the functional perspective of health was considered vital to living a fulfilling life not only from a personal perspective, *'Being healthy makes it easier to achieve what you want to'* (Dora, 3rd year), but also from a societal perspective:

> *'Society cannot function normally if there is a threat to health, look at the way people have been acting in the supermarkets, people who have made huge amounts of money from the Government by providing faulty PPE* [.....]. W*e have seen both the very best and the very worst of people'*
>
> Ada, 3rd year

with health being of key relevance to all individuals and situations,

> *'Even though we might want to ignore it, put it to the back of our minds, sort it out later, health is an underlying factor for us all, in all the decisions we make. Every single one. COVID made that clear'*
>
> Florence, 3rd year

The experience of the pandemic enabled participants to view health as resource which could be developed, with health promotion being an important nursing role,

> *'Health is something you can increase if you are healthy or ill. Some people realised they needed to live a different lifestyle because of COVID. They were healthy when it was going on, but it gave them the desire to be healthier* [.....] *by taking more exercise, or losing weight'*
>
> Róisín, 3rd year

> *'During COVID I was in the community and saw how health promotion is part of health. It's important for us nurses, to do. We have lots of ill patients, long-term illnesses, but they really are becoming healthier, they're keen to be as healthy as possible, even although they are ill. We are using every opportunity to promote all round health, good diet, some exercise they can do, stress reduction, as well as COVID stuff - masks, hand hygiene'*
>
> Florence, 3rd year

The ability to be healthy in illness was a distinct element within participants' definitions of health. They felt it possible to maintain health in illness through a range of factors such as medication, physical and mental support, plus being hopeful and positive in outlook. Regarding shared elements within participants' definitions of health, the most striking factor was that all participants viewed the definitions to be personal and unique. The ability to maintain health in illness was an item frequently mentioned (see Figure 7-1) in the definitions of views of participants in all years of the nursing programme (see Figure 7-2). These data included views shared by participants at a point in the nursing programme prior to placement learning when they had only been exposed to the university-based element of their studies.

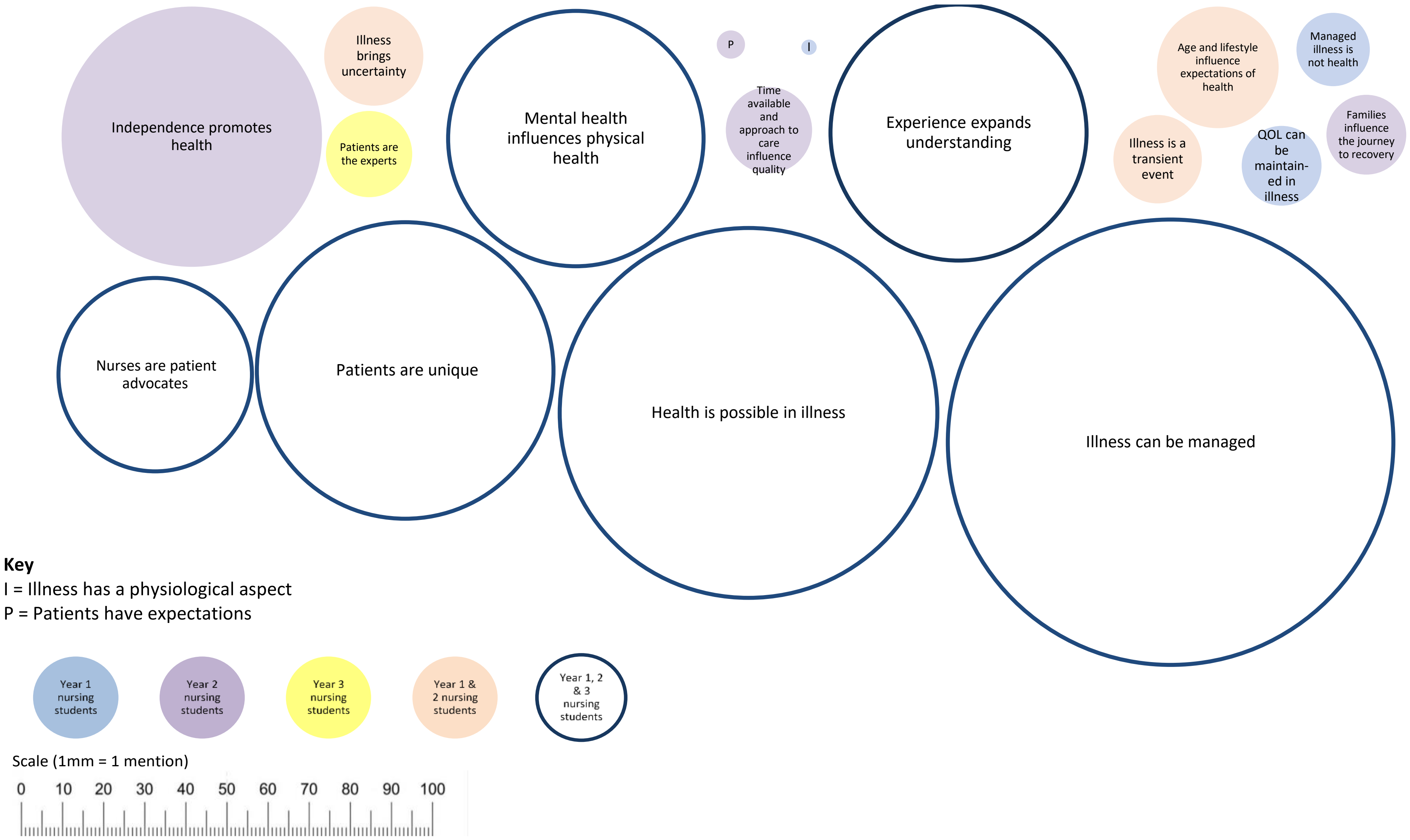


Figure 7-1. Frequency of mention

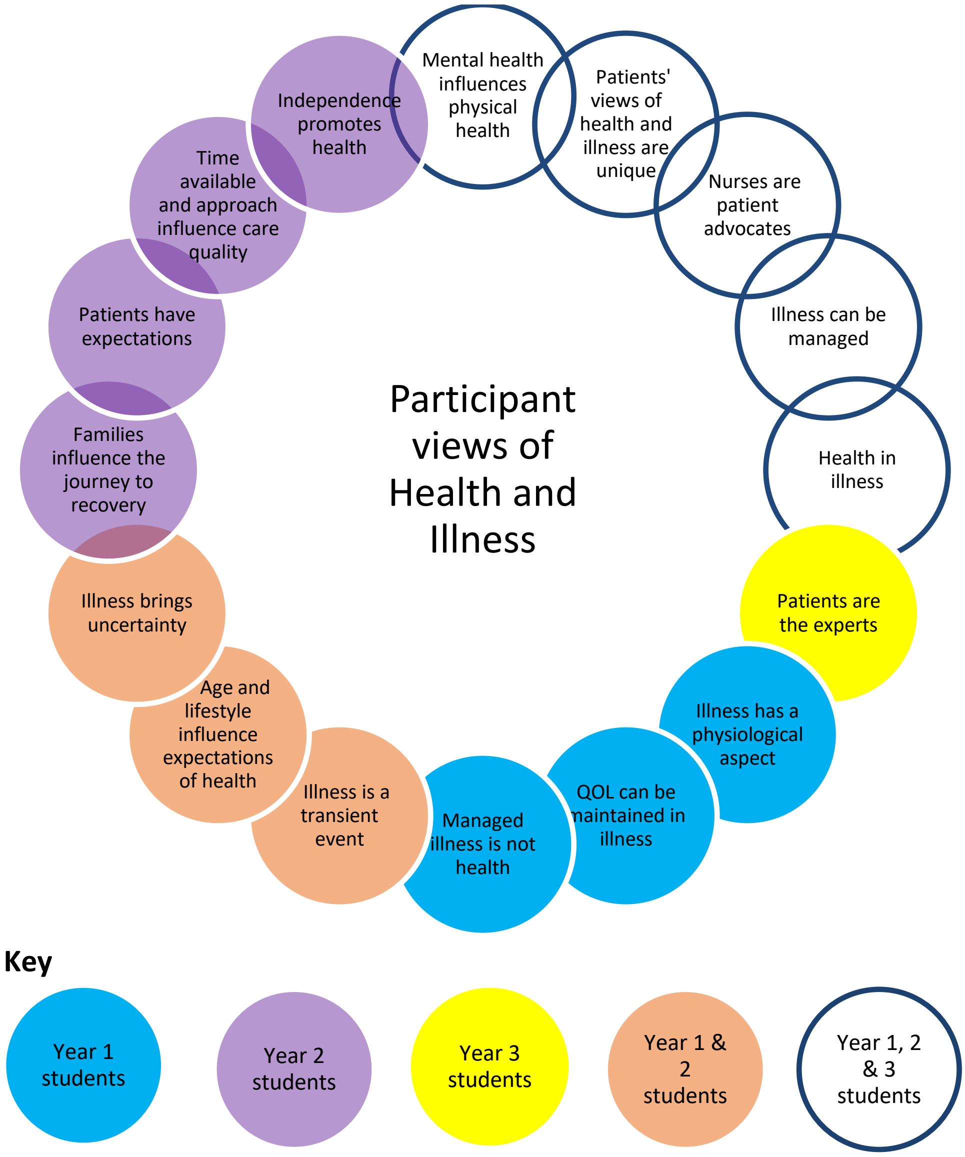


Figure 7-2. Similarities and differences across year groups

Considering these Figures and specifically Figure 7-1, it is appreciated that numbers are not the focus of qualitative data, as what might be said by just one person in a single utterance could be pivotal. However, an overview of the frequency at which items were mentioned highlighted shared views and indicated what was identified as potentially important.

Figure 7-1 depicts how often participants made specific comments. The size of each circle surrounding the participant comment increases the more often the comment is made. The colour of each circle indicates whether the comments were made by participants in one specific year of their programme, or whether the view was shared by participants across more than one year.

Figure 7-2 focuses on participant year group. The colour of each circle identifies whether the comments were made by participants in one specific year of their programme, or whether the view was shared by participants across more than one year.

Age and lifestyle were factors which featured in the definitions of participants in year one and two of their programme (Figure 7-2). There was general ambivalence about whether age was relevant to health, *'Age may or may not influence health'* (Sydney, 1st year) and *'It is perfectly possible to be old and healthy, or old and unhealthy, or even young and unhealthy'* (Maeve, 2nd year), whereas lifestyle was thought to be of more direct relevance, *'If you have poor health habits, live an unhealthy life, it's difficult to attain health'* (Quinlan, 2nd year) and

> *'a poor lifestyle catches up with you. Good health isn't associated with smoking, drinking and neglecting yourself'*
>
> Lizzie, 2nd year

While there were strong links between making wise health choices and remaining healthy, there was not any element of blaming individuals for not attaining a good level of health. It was felt, '*health is a lottery – it depends on good luck'* (Kathleen, 2nd year), *'health is a tightrope walk and it's easy to fall off'* (Ellery, 3rd year), with those caring for individuals who had followed healthy lifestyles but still became ill not passing blame,

> *'I looked after a patient* [aged] *28 with MI* [myocardial infarction]. *So young! He was a runner, every day he ran. Didn't stop him becoming ill though* […..]*, It was due to his genes, strong cardiac family history. He couldn't outrun it, no matter how hard he tried'*
>
> Maeve, 2nd year

While it was clear that the participants related the outcome health to healthy behaviours, they also expressed an element of fatalism in their views as to whether health could be maintained.

In their definitions of health participants also frequently referred to illness because the two concepts were not seen to be mutually exclusive,

> *'health is in dynamic continuum with illness. They cannot be separated because they're intertwined'*
>
> Grace, 1st year

> *'Health and illness co-exist, are complex* [and] *comprised of mental, social and physical elements'*
>
> Harriet, 3rd year

7.3 Defining Illness

During participants' discussions on their definitions of health and illness the similarities between the contents of what they were saying and the words they were using were noticeable. This finding will become increasingly evident throughout this section.

Participants very clearly identified the issue of personalised perceptions in their definitions of illness, recognising that *'views of what constitutes illness differ greatly'* (Florence, 1st year), *'views of illness are individual'* (Maeve, 2nd year) and '*Illness is unique to each individual'* (Iris, 3rd year), in which the participant duplicated exactly what they said about health. The importance of taking a person-centred approach was also stressed, *'always view illness from the patient's perspective'* (Phoebe, 2nd year), which again mirrors the words applied in the discussion referring to health. Participants believed in ensuring that in illness individuals remained autonomous and were respected, consulted and enabled to maintain as much independence as they wished: *'illness can be managed to maintain dignity'* (Phoebe, 2nd year), '*even in illness it's possible to ensure people are in control'* (Harriet, 3rd year), *'We can promote independence in illness, that's a good approach'* (Sydney, 1st year). The participants viewed the persons they delivered care to as precisely that, persons, despite being ill and needing support, *'Patients are more than their* *illnesses'* (Iris, 3rd year), although there was recognition of the differing manifestations of illness, *'how illness shows itself can contrast greatly'* (Phoebe, 2nd year), *'Illness is hugely variable - it can be invisible or can make a big impact on life'* (Harriet, 3rd year).

Similar to the definitions of health, there was recognition of a link between mental and physical aspects of illness, '*Mental illness can result in physical illness'* (Iris, 3rd year), but the converse was not necessarily seen to follow, *'You can be physically ill but mentally healthy'* (Sydney, 1st year), '*Mental illness can impact physical health, but physical illness doesn't always influence mental health'* (Harriet, 3rd year).

Participants viewed illness from a positive perspective, outlining that '*illness doesn't have to stop you from living a productive life, achieving what you want'* (Tatum, 1st year), with the possibility of illness being *'managed to achieve a healthier state'* (Florence, 3rd year). When talking about illness participants frequently mentioned that illness could be managed; as identified in Figure 7-1, this comment occurred the most frequently. Participants did not view illness as necessarily being a negative state and felt it was possible to maintain quality of life: *'quality of life and illness aren't mutually exclusive'* (Betty, 1st year), *'patients do maintain a positive outlook in illness'* (Iris, 3rd year) and *'Patients with extensive illness can still live a life that's worth living'* (Sydney, 1st year). Adapting to, coping with and being accepting of illness were seen as strategies which enabled a positive approach, which they thought became more achievable as time progressed and illness became longer term. This perspective was clearly captured when participants spoke about what they had observed:

> *'Patients can adapt incredibly quickly to illness and be accepting of* [the] *limitations* [it may bring]. *It has been amazing to see what patients cope with, how they can accommodate illness and still live their life* [.....] *go out with friends, visit their family. I saw this so often'*
>
> Harriet, 3rd year

> *'With the passage of time people adapt their lives to cope with illness. I've seen that on my placement, in patients with long-term illness. It's also the same for my friends and for me with my long-term illness'*
>
> Betty, 1st year

In a further similarity with the definition of health, age and lifestyle factors were mentioned within definitions of illness, *'The chances of illness increase with age, but it isn't definite, you can be aged and not ill'* (Grace, 1st year) and '*Lifestyle factors will make you ill if you don't look after yourself properly'* (Phoebe, 2nd year). Again, while there was an element of personal responsibility within discussions relating to lifestyle-related factors, there was no undercurrent of blaming individuals for illness potentially resulting from lifestyle choices. This was felt to be especially relevant to the participants' personal experiences in the programme, with recognition of how specific work patterns and financial issues can increase the ease of living what could be viewed as an unhealthy lifestyle:

> *'Lifestyle is linked to illness, but many lifestyle factors aren't easy to change. We have learnt about modifiable risk factors and what can be done to effect change. But, well, using me as an example, when working shifts, it isn't easy. When I'm tired, hungry and don't finish a shift until after 9pm, a salad just isn't going to cut it.* [Laughs] *Stopping at the chip shop will always be a more enticing option!'*
>
> Florence, 3rd year

While positivity was inherent in definitions of illness, there was also a clear understanding of difficulties. The experience of illness was seen to be challenging, '*Accepting illness is challenging, being ill is challenging'* (Catherine, 3rd year), as was supporting others who were ill, *'seeing others being ill is challenging - family, friends and patients. It's hard'* (Dora, 3rd year). Further challenges were seen to be presented by the structures of health and social care, financial support and dealing with the attitudes of others:

> *'getting patients accepted by the correct department for treatment they need is hard, not sufficient services, in hospitals and in community care, so people can't get what they need'*
>
> Dora, 3rd year

> *'I don't know how some patients manage to survive with their finances. Illness makes you poor.* W*hat people are expected to live on isn't generous'*
>
> Uliana, 3rd year

> *'Some of the public aren't helpful to ill people. I've seen shocking attitudes, no patience, no understanding. They don't think that it could, so easily, be them in the ill person's position'*
>
> Ellery, 3rd year

The SARS-CoV-2 pandemic was frequently highlighted within participants' definitions, clearly identifying feelings of uncertainty, fear and realisation of the impact of illness:

> *'COVID showed how healthy people become ill and die. Illness is a possibility for us all.'*
>
> Ada, 3rd year

> *'COVID caused so much devastation. It was desperate, patients were so ill, we were doing everything we could, so many died. It was so scary. I realised illness can just arrive, in your country,* [.....] *and be life ending for people and devastating for their families'*
>
> Florence, 3rd year

Participants' definitions of illness, similar to their definitions of health, indicated a spectrum:

> *'It's difficult to pinpoint exactly where it* [illness] *starts and health ends. Talking to patients, unless they've had acute trauma for example, they find this hard to describe, hard to define. One day you are well, next day you are ill, no! It doesn't work like that* [.....] *the dividing line isn't precise; it's like a spectrum* [.....] *and you can flip back and forth'*
>
> Naima, 2nd year

7.4 Wrestling with the Concepts of Health and Illness

Within participants' discussions, struggles to comprehend the concepts of health and illness, from a personal and a professional perspective, were frequently evident:

> *'Participants decide to work together to produce a definition of health for me. This activity provided insight as to the range of views, specifically difference in what was important. This caused debate, with the participants realising their views differed.*
>
> *The best description of the participants processes in this self-devised activity is that they were 'wrestling with the concepts'. They had moments of insight, followed by what they termed as 'confusion' when they realised what they had said worked in one situation but not another. After 18 minutes participants decide that they couldn't achieve an agreed definition that bettered the WHO, 'so we will stick with that' was their choice.'*
>
> Field Notes 05.11.2019

> *'Even though the WHO definition of health isn't completely right, it will have to do. I don't think we are going to be able to improve it!'*
>
> Joan, 2nd year

While this was the only incident of participants deciding to devise a definition, the processes outlined in this focus group, experiencing a combination of insight and confusion, were replicated on many occasions.

The complexity involved in the participants' attempts to assimilate their new and prior experience and/or knowledge was further shown in discussion relating to the use professional language. Participants spoke about the need to learn nursing and medical terminology and to be able to discuss illness in an accepted professional manner,

> *'In placement I learn so many new words. I keep a nursing dictionary in my pocket so I can understand and write down new ones* [.....] *so many new words that are so difficult to pronounce correctly!* [Laughs]'
>
> Betty, 1st year

While learning the relevant formal nursing and medical terminology was an expected element of the programme, what added further confusion was interpreting informal, colloquial use of language relating to illness, mainly used by nurses:

> *'I had a confusing experience. Afterwards my supervisor told me it was nurse speak,* [.....] *but not something you find in a nurse dictionary! Agh!!* [Laughs] *I was on placement in ITU* [Intensive Therapy Unit]*, Sister was telling us about the patients.* [.....] *She introduced a patient by saying, 'This is our poorly patient'* [.....] *I thought, great! I can look after this patient without being afraid something bad was going to happen. I can cope with poorly,* [.....] *poorly is a bad cold.* [.....] *But no, not in ITU!* [Laughs]. *As my supervisor told me*

> *afterwards, in ITU nurse speak a poorly patient is really, bad.* [.....] *They're the sickest of all and ITU patients are all really sick to start with!* [Laughs] [.....] *That was a totally new level of poorly to me'*
>
> Harriet, 3rd year

Confusion was a word often used by the participants when talking about the experience associated with the assimilation of new learning which enabled them to view situations from a different perspective. Participants recognised that they needed not only to become fluent in a formal new language, that of medical and nursing terminology, but also to be initiated into a less formal use of words. This was all compounded further by the need for participants to work as an advocate for the persons they were delivering care to, promoting, upholding and supporting views of health and illness which could differ from their own. When discussing this, the learning and experience gained was referred to by one participant as their *'journey to becoming a knowledgeable doer'* (Catherine, 3rd year), a comment inspiring the presentation of the data in visual format (see Figure 7-3). Figure 7-3 depicts participants as they progress through the programme, developing their understanding of different definitions of health and illness. All comments cited are the words used by participants.

Regarding the evolution of views and the increase of understanding, it was noticeable that development occurred even if they had prior caring experience, with the range of perspectives they appreciated still expanding, accompanied by the ability to underpin discussion with theory. Their views acquired breadth and depth during the programme, no matter whether they started with small amounts of knowledge and/or experience or more extensive ones.

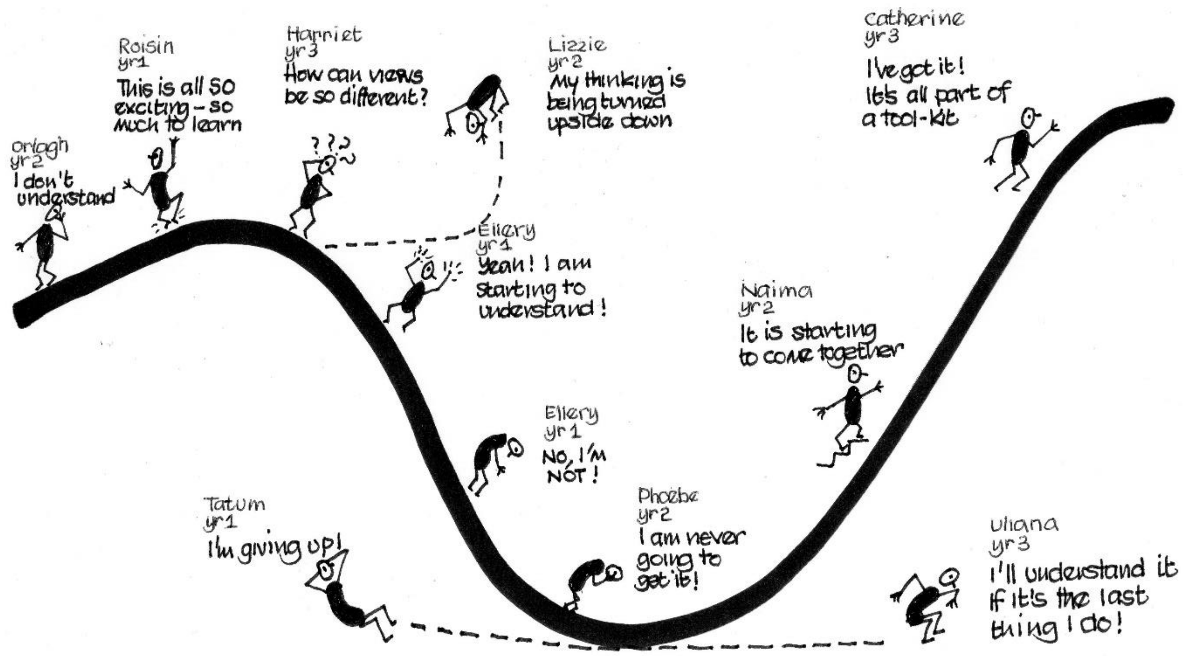


Figure 7-3. Evolving views of health and illness
illustration adapted from Fisher (2012)

The comment positioned at the top right-hand corner of Figure 7-3, *'I've got it – it's all part of a tool-kit'* (Catherine, 3rd year), is of clear significance. It indicates understanding of how it is possible to apply knowledge and experience to choose the correct approach (tool) to work in partnership with a person receiving care from the range of approaches available (tool-kit). In gaining experience and developing their knowledge, the participants were also gathering a wide range of potential approaches they could apply, a repository of experience. Some participants had developed the ability to be a 'polyglot' speaking and understanding 'a wide range of languages' which enabled them to support the different views of health and illness in the persons they delivered care to. Not all participants, however, attained this level of understanding prior to completing their nursing programme.

7.5 Category Summary

Within their definitions of both health and illness participants recognised the importance of the perspective of the person experiencing these states and identified a link between mental and physical elements. In response to being involved in the delivery of care during the pandemic, participants had a very deep sense of the influence of health on all decisions taken and the sudden devastation illness could bring.

Participants found the concepts of health and illness to be complex and difficult to explain, which was further compounded by two issues in nursing practice. First was a need to understand how it was possible to deliver care in a manner which upheld the perspective of the individuals receiving care, which may differ from the participants'. Second was a need to understand and apply not only a generally accepted nursing or medical language when discussing issues relating to the concepts of health and illness, but also a colloquial nursing language. Participants described that this informal language was used between nurses and healthcare assistants, involved the use of terms that were already familiar and frequently used in everyday discussion, but in manner that held a slightly different meaning than they had previously experienced.

While participants recognised personal responsibility for health and the prevention of illness in the respect of lifestyle factors, there was no feeling of blaming individuals for illness. In fact, there was clear comprehension of issues which could be out of an individual's control and the impact these had on their attainment of health. There was understanding of the challenges faced by those experiencing illness and the approach to illness was positive with a widely-shared view that health and illness were not mutually exclusive.

Participants described a process of insight and confusion within their evolution of views of health and illness, where new learning and experience did not always fit easily within their pre-existing perspectives.

While the participants demonstrated understanding of the objective classification of both health and illness, they adopted a subjective perspective in their definitions, reflecting the seminal work of Margo McCaffery (1968) relating to human suffering. Her definition of pain is that it is whatever the person who experiences it says it is and exists whenever the person says it does.

This definition can be repurposed to express the participants' subjective view of health and illness, that they are whatever the person experiencing them says they are and exist whenever the person says they do.

7.6 Conclusion

This chapter has detailed the emergent data category, 'Developing a Nursing Lexicon'. Data from this category underpinned the answering of the first and third research questions. Defining health, defining illness and wrestling with the concepts of health and illness were all considered, with experience resulting from the pandemic being an aspect of this consideration. The processes involved in developing a nursing understanding of the concepts of health and illness were described, as were examples to characterise how these processes were observed. There was agreement that views of health and illness are unique and individual, being whatever the person experiencing them says they are and existing whenever they say they do.

The following chapter in this Part of the thesis will continue the consideration of the emergent data categories and will present the category, 'Influencing Care'.

Chapter 8 Emergent Data Category – Influencing Care

'If, in nursing care, you don't understand the role of health and how to approach illness, you would make a very poor nurse.'

Florence, 3rd year

8.1 Introduction

This chapter reports the emergent data category, 'Influencing Care'. This was the final category to emerge in the research, fully emerging at the point of the individual interviews. Experience resulting from the pandemic is integral to the category. Ongoing iterative data collection applying constant comparative enabled the category to be fully populated, developed and refined, with the resultant data supplementing the detail of the answer to the first research question but the main contribution was the answering of the third.

This category recognises how views of health and illness relate to and underpinned care delivery. These views are also relevant to the initial decision to become involved in care delivery and undertake a nursing programme and, subsequently, in the choice of area to work in on completion of the nursing programme.

Students in the MH and LD fields of nursing reported experience of views of health and illness being applied to determine the worthiness of care delivery. This specifically related to the performance of practical care skills and contrasting approaches to care within care delivery.

8.2 Views Influence Care Delivery

Discussion with participants made it evident that their views of health and illness could motivate them to participate in care delivery and to choose to apply to a nursing programme. For some this was as a result of their view of health and illness resulting from the experience of caring for others or personal illness, but for others the stimulus was entirely different:

> *'My view was influenced by experience before I started the nursing course, which made me want to nurse.* [.....] *Helping at a care-home made me think positively about older people. They could be very healthy, but I enjoyed working with those who were ill the most.* [.....] *I saw illness,* [3-second pause] *as, sort of a good thing I want to be involved with.* [Laughs] *That sounds wrong! I don't mean it in a bad way! But* [4-second pause] *that I could help people who are ill and get something back from doing it.'*
>
> Orlagh, 2nd year

> *'it* [nursing] *was a snap decision for me, but I always knew I wanted to work, like, helping people.* [.....] *In a documentary I watched nurses were helping people who were ill. I just thought I want to, you know, to be able to help people when they are in, you know, the greatest hour of need. And then I was like, that's what I want to do.'*
>
> Uliana, 3rd year

A positive view of illness resulting from having a family member who was a healthcare professional was also influential in participants' choice to become a nurse. What was frequently highlighted was the personal reward their family member gained from their role, that they *'got something back, not money, a good feeling, a buzz, from what they did'* (Tatum, 1st year). Typically, a female relative who was a nurse was the family member identified as being responsible for having this influence, although for one participant:

> *'Mum and Dad, Aunt, Grandmother – all nurses. It was sort of inescapable for me!* [Laughs] [.....] *What influenced my view of illness was that they really loved what they did and were such good role models.'*
>
> Ellery, 3rd year

As is mentioned within this view, the influence of role models was frequently discussed during all elements of data collection. Participants often spoke about experience of working with others who demonstrated care delivery and shared views of health and illness they wanted to emulate. They also, however, used the term ‘negative role modelling’ when discussing the practice of others. This term referred to care being delivered, usually by Registered Nurses, in a manner they viewed as unacceptable:

> *‘I learnt how not to do things from negative role models’* (Quinlan, 2nd year)
>
> *‘I learnt how important being person-centred was from someone who didn’t seem to have that as an essential aspect of their view of illness. Their bad care is something I will not repeat.’*
>
> Uliana, 3rd year
>
> *‘Negative role models,* […..] *made me realise how important it was that I did things in a good way, not follow their example. Very powerful learning.’*
>
> Orlagh, 2nd year

Participants expressed concerns about their difficulty in discriminating between positive and negative role modelling, especially during placements at the start of the programme. At the programme’s start participants had felt highly vulnerable, lacking nursing skills, knowledge and confidence, so wanted to be exposed to others who they viewed as having positive views of health and illness from whom they could learn:

> *‘on my first placement, there were staff who had forgotten the things that we were being taught, the importance of communicating, finding out what patients want and helping them to get that, encouraging them to be independent.* […..] *It was a busy area, they were short of staff, but they just ‘did tasks’, they didn’t do ‘care for patients’,* […..] *They didn’t*

> *individualise things or motivate patients to do what they could.* [5-second pause] *There is a difference between doing tasks and nursing properly. You need to be person-centred.'*
>
> Florence, 3rd year

The observation of care delivery unsupportive of the perspective of health and illness held by the person receiving care strengthened a participants desire to deliver care in a manner that did. Even though students felt they should conform to the dominant caring culture in a clinical placement,

> *'it is a difficult one* [.....]*. The placement are completing my assessment* […..] *so they expect to see me doing things their way'*
>
> Ada, 3rd year

they were discriminating in the practice they adopted. The importance of having insight into your own views was emphasised when deciding whether or not the care being role modelled should be viewed positively and therefore something to emulate,

> *'I think how I would want my relatives treated – that's a good way to judge good care'*
>
> Quinlan, 2nd year

> *'it really isn't hard.* […..] *Patients should be listened to and treated with respect, dignity, be compassionate. You don't need to be a professional to know that - you should just instinctively treat others that way'*
>
> Iris, 3rd year

Participants could, however, appreciate the importance of working with others who viewed health and illness from a perspective distinct from their own. This was seen to enable them to consider their own views, '*I can feel my brain expanding when I work with nurses who challenge my views'* (Ada, 3rd year), and to offer the potential of developing them:

> ‘*I’m learning different isn’t bad,* […..] *there isn’t just one view that’s right in how best to work with patients. Different is just different!’*
>
> Kathleen, 2nd year

Thus, differing perspectives were clearly valued, as long as they upheld what was seen by participants to be care of good quality,

> *‘as long as the person we are caring for gets care they want, it’s based on good evidence and delivered with compassion. Even if I would do it another way, it’s still good care.’*
>
> Dora, 3rd year

As already mentioned, the view that illness can be managed was one strongly shared by participants. This, in turn, influenced the ways in which participants delivered care,

> *‘I think carefully about how I can help patients to understand things about their illness, so at mealtimes, or giving out pills, I make the most of that time to talk with them about how they can use nutrition, or their tablets to stay as well as possible’*
>
> Lizzie, 2nd year

> *‘Patients want to live a normal life, do what they want to do.* […..] *I think they should still be able to do this when they’re ill. So, the first thing I do is find out what is important to them* […..] *and as I work with them we fathom out, together, how we can still get that’*
>
> Phoebe, 2nd year

as well as delivering care which featured activities they personally felt were important in remaining healthy,

> *‘For me, exercise is important in staying healthy, so I do lots of walking! When I’m with patients, I get them to walk as much as they can. I stay healthy by going on long walks,*

> *climbing mountains, well big hills.* [Laughs] *I don't get patients to do that, but I get them to walk around the bay, around the ward if they can, or if they can't do that, just around their bed.'*
>
> Róisín, 3rd year

thus, participants expressed congruence between their personal views of health and illness and their care delivery.

Consideration of all aspects of the participants' discussion on how their views of health and illness related to their delivery of care enabled the identification of processes and approaches, as demonstrated in Figure 8-1.

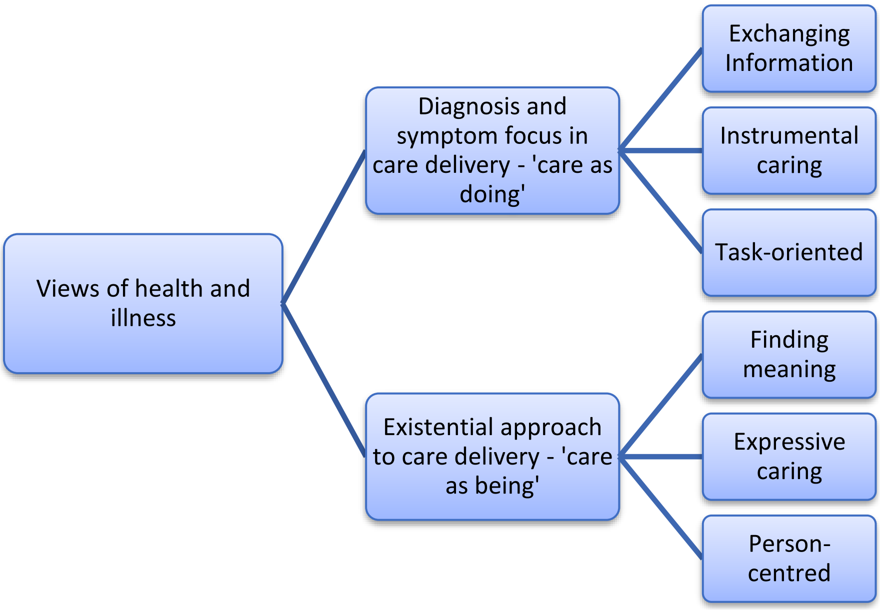


Figure 8-1. Relationship between views of health and illness and care delivery

When discussing care delivery, participants holding less complex views of health and illness described care delivery with a greater focus on the cause of illness, diagnosis and symptom management. This was associated with implementing care processes relating to information exchange: for example, asking the person they were caring for questions to obtain the information they required to complete assessment paperwork, or providing educational information in response to symptom management:

> *'What I do, make sure is done, is to get all the documentation completed, plus do the obs* [recording blood pressure, pulse, temperature and respirations]. *This is good, as I get the patient to answer questions, so I have their information* [.....] *this helps us improve their symptoms.'*
>
> *Grace, 1st year*

This approach to care focused on meeting physical activity-related needs and undertaking practical care skills. From the narratives shared by participants the care delivered was appropriate and instrumental in achieving a specific aim. Clear connections were being made with the recipient of care but on a functional level, with support being in response to physical need. The perspective described by participants identified the recipient of care as an individual with a specific disease or condition, someone whose primary needs related to their diagnosis to whom care was done.

In discussions about care delivery, participants holding multifactorial and multi-perspective views of health and illness placed greater importance on psychological support. They not only highlighted processes relating to information exchange, but also offered opportunities to discuss relevant issues regarding the impact they have on the individual's perspective of health, illness and their personhood:

> *'What is important is to give people time. They might want to talk with me, or they might not! When doing everyday things, I include the patient. So, I complete the paperwork as close to the person as I can. We talk about what I'm writing and what it means. When we are doing other care activities, we talk about everything. What I really want to know is how they're feeling, in their heads, what is important to them and how is their world'*
>
> Ada, 1st year

This approach focused not only on meeting physical activity-related needs and undertaking practical care skills but also on the care delivered which encouraged expression of psychological needs and recognised social factors. The perspective described was one which viewed the recipient of care as unique and individual, a member of a family and a community, with desires and goals they wished to attain who also had a specific disease or condition. The individual was seen as a person and the approach to care delivery was holistic with care part of the person's being. This approach was highlighted far more frequently as the participants progressed through the programme. As student understanding of views of health and illness became more complex, their care correspondingly became more person-centred, but as Ada demonstrated in the previous quote, this was not exclusively the case: some participants in the first year of their programme were also clearly able to articulate the importance of different approaches to care, outlined their value and demonstrated the perspective that care delivery involved 'being with' a person rather than 'doing to' them:

> *'you have to offer care that meets all needs. So, undertaking nursing tasks – making someone's bed – a 'doing task',* [.....] *can be a good opportunity to offer the person the ability to talk about their feelings.* [.....] *and if you turn a 'doing task',* [.....] *into a 'thinking task' so, use the time while you are doing the task* [.....] *to talk about how they're feeling, what they're experiencing, what their family is feeling. Give them space to say whatever they want* [.....] *that's making a 'doing task' into a 'thinking task'. Nursing isn't just 'doing*

> *task's', it's making the most of them, thinking about the extra value you get from offering support to a person as you do.* [.....] *'doing tasks' become 'thinking tasks' and that makes a difference.'*

Catherine, 1st year

Participants also applied differing classifications to the approach to health and illness in placement areas and in wider healthcare organisations. In respect of the culture of the specific care area or team they could describe a prevailing professional perspective in relation to views of health and illness. This also reflected the two previously described perspectives, either being task-oriented, where connections were made with a recipient of care but on a functional level, or with an approach they described as person-centred and holistic:

> *'there are different approaches in placement areas.* [.....] *this can show a view of health and illness* [.....] *with some areas really supporting the view that the patient should supported to achieve what is their goal,* [.....] *care focuses on health as is what the patient wants.* [.....] *other areas, not really, well not at all. It is about doing tasks, a bit like a production line with the same plan of care and goals for all.'*

Uliana, 3rd year

and they also applied such distinction at the wider organisational level:

> *'different Trusts see health and illness differently. The community Trusts, they have a view that supports a much more person-centred approach.'*

Ada, 3rd year

Participants' views of health and illness were presented as factors taken into consideration when deciding where to work once they completed their programme and therefore the type of care they would be delivering:

> *'I was an HCA* [Health Care Assistant] *before I started the programme* […..] for *more than 10 years. I worked in A&E* [Accident and Emergency] […..] *I enjoyed it but I'm not going back to be a Staff Nurse.* [….] *I've realised I want more in my nursing than patching people up, well, that's unfair,* [4-second pause] *what I'm trying to say, it sort of goes back to my views of health and illness, things we have spoken about.* […..] *As an HCA I was happy with what I did, but now, I think my view of illness is different. It isn't just about immediate care, a quick fix* […..] *it's more complicated.* […..] *Being healthy is something I want to work with patients to gain on a longer-term basis.* […..] *I wouldn't fit in A&E anymore; my Staff Nurse job is Stroke Rehab.* […..] *I can work there with patients in the way I enjoy.'*

Róisín, 3rd year

> *'In choosing my Staff Nurse job* […..] *I thought about how I wanted to nurse.* […..] *What I wanted to do as a job* […..] *how I wanted to nurse, reminded me of what I had said about my views of health and illness!* [Laughs] […..] *The perspective I view them* [health and illness] *from is broad, the sociological aspects are what I think are important, across the whole family. That interests me.* […..] *So, I'm not a hospital nurse, that isn't me, I've got a job in the community, that's how I see health and illness, that's my sort of nursing!'*

Dora, 3rd year

The participants' choice of areas they wanted to deliver care in as a Registered Nurse reflected three potentially differing perspectives in respect of health and illness. In the first instance the participants' personal perspective made a care area or speciality interesting and an area where they wanted to work. The second perspective was the prevailing professional perspective, the culture in the specific care area or team relating to views of health and illness, while the final one was the wider organisational perspective, the perspective of the healthcare provider. It was seen as important that these *'all fit together' (*Ellery, 3rd year) in respect of views of health and illness and *‘synchronise - for me to have found my nursing people!’* (Ada, 3rd year). This is presented pictorially in Figure 8-2.

Figure 8-2. Three perspectives in synchrony

If the participants’ personal perspective aligned with the prevailing professional perspective of an area and the organisational perspective of the healthcare provider, in a manner like cogs turning in synchrony, participants felt it was more likely that they would be able to deliver care in the manner they desired and be happy working in the area.

8.3 Views May Influence Worthiness

Throughout the focus groups, discussions were harmonious and topics were considered in a collaborative, amiable manner, supportive of the range of views. As has been previously discussed, participants’ views of health and illness differed: while there were shared features, individual views were unique and distinct. All views, however, had been consistently accepted within the group of participants, without any indication of judgemental reactions. This made the recounting of experience in which the approach could be described as tribalistic extremely salient. In this discussion between participants there was the recounting of examples where the difference in the prevailing views of health and illness held by separate nursing fields was applied as a factor discriminating the worthiness of care delivery.

'As a mental health nurse, we aren't 'proper' nurses. [moves fingers to signal speech marks when 'proper' and later when 'properly' are said] [.....] *In the views of some other nursing students, mental health illness isn't proper illness, and how you care for patients with mental health needs isn't proper nursing. It is just talking!* [.....] *The people we care for aren't 'properly' ill - we don't do 'proper' nursing skills, well, that's what some other fields think.* [.....] *Us,* [mental health nurses] *we aren't thought to be at the same level as adult or child* [students] *but, at least we are higher up the pecking order than LD* [learning disability]. *They* [points towards group member who is a learning disability student] *aren't proper at all!* [Laughs]'

Anonymised, 1st year

'[Laughing] [Response from group member who is a learning disability nurse] *Yes, yes! That's all true! As a learning disability student, I'm at the very bottom of the pile! Every pile!* [Laughs] *The people I work with, well, such stigma, it rubs off, plus, well* [3-second pause] *I think it seems to all revolve around skills.* [.....] *In the programme these comments started as a skills issue. Nurses do skills, dressings, giving medications, giving IVs* [intravenous drugs], *but it has been commented on by other students and even a lecturer, 'These skills are for adult and child field nurses'. So, not for us, mental health or learning disability students.* [5-second pause] *It seems to be because we don't do those skills very often, the technical skills some people think are important in nursing,* [.....] *so we aren't proper nurses. They don't see the things we do, helping someone gain a bit of independence for example, as being just as important.'*

Anonymised, 1st year

'Yes! To me, I think that can be a definition of health - someone being able to achieve independence, even a little bit, that is health. Not everyone sees it like that though. [.....] *It*

> *seems that some adult and child students think that doing skills are important in health* [3-second pause] *and in illness, maybe more so in illness. We see it differently I suppose'*

Anonymised, 1st year

A perceived lack of parity of esteem relating to the general perspective of care delivery within different nursing fields was also reported regarding experiences during the pandemic:

> *'In the news, all that's being reported is the COVID frontline is in ITUs. I want them to come with me for a shift! Come to my mental health hospital. The news is just about adult field nurses. No other* [field of] *nurse has been on the front line! That's not right. In my mental health hospital, a couple of the wards absolutely turned into COVID wards.* [.....] *And is it not kind of more impressive? The fact that you've got mental health staff without all the equipment that general hospitals have? But again, no! The news reports are only that the general hospitals have had COVID over the last 18 months. While mental health, if you look at the current government's manifesto, there is a lot of talk about mental health. But it's just paying lip service, double standards, healthcare is physical health focused.* [.....] *Adult health nurses are viewed positively, mental health* [nurses], *even if people are starting to see that they need to think about their mental health, we aren't as important.'*

Anonymised, 3rd year

8.4 Category Summary

Views of health and illness were identified as being influential in the decision to become involved in care delivery and commence a nursing programme. The view that illness could be a positive experience from the perspective of those delivering care was gained by participants from family members in healthcare professions, who were frequently identified as early role models. The influence of role models on views of health and illness persisted throughout the participants' nursing programme. These role models were not exclusively responsible for the delivery of good care, as participants also recognised what they called ‘negative role models’ who were viewed to provide potentially very powerful learning by demonstrating how not to deliver care effectively. Participants recognised that care was delivered differently by different individuals, which didn’t necessarily make it bad, but, at the start of the programme particularly, they found it difficult to distinguish between good and bad care. They relied on their own views of what was important in illness, in combination with care delivered in a person-centred manner to identify what care delivery they should emulate. As views of health and illness become more complex, care delivery became increasingly person-centred. The influence of role models, frequently within placement areas, but also those who had been encountered prior to and outside the nursing programme, was fundamental in developing an approach to care delivery that was congruent with views of health and illness.

The view that illness could be managed was a clear influence on care, with participants outlining that assisting the persons to whom they delivered care in the management of their illness was an important part of their role. Strategies participants recommended to remain healthy were based on the activities they viewed as being important to their health. There was the suggestion of a desire to achieve congruence between their views of health and illness and care delivery. The desire to be able to deliver care in a manner which upheld their views of health and illness was a factor in participants’ choice of where they chose to work at the end of the nursing programme. Views of health and illness were also considered by participants in the MH and LD fields to have a potential to be used judgementally, in that they could imply the worthiness of care delivery.

8.5 Conclusion

This chapter has detailed the emergent data category, ‘Influencing Care’, and discussed its properties. How views of health and illness influence care delivery and the impact of tribalism were considered, with experience resulting from the pandemic being integral. Views of health and illness related to and underpinned care delivery. Furthermore, views of health and illness were relevant to the decision to undertake a nursing programme and, subsequently, to choose the clinical area to work in on completion of the nursing programme.

The processes underpinning the link between views of health and illness and care delivery were outlined, with examples presented to characterise how these processes were observed. It was demonstrated that as views of health and illness develop, care becomes increasingly person-centred. The data from this category supplemented the detail of the answer to the first research question but mainly contributed to the answering of the third.

The following chapter, the fifth in this Part of the thesis, will present the last of the emergent data categories, ‘Caring for Self’.

Chapter 9 Emergent Data Category – Caring for Self

'you can't fill from an empty cup'

Ada, 3rd year

9.1 Introduction

This chapter outlines and provides details of the emergent data category, 'Caring for Self'. Within this category experience from caring for individuals during the SARS-CoV-2 pandemic featured strongly. While the embryo of the category was present in the first focus group discussions, it fully emerged during interviews with participants at the end of their programme. Ongoing iterative data collection applying constant comparative enabled the category to be fully populated, developed and refined. The category incorporates the properties of professional boundaries, which captured findings of how students applied their understanding of health and illness care to themselves and healthy working, which identified how their health was promoted within placement areas. This category provided data relevant to the answering of the third research question.

9.2 Professional Boundaries

At the end of their programme, when participants were looking back on their experience, there was understanding of the importance of nurses applying their understanding of health and illness to the care they delivered to themselves. There was, however, agreement that the nurses they had worked with were not effective in managing their workload within the time allocated to it to create a healthy work-life balance,

> *'Nurses can't work out what it's possible to achieve in the time they have.* [.....] *they think they are superhuman!'*

Joan, 3rd year

> *'What I've seen with nurses and other caring professions, we hold ourselves to different standards than we hold others to.* [.....] *We expect ourselves to achieve the impossible'*
>
> Ada, 3rd year

Such an approach was recognised to have a negative impact on the health of those who adopted this working style, *'when they* [nurses] *get really busy, they stop looking after themselves'* (Uliana, 3rd year), *'the Registered Nurses, they all worked extra hours, had no breaks, it was not healthy'* (Róisín, 3rd year), *'nurses aren't good at looking after themselves'* (Ada, 3rd year). The approach adopted, however, was not seen as particularly surprising by participants,

> *'if you think of nurses as a cohort of human beings that want to help others, it's natural that they put the needs of others ahead of themselves'*
>
> Ellery, 3rd year

but what was unexpected was how ingrained and accepted this was within nursing culture and normal working practices,

> *'Matron and Sister, they were just like the other nurses, it was known in the whole Trust that so many staff were not having their breaks, but none of the people in management roles thought it was a priority to be tackled'*
>
> Florence, 3rd year

with the situation further compounded by the views of others,

> *'Staff Nurses and Sisters, sometimes, they look down on the others who were keeping their boundaries, finishing on time, having their breaks – and kind of going – 'they're not working hard enough' or 'they're not doing their job properly'.'*
>
> Ada, 3rd year

While participants were able to demonstrate an understanding of why such working practices were adopted, *'there is just too much to do and not enough staff to do it'* (Ellery, 3rd year), with the high workloads staff were expected to manage being a frequent feature of discussion, the accepted working practice was not thought of as positive role modelling,

> *'Nurses have unmanageable workloads, crazy amounts to do. Then they can't do it in the way they want to – properly, so they get demoralised and burnout. A downward spiral'*
>
> Uliana, 3rd year

Such a perspective was often highlighted and while the participants understood the background to the situation, they viewed the staff responses as having a negative impact,

> *'What I see, in both community and hospital-based nurses, they all must work additional hours. They start their shifts early, they go home late and they work on their days off. These extra, unpaid hours are called 'Angel hours'. Even the high-level managers call them that!* [.....] s*o, when people are doing a physically and emotionally hard job they're still expected to give more, for free. So, they burn out.'*
>
> Ada, 3rd year

The mention of burnout was another frequent feature in discussion, with participants linking this to the delivery of care they viewed as not being of the quality required:

> *'I've worked with nurses who are just too worn down to do their job. It sounds harsh, but they need to move on, be moved on. They're weary, have had so much stress, so much change, but the pace of work is relentless. So, they go through the motions, the care they deliver is a range of tasks, they're mechanical, they don't give 'themselves'. Their care is missing something, because they can't give anything more and this leads to patients not getting the care they deserve'*

Dora, 3rd year

> *'It comes back to health again, if nurses aren't being healthy themselves, how can they promote this to others? How can they work with others to be healthy? They work too long, rest too little, eat badly, don't exercise. That's a recipe for disaster'*

Róisín, 3rd year

While participants could see that many of the Registered Nurses they were working with were not following healthy work-life approaches, they still reported similarities in their personal experience,

> *'Since I started* [the] *nursing* [programme] *I've tried to have better health, make good choices. But, oh no, I do a lot of wrong choices!* [laughs] *I don't exercise. I haven't exercised for weeks, months and shifts make it more difficult to eat healthily, so I've gained a lot of weight.* […..] *I find a lot of reasons for not eating healthily, not exercising, but um, you know, those reasons* [4-second pause] *they're not reasons, they're excuses!'*

Florence, 3rd year

One participant, however, found that their view of the importance of maintaining their health was not always met positively,

> *'There is a view in some* [nurses] *that looking after yourself isn't the right thing! It seems almost as if, umm, self-care is being selfish. That's such a damaging view. I do lots of exercise, I'm careful with my diet and keep myself hydrated. My approach hasn't always been supported in placements. I bring fruit to eat at work and a big water bottle. Too often other nurses feel the need to comment on this and it normally isn't supportive!'*
>
> Róisín, 3rd year

a perspective also noticed by others,

> *'There seems to be a whole thing of 'if nurses look after themselves, they're being selfish'. I don't really understand, it's a very strange approach for people who are responsible for improving health to take.'*
>
> Catherine, 3rd year

> *'Some wards don't allow you to have a water bottle, so if you don't get off the ward, you can't have anything to drink.* [.....] *When I asked why not, I was told, 'infection control'. Then you find, other wards, in the same Trust, just a bit further down the corridor, that have a 'hydration station' on the ward for the staff. So, it's not infection control, is it! On that ward it was because Matron doesn't want it.* [.....] *In nursing, at times it feels like the Labours of Hercules!* [Laughs] *That's what it feels like! So, don't try to be healthy, don't try to look after yourself because your view is 'If I keep myself healthy I will be better at keeping others healthy'. Being healthy isn't the accepted view.* [3-second pause] *Well, not everywhere, but in a fair number of places. So, you keep quiet.'*
>
> Ada, 3rd year

In discussion relating to the application of health-related knowledge to self, the perspective of one participant varied from the others. As identified in her previous comment, Róisín consistently described how she exercised and ate healthily, before she started the programme and since. Her focus on the importance of living a healthy lifestyle underpinned her perspective and was also one she applied to the care she delivered, as was detailed in Section 8.2.

9.3 Healthy Working

While participants shared experiences relating to differing perspectives on the importance of maintaining health for themselves and others they worked with, they also reported significant experiences regarding systems that influenced healthy working in their workplaces,

> *‘One ward was excellent at making sure everyone got breaks and were able to eat and drink at sensible times. How they managed it was the NIC* [Nurse in Charge] *was really on it! They role modelled healthy behaviour, looking after themselves. If you see the NIC having a drink, going for break, making it a priority that everyone gets off work on time, you go, ‘oh, that’s OK for me then’. On that ward, the senior staff, their actions said, ‘You are important and need to be looked after too’. Such an excellent ward. If you want staff to be healthy, it comes down to people’s leadership ability, management styles and walking the walk themselves. I’ll do this now.’*
>
> Ellery, 3rd year

Not all experience reported, however, was viewed as positive and replicable,

> *‘Halfway through a placement I got unwell and ended up in A&E. The ward I was on, it was hard to have the time to look after yourself.* [.....] *I have a long-term condition, which was a factor in me getting unwell.* [.....] *Because of the placement type I had to leave the drugs I usually keep with me in a locked cupboard. I managed my condition as best I could, but it was impossible to get to my medication when I needed it. As a student I wasn’t allowed a key to the cupboard.* [.....] *I tried to find someone with one when I needed my drugs, but everybody was always busy* [.....]. *It took me being admitted to A&E before a*

> *special arrangement was made. Surely, we should be looking after everyone's health, based on individual need? That should be the workplace culture, staff deserve that. Their health is important too.'*

Catherine, 3^{rd} year

While this experience was certainly the most extreme, in the interviews undertaken participants reported that it was unusual to have a shift where they had all the breaks they were due. On most shifts they felt that their basic nutrition and hydration needs had not been met. Being well-hydrated, however, was seen as leading to additional problems,

> *'I soon learnt not to drink too much while at work, because then you don't have to worry about not having the time to go for a 'wee'.'*

Florence, 3^{rd} year

Although such a comment could be seen to reflect the participants' application of 'typical nursing humour' in response to challenging situations, that itself demonstrates how the frequently-encountered unhealthy working conditions have become a normalised feature of a working day. None of the participants was either able to identify involvement in initiatives designed to improve the health of NHS staff or aware that such initiatives were in existence.

For many participants, the issue of considering their health in relation to working was one which they discussed regarding their experience before and/or during the pandemic,

> *'In my decision to work on the wards during COVID, my personal circumstances of needing to complete the course on time outweighed my concern for my health. I was petrified, but I just took I took a gamble, because that's what it was. We didn't know what was going to happen.'*

Ellery, 3^{rd} year

> *‘Deciding what to do in COVID-19, I did the risk assessments.* [.....] *I'm probably healthier than average.* [.....] *What was important was being out there, helping.* [3-second pause] *It sounds heroic now, it wasn’t! It was scary. I was really scared, but I didn’t think about dying, I was more worried about getting sick and being incapacitated, as it’s just me and the dog!* [Laughs]’

Ada, 3rd year

and the emotions they had been left with having a lasting impact,

> *‘People like to believe that we're superheroes, some nurses do too, but we’re not! COVID,* [5-second pause] *the impact on my mental health has been truly awful.* [.....] *One of the nurses who worked in the Trust I was in died and a friend ended up in ITU.* [.....] *I’m angry that people said the whole COVID thing was fake. I was terrified but chose to step up and do something about it.* [.....] *There is a health consequence in this, so many people are now struggling with mental health, it’s made a lifelong impact.* [.....] *I won’t forget that nurses went to work to help others and never returned home.’*

Joan, 3rd year

9.4 Category Summary

A range of challenges encountered during the programme were clearly expressed regarding creating and maintaining a healthy work-life balance. It was recognised that many nurses try to be ‘superhuman’, attempting to manage unmanageable workloads at a cost to their own health. Consequently, it was noticed that nurses frequently put the needs of others at a higher priority than their own health needs, but these actions were viewed as not being surprising in a group who chose to undertake roles where caring for others was a feature. What was viewed as surprising was that this approach had become an accepted working practice and could go unchallenged within the wider system of working and healthcare organisations.

Participants spoke about the negative impact of nurses attempting to manage unmanageable workloads, linking this to burnout and a reduction in the quality of care delivered. Within their personal practice, however, participants reported similar situations. Self-care and health-seeking behaviours were frequently not either seen to be a priority or met with positive affirmation from others.

In their experience of working clinically, participants described systems and structures in place in some areas that were supportive of health. These were not consistent, however, with experience of approaches that were clearly unsupportive and not facilitating health, especially for those with specific needs. The experience of delivering care during the pandemic was described using words such as terrifying, frightening and scary. Many participants were still processing the emotions they had been left with from their experience and expected what they had seen and been involved with to have lasting impact on their mental health.

9.5 Conclusion

This chapter presented the emergent data category, ‘Caring for Self’, providing precise details using the participants’ voices. They emphasised the challenges they experienced in valuing and maintaining their own health, resulting from personal and professional factors. The data from this category was relevant to the answering of the third research question.

While the participants were aware of the importance of a healthy lifestyle, they found difficulty implementing this within their own lives, due to challenges regarding mental and physical health. While there were instances of the culture within their working environment being one in which health for staff was promoted, this was not the experience most frequently encountered. Many staff did not value health in themselves or colleagues, with the environment generally being one where health was not promoted. Throughout the discussions, it was evident that experience of SARS-CoV-2 had an impact on participants’ mental health, leaving them with emotions they were still to fully evaluate and process.

This chapter concludes the reporting of the four emergent data categories. The next chapter, Chapter 10, which ends this Part of the thesis, will present and discuss the emergent grounded theory.

Chapter 10 Presenting the Theory of Balance

'Order out of chaos, gosh!, it really seems to be happening – I think the grounded theory process could be working!!! Now I just need to keep the faith!'

Reflective Journal Entry 25.09.21

10.1 Introduction

This chapter presents the emergent Grounded Theory: The Theory of Balance in Perception of Health and Illness and Care Delivery (Theory of Balance), drawing together the findings of the four data categories, 'Evolving Views', 'Developing a Nursing Lexicon', 'Influencing Care' and 'Caring for Self', which have been reported in Chapters 5-9.

The findings of the data categories identified views of health and illness to be progressive, where influences and reflective processes were fundamental in the progression between a simple view (an inductively-derived term used by students) and a more complex, multifactorial and multi-perspective one. As views of health and illness progressed in complexity, descriptions of care delivery became increasingly person-centred. Within their definitions of health and illness students made a link between mental and physical factors with the individual experience of the person being identified as important. Health and illness were seen to be states that were not mutually exclusive and could co-exist. The influence of role models was fundamental in developing an approach to care delivery that students felt was congruent with their views of health and illness. While demonstrating awareness of the importance of self-care and health-seeking behaviours, students frequently did not view these to be a priority to apply to themselves.

The Theory of Balance developed from these findings, explains how, within the context of pre-registration nurse education, views of health and illness may be related to care delivery through a logical pattern of connectivity. The emergent theory is presented in this chapter in both narrative and diagrammatic form.

10.2 The Theory of Balance in Perception of Health and Illness and Care Delivery

Throughout the presentation of the research findings, it was identified that student views of health and illness could be influenced by a wide range of interactions, experiences and social processes. Their perceptions were constructed as a result of this. Although individuality and difference were features of these data, there was agreement regarding a number of specific experiences and knowledge, which, over the course of their nursing programme, had been most significant in the development of their views (identified in Table 10.1). While elements of the formal teaching and practice experience provided throughout their nursing programme were clearly identified as factors influencing the evolution of views, they were not exclusively responsible for change. The impact of personal experience of health and illness was also clearly recognised, *'Walking in the shoes of a patient, by being one* [.....] *is a powerful teacher'* (Catherine, 3rd year).

Table 10-1. Most significant experience and knowledge

Formal teaching	Practice experience	Personal experience
Talks delivered by persons receiving care Lecturer-led sessions considering health and illness and reading pre/post these sessions Discussions relating to views of health and illness with lecturers and other students Assignments relating to health and illness	Involvement in care delivery Influence of role models Talking to persons receiving care and their relatives/significant others Learning to become a healthcare professional	Health challenges and illness, either personal or by family/significant others

From the descriptions the students provided of the care they delivered, it was also possible to characterise the impact their own experiences could have on their care delivery. The insight this provided, supplemented by my ongoing iterative analysis of the research data and application of abductive reasoning, identified that the emergent grounded theory consisted of three components:

Component 1 - perception of health and illness

Component 2 - the linked activities of noticing, experience and reflection

Component 3 - care delivery

Figure 10.1 outlines the connection between these components and the research questions, emergent data categories and their expression in the grounded theory, both illustrating how more than one emergent data category could relate to a research question and identifying that the data categories were the antecedents of the grounded theory component. These connections and relationships are examined in greater detail in 10.2.1, 10.2.2 and 10.2.3, with this consideration followed by the presentation of the Theory of Balance in 10.2.4.

Research question number	Relevant emergent data category	Related grounded theory component	Relationship with other components
1.	Evolving Views, Developing a Nursing Lexicon, Influencing Care	Perception of health and illness	In equilibrium with care delivery
2.	Evolving Views	Noticing, experience, reflection	Fundamental to change in equilibrium between perception of health and illness and care delivery
3.	Evolving Views, Developing a Nursing Lexicon, Influencing Care, Caring for Self	Care delivery	In equilibrium with perception of health and illness

Research Questions

1. How do nursing students perceive the concepts of health and illness?
2. How do nursing students make sense of their personal and professional experiences before and during a nursing programme, in terms of their perceptions of health and illness?
3. How do nursing students’ perceptions of health and illness influence their views of the care they deliver?

Figure 10-1. Connections and relationships

10.2.1 Grounded theory component 1. Perception of health and illness

The first component of the grounded theory relates to the first research question, ‘How do nursing students perceive the concepts of health and illness?’, and emerges from data existing in the data categories of ‘Evolving Views’, ‘Developing a Nursing Lexicon’ and ‘Influencing Care’. These data suggest that not all nursing students explicitly consider their personal views of health and illness during their nursing programme and not all nursing students are able to articulate and critically discuss their perception of health and illness. For those who did and could, the evidence gathered supports the proposition that students commence the nursing programme with different perceptions of health and illness. Difference was a clear feature which persisted throughout the course of their studies. Students regarded difference in perceptions of health and illness in those they delivered care to as being important because, by being aware of this difference, they could identify what had meaning to the individual. They also recognised that there was difference not only in the views of the persons they delivered care to but also in their peers views.

Students’ perceptions of health and illness are individual, reflecting personal, professional, sociocultural and organisational influences. When considering the perceptions they held at the start of their programme, students frequently characterised them as naïve or simple. By the end of the programme students all stated that they felt their perceptions had ‘matured’, ‘evolved’ ‘developed further’ or become ‘more complex’. Using the words of the students to describe this progression it is possible to categorise student perceptions of health and illness as between simple or more complex.

i. Simple (an inductively-derived term used by students) meaning they have little understanding of the perspective of others, or
ii. More complex, whereby students can clearly describe and comprehend differences between individually-held perspectives of others.

The concepts of a simple perspective of health and illness or a more complex one are integral to the Theory of Balance and will be discussed further in Chapter 11.

While the students demonstrated understanding of the existence of objective classifications of health and illness, such as identifying recognised signs and symptoms of specific illnesses, they adopted a subjective approach in their definitions. A key feature in student definitions of health and illness was the recognition that the elements viewed to be worthy of inclusion were variable due to context and the perspective of an individual. Such an approach reflects McCaffery's (1968) seminal work on human suffering. Her definition of pain can be repurposed to explain how the students perceive health and illness: they are whatever the person who experiences them says they are and exist whenever the person says they do.

The definitions students shared provided insight into the meaning they were allocating to the concepts of health and illness, from which I could comprehend their individual interpretations. This individual process of interpretation was influenced by broader cultural and social features, some of which are identified by the interactions, experiences and social processes outlined by Table 10.1. Thus student perception of health and illness can be shaped by the values, beliefs and norms the students experience.

The students held the generally shared perception that it was possible to manage illness and enable positive outcomes and a measure of normality within the everyday life of a person experiencing illness. What was notable was that students recognised that their perception was reflective of their current thinking and that, with increased experience, their perception may alter.

10.2.2 Grounded theory component 2. Noticing, experience and reflection

This second component of the grounded theory emerges from answers to the second research question, 'How do nursing students make sense of their personal and professional experiences before and during a nursing programme, in terms of their perceptions of health and illness?', and reflects data in the emergent data category of ‘Evolving Views’. In these data the linked activities of noticing, experience and reflection were identified to be a process by which views of health and illness evolved.

Student views are developed by making sense of both personal and professional experiences of health and illness by noticing the significance of the experience and reflectively engaging with it. These significant experiences may have occurred prior to and/or during the nursing programme. Students who could define their perceptions of health and/or illness identified that their views evolved by the application of a reflective process which focused on significant experiences of health and illness. The students who, in their narratives of their experiences, described this process of progression were not explicitly aware of the mechanism resulting in the development of their views and did not apply the term reflection to their description of what was taking place.

The noticing of the significance of experience and the use of storytelling to share the event were discernible features within this approach, which facilitated student understanding of what had happened and why. This process enabled students to find meaning in their experience and translate the learning gained to other relevant situations. Experiences that were seen to be significant could involve the students’ delivery of nursing care or observing care delivery by others and/or situations in their personal lives where they perceived a link to health and illness.

While students reported experience as central to evolving their views of health and illness, what was essential was their noticing the significance of the experience and then engaging reflectively with it. It is possible for the learning experience to be ignored, which was made evident when not all students noticed the significance of experience or reflectively engaged with it. In such cases students described how they performed the activities involved in an experience, care delivery for example, but did not consider or analyse what they were doing. The perception of health and illness of these students aligned with the simple category, identifying that the linked activities of noticing the significance of experience and reflectively engaging with it may be key to the evolution of views.

Students who noticed the significance of their experience engaged with it by the application of one of two slightly differing reflective processes, either The Eutheos Approach or The Janus Approach. The Eutheos Approach is a one-stage process (which I named using the Greek word, ‘eutheos’, which means immediately) where learning was derived from an experience either as it is happening or sometime soon after. This learning was translated into insight relating to nursing practice that was immediately applicable. The Janus Approach is a two-stage process (which I have named after the Roman god of transitions and duality, ‘Janus’; usually depicted with two faces, he looks both ways) where learning was derived by the experience of significance triggering realisation that the student needed further knowledge and understanding. Once they had gained the additional learning required, they were able to apply it to their nursing practice. Application of either The Eutheos or The Janus Approach assisted students’ to progress their views of health and illness from simple (a term the students used) towards more complex ones.

Therefore, the processes involved in noticing experience and reflecting on it appear to have relevance to the evolution of students’ views of health and illness. The process was dynamic, iterative and ongoing, with students constantly relating experience to their views of health and illness throughout their nursing programme. Previously held views were rethought, a new perspective was developed and then subjected to questioning, making the process continuous and one which students anticipated would continue once their programme had been completed. It appeared that student views acquired breadth and depth during their nursing programme through this process, with a period of confusion being a constant feature of the process.

10.2.3 Grounded theory component 3. Care delivery

The third and final component, care delivery, addresses the third research question, ‘How do nursing students’ perceptions of health and illness influence their views of the care they deliver?’, and reflects data from the data categories of ‘Evolving Views’, ‘Developing a Nursing Lexicon’, ‘Influencing Care’ and ‘Caring for Self’.

When they delivered care, students said that they held their own views of health and illness in abeyance and endeavoured to adopt and advocate for the view held by those they were delivering care to. Students identified the delivery of care in this fashion as an important feature of a person-centred approach. Person-centred nursing care was strongly aligned with good care, in that care was said to be tailored to the specific needs and desires of the person receiving it, which was what students stated they were aiming to deliver. In their descriptions of the care they delivered, some students, especially at the start of the programme, did not achieve this aim. What was highlighted instead was a functional approach, which is defined as involving the exchanging of health-related information and the task-oriented maintenance of physical health and comfort. It became possible to identify a potential relationship between views of health and illness and care delivery to others, with the approach a student adopted to care delivery existing in equilibrium with their perception of health and illness. In the data it was possible to identify that students with a simple perception of health and illness delivered care in a functional manner, while students whose perception was more complex adopted a more person-centred approach in their care delivery to others.

In terms of self-care, however, even students with a more complex perception of health and illness, plus comprehension of the importance of healthy lifestyles, were unable to adopt a person-centred approach, and struggled to apply their knowledge to themselves.

10.2.4 An emergent grounded theory

The Grounded Theory components of

1. Perception of health and illness
2. Noticing, experience and reflection
3. Care delivery

were, therefore, fundamental to the construction of the grounded theory, providing structure and enabling expression of the potential relationships being identified. The emergent grounded theory, the Theory of Balance in Perception of Health and Illness and Care Delivery (Theory of Balance), outlines how the concepts identified in answer to the research questions posed may be linked. Logical patterns of connectivity identify that there is a possible relationship between how nursing students perceive the concepts of health and illness and the care they deliver. Within this relationship how they make sense of their personal and professional experiences of health and illness before and during a nursing programme is pivotal, as presented in a diagrammatic representation in Figure 10-2. Examples of the developmental stages facilitating the development of this theory are provided in Appendix 17.

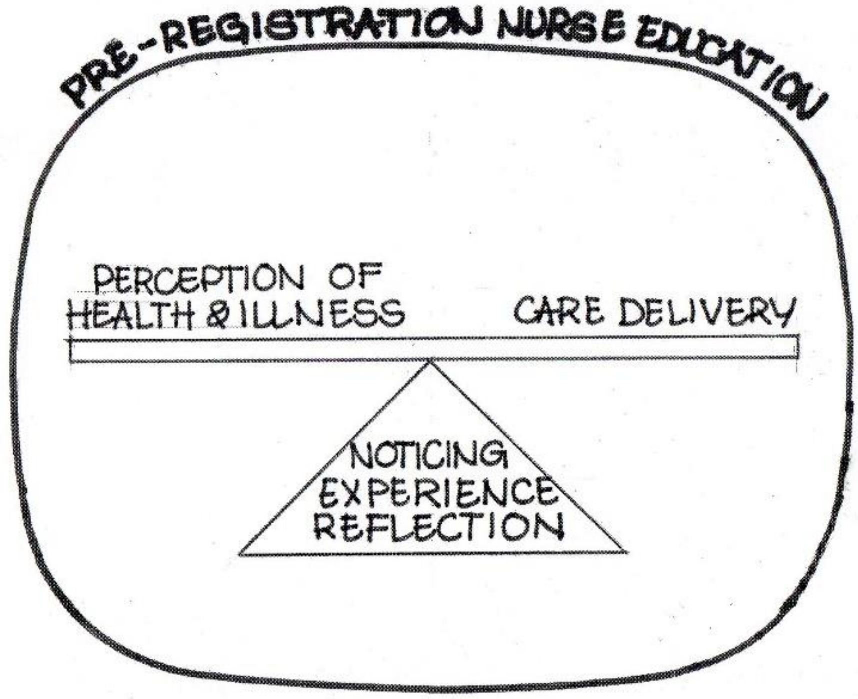


Figure 10-2. The theory of balance in perception of health and illness and care delivery

The Theory of Balance proposes that, within the context of pre-registration nurse education, a student’s perception of health and illness will be in equilibrium with their care delivery. The fulcrum to this equilibrium is the student’s experience of health and illness and their ability to make sense of this. Students with perceptions of health and illness that are simple (a term the students used) which means they have little understanding of the perspective of others and will deliver care in a functional manner. Students whose perceptions are more complex, whereby they can clearly describe differences in views and the impact these differences may have, adopt a more person-centred approach in their care delivery. It is possible for views of health and illness to progress from simple to more complex and this can result in a change in care delivery from functional to person-centred. What is essential to this progression is the noticing of significant experience and reflective engagement with it, which enables students to make sense of their personal and professional experiences of health and illness.

The noticing of significant experience and engaging reflectively with this can cause temporary disruption to the equilibrium between a student's view and their care delivery. This will result in a period of disequilibrium as a new order is being established, which students described as a period of confusion. The establishing of a new order is typified by challenge and struggle, as students wrestle with their understanding of the concepts of health and illness and the impact this has on care delivery. Once a new order has been established it is likely that equilibrium will return as new and existing experience and knowledge become amalgamated. Within the data there was evidence that the notion of equilibrium was restored following a period of confusion when students experienced disequilibrium. Student explanations of their perceptions of health and illness and approach to care delivery following this period supported the existence of a new order. It remains unknown, however, whether this is always the case. Also, as has been highlighted, not all students noticed experience as significant and engaged reflectively with it. Therefore it is not expected that they would experience disequilibrium and evolution of views through the process described. The existence of a different process was not evident from the data, so it currently remains unknown whether this could be so.

Students had differing perceptions of health and illness at the start of the nursing programme: while many had simple views, those of others were more developed. The categorisation of a student’s perception of health and illness, between simple to more complex, and the potential impact on care delivery this may bring, is unique to each individual and can change. It was possible for students to experience disequilibrium and for the outcome to be that their perception of health and illness remained simple, as well as for their perception to progress to something more complex. While the noticing of significant experience and reflective engagement with this can disrupt the equilibrium between perception of health and illness and care delivery, the amount and nature of noticing of significant experience and reflective engagement that resulted in a change of categorisation. The path followed among the students is very individual. Views of health and illness can be difficult to comprehend and achieving the effective delivery of person-centred nursing care takes understanding, knowledge and practice. It is possible therefore that a student could experience disequilibrium many times before their perspective became more complex and care delivery person-centred. Furthermore, and although it was not clearly captured within the research data, there is the potential that a student could be unable to gain sufficient significant experience to cause progression of their perspective from simple to more complex during their pre-registration nursing programme. The possibility of being unable to gain sufficient significant experience could also provide insight into why even students who have a more complex perception of health and illness and also comprehend the importance of healthy lifestyles struggle to apply their knowledge of health and illness to themselves. While they may have gained sufficient experience and reflective learning to enable progression to a more complex perception of health and illness which has resulted in a person-centred approach to the care of others, this may not be the case in respect of caring for themselves. Thus, they may require more experience and reflective engagement to achieve this. Currently, however, this remains unproven as, while it was not captured in the data, it may also be that the Theory of Balance describes only the potential relationship between perception of health and illness and care delivery to others and that the same potential relationship does not exist in respect of care delivery to self.

As the process of perception development was one where change was ongoing, what else currently remains unknown is whether, once views have become more complex and care delivery person-centred, the reverse of the process described within the research data could also be possible: that views can return to simple and care delivery to functional. While there was no suggestion of this in the data, there is the potential for any balance to enable movement in two ways, identifying, at least in theory, the possibility that views and care delivery could regress. Moreover, there is also the possibility that the position of the fulcrum of the equilibrium described within the Theory of Balance may not remain fixed at the mid-point, resulting in the equal weighting of perception of health and illness with care delivery being changed and therefore altering the equilibrium. Thus, the Theory of Balance is presented as a propositional grounded theory requiring further exploration.

10.3 Conclusion

This chapter has drawn together the findings reported in the previous chapters in Part 3 of the thesis by outlining the emergent theory, in both narrative and diagrammatic form.

Nursing students commence their nursing programme with differing and unique views of health and illness and maintain this individuality throughout the programme. The propositional grounded theory, the Theory of Balance, emergent from this research identifies the potential for a relationship between nursing students’ perceptions of health and illness and their identification of the care they deliver, where their approach to care delivery is influenced by the complexity of their understanding of health and illness. Three linked activities appear to be pivotal in the evolution of student views during their nursing programme: noticing, experience and reflection. It is proposed therefore that student views of health and illness have the potential to influence their care delivery, and that student views evolve due to experience, as long as the significance of the experience is noticed and the experience is engaged with reflectively.

The presentation of the emergent grounded theory, the Theory of Balance, brings Part 3 of the thesis to a close. What follows is the fourth and final Part, which discusses, reflects on and concludes what has been presented.

Part Four – Discussing, Reflecting and Concluding

‘Healthy citizens are the greatest asset any country can have’

(Churchill, 1944)

Chapter 11 Discussing the Thesis to Generate New Insight

'Reviewing the literature has not only added further detail, but identified so many more perspectives to consider'

Reflective Journal Entry 12.05.2023

11.1 Introduction

This chapter addresses the research questions by considering the findings and situating them in the context of the existing literature and theory to generate new insights. Throughout this discussion the role of the emergent theory is highlighted and its contribution to existing knowledge examined. Trustworthiness and the strengths and limitations of the research are considered and there is also deliberation of the implications for nurse education. The chapter ends by making recommendations which involve change at organisational and individual level plus a proposal for further research.

11.2 Reiterating the Research Questions, Methodology and Methods

This research explored the following questions:

1. How do nursing students perceive the concepts of health and illness?
2. How do nursing students make sense of their personal and professional experiences before and during a nursing programme, in terms of their perceptions of health and illness?
3. How do nursing students' perceptions of health and illness influence their views of the care they deliver?

A longitudinal qualitative and CGT methodological approach was adopted because this reflected my view that reality, regarding the focus of the research and more generally, is not fixed but is subjective depending on the perspective of the individual. The methodological choices made enabled me to gather the meanings and interpretations of the research participants over time, which facilitated the understanding I desired. Sampling was initially purposive and progressed to theoretical as the research proceeded, in line with GT theory. The sample comprised 21 students registered on a full-time undergraduate (BSc) pre-registration nursing programme at either of two English universities. Students were in all three years of study and represented all four fields of nursing. Qualitative data were collected through nine in-person focus groups and eight individual online interviews. All of the in-person focus groups were held prior to the SARS-CoV-2 pandemic at the university where the student was registered to study. Each focus group was comprised of students in the same year of study, year 1, year 2 or year 3, without separation of students from different fields of nursing. Focus groups took place at the start and end of each academic year, with the same students taking part in both. The individual online interviews occurred during the SARS-CoV-2 pandemic and were conducted via an online platform of the participant's choosing using a semi-structured interview format. The eight students interviewed online had also taken part in the in-person focus groups, up to 31 months earlier.

Data were analysed and theory constructed following GT approaches, using individual coding which developed into focused coding enhanced by theoretical sensitivity. Throughout these processes the constant comparative method was a consistent feature as was constant iterative data integration. Theory construction was further supported by conceptual interpretation of the data.

11.3 Summarising the Key Research Findings

Data analysis led to the emergence of four categories, 'Evolving Views', 'Developing a Nursing Lexicon', 'Influencing Care' and 'Caring for Self' which, in combination, identified that at the start of their programme students held diverse views of health and illness. These reflected the personal, professional, sociocultural and organisational influences they were exposed to prior to commencing their programme. It is not unusual for students to have experience of care delivery before they commence their studies, so the influences they have been exposed to could include professional healthcare ones.

When reflecting on the views they held at the start of their programme, students frequently characterised them as simple or naïve. A minority of students identified that, prior to commencing their studies, they had not explicitly considered the concepts of health and illness.

As students progressed through their programme evolution in their understanding of the concepts of health and illness was common to all. Students described and demonstrated that their original interpretations had expanded, developing an understanding of a wider range of perspectives of health and illness. Students stated that this development was, at times, a struggle. This was especially the case in adopting and understanding a professional language, the nursing lexicon, necessary for engaging in discussion, expressing their views to nurses effectively and correctly interpreting what they were told. The wide-ranging experiences of health and illness that students gained both prior to and during their studies formed a personal repository of experience they were able to apply to future situations. Students assimilated their learning to become polyglots regarding views of health and illness and were able to work as a translator between the healthcare team/environment and the person receiving care. While the students demonstrated understanding of the objective classification of health and illness, they adopted a subjective approach in their definitions supporting the perspective that views of health and illness are whatever the person experiencing them says they are and exist whenever the person says they do, a perspective reflecting the McCaffery (1968) definition of pain. Frequently, students described the perspective of the person receiving care as different from their own. This perspective was accepted and upheld, with the student working to achieve a care outcome in accordance with this.

Although students’ knowledge of the concepts of health and illness expanded and they were able to provide detailed lifestyle advice to those receiving care, they struggled to apply this knowledge to themselves, identifying barriers and limitations to their ability to achieve a healthy lifestyle themselves. While students related the outcome health to healthy behaviours, they also expressed an element of fatalism in their views as to whether health could be maintained. This was particularly evident regarding areas such as genetic predispositions to disease. Despite increasing their knowledge of the impact of healthy lifestyle factors, it was thought, for example, that persons with familial histories of cardiac disease had little control over their health, with it being inevitable that genetic predisposition would eventually be expressed within the person's health state.

Students recognised that their views had evolved during their programme and unanimously anticipated this evolution would continue when they became Registered Nurses.

11.3.1 The Theory of Balance in perception of health and illness and care delivery (Theory of Balance)

The Theory of Balance was derived inductively from the accounts of the students and is therefore grounded in the research data. This theoretical model outlines how the grounded theory components

Perception of health and illness
Noticing, experience and reflection
Care delivery

are linked. The Theory of Balance is proposed as an exploratory theoretical model requiring further research for validation and testing.

The Theory of Balance proposes that within the context of pre-registration nurse education, a student's perception of health and illness and their care delivery should be in equilibrium. Students with perceptions of health and illness that are simple (an inductively-derived term used by students) will deliver care in a functional manner, while students whose perception is more complex adopt a person-centred approach in their care delivery. Pivotal to this equilibrium and evolution of the student's view is the noticing of significant experience and engaging reflectively with this. The noticing of significant experience and reflective engagement can result in a period of disequilibrium as the student develops their understanding and insight of views of health and illness and the potential influence this can have on care delivery. Once the student has amalgamated new and existing experience and knowledge, balance is likely to return.

11.3.2 Answering the Research Questions

In answer to the research questions posed by this research, it is possible to conclude that nursing students perceive the concepts of health and illness in an individualised manner, reflecting personal, professional, sociocultural and organisational influences. In addition to identifying these properties, student perceptions of health and illness can be classified into two categories as either simple (a term the students used) or more complex.

Nursing students make sense of the personal and professional experiences they accrue before and during a nursing programme through a process involving noticing them to be significant to health and illness and reflecting on them in order to amalgamate this experience to form a personal repository. Exposure to varying perspectives of health and illness has the potential to facilitate an increase in the student’s ability to comprehend, navigate and support the unique perspective of the person to whom they deliver care. Students can hold complex perceptions of health and illness and act as a polyglot, knowing and understanding differing approaches which they translate into the care they deliver. Pre-registration nurse education can be a trigger for the development of complexity in perception of health and illness which can result in care delivery becoming increasingly person-centred.

11.4 Returning to the Literature

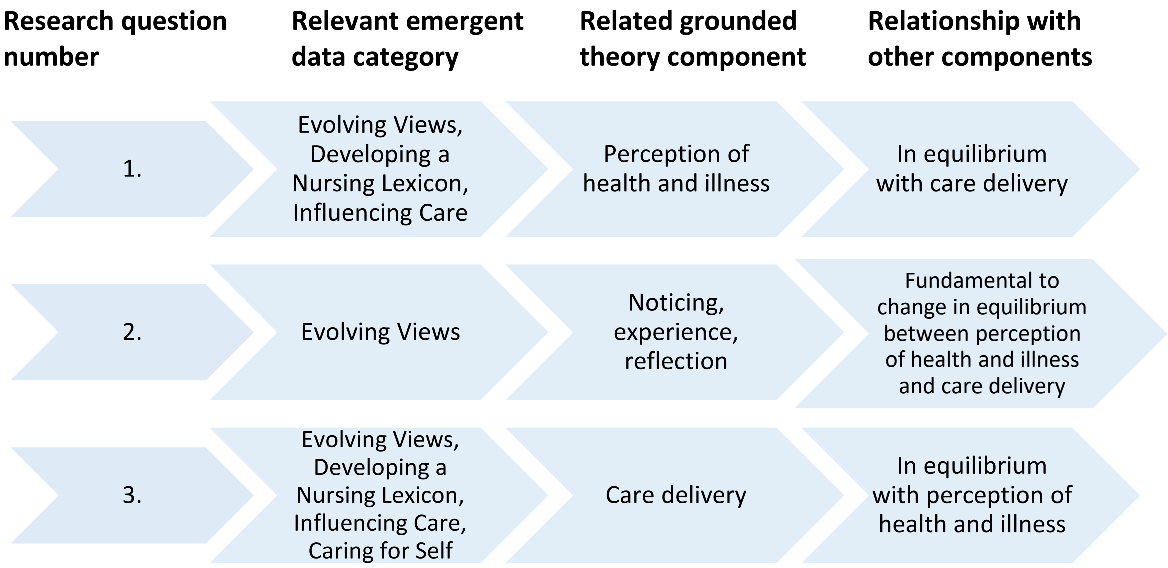
As was outlined in Chapter 2, a staged approach was taken to reviewing the literature. This entailed the literature being consulted prior to the research commencing only to undertake concept analyses of health and illness in order to map key areas of research, place the area of investigation within the appropriate context and provide a rationale for my inquiry. Such an approach fulfilled the need of the required application for ethical approval (there were no funder requirements as the research did not receive funding). Literature was not consulted again until after data collection and initial analysis had been completed.

The literature was consulted in the manner of a scoping exercise, with an iterative approach taken. A total of twelve searches of the literature were undertaken in order to both identify the work that had previously been undertaken relevant to the area of the views of health and illness of nursing students and review the diverse concepts that the four final data categories contained. These searches varied in design from those which had specifically constructed search terms applying the formal structure of the PICOT - qualitative tool (Fineout-Overholt and Johnston, 2005), as outlined by Aveyard et al. (2021) (see Appendix 18 for an example) to those that were less formally structured and focused on individual concepts. Thus, a series of individual search strategies were developed to ensure the search was comprehensive and to enable a full exploration of the range of literature and diversity of relevant areas. The formal search strategies were devised in consultation with a specialist librarian, who was able to advise whether the planned approaches to searching were likely to achieve the results desired and assist in the modification of searches to maximise the relevance and numbers of papers they returned. In this way, applying a versatile and flexible approach when consulting the literature it was possible to map both key areas of research and the use of the relevant concepts (Aveyard et al., 2021).

The Cumulative Index to Nursing and Allied Health Literature (CINAHL), PsycINFO and MEDLINE complete and EThOS databases were selected for the search. This was due to their combined coverage of the subject areas of behavioural science, mental health (PsycINFO), medicine and clinical science (MEDLINE), midwifery, nursing, occupational therapy, physiotherapy, podiatry and health education (CINAHL) and UK PhD theses (EThOS). This combination provided a thorough overview of relevant literature. Searching of the literature was performed between 27th February 2022 and 17th May 2023.

Further search strategies were applied to promote the comprehensiveness of the literature-searching approach. The ‘cited by’ function within the relevant databases was used to identify other authors who had cited an article identified as relevant. Reference lists of included papers were searched to check for further relevant papers with the application of snowballing, noting relevant references and reviewing these publications. Literature alerts were also set to enable awareness of the university library acquiring any new item matching a saved search, thus identifying any new papers of potential relevance. No items were, however, added via this route. The approach taken aimed to incorporate all types of research and other relevant information in the review, such as professional opinion and theory, in order to provide consideration, understanding and expansion of the concepts identified in this research. This enabled the research findings to be situated within previous and current knowledge and to generate new insights.

Charmaz (2014, 2017) describes the potential of applying the constant comparative method when consulting the literature in a CGT study, as working in this way enables the evidence from the literature to be compared with all forms of data collected in the research. This approach was therefore applied to consider the research questions, the four final data categories, the components of the emergent grounded theory and the connections and relationships between these (Figure 11-1), in the context of the existing literature.



Research question number	Relevant emergent data category	Related grounded theory component	Relationship with other components
1.	Evolving Views, Developing a Nursing Lexicon, Influencing Care	Perception of health and illness	In equilibrium with care delivery
2.	Evolving Views	Noticing, experience, reflection	Fundamental to change in equilibrium between perception of health and illness and care delivery
3.	Evolving Views, Developing a Nursing Lexicon, Influencing Care, Caring for Self	Care delivery	In equilibrium with perception of health and illness

Research Questions

1. How do nursing students perceive the concepts of health and illness?
2. How do nursing students make sense of their personal and professional experiences before and during a nursing programme, in terms of their perceptions of health and illness?
3. How do nursing students' perceptions of health and illness influence their views of the care they deliver?

Figure 11-1. Connections and relationships

Throughout this process the research data collected in this study was *'constantly and actively put first over any literature'* (Ramalho et al., 2015, p. s6), adopting an approach of '*theoretical agnosticism'* (Henwood and Pidgeon, 2003, p. 138) to the body of existing knowledge. I was open-minded, adopting a critical stance towards pre-existing research findings, other relevant literature and theories. I also utilised the GT technique of theoretical memoing in my consideration of the literature, to promote critical and creative thinking, enabling me to make connections between differing elements of the work and encouraging reflexivity (Charmaz, 2014). This documented my thinking in an insightful and critical way regarding what was already known and assisted me to link existing literature with my data and the grounded theory.

11.5 Situating the Findings and Theory of Balance within the Existing Literature

The Theory of Balance builds on and develops existing knowledge as well as presenting a novel contribution to knowledge. While exploration of the relevant literature identified that findings reported in this thesis can be seen to support and reflect existing knowledge, much of this has not previously been explicitly aligned to nursing students. The existing literature also provides further evidence which underpins the emergent theory, the Theory of Balance in Perception of Health and Illness and Care Delivery (Theory of Balance), which is outlined in Figure 11-2.

Figure 11-2. The theory of balance in perception of health and illness and care delivery

The Theory of Balance brings new insight by providing an explanatory scheme to identify how, within the context of pre-registration nurse education, perceptions of health and illness can be related to care delivery through a logical pattern of connectivity. Such a theoretical explanation has not been identified previously in the existing nursing research literature.

While the Theory of Balance is novel, it is possible to find resonance between the theory components and the findings underpinning them within the existing literature and theory. To provide comprehensive consideration of the relevant issues discussion throughout the rest of this section will commence by considering the individual construction of perceptions of health and illness and move to how these may be progressive. Debate will then focus on the possibility of health and illness to co-exist, which will be followed by consideration of influences on perceptions of health and illness. The notions of both noticing and reflective engagement will then be examined, which will be followed by consideration of person-centred care. The section will end with identification of the two significant theoretical tenets underpinning the Theory of Balance. Throughout this discussion the theories and frameworks of Benner (1984), McCormack and McCance (2019a, 2019b), Dewey (1933, 1959) and Piaget et al. (1952) are specifically highlighted for their relevance to the findings reported in this thesis.

11.5.1 Individually constructed perceptions of health and illness

The finding that nursing student perceptions of health and illness are unique and individually constructed echoes previous findings relating to other healthcare professionals. In an anthropologically-focused exploration of illness and healthcare in Taiwan and USA, Kleinman (1980) reported individuality in the views of medical doctors, as did Helman (1981) in a narrative literature review considering the relationship between the concepts of disease and illness. The individuality of views of illness of Registered Nurses is highlighted by Nordby (2004) in a narrative literature review exploring reference to illness as a negative first-person experience in communication between nurses and persons receiving care.

Existing empirical research specifically relating to how nursing students acquire, modify and consolidate their perceptions of the concepts of health and illness is limited. It has only been possible to locate one empirical study focusing on this, a Swedish phenomenographic study undertaken by Skär and Söderberg (2016). Phenomenography is an interpretative qualitative methodology which aims to describe the ways a group of individuals comprehend a phenomenon. The focus of phenomenography is on the essence of the experiences and the consequent perceptions of a phenomenon, an approach that differs from phenomenology, where the focus is on the essence of the phenomenon (Larsson and Holmström, 2007). This difference presents phenomenography as an appropriate approach to adopt in a study aiming to understand nursing students’ perceptions of the concept of health.

In their study Skär and Söderberg (2016) explored the perceptions of 223 nursing students on a Swedish pre-registration nursing programme that lasted a total of six semesters. Data were gathered from participants at one point in time, which was in their first, second or sixth semester. Participants were asked to complete, in writing and in a classroom setting, the incomplete sentence, '*I perceive that health is….*' and took, *'approximately ten minutes to complete this task'* (Skär and Söderberg, 2016, p. 387). Data were analysed using the four steps of the phenomenographic method as described by Marton (1994).

In their findings Skär and Söderberg (2016) identified that the Swedish nursing student perceptions of the concept of health were characterised by individuality and uniqueness. This resonates with the individually-constructed perceptions of health and illness reported in this thesis, where UK students demonstrated understanding of their personal perspective, individuality of views, personal and cultural values, the perspective of others and made links between mental and physical health and illness. Health was seen as a resource which can be both enabling and improved. The UK student definitions of health and illness rejected a restrictive, medicalised understanding where there is separation of the mind and body with health equated to a disease-free state. Thus the UK student definitions were holistic, with health resulting from harmony in mind, body, environment and lifestyle. Conversely, Skär and Söderberg (2016, p. 391) found that the Swedish nursing students' perspectives '*mirror a largely medical perspective of health',* depicting that student definitions focused on the absence of signs and symptoms of illness in their perceptions of health.

The identification by Skär and Söderberg (2016) that Swedish nursing students held a medically-focused perception of health presents a noteworthy difference to the findings presented in this thesis. This is seen to require consideration from three perspectives. First, there could be curriculum-related factors that may result in the dissimilarity. The research undertaken by Skär and Söderberg (2016) was in Sweden, where students follow a different nursing educational programme than students in the UK. It is possible that the Swedish curriculum is more medically focused than UK pre-registration nursing education, which could account for a difference in perspective. However, while the two curricula have not been directly compared, literature considering the ethos of a Swedish nursing curriculum at the time of Skär and Söderberg's (2016) work identifies a decreased emphasis on biomedicine and an increased focus on nursing science (Edberg and Andersson, 2015, Hallberg, 2019). It is possible therefore that the medical perspective may not be arising from the curriculum being followed but may result from a different influence. In a Jordanian study Safadi et al. (2011) explored the perceptions 606 nursing students held of the concept of nursing during their pre-registration education using a descriptive cross-sectional design. In their findings they identified that the perspective students are exposed to in practice learning has a strong impact on their perceptions. This could have been a factor for the Swedish students, their perceptions of health may have replicated the medical perspective they were exposed to in their practice learning.

Second, dissimilarity in the findings of the Swedish and UK studies could be the result of the application of different data collection methods. Skär and Söderberg (2016) collected data at just one point in time that lasted for a period of approximately ten minutes, using a written format. Such an approach is neither as extensive nor as robust as the approach adopted in the research reported in this thesis. It may also have been that the data collection method applied in the Swedish research made it more challenging for students to share the nuances of their perceptions, identify the breadth and depth of their conceptions and clearly articulate holism. Being asked to write down your thoughts in a classroom setting may have, for some participants, replicated the context of an examination where students thought anchoring their answers to a medical perspective was the expected approach. By contrast, in the UK research the use of focus groups and interviews, over a longer period of time, may have enabled participants to develop a trusting relationship with the researcher and feel able to share their personal conceptions more authentically.

A third perspective, which is also a noteworthy comparison between the findings of Skär and Söderberg (2016) and those reported in this thesis, relates to the issue of the complexity of views of health held by the Swedish nursing students. Skär and Söderberg (2016) do not explicitly discuss the issue of complexity but, as previously highlighted, they conclude that perspectives focused on the absence of signs and symptoms of illness. It is possible that this could suggest that the student views were lacking complexity. However, in the Swedish study there is also the report of a *'multifaceted picture of the concept of health'* with students reflecting on the concept and adopting *'a holistic and encouraging attitude'* which starts *'at the individual person'* (Skär and Söderberg, 2016, p. 393). Thus, there is mention of a broader perspective and maybe moving towards a more complex understanding of health. What is not considered in the Swedish work is whether it was possible to discern any change in perception of health between the data collected from students in their first, second or sixth semester. This would have provided a comparison for the data reported in this thesis and enabled understanding of whether the Swedish students' perceptions of health increased in complexity in response to experience.

11.5.2 Change of perceptions of health and illness

As previously highlighted, there is a paucity of literature focusing on perception change of health and illness in nursing students during their pre-registration nursing education, but within the existing literature, it may be possible to make parallels with three quantitative empirical studies undertaken by Manninen (1998), Karaöz (2004) and Safadi et al. (2011). While there is difference in focus, with these three studies describing nursing students' change in perception of the concept of nursing as they undertake a pre-registration programme, there are also similarities. What is being considered in these three studies is the relationship between new experience and how this may develop existing understanding or interpretation. Manninen (1998), in a longitudinal quantitative study of 1129 Finnish nursing students using a self-report questionnaire where the data was collected at three points in time (6, 18 and 30 months), identified changes in student perception as experience increased. In a Turkish quasi-experimental study of 39 nursing students in their first term of pre-registration nursing education, Karaöz (2004) identified a change in perception of nursing students' concepts of nursing between the start and end of term, with end-of-term views demonstrating an increased understanding of the concept of nursing. There is an echo of the findings of Karaöz's (2004) study in those reported in this thesis, as participants reported an increased understanding in their views of health and illness during data collection after three months of their nursing programme,

> '*I'm only 3 months into the programme, but what we have been taught already has really changed my view about it'*
>
> (Sydney, 1st year)

In the third study, undertaken in Jordan using a descriptive cross-sectional design applying self-report questionnaire to investigate views of 606 nursing students studying on a four-year pre-registration nursing programme, Safadi et al. (2011) also identified that perceptions of the concept of nursing changed as experience increased. Thus, what is being demonstrated in the three quantitative empirical studies undertaken by Manninen (1998), Karaöz (2004) and Safadi et al. (2011) and also in the research reported in this thesis is that the perceptions of nursing students can change due to experience.

The identification of a change in perception of health and illness depending on experience was also a feature in Charmaz's (1994, 1995) findings, although in a different population of individuals, persons with long-term illness. Charmaz (1994) undertook a GT study focusing on identity dilemma with 20 American adult men experiencing serious but not terminal long-term illness. In her study Charmaz (1994) provides a clear account of a progressive, non-fixed perception of illness. The progressive nature of views of health and illness was also clear in a further GT study undertaken by Charmaz (1995), this time focusing on 55 American adult men and women with long-term illness, which considered adaption to impairment. Again, perception could be seen to change depending on experience.

There is a clear similarity between the work of Charmaz (1994, 1995) and the findings reported in this thesis, in that within all the findings there is the identification of a progressive, non-fixed perception of illness, where experience is a factor in change of an originally-held perspective. There is also a further similarity in all of the studies and that is in the methodology applied, as each of the three empirical studies adopt a GT approach. Reports of a change in perception of health and illness due to experience are not confined to work applying GT methodology, however. They are also evident in the work of Tishelman (1997), in a Swedish study using semi-structured interviews to explore the experience of becoming unwell and recovering. In Tishelman's (1997) qualitative longitudinal study a total of 46 adult male and female participants who had received a diagnosis of cancer were interviewed soon after diagnosis and 20 surviving persons were re-interviewed four years later. In the participants' interpretation of their experiences a changing perception of health and illness was evident. While the focus of the work of Charmaz (1994, 1995) and Tishelman (1997) is persons living with long-term illness, what clearly resonates with the findings relating to nursing students reported in this thesis is a change in perception of health and illness following experience.

It is therefore possible to conclude from the literature that change following experience has been identified in work considering nursing students' perception of the concept of nursing and the perception of health and illness of persons with long-term illness. The finding that nursing student perception of the concepts of health and illness can change following experience has not previously been reported and is therefore a unique contribution.

11.5.3 Influences on perceptions of health and illness

Influences on perceptions of health and illness have been widely discussed within the literature over many years. For example Helman (1978) identifies the influence the perceptions individuals hold about health and illness can have on communication in General Practice and qualitative research undertaken by Blaxter and Paterson (1982) identify the influence the health attitude of a mother can have through three generations of their family. More recently Crawford et al. (2023) concluded, following an interpretative qualitative study with 19 university students aged between 18-40 years who self-reported as being ethnically Georgian, that cultural norms influence perception of health and illness. Such a finding was also identified in the much earlier work of Kleinman (1980) who presents an anthropological perspective of cultural influences on illness. Within the body of existing literature much of the work considering an anthropological perspective of health and illness is older material, as typified by the previously discussed work of Helman (1978), Kleinman (1980) and Blaxter and Paterson (1982), so change over time could be expected. The findings reported in this thesis identify continued reflection of this knowledge. Data presented in the category of 'Evolving Views' identified students highlighting the cultural influences they had personally experienced as well as the impact of their mother's perspective of health and illness. The impact of their mother's perspective of health is noteworthy for two reasons. First, that it was only the mother's perspective of health that was discussed, which accords with the work of Blaxter and Paterson (1982). Second, that the students involved in the discussion of the impact of their mother's view were aged between 26-55 years at the time they took part in this conversation, indicating the potential for such an influence to be lasting.

Cultural health-related values include fatalistic views of health, the belief that fate, luck or God, not the individual, has the power to influence an outcome (Moore, 2015). Within the findings presented in this thesis there was the suggestion of a fatalistic approach in some of the student perspectives, with the identification of the view that it was not possible to sufficiently modify genetic factors impacting on health to prevent a negative outcome. The existence of a fatalistic approach to health and illness in nursing students has recently been highlighted by Turan et al. (2022) in a descriptive cross-sectional study of 423 nursing students studying in Turkey, with the study finding that levels of fatalism increased over the programme. This is particularly notable, as in a cross-sectional design study undertaken by San Diego and Merz (2022) investigating fatalistic views of 345 students studying on a non-healthcare programme (no further details provided as to subjects being studied) it was identified that fatalism reduced throughout the course of their studies as knowledge increased. From the data collected in the research reported in this thesis, it is not possible to contribute any further to this discussion, as comparative measures of fatalism were not made. What is noteworthy and clearly identified by Turan et al. (2022) is that a fatalistic approach to health impacts the extent to which knowledge is associated with preventative behaviour, influences lifestyles and attitudes towards illness can be negative. None of the data collected in the research reported in this thesis contained identification of negative views towards illness, the opposite being the prevailing perspective. Therefore the findings reported in this research are reflected in the existing literature to some extent, in as much that nursing students' views may be fatalistic. The in-depth GT approach adopted in the study is seen as being a strength in ascertaining the perspective of the nursing students, but the specific area of fatalism in their perceptions of health and illness requires greater investigation before determining any further conclusion.

The influence of experience and knowledge proved to be particularly relevant in the findings of this research. No student commences their nursing programme without any experience of the concepts of health and/or illness, all bring personal experience and knowledge of some sort with them. Students may not have considered this explicitly. Callaghan (1999), in a cross-sectional survey of 113 Registered Nurses investigating health beliefs, identified that greater levels of both experience and knowledge correlated positively with more complex approaches to the concepts of health and illness. This thesis identified a similar finding, albeit from a GT approach. As nursing students gained experience and knowledge from the nursing programme they were studying, their conceptions of health and illness developed in complexity.

11.5.4 Co-existence of health and illness

A feature of the findings reported in this thesis was the co-existence of health and illness, with the ability to be healthy in illness being a distinct element within participants' definitions of health. The ability to maintain health in illness was an item frequently mentioned in the definitions of views of participants in all years of the nursing programme, which included views shared by participants at a point in the nursing programme prior to placement learning when they had only been exposed to the university-based element of their studies. This perspective highlights an area of consensus between the findings of the previously considered Swedish phenomenographic study exploring nursing students' perceptions of the concept of health undertaken by Skär and Söderberg (2016) and the research reported in this thesis. Both studies identified that students perceived the concepts of health and illness as able to co-exist, with the boundary between them being unclear. In a quantitative investigation of the understanding of concepts of health and illness in 218 American adolescents, Millstein and Irwin (1987) identify health and illness as different but overlapping concepts, a view that reverberates with the findings of both Skär and Söderberg (2016) and the findings reported in this thesis. Skär and Söderberg (2016) do not identify the age range of their sample and in the research reported in this thesis the majority of participants were in the age range of 'mature' students (21 years of age or older). The findings presented by Millstein and Irwin (1987) could, however, be indicative of the perspective of individuals at the end of their primary and secondary education, which could make the continued expression of such a perspective unsurprising. Theoretical support for such an approach is provided by the work of Sadegh-Zadeh (2000) who in an analysis of the concepts of health, illness and disease proposed that health and illness neither fit with classical logic nor are conceptual opposites and can therefore exist at the same time.

11.5.5 Noticing

The fundamental importance of the act of noticing the significance of experience, plus the recognition that noticing is an important precursor to the application of reflective processes are clearly identified in the findings of this research. This acknowledgement provides novel appreciation of how students review their experience regarding health and illness in order to increase their understanding and potentially develop their approach to care delivery. In the Theory of Balance, therefore, the linked activities of noticing, experience and refection are the fulcrum on which student perceptions of health and illness balance with care delivery. This positioning outlines the proposition that views evolve due to experience and this influences care delivery, but only when the significance of the experience is noticed and the experience is engaged with reflectively.

Noticing the significance of experience originates in the writing of Mason (2002b), in which he provides guidance as to how healthcare professionals can improve their practice. The conception of noticing is developed further by Edwards (2012) who, in her personal narrative of her nursing life through the lens of a nurse educator, outlined the importance of noticing, in order to reflect on experience. Noticing is also evident in the work of Tronto (1998). In her ethic of care Tronto (1998, p. 16) identified care as a process within which, although the term noticing was not used, what is being described and underpins the ability to make *'thoughtful judgements about caring'* is the noticing of significance. It is the combined approach to noticing, from the work of Edwards (2012) and that of Tronto (1998), which is applied in the Theory of Balance. Thus, the act of noticing is recognised as not only a fundamental precursor to reflection but also the appreciation of significance.

In her narrative Edwards (2012) describes that not all students noticed experience which could be of significance. Albert Bandura (1925-2021), a Canadian psychologist in his Social Learning Theory (Bandura, 1986), also recognises that students can be selective in what they notice. As was identified in this research in the data category 'Evolving Views', students can exist in a pre-noticing stage, not noticing the significance of what they are experiencing while they undertake care delivery and interact with others. In this situation, as experience is not noticed, it cannot be either considered or analysed, which results in the individual not gaining experience but just performing actions.

11.5.6 Reflective engagement

As has been highlighted, the findings described in this thesis identify that the act of noticing is key to converting the performance of actions into experience that, following reflective engagement, can result in learning and knowledge. In nursing the relationship between experience, skills (or actions) and knowledge has been outlined most notably by Benner and Wrubel (1982) and Benner (1984, 2004) who identify how nurses expand their ability to deliver care based on a combination of education and prior experience. Benner and Wrubel (1982) and Benner (1984, 2004) consider the value of perceptual awareness, identifying that nurses (a term used by Benner and Wrubel which is inclusive of nursing students) learn by recognising the possibilities of what can happen and how they can respond to this from the experience they have gained in a range of situations, with this learning informing the perception and understanding of subsequent situations. Thus, it is outlined in the work of Benner and Wrubel (1982) and Benner (1984, 2004) that nurses develop their care delivery skills and understanding over time from making sense of a combination of education and personal experience. Their conclusion is reflected in the research reported this thesis.

In the findings reported in this thesis it is demonstrated that as students increased their experience and, crucially, noticed its significance and engaged reflectively with it, the descriptions of the care they provided moved away from a ‘doing to’ approach to one fulfilling the definition of ‘being with’ the person receiving care. These perspectives were clear echoes of those described by the writings of Buber (1923) as ‘I-Thou’, where there is recognition of the person receiving care as a person not an object, of Eriksson (1992, 1997), where there is communion with the person receiving care and of Kitwood (1993, 1997) where there is recognition of the personhood of the person receiving. In the data collected in this research, as students engaged in an increasing range of situations involving care delivery, they learnt by making sense of the experience they gained. This learning had the potential to result in an increased ability to deliver care upholding the care recipient's perspective of health and illness. As is illustrated by Benner (1984) in her Stages of Clinical Competence, students were learning about involvement and interconnectedness by making sense of their personal and professional experience and the knowledge gained from this was added to the student's personal repository of experience. As the students' knowledge and understanding of the perspectives of health and illness of themselves and others increased, their care became increasingly person-centred. It is therefore possible to apply the work relating to the development of knowledge and skills due to experience identified by Benner and Wrubel (1982) and Benner (1984, 2004) to the evolution of views of health and illness.

Reflective engagement with significant experience was fundamental in the students' evolution of views of health and illness. In nursing reflection is widely used because of its association with improved nursing practice (Johns, 1995, 2000). Such an approach is supported by an extensive evidence-base, which includes empirical studies specifically related to the use of reflection by nursing students. Bulman et al. (2012) identified reflection as a valuable way to make sense of practice in a UK-based interpretive ethnographic study that adopted the perspective of nursing students and lecturers, while paying attention to local organisational, contextual and cultural issues. Hayes et al. (2018), in an Australian qualitative study applying thematic content analysis to the reflections of 451 nursing students following a role-play simulation, concluded that reflection can increase the safety of persons receiving care. More recently Merduaty and Arum (2023), in an Indonesian experimental design study with 12 nursing students, identified that reflection can increase critical thinking which has the potential to improve practice. Further support for validity of reflection in nursing comes from the UK nursing regulator, the Nursing and Midwifery Council (NMC) which have made reflection mandatory in the three-yearly revalidation processes UK Registered Nurses undertake (NMC, 2021b). The NMC also require reflection to be an integral element of a UK nursing curriculum (NMC, 2018c). It is possible to conclude therefore that within the existing literature the value of reflection has been described by differing methodological sources of evidence, with this value also identified within the findings reported in this thesis.

11.5.7 Person-centred care

Notably, although the focus of the findings reported by this thesis was students' developing understanding of the concepts of health and illness, the process students described was entwined with their developing ability to provide person-centred nursing care. To be able to deliver care in a person-centred manner it is necessary to have an appreciation that persons receiving care have different perspectives of what they value and what brings meaning. The most widely recognised frameworks identifying the constructs required for the delivery of person-centred care result from the work of Brendan McCormack and Tanya McCance, both of whom are nurses and academics. McCormack and McCance (2006) developed their initial framework for person-centred nursing nearly 20 years ago by integrating the conceptual framework developed by McCormack (2001a, 2003) relating to person-centred practice with older people, with that of McCance (2003) which focused on caring in nursing practice. Since the initial model was devised there has been consistent development underpinned by research, refinement and debate within the national and international community resulting in a Person-centred Nursing Framework (PCNF) (McCormack and McCance, 2019a) and a Person-centred Practice Framework (PCPF) (McCormack and McCance, 2019b) (Appendix 19). In a similar manner to the PCNF, which was developed based on attempts to implement person-centredness (McCance et al., 2021), the PCPF has been devised to support the delivery of person-centredness while reflecting the multidisciplinary/interdisciplinary nature of a contemporary care setting. Both frameworks provide a theoretical model with a clear philosophical underpinning and evaluation has demonstrated their effectiveness in many contexts.

Considering the McCormack and McCance (2019a, 2019b) person-centred frameworks, the elements identified in the domains ‘Care environment’ and ‘Nursing prerequisites’ (Table 11-1) are relevant to the experience described by the students in the findings reported in this thesis.

Table 11-1. Elements identified in care environment and nursing prerequisites domains (identified by McCormack and McCance, 2019a, 2019b)

Domain	Elements
Care environment	shared decision-making systems, effective staff relationships, supportive organisation systems, power-sharing
Nursing prerequisites	professionally competent, developed interpersonal skills, clarity of beliefs and values, knowing self

Students discussed how, within a placement where they were exposed to the elements identified within the domain of care environment, they were able to develop their understanding of how views of health and illness can influence care delivery. Thus, progression from a simple (an inductively-derived term used by students) view of health and illness to a more complex one was being facilitated. This was due to being exposed to role models who in their practice provided effective care focusing on the needs of the recipient while being supported to do so by a range of organisational and social structures. In a placement where these elements were absent, students viewed approaches to care as ‘task-oriented’, with care not being individually tailored to the unique view of health and illness of the care recipient or staff supported in their care delivery. Such an approach did not enable progression of student views of health and illness.

Furthermore, the domain of ‘nursing prerequisites’ was also relevant to the students’ development. As students became increasingly able to fulfil each of the elements contained within this domain, their individual comprehension of views of health and illness increased and their care delivery became increasingly person-centred. As previously identified the Theory of Balance identifies the potential for a link between perceptions of health and illness and care delivery, which has not formerly been recognised within the existing literature. A clear characteristic of the research data were that, as views of health and illness became more complex, the care the students identified that they delivered became increasingly person-centred. Such a relationship reflects a student's developing understanding of the importance of appreciating the perspective of another which is fundamental in comprehending the importance of person-centred approach to care delivery.

11.5.8 Applying the theory of Dewey and Piaget

As was described by students in the findings reported in this experience, for experience to be transformational it needs to involve revisiting preconceived notions and expectations in light of real-life situations. The findings identified in this thesis extend the current knowledge by capturing, within the Theory of Balance, the struggles students encounter when they were revisiting preconceived notions and expectations in light of real-life situations. The Theory of Balance explains how students amalgamated their new experience and perception of health and illness with those pre-existing, and how the knowledge from this can inform their care delivery. This specific process is not identified within the existing literature, so within the Theory of Balance there is contribution of a new explanation of how student perception develops and can result in an alteration in care delivery. The explanation provided by the Theory of Balance is underpinned by two significant theoretical tenets, Dewey's Theory of Learning (Dewey, 1933, 1959) and Piaget's Cognitive Development Theory (Piaget et al., 1952).

John Dewey (1859–1952) was an American philosopher, psychologist, educational reformer and founder of the philosophical movement known as pragmatism and Jean Piaget (1896–1980) was a Swiss psychologist known for his work on cognitive development. While they did not work together, they both focused on thinking as a process of growth, with Tanner (2016, p. 6) remarking on the *'powerful and unmistakable isomorphism'* between their work. Thus, there are strong similarities between their work, with it being possible to comprehend that in the work of Piaget there is development from that of Dewey, although Piaget never formally recognised this (Tanner, 2016). The theoretical concepts identified in the work of Dewey and Piaget are used conjointly to underpin the Theory of Balance. In combination their work describes the potential evolution of nursing students' views of health and illness during a pre-registration nursing programme, with Dewey providing an over-all perspective and Piaget a more detailed one.

The proposition of a relationship between experience and change made in the Theory of Balance clearly resonates with Dewey's Theory of Learning (Dewey, 1933, 1959). In his theory Dewey describes how meaningful learning and change can follow active reflective engagement with experience. This identifies the overall perspective of the Theory of Balance: in the act of noticing and reflectively engaging with significant experience, students were facilitated to develop, or change, their perception of health and illness. The potential impact of this was also a development, or change, to their care delivery. Thus Dewey's Theory of Learning (Dewey, 1933, 1959) is the first significant theoretical tenet of the Theory of Balance identified in this thesis.

Piaget's Cognitive Development Theory (Piaget et al., 1952) is applied specifically to the students' descriptions of wrestling with the concepts of health and illness, a process the students encountered where insight was followed by confusion, as they tried to make sense of their new experience and knowledge. Within his Cognitive Development Theory Piaget applied the concepts of schema, assimilation and accommodation, which are defined in Table 11.2.

Table 11-2. Definitions of concepts in Piaget's cognitive development theory.

Concept	Definition
Schema	Cognitive structures individuals use to intellectually adapt to and organise their environment which provide an individual way to understand or create meaning about an entity or experience.
Assimilation	The process of fitting a new entity or experience into an existing cognitive structure or schema.
Accommodation	The process of creating new cognitive structures or schema.

In the development of their perception of health and illness and the potentially resulting influence on care delivery described in this thesis, nursing students were either fitting their new experience into existing schema or creating new ones. It is likely that the struggles students identified during this process represented what Piaget referred to as cognitive disequilibrium, a period of confusion caused by an experience not aligning with existing schema. This is resolved by accommodation, the process of creating new schema and explains why the students experienced confusion caused by disequilibrium as a temporary state. Thus Piaget’s Cognitive Development Theory (Piaget et al., 1952) is the second significant theoretical tenet of the Theory of Balance identified in this thesis.

11.5.9 Greater understanding

In summary, the Theory of Balance develops the existing knowledge to provide greater understanding of how nursing students perceive the concepts of health and illness, make sense of their personal and professional experiences of health and illness and how this may influence their views of the care they deliver. Links can be drawn between the Theory of Balance and both Dewey’s Theory of Learning (Dewey, 1933, 1959) and Piaget’s Cognitive Development Theory (Piaget et al., 1952). Both of these theories underpin the proposition that reflection on experience that has been noticed to be significant to views of health and illness can enable deep learning and perception change which may result in increasing person-centredness in care delivery. The work of Benner and Wrubel (1982) and Benner (1984, 2004) is also of relevance, as it is possible to apply the notion they identify, that development of knowledge and skills is related to experience, to the evolution of nursing students’ views of health and illness that could influence care delivery. This is important to nurse education and outlines the need to support students not only to gain relevant experience in their pre-registration programme but also to aid them to notice its significance and reflectively engage with it. The work of McCormack and McCance (2019a, 2019b) is also of importance, clearly outlining elements that are of fundamental importance not only in the delivery of person-centred care but also in facilitating the evolution of nursing students views of health and illness.

11.6 Attributes of health and illness

The concept analyses of health and illness undertaken in the preliminary review of the literature identified a total of nine attributes.

Health as

i. enablement
ii. dependence on healthcare and adherence
iii. personal responsibility
iv. a sociocultural construction

Illness as

v. a fundamental loss of wholeness
vi. reality
vii. meaning
viii. hope and positivity
ix. a sociocultural construction

The attribute of sociocultural construction characterised both health and illness.

In returning to the concept analyses after a period of nearly eight years, having completed data collection, analysis and theory development, I thought that the attributes defined remain relevant. In the time since the concept analyses were undertaken (2015-16) the global pandemic (2020-22) placed issues relating to health and illness in the spotlight. Despite the demonstration across the globe throughout the pandemic of the importance of the social determinants of health (Paremoer et al., 2021), the dominant paradigm remains '*the reductionist view of disease and the biomedical model of health*' (Park, 2022, p. 711). What was also notable was a substantial increase in literature focusing on health anxiety, which was directly related to the pandemic and recognised the existence of the wide-spread psychological distress experienced. Reviewing the data collected from the individual interviews with participants, between June and August 2021, at the end of the third UK lockdown, health anxiety and psychological distress were clearly evident, specifically in respect of the health of family members.

Relating the nine attributes of health and illness defined in the concept analyses to the research findings, the attributes can be traced through the developing data categories and identified in the emergent data categories (see Appendix 20 for the mapping). A common theme throughout the research was the individuality of views of health and illness. Difference, albeit not always on a wide scale, was a constant feature. However, there were also commonalities, which mapping the attributes to the developing and emergent data categories made evident.

The attribute of sociocultural construction identified by the concept analyses to be shared by health and illness was clearly identified in the findings reported in this thesis. Students discussed in detail experiences they were able to recognise as relevant to their views of health and illness prior to starting the programme. Family approaches were a clear and lasting influence, with the view of their mother being one that had the strongest impact. Cultural experiences were also discussed in detail, with students who had experiences of health and illness from the perspective of more than one culture able to define difference, for example from the perspective of the role of relatives in providing support to family members experiencing illness. The attribute of health as enablement was echoed in the students perspective that health equates to being able to achieve what you desire and that strength and stamina were seen as markers of health that the students needed to perform effectively in their nursing programmes. The attribute of illness as fundamental loss of wholeness was reflected in discussion relating to the pandemic. In the views students shared it was clear that they appreciated the devastating impact illness could have, not only on an individual but that the impact could extend to their family and friends. Thus the primary data reported in this thesis have extended what was collected in the concept analysis, contributing the perspective of nursing students, an area where the existing literature is limited.

11.7 Reflecting on Trustworthiness and Recognising Strengths and Limitations

The discussion in this section focuses on the topics and ‘conversations with myself’ I noted in my reflexive diary relating to what I viewed as strengths and limitations. These are interlaced with Lincoln and Guba’s (1985) four criteria for addressing trustworthiness: credibility, transferability, dependability and confirmability, in order to conclude the consideration of trustworthiness which has been ongoing within the research.

Throughout this thesis the aim has been to address trustworthiness by being transparent in producing credible, dependable work. This study increases the understanding of the perceptions of health and illness held by nursing students, with the Theory of Balance theorising the evolution of nursing students' concepts of health and illness during their undergraduate nursing programme and identifying the existence of a relationship between perceptions of health and illness and the care students deliver. Thus a novel contribution is made to existing knowledge. It is important to ensure that limiting factors are acknowledged, although reflection on my experiences throughout the course of this research has enabled me to realise that the same issues or situations may be seen as limitations from one perspective and strengths when considered from another.

11.7.1 Credibility

Credibility considers the congruence of the findings with reality and whether they can be trusted to provide sensible interpretations of the data (Lincoln and Guba, 1985). The application of the chosen methodology, data collection, analysis, theory development and the reporting of the findings are all infused with my positionality. My fingerprints are clear throughout this work with the research focus reflecting my area of interest and experiences. As a researcher it was not possible for me to undertake this work as an objective being, free from prior knowledge, experience and insight. My thoughts propelled the research, the product of which is a co-construction of reality between myself and the participants that reflects our shared experiences. It is recognised that our interpretation and co-construction is one narrative among many possibilities (Mauthner and Doucet, 2003). Measures taken to promote credibility included the use of participant verification, peer debriefing, supervisory discussions and prolonged engagement in reflexive analysis regarding all aspects of the research process. These measures facilitated wide-ranging discussion and extensive personal deliberation that developed my judgement of how the findings could be presented in a way that made the co-construction of reality credible and believable.

The research set out to explore how nursing students perceive the concepts of health and illness, but the pandemic changed the context for this, highlighting specific issues within the students' perceptions. At the present time it can only be hypothesised as to how the perceptions of those involved in this research may differ from cohorts of students who have not shared this experience.

The arrival of SARS-CoV-2 in the UK in January 2020 resulted in an unprecedented situation for the NHS and the whole country. Many nursing students were fully involved in the delivery of healthcare in response to this. To be undertaking research focusing on health and illness during a global pandemic was unanticipated and resulted in rethinking practical arrangements for continuing the study and data collection. The first data were collected between November - December 2018 and June - September 2019, prior to the pandemic, but data collection using theoretical sampling was collected in June - August 2021, at the end of the third UK lockdown. The global pandemic placed issues relating to health and illness in the spotlight, a perspective clear in the views of the students. It is possible to perceive the experience of the pandemic as a strength and a limitation in this study. The research was influenced by the pandemic and the experience of the students during the pandemic was a clear aspect of their understanding of health and illness. In their descriptions of experiences of care delivery students spoke about how the pandemic had enabled them to appreciate the rapid and devastating impact illness could bring. Many students had not previously experienced death as a daily, sometimes more than once daily, reality of their experience. They were able to fully appreciate the effect this had on all of those closely involved with the ill individual, including the staff delivering care. The students spoke about how their involvement in care delivery during the pandemic had made them anxious about the health of their family and friends, especially the concern that they could take the virus home with them at the end of their shift.

> *'I was so scared, not so much for myself, but I could have brought it home to my family. I could have been a cause of illness for them. Never have I done so much washing, cleaning, bathing in hand sanitizer!* [laughs] [10-second pause, controlling emotions] *It really wasn't funny'*
>
> Ellery, 3rd year

As is highlighted by Ellery above, students were anxious about the health of their families but were dismissive of any potential risk to themselves, although there was acknowledgement that it existed. In her ethical dimensions of care Tronto (2013) presented the dimension of Responsibility, which identifies that Registered Nurses, in their response to crisis, frequently demonstrate an acceptance of the personal risk inherent in their own exposure as an occupational necessity. This was reflected in the narratives of the students in this research who, at this point, were fully focused on caring for others, with their self-care not seen as a priority.

11.7.2 Transferability

The intention of transferability is to extend the degree to which findings can be related to other settings by providing rich descriptions so those interested can determine usefulness and usability within their own contexts. Therefore, an aim of the narrative of the thesis has been to provide sufficient thick description to enable others to judge whether the patterns and descriptions highlighted could apply to and reflect their experience. It is acknowledged therefore that the findings of this research reflect the experiences of a specific group of students within a particular context and time. What is presented has been done so to provide robust detail and has been triangulated with other work so readers are able to identify what is transferrable to their own practice. What may be significant are the insights gained throughout the research, which could be of value to others involved in pre-registration nurse education.

A feature that is noteworthy in respect of the participants of this research and may be relevant to their experiences is that the majority of the participants (16 of 21) were in the age range of ‘mature’ students (21 years of age or older). Within the literature it is consistently identified that younger individuals are less likely to consider the topic of health and illness in general terms and more specifically in relation to their everyday activities compared with older individuals (Petrovici and Ritson, 2006, Deeks et al., 2009, Moyle et al., 2010, Kelly et al., 2016, Zajacova et al., 2020). Further to this, Ünver et al. (2018) found, in a Turkish cross-sectional survey with 375 nursing students aged between 18 – 30 years, using an attitude scale towards scientific research, that older nursing students had more positive attitudes to research. It could therefore be possible that, for both of the reasons outlined, mature students would be more likely to engage in this research.

11.7.3 Dependability

Dependability considers whether the research can be trusted in respect of whether the processes and procedures have been applied logically. Within the research there is demonstration of coherence between methodology, methods and findings plus the application of participant verification and a transparent audit trail of decisions and actions. Triangulation and reflexivity have also been a feature. Patton (1999) describes four types of triangulation: method, investigator, theory and data source, each of which enables the consideration of the data from a range of perspectives. Method triangulation in this research included the use of interviews and field notes to collect the data. Investigator triangulation was provided by the research supervisors, with their views providing perspectives that expanded my own. Theory triangulation was gained by consideration of different theories to analyse and interpret the data, supporting or refuting the findings. Finally, the use of focus groups and individual semi-structured interviews achieved data source triangulation (Carter et al., 2014). Each approach enabled the development of a broader understanding of the data. This, in combination with frequent reflexive discussions, produced a ‘reflexive audit’ enabling me to monitor and react to the influence of my values and passion for the subject, therefore producing dependable work.

The adoption of a longitudinal qualitative and CGT methodological approach is a strength of this work. The CGT methodology was a natural fit with my personal ontology and the inductive-deductive interplay of CGT effectively facilitated wide-ranging exploration in an area where there is a paucity of existing literature. A CGT approach supported the development of a novel theory that will be useful in understanding student learning in a way that has not previously been expressed. This approach was the most appropriate to enable the emergence of a theory that was grounded in the experience of the students. It is acknowledged that the research process presents challenges. The quality of qualitative research is heavily dependent on the individual skills of the researcher, can be influenced by their personal biases and idiosyncrasies and trustworthiness may be difficult to demonstrate. Further challenges were that the volume of the data made analysis, interpretation and theory construction time-consuming and my presence during data collection had the potential to influence the students' responses. Reflexivity, however, was interlaced with each stage of the process of the theory emerging, which is a further strength. Despite the challenges the theory that emerged was grounded in the experience of the students, reflected their compelling narratives and defines reality as experienced by the participants in our co-construction.

Relationships with others throughout the research process have been a strength, with my ability to develop and maintain relationships magnifying the inherent positives of the qualitative research process and reducing some limitations. This has been relevant to two fundamental areas. First, having a supportive, developmental relationship with my supervisors has been pivotal in producing trustworthy research. Throughout the entire course of the research there have been detailed discussions with the supervisory team. While these became more intense at certain points in the research process, such as at the beginning of my Doctorate study, during data collection and analysis and in the recognition of the emergent grounded theory, the robustness of this research results from this process. Second, relationships were important when working with the participants: my ability to rapidly gain their trust, enabling them to see that I was listening to them and authentically interested in their experience, was pivotal.

Whether it is possible to achieve theoretical saturation continues to be considered debatable and an act of judgement (Charmaz, 2014). In this study the judgement was made at the point where no new codes or meanings had been revealed in the data added after four further online interviews. This felt appropriate as I thought I had sufficient data saturation to address the research questions. Whether asking one more pertinent question in the four online interviews (which were held after the point of theoretical saturation was thought to have been met) might have elucidated further revelation however remains unknown. Despite this, it is possible to conclude with certainty that the standard of 'theoretical sufficiency' as described by Dey (1999) was achieved in that there was sufficient data to suggest categories and enable analytical conceptualisation of the data, theoretical abstraction and the development of a robust grounded theory that represents the research findings.

Throughout the research process use has been made of diagrams and drawings to assist in data analysis and explanation of the findings. This procedure is viewed as a strength of the work and will be of further benefit in the dissemination of the study, presenting material in an engaging and accessible format.

A further issue relating to processes related to organisation of the focus groups. All focus groups were planned at a time when participants were on their university campus but not involved in teaching, with focus groups in a quiet location, a classroom. The advent of a flood caused the room planned for one focus group to be unusable and it was not possible to find another classroom. The participants were keen for the focus group to continue and suggested using the student common room. While this location provided an area where discussion would not be overheard by others, the area was noisy but, as each participant was happy for the focus group to occur, we continued. While this focus group did not follow most of the accepted advice regarding how to run a focus group effectively (Carey, 2016, Denny and Weckesser, 2022), it was highly successful in terms of participant interaction and free-flowing discussion with equal input from all participants. There are possible reasons for this. The participants wanted the focus group to occur and had been involved in decision-making regarding its organisation. They also felt relaxed and comfortable in the environment where it was held. What I assumed would act as distraction, background noise and general activities of others, proved to be a positive addition for the participants, although it did increase the difficulty of transcribing this particular focus group. However, this experience highlighted the importance of participants being 'invested in' the group running and feeling 'at home' in the environment, being in 'their space' with less power imbalance and having a shared experience.

11.7.4 Confirmability

The final criterion, confirmability, focuses on whether findings and interpretations are linked to the data and if there is confidence that the results reported would be corroborated by other researchers. The application of independent duplicate coding of the data and frequent discussion with the research supervisors and my peers have been integral aspects of the research process. These strategies provided guidance, feedback and practical suggestions based on the experience of others, which challenged and developed my interpretation of what I thought I was seeing. Thus, there was confirmation of the reality being recorded.

I attempted to be acutely aware of my potential to influence others at all stages of the research. In the PIS, the scenarios used in the focus groups and on the consent forms I was very careful to ensure that I did not dictate precisely what data I wanted participants to provide. While participants needed to be fully informed about the reasons for and purpose of the research, the organisation of the data collection sessions and be aware that taking part involved talking about their views of health and illness, I wanted to minimise my influence. What I had not considered was that I could potentially influence participants by my tendency to say 'health and illness' in discussion, rather than referring to each concept individually. In analysing the data I became aware of a noteworthy pattern of usage of this term, which highlights the value of concurrent data analysis with data collection in CGT methodology and identifies a strength. Throughout the first round of focus groups this term was consistently used by me, not by any of the participants. In the second round of focus groups three of the participants were using this term rather than referring to the concepts individually. In the recordings of the individual interviews, four of eight participants consistently said this. The literature made me aware that my positionality and worldview would exert influence on the research, but to hear the participants adopting a term I used and being able to track its spread was unexpected. It is not possible to definitively conclude that the participants adoption of the term I used was due to my influence, but it is a possibility. Considering this issue further I also wonder whether, prior to the start of the research in my investigation of the sensitising concepts, this tendency may also have had an impact. Again, it is not possible to arrive at a definitive conclusion, but it could have been the case. Relating this to the trustworthiness of the research, my interpretation may have been picked up by participants, other researchers may not have shared this approach, and some participants could have been influenced by me.

A further limitation to the work reflecting my potential influence was in the approach I applied regarding participant verification. Participant verification was applied by offering, at the end of each focus group, an overview of the themes of discussion in the form of a bullet-pointed list sent by email. Four participants requested to receive this and provided feedback regarding their experience of the focus group rather than confirming whether the bullet points outlined what they thought had been discussed. This may be because they felt it unnecessary to add any further comments as the overview was acceptable, or they were unable to recall details of the discussion. It could also have been that they were uncertain as to what I was asking them to do, reflecting a need for greater guidance supported by written information. Following the individual interviews, participants were not offered the opportunity to verify the discussion because I felt it was likely to be overly burdensome. While my motivation for this action was so the pressure on participants who were already experiencing considerable stress was not increased, the decision as to whether the participants took part in verifying discussion should have been one they made, not me.

In conclusion, as Lincoln and Guba (1986) advise, research lacking trustworthiness is worthless and becomes fiction. Maintaining quality in qualitative research is fundamentally important and has therefore been a consideration throughout the entire course of this research.

11.8 Implications for Nurse Education

In the processes involved in adding new insight to the existing knowledge of nursing student learning, there has been identification that a number of issues relating to student experience and the organisation of nurse education require consideration. For students to learn good care delivery based upon the principles of person-centred care they need to be routinely supervised by nurses, in practice and education, who not only have the skills and knowledge to deliver such an approach but also are supported to teach others to do so. The experience students gain throughout their nursing programme is the foundation for their professional attitudes and practice as Registered Nurses. As students learn by observing, imitating and identifying with the actions of others, their future practice is based on that of role models, with those students meet on placement being particularly influential. While the design, content and teaching of a nursing curriculum is of importance in student development, the practical application of nursing is learnt while on placement (Salisu et al., 2019). Therefore, the fundamental importance of those who supervise students in clinical practice needs greater recognition in the wider framework of nurse education.

While the NMC (2018c) recognise the important role of practice learning, the ongoing support and development of those who supervise students requires strengthening. The placements students attend are clinical environments which are both places of learning and focused on workplace goals. Registered Nurses require support and education to assist them to meet the requirements of busy clinical practice areas while effectively facilitating student learning. Although professional development is a mandatory element of the three-yearly process of revalidation for all nurses registered in the UK (NMC, 2021b), there is no requirement for the nurse to focus specifically on the development of their ability to supervise students. Further initiatives are required to strengthen both support for learning in clinical practice and the dissemination of good practice models for partnership working between care providers and educational institutions. In tandem with this, opportunities for closer working between university and clinical staff regarding curriculum development and delivery need to be maximised, including the co-delivery of teaching to unite the perspectives of the practice of nursing and its theoretical underpinning.

11.9 Recommendations

To address the issues and constraints identified throughout the research reported in this thesis, a series of recommendations are proposed (see Table 11-3) which involve change at organisational and individual level plus a proposal for further research.

Table 11-3. Recommendations

Organisational – NMC/Educational institutions/NHS
• Adopt teaching strategies in nurse education programmes that support students to notice significant experience by using students’ evolving views of health and illness as a focus and a storytelling approach for regular guided reflection and discussion. This should occur both during and after periods of placement learning and be co-facilitated by clinical and academic staff. • Devise health promotional education that specifically challenges students’ fatalistic views. • Strengthen continuous education for Registered Nurses to ensure that it focuses on providing the skills and knowledge required to effectively facilitate student learning and understanding of the importance of person-centred care delivery. • Develop organisational cultures that promote and provide the delivery of person-centred care, ensuring that all staff are supported to do so. • Develop organisational cultures that facilitate leaders and role models who inspire and motivate others to replicate their healthy lifestyle behaviour. Strengthen role modelling in the care and education contexts through the targeted selection of experienced individuals who lead healthy lifestyles to support others. • Include education regarding self-care and personal health in all nurse education programmes. • Increase partnership working between health education organisations and healthcare providers to develop and maintain effective educational environments within clinical placement. • Disseminate innovative models of good practice regarding partnership working between care providers and educational institutions. • Promote initiatives/directives at personal and organisational levels for healthy lifestyles.
Individual
• Respond to initiatives/directives for healthy lifestyles.
Research
• Identify opportunities for further research to investigate the Theory of Balance with a range of stakeholders, including persons receiving care.

11.10 Conclusion

This chapter has considered the research questions by discussing the findings and emergent grounded theory and situating them in the context of the existing literature to generate new insights.

The findings of this research provide insight into how, through experience, students develop their ability to comprehend, navigate and deliver care upholding the perspective of health and illness of persons receiving care. In the discussion of the findings and emergent grounded theory, links with existing knowledge and theory have been made with new insights identified. The grounded theory emergent in this research, the Theory of Balance, explains the evolution of nursing students' concepts of health and illness during their undergraduate nursing programme and also proposes the existence of a relationship between perceptions of health and illness and the care students describe that they deliver. Thus the Theory of Balance provides an original contribution to knowledge.

Within the chapter there has been consideration of the attributes of health and illness defined at the start of the research, nearly eight years ago, and identification that they remain relevant and are evident in the emergent data categories. There has also been exploration of the strengths and limitations of the study and a demonstration of the trustworthiness of this work. The chapter ends by discussing the implications of the research for nurse education, with recommendations being proposed for nurse education, nursing practice and further research.

Discussion in this chapter demonstrates that the research questions, aim and objectives identified at the start of this thesis have been addressed by comprehensive exploration of the evolution of the views of health and illness of nursing students during a pre-registration nursing programme.

The following chapter concludes the thesis.

Chapter 12 Summarising and Concluding

'more is needed than a good curriculum'

Reflective Journal Entry 08.05.2022

12.1 Introduction

This final chapter concludes the thesis by providing a summary of the significant aspects of the research. The key findings of the research and the emergent grounded theory are summarised and the original contribution to knowledge provided by this thesis is outlined.

The chapter concludes with a review of dissemination of the findings so far and a plan for future activities, including development of the emergent grounded theory. This final chapter outlines the significance of the thesis to nursing students' concepts of health and illness and provides a summary of the work.

12.2 Key Findings

The findings of the research facilitated identification of attributes of health and illness, model cases of health and illness and a rich and detailed understanding of students' perceptions of health and illness. Thus the research questions posed at the start of the inquiry have been answered. It was clearly demonstrated that nursing students' perceptions of the concepts of health and illness reflect personal, professional, sociocultural and organisational influences and are therefore unique to each individual. In addition to identifying these properties it is possible to classify student perceptions into two categories, as either simple (an inductively-derived term used by students) or more complex. As students progress through pre-registration education, their perceptions develop in complexity, with this development in understanding resulting in an increase in the delivery of person-centred care. The developing views of the students were dynamic and characterised by evolution, a quality which students viewed likely to continue after they had completed their programme.

Students develop a personal repository of experience regarding health and illness, which is composed of the relevant personal and professional experiences they have accrued before and during a nursing programme. Students' ability to comprehend, navigate and support the unique perspective of the person to whom they deliver care is increased by noticing and engaging reflectively with their exposure to varying perspectives of health and illness. The learning from such exposure enables students to hold complex perceptions of health and illness and act as a polyglot, knowing and understanding differing approaches which they translate in the care they deliver.

12.3 The Theory of Balance in Perception of Health and Illness and Care Delivery

The grounded theory emergent from this work, the Theory of Balance, identifies that a student's perception of health and illness and their care delivery will be in equilibrium with their ability to make sense of experience pivotal to this. Thus, students with perceptions of health and illness that are simple (an inductively-derived term used by students) will deliver care to others in a functional manner, while students whose perception is more complex will adopt a person-centred approach in their care delivery to others. In terms of self-care, however, students struggle and frequently are unable to apply these principles or their knowledge to their self-care.

What is influential in the progression of views of health and illness from simple to more complex and any resultant change in care delivery from functional to person-centred is the noticing of significant experience and engaging reflectively with this. Therefore, students making sense of their personal and professional experiences before and during the nursing programme is fundamental to development of their views and their delivery of care.

Development of views of health and illness is inhibited by a lack of noticing. The ability to notice is a fundamental precondition to reflection which enables students to recognise experience as significant and relevant to views of health and illness. When students engage with the process of noticing and reflecting on significant experience, their actions are dynamic, iterative and ongoing.

In this way students continuously relate experience to their views of health and illness throughout their nursing programme. The Theory of Balance provides an original contribution to the knowledge informing understanding of students' views of health and illness.

12.4 Original Contribution

Work throughout this thesis has presented a unique, original insight into the concepts of health and illness held by students. The theory emergent from the research complements and contributes to existing knowledge, providing new insights into how students make sense of their personal and professional experiences before and during a nursing programme, in terms of their perceptions of health and illness and how these influence their views of the care they deliver. The key aspects of the original contribution are:

- The thesis is the only CGT study to exclusively explore nursing students' concepts of health and illness in two universities in England. Within the existing body of literature no other empirical studies focusing on nursing students' perceptions of both health and illness have been located, from any country. The research therefore provides a unique contribution to knowledge.
- The adaptation of Rodgers' (1989) evolutionary concept analysis model (Delves-Yates et al., 2018) provides a novel approach to concept analysis.
- Concept analyses defining the attributes and model cases of health and illness.
- Innovative insight into definitions of health and illness by stating that nursing students view health and illness as being whatever the person experiencing them says they are and existing whenever the person says they do.
- The recognition that the wide-ranging experiences of health and illness students gain both prior to and during their studies form a repository of experience they apply to future situations.
- The existence of links between students' developing views of health and illness and their

    - developing understanding of person-centred nursing practice, and
    - choice of Registered Nurse post at the end of the nursing programme.
- A detailed outline of the reflective approach applied by students as they develop their views of health and illness, identifying two processes, the Eutheos Approach and the Janus Approach.
- Creative presentation of findings and processes in the drawings of
    - model cases of health and illness,
    - the data refining process,
    - the snakes and ladders of a three-year nursing programme, and
    - evolving views of health and illness.
- The presentation of a unique grounded theory, the Theory of Balance in Perception of Health and Illness and Care Delivery (Theory of Balance). This theory identifies a relationship between a student's perception of health and illness and their care delivery, with the noticing of significant experience and engaging reflectively with this being fundamental to perception development.

12.5 Disseminating the Findings

An essential part of the research process is the dissemination of findings to diverse audiences (Fisher and Bloomfield, 2019). The dissemination of findings can be undertaken in different ways, but typically it entails publication in peer-reviewed journals and presentations at conferences, either nationally or internationally. There are other approaches, including sharing with colleagues or using social media.

Dissemination has been considered an integral part of the research process for this work from the start. Throughout the course of the research the adaptation of Rodgers' (1989) evolutionary concept analysis model and the early findings have been disseminated as relevant opportunities arose, such as informal talks, conferences and by publication in a peer-reviewed journal (see Appendix 21 for further details).

The plan for the phase following research completion is to continue this dissemination activity through the development of articles for publication in peer-reviewed research journals and to share the Theory of Balance at relevant national and international conferences. Plans to present the findings to stakeholders within the educational context have already been made, including the contribution of ‘plain English summaries’ of the findings directly to students and via relevant blogs. The importance of noticing and use of stories in reflection will also be included in a textbook on reflection for nursing students.

12.6 New Beginnings

A goal of nurse education, not just in the UK but also globally, is to enable students to collaborate with a person receiving care while respecting their individual view on all aspects of their health or illness. In this way it is possible to maximise the positive impact of the care being delivered (ICN, 1987, NMC, 2018a, NMC, 2018c, DoH, 2023). Regarding views of health and illness there are two important elements in nursing care delivery: first, an understanding of the need to respect the views of health and illness held by persons receiving care and, second, being able to work effectively in response to the many and differing views individuals can hold, including those opposing your personal positions. The research presented in this thesis identifies that students sustained the desire to deliver care achieving both elements, which they identified as person-centred practice, even when such an approach was not the prevailing culture of the clinical environment.

As a nurse the most effective way to work in partnership with persons receiving care is by knowing what they value and how they make sense of their illness experience. To achieve this, it is necessary to be a skilled communicator, able to make meaningful connections with others. The findings from this research provide insight into an aspect of this, in that through experience students develop their ability to comprehend, navigate and work with the perspectives of health and illness held by the persons they deliver care to. The emergent grounded theory proposed in this thesis, the Theory of Balance, provides an original contribution to knowledge by identifying a potential relationship between a student's perception of health and illness and the care they deliver. Within this relationship, noticing of significant experience and engaging reflectively with it is fundamental to a development in perception.

According to Charmaz (2014) an emergent grounded theory provides a preliminary foundation of knowledge and requires development through further research activity. Thus, the Theory of Balance requires further empirical investigation to explore its relevance to other stakeholders and contexts, with my engagement in post-doctoral research, and the commencement of another research journey necessary to enhance its credibility. As Uliana, 3rd year, emphasised:

> '*My experiences of things relating to health and illness, thinking about them is what makes me nurse better.* [.....] *Knowing what I value, and why, helps me understand how different things can be important to others. So, in my care I respect what others value about health and illness.* [.....] *That is good nursing.'*

References

Abrams, K. M., Wang, Z., Song, Y. J. & Galindo-Gonzalez, S. (2015) 'Data richness trade-offs between face-to-face, online audiovisual, and online text-only focus groups', *Social Science Computer Review,* 33, pp. 80-96.

Adom, D., Hussein, E. K. & Agyem, J. A. (2018) 'Theoretical and conceptual framework: Mandatory ingredients of a quality research', *International Journal of Scientific Research,* 7, pp. 438-441.

Afaneh, T., Abu-Moghli, F. & Ahmad, M. (2021) 'Nursing-sensitive indicators: a concept analysis', *Journal of Nursing Management,* 28, p. 3.

Ahmed, P. I., Kolker, A. & Coelho, G. V. (1979) *Toward a new definition of health: An overview,* New York, Springer Publishing.

Alexander, C. S. & Becker, H. J. (1978) 'The use of vignettes in survey research', *Public Opinion Quarterly,* 42, pp. 93-104.

Alford, V. M., Remedios, L. J., Webb, G. R. & Ewen, S. (2013) 'The use of the international classification of functioning, disability and health (ICF) in indigenous healthcare: a systematic literature review', *International Journal for Equity in Health,* 12, p. 32.

Andrews, T. (2012) 'What is social constructionism?', *Grounded Theory Review,* 11, pp. 39-47.

Archer, M. S. (2007) *Making our way through the world: Human reflexivity and social mobility,* Cambridge, Cambridge University Press.

Armstrong, D. L. (1989) *An outline of sociology as applied to medicine,* London, Wright.

Arthur, C. M., Hickling, F. W., Robertson-Hickling, H., Haynes-Robinson, T., Abel, W. & Whitley, R. (2010) '“Mad, sick, head nuh good”: Mental illness stigma in Jamaican communities', *Transcultural Psychiatry,* 47, pp. 252-275.

Asp, M. & Fagerberg, I. (2005) 'Developing concepts in caring science based on a lifeworld perspective', *International Journal of Qualitative Methods,* 4, pp. 57-67.

Audulv, Å., Hall, E. O., Kneck, Å., Westergren, T., Fegran, L., Pedersen, M. K., Aagaard, H., Dam, K. L. & Ludvigsen, M. S. (2022) 'Qualitative longitudinal research in health research: a method study', *BMC Medical Research Methodology,* 22, pp. 1-19.

Aveyard, H., Payne, S. & Preston, N. (2021) *A Postgraduate's Guide to Doing a Literature Review in Health and Social Care,* London, Open University Publishing.

Awofeso, N. (2012) 'Vaccination, public health and national security', *Australian and New Zealand Journal of Public Health,* 36, p. 90.

Bandura, A. (1986) *Social foundations of thought and action : a social cognitive theory,* Englewood Cliffs, NJ, Prentice-Hall.

Barchard, F. (2019) *Adult nurses' understanding and use of courage in their professional practice : 'Realising Courage' in nursing.* University of Northampton.

Barrett, D. (2022) 'Impact of COVID-19 on nursing students: what does the evidence tell us?', *Evidence Based Nursing,* 25, pp. 37-38.

Beauchamp, T. & Childress, J. (2019) *Principles of Biomedical Ethics,* Oxford, Oxford University Press.

Becker, H. S. (1993) 'How I learned what a crock was', *Journal of Contemporary Ethnography,* 22, pp. 28-35.

Beckwith, S., Dickinson, A. & Kendall, S. (2008) 'The “con” of concept analysis: a discussion paper which explores and critiques the ontological focus, reliability and antecedents of concept analysis frameworks', *International Journal of Nursing Studies,* 45, pp. 1831-1841.

Benner, P. (1984) *From novice to expert,* Menlo Park, CA, Addison-Wesley Publishing.

Benner, P. (2004) 'Using the Dreyfus model of skill acquisition to describe and interpret skill acquisition and clinical judgment in nursing practice and education', *Bulletin of Science, Technology & Society,* 24, pp. 188-199.

Benner, P. & Wrubel, J. (1982) 'Skilled Clinical Knowledge: The Value of Perceptual Awareness', *Nurse Educator,* 7, pp. 11-17.

Bennett, D., Kajamaa, A. & Johnston, J. (2020) 'How to … do longitudinal qualitative research', *Clinical Teacher,* 17, pp. 489-492.

Bergdahl, E. & Berterö, C. M. (2016) 'Concept analysis and the building blocks of theory: misconceptions regarding theory development', *Journal of Advanced Nursing,* 72, pp. 2558-2566.

Bergen, N. & Labonté, R. (2020) '"Everything is perfect, and we have no problems": detecting and limiting social desirability bias in qualitative research', *Qualitative Health Research,* 30, pp. 783-792.

Berwick, D. (2013) *A promise to learn - a commitment to act: improving the safety of patients in England,* London, Department of Health.

Biesta, G. (2010) *Pragmatism and the philosophical foundations of mixed methods research,* Thousand Oaks, CA, SAGE Publications Inc.

Bircher, J. (2005) 'Towards a dynamic definition of health and disease', *Medicine, Health Care and Philosophy,* 8, pp. 335-341.

Birks, M., Chapman, Y. & Francis, K. (2008) 'Memoing in qualitative research: Probing data and processes', *Journal of Research in Nursing,* 13, pp. 68-75.

Birks, M., Hoare, K. & Mills, J. (2019) 'Grounded theory: the FAQs', *International Journal of Qualitative Methods,* 18, p. 1609406919882535.

Birks, M. & Mills, J. (2022) *Grounded theory: A practical guide,* London, SAGE Publications Ltd.

Birt, L., Scott, S., Cavers, D., Campbell, C. & Walter, F. (2016) 'Member checking: a tool to enhance trustworthiness or merely a nod to validation?', *Qualitative Health Research,* 26, pp. 1802-1811.

Bishop, F. & Yardley, L. (2010) 'The development and initial validation of a new measure of lay definitions of health: The wellness beliefs scale', *Psychology and Health,* 25, pp. 271-287.

Blaikie, N. & Priest, J. (2019) *Designing social research: The logic of anticipation,* New Jersey, John Wiley & Sons.

Bland, R. & Darlington, Y. (2002) 'The nature and sources of hope: Perspectives of family caregivers of people with serious mental illness', *Perspectives in Psychiatric Care,* 38, pp. 61-68.

Blaxter, M. (1983) 'The causes of disease: women talking', *Social Science & Medicine,* 17, pp. 59-69.

Blaxter, M. (2004) 'Life narratives, health and identity', *Identity and Health*, pp. 170-99.

Blaxter, M. (2010) *Health,* Cambridge, Polity Press.

Blaxter, M. & Paterson, E. (1982) Mothers and Daughters: A Three-Generational Study of Health Attitudes and Health Behaviour. London: Heinemann Educational Books.

Blumer, H. (1969) *Symbolic interactionism: Perspective and Method.,* Engelwood Cliffs, Prentice Hall.

Borton, T. (1970) *Read, Touch and Teach,* London, Hutchinson.

Bowen, G. A. (2006) 'Grounded Theory and Sensitizing Concepts', *International Journal of Qualitative Methods,* 5, pp. 12-23.

Boyd, K. M. (2000) 'Disease, illness, sickness, health, healing and wholeness: exploring some elusive concepts', *Medical Humanities,* 26, pp. 9-17.

Branch, J. & Rocchi, F. (2015) 'Concept Development: A Primer', *Philosophy of Management,* 14, pp. 111-133.

Braun, V. & Clarke, V. (2006) 'Using thematic analysis in psychology', *Qualitative Research in Psychology,* 3, pp. 77-101.

Braun, V. & Clarke, V. (2012) *Thematic analysis*, American Psychological Association.

Brown, L. (1993) *New shorter Oxford English dictionary on historical principles,* Oxford, Clarendon Press.

Browne, A., Anderson, B., Pullinger, M. & Medd, W. (2014) *Method as intervention: Intervening in practice through quantitative and mixed methodologies,* New York, Taylor Francis Inc.

Browne, A. L. (2016) 'Can people talk together about their practices? Focus groups, humour and the sensitive dynamics of everyday life', *Area,* 48, pp. 198-205.

Bryant, A. & Charmaz, K. (2010) *The SAGE handbook of grounded theory,* London, SAGE Publications Ltd.

Bryman, A. (2008) *The end of the paradigm wars,* London, SAGE Publications Ltd.

Buber, M. (1923) *I and Thou,* New Jersey, Paulist Press.

Buckley, C. A. & Waring, M. J. (2013) 'Using diagrams to support the research process: Examples from grounded theory', *Qualitative Research,* 13, pp. 148-172.

Bulman, C., Lathlean, J. & Gobbi, M. (2012) 'The concept of reflection in nursing: Qualitative findings on student and teacher perspectives', *Nurse Education Today,* 32, pp. e8-e13.

Bury, M. (2005) *Health and illness in a changing society,* Cambridge, Polity Press.

Butler, A. E., Copnell, B. & Hall, H. (2018) 'The development of theoretical sampling in practice', *Collegian,* 25, pp. 561-566.

Callaghan, P. (1999) 'Health beliefs and their influence on United Kingdom nurses' health-related behaviours', *Journal of Advanced Nursing,* 29, pp. 28-35.

Campbell, M. K., Meier, A., Carr, C., Enga, Z., James, A. S., Reedy, J. & Zheng, B. (2001) 'Health behavior changes after colon cancer: a comparison of findings from face-to-face and on-line focus groups', *Family and Community Health*, pp. 88-103.

Carel, H. (2014) 'The philosophical role of illness', *Metaphilosophy,* 45, pp. 20-40.

Carey, M. A. (2016) 'Focus Groups—What Is the Same, What Is New, What Is Next?', *Qualitative Health Research,* 26, pp. 731-733.

Carlsen, B. & Glenton, C. (2011) 'What about N? A methodological study of sample-size reporting in focus group studies', *BMC Medical Research Methodology,* 11, pp. 1-10.

Carter, H., MacLeod, R., Brander, P. & McPherson, K. (2004) 'Living with a terminal illness: patients' priorities', *Journal of Advanced Nursing,* 45, pp. 611-620.

Carter, N., Bryant-Lukosihs, D., DiCenso, A., Blythe, J. & Neville, A. (2014) 'The use of triangulation in qualitative research', *Oncology Nursing Forum,* 41, pp. 545-7.

Cassell, E. (1977) *The Healers Art: A New Approach to the Doctor-Patient Relationship,* Harmondsworth, Penguin.

Charmaz, K. (1990) ''Discovering'chronic illness: using grounded theory', *Social Science & Medicine,* 30, pp. 1161-1172.

Charmaz, K. (1991) *Good days, bad days: The self in chronic illness and time,* New Jersey, Rutgers University Press.

Charmaz, K. (1994) 'Identity dilemmas of chronically ill men', *The Sociological Quarterly,* 35, pp. 269-288.

Charmaz, K. (1995) 'The body, identity, and self: Adapting to impairment', *The Sociological Quarterly,* 36, pp. 657-680.

Charmaz, K. (2000) 'Looking backward, moving forward: Expanding sociological horizons in the twenty-first century: 2000 presidential address to the pacific sociological association', *Sociological Perspectives,* 43, pp. 529-547.

Charmaz, K. (2002) 'The self as habit: The reconstruction of self in chronic illness', *OTJR: Occupation, Participation and Health,* 22, pp. 31S-41S.

Charmaz, K. (2004) Grounded Theory. *In:* Lewis-Beck, M., Bryman, A. & Liao, T. (eds.) *The SAGE Encyclopedia of Social Science Research Methods.* Thousand Oaks: SAGE Publishing Inc.

Charmaz, K. (2006) 'Measuring pursuits, marking self: Meaning construction in chronic illness', *International Journal of Qualitative Studies on Health and Well-being,* 1, pp. 27-37.

Charmaz, K. (2008) 'Views from the margins: Voices, silences, and suffering', *Qualitative Research in Psychology,* 5, pp. 7-18.

Charmaz, K. (2012) 'The power and potential of grounded theory', *Medical Sociology Online,* 6, pp. 2-15.

Charmaz, K. (2014) *Constructing Grounded Theory,* London, SAGE Publications Ltd.

Charmaz, K. (2017) 'Constructivist grounded theory', *The Journal of Positive Psychology*, pp. 299-300.

Charmaz, K. & Mitchell, R. G. (1996) 'The myth of silent authorship: Self, substance, and style in ethnographic writing', *Symbolic Interaction,* 19, pp. 285-302.

Cheng, Y., Huang, L., Yang, C. & Chang, H. (2020) 'Experiential learning program to strengthen self-reflection and critical thinking in freshmen nursing students during COVID-19: A quasi-experimental study.', *International Journal of Environmental Research and Public Health,* 17, p. 5442.

Chilisa, B. & Kawulich, B. (2012) 'Selecting a research approach: Paradigm, methodology and methods', *Doing Social Research: A Global Context,* 5, pp. 51-61.

Chinn, P. L. & Kramer, M. K. (1987) *Theory and nursing: A systematic approach,* St Louis, Mosby.

Chun Tie, Y., Birks, M. & Francis, K. (2019) 'Grounded theory research: A design framework for novice researchers', *SAGE Open Medicine,* 7, pp. 1-8.

Churchill, W. (1944) *Onwards to Victory,* London, Cassell.

Cole, S. & Lejeune, R. (1972) 'Illness and the Legitimation of Failure', *American Sociological Review,* 37, pp. 347-356.

Cole, S. A. & Bird, J. (2013) *The Medical Interview: The Three Function Approach,* Amsterdam, Elsevier.

Collins, J. & Rodgers, J. (2009) Concept analysis: Health. Kansas: Washburn University.

Corbin, J. & Strauss, A. (2008) *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory,* Thousand Oaks, California, SAGE Publications Inc.

Coşkun, K. (2020) 'A New Explanation for the Conflict Between Constructivist and Objectivist Grounded Theory', *International Journal of Qualitative Methods,* 19, pp. 1-5.

Coulter, A. & Collins, A. (2011) *Making shared decision-making a reality,* London, King's Fund.

Coutu, M.-F., Baril, R., Durand, M.-J., Côté, D. & Cadieux, G. (2011) 'Health and illness representations of workers with a musculoskeletal disorder-related work disability during work rehabilitation: a qualitative study', *Journal of Occupational Rehabilitation,* 21, pp. 591-600.

Crawford, K., Jakub, K., Lockhart, J. S. & Wold, J. L. (2023) 'Knowledge, attitudes, and beliefs of cardiovascular disease prevention in young adults in the country of Georgia', *Journal of Nursing Scholarship*.

Creswell, J., Plano Clark, V., Guttman, M. & Hanson, W. (2003) *Handbook on mixed methods in the behavioural and social sciences,* Thousand Oaks, California, SAGE Publications Inc.

Creswell, J. W. & Poth, C. N. (2016) *Qualitative inquiry and research design: Choosing among five approaches,* London, SAGE Publications Ltd.

Cronin, P., Ryan, F. & Coughlan, M. (2010) 'Concept analysis in healthcare research', *International Journal of Therapy and Rehabilitation,* 17, pp. 62-68.

Crotty, M. (1998) *The Foundations of Social Research: Meaning and Perspective in the Research Process,* London, SAGE Publications Ltd.

Daly, K. J. (2007) *Qualitative methods for family studies and human development,* London, SAGE Publications Ltd.

Darzi, A. (2008) *High quality care for all: NHS next stage review final report,* London, The Stationery Office.

Day, R. A. (1983) *How to write a scientific paper,* Philadelphia, ISI.

de Silva, D. (2011) *Helping people help themselves,* London, The Health Foundation.

de Silva, D. (2012) *Helping people share decision making,* London, The Health Foundation.

Deeks, A., Lombard, C., Michelmore, J. & Teede, H. (2009) 'The effects of gender and age on health related behaviors', *BMC Public Health,* 9, pp. 1-8.

Delves-Yates, C., Stockl, A. & Moore, J. (2018) 'Making sense of concept analysis', *Nurse Researcher,* 25, p. 43.

Denny, E. & Weckesser, A. (2022) 'How to do qualitative research?: qualitative research methods', *Bjog,* 129, p. 1166.

Denzin, N. K. (1997) *Interpretive ethnography: Ethnographic practices for the 21st century,* Thousand Oaks, Sage Publications Inc.

Denzin, N. K. & Lincoln, Y. S. (2008) *The landscape of qualitative research,* London, SAGE Publications Ltd.

Dewey, J. (1933) *How we think : a restatement of the relation of reflective thinking to the educative process,* Boston, D.C. Heath and Company.

Dewey, J. (1959) *Experience and Education,* New York, Macmillan.

Dey, I. (1999) *Grounding Grounded Theory: Guidelines for Qualitative Inquiry,* London, Academic Press.

Dey, I. (2004) Grounded theory. *In:* Seale, C., Gobo, G., Gubrium, J. F. & Silverman, D. (eds.) *Qualitative Research Practice.* London: SAGE Publications Ltd.

DH. (2018) *Getting Informed Consent for User Research* [Online]. Gov.UK. Available: https://www.gov.uk/service-manual/user-research/getting-users-consent-for-research [Accessed 3rd June 2023].

DHSS (1980) The Black Report - Inequalities in health. London: DHSS.

Dillon, D. R., O'Brien, D. G. & Heilman, E. E. (2000) 'Literacy research in the next millennium: From paradigms to pragmatism and practicality', *Reading Research Quarterly,* 35, pp. 10-26.

DoH (2012) The NHS Constitution for England. London: HMSO.

DoH (2023) *The NHS Constitution for England,* London, HMSO.

Doody, O. & Noonan, M. (2013) 'Preparing and conducting interviews to collect data', *Nurse Researcher,* 20.

Drach-Zahavy, A., Goldblatt, H., Admi, H., Blau, A., Ohana, I. & Itzhaki, M. (2022) 'A multi-level examination of nursing students' resilience in the face of the COVID-19 outbreak: A cross-sectional design', *Journal of Advanced Nursing,* 78, pp. 109-120.

Draper, P. (2014) 'A critique of concept analysis', *Journal of Advanced Nursing,* 70, pp. 1207-1208.

Dubos, R. J. (1965) *Man adapting,* New Haven, Connecticut, Yale University Press.

Dunne, C. (2011) 'The place of the literature review in grounded theory research', *International Journal of Social Research Methodology,* 14, pp. 111-124.

Eachus, P. (1991) 'Multidimensional health locus of control in nurses', *Journal of Advanced Nursing,* 16, pp. 165-171.

Earle, S., Lloyd, C. E., Sidell, M. & Spurr, S. (2007) *Theory and research in promoting public health,* London, SAGE Publications Ltd.

Easter, M. M., Linnan, L. A., Bentley, M. E., DeVellis, B. M., Meier, A., Frasier, P. Y., Kelsey, K. S. & Campbell, M. K. (2007) '"Una Mujer Trabaja Doble Aquí": Vignette-Based Focus Groups on Stress and Work for Latina Blue-Collar Women in Eastern North Carolina', *Health Promotion Practice,* 8, pp. 41-49.

Easton, K. L., McComish, J. F. & Greenberg, R. (2000) 'Avoiding common pitfalls in qualitative data collection and transcription', *Qualitative Health Research,* 10, pp. 703-707.

Eckroth-Bucher, M. (2010) 'Self-awareness: A review and analysis of a basic nursing concept', *Advances in Nursing Science,* 33, pp. 297-309.

Edberg, A.-K. & Andersson, P. L. (2015) 'The shift from a medical to a nursing orientation: A comparison of Swedish nursing students' expectations when entering the nursing degree programme in 2003 and 2013', *Nurse Education Today,* 35, pp. e78-e83.

Edwards, S. (2012) *Learning from practice: the value of story in nurse education* Doctorate in Education, University of Hertfordshire.

Eisenberg, L. (1977) 'Disease and illness Distinctions between professional and popular ideas of sickness', *Culture, Medicine and Psychiatry,* 1, pp. 9-23.

Eldh, A. C., Årestedt, L. & Berterö, C. (2020) 'Quotations in Qualitative Studies: Reflections on Constituents, Custom, and Purpose', *International Journal of Qualitative Methods,* 19, pp. 1-6.

Elliott, N. & Higgins, A. (2012) 'Surviving grounded theory research method in an academic world: Proposal writing and theoretical frameworks', *Grounded Theory Review,* 11.

Emami, A. & Torres, S. (2005) 'Making sense of illness: late-in-life migration as point of departure for elderly Iranian immigrants' explanatory models of illness', *Journal of Immigrant Health,* 7, pp. 153-164.

Emerson, K. & Northway, R. (2022) Patient, Service User, Family and Carer Perspectives. *In:* Delves-Yates, C. (ed.) *Essentials of Nursing Practice.* 3 ed. London: SAGE Publicatins Ltd.

Engel, G. L. (1977) 'The need for a new medical model: a challenge for biomedicine', *Science,* 196, pp. 129-136.

Eriksson, K. (1992) Nursing: the caring practice" being there" caring communication. *In:* Gault, D. (ed.) *The presence of caring in nursing.* New York: National League for Nursing publications.

Eriksson, K. (1997) 'Understanding the world of the patient, the suffering human being: the new clinical paradigm from nursing to caring', *Advanced Practice Nursing Quarterly,* 3, pp. 8-13.

Eriksson, K. (2007) 'Becoming through suffering — the path to health and holiness', *International Journal of Human Caring,* 11, pp. 8-16.

ESRC. (2023) *Consent* [Online]. UKRI. Available: https://www.ukri.org/councils/esrc/guidance-for-applicants/research-ethics-guidance/consent/ [Accessed 3rd June 2023].

European Parliament (2016) Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data. *In:* Parliament, E. (ed.). Strasbourg: European Parliament.

Evans, G. L. (2013) 'A novice researcher's first walk through the maze of grounded theory: Rationalization for classical grounded theory', *Grounded Theory Review,* 12.

Farquharson, B., Johnston, M. & Bugge, C. (2011) 'How people present symptoms to health services: a theory-based content analysis', *British Journal of General Practice,* 61, pp. 267-273.

Farragher, R. & Coogan, D. (2020) 'Constructivist grounded theory: Recognising and raising the voice of young people with experience of care systems', *Child Care in Practice,* 26, pp. 38-49.

Fineout-Overholt, E. & Johnston, L. (2005) 'Teaching EBP: asking searchable, answerable clinical questions', *Worldviews on Evidence-Based Nursing,* 2, pp. 157-160.

Finlay, L. & Gough, B. (2003) *Reflexivity: a practical guide for researchers in health and social science,* Oxford, Blackwell Publishing.

Fisher, J. (2012) *Process of Personal Transition* [Online]. Available: https://www.r10.global/wp-content/uploads/2017/05/fisher-transition-curve-2012-1.pdf [Accessed 31st January 2022].

Fisher, M. J. & Bloomfield, J. (2019) 'Understanding the research process', *Journal of the Australasian Rehabilitation Nurses Association,* 22, pp. 22-27.

Flick, U. (2013) *The SAGE handbook of qualitative data analysis,* London, SAGE Pulications Ltd.

Foley, A. S. & Davis, A. H. (2017) 'A guide to concept analysis', *Clinical Nurse Specialist,* 31, pp. 70-73.

Fredriksson, L. & Eriksson, K. (2003) 'The ethics of the caring conversation', *Nursing Ethics,* 10, pp. 138-148.

Freidson, E. (1970) *Profession of Medicine: A study in the sociology of applied knowledge,* Chicago, University of Chicago Press.

Fulford, K. W. M. (1989) *Moral theory and medical practice,* Cambridge, Cambridge University Press.

Gale, N. K., Heath, G., Cameron, E., Rashid, S. & Redwood, S. (2013) 'Using the framework method for the analysis of qualitative data in multi-disciplinary health research', *BMC Medical Research Methodology,* 13, pp. 1-8.

Galvin, R. D. (2005) 'Researching the disabled identity: Contextualising the identity transformations which accompany the onset of impairment', *Sociology of Health & Illness,* 27, pp. 393-413.

Gardner, A., McCutcheon, H. & Fedoruk, M. (2012) 'Discovering constructivist grounded theory's fit and relevance to researching contemporary mental health nursing practice', *Australian Journal of Advanced Nursing,* 30, pp. 66-74.

Gastmans, C. (1998) 'Challenges to nursing values in a changing nursing environment', *Nursing Ethics,* 5, pp. 236-245.

Geertz, C. (1973) 'Thick description: Toward an interpretive theory of culture', *Turning points in qualitative research,* 3, pp. 143-168.

Gillon, R. (1986) 'On sickness and on health', *British Medical Journal,* 292, p. 318.

Given, L. (2008) The SAGE Encyclopedia of Qualitative Research Methods. Thousand Oaks, California: SAGE Publications Inc.

Glaser, B. (1992) *Basics of Grounded Theory Analysis,* California, Sociology Press.

Glaser, B. G. (1978) *Theoretical Sensitivity,* Mill Valley, CA, Sociology Press.

Glaser, B. G. (2001) *The Grounded Theory Perspective,* Mill Valley, CA, Sociology Press.

Glaser, B. G. & Kaplan, W. D. (1996) *Gerund grounded theory: The basic social process dissertation,* Mill Valley, California, Sociology Press.

Glaser, B. G. & Strauss, A. L. (1965) *Awareness of Dying,* Chicago, IL, Aldine Publishing.

Glaser, B. G. & Strauss, A. L. (1967) *The Discovery of Grounded Theory: Strategies for Qualitative Research,* Chicago, IL, Aldine Publishing.

Gobat, N., Butler, C., Mollison, J., Francis, N., Gal, M., Harris, V., Webb, S., Byrne, J.-P., Watkins, A. & Sukumar, P. (2019) 'What the public think about participation in medical research during an influenza pandemic: an international cross-sectional survey', *Public Health,* 177, pp. 80-94.

Godlee, F. (2011) 'What is health?', *British Medical Journal,* 343.

Good, M.-J. D., Brodwin, P., Good, B. & Kleinman, A. (1994) *Pain as human experience: An anthropological perspective,* Berkeley, California, University of California Press.

Gothberg, J., Reeves, P., Thurston, L., Applegate, B., Kohler, P. & Peterson, L. (2013) 'Is the Medium Really the Message? A Comparison of Face-to-Face, Telephone, and Internet Focus Group Venues', *Journal of Ethnographic & Qualitative Research,* 7.

Grealish, L. & Trevitt, C. (2005) 'Developing a professional identity: Student nurses in the workplace', *Contemporary Nurse,* 19, pp. 137-150.

Grønkjær, M., Curtis, T., De Crespigny, C. & Delmar, C. (2011) 'Analysing group interaction in focus group research: Impact on content and the role of the moderator', *Qualitative Studies,* 2, pp. 16-30.

Gunderman, R. (2000) 'Illness as Failure: Blaming Patients', *The Hastings Center Report,* 30, pp. 7-11.

Haidet, M., Hatem MD, D. S., Stein PhD, H., Lynn, M., Haley PhD, H.-L. A., Kimmel MS, B., Mossbarger MS, D. & Inui, M. (2007) 'The role of relationships in the professional formation of physicians'.

Halcomb, E. J. & Davidson, P. M. (2006) 'Is verbatim transcription of interview data always necessary?', *Applied Nursing Research,* 19, pp. 38-42.

Hallberg, I. R. (2019) Nursing Science in Sweden: Internal and External Forces Contributing to Its Development. *In:* Hafsteinsdóttir, T. B., Jónsdóttir, H., Kirkevold, M., Leino-Kilpi, H., Lomborg, K. & Rahm Hallberg, I. (eds.) *Leadership in Nursing: Experiences from the European Nordic Countries.* Cham: Springer International Publishing.

Hallberg, L. R. (2006) 'The “core category” of grounded theory: Making constant comparisons', *International Journal of Qualitative Studies on Health and Well-being,* 1, pp. 141-148.

Hampson, S. E., Glasgow, R. E. & Toobert, D. J. (1990) 'Personal models of diabetes and their relations to self-care activities', *Health Psychology,* 9, p. 632.

Handberg, C., Thorne, S., Midtgaard, J., Nielsen, C. V. & Lomborg, K. (2015) 'Revisiting symbolic interactionism as a theoretical framework beyond the grounded theory tradition', *Qualitative Health Research,* 25, pp. 1023-1032.

Harding, S. (2016) *Whose science? Whose knowledge?,* New York, Cornell University Press.

Haug, M. R., Musil, C. M., Warner, C. D. & Morris, D. L. (1998) 'Interpreting bodily changes as illness: a longitudinal study of older adults', *Social Science & Medicine,* 46, pp. 1553-1567.

Hayes, C., Jackson, D., Davidson, P. M., Daly, J. & Power, T. (2018) 'Pondering practice: Enhancing the art of reflection', *Journal of clinical nursing,* 27, pp. e345-e353.

Helman, C. (2007) *Culture, health and illness,* Boca Raton, Florida, CRC Press.

Helman, C. G. (1978) '“Feed a cold, starve a fever”—folk models of infection in an English suburban community, and their relation to medical treatment', *Culture, Medicine and Psychiatry,* 2, pp. 107-137.

Helman, C. G. (1981) 'Disease versus illness in general practice', *The Journal of the Royal College of General Practitioners,* 31, pp. 548-552.

Hennelly, N. & O’Shea, E. (2019) 'Personhood, dementia policy and the Irish national dementia strategy', *Dementia,* 18, pp. 1810-1825.

Hennink, M. M. (2007) *International focus group research: A handbook for the health and social sciences,* Cambridge, Cambridge University Press.

Hennink, M. M., Kaiser, B. N. & Marconi, V. C. (2017) 'Code saturation versus meaning saturation: how many interviews are enough?', *Qualitative health research,* 27, pp. 591-608.

Hennink, M. M., Kaiser, B. N. & Weber, M. B. (2019) 'What influences saturation? Estimating sample sizes in focus group research', *Qualitative Health Research,* 29, pp. 1483-1496.

Henwood, K. & Pidgeon, N. (2003) Grounded theory in psychological research. *In:* Camic, P., Rhodes, J. & Yardley, L. (eds.) *Qualitative Research in Psychology: Expanding Perspectives in Methodology and Design.* Washington, DC: American Psychological Association.

Herberts, S. & Eriksson, K. (1995) 'Nursing leaders’ and nurses’ view of health', *Journal of Advanced Nursing,* 22, pp. 868-878.

Hewitt, P. (2023) The Hewitt Review. *In:* Care, H. a. S. (ed.). London: UK Government.

Hibbard, J. & Gilburt, H. (2014) *Supporting people to manage their health,* London, The King's Fund.

Higgins, J. P., Thomas, J., Chandler, J., Cumpston, M., Li, T., Page, M. J. & Welch, V. A. (2019) *Cochrane handbook for systematic reviews of interventions,* New Jersey, John Wiley & Sons.

Hofmann, B. (2002a) 'On the triad disease, illness and sickness', *The Journal of Medicine and Philosophy,* 27, pp. 651-673.

Hofmann, B. (2002b) *The Technological Invention of Disease-: On Disease, Technology and Values,* Oslo, Unipub AS.

Holloway, I. & Galvin, K. (2016) *Qualitative research in nursing and healthcare,* New Jersey, John Wiley & Sons.

Horton, R. (2009) 'What is health? The ability to adapt', *The Lancet,* 373, p. 781.

Huber, M., Knottnerus, J. A., Green, L., van der Horst, H., Jadad, A. R., Kromhout, D., Leonard, B., Lorig, K., Loureiro, M. I. & van der Meer, J. W. (2011) 'How should we define health?', *British Medical Journal,* 343.

Huberman, A. & Miles, M. (2011) The Qualitative Researcher's Companion. Thousand Oaks, California: SAGE Publications Inc.

Hughes, E. C. (1968) *Ethnomedicine,* New York, Macmillan.

Hwu, Y.-J., Coates, V. E. & Boore, J. R. (2001) 'The evolving concept of health in nursing research: 1988–1998', *Patient Education and Counseling,* 42, pp. 105-114.

ICN (1987) *Definition of a nurse,* Geneva, International Council of Nurses.

IfG. (2022) *Timeline of UK government coronavirus lockdowns and measures* [Online]. Institute for Government Analysis. [Accessed 5th June 2023].

Illich, I. (1976) *Limits to Medicine,* London, Marion Boyars.

Irvine, A., Drew, P. & Sainsbury, R. (2013) '‘Am I not answering your questions properly?’Clarification, adequacy and responsiveness in semi-structured telephone and face-to-face interviews', *Qualitative Research,* 13, pp. 87-106.

Jackson, D., Hutchinson, M. & Wilson, S. (2016) 'In defence of patients', *Journal of Clinical Nursing*.

Jadad, A. R. & O’Grady, L. (2008) 'How should health be defined?', *British Medical Journal,* 337, p. a2900.

Jamshed, S. (2014) 'Qualitative research method-interviewing and observation', *Journal of Basic Clinical Pharmacy,* 5, pp. 87-8.

Johns, C. (1995) 'Framing learning through reflection within Carper's fundamental ways of knowing in nursing', *Journal of Advanced Nursing,* 22, pp. 226-234.

Johns, C. (2000) *Becoming a Reflective Practitioner,* New Jersey, Wiley.

Jormfeldt, H., Svedberg, P., Fridlund, B. & Arvidsson, B. (2007) 'Perceptions of the concept of health among nurses working in mental health services: A phenomenographic study', *International Journal of Mental Health Nursing,* 16, pp. 50-56.

Kangas, I. (2001) 'Making sense of depression: perceptions of melancholia in lay narratives', *Health,* 5, pp. 76-92.

Karaöz, S. (2004) 'Change in nursing students’ perceptions of nursing during their education: the role of the introduction to nursing course in this change', *Nurse Education Today,* 24, pp. 128-135.

Kaushik, V. & Walsh, C. A. (2019) 'Pragmatism as a research paradigm and its implications for social work research', *Social Sciences,* 8, p. 255.

Kean, S., Salisbury, L., Rattray, J., Walsh, T., Huby, G. & Ramsay, P. (2016) 'ICU 'Survivorship'- a constructivist grounded theory of surviving critical illness', *Journal of Clinical Nursing*, pp. 3111-3124.

Kelly, S., Martin, S., Kuhn, I., Cowan, A., Brayne, C. & Lafortune, L. (2016) 'Barriers and facilitators to the uptake and maintenance of healthy behaviours by people at mid-life: a rapid systematic review', *PloS One,* 11, p. e0145074.

Kennedy-Lewis, B. L. (2014) Using Diagrams to Make Meaning in Grounded Theory Data Collection and Analysis. London.

Kidd, I. J. & Carel, H. (2017) 'Epistemic injustice and illness', *Journal of Applied Philosophy,* 34, pp. 172-190.

Kitwood, T. (1993) 'Towards a theory of dementia care: the interpersonal process', *Ageing & Society,* 13, pp. 51-67.

Kitwood, T. (1997) *Dementia reconsidered: The person comes first,* Buckingham, Open University Press.

Kitwood, T. & Brooker, D. (2019) *Dementia Reconsidered, Revisited : The Person Still Comes First,* Bielefeld, McGraw-Hill Education.

Kitzinger, J. (1995) 'Qualitative Research: Introducing focus groups', *British Medical Journal,* 311, pp. 299-302.

Kleinman, A. (1980) *Patients and healers in the context of culture: An exploration of the borderland between anthropology, medicine, and psychiatry,* Berkeley, California, University of California Press.

Kleinman, A. (1988) *The illness narratives : suffering, healing, and the human condition,* New York, Basic Books.

Kleinman, A. (2012) 'Caregiving as moral experience', *The Lancet,* 380, pp. 1550-1551.

Kleinman, A. (2015) 'Care: in search of a health agenda', *The Lancet,* 386, pp. 240-241.

Kleinman, A., Eisenberg, L. & Good, B. (1978) 'Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research', *Annals of internal medicine,* 88, pp. 251-258.

Knafl, K. A. & Deatrick, J. A. (2014) 'Commentary on: Draper P. (2014) Editorial: a critique of concept analysis. Journal of Advanced Nursing 70, 1207-1208', *Journal of Advanced Nursing,* 70, p. 2968.

Kool, M. B., van Middendorp, H., Boeije, H. R. & Geenen, R. (2009) 'Understanding the lack of understanding: invalidation from the perspective of the patient with fibromyalgia', *Arthritis Care & Research,* 61, pp. 1650-1656.

Kramer-Roy, D. (2015) 'Using participatory and creative methods to facilitate emancipatory research with people facing multiple disadvantage: A role for health and care professionals', *Disability & Society,* 30, pp. 1207-1224.

Krueger, R. A. (2014) *Focus groups: A practical guide for applied research,* London, SAGE Publications Ltd.

Kvale, S. (1996) *Interviews: An introduction to qualitative Research interviewing,* London, SAGE Publications Ltd.

Lambert, S. D. & Loiselle, C. G. (2008) 'Combining individual interviews and focus groups to enhance data richness', *Journal of Advanced Nursing,* 62, pp. 228-237.

Larson, J. S. (1999) 'The conceptualization of health', *Medical Care Research and Review,* 56, pp. 123-136.

Larsson, J. & Holmström, I. (2007) 'Phenomenographic or phenomenological analysis: Does it matter? Examples from a study on anaesthesiologists' work', *International Journal of Qualitative Studies on Health and well-being,* 2, pp. 55-64.

Last, J. M. (2007) *A dictionary of public health,* Oxford, Oxford Univeristy Press.

Leininger, M. (1992) 'Current Issues, Problems, and Trends to Advance Qualitative Paradigmatic Research Methods for the Future', *Qualitative Health Research,* 2, pp. 392-415.

Leininger, M. (1996) 'Culture care theory, research, and practice', *Nursing Science Quarterly,* 9, pp. 71-78.

Leininger, M. & Reynolds, C. (1991) *Culture care diversity and universality theory,* Washington, Pearson.

Leventhal, H. (1985) 'Commentary: The Role of Theory in the Study of Adherence to Treatment and Doctor-Patient Interactions', *Medical Care,* 23, pp. 556-563.

Leviw, E. P. (1975) 'Pretentious Prose', *Journal of Occupational and Environmental Medicine,* 17, p. 134.

Li, Z.-S. & Hasson, F. (2020) 'Resilience, stress, and psychological well-being in nursing students: A systematic review', *Nurse Education Today,* 90, p. 104440.

Lincoln, Y. & Guba, G. (2000) Paradigmatic controversies, contradictions, and emerging confluences. *In:* Denzin, N. & Lincoln, Y. (eds.) *Handbook of qualitative research.* 2nd ed. Thousand Oaks, California: SAGE publishing, Inc.

Lincoln, Y. S. & Guba, E. G. (1985) *Naturalistic inquiry,* Beverly Hills, CA, SAGE Publications Inc.

Lincoln, Y. S. & Guba, E. G. (1986) 'But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation', *New Directions for Program Evaluation,* 1986, pp. 73-84.

Litva, A. & Eyles, J. (1994) 'Health or healthy: Why people are not sick in a Southern Ontarian town', *Social Science & Medicine,* 39, pp. 1083-1091.

Liyanapathirana, N. S., Samkin, G., Low, M. & Davey, H. (2016) 'Developing written and video vignettes for ethical decision-making research', *New Zealand Journal of Applied Business Research,* 14, pp. 29-41.

Loke, J. C., Lee, K. W., Lee, B. K. & Noor, A. M. (2015) 'Caring behaviours of student nurses: Effects of pre-registration nursing education', *Nurse Education in Practice,* 15, pp. 421-429.

Long, A. (2000) 'The labyrinth of health as perceived by two groups of community nurses', *Journal of Psychiatric and Mental Health Nursing,* 7, pp. 233-240.

Long, A. & Baxter, R. (2001) 'Functionalism and holism: community nurses' perceptions of health', *Journal of Clinical Nursing,* 10, pp. 320-329.

Lorig, K. R., Ritter, P. L. & González, V. M. (2003) 'Hispanic chronic disease self-management: a randomized community-based outcome trial', *Nursing Research,* 52, pp. 361-369.

Loseke, D. R. (2017) *Methodological thinking: Basic principles of social research design,* Thousand Oaks, California, SAGE Publications Inc.

Lupton, D. (2012) *Medicine as culture: Illness, disease and the body,* Thousand Oaks, California, SAGE Publications Inc.

Maccarthy, J., Guerin, S., Wilson, A. G. & Dorris, E. R. (2019) 'Facilitating public and patient involvement in basic and preclinical health research', *PLoS One,* 14, p. e0216600.

Mackintosh, C. (2006) 'Caring: the socialisation of pre-registration student nurses: a longitudinal qualitative descriptive study', *International Journal of Nursing Studies,* 43, pp. 953-962.

Malacrida, C. (2007) 'Reflexive journaling on emotional research topics: Ethical issues for team researchers', *Qualitative Health Research,* 17, pp. 1329-1339.

Manninen, E. (1998) 'Changes in nursing students' perceptions of nursing as they progress through their education', *Journal of Advanced Nursing,* 27, pp. 390-398.

Manning, N. & Tikhonova, N. (2009) *Health and Healthcare in the New Russia,* Farnham, Ashgate.

Marinker, M. (1975) 'Why make people patients?', *Journal of Medical Ethics,* 1, pp. 81-84.

Martin, P. & Barnard, A. (2013) 'The experience of women in male-dominated occupations: A constructivist grounded theory inquiry', *Journal of Industrial Psychology,* 39, pp. 1-12.

Marton, F. (1994) On the structures of awareness. *In:* J, B. & E, W. (eds.) *Phenomenographic Research: Variations in Methods. .* Melbourne: Royal Melbourne Institute of Technology.

Mason, J. (2002a) *Qualitative Researching,* London, SAGE Publications Ltd.

Mason, J. (2002b) *Researching Your Own Practice: The Discipline of Noticing,* London, Routledge.

Mason, J. (2017) *Qualitative researching,* London, SAGE Publications Ltd.

Masterman, M. (1970) The nature of paradigms. *In:* Lakatos, I. & Musgrave, A. (eds.) *Criticism and the growth of knowledge.* Cambridge: Cambridge University Press.

Mauthner, N. S. & Doucet, A. (1998) Reflections on a Voice Centred Relational Method of DataAnalysis: Analysing Maternal and Domestic Voices. *In:* Ribbens, J. & Edwards, R. (eds.) *Feminist Dilemmas in Qualitative Research: Private Lives and Public Texts.* London: SAGE Publishing Ltd.

Mauthner, N. S. & Doucet, A. (2003) 'Reflexive Accounts and Accounts of Reflexivity in Qualitative Data Analysis', *Sociology,* 37, pp. 413-431.

Maxcy, S. J. (2003) 'Pragmatic threads in mixed methods research in the social sciences: The search for multiple modes of inquiry and the end of the philosophy of formalism', *Handbook of Mixed Methods in Social and Behavioral Research*.

Maxwell, J. A. (2011) 'Paradigms or toolkits? Philosophical and methodological positions as heuristics for mixed methods research', *Mid-Western Educational Researcher,* 24, pp. 27-30.

May, T. & Perry, B. (2022) *Social research: Issues, methods and process,* London, McGraw-Hill Education.

McCaffery, M. (1968) *Nursing practice theories related to cognition, bodily pain, and man-environment interactions,* Los Angeles, California, University of California Print Office.

McCance, T., McCormack, B. & Dewing, J. (2011) 'An exploration of person-centredness in practice'.

McCance, T., McCormack, B., Slater, P. & McConnell, D. (2021) 'Examining the Theoretical Relationship between Constructs in the Person-Centred Practice Framework: A Structural Equation Model', *International Journal of Environmental Research and Public Health,* 18, p. 13138.

McCance, T. V. (2003) 'Caring in nursing practice: the development of a conceptual framework', *Research and Theory for Nursing Practice,* 17, pp. 101-116.

McCann, T. V. & Clark, E. (2003) 'Grounded theory in nursing research: Part 1--Methodology', *Nurse Researcher,* 11, pp. 7-18.

McCormack, B. (2001a) 'Autonomy and the relationship between nurses and older people', *Ageing & Society,* 21, pp. 417-446.

McCormack, B. (2001b) *Negotiating partnerships with older people: A person centred approach,* London, Routledge.

McCormack, B. (2003) 'A conceptual framework for person-centred practice with older people', *International Journal of Nursing Practice,* 9, pp. 202-209.

McCormack, B. (2004) 'Person-centredness in gerontological nursing: an overview of the literature', *Journal of Clinical Nursing,* 13, pp. 31-38.

McCormack, B. & Dewing, J. (2019) 'International Community of Practice for Person-centred Practice: position statement on person-centredness in health and social care', *International Practice Development Journal,* 9.

McCormack, B., Dewing, J. & Mccance, T. (2011) 'Developing person-centred care: addressing contextual challenges through practice development'.

McCormack, B. & McCance, T. (2016) *Person-centred practice in nursing and health care: theory and practice,* Oxford, Wiley-Blackwell.

McCormack, B. & McCance, T. (2019a) *The Person-Centred Nursing Framework* [Online]. Available: www.cpcpr.org/resources [Accessed 9th May 2023].

McCormack, B. & McCance, T. (2019b) *The Person-Centred Practice Framework* [Online]. Available: www.cpcpr.org/resources [Accessed 9th May 2023].

McCormack, B. & McCance, T. V. (2006) 'Development of a framework for person-centred nursing', *Journal of Advanced Nursing,* 56, pp. 472-479.

McGhee, G., Marland, G. R. & Atkinson, J. (2007) 'Grounded theory research: literature reviewing and reflexivity', *Journal of Advanced Nursing,* 60, pp. 334-342.

McKenna, H. P. & Cutcliffe, J. R. (2005) *An introduction to concepts and their analyses,* Edinburgh, Elsevier.

McLaughlin, H. (2009) 'What's in a name:'client','patient','customer','consumer','expert by experience','service user'—what's next?', *The British Journal of Social Work,* 39, pp. 1101-1117.

McPhail-Bell, K., Fredericks, B. & Brough, M. (2013) 'Beyond the accolades: a postcolonial critique of the foundations of the Ottawa Charter', *Glob Health Promot,* 20, pp. 22-9.

Melia, K. (1987) *Learning and Working. The Occupational Socialization of Nurses.,* London, Tavistock Publications.

Mensah, R., Agyemang, F., Acquah, A., Babah, P. & Dontoh, J. (2020) 'Discourses on Conceptual and Theoretical Frameworks in Research: Meaning and Implications for Researchers', *Journal of African Interdisciplinary Studies,* 4, pp. 53-64.

Merduaty, R. & Arum, A. (2023) 'How guided self-reflection improves critical thinking of nursing students in the pre-clinical stage?', *Journal of Holistic Nursing Science,* 10.

Meurier, C. (2016) Concepts of health, illness and holism. *In:* Crouch, A. & Meurier, C. (eds.) *Vital Notes for Nurses: Health Assessment.* New Jersey: John Wiley & Sons.

Milani, S. & Schoonderbeek, M. (2010) 'Drawing Theory. An Introduction', *Footprint*, pp. 1-8.

Miles, M. B., Huberman, A. M. & Saldaña, J. (2018) *Qualitative data analysis: A methods sourcebook,* London, SAGE Publications Ltd.

Miller, S., Ross, S. & Cleland, J. (2009) 'Medical students' attitudes towards disability and support for disability in medicine', *Medical Teacher,* 31, pp. e272-e277.

Mills, J., Bonner, A. & Francis, K. (2006) 'The development of constructivist grounded theory', *International Journal of Qualitative Methods,* 5, pp. 25-35.

Millstein, S. G. & Irwin, C. E. (1987) 'Concepts of health and illness: different constructs or variations on a theme?', *Health Psychology,* 6, p. 515.

Mitchell, D. (2014) 'Advancing grounded theory: Using theoretical frameworks within grounded theory studies', *The Qualitative Report,* 19, pp. 1-11.

Mlinar, S. (2010) 'First-and third-year student nurses’ perceptions of caring behaviours', *Nursing Ethics,* 17, pp. 491-500.

Moch, S. D. (1998) 'Health-within-illness: concept development through research and practice', *Journal of Advanced Nursing,* 28, pp. 305-310.

Mohr, W. K. (1999) 'Reflections on writing', *Nursing Outlook,* 5, pp. 198-199.

Moore, C. (2015) *The Role of Altruism and Fatalism in Economic Development* PhD, University of Arizona.

Mordacci, R. (1995) 'Health as an analogical concept', *The Journal of Medicine and Philosophy,* 20, pp. 475-497.

Morgan, D. L. (2007) 'Paradigms lost and pragmatism regained: Methodological implications of combining qualitative and quantitative methods', *Journal of Mixed Methods Research,* 1, pp. 48-76.

Morgan, J. & Gazarian, P. (2022) 'A good death: A synthesis review of concept analyses studies', *Collegian*.

Morse, J. M. (2001) 'Toward a praxis theory of suffering', *Advances in Nursing Science,* 24, pp. 47-59.

Morse, J. M., Barrett, M., Mayan, M., Olson, K. & Spiers, J. (2002) 'Verification Strategies for Establishing Reliability and Validity in Qualitative Research', *International Journal of Qualitative Methods,* 1, pp. 13-22.

Moyle, W., Park, Y. S., Grimbeek, P., Griffiths, S., Murfield, J. & Olorenshaw, R. (2010) 'The influence of personal characteristics on student nurse health attitudes', *Australian Journal of Advanced Nursing,* 27, pp. 55-61.

Murphy, F., Jones, S., Edwards, M., James, J. & Mayer, A. (2009) 'The impact of nurse education on the caring behaviours of nursing students', *Nurse Education Today,* 29, pp. 254-264.

Murphy, R. (1987) *The Body Silent,* New York, Henry Holt and Company.

Namey, E., Guest, G., O’Regan, A., Godwin, C. L., Taylor, J. & Martinez, A. (2020) 'How does mode of qualitative data collection affect data and cost? Findings from a quasi-experimental study', *Field Methods,* 32, pp. 58-74.

Nasrawi, D., Reid, C., Lee, M. & Coyne, E. (2022) 'Nursing assessment and management of nutrition in older people with cancer: An integrative review', *Collegian,* 29, pp. 924-930.

Neale, B. (2016) Introducing qualitative longitudinal research. *What is Qualitative Longitudinal Research?* 1 ed. London: Bloomsbury Academic.

Newman, M. A. (1992) 'Prevailing paradigms in nursing', *Nursing Outlook,* 40, pp. 10-3, 32.

NHS-England (2019a) Comprehensive Model of Personalised Care. London: NHS.

NHS-England (2019b) The NHS Long Term Plan. London: NHS.

NICE (2009) Medicines adherence: Involving patients in decisions about prescribed medicines and supporting adherence. . London: NICE.

Nielsen-Bohlman, L., Panzer, A. & Kindig, D. (2004) Institute of Medicine (US). Committee on Health Literacy. *Health literacy: A prescription to end confusion.* Washington (DC): National Academies Press (US).

Nightingale, F. (1859) Notes on Nursing What It is, and What It is Not. *Republished as an E-book in 2004 by Project Gutenberg.* London: Harrison.

NIHR. (2021) *Briefing notes for researchers - public involvement in NHS, health and social care research* [Online]. London: NIHR. Available: https://www.nihr.ac.uk/documents/briefing-notes-for-researchers-public-involvement-in-nhs-health-and-social-care-research/27371 [Accessed 16th June 2023].

NMC (2010) *Standards for Pre-registration Nursing Education,,* London, Nursing and Midwifery Council.

NMC (2018a) *The Code,* London, Nursing and Midwifery Council.

NMC (2018b) *Future nurse standards of proficiencies for registered nurses,* London, Nursing and Midwifery Council.

NMC (2018c) *Standards for pre-registration nursing programmes.,* London, Nursing and Midwifery Council.

NMC (2020) *Emergency standards for nursing and midwifery education,* London, NMC.

NMC (2021a) *Enabling students to support the workforce,* London, Nursing and Midwifery Council.

NMC (2021b) *How to revalidate with the NMC,* London, Nursing and Midwifery Council.

NMC. (2022a) *Becoming a Nurse* [Online]. Available: https://www.nmc.org.uk/education/becoming-a-nurse-midwife-nursing-associate/becoming-a-nurse/ [Accessed 10th October 2022].

NMC (2022b) *The NMC register mid-year update,* London, Nursing and Midwifery Council.

NMC (2022c) *Recovery Programme Standards,* London, Nursing and Midwifery Council.

Noble, H. & Mitchell, G. (2016) 'What is grounded theory?', *Evidence Based Nursing,* 19, pp. 34-35.

Nordby, H. (2004) 'The importance of knowing how to talk about illness without applying the concept of illness', *Nursing Philosophy,* 5, pp. 30-40.

Nordenfelt, L. (1987) *On the nature of health. An action-theoretic approach.,* Dordrecht, D. Reidel Publishing Company.

Nordenfelt, L. (1993) *Quality of life, health and happiness,* Nevada, Avebury Books.

Norris, C. M. (1982) *Concept clarification in nursing,* Rockville, Aspen.

North, S. (2018) 'What do we call you?' poll. Unpublished: University of East Anglia.

Nuopponen, A. (2010a) 'Methods of Concept Analysis - A comparative study', *LSP Journal,* 1.

Nuopponen, A. (2010b) 'Methods of Concept Analysis - Towards systematic concept analysis', *LSP Journal,* 1.

Nuopponen, A. (2011) 'Methods of Concept Analysis - Tools for systematic concept analysis', *LSP Journal,* 2.

O'Baugh, J., Wilkes, L. M., Luke, S. & George, A. (2003) '‘Being positive’: perceptions of patients with cancer and their nurses', *Journal of Advanced Nursing,* 44, pp. 262-270.

O'Connor, A. M., Llewellyn-Thomas, H. A. & Flood, A. B. (2004) 'Modifying Unwarranted Variations In Health Care: Shared Decision Making Using Patient Decision Aids: A review of the evidence base for shared decision making', *Health affairs,* 23, pp. VAR-63-VAR-72.

Ochieng, B. M. (2006) 'Factors affecting choice of a healthy lifestyle: implications for nurses', *British Journal of Community Nursing,* 11, pp. 78-81.

Omori, Y., Mori, C. & White, A. H. (2014) 'Self-Stigma in Schizophrenia: A Concept Analysis', *Nursing Forum,* 49, pp. 259-266.

ONS (2012) Anonymised Census Data. London: UK Government.

ONS. (2021) *Exploring local income deprivation* [Online]. Available: ons.gov.uk/visualisations/dvc1371/#/E07000223 [Accessed 19th March 2023].

ONS (2023) Anonymised Census Data. London: UK Government.

Osanloo, A. & Grant, C. (2016) 'Understanding, selecting, and integrating a theoretical framework in dissertation research: Creating the blueprint for your “house”', *Administrative Issues Journal,* 4, p. 7.

Paley, J. (1996) 'How not to clarify concepts in nursing', *Journal of Advanced Nursing,* 24, pp. 572-576.

Paley, J. (2021) *Concept analysis in nursing: A new approach,* Oxford, Routledge.

Paremoer, L., Nandi, S., Serag, H. & Baum, F. (2021) 'Covid-19 pandemic and the social determinants of health', *BMJ,* 372, p. n129.

Park, S. W. (2022) 'A reflection on health and disease amid COVID-19 pandemic', *Journal of Evaluation in Clinical Practice,* 28, pp. 711-716.

Parse, R. R. (1990) 'Health: A personal commitment', *Nursing Science Quarterly,* 3, pp. 136-140.

Parsons, T. & Jaco, E. G. (1958) *Patients, Physicians and Illness,* New York, Free Press.

Parvaresh-Masoud, M., Cheraghi, M. & Imanipour, M. (2021) 'Workplace interpersonal conflict in prehospital emergency: Concept analysis', *Journal of Education and Health Promotion,* 10, pp. 347-347.

Patton, M. Q. (1999) 'Enhancing the quality and credibility of qualitative analysis', *Health Services Research,* 34, pp. 1189-1208.

Patton, M. Q. (2014) *Qualitative Research and Evaluation Methods: integrating theory and practice,* Los Angeles, California, SAGE Publishing Inc.

Peplau, H. E. (1991) *Interpersonal relations in nursing: A conceptual frame of reference for psychodynamic nursing,* New York, Springer.

Petrovici, D. A. & Ritson, C. (2006) 'Factors influencing consumer dietary health preventative behaviours', *BMC Public Health,* 6, pp. 1-12.

Pettersson, B. (2011) 'Some bitter-sweet reflections on the Ottawa Charter commemoration cake: a personal discourse from an Ottawa rocker†', *Health Promotion International,* 26, pp. ii173-ii179.

Piaget, J., Tomlinson, A. & Tomlinson, J. (1952) *The Child's Conception of the World. (Translated by Joan and Andrew Tomlinson from 1929 original work),* London, Kegan Paul & Company.

Piat, M., Sabetti, J. & Bloom, D. (2009) 'The importance of medication in consumer definitions of recovery from serious mental illness: A qualitative study', *Issues in Mental Health Nursing,* 30, pp. 482-490.

Piko, B. (1999) 'Teaching the mental and social aspects of medicine in Eastern Europe: role of the WHO definition of health', *Administration and Policy in Mental Health and Mental Health Services Research,* 26, pp. 435-438.

Pollock, K. (2005) *Concordance in medical consultations: a critical review,* London, CRC.

Poortaghi, S., Raiesifar, A., Bozorgzad, P., Golzari, S. E., Parvizy, S. & Rafii, F. (2015) 'Evolutionary concept analysis of health seeking behavior in nursing: a systematic review', *BMC Health Services Research,* 15, pp. 1-8.

Pörn, I. (1984) An equilibrium model of health. *Health, disease, and causal explanations in medicine.* New York: Springer.

Potvin, L. & Jones, C. M. (2011) 'Twenty-five years after the Ottawa Charter: the critical role of health promotion for public health', *Can J Public Health,* 102, pp. 244-8.

Public Health England (2016a) Anonymised - University 1 Borough Health Profile. London: Public Health England.

Public Health England (2016b) Anonymised - University 1 Town Health Profile. London: Pubic Health England.

Public Health England (2016c) Anonymised - University 2 County Health Profile. London: Public Health England.

Ramalho, R., Adams, P., Huggard, P. & Hoare, K. (2015) 'Literature review and constructivist grounded theory methodology', *Forum: Qualitative Social Research,* 16, p. Art 19.

Rand, J. (2013) 'Action learning and constructivist grounded theory: powerfully overlapping fields of practice', *Action Learning: Research and Practice,* 10, pp. 230-243.

Randall, D. M. & Gibson, A. M. (1990) 'Methodology in business ethics research: A review and critical assessment', *Journal of Business Ethics,* 9, pp. 457-471.

Ranheim, A. & Dahlberg, K. (2012) 'Expanded Awareness as a Way to Meet the Challenges in Care that is Economically Driven and Focused on Illness--A Nordic Perspective', *Aporia,* 4.

Ravitch, S. M. & Riggan, M. (2016) *Reason & rigor: How conceptual frameworks guide research,* Thousand Oaks, California, SAGE Publications Inc.

Reder, E. A. K. & Serwint, J. R. (2009) 'Until the last breath: exploring the concept of hope for parents and health care professionals during a child's serious illness', *Archives of Pediatrics & Adolescent Medicine,* 163, pp. 653-657.

REF. (2021) *Research Excellence Framework Results* [Online]. Available: https://results2021.ref.ac.uk/ [Accessed 10th October 2022].

Reynolds, S. (2023) 'Community nurse lecturers' experiences of pre-registration nurse education: a phenomenological study', *British Journal of Community Nursing,* 28, pp. 38-43.

Richards, T., Coulter, A. & Wicks, P. (2015) 'Time to deliver patient centred care', *British Medical Journal,* 350.

Ricoeur, P. (1992) *Oneself as another,* Chicago, University of Chicago Press.

Risjord, M. (2009) 'Rethinking concept analysis', *Journal of Advanced Nursing,* 65, pp. 684-691.

Rivai, F., Pasinringi, S. A., Sari, N., Nadia, S. & Mallongi, A. (2023) 'Relationship Between the Implementation of Patient Centered Care with Patient Satisfaction and Quality of Service Inpatient Installation at Hasanuddin University Hospital', *Journal of Pharmaceutical Negative Results,* 14, pp. 77-81.

Rodgers, B. (1989) 'Concepts, analysis and the development of nursing knowledge: the evolutionary cycle.', *Journal of Advanced Nursing,* 14, pp. 330-335.

Rodgers, B. L. & Knafl, K. A. (2000) *Concept development in nursing : foundations, techniques, and applications,* Philadelphia, Saunders.

Rogal, S. M. & Young, J. (2008) 'Exploring critical thinking in critical care nursing education: A pilot study', *The Journal of Continuing Education in Nursing,* 39, pp. 28-33.

Romagon, J. & Jabot, F. (2020) 'The challenge of assessing social cohesion in health impact assessment', *Health Promotion International,* 36, pp. 753-764.

Romero-Martín, M., Gómez-Salgado, J., Robles-Romero, J. M., Jiménez-Picón, N., Gómez-Urquiza, J. L. & Ponce-Blandón, J. A. (2019) 'Systematic review of the nature of nursing care described by using the Caring Behaviours Inventory', *Journal of Clinical Nursing,* 28, pp. 3734-3746.

Rose, N. (1999) *Governing the soul,* London, Free Associations Books.

Rosenthal, M. (2016) 'Qualitative research methods: Why, when, and how to conduct interviews and focus groups in pharmacy research', *Currents in Pharmacy Teaching and Learning,* 8, pp. 509-516.

Sadegh-Zadeh, K. (2000) 'Fuzzy Health, Illness, and Disease', *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine,* 25, pp. 605-638.

Safadi, R., Saleh, M., Nassar, O., Amre, H. & Froelicher, E. (2011) 'Nursing students' perceptions of nursing: a descriptive study of four cohorts', *International Nursing Review,* 58, pp. 420-427.

Salisu, W. J., Dehghan Nayeri, N., Yakubu, I. & Ebrahimpour, F. (2019) 'Challenges and facilitators of professional socialization: A systematic review', *Nursing Open,* 6, pp. 1289-1298.

San Diego, E. R. N. & Merz, E. L. (2022) 'Diabetes knowledge, fatalism and type 2 diabetes-preventive behavior in an ethnically diverse sample of college students', *Journal of American College Health,* 70, pp. 385-394.

Saracci, R. (1997) 'The World Health Organization needs to reconsider its definition of health', *British Medical Journal,* 314, p. 1409.

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., Burroughs, H. & Jinks, C. (2018) 'Saturation in qualitative research: exploring its conceptualization and operationalization', *Qual Quant,* 52, pp. 1893-1907.

Scammell, S. H. (2001) *Illness as transformative gift in people with fibromyalgia,* California, Institute of Integral Studies.

Schang, L. K., Czabanowska, K. M. & Lin, V. (2011) 'Securing funds for health promotion: lessons from health promotion foundations based on experiences from Austria, Australia, Germany, Hungary and Switzerland', *Health Promotion International,* 27, pp. 295-305.

Schüssler, G. (1992) 'Coping strategies and individual meanings of illness', *Social Science & Medicine,* 34, pp. 427-432.

Schutz, A. (1962) On multiple realities. *In:* Natanson, M. (ed.) *Alfred Schutz: Collected Papers.* The Hague: Martinus Nijhoff.

Schwandt, T. A. (2001) *Dictionary of qualitative inquiry,* Thousand Oaks, California, SAGE Publications Inc.

Schwartz-Barcott, D. & Kim, H. (2000) An expansion and elaboration of the hybrid model of concept development. *In:* Rodgers, B. & Knafl, K. (eds.) *Concept Development in Nursing Foundations, Techniques and Applications.* Philadelphia: Saunders.

Seah, S. S. L., Chenoweth, L. & Brodaty, H. (2022) 'Person-centred Australian residential aged care services: how well do actions match the claims?', *Ageing & Society,* 42, pp. 2914-2939.

Sebastian, K. (2019) 'Distinguishing between the strains grounded theory: Classical, interpretive and constructivist', *Journal for Social Thought,* 3.

Secker, J. (1998) 'Current conceptualizations of mental health and mental health promotion', *Health Education Research,* 13, pp. 57-66.

Seedhouse, D. (1986) 'Health: a universal concern', *Nursing Times,* 82, pp. 36-38.

Seedhouse, D. (2001) *Health: the foundations for achievement,* New Jersey, John Wiley & Sons.

Seyedfatemi, N., Salsali, M., Rezaee, N. & Rahnavard, Z. (2014) 'Women's health concept: A meta-synthesis study', *Iranian Journal of Public Health,* 43, p. 1335.

Shannon-Baker, P. (2016) 'Making paradigms meaningful in mixed methods research', *Journal of Mixed Methods Research,* 10, pp. 319-334.

Shaw, I. (2002) 'How lay are lay beliefs?', *Health,* 6, pp. 287-299.

Sherwood, G. (2011) 'Integrating quality and safety science in nursing education and practice', *Journal of Research in Nursing,* 16, pp. 226-240.

Silverman, D. (2019) *Interpreting Qualitative Data,* London, SAGE Publications Ltd.

Sim, J. & Waterfield, J. (2019) 'Focus group methodology: some ethical challenges', *Quality & Quantity,* 53, pp. 3003-3022.

Simmons, S. J. (1989) 'Health: a concept analysis', *International Journal of Nursing Studies,* 26, pp. 155-161.

Skär, L. & Söderberg, S. (2016) 'Swedish nursing students' perceptions of the concept of health: A phenomenographic study', *Health Education Journal,* 75, pp. 385-395.

Skobba, K. (2023) 'Housing Careers and Housing Pathways: Conceptual Evolution or Confusion?', *Housing, Theory and Society*, pp. 1-18.

Smith, A. (1992) 'Setting a strategy for health', *British Medical Journal,* 304, pp. 376-378.

Smith, J., Rapport, F., O'Brien, T. A., Smith, S., Tyrrell, V. J., Mould, E. V. A., Long, J. C., Gul, H., Cullis, J. & Braithwaite, J. (2020) 'The rise of rapid implementation: a worked example of solving an existing problem with a new method by combining concept analysis with a systematic integrative review', *BMC Health Services Research,* 20, p. 449.

Smith, R. (2008). The end of disease and the beginning of health. Available from: https://blogs.bmj.com/bmj/2008/07/08/richard-smith-the-end-of-disease-and-the-beginning-of-health/ [Accessed 3rd June 2015].

Smith, R. (2020) 'Writing Up and Down: The Language of Educational Research', *Journal of Philosophy of Education,* 54, pp. 666-678.

Smith, S. & Mörelius, E. (2021) 'Principle-Based Concept Analysis Methodology Using a Phased Approach With Quality Criteria', *International Journal of Qualitative Methods,* 20, p. 16094069211057995.

SmithBattle, L., Lorenz, R., Reangsing, C., Palmer, J. L. & Pitroff, G. (2018) 'A methodological review of qualitative longitudinal research in nursing', *Nursing Inquiry,* 25, p. e12248.

Song, M. & Kong, E.-H. (2015) 'Older adults' definitions of health: A metasynthesis', *International Journal of Nursing Studies,* 52, pp. 1097-1106.

Sorrell, J. M. (2007) 'Aging matters. The transparency of aging: seeing is believing, but sometimes the most real things in the world are the things we can't see', *Journal of Psychosocial Nursing & Mental Health Services,* 45, pp. 19-21.

Spector, R. E. (2002) 'Cultural Diversity in Health and Illness', *Journal of Transcultural Nursing,* 13, pp. 197-199.

Stainton Rogers, W. (1991) *Explaining health and illness: An exploration of diversity,* London, Harvester Wheatsheaf.

Starr, J. & Marsden, L. (2008) 'Characterisation of user-defined health status in older adults with intellectual disabilities', *Journal of Intellectual Disability Research,* 52, pp. 483-489.

Stern, P. N. (2007) On Solid Ground: Essential Properties for Growing Grounded Theory. *In:* Bryant, A. & Charmaz, K. (eds.) *The SAGE Handbook of Grounded Theory.* Thousand Oaks: SAGE Publications Inc.

Strauss, A. & Corbin, J. (1990) *Basics of qualitative research,* London, SAGE Publications Ltd.

Strauss, A. & Corbin, J. (1998) *Basics of qualitative research: Techniques and procedures for developing grounded theory,* Thousand Oaks, California, SAGE Publications, Inc.

Strauss, A. L. (1987) *Qualitative analysis for social scientists,* Cambridge, Cambridge University Press.

Sullivan, R. J. (1989) *Immanuel Kant's moral theory,* Cambridge, Cambridge University Press.

Surís, A., Holliday, R. & North, C. S. (2016) 'The Evolution of the Classification of Psychiatric Disorders', *Behavioral Sciences,* 6.

Swanson, R. A. & Chermack, T. J. (2013) *Theory building in applied disciplines,* Oakland, California, Berrett-Koehler Publishers.

Synnot, A., Hill, S., Summers, M. & Taylor, M. (2014) 'Comparing face-to-face and online qualitative research with people with multiple sclerosis', *Qualitative Health Research,* 24, pp. 431-8.

Takahashi, R., Liehr, P., Nishimura, C., Ito, M. & Summers, L. C. (2005) 'Meaning of health for Japanese elders who have had a stroke', *Japan Journal of Nursing Science,* 2, pp. 41-49.

Tanner, D. (2016) 'Jean Piaget's debt to John Dewey', *AASA Journal of Scholarship & Practice,* 13, pp. 6-27.

The King’s Fund (2012) *Leadership and engagement for improvement in the NHS: Together we can.,* London, The King’s Fund.

Thornberg, R. & Dunne, C. (2019) The SAGE Handbook of Current Developments in Grounded Theory. London: SAGE Publications Ltd.

Thorne, S. E. (1999) 'The science of meaning in chronic illness', *International Journal of Nursing Studies,* 36, pp. 397-404.

Thorpe, G., Mason, J. & Delves-Yates, C. (2015) Core Academic Skills. *In:* Delves-Yates, C. (ed.) *Essentials of Nursing Practice.* London: SAGE Publications Ltd.

Tie, Y. C., Birks, M. & Francis, K. (2019) 'Playing the game: A grounded theory of the integration of international nurses', *Collegian,* 26, pp. 470-476.

Timmermans, S. & Tavory, I. (2012) 'Theory Construction in Qualitative Research:From Grounded Theory to Abductive Analysis', *Sociological Theory,* 30, pp. 167-186.

Timonen, V., Foley, G. & Conlon, C. (2018) 'Challenges when using grounded theory: A pragmatic introduction to doing GT research', *International journal of qualitative methods,* 17, p. 1609406918758086.

Tishelman, C. (1997) 'Getting sick and getting well: a qualitative study of aetiologic explanations of people with cancer', *Journal of Advanced Nursing,* 25, pp. 60-67.

Tofthagen, R. & Fagerstrøm, L. M. (2010) 'Rodgers’ evolutionary concept analysis–a valid method for developing knowledge in nursing science', *Scandinavian Journal of Caring Sciences,* 24, pp. 21-31.

Tong, A., Sainsbury, P. & Craig, J. (2007) 'Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups', *International Journal for Quality in Health Care,* 19, pp. 349-357.

Toombs, S. K. (1987) 'The meaning of illness: a phenomenological approach to the patient-physician relationship', *The Journal of Medicine and Philosophy,* 12, pp. 219-240.

Topping, M., Douglas, J. & Winkler, D. (2021) 'General Considerations for Conducting Online Qualitative Research and Practice Implications for Interviewing People with Acquired Brain Injury', *International Journal of Qualitative Methods,* 20, pp. 1-15.

Toulmin, S. (1972) *Human understanding: An inquiry into the aims of science,* Princeton, New Jersey, Princeton University Press.

Tronto, J. C. (1998) 'An ethic of care', *Generations: Journal of the American Society on Aging,* 22, pp. 15-20.

Tronto, J. C. (2013) *Caring democracy: Markets, equality, and justice,* New York, NYU Press.

Tu, M.-S. (2006) 'Illness: An opportunity for spiritual growth', *Journal of Alternative and Complementary Medicine,* 12, pp. 1029-1033.

Tulloch, A. (2005) 'What do we mean by health?', *The British Journal of General Practice,* 55, pp. 320-322.

Turan, G. B., Dayapoğlu, N. & Özer, Z. (2022) 'Evaluation of nursing students' health fatalism, knowledge, and attitudes toward patients with epilepsy', *Epilepsy & Behavior,* 127, p. 108497.

Turner Goins, R., Spencer, S. M. & Williams, K. (2011) 'Lay meanings of health among rural older adults in Appalachia', *The Journal of Rural Health,* 27, pp. 13-20.

UEA (2023) The Code of Practice For Research Degrees. Norwich: University of East Anglia.

UK Government (1997) Nurses, Midwives and Health Visitors Act.

UK Government (2012) Health and Social Care Act. London: UK Government.

UK Government (2018) Data Protection Act 2018. London: UK Government.

United Nations (1948) Article 25: Universal declaration of human rights. *In:* Nations, U. (ed.) *General Assembly Resolution 217A III.*

University 1 (2022) Student data.

University 2 (2021) Facts and figures.

University 2 (2022) Prospectus. *University-2.* University-2.

Ünver, S., Semerci, R., Özkan, Z. K. & Avcibasi, I. (2018) 'Attitude of nursing students toward scientific research: A cross-sectional study in Turkey', *Journal of Nursing Research,* 26, pp. 356-361.

van Belle, E., Giesen, J., Conroy, T., van Mierlo, M., Vermeulen, H., Huisman-de Waal, G. & Heinen, M. (2020) 'Exploring person-centred fundamental nursing care in hospital wards: A multi-site ethnography', *Journal of Clinical Nursing,* 29, pp. 1933-1944.

Van den Hoonaard, W. C. (1997) *Working with sensitizing concepts: analytical field research,* Thousand Oaks, California, SAGE Publications Inc.

Varpio, L., Paradis, E., Uijtdehaage, S. & Young, M. (2020) 'The Distinctions Between Theory, Theoretical Framework, and Conceptual Framework', *Academic Medicine,* 95, pp. 989-994.

Vena, J. A. & Copel, L. C. (2021) 'A concept analysis of remission within the domain of cancer survivorship', *Nursing Forum,* 56, pp. 421-428.

Viner, R. M., Ozer, E. M., Denny, S., Marmot, M., Resnick, M., Fatusi, A. & Currie, C. (2012) 'Adolescence and the social determinants of health', *The Lancet,* 379, pp. 1641-1652.

Viswanathan, H. & Lambert, B. L. (2005) 'An inquiry into medication meanings, illness, medication use, and the transformative potential of chronic illness among African Americans with hypertension', *Research in Social and Administrative Pharmacy,* 1, pp. 21-39.

Walker, L. O. & Avant, K. C. (2005) *Strategies for theory construction in nursing,* New Jersey, Pearson/Prentice Hall.

Wang, Y., Zhang, Y., Liu, M., Zhou, L., Zhang, J., Tao, H. & Li, X. (2020) 'Research on the formation of humanistic care ability in nursing students: A structural equation approach', *Nurse Education Today,* 86, p. 104315.

Ware, N. C. (1992) 'Suffering and the social construction of illness: The delegitimation of illness experience in chronic fatigue syndrome', *Medical Anthropology Quarterly,* 6, pp. 347-361.

Watson, R., Deary, I. J. & Lea, A. (1999) 'A longitudinal study into the perceptions of caring and nursing among student nurses', *Journal of Advanced Nursing,* 29, pp. 1228-1237.

Weaver, K. & Olson, J. K. (2006) 'Understanding paradigms used for nursing research', *Journal of Advanced Nursing,* 53, pp. 459-469.

Weiss, M. G., Ramakrishna, J. & Somma, D. (2006) 'Health-related stigma: rethinking concepts and interventions', *Psychology, Health & Medicine,* 11, pp. 277-87.

Whitbeck, C. (1981) A Theory of Health. *In:* Caplan, A. L., Engelhardt, H. T. & McCartney, J. J. (eds.) *Concepts of health and disease: Interdisciplinary perspectives.* Boston, Massachusetts: Addison-Wesley.

Whitman, S. M. (2007) 'Pain and suffering as viewed by the Hindu religion', *The Journal of Pain,* 8, pp. 607-613.

WHO (1946) 'Constitution of the World Health Organization. 1946', *Bulletin of the World Health Organization,* 80, pp. 983-984.

WHO (1980) International Classification of Impairments, Disabilities, and Handicaps. Switzerland: WHO.

WHO (1984) *Health promotion : a discussion document on the concept and principles : summary report of the Working Group on Concept and Principles of Health Promotion, Copenhagen, 9-13 July 1984,* Copenhagen, World Health Organization.

WHO. Ottawa Charter for health promotion. First international conference on health promotion, 1986. p.^pp. 17-21.

WHO (2001) International classification of functioning, disability and health : ICF. Geneva WHO.

WHO. (2017) *Determinants of Health* [Online]. World Health Organization. Available: https://www.who.int/news-room/questions-and-answers/item/determinants-of-health [Accessed 23rd March 2023].

WHO (2020) *State of World's Nursing 2020,* Geneva, World Health Organization.

Williams, R. (1983) 'Concepts of health: an analysis of lay logic', *Sociology,* 17, pp. 185-205.

Wilson, J. (1963) *Thinking with concepts,* Cambridge, Cambridge University Press.

Woodhouse, J. (2012) 'The use of visual methodology in nursing', *Nurse Researcher,* 19, pp. 20-25.

Woodyatt, C. R., Finneran, C. A. & Stephenson, R. (2016) 'In-person versus online focus group discussions: A comparative analysis of data quality', *Qualitative Health Research,* 26, pp. 741-749.

Yao, C. W. & Vital, L. M. (2018) 'Reflexivity in international contexts: Implications for US doctoral students international research preparation', *International Journal of Doctoral Studies,* 13, pp. 193-210.

Younas, A., Inayat, S. & Masih, S. (2023) 'Nurses' perceived barriers to the delivery of person-centred care to complex patients: A qualitative study using theoretical domains framework', *Journal of Clinical Nursing,* 32, pp. 368-381.

Young, R. A. & Collin, A. (2004) 'Introduction: Constructivism and social constructionism in the career field', *Journal of Vocational Behavior,* 64, pp. 373-388.

Yurkovich, E. E. & Lattergrass, I. (2008) 'Defining health and unhealthiness: Perceptions held by Native American Indians with persistent mental illness', *Mental Health, Religion and Culture,* 11, pp. 437-459.

Zajacova, A., Jehn, A., Stackhouse, M., Denice, P. & Ramos, H. (2020) 'Changes in health behaviours during early COVID-19 and socio-demographic disparities: a cross-sectional analysis', *Canadian Journal of Public Health,* 111, pp. 953-962.

Zola, I. K. (1966) 'Culture and symptoms - an analysis of patient's presenting complaints', *American Sociological Review*, pp. 615-630.

Appendices

1. COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

Developed from Tong et al. (2007)

Item No./Topic	**Guide Questions/Description**	**Reported in Section/Location**
Domain 1: Research team and reflexivity		
Personal Characteristics		
1.Interviewer/ facilitator	Which author/s conducted the interview or focus group?	4.5.1, 4.5.2
2.Credentials	What were the researcher's credentials? e.g., PhD, MD	1.2, 1.6
3.Occupation	What was their occupation at the time of the study?	1.6
4.Gender	Was the researcher male or female?	1.6
5.Experience and training	What experience or training did the researcher have?	1.2, 1.6
Relationship with participants		
6.Relationship established	Was a relationship established prior to study commencement?	4.3.5
7.Participant knowledge of the interviewer	What did the participants know about the researcher? e.g., personal goals, reasons for doing the research	4.3.2, PIS
8.Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? e.g., Bias, assumptions, reasons and interests in the research topic	1.2, 1.6, PIS
Domain 2: Study design		
Theoretical framework		
9.Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g., grounded theory, discourse analysis, ethnography, phenomenology, content analysis	3.2, 3.3, 3.4
Participant selection		
10.Sampling	How were participants selected? e.g., purposive, convenience, consecutive, snowball	4.4
11.Method of approach	How were participants approached? e.g., face-to-face, telephone, mail, email	4.4
12.Sample size	How many participants were in the study?	5.4

Item No./Topic	**Guide Questions/Description**	**Reported in Section/Location**
13.Non-participation	How many people refused to participate or dropped out? Reasons?	5.4
Setting		
14.Setting of data collection	Where were the data collected? e.g., home, clinic, workplace	4.5.1, 4.5.2
15.Presence of non-participants	Was anyone else present besides the participants and researchers?	4.5.1
16.Description of sample	What are the important characteristics of the sample? e.g., demographic data	5.5
Data collection		
17.Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	4.5.1, 4.5.2, Appendix 10, 11, 12
18.Repeat interviews	Were repeat interviews carried out? If yes, how many?	4.4, 4.4.1
19.Audio/visual recording	Did the research use audio or visual recording to collect the data?	4.5.1, 4.5.2
20.Field notes	Were field notes made during and/or after the interview or focus group?	4.5.1, 4.5.2
21.Duration	What was the duration of the interviews or focus group?	4.5.1, 4.5.2
22.Data saturation	Was data saturation discussed?	4.4, 4.5.2, 4.7, 4.9, 11.8.2
23.Transcripts returned	Were transcripts returned to participants for comment and/or correction?	4.5.1, 4.5.2, Appendix 13
Domain 3: analysis and findings		
Data analysis		
24.Number of data coders	How many data coders coded the data?	4.7.1
25.Description of the coding tree	Did authors provide a description of the coding tree?	4.7.2, Appendix 16
26.Derivation of themes	Were themes identified in advance or derived from the data?	4.7
27.Software	What software, if applicable, was used to manage the data?	4.7
28.Participant checking	Did participants provide feedback on the findings?	4.6.1, 11.8.4

Item No./Topic	**Guide Questions/Description**	**Reported in Section/Location**
Reporting		
29.Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g., participant number	6.2, 6.3, 7.2, 7.3, 7.4, 8.2, 8.3, 9.2, 9.3
30.Data and findings consistent	Was there consistency between the data presented and the findings?	6.2, 6.3, 7.2, 7.3, 7.4, 8.2, 8.3, 9.2, 9.3
31.Clarity of major themes	Were major themes clearly presented in the findings?	6.2, 6.3, 7.2, 7.3, 7.4, 8.2, 8.3, 9.2, 9.3
32.Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	6.3, 8.2, 9.2, 9.3

2. Reflexive Narrative for Citations Starting each Part or Chapter

Part One – Understanding the Background

'Research can be a very personal journey'

Reflective Journal Entry 05.06.2018

This research has been a very personal journey in several ways and from differing perspectives. The personal journey reflects my personal experiences, prior to becoming a nursing student and after, including the personal journey of being a PhD student. In the respect of the differing perspectives the personal journey relates to my development from child to adult, my academic development, but most personally, my journey of developing my insight into myself.

Chapter 1 - Overview of the Thesis

'An exploration of experience and a development of my knowledge and understanding in so many realms'

Reflective Journal Entry 19.03.2023

The production of this thesis has enabled me to explore my experience at the same time as developing my knowledge and understanding. The knowledge and understanding I expected to develop as a PhD student, academic and research, has most certainly been fulfilled. There has, however been much more, often surprising development as part of my experience. Navigating access to the research participants, for example, facilitated unexpected development of my negotiation skills and working with my supervisors and participants enhanced my ability to develop effective relationships with a diverse group of individuals. Both of these were areas of development I had not expected to be part of my doctoral studies.

Chapter 2 – Implementing a Staged Approach to the Literature

'Overcoming the hurdle of preconceived ideas'

Reflective Journal Entry 26.09.2016

I truly enjoyed the experience of applying CGT in this work, the methodology was a very good fit with my inherent approach. One of the aspects I enjoyed most were the aspects of the methodology that supported me to find the answers in my data first, before comparing this with the existing literature. Thus, seeing what I had through my eyes before considering the views of others, rather than seeing what I had through spectacles composed of the views of others.

One of the first activities I undertook at the start of my PhD studies in relation to reviewing the literature was investigation of the notion of a concept and conceptual analysis. This was an area I had not considered previously and it proved to be fascinating, but complex. The investigation I undertook led me to consider issues from perspectives I had previously not appreciated and introduced me to an aspect of philosophy that will continue to inform my thinking.

Part two - Considering Research Methodology and Methods

'Design follows purpose – but what do I want to produce?'

Reflective Journal Entry 25.09.17

I commenced my PhD journey with a clear idea of what I wanted to explore. How I was going to do this however, I was uncertain. The exposure I had to the full range of research methodologies made me aware of the myriad possible approaches. All of which would have increased my research knowledge and skills, but I wanted to ensure that my choice resulted in a tangible product. A great deal of reading and thinking later CGT was discovered, presenting a research approach I found appealing with the end point of theory production, which, when the research was complete, I could test further.

Chapter 3 - Selecting a Research Methodology

'how best to explore perceptions in order to gain a rich and detailed understanding?'

Reflective Journal Entry 25.10.2016

This aspect of the research design was actually one of the least difficult choices. Once I located the literature relating to GT and from that found CGT, I knew it was an approach that I could work with that had the potential to provide the rich and detailed understanding I desired. I 'just' needed to apply the correct research methods and provide the environment, physical and psychological, for the participants to feel able to do this…

Chapter 4 - Determining the Research Methods

'the real questions are, who to ask and how to ask them'

Reflective Journal Entry 02.03.2016

In a study involving nursing students, it was clear that they would be the participants, but which nursing students and when in their programme? Many combinations were considered and balanced with factor such as the impact on the participant, the practicality of the approach and the time available before what was thought to be the combination that offered the best for all was devised. Identifying a way to ask the participants about their views also resulted in much consideration. For individuals to share their perspective with me and their peers in focus groups without feeling uncomfortable was the situation I desired. Finding a good vehicle to assist participants to feel comfortable while doing this was an initial challenge which allowed me to apply my creative skills to find a solution – vignettes based on the attributes of health and illness identified in the concept analyses.

Part three - Reporting the Research Findings

‘the participants have trusted me with so much to say – so much of which needs to be said……..but how do I say it?’

Reflective Journal Entry 27.09.2021

Throughout this research one of my personal triumphs is that the participants trusted me sufficiently to share their many experiences. These experiences covered a wide range of situations and, at times, included the recounting of emotionally charged situations. Thus, I felt a large responsibility to produce an authentic account of what was shared, accurately representing the voice of all who contributed. While the word allowance for this thesis is not inconsiderable, to include all the material collected would need more than three times as many words. The choice of material has been the result of much carefully deliberation and is generally representative of the views of more than one participant. However, based on what has been said there is more work to do, which I will need to address once my studies are complete.

Chapter 5 – Introducing the Findings

‘and some features have been surprising’

Reflective Journal Entry 23.02.2023

The geographical locations in which my research was undertaken were known to me, or so I thought, until I started to look closely at them. It was only then that they revealed features to me I was unaware of, some of which were surprising and proved to be of significance to this research. This was important learning, the situation I thought I knew and what the situation objectively was, differed.

Chapter 6 - Emergent Data Category – ‘Evolving Views’

‘views change. If they didn’t change, I’d be worried, [because] it means that you’ve stopped listening, you’ve stopped learning. Once you stop listening and learning you’ve stopped nursing’

Ada, 3rd year

In my experience as a nurse educator, I have found the comments made by many of the students I work with to frequently be profound and I would struggle to express such wisdom in similarly concise language. Ada’s comment is an excellent representation of this. She beautifully summed up the essence of the emergent data category – ‘Evolving Views’.

Chapter 7 – Emergent Data Category – Developing a Nursing Lexicon

> 'never could I have anticipated the depth of understanding and the profound insight the participants would share'

Reflective Journal Entry 18.06.2019

It became clear during the first focus group I undertook that the participants recruited for this study were going to provide insightful and informative views. As circumstances turned out this first focus group was with a group of participants containing individuals I spoke with twice in their first year and then again at the end of their third year. Reflection on these meetings highlighted the wide range of skills a researcher needs to possess regarding running effective data collection events. One of these skills that was of much use I feel is best described as 'chat-show host'. This describes the skill of getting others to talk by delivering small 'nuggets' to start conversation and then if the 'nugget' is taken up and conversation ensues, 'growing the nugget' by adding only the minimum number of comments to keep the conversation flowing and developing. This is a case when less certainly did prove to be more, in as much that me saying less got more of what truly were the golden nuggets – the thoughts and insights of the participants.

Chapter 8 – Emergent Data Category – 'Influencing Care'

> 'if, in nursing care, you don't understand the role of health and how to approach illness, you would make a very poor nurse.'

Florence, 3rd year

A further example of the profound words of a participant, where I would struggle to express such wisdom in similarly concise language. Florence, in this comment, concisely summed up the essence of the emergent data category – 'Influencing Care'.

Chapter 9 – Emergent Data Category – 'Caring for Self'

> 'you can't fill from an empty cup'

Ada, 3rd year

The final example of a participant sharing their thoughts and insights which prove to be profound and sums up the emergent data category – 'Caring for Self'.

Chapter 10 – Envisioning the Theory

> 'order out of chaos, gosh!, it really seems to be happening – I think the grounded theory process could be working!!! Now I just need to keep the faith!'

Reflective Journal Entry 25.09.21

One of the points during my PhD journey where I felt overwhelmed was by the amount of data generated and my attempts to create order out of this. Time, thinking and talking about my thinking with others proved to be the amongst the most important factors preventing me from drowning in the data. While this experience was at the time, one characterised by confusion, I now appreciate the benefit of this. Wallowing in the data, living with the confusion and letting the process of constructing a narrative develop organically from what was happening describes the process as I experienced it. Thus, keeping the faith, even when it was hard.

Part four – Discussing, Reflecting and Concluding

‘Healthy citizens are the greatest asset any country can have’

(Churchill, 1944)

While the Churchill quote originates with the background being a world war, it was often brought to mind by the experiences the participants shared with me relating to the SARS-CoV-2 pandemic. Their perspectives, most certainly, were a reminder of the value of health and how it underpins everyday activities, either in its presence or absence and thus how fundamental it is to the functioning of society.

Chapter 11 – Discussing the Findings and Generating New Insights

‘Reviewing the literature has not only added further detail, but identified so many more perspectives to consider’

Reflective Journal Entry 12.05.2023

The perspectives the participants shared with me during the research were wide-ranging and covered many differing topics, the underpinning literature was similar. Many of elements reported in the findings were corroborated by the literature, providing a wealth of information which added further detail and issues to consider. As I was approaching the final writing up of the study however, I realised that, while I have been able to develop understanding of the evolution of nursing students views of health and illness, there is still more to consider. The research journey has come a full circle and begins again but this time there are different questions to answer.

Chapter 12 - Summarising, Reflecting and Concluding

‘More is needed than a good curriculum’

Reflective Journal Entry 08.05.2022

As a nurse educator with an interest in and experience of curriculum development, I have no doubt that a good curriculum is of importance in pre-registration nurse education. There is, however, more needed than this. Role modelling is so important and as was highlighted by one of the participants, *‘…that's the most powerful way of delivering education…’*. As educators, either in clinical or academic roles, the overall combination of our actions and the environments we function in, have far more impact than the individual content of any lecture or skills teaching, delivered as part of the most well designed and contemporary curriculum.

3. Making Sense of Concept Analysis

PHILOSOPHICAL UNDERPINNINGS

Making sense of concept analysis

Delves-Yates C, Stockl A, Moore J (2018) Making sense of concept analysis. Nurse Researcher. 25, 4, 43-46.
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Catherine Delves-Yates
Lecturer, School of Nursing Sciences, University of East Anglia, Norwich, Norfolk, England

Andrea Stockl
Lecturer, University of East Anglia, Norwich, Norfolk, England

Jenny Moore
Senior lecturer, University of East Anglia, Norwich, Norfolk, England

Correspondence
c.delves-yates@uea.ac.uk

Review
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Conflict of interest
None declared

Abstract

Background Concept analysis is frequently the first step novice nurse researchers take when beginning their work. However, the value of concept analysis in generating theory is debated, and although there are many models researchers can use, few provide guidance for applying them or overviews of their philosophical underpinnings.

Aim To share learning about challenges encountered when undertaking concept analysis and to present an adaptation of Rodgers (1989) model created to overcome these.

Discussion The authors explore the philosophical underpinning of several models of concept analysis and present an adapted model based on the work of Rogers (1989) and Tofthagen and Fagerstrøm (2010).

Conclusion Concept analysis is a valuable tool when used with an understanding of a model's philosophical underpinnings and sufficient measures are taken to assure analytical depth, rigour and transparency.

Implications for practice The experiences of a novice nurse researcher described in this paper will be helpful in informing others who are starting a study.

Keywords

concept analysis, nurse researcher, nursing research

Introduction

In its simplest form, concept analysis is the application of a specified method to examine a concept of interest to ascertain its attributes. This paper arose from the experience of a novice nurse researcher wishing to use concept analysis as a starting point in a literature review for a doctoral-level enquiry. The process was found to be multifaceted and far more complex than expected, involving the navigation of differing views of the meaning of concepts and the comprehension of different ontological and epistemological stances.

The aim of this paper is to highlight the strengths of using concept analysis as a starting point for doctoral work, identify the processes underpinning concept analysis and present an adapted version of Rodgers (1989) model as a framework for use in research.

An overview of concept analysis

The purpose of concept analysis is to analyse, define, develop and evaluate a concept. Although some research traditions such as classical grounded theory disagree, most maintain that research undertaken to develop knowledge should start with an exploration of the existing knowledge. This helps to develop a conceptual and theoretical understanding of the phenomenon to be researched (Kvale 1996), enabling the researcher to use the concept effectively and evaluate its strengths, limitations and variations, improving the research's contribution to current knowledge.

One of the main aims of concept analysis is to identify the attributes of a concept. These are the critical characteristics that differentiate it from related concepts and so clarify its meaning (Walker and Avant 2005). Attributes are most easily thought of as the 'hallmarks' of the concept (McKenna and Cutcliffe 2005) – for example, an attribute of the concept of 'pregnancy' could be a fetal heartbeat, while determination to change or surmount the problem could be an attribute of 'overcoming'. Attributes are identified by considering a concept's common use, as the words we use to talk and think about a concept are central to our understanding of it.

McKenna and Cutcliffe (2005) claimed that concepts are the building blocks of theory, so any attempt to build or use a theory without a clear understanding of these building blocks risks laying faulty theoretical foundations. Therefore, concepts play a fundamental role in the development of knowledge (Rodgers 1989). However, this view is not universally accepted, with Bergdahl and Berterö (2016) arguing that concepts do not have any specific meaning outside the context in which they are defined.

Walker and Avant (2005) proposed that concepts are not words, but mental images of phenomena. A concept therefore only has a pure expression in the mind of the individual using it, so its essence cannot be truly captured by the spoken or written word (Beckwith et al 2008). Asp and Fagerberg (2005) defined concepts as being 'cognitive in nature and comprised attributes abstracted from reality, expressed in some form and utilised for some common purpose'. However, as concepts acquire meaning through personal interpretation, different people can apply the same concept differently (Toulmin 1972). Therefore, not only can concepts be complex, there may be no shared meanings.

Concept analysis may be an ideal tool to navigate the complex nature of concepts and ascertain the meanings associated with their common usage (Tofthagen and Fagerstrøm 2010). However, its value is debated. Opinions vary in nursing research, from concept analysis being the starting point for many scholarly endeavours (Knafl and Deatrick 2014) to its having no place in nursing research (Draper 2014) and needing to be abandoned (Bergdahl and Berterö 2016). Concept analysis is frequently advocated and undertaken as the starting point for further study, but Beckwith et al (2008) argued that few concept analysis models have the necessary analytical depth, rigour and replicability to enable the theoretical development claimed for them. There are frequently also weaknesses in how the models are applied, such as no justification being provided for the inclusion and exclusion criteria used to choose attributes (Risjord 2009).

More specific criticism is directed at the simplicity of some models and their inability to determine concepts' rich and diverse world views (Draper 2014). Such criticism is highly relevant to many concept analysis models, including those of Norris (1982), Schwartz-Barcott and Kim (1993), Chin and Kramer (1995), and Walker and Avant (2005). All of these are adaptations of Wilson's (1963) model, which has been singled out as being overly simplistic as it focuses on the use of the concept alone, so is unable to capture the complex nature of a concept (Beckwith et al 2008).

Further criticism relates to the lack of clear articulation of the philosophical foundations underpinning many concept analysis models. While the approaches taken by different models may appear similar, many possess significant philosophical differences about the theoretical views of concepts (Rodgers 2000). There are three main schools: the 'entity' view; the 'dispositional' view; and Rodgers (1989) 'evolutionary' view (Table 1).

Models derived from Wilson's (1963) work, such as Walker and Avant's (2005), have a positivistic perspective, reflecting the entity view. Rodgers (1989) model is underpinned by a constructivist perspective, despite sharing a common ancestry with positivistic models and the entity view of a concept. There is therefore an element of philosophical dualism – and possibly confusion – in many of the commonly used models of concept analysis (Asp and Fagerberg 2005). As concept development is a scientific process based on philosophical ideas about concepts, any possible confusion has to be viewed as a weakness.

These issues highlight the need to ensure there is an understanding of a model's philosophical stance and sufficient measures are taken to assure analytical depth, rigour and replicability. Despite these limitations, the processes involved in concept analysis can be beneficial in understanding a concept of interest and contributing to the development of knowledge.

Adaption of Rodgers model

Taking note of the issues, weaknesses and limitations identified in the previous discussion, the adaptation of Rodgers (1989) evolutionary concept analysis shown in Figure 1 was devised. This involved breaking down the model into several stages, merging it with Tofthagen and Fagerstrøm's (2010) phased approach to concept analysis, and further clarifying the underpinning processes to make the process more transparent and guide the researcher. By presenting the model in the three phases described by Tofthagen and Fagerstrøm (2010), the process moves away from Rodgers (1989) step-by-step, linear approach. Researchers are guided to return where necessary to a previous stage or phase, enabling them to reconsider their actions and decisions in the light of new data and alter them if necessary.

A. The initial phase

Stage 1. Identify and name the concept of interest

The process starts with a brief introduction to the concept being analysed, including an outline of personal experience, interests and influences. Therefore a reflexive approach is incorporated, enabling meaning to be induced while personal influences and existing knowledge are acknowledged.

Stage 2. Identify and select an appropriate sample for data collection

An extensive literature review should be undertaken using relevant databases and a wide time frame, the exact parameters being set according to seminal work. The use of databases reduces the risk of selection bias and increases the chance that the material found will be representative. Considering a wide time frame highlights the evolution of the concept and the continual emergence of knowledge.

The richness of the resultant data will be increased by selecting material that does not focus solely on the use of the concept but includes theoretical perspectives, research data, definitions, and personal perspectives of patients and healthcare providers, for example.

Stage 3. Identify surrogate terms and uses

Concepts are often discussed using differing or surrogate terms. This stage identifies these terms and, if relevant, locates them in their specific category of use.

B. Core analysis

Stage 1. Identify the attributes of the concept

Data extraction involves identifying any themes in the literature sampled. Similar points are organised and reorganised until a 'cohesive, comprehensive and relevant system of descriptors is generated' (Rodgers and Knafl 2000). The attributes of the concept will emerge from the themes extracted.

Details of the process should be included in any report of the analysis, to enable the reader to understand exactly how the data were generated. This serves to ensure transparency and inspire confidence in the procedure. Acknowledging personal and other influences relating to the choice of attributes can further increase transparency and integrity, as can including the components of each theme in a table, for example, to enable the reader to view the raw data underpinning each theme and see how the attributes have been identified.

Stage 2. Identify the references, antecedent and consequences of the concept

Identification of the references, 'antecedents' and consequences of the concept provide additional information and clarity in understanding what a concept is – or possibly more importantly what it is not. The purpose of references is to identify the range of situations, incidents or phenomena in which the concept can be considered. Antecedents are 'events or phenomena generally found to precede an instance of the concept' (Rodgers 1989), while consequences are the occurrences that follow a concept.

Stage 3. Identify concepts related to the concept of interest

This is an opportunity to identify and briefly discuss the main concepts related to the one being analysed, focusing on the important aspects of the relationship.

Stage 4. Identify a model case of the concept

The model case of the concept is a significant part of the analysis because it unites all the other aspects of the model and presents a clear example. This may not, however, be possible for all concepts (Rodgers 1989).

C. Further analysis

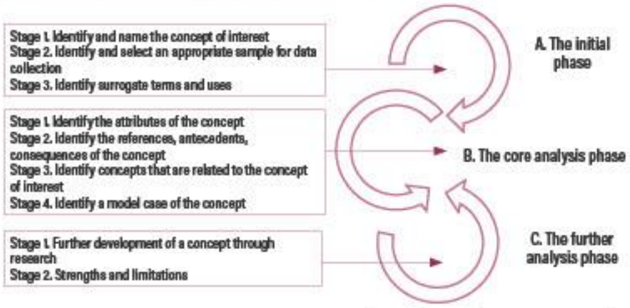
Stage 1. Further development of a concept through research

Rodgers (1989) viewed concept analysis not as an endpoint, but as a method of

TABLE 1. Outline of the entity, dispositional and evolutionary view of concepts

	Entity view	Dispositional view	Evolutionary view
Concepts	Concepts are entities or 'things', such as an abstract mental image or idea, a word with a specific grammatical function or an element in a system of formal logic	Concepts are regarded as habits or abilities to perform certain behaviours or capabilities	Concepts are regarded as an abstraction expressed in some form
Focus	The entity, regardless of its form	The use of the concept, behaviours or capabilities that are possible when an individual grasps the nature of the concept	By socialisation and repeated interaction, a concept becomes associated with a particular set of attributes, which can be seen as the concept's definition
Features	A concept is characterised by a rigid set of conditions necessary to identify an instance of the concept. Therefore, concepts have clear and distinct boundaries or lines of division and do not change	Focusing on the use of concepts overcomes the distinction between the private and public realms of cognition and reveals interrelationships. There is, however, considerable difficulty associated with the idea of 'use,' as the term is vague and ambiguous	Concepts are viewed as subject to change, developing in a cyclic fashion that progresses through time, and influenced by significance, use and application. Dynamism and interrelationships are valued, overcoming the limitations of the entity and dispositional views
Foundational texts	The foundations of entity theories can be identified in the works of philosophers such as Aristotle, Locke, Kant, Frege and the earlier writings of Wittgenstein (Rodgers 1989, 2000)	The foundations of dispositional theories are in the later writings of Wittgenstein and the works of Ryle (Rodgers 1989, 2000)	The foundations are in Rodgers (1989, 2000)
Summary	Concepts have clear boundaries and are unchanging	Concepts are fluid and determined by the person applying them	Concepts are subject to change, develop through time, and are influenced by significance, use and application

Figure 1. An adaption of Rodgers' (1989) Evolutionary Model of Concept Analysis



increasing understanding of a concept central to further research. The clarity of understanding obtained using concept analysis will enable greater focus in the development of the proposed research, which will be undertaken from a more informed perspective.

Stage 2. Strengths and limitations

This is a final opportunity to highlight the steps undertaken to ensure the quality and authenticity of the process, while accepting that there will always be limitations.

Reflections

Applying the model

When the lead author of this paper used the adapted version of Rodgers (1989) model to examine the concept of 'health', it proved an effective way of identifying what was common in the use of the concept. It was revealed that the concept of 'health' was being used in three ways: from the perspective of experiences of healthcare; in a traditional nursing or medical model; and as an integral aspect of wholeness. Further analysis identified the relevant attributes of health were: enablement; dependence on healthcare use and adherence; sociocultural construction; and personal responsibility. It also revealed the importance of nurses having an awareness of the subjectivity of health.

This approach resulted in an understanding of the concept that was contemporary and contextually appropriate. It also indicated a clear direction for further research: to explore nursing students' concepts of health as they become professionally socialised.

Strengths

The process revealed different directions the research project could take, by identifying issues and questions that had not been appreciated before. Applying measures from the new model resulted in a robust process that enhanced the quality and transparency of the data and produced more accurate and dependable findings (Mason 2002). The adapted model also encouraged reflexivity, an approach that aligns with the philosophy underpinning the original model.

Conclusion

Concept analysis is a tool that helps to develop a conceptual and theoretical understanding of a phenomenon. However, to obtain the greatest value when using concept analysis as a starting point for doctoral research, it is necessary to understand the philosophy underpinning the model and take additional steps to ensure analytical depth, rigour and replicability.

The adapted version of Rodgers (1989) model in this paper is recommended for the novice nurse researcher, as it allows for the dynamism and interrelationships that exist in scientific enquiry. The end result is a valuable indicator of the possible direction of further research and can provide new insights. The new model is systematic, but recognises complexity and includes measures to reduce bias and increase rigour and replicability.

References

Asp M, Fagerberg I (2005) Developing concepts in caring science based on a lifeworld perspective. International Journal of Qualitative Methods. 4, 2, Article 5.

Beckwith S, Dickinson A, Kendall S (2008) The 'con' of concept analysis: a discussion paper which explores and critiques the ontological focus, reliability and antecedents of concept analysis frameworks. International Journal of Nursing Studies. 45, 12, 1831-1841.

Bergdahl E, Berterö CM (2016) Concept analysis and the building blocks of theory: misconceptions regarding theory development. Journal of Advanced Nursing. 72, 10, 2558-2566.

Chin PL, Kramer MK (1995) Theory and Nursing: A Systematic Approach. Fourth edition. Mosby, St Louis MO.

Draper P (2014) A critique of concept analysis. Journal of Advanced Nursing. 70, 6, 1207-1208.

Knafl KA, Deatrick JA (2014) Commentary on: Draper P (2014) Editorial: a critique of concept analysis. Journal of Advanced Nursing. 70, 12, 2968.

Kvale S (1996) InterViews: An Introduction to Qualitative Research Interviewing. First edition. Sage Publications, Thousand Oaks CA.

Mason J (2002) Qualitative Researching. Second edition. Sage Publications, London.

McKenna HP, Cutcliffe JR (2005) An introduction to concepts and their analyses. In Cutcliffe JR, McKenna HP (Eds) The Essential Concepts of Nursing. Elsevier, Edinburgh, 1-14.

Norris C (1982) Concept Clarification in Nursing. Lippincott Williams and Wilkins, Philadelphia PA.

Risjord M (2009) Rethinking concept analysis. Journal of Advanced Nursing. 65, 3, 684-691.

Rodgers BL (2000) Philosophical foundation of concept development. In Rodgers BL, Knafl KA (Eds) Concept Development in Nursing: Foundation, Techniques, and Application. Second edition. Saunders, London, 7-37

Rodgers BL (1989) Concepts, analysis and the development of nursing knowledge: the evolutionary cycle. Journal of Advanced Nursing. 14, 4, 330-335.

Rodgers BL, Knafl KA (Eds) (2000) Concept Development in Nursing: Foundation, Techniques, and Application. Second edition. Saunders, London.

Schwartz-Barcott D, Kim H (1993) An expansion and elaboration of a hybrid model of concept development. In Rodgers BL, Knafl KA (Eds) Concept Development in Nursing: Foundation, Techniques, and Application. First edition. Saunders, London, 45-71.

Tofthagen R, Fagerstrøm LM (2010) Rodgers' evolutionary concept analysis – a valid method for developing knowledge in nursing science. Scandinavian Journal of Caring Sciences. 24, Suppl 1, 21-31.

Toulmin S (1972) Human Understanding. Princeton University Press, Princeton NJ.

Walker LO, Avant KC (2005) Strategies for Theory Construction in Nursing. Fourth edition. Appleton and Lange, Stamford CT.

Wilson J (1963) Thinking with Concepts. Cambridge University Press, Cambridge.

4. Gatekeeper Consent.

University 1 agreement
From: [redacted]>
Date: 9 October 2017 at 23:40:12 GMT+2
To: "'Kate Delves-Yates (HSC - Staff)'" <C.Delves-Yates@uea.ac.uk>
Subject: RE: Data collection
Dear Kate
I agree to this.
Please say, but there will be challenges from previous experience with external colleagues doing their PhDs who have tried to run focus groups with our students in trying to access them as they cannot come in from practice so it must fit round their school timetable which is full and rooms for meeting with them can be problematic. We can however give it a go.
Regards
[redacted]
Head of Programmes – Deputy Head of School
University 1

University 2 agreement
From: [redacted]
Sent: 10 October 2017 15:24
To: Kate Delves-Yates (HSC - Staff); [redacted]
Subject: RE: Request to data collect
Thanks very much for this Kate. This would work well with the Nursing students, so I would support it. The ethics committee will do a full review of all the details of course.
I'd be interested to see your results and do please let me know if there is anything we can do to help with the study.
[redacted]
Director of Teaching and Learning
University 2

From: [redacted]
Sent: 10 October 2017 17:26
To: Kate Delves-Yates (HSC - Staff); [redacted]
Subject: Re: Request to data collect in HSC
I too look forward to the results
Best
[redacted]
Director of Research
University 2

5. Participant Information Sheets

Participant Information Sheet 1

Version2 Date 12/17

School of Health Sciences
Edith Cavell Building
University of East Anglia
Norwich
NR4 7TJ
Phone: 01603 597059
c.delves-yates@uea.ac.uk

Participant Information Sheet

Title of the study – Nursing Students views of health and illness

Dear Student,

My name is Catherine Delves-Yates and I am a Lecturer in Adult Nursing at the University of East Anglia. I, along with my research supervisors from the University of East Anglia, am undertaking research as part of an educational project with students from all four fields of nursing about their views of health and illness and whether these alter over the duration of their programme.

We would like to invite you to take part in this research study. Before you decide you need to understand why the research is being undertaken and what it would involve for you. Please take time to read the following information carefully. Please ask questions if anything you read is not clear or if you would like more information. My contact details are c.delves-yates@uea.ac.uk or 01603597059.

This study is also being undertaken at [*insert location*].

What is the aim of the research?

The aim of this research is to investigate the views nursing students' hold of health and illness at the start of their undergraduate nursing programme and to explore whether these views alter during their pre-registration education. A better understanding of this may help in the provision of future nurse education and ultimately benefit patient care.

Why have I been invited?

You have been invited to take part as you are a nursing student. We value your views because you have specific knowledge and experience relating to the focus of our study. The Faculty of Medicine and Health Ethics committee at the University of East Anglia and your School have given approval for you to be invited to participate.

What does taking part involve?

If you do agree to take part, you need to be aware that it will involve you giving approximately 2 hours of your time to the study. This will be via participation in two focus groups, which will both last a maximum of 1 hour. The first of these focus groups will be in the next few weeks and the second will be held at the end of the academic year. In these focus groups you will be asked to consider patient scenarios describing the situation of individuals with a variety of health disorders. The scenarios are examples of real-life experiences and have been developed in consultation with clinical colleagues.

At the focus groups there will be a maximum of seven other nursing students from your nursing programme. You will be given patient scenarios to read and asked to discuss your views relating to health and illness in these scenarios. I will facilitate the focus group. At the end of the focus group, you will also be asked to anonymously provide your age and gender. The first focus group will take place within the next few weeks; the second will take place either in the last few weeks of your nursing programme this year or at the start of your nursing programme next year. All the focus groups will take place at your University, at a time when you are not due to be in lectures or other educational activity.

Do I have to take part?

You do not have to take part if you do not want to. If you decide not to take part, please be assured that this will not affect your status or future progress at the University.

What do I have to do to take part?

If you are interested in taking part in this study, please send an email to me at c.delves-yates@uea.ac.uk by [*insert date (giving 5 working days)*] saying that you are interested in being involved in the research. I will then contact you to discuss the study and answer any questions you may have. If you agree to take part, your name will be included in the pool of volunteers from which eight participants will be randomly selected by computer. If your name is randomly selected, I will contact you to invite you to a focus group.

Are there any disadvantages in being involved?

Being involved in this research will not have any impact on you or your nursing programme, apart from the time it takes to participate in the focus groups.

Will I benefit from taking part in this research?

You will not benefit directly by being involved in this research and there is no financial incentive to participate. Your views, however, are valued and what you say will increase knowledge of the subject. The deeper understanding gained from this may help in the provision of future nurse education and ultimately benefit patient care.

Who else will know I am taking part in the research?

That you are taking part in the research will be known by the

1. research team, which is comprised of me, my research supervisors and a note-taker.
2. other students in your programme who are also taking part in the research and are invited to the same focus group as you.

Will my taking part in the research be kept confidential?

All information will be kept confidential by the research team.

The focus group discussions will be audio recorded. There will also be a note-taker at the focus group who will record additional information. The note-taker will not take part in the discussion. The audio recording will also enable me and the research supervisors to listen to what has been said after the discussion. When the focus group has ended I will make an anonymised written record of the discussion. Your views will be combined with others who are also taking part in the research. Your name will not be used at any stage of the research or in any write up or published findings. Quotations from what you have said may be used, to help emphasise a point, but this will have a false name attached to it.

All information provided during the research will be stored in accordance with the 1998 Data Protection Act and the UEA Research Degrees' Code of Practice (2012). On completion of the research all information will be passed into secure file storage within the Faculty of Health Sciences and will be destroyed after 10 years.

There are however two areas where confidentiality cannot be guaranteed:

1. If an issue relating to safeguarding, self-harm or security is raised. Should such an issue be raised, in the first instance the situation will be discussed with one of the research supervisors, [redacted] or [redacted]. Following this the appropriate action will be taken. If you are involved you will be informed that such action is being taken and will receive further information relating to the outcome.
2. The focus groups. Although the ground rules established at the start of each focus group will highlight the importance of confidentiality and this will be maintained by me and the note-taker, it is not possible to guarantee that other focus groups participants will abide by this.

What if I change my mind?

If, after agreeing to take part in the study, you change your mind and no longer wish to participate you are free to withdraw at any time. You will not have to provide a reason for withdrawing. However, whilst you are free to withdraw from the study at any time, it will not be possible to remove any data you have already contributed.

What if there is a problem?

In the unlikely event of a problem occurring, indemnity (a form of insurance cover) will be provided by the University of East Anglia.

Who has reviewed the research?

The research has been reviewed by the University of East Anglia Research Ethics and Governance Committee to ensure that the interests of the participants are protected.

How to complain:

If you have a concern about any aspect of this research, please contact me, the lead researcher, Catherine Delves-Yates and I will do my best to solve the problem. My contact details are (01603) 597059 or c.delves-yates@uea.ac.uk. If you remain unhappy after doing this or would like to complain to an individual not involved in the study please contact your Head of School.

[redacted]

[redacted]

Thank you for taking the time to read this information.

Please keep this information so that you can refer to it in the future.

Yours faithfully

Catherine Delves-Yates
Lead Researcher
Lecturer in Adult Nursing
University of East Anglia

Participant Information Sheet 2.

Version3 Date 01/21

School of Health Sciences
Edith Cavell Building
University of East Anglia
Norwich
NR4 7TJ
Phone: 01603 597059
c.delves-yates@uea.ac.uk

Participant Information Sheet

Title of the study – Nursing Students views of health and illness

Dear Student,

My name is Catherine Delves-Yates and I am a Lecturer in Adult Nursing at the University of East Anglia. I, along with my research supervisors from the University of East Anglia, am undertaking research as part of an educational project with students from all four fields of nursing about their views of health and illness and whether these alter over the duration of their programme.

We would like to invite you to take part in this research study again. Before you decide I would like to remind you why the research is being undertaken and what it would involve for you. Please take time to read the following information carefully. Please ask questions if anything you read is not clear or if you would like more information. My contact details are c.delves-yates@uea.ac.uk or 01603597059.

This study is also being undertaken at [*insert location*].

What is the aim of the research?

The aim of this research is to investigate the views nursing students' hold of health and illness at the start of their undergraduate nursing programme and to explore whether these views alter during their pre-registration education. A better understanding of this may help in the provision of future nurse education and ultimately benefit patient care.

Why have I been invited?

You have been invited to take part as you are a final year nursing student who took part in the study during the first-year of your programme. We would like to talk with students who are in the final year of their nursing programme. We value your views because you have specific knowledge and experience relating to the focus of our study. The Faculty of Medicine and Health Ethics committee at the University of East Anglia and your School have given approval for you to be invited to participate.

What does taking part involve?

If you do agree to take part again, you need to be aware that it will involve you giving approximately 1 hour of your time to the study. This will be via participation in one individual online interview (using an online platform you are familiar with e.g., MS Teams) where we will talk about how your views of health and illness have developed during your nursing programme. I will be the interviewer. At the end of the interview, you will also be asked to anonymously provide your age, gender and nursing field. The interview will take place using an online platform such as MS Teams, at a time when you are not due to be in placement, lectures, or other educational activity. As the interview will be online you can choose where you are whilst it occurs. I would suggest, however, that you consider finding a private, quiet location.

Do I have to take part?

You do not have to take part if you do not want to. If you decide not to take part, please be assured that this will not affect your status or future progress at the University.

What do I have to do to take part?

If you are interested in taking part in this study, please send an email to me at c.delves-yates@uea.ac.uk by [*insert date (giving 5 working days)*] saying that you are interested in being involved in the research. I will then contact you to discuss the study and then answer any questions you may have. If you agree to take part, I will invite you to an online meeting with me to arrange a convenient time for your interview.

Are there any disadvantages in being involved?

Being involved in this research will not have any impact on you or your nursing programme, apart from the time it takes to participate in the focus groups.

Will I benefit from taking part in this research?

You will not benefit directly by being involved in this research and there is no financial incentive to participate. Your views, however, are valued and what you say will increase knowledge of the subject. The deeper understanding gained from this may help in the provision of future nurse education and ultimately benefit patient care.

Who else will know I am taking part in the research?

That you are taking part in the research will be known by the research team, which is comprised of me and my research supervisors.

Will my taking part in the research be kept confidential?

All information will be kept confidential by the research team.

The interview will be audio-visually recorded. The recording will also enable me and the research supervisors to listen to what has been said after the discussion. When the interview has ended I will make an anonymised written record of the discussion. Your views will be combined with others who are also taking part in the research. Your name will not be used at any stage of the research or in any write up or published findings. Quotations from what you have said may be used, to help emphasise a point, but this will have a false name attached to it.

All information provided during the research will be stored in accordance with the 2018 Data Protection Act and the UEA Research Degrees' Code of Practice (2019). On completion of the research all information will be passed into secure file storage within the Faculty of Health Sciences and will be destroyed after 10 years.

There is however one area where confidentiality cannot be guaranteed:

If an issue relating to safeguarding, self-harm or security is raised. Should such an issue be raised, in the first instance the situation will be discussed with one of the research supervisors, [redacted], [redacted], or [redacted]. Following this the appropriate action will be taken. If you are involved you will be informed that such action is being taken and will receive further information relating to the outcome.

What if I change my mind?

If, after agreeing to take part in the study, you change your mind and no longer wish to participate you are free to withdraw at any time. You will not have to provide a reason for withdrawing. However, whilst you are free to withdraw from the study at any time, it will not be possible to remove any data you have already contributed.

What if there is a problem?

In the unlikely event of a problem occurring, indemnity (a form of insurance cover) will be provided by the University of East Anglia.

Who has reviewed the research?

The research has been reviewed by the University of East Anglia Faculty of Medicine and Health Sciences Research Ethics and Governance Committee to ensure that the interests of the participants are protected.

How to complain:

If you have a concern about any aspect of this research, please contact me, the lead researcher, Catherine Delves-Yates and I will do my best to solve the problem. My contact details are (01603) 597059 or c.delves-yates@uea.ac.uk. If you remain unhappy after doing this or would like to complain to an individual not involved in the study please contact your Head of School.

[redacted] [redacted]

Further sources of support

If following our discussion, you feel that you need any further support or would like to talk about any issues raised, the following individuals/organisations will be able to assist you:

University-based services

- Your Personal Advisor or Personal Tutor
- Your Course Director
- Your health and well-being services

External sources

- Samaritan's - dedicated helpline for health and social care workers (0800 069 622)
- Student minds - information and advice to help manage your mental health and COVID-19 https://www.studentminds.org.uk/coronavirus.html
- HOPELINEUK Call: 0800 068 4141, Text: 07786209697 or Email:pat@papyrus-uk.org
- Young Minds Text: YM to 85258 https://youngminds.org.uk/find-help/get-urgent-help/youngminds-crisis-messenger/

Thank you for taking the time to read this information.

Please keep this information so that you can refer to it in the future.

Yours faithfully

Catherine Delves-Yates
Lead Researcher
Lecturer in Adult Nursing
University of East Anglia

6. Informed Consent Forms

Informed Consent Form 1.

Version 1 Date 10/17

School of Health Sciences
Edith Cavell Building
University of East Anglia
Norwich
NR4 7TJ
Phone: 01603 597059
c.delves-yates@uea.ac.uk

Informed consent form 1 - Nursing Students views of health and illness

Please initial boxes

1. I confirm that I have read and that I understand the information sheet for this research. I have had the opportunity to consider the information, ask questions and have these answered by the lead researcher. ☐
2. I agree for the focus groups to be audio recorded. ☐
3. I understand that data collected during the research will be looked at by all the people in the research team. ☐
4. I understand that I am under no obligation to take part and that I can withdraw at any stage during the research. If I do withdraw from the research I am aware that any information I have contributed will remain part of the research. ☐
5. I have a copy of the participant information sheet so that I know who to contact if I have any questions or concerns. ☐
6. I am aware that confidentiality cannot be guaranteed regarding discussion in the focus groups. ☐
7. I agree to take part in the above research. ☐

Research Participant	Researcher
Name (please print)	Name (please print)
Signature	Signature
Date	Date

Form 2 Version 3 Date 01/21

University of East Anglia

School of Health Sciences
Edith Cavell Building
University of East Anglia
Norwich
NR4 7TJ
Phone: 01603 597059
c.delves-yates@uea.ac.uk

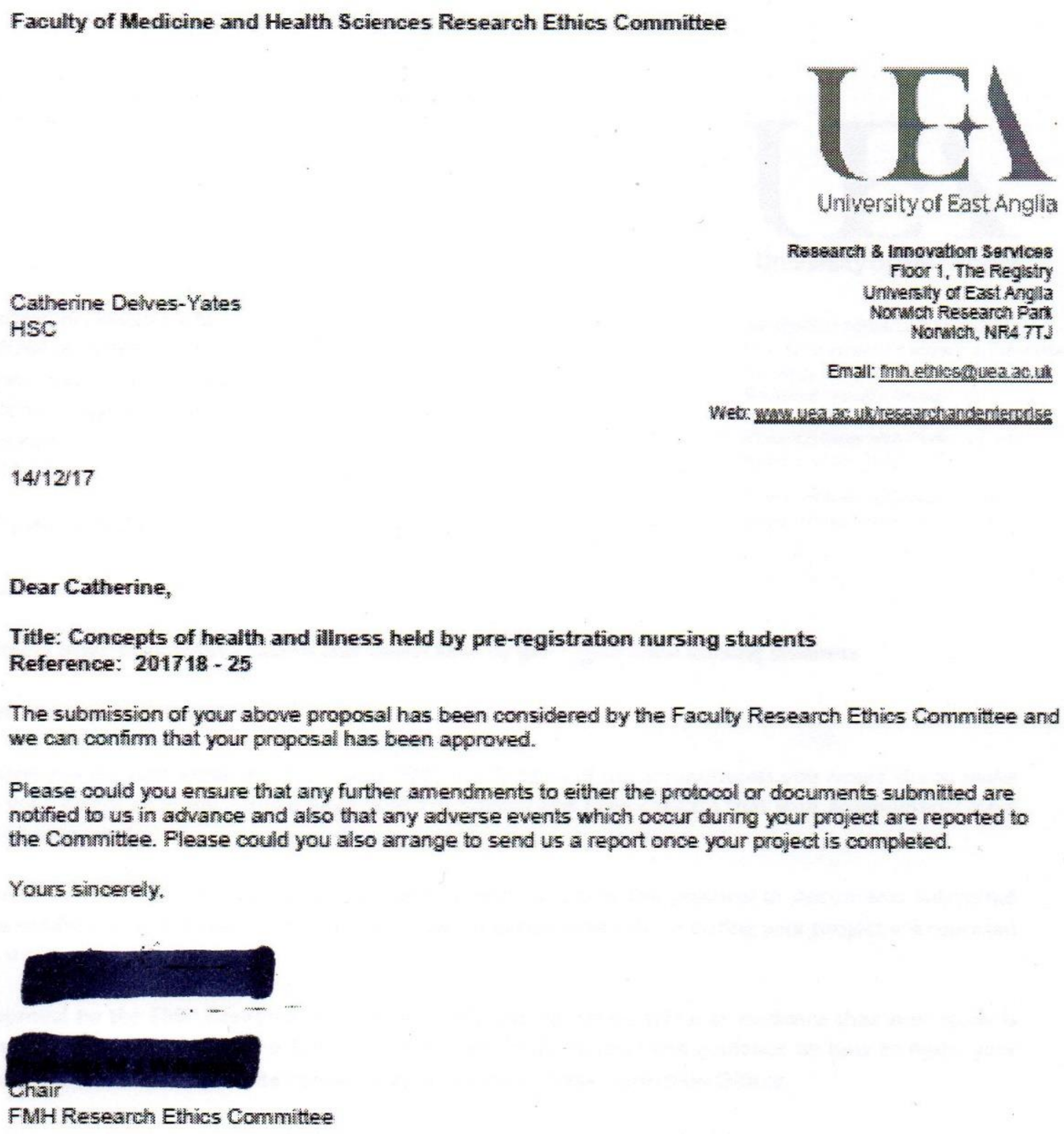
Informed consent form 2 - Nursing Students views of health and illness

Please initial boxes

1. I confirm that I have read and that I understand the participant information sheet 2 (version 3 date 01/21) for this research. I have had the opportunity to consider the information, ask questions and have these answered by the lead researcher. ☐
2. I agree for the interview to be audio-visually recorded. ☐
3. I understand that data collected during the research will be looked at by all the people in the research team. ☐
4. I understand that I am under no obligation to take part and that I can withdraw at any stage during the research. If I do withdraw from the research I am aware that any information I have contributed will remain part of the research. ☐
5. I have a copy of the participant information sheet so that I know who to contact if I have any questions or concerns. ☐
6. I agree to take part in the above research. ☐

Research Participant	Researcher
Name (please print)	Name (please print)
Signature	Signature
Date	Date

7. Ethical Agreement



Faculty of Medicine and Health Sciences Research Ethics Committee

University of East Anglia

Research & Innovation Services
Floor 1, The Registry
University of East Anglia
Norwich Research Park
Norwich, NR4 7TJ

Email: fmh.ethics@uea.ac.uk

Web: www.uea.ac.uk/researchandenterprise

Catherine Delves-Yates
HSC

14/12/17

Dear Catherine,

Title: Concepts of health and illness held by pre-registration nursing students
Reference: 201718 - 25

The submission of your above proposal has been considered by the Faculty Research Ethics Committee and we can confirm that your proposal has been approved.

Please could you ensure that any further amendments to either the protocol or documents submitted are notified to us in advance and also that any adverse events which occur during your project are reported to the Committee. Please could you also arrange to send us a report once your project is completed.

Yours sincerely,

[redacted]

[redacted]
Chair
FMH Research Ethics Committee

8. Ethical Agreement Amendment

School of Health Sciences
Edith Cavell Building
University of East Anglia
Norwich
NR4 7TJ
c.delves-yates@uea.ac.uk
1st February 2021

Dear [redacted],

Request for amendment to ethical approval of a health-related research project 201718-25

I would like to request an amendment to the above approval to alter the method of data collection used for theoretical sampling and the approach to key informants. There are two reasons for this, firstly the impact of the COVID-19 pandemic and secondly increased understanding of the best approach for theoretical sampling.

The restrictions and requirements resulting from the COVID-19 pandemic mean that the most appropriate approach to data collection ensuring participant and researcher safety is to meet remotely. Therefore, the data collection from the theoretical sampling in this project, to be undertaken between April-July 2021, needs to be undertaken via an online platform.

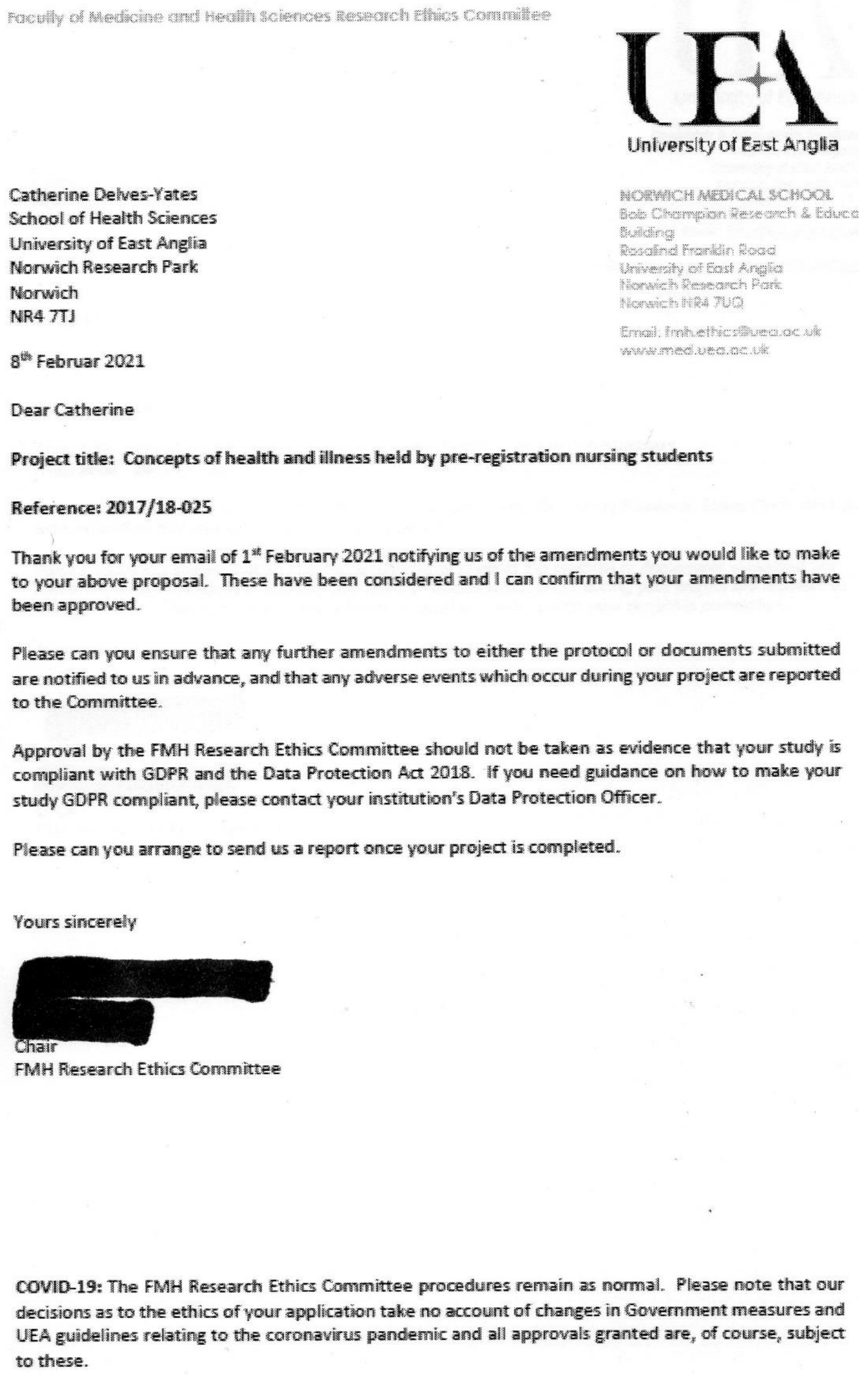
In addition to this however, as relevant data categories have emerged in the study, it has become apparent that individual semi-structured interviews are a more appropriate approach than the focus groups originally planned. It has also become clear that the best 'key informants' to be involved in this are nursing students currently in their third-year who participated in the previous rounds of data collection. These individuals not only have the nursing experience and knowledge required, but their pre-existing familiarity with the lead researcher and the trust and rapport already developed is likely to make them feel comfortable in an interview situation. An 'open-door' approach was agreed with students who participated in the first part of the study; they were happy to be re-contacted using the email they had already supplied to consider further participation at a later stage. If it is not possible to re-recruit sufficient participants using this approach (at least eight), an invitation to participate will be sent to all current year three nursing students at the two research locations. This invitation will be sent using their virtual learning management system (e.g., Blackboard). Please see amended approval form 201718-25 (attached) for further details.

In summary therefore I would like to request the following changes
1. Online synchronous individual semi-structured interviews to replace face-to-face focus groups.
2. Re-recruit previous participants seen as key informants for theoretical sampling.
3. If it is not possible to re-recruit at least eight previous participants, recruit year three nursing students from both research locations to achieve an overall total of eight.

Please do not hesitate to contact me if you have any further questions

Yours sincerely

Catherine Delves-Yates



Faculty of Medicine and Health Sciences Research Ethics Committee

University of East Anglia

NORWICH MEDICAL SCHOOL
Bob Champion Research & Educa
Building
Rosalind Franklin Road
University of East Anglia
Norwich Research Park
Norwich NR4 7UQ

Email: fmh.ethics@uea.ac.uk
www.med.uea.ac.uk

Catherine Delves-Yates
School of Health Sciences
University of East Anglia
Norwich Research Park
Norwich
NR4 7TJ

8th Februar 2021

Dear Catherine

Project title: Concepts of health and illness held by pre-registration nursing students

Reference: 2017/18-025

Thank you for your email of 1st February 2021 notifying us of the amendments you would like to make to your above proposal. These have been considered and I can confirm that your amendments have been approved.

Please can you ensure that any further amendments to either the protocol or documents submitted are notified to us in advance, and that any adverse events which occur during your project are reported to the Committee.

Approval by the FMH Research Ethics Committee should not be taken as evidence that your study is compliant with GDPR and the Data Protection Act 2018. If you need guidance on how to make your study GDPR compliant, please contact your institution's Data Protection Officer.

Please can you arrange to send us a report once your project is completed.

Yours sincerely

[redacted]

Chair
FMH Research Ethics Committee

COVID-19: The FMH Research Ethics Committee procedures remain as normal. Please note that our decisions as to the ethics of your application take no account of changes in Government measures and UEA guidelines relating to the coronavirus pandemic and all approvals granted are, of course, subject to these.

9. Recruitment Emails

All sent from Catherine Delves-Yates UEA email account

Email A Version 1 Date 10/17

School of Health Sciences
Edith Cavell Building
University of East Anglia
Norwich
NR4 7TJ
Phone: 01603 597059
c.delves-yates@uea.ac.uk

Dear [*Insert name*]

Thank you for expressing your interest in participating in the research study – Nursing students views of health and illness.

Please find attached to this email the informed consent form I will ask you to sign before the research starts. Please read this carefully before you make your final decision as to whether you would like to participate in the study. Please feel free to ask me any questions you have or request any further information about the study. You can do this either by emailing me c.delves-yates@uea.ac.uk or phone me (01603) 597059.

If you do not have any questions or do not need any further information and feel able to make your decision please email me c.delves-yates@uea.ac.uk to confirm whether you would like to participate or not.

If you have not responded to this email after 3 days from receipt I will assume that you do not wish to participate in the study.

Very best wishes

Kate

Catherine Delves-Yates

Attached – Informed consent form

Email B Version 1 Date 10/17

School of Health Sciences
Edith Cavell Building
University of East Anglia
Norwich
NR4 7TJ
Phone: 01603 597059
c.delves-yates@uea.ac.uk

Dear [*Insert name*]

Thank you for taking the time to think about participating in the research study – Nursing students views of health and illness and for informing me that you do not wish to participate.

Very best wishes

Kate

Catherine Delves-Yates

Email C Version 1 Date 10/17

School of Health Sciences
Edith Cavell Building
University of East Anglia
Norwich
NR4 7TJ
Phone: 01603 597059
c.delves-yates@uea.ac.uk

Dear [*Insert name*]

Thank you for informing me that you would like to participate in the research study – Nursing students views of health and illness.

I would like to invite you to a focus group, which will be on [*insert date*] at [*insert time*] with the venue being [*insert venue*]. We will have some time at the start of the focus group to sign the informed consent form for the study, please feel free to contact me before our meeting if you have any further questions about the study.

I look forward to meeting you on [*insert date*].

Very best wishes

Kate

Catherine Delves-Yates

Email D Version 1 Date 01/21

School of Health Sciences
Edith Cavell Building
University of East Anglia
Norwich
NR4 7TJ
Phone: 01603 597059
c.delves-yates@uea.ac.uk

Dear [*Insert name*],

My name is Catherine Delves-Yates and I am a Lecturer in Adult Nursing at the University of East Anglia. As you may remember from your previous participation, I, along with my research supervisors from the University of East Anglia, am undertaking research as part of an educational project with students from all four fields of nursing about their views of health and illness and whether these alter over the duration of their programme.

We would like to invite you to take part in this research study for a second time.

You have been invited to take part as you are a final year nursing student who took part in the focus groups during the earlier stage of the research. We would like to talk with students who are in the final year of their nursing programme. We value your views because you have specific knowledge and experience relating to the focus of our study.

Before you decide you need to understand why the research is being undertaken and what it would involve for you. Please take time to read the attached Participant Information Sheet carefully. Please ask questions if anything you read is not clear or if you would like more information. My contact details are c.delves-yates@uea.ac.uk or 01603597059.

If, after reading the Participant Information Sheet you are interested in taking part in this study again, please send an email to me at c.delves-yates@uea.ac.uk by [*insert date (giving 5 working days)*] saying that you are interested in being involved in the research. I will then contact you to discuss the study and then answer any questions you may have. If you agree to take part, I will invite you to an online interview at a time convenient to you.

Thank you for taking the time to consider taking part in the study.

Very best wishes

Kate

Catherine Delves-Yates

Attachment – Participant Information Sheet 2

Email D2 Version 1 Date 01/21

School of Health Sciences
Edith Cavell Building
University of East Anglia
Norwich
NR4 7TJ
Phone: 01603 597059
c.delves-yates@uea.ac.uk

Dear Final Year Nursing Students,

My name is Catherine Delves-Yates and I am a Lecturer in Adult Nursing at the University of East Anglia. I, along with my research supervisors from the University of East Anglia, am undertaking research as part of an educational project with students from all four fields of nursing about their views of health and illness and whether these alter over the duration of their programme.

We would like to invite you to take part in this research study.

You have been invited to take part as you are a final year nursing student and we would like to talk with students who are in the final year of their nursing programme. We value your views because you have specific knowledge and experience relating to the focus of our study.

Before you decide you need to understand why the research is being undertaken and what it would involve for you. Please take time to read the attached Participant Information Sheet carefully. Please ask questions if anything you read is not clear or if you would like more information. My contact details are c.delves-yates@uea.ac.uk or 01603597059.

If, after reading the Participant Information Sheet you are interested in taking part in this study, please send an email to me at c.delves-yates@uea.ac.uk by [*insert date (giving 5 working days)*] saying that you are interested in being involved in the research. I will then contact you to discuss the study and then answer any questions you may have. If you agree to take part, I will invite you to an online interview at a time convenient to you.

Thank you for taking the time to consider taking part in the study.

Very best wishes

Kate

Catherine Delves-Yates

Attachment – Participant Information Sheet 2

Email E Version 1 Date 01/21

School of Health Sciences
Edith Cavell Building
University of East Anglia
Norwich
NR4 7TJ
Phone: 01603 597059
c.delves-yates@uea.ac.uk

Dear [*Insert name*]

Thank you for expressing your interest in participating in the research study – Nursing students views of health and illness.

Please find attached to this email the informed consent form I will ask you to sign before the research starts. Please read this carefully before you make your final decision as to whether you would like to participate in the study again. Please feel free to ask me any questions you have or request any further information about the study. You can do this either by emailing me c.delves-yates@uea.ac.uk or phone me (01603) 597059.

If you do not have any questions or do not need any further information and feel able to make your decision please email me c.delves-yates@uea.ac.uk to confirm whether you would like to participate or not.

If you have not responded to this email after 3 days from receipt I will send you a reminder email. If after 3 days from receipt of the reminder email you do not respond, I will assume that you do not wish to participate in the study.

Very best wishes

Kate

Catherine Delves-Yates

Attached – Informed Consent Form 2

Email E2 Version 1 Date 01/21

School of Health Sciences
Edith Cavell Building
University of East Anglia
Norwich
NR4 7TJ
Phone: 01603 597059
c.delves-yates@uea.ac.uk

Dear [*Insert name*]

Thank you for taking the time to think about participating in the research study – Nursing students views of health and illness. This is a reminder that I sent you an email on [*insert date*] which you have not yet responded to. If you did not receive this email, require any further information about the study or would like to ask me any questions please do not hesitate to contact me. You can do this either by emailing me c.delves-yates@uea.ac.uk or phone me (01603) 597059.

If you have not responded to this email after 3 days from receipt I will assume that you do not wish to participate in the study.

Very best wishes

Kate

Catherine Delves-Yates

Email F Version 1 Date 01/21

School of Health Sciences
Edith Cavell Building
University of East Anglia
Norwich
NR4 7TJ
Phone: 01603 597059
c.delves-yates@uea.ac.uk

Dear [*Insert name*]

Thank you for informing me that you would like to participate again in the research study – Nursing students views of health and illness.

I would like to invite you to an online interview. For us to find a convenient date for this I have emailed you a TEAMs meeting request, for [*insert date*] at [*insert time*]. If this date and time is not convenient, please let me know and we can arrange a more appropriate time. Please note, this is not the date and time of the interview, but a brief meeting (expected to last a maximum of 10 minutes) for you to

1. ask any further questions you may have,

2. complete an informed consent form for participation in the research (attached),

and for us to organise an appropriate time for the interview.

Please do not hesitate to contact me if you have any further questions. I look forward to meeting you again.

Very best wishes

Kate

Catherine Delves-Yates

Attached – Informed Consent Form 2

10. Focus Group Guide

Research study – Nursing students views of health and illness

Interview guide – focus group - Version1 Date 10/17

Focus group aims

- Explore nursing students' concepts of health and illness.
- Understand the influences on a nursing student's concept of health and illness whilst they undertake a three-year undergraduate programme.

Introduction

1. Establish ground rules (to include confidentiality) at the start of the focus group
2. Provide overview of how the focus group will progress and introduce note-taker

Discussion

1. Provide all participants with individual hard copy of vignette
2. With reference to vignette encourage participants to explore
    - understandings of the term's health and illness
    - perceptions of health and illness in relation to nursing
    - influences on views of health and illness
    - any other issues that become relevant throughout the discussion

Summing up

Of all the things we have discussed today, what would you say is the most important?

Conclusion

- Thank you for participating. This has been a very successful discussion
- Your opinions will be a valuable asset to the study
- We hope you have found the discussion interesting
- I would like to remind you that the details of who participated in this discussion and the views we have shared are confidential
- Before you leave, please hand in your completed personal details questionnaire

11. Example Vignette

Mr Evans Attanga (DOB 25.06.23)

Mr Attanga is 94 years old and was admitted to hospital six days ago with an exacerbation of his chronic cardiac failure.

Previous Medical History

MI x2 (2015, 2016)
Angina
Insulin controlled diabetic
Left below knee amputation (2014)

Social history

Mr Attanga lives with his daughter (who is his full-time carer), son-in-law and their 3 adult children in a bungalow full adapted for his mobility needs (full-time wheelchair user). He is an active member of his local church, through which he attends a day club once each week.

Mr Attanga is fully aware that the treatment he is receiving for his chronic cardiac failure is palliative, but feels that his, 'life is for living' and that 'he isn't giving in yet'. In his view he still feels like, 'a young man in his head, it is only when he moves he remembers that he is 94'.

You are caring for Mr Attanga and are preparing him for discharge home later today. He is in very good spirits, feels that the care and treatment he has received has, 'topped him up'. Mr Attanga has asked you to go over his new medication regime with him again, which he says will, 'keep him going for a few years yet', so he wants to be certain he knows when and how to take his new tablets. He is looking forward to being back in his home with his family and socialising with his friends from church.

Mr Evans Attanga vignette mapped to attributes of health and illness identified in concept analysis (this was not shared with participants)

Health	
Attribute	Identified by
Enablement	Able to return home and socialise with his friends from church.
Dependence on healthcare and adherence	Feels that the care and treatment he has received has, ‘topped him up’. New medication regime will, ‘keep him going for a few years yet’. Wants to be certain he knows when and how to take his new tablets.
Sociocultural construction	Is fully aware that the treatment he is receiving for his chronic cardiac failure is palliative, but feels that his, ‘life is for living’ and that, ‘he isn’t giving in yet’. In his view he still feels like, ‘a young man in his head, it is only when he moves he remembers that he is 94’.
Personal responsibility	Wants to be certain he knows when and how to take his new tablets.
Illness	
Attribute	Identified by
Loss of wholeness	MI x2 (2015, 2016), Angina, Insulin controlled diabetic, Left below knee amputation (2014). Daughter is his full-time carer
Reality	Lives with his daughter (who is his full-time carer), son-in-law and their 3 adult children in a bungalow full adapted for his mobility needs (full-time wheelchair user).
Meaning	Is looking forward to being back in his home with his family and socialising with his friends from church
Hope and positivity	New medication regime will, ‘keep him going for a few years yet’
Sociocultural construction	Is fully aware that the treatment he is receiving for his chronic cardiac failure is palliative, but feels that his, ‘life is for living’ and that, ‘he isn’t giving in yet’. In his view he still feels like, ‘a young man in his head, it is only when he moves he remembers that he is 94’.

12. Semi-structured Interview Guide

Research study – Nursing students views of health and illness

Interview guide – online synchronous individual semi-structured interview - Version1 Date 01/21

Interview aims

1. Explore nursing students' views as to how their concepts of health and illness have changed since the start of their programme with specific reference to
    - Nursing care delivery
    - Influences on their views
    - The development of a professional nursing approach
    - Managing health in illness
    - The impact of the COVID-19 pandemic
2. Understand the strategies nursing students apply to hold their own views in abeyance to support patients to achieve their health and illness related goals

Introduction

- Establish ground rules, including confidentiality
- Provide overview of how the interview will progress

Discussion

Topics to be addressed

- How the students' concepts of health and illness have changes since the start of their programme with specific reference to
    - Nursing care delivery
    - Influences on the students' views
    - How they have developed a professional nursing approach
    - Managing health in illness
    - The impact of the COVID-19 pandemic
- The strategies the nursing students apply to hold their own views in abeyance to support patients to achieve their health and illness related goals
- Any other issues that become relevant throughout the discussion

Summing up

Of all the things we have discussed today, what would you say is the most important?

Conclusion

- Thank you for participating. This discussion has been very useful for me
- Your opinions will be a valuable asset to the study
- I hope you have found our discussion interesting

13. Example of an Overview of the Themes of Discussion

Physical and mental health are related
Ill people can be socially busy and have interests
You can be physically ill and mentally healthy, but not mentally ill and physically healthy
Health is being able to do what you want to
There are two interpretations of health and illness, those of the persons we care for and ours
Illness can be managed
Who is the problem for, the person receiving care, or us
Physically changing position is important
You can be very ill with a cold, but well with Multiple Sclerosis
The persons we deliver care for do not have to follow our advice
Is the care being delivered good
It is important to talk with the persons we deliver care to
People act differently when they are unwell
Illness lasts as long as the person feels ill
People live with long-term conditions
A diagnosis is needed to access treatment
Pressure ulcers are the result of bad care
The persons we deliver care for have favourite nurses
Being dependent on others is hard
We must be holistic in the care we deliver
Nurses don’t always like the people they deliver care to
Nurses should empower people
People are complicated
My views of health and illness came from my experience
Always respect the persons you deliver care to

14. Reflexivity and Me

Me as a child/teenager

The world, from my earliest memories, was full of difference and exciting potential. I grew up in a small, rural and affluent village just outside a university city. The university had a large impact on my experiences as a child. It enabled easy access to a wide range of educational and cultural opportunities which resulted in me spending much of the time I was not in school, engaged in activities focusing on museums, music and sport. Being close to the university also enabled me to mix with individuals originating from different geographical locations and cultures, as frequently 'visiting professors' either lived in the village or sent their children to the same schools as I attended. Thus, I recognise that being emersed in these experiences developed within me not only the desire to discover how life is lived by others and to travel, but also a love of learning.

Even as a small child, being independent, making my own decisions and organising others have always been amongst my characteristics. Although I was the second child of three, it was me who organised family games and activities, plus looked after the purse when in the school holidays, my older sister and I travelled into the city to visit a museum or the shops.

Focusing on views of health and illness, mine were profoundly impacted by my mother being diagnosed with a terminal illness when I was nine and her death when I was 14. Throughout this time, I functioned as what I now recognise to be a young carer, assuming some activities involved in caring for my mother, but many more in caring for my much younger brother and keeping a family home running. While I recognise that such experience at a young age was challenging, it did also instil in me an inner core of resilience and the ability to 'turn my hand' to whatever needed to be done – with varying degrees of success. I learnt that there was value in supporting others and that nothing was unmanageable, it just sometimes took time and practice or maybe an alteration in what was judged as the criteria for success.

Reflecting on this time, while my experiences as a child/teenager were not always happy, I see my childhood/teenage years as being filled with unconditional love, support and nurture. My stepfather, sister and brother were the source of this and their demonstration of how, even as flawed individuals during troubled times, simply ‘being there’ even when you don’t have the answer, taught me so much.

I emerged from my childhood and teenage years with a quiet confidence that, although circumstances can be difficult, whatever happens, I can cope and life is full of exciting opportunities.

Me as a nurse

Unsurprisingly maybe, after completing A levels I chose to become a nurse. While part of what attracted me was that nursing would enable me to ‘give’ to others, I am aware that I gaining far more in return was just as important. I recognise that this, always has and continues to be, fundamental for me. Also importantly, I was able to indulge my desire to constantly learn, to organise others and, as I became more senior, make decisions.

I moved away from my home city to undertake my initial nursing education and a short time after I became a Registered Nurse, moved again to work as a nurse in a critical care environment. Wanting to gain as many different experiences as I could is a persistent feature in my history, while critical care nursing has always been my ‘clinical home’, I have worked in many different specialities within this area.

While becoming increasingly senior in the nursing roles I held, I realised the limitations of the impact I could have on others. My desire to maximise experience related not just to differing geographical locations, but also to developing clinical practice and a desire to implement change when it was needed. When I felt constrained because I was unable to develop practice at the pace

I felt reflected the need of the persons receiving care and the staff, I realise this challenge required a change in role.

Me as an educator

Moving into an academic role enabled my focus to be on enabling those I worked with to develop the skills and the mind-set necessary to deliver effective care. Again, as I held increasingly senior roles, my desire to organise and make decisions found an outlet, as well as my love of making order out of chaos and translating complex issues into understandable discussion, prose, or pictures. The autonomy of the role of a lecturer, giving me the ability to expand my experiences by working on educational projects in the UK and other countries, has been foundational in the development of my worldview. This has also had an impact on my view as to the most effective way to educate nursing students. Within nurse education I view ensuring students understand the importance of respecting and working in partnership not only with the persons who receive care but all of those they engage with daily as being fundamental.

By moving away from direct care delivery, I recognised in myself the satisfaction I gained from working with people in crisis. In my experience of critical care nursing this frequently originated from a physical health crisis, which then developed psychological aspects. Working with students focused my abilities far more on psychological needs, leading to my recognition that I am empathetic when dealing with others and can pick up on cues and emotions others may be trying to conceal. This led me to reflect on my childhood/teenage experiences, where I realised that I frequently managed my emotions by hiding them and focusing on the routine of everyday living.

Me as a researcher

This thesis contains many echoes of my prior experience and I recognise that my worldview has been developed by the process of undertaking this research. Discussing health and illness with the participants, comparing and analysing the data they provided has enabled me to contextualise my own experiences. I have become aware of the power of socialisation, the difficulties not conforming to the expected norms can bring and the influence my experiences have on my thoughts, feelings and actions. My developing perspective throughout the study will have impacted how I viewed the data and will have influenced my co-construction with the participants.

A question I frequently debated with myself in my reflexive discussions during data collection was, who is me? This reflexive writing is presented in four sections and while I can accept that I am no longer the child/teenager version of me (although that me will always be part of my foundation) it is more complex to identify whether I am a nurse, an academic, or a researcher. I think that there is a great deal of complexity here, in that I feel I integrate these identities at times, while also inhabiting them individually at other times. I also recognise that this is integral in how I presented to the participants. Within the thesis I declared my positionality thus,

> ‘*It is therefore appropriate to recognise that the findings identified in this research are presented as one possible co-construction of experience, based on my positionality as a female, middle-aged, white British, middle-class lecturer in adult nursing, registered adult nurse and PhD student. These qualities were revealed, either directly or indirectly, to the research participants in our discussions relating to health and illness.*’

in which I claim to be all three versions of me.

Reflecting on and listening again to the data collection meetings, I recognise that I presented myself in each of these identities, using what I felt at the time was the most appropriate identity to make connections, encourage the participant, advance discussion, reflect understanding or develop further clarification. From the perspective of looking back over the data gathering processes, I wonder now whether participants found this confusing.

There are also potential issues of power. The relationship between a nursing student and a lecturer is not an equal one. I also feel that nurses speak differently when talking to other nurses than they do when talking with non-nurses, which reflects a mutual level of understanding and knowledge among nurses. By presenting myself as a nurse, maybe I did not take full advantage of all the possible opportunities to deconstruct the meaning participants were attributing to their experiences.

Me as a person

Reflecting on the insights contained within the reflective discussions I have engaged in with myself during this research I can see how all my experiences have culminated to make me the person I am now. The impact of my early experience is pertinent to this research, as it not only underpins my views of health and illness, but I can now appreciate how it formed my perspective on the importance of treating all others I have contact with as persons.

I recognise however that there is still more to be revealed. As I get toward the end of the research I have sufficient material for a great deal more reflexive discussions with myself and others, which will continue. While the end point of the research is ahead, the processes involved in the consideration of reflexivity and me remains a work in progress.

15. Recognising the Potential Influence of Emotional Responses

To recognise the potential influence my emotional responses could have and enable me to fully appreciate this I applied the approach detailed by Mauthner and Doucet (1998, 2003). In this approach the participants words are presented in one column and researcher reactions and interpretations in an adjacent column, as in the example below. This approach enabled me to examine where and how my emotions and the assumptions and views based on these, may be influencing my interpretation of what the participant is saying and how I represent the person.

Participant words	**My reactions and interpretations**
'I've always prepared myself for the worst. I'm being real - bad things happen. They have happened to me in the past, so they can and will happen again, to me and others. I don't dwell on the worst things possible, but I'm ready for it. If I'm preparing, prepping myself so that when something does happen, I'm able to cope. *I always use it when I'm working with patients and talking with relatives. And maybe I've done that because of what I had to cope with as a child, as a safety mechanism, which enabled me to, to function as a normal human, I have created this approach, so that I can say, okay, this could happen. If it does happen things will get to be OK again. It will be hard at the time, but you can manage, you can cope. You can get through it. It's about resilience, nursing resilience and in everyday life, that's what I do coping with the down turns, because not everything is going to be great.'*	I recognise what is being said here to be an approach I adopt. I had similar experiences to what this participant describes growing up and I am able to identify with many of the ways she responds and strategies she has developed to manage her experiences. This account brings to my mind many memories and emotions. These are influencing my ability to represent her perspective in the findings.

This discussion extract was the focus of many reflexive discussions, with myself and others, in order for me to be able to feel sufficiently comfortable to be able to represent what I originally viewed as a perspective too close to my own which provoked emotions within me. The application of this process in combination with further reflexive discussion assisted me to disentangle the information from my emotional responses.

16. Example of the Coding Tree

Category name - Influencing student views	
Subcategory	Code
AB2-2-1 & GH-2-1 (*The label AB2-1 & GH-2-1 indicates which transcript the data is on)* Experience expands understanding	AB2-2-K61 (*the label AB2-2-K61 indicates the precise location of the data on the transcript)* At the start of the programme my view was if you are ill it is unhealthy. Illness can be physical or mental. Now so much more is involved, it can be physical and mental, or social circumstances – anything
	AB2-2-K81 My view of health and illness has changed during the programme
	AB2-2-K82 I have explored my view and know more
	AB2-2-K83 My view has developed
	AB2-2-K89 My view has changed beyond words!
	AB2-2-K91 I have developed my views during the programme
	GH-2-K46 My experiences on the programme have influenced my views of health and illness
	GH-2-K48 I thought I knew about mental illness when I started the programme. I didn't.
	GH-2-K52 My view of health and illness before the programme came from my previous experience.
AB2-2 Lectures expand understanding	AB2-2-K64 The content of lectures is empowering and enable me to think more deeply about the patient's perspective
	AB2-2-K65 I feel privileged to be listening to lectures
	AB2-2-K66 Lectures have taught me what to do in practice and I know more than before I started the programme. Not everyone has this view though.
	AB2-2-K67 Lectures have changed my vocabulary and provided me with evidence
	AB2-2-K68 I think I gain knowledge from lectures subconsciously at times
	AB2-2-K69 Lectures have given me not just knowledge but helped me to think differently to challenge things.
	AB2-2-K74 Lectures have enabled me to feel more connected to patients
	AB2-2-K75 Anecdotes have made me more sensitive to patients
	AB2-2-K76 Lectures provide you with material to think about things later
	AB2-2-K77 Talking about lecture material outside of the lecture helps you to learn
	AB2-2-K78 I would not have the knowledge I do without going to lectures
AB2-2-15 & CD-2	AB2-2-K79 I have an increased knowledge of the theory behind illnesses
	AB2-2-K80 I have gained knowledge from my colleagues

Knowledge increases understanding	CD-2-K46 We have been taught information in sessions, but seeing it in practice has made me understand
	CD-2-K48 Person-centred planning in year one was where it started to sink in – looking at people holistically.
	CD-2-K52 My views started to change in the first-year, about 3 months in.
AB2-2-16 Upbringing increases understanding	AB2-2-K90 The way I was bought up had an impact on my view of health and illness
AB2-2-17 & GH-2 & EF-2 & CD-2 Patients increase understanding	AB2-2-K70 Expert patient groups have taught me a great deal
	AB2-2-K71 Talking with expert patients has made me think more sensitively
	GH-2-K58 Patients have been the biggest influence on my thoughts about health and illness
	GH-2-K58 Patients have been the biggest influence on my thoughts about health and illness
	GH-2-K47 Patients have influenced my views on health and illness
	GH-2-K50 Patients have changed my view of health and illness
	GH-2-K53 Patients has enabled me to realise more about health and illness
	GH-2-K59 Patients have been the biggest influence on my views of health and illness
	GH-2-K62 Patients have influenced my views of health and illness
	EF-2-K8 Patients have developed my view
	CD-2-K44 Talking to patients, service users, has enabled me to have a more overall view
GH-2 & EF-2 Teaching increases understanding	GH-2-K36 We have been taught to view patients holistically
	GH-2-K61 Lectures have made me a bit more rounded
	EF-2-K62 Learning in the long-term conditions module has made me think differently
GH-2 & CD-2 Placement expands understanding	GH-2-K47 Placement has influenced my views on health and illness
	GH-2-K50 Placement has changed my view of health and illness
	GH-2-K53 Placement has enabled me to realise more about health and illness
	GH-2-K59 Placements have been the biggest influence on my views of health and illness
	GH-2-K62 Placement has influenced my views of health and illness
	CD-2-K53 Going to my first placement changed my views and I realised what health was
GH-2 & CD-2	GH-2-K60 Lectures are shaping and refining my views on health and illness
	CD-2-K56 In the future I might come across things that make my view change slightly

The future may influence my view	
GH-2 Publicity campaigns influence views	GH-2-K44 Views are influenced by charity publicity campaigns (i.e., MENCAP ‘I am not a learning disability’ posters)
GH-2 Other professionals influence views	GH-2-K63 Other professionals have influenced my views of health and illness
	GH-2-K64 Being able to ask questions of consultants, as a student, has influenced my views of health and illness

Defining illness	
Subcategory	Code
AB2-2 Illness and time	AB2-2-K24 Health and illness can be dynamic states for those with long-term illnesses
	AB2-2-K28 Illness can last for years
	AB2-2-K30 Illness can last for life
H-2 & AB2-2 & CD-2-7 & EF-2 Illness manifestations	GH-2-K6 A condition is not a health issue
	GH-2-K8 Patients can feel very ill with a cold
	GH-2-K11 Illness lasts as long as the patient feels ill
	GH-2-K17 Some illnesses can be cured; others must be lived with
	GH-2-K18 You are medically ill with illnesses that can be cured
	GH-2-K23 A diagnosis of illness is the ticket to support
	GH-2-K34 Illness is hard because you are dependent on others
	AB2-2-K1 A cold is illness
	AB2-2-K2 MS is not illness
	AB2-2-K5 MS can be illness
	AB2-2-K8 If you are functioning you are not ill
	AB2-2-K9 MS is not illness
	AB2-2-K10 wouldn’t describe her as ill when she is functioning
	AB2-2-K11 A cold is illness when you are not able to function as you normally do
	AB2-2-K12 Illness is when you are not coping as well as normal

	AB2-2-K13 Illness is when you are not managing your condition as well as usual
	AB2-2-K20 Illness is when you are not functioning
	AB2-2-K24 Health and illness can be dynamic states for those with long-term illnesses
	AB2-2-K26 Illness doesn't have a set time limit
	AB2-2-K27 An illness period is when people are not coping or not functioning at their optimum
	AB2-2-K32 When people are functional with good quality of life, even if they have a diagnosis, they are not ill.
	AB2-2-K31 A person with a diagnosed illness is not always ill
	AB2-2-K33 Ill people can be physically fit and train at a high level
	AB2-2-K34 Patients can lead a normal life with illness
	AB2-2-K35 Sometimes you can't tell people are living with illness
	AB2-2-K36 Patients can function even with severe illness
	AB2-2-K61 At the start of the programme my view was if you are ill it is unhealthy. Illness can be physical or mental. Now so much more is involved, it can be physical and mental, or social circumstances - anything
	AB2-2-K62 Because you have an illness doesn't mean you are unhealthy
	CD-2-K3 Can be physically unwell but mentally well
	CD-2-K15 Someone with a long-term condition is not well if they can't do what they usually do.
	CD-2-K31 Illness is an indicator that somebody is not healthy
	CD-2-K33 Illnesses make you unhealthy and not in the state of well-being you want to be in
	CD-2-K35 Whether a long-term condition is an illness depends on how the patient sees it
	CD-2-K36 A patient may see MS as an illness, or they may not.
	CD-2-K39 I think that colds are pressure ulcers are illnesses
	CD-2-K62 Mental and physical health play a part with each other. Poor physical health, as simple as a cold can throw a patient's mental health.
	CD-2-K63 I have seen in placements that physical illness can cause mental health deterioration.
	CD-2-K17 You can become ill with a long-term condition if you have a cold
	EF-2-K43 Because a person has diabetes does not mean they are unhealthy – it is the potential effects of diabetes than can make them unhealthy
	EF-2-K48 Being ill is the final stage of life
	EF-2-K49 You are ill when you no longer have quality of life

	EF-2-K50 Being unwell is the pre-stage of being ill
	EF-2-4-K52 If your long-term illness has a negative impact on your daily living you are ill
	EF-2-K55 Illness can be temporary
	EF-2-K56 Illness can be long-term
	EF-2-K83 Illness occurs when long-term conditions negatively affect a person’s life
	EF-2-K86 People with diagnosed illnesses are not ill – it is the symptoms of the diagnosis that make them ill
	EF-2-K87 If people have a low quality of life with their diagnosis they are ill
	EF-2-K88 Having a low intelligence level (learning disability) does not make you unwell.
	EF-2-K101 An unmanaged long-term mental health issue is illness
	EF-2-K107 People are ill when their illness is running their life
	EF-2-K108 Illness is temporary
	EF-2-K110 A person’s level of functioning reflects their level of illness
	EF-2-K114 Illnesses remove choices
	EF-2-K116 Illness removes choices
	EF-2-K117 Having a bad cold makes you ill
	EF-2-K118 Illness is temporary
	EF-2-K119 You are ill when your functioning and ability to make choices have been taken away and your norm affected
	EF-2-K120 The length of illness depends on a person’s underlying condition
	EF-2-K121 A person with a long-term condition is unwell if they can achieve their ADLs but are ill if they can’t function

17. Examples of Theory Evolving

Version 1

In summary, what students are telling me about health and illness reflects McCaffery's 1968 definition of pain —'It's whatever the experiencing person says it is, existing whenever and wherever the person says it does.'

Further to this and I think this is where the theory is really emerging, the key feature of their developing views is that they are based on experience. This can be within and outside their nursing programme (most were within, but this is not exclusive). The experience outside the nursing programme can happen prior to the student starting their studies or be happening at the same time.

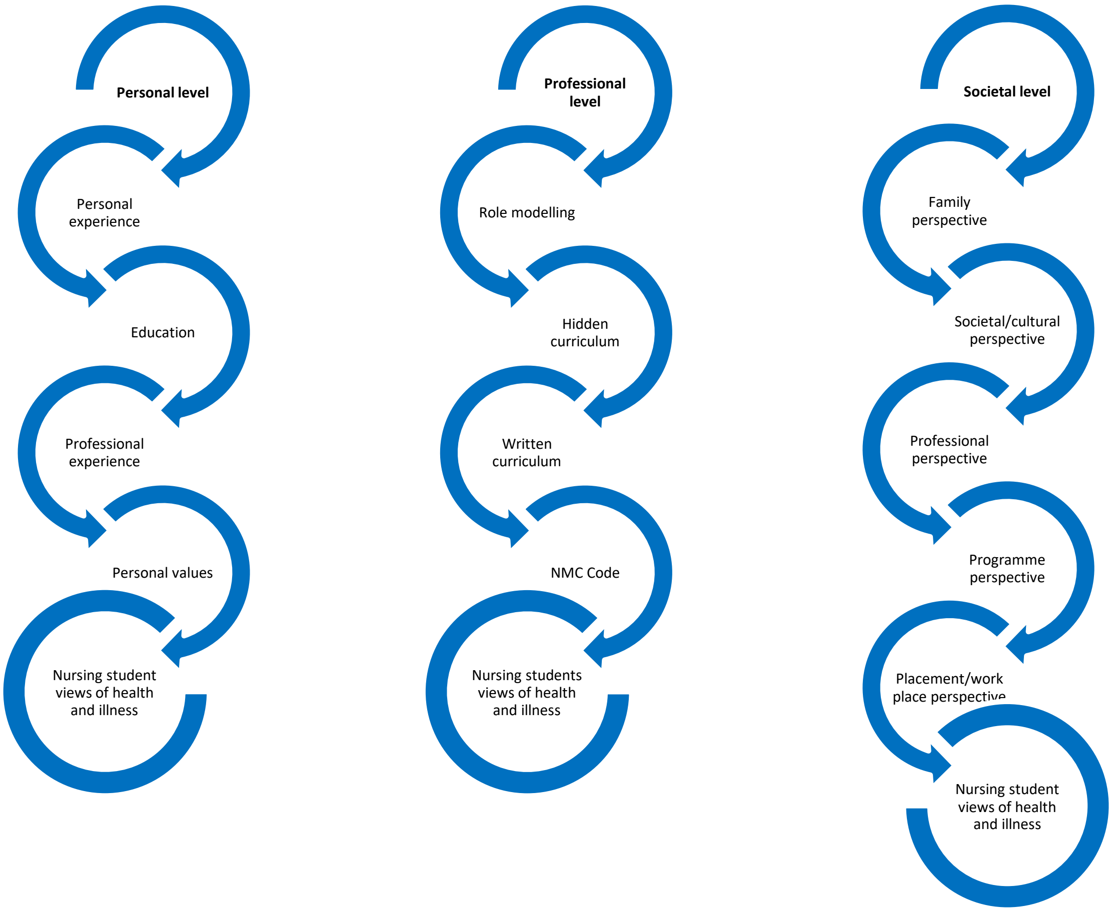
To be developed the students experience needs to be underpinned by

- *Theory and application of a wide range of skills (using this term to identify non-technical skills too) – so clinical practice in the widest of sense – application is important because it is the learning by doing….*
- *The influence of 'role models' who apply person-centred approaches – or conversely and just as importantly, who don't*
- *Reflection – reflection is important – but there is something further here – an experience needs to be labelled as 'reflection worthy' so it can get 'into the system'*

Looking at it across a broader perspective I have lots of elements, but I am not yet sure what is the focus.

(Theoretical memo 28.11.2018

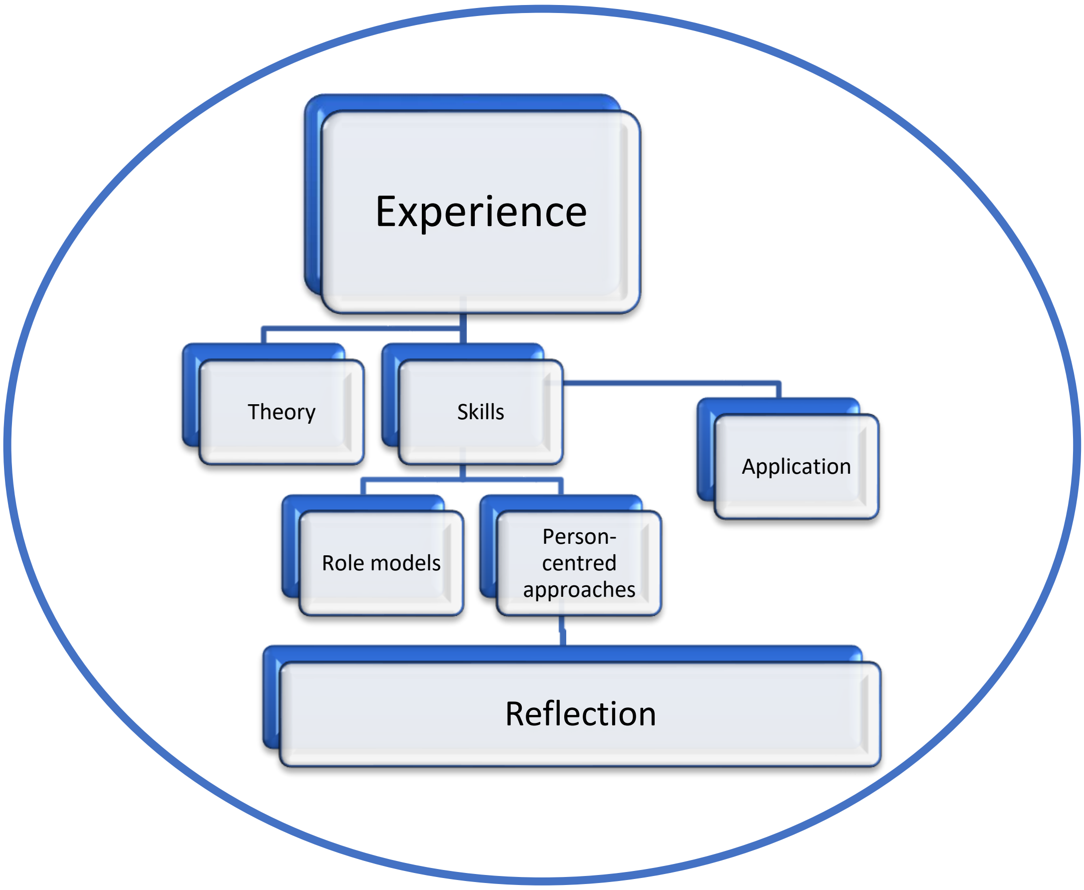
Version 2



These are the elements I am mulling over. How they fit together I need to think about further. They need to be in the model, but I am not sure whether they need to be written individually.

(Theoretical memo 03.08.2019)

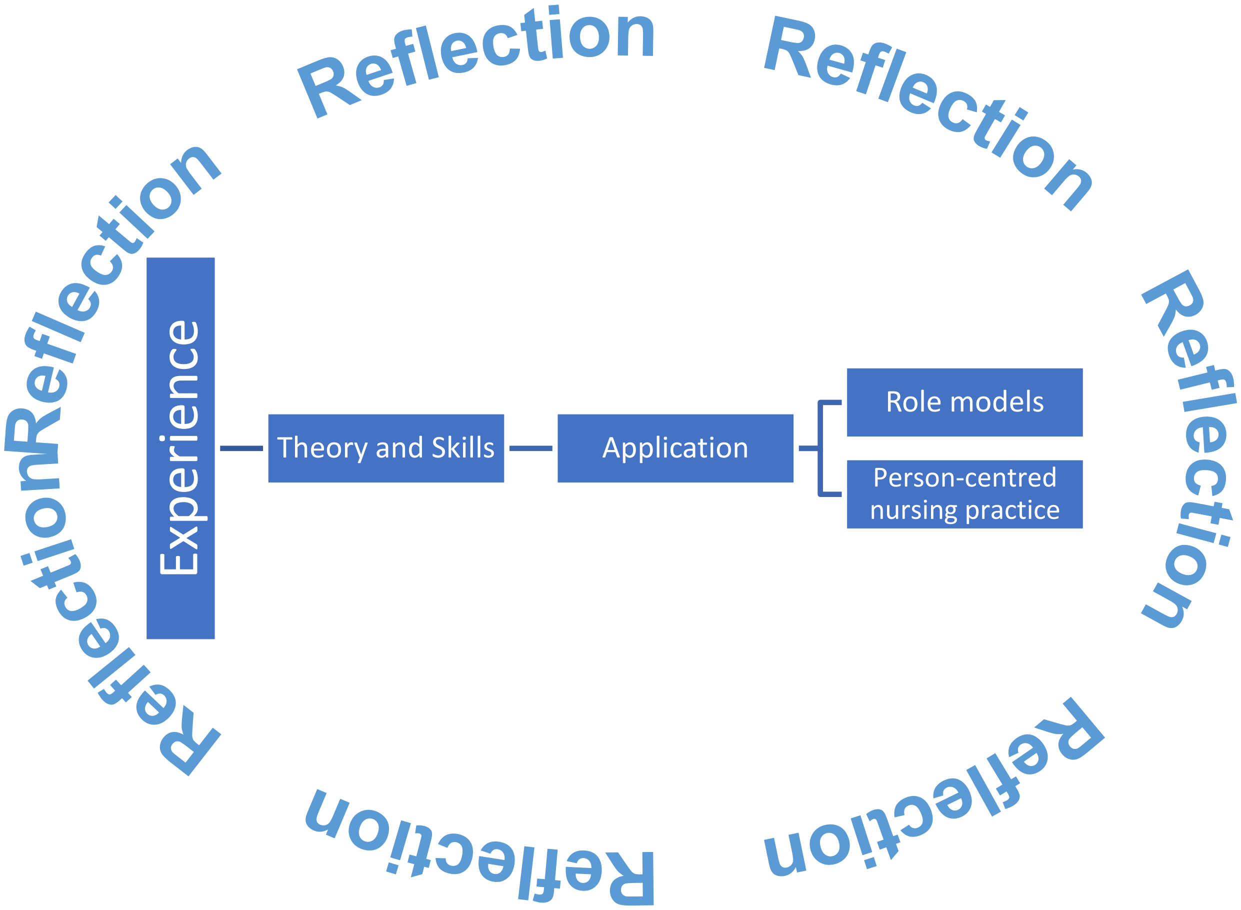
Version 4



…there needs to be an outer layer – here it is the outer circle, representing something along the lines of personal nursing ideology, to get the link to the influence this has on all aspects of care delivery and thinking…

(Theoretical memo 29.07.2021)

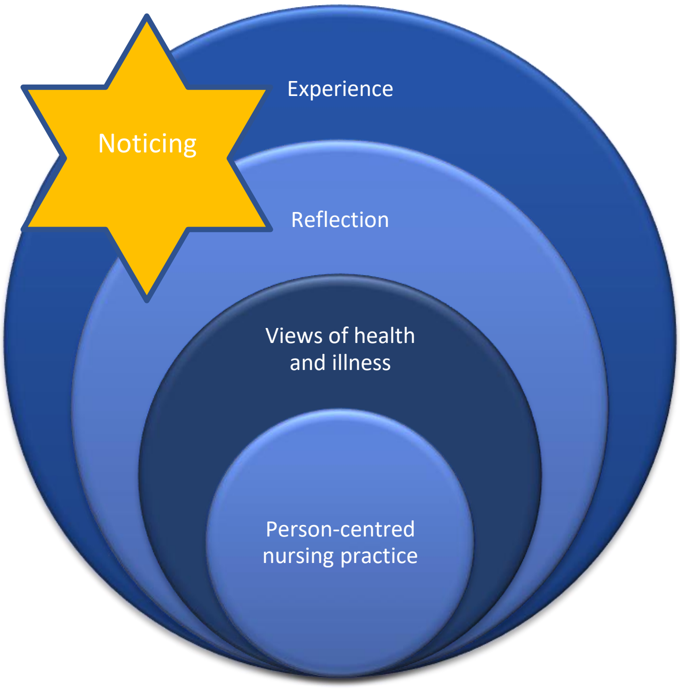
Version 8



…still working to identify that there is influence on all aspects of nursing practice

(Theoretical memo 13.08.2021)

Version 13



(Theoretical memo 12.02.2022)

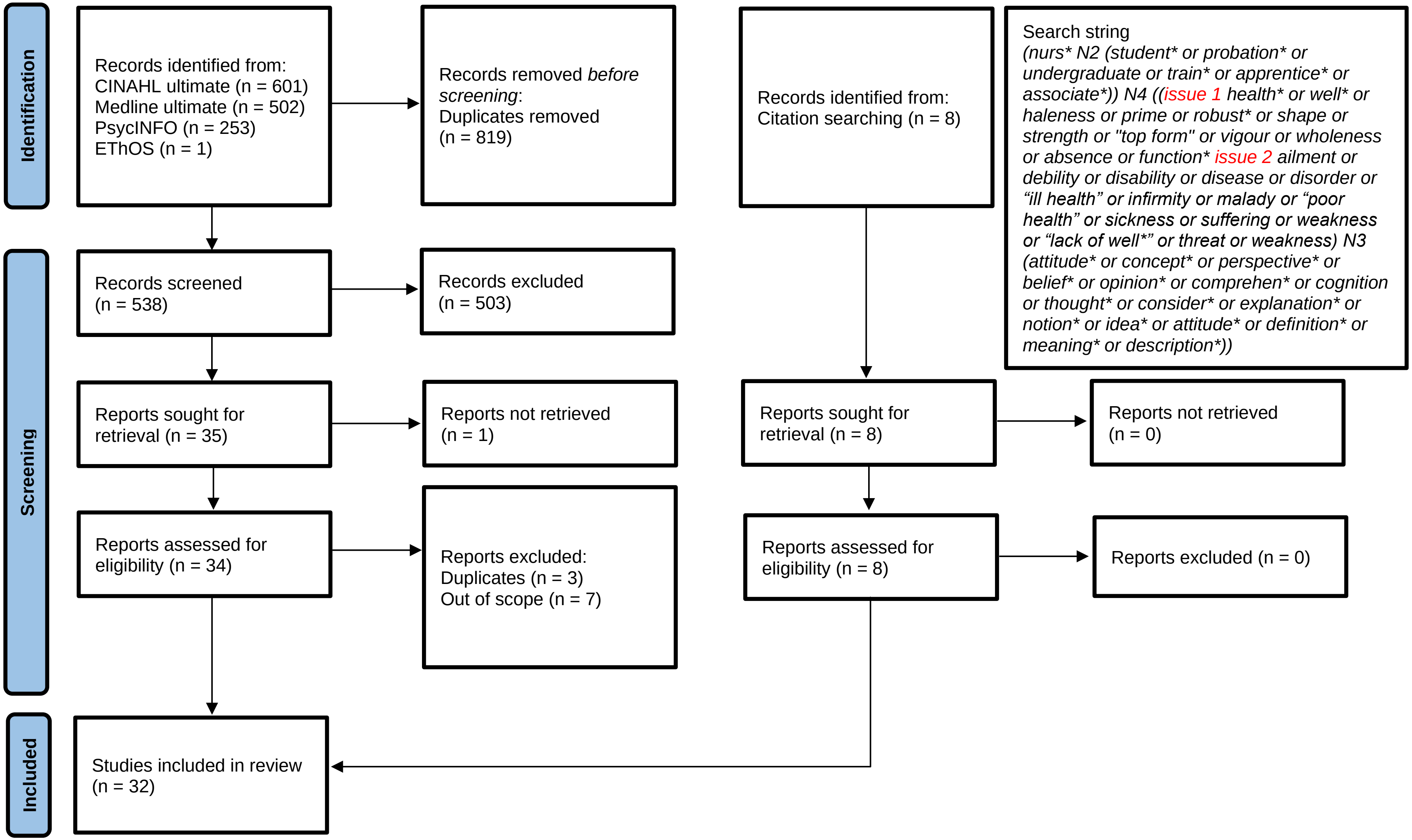
18. Literature Searching

An example of the key terms and synonyms identified in one of the formal searches designed to identify literature addressing nursing students views of health and illness is presented below.

Identifying key terms and synonyms using PICO (qualitative version)

	Population	**Issue** (The issues of health and illness were searched independently and then the results combined)		**Context**	**Outcome**
PICO term	Nursing students	1. Health	2. Illness	BSc pre-registration programme	Concepts
Synonyms	Student nurse, student, probationer, trainee, undergraduate	Fitness, good condition, haleness, healthiness, physical wellness, mental wellness, prime, robustness, shape, strength, top form, vigour, well-being, wholeness, disability absence, disease absence, functioning, adaptability	Ailment, debility, disability, disease, disorder, ill-health, infirmity, malady, poor health, sickness, suffering, weakness, lack of well-being, lack of wellness, threat, weakness	Nurse education, nurse training, undergraduate, nursing programme, nursing school, nurse teaching	Views, perspective, belief, opinion, conceptions, comprehension, cognition, thoughts, consideration, explanation, notions, ideas, attitude, definition, meaning, description

Each of the databases identified were searched individually to increase comprehensiveness and then results combined, as summarised in the following PRISMA diagram.

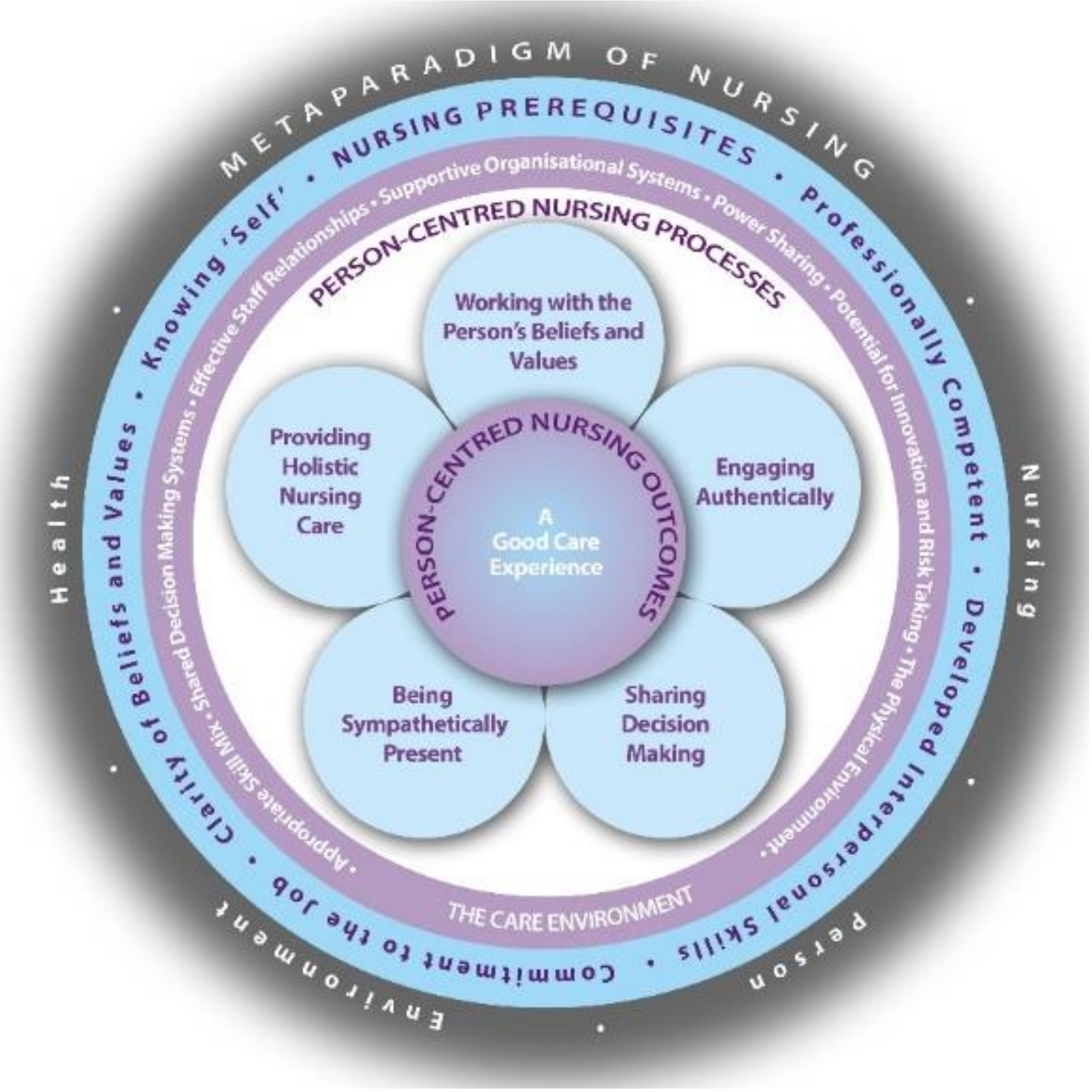


Search string
(nurs N2 (student* or probation* or undergraduate or train* or apprentice* or associate*)) N4 ((issue 1 health* or well* or haleness or prime or robust* or shape or strength or "top form" or vigour or wholeness or absence or function* issue 2 ailment or debility or disability or disease or disorder or "ill health" or infirmity or malady or "poor health" or sickness or suffering or weakness or "lack of well*" or threat or weakness) N3 (attitude* or concept* or perspective* or belief* or opinion* or comprehen* or cognition or thought* or consider* or explanation* or notion* or idea* or attitude* or definition* or meaning* or description*))*

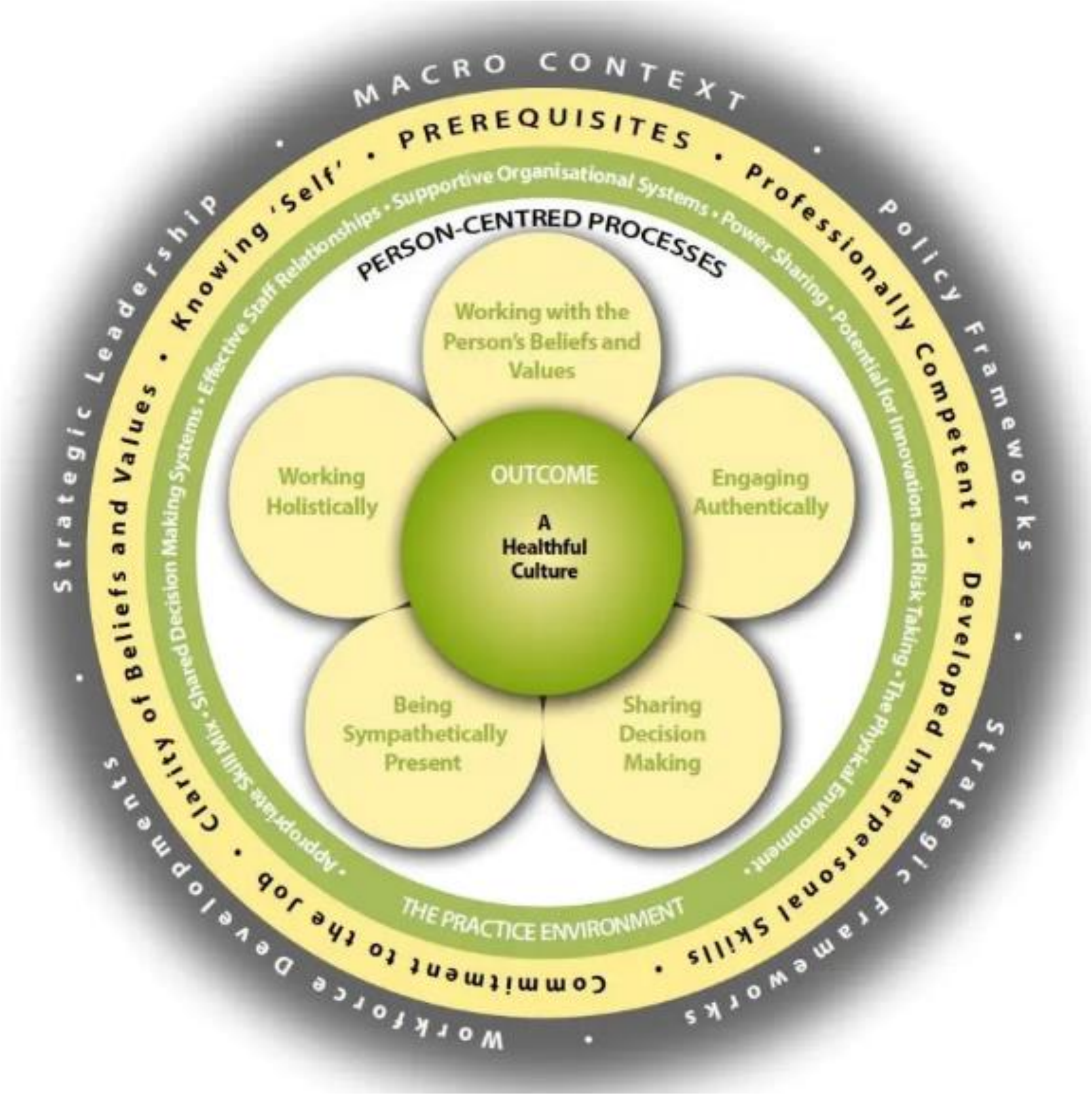
Adapted from Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71.

PRISMA diagram – Nursing students' views of health and illness

19. Person-Centred Nursing and Person-Centred Practice Frameworks



Person-Centred Nursing Framework (McCormack and McCance, 2019a)



Person-Centred Practice Framework (McCormack and McCance, 2019b)

20. Mapping Attributes

Concept analysis attributes

Health as

- **enablement**
- **dependence on healthcare use and adherence**
- **sociocultural construction**
- **personal responsibility**

Illness as

- **fundamental loss of wholeness**
- **reality**
- **meaning**
- **hope and positivity**
- **sociocultural construction**

Categories in development

Influencing student views

- Original views
- Experience expands understanding

Caring for people

- Person-centred care
- Delivering care
- People have expectations

Maintaining health in illness

- Managing illness
- Being healthy in illness

Developing a Nursing Lexicon

- Defining health
- Defining illness
- Existing within a spectrum
- Influencing (?promoting) health
- Wresting with the concept of health and illness

Changing views

- Prior experiences of health and illness influence consideration of nursing
- Learning through experience
- Individualised views of health and illness
- Innovative approach
- Knowing own views
- Talking with patients
- Physical and mental health are linked
- No parity of esteem
- Effective role modelling
- Defining illness
- Patients' views

Influencing Care

- Choice of first SN post
- Physical health focused
- Negative attitudes
- Lacking congruence
- Benefitting from different perspectives
- Being judgemental
- Tribalism unites and divides

Caring for Self

- Professional boundaries
- Healthy workplaces
- Different standards
- Choices made during COVID

COVID impacts

- Living alone
- COVID and judgements
- COVID frontline

Concept analysis attributes

Health as

- enablement
- dependence on healthcare use and adherence
- sociocultural construction
- personal responsibility

Illness as

- fundamental loss of wholeness
- reality
- meaning
- hope and positivity
- sociocultural construction

Emergent Data Categories

Evolving Views

Influencing student views
Changing views
COVID impacts

Developing a Nursing Lexicon

Developing a Nursing Lexicon
COVID impacts

Influencing Care

Influencing Care
Caring for people
Maintaining health in illness
COVID impacts

Caring for Self

Caring for Self
COVID impacts

(size of coloured highlight is not indicative of any metric)

21. Dissemination

Journal publication – Making Sense of Concept Analysis. 2018. Nurse Researcher, 25, 4, pp43-46.

Conference presentation – Concepts of Health and Illness held by pre-registration Nursing Students. 17th May 2018. Post Graduate Research Conference, University of East Anglia.

Presentation – 'Views of Health and Illness' 13th March 2019. Peer Presentation, University of East Anglia.

Conference poster presentation - Understanding Concept Analysis' 2nd September 2019. RCN International Research Conference. Sheffield Hallam University.

Conference oral presentation – 'Understanding Concept Analysis' 2nd September 2019. RCN International Research Conference. Sheffield Hallam University.

3 Minute Thesis Presentation – 'Pre-registration nursing students' concepts of health and illness: a Constructivist Grounded Theory study.' 16th June 2022. Post Graduate Research Conference, University of East Anglia.

Conference poster presentation – 'Evolving Views: A Constructivist Grounded Theory Exploration of Nursing Students' Concepts of Health and Illness.' 15th June 2023 Post Graduate Research Conference, University of East Anglia.