The Nurse Educator in Aotearoa New Zealand

by

Leanne Gay Pool

A thesis submitted to Auckland University of Technology
in partial fulfilment of the requirements for the degree of
Doctor of Education

2021

Abstract

In Aotearoa New Zealand and globally, nurses are not choosing careers as nurse educators. One of the biggest challenges is the recruitment and retention of sufficient numbers of qualified nurse faculty that matches the Aotearoa New Zealand population. There is no formal data on the workforce situation for the nurse educator, and no plan as to how the need for more nurse educators will be addressed in response to the predicted nursing shortage. This shortage of nurse educators has a direct impact on the global nursing workforce shortage. There is a need to develop a sound understanding of the work of nurse educators, to which this research seeks to contribute. This research aims to provide some approaches for enhancing the experiences of nurse educators today and in the future.

This research begins with my own practice and over 25 years of experience in nursing education, which lead me to problematise the competing demands and power relationships in the social world of nursing education. Changing health care and nursing workforce demands have resulted in a complex nurse educator role. Critical readings of the literature identify the nurse educator role as someone who is expected to be an expert practitioner, a skilled educator, and involved in research knowledge generation or translation. For the nurse educator, there is a disjuncture as nurse working between the worlds of nursing and education.

Methodology draws on two writing modes as a deliberate strategy to traverse the complexity in nursing education work. Being flexible with some of the conventions of traditional scientific qualitative research presents an opportunity to theorise nursing education in a different manner and from a women's standpoint. The research design includes academic writing supported by reliable evidence in the form of a literature review and use of the literature to critique. The research also uses the power of the narrative writing genre to capture the complexities of the research question in context, and to bring it 'up close and personal' for the reader. This approach includes fictionalised narratives, based on the experiences of colleagues as interview participants, documenting the complexity of the social world of nursing education.

The literature and research narratives illustrate the complexity of the everyday work of the nurse educator. It is important to consider about how we 'think' about nursing, how we teach students to think and how we develop nursing education knowledge and academic reasoning. The nurse educator's practice should be positioned firmly on the middle ground between

nursing and education. Identity formation is crucial for the nurse educator in claiming their space. A collective voice will provide a shared focus for developing opportunities for both nurses and nurse educators as leaders in their practice. Mentorship and organisational culture needs to support social networks that build resilience and address inequalities in nursing education.

Valuing what nursing education has to offer as academic scholarship will enhance nursing education practice and provide the recognition needed to forge a positive career pathway. A legitimate career pathway is needed to promote academic scholarship. Authentic role models and leaders who represent the gender and cultural diversity in our society are needed. Building the workforce of indigenous nurse educators must be a priority for Aotearoa New Zealand.

Table of Contents

Table of Abbreviations

24/7	24 hours per day/7 days per week
AACN	American Association of Colleges of Nursing
AUT	Auckland University of Technology
AUTEC	Auckland University of Technology Ethics Committee
BN	Bachelor of Nursing
BSN	Bachelor of Science in Nursing
COVID 19	2019 novel Corona Virus Disease
DHB	District Health Board
DNP	Doctor of Nursing Practice
EBP	evidence based practice
ED	Emergency Department
FTE	Full-time equivalent
HR	Human resources
ICN	International Council of Nursing
ICT	Information Communication Technology
NCNZ	Nursing Council of New Zealand
NETS	Nurse Educators in the Tertiary Sector
NZIST	New Zealand Institute of Skills and Technology
NZNO	New Zealand Nurses Organisation
NZQA	New Zealand Qualifications Authority
OCN	Office of the Chief Nursing Officer
PBRF	Performance Based Research Fund
PhD	Doctor of Philosophy
TEC	Tertiary Education Commission
TEU	Tertiary Education Union
WHO	World Health Organization

Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the Acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed: *Date:* 28 May 2021

_____

Leanne Pool

Acknowledgements

This research thesis and journey represent a significant achievement in my work as a nurse educator. I write my acknowledgements with a desire to recognise and thank those who have guided, supported and contributed to this work. My first thanks are to the research participants, who have shared their stories and experiences with me, ensuring this research reflects the everyday work of nurse educators in Aotearoa New Zealand. I look forward to sharing the results with you.

To my primary supervisor, Associate Professor Georgina Stewart I offer a heart-felt thank you. You have introduced me to new ways of thinking and writing that have enabled me to undertake this research using a less conventional approach. Your wisdom, honest critique and patience were very welcome, pushing me out of my comfort zone to complete this work. To my secondary supervisor, Professor Eleanor Holroyd, thank you for providing a nursing lens through your feedback and critique. Thanks also to my proof-reader, who has provided support for final formatting and editing of this document.

To my employer, Whitireia New Zealand, I am grateful for the financial support I received for tuition fees and for the flexibility given in allowance of time for study and writing. For my nursing education colleagues, especially my Whitireia colleagues past and present, you are all part of my thesis work, in my stories, and my thinking about nursing education. I appreciate that some of you have taken on additional work and responsibilities in the times that I have needed to be away. You have granted me the time and space to do this work, and I would not have been able to get this far without your encouragement and support.

Final thanks to my family and friends who have shared this journey with me. I appreciate the words of encouragement and interest in my work that has been unfailing throughout this time. A special acknowledgement for my family in Canada - my parents, sister, brother and their families who are part of my story and have formed me into the person that I am. To my husband Bruce, and our children, Dan and Sarah, you have always had faith in me, and your love, support, and understanding about the commitment that this type of work requires has continued to motivate me and made this work an experience that I will always treasure. I am very proud to include an original piece of artwork, that my son Dan has created in response to my research findings.

Chapter 1: Introduction

The World Health Organization (WHO) designated 2020 as the Year of the Nurse and Midwife to recognise the significance of the disciplines of nursing and midwifery in relation to world health outcomes. For many years, a global shortage of nurses has been predicted and the International Council of Nursing (ICN) has been raising awareness of this issue. The ICN estimates up to 13 million nurses will be needed to fill the global shortage gap that has now been exacerbated by the global pandemic (ICN, 2021) Nursing education needs to be positioned to respond to the nursing workforce needs. The WHO commissioned a report on the *State of the World's Nursing* (2020) with a significant focus on the state of nursing education. Nurse educators have a considerable responsibility in preparing the nurse of the future who will influence future health outcomes. The nurse educator's role should be highly desirable in recognition of this contribution – so why is it not?

The *State of the World's Nursing* report identified one of the biggest challenges in nurse education to be the recruitment and retention of sufficient numbers of qualified nurse faculty. This shortage of nurse educators has a direct impact when addressing the global nursing workforce shortage. Lack of job satisfaction, poor salaries, high workload and lack of job security linked to the tenure process are key deterrents in for a career as a nurse educator in American university settings (Laurencelle et al., 2016). Challenging aspects of the role include: dealing with student failure, and the emotional impact of managing difficult situations; balancing multiple roles including teaching, scholarship and practice; lack of support; and the uncivil workplace relationships that are unfortunately common in such a stratified sector as medicine. Taken together, these unattractive aspects of the job impact negatively on the nurse educator's experience of the role (Gazza, 2009).

In Aotearoa New Zealand and globally, nurses are not choosing careers as nurse educators. Countries such as the United States have significant data signalling their nursing faculty shortage challenge including an ageing workforce with the potential implications in relation to workforce demands for nursing and nursing education (AACN, American Association of Colleges of Nursing, 2020). The Aotearoa New Zealand nursing leadership group identified this as an issue seven years ago without the support of any nationally collected data nor a nationally focussed workforce development strategy for this area (National Nursing Organisations, 2014). Heads of Nursing Schools, who are members of the Nurse Educators in the Tertiary Sector (NETS) group, regularly discuss issues with the recruitment of nurse educators, citing issues such as budget restraints that make it difficult to match the market value of nurses shifting from practice and

the additional requirements for the nurse educator to complete a higher qualification. Significant concerns are raised in relation to having a nurse educator workforce that matches the Aotearoa New Zealand population, with currently only a small number of Māori and Pacific nurses choosing a career in nursing education. The Nursing Council of New Zealand (NCNZ) register provides limited information about the current workforce. As of September 30, 2020, Aotearoa New Zealand has 60,098 nurses with a current annual practising certificate, of whom 4,585 (7.6%) identify as Māori and 2,271 (3.8%) as Pacific peoples. The NCNZ workforce report (2012) lists 28 different areas of nursing practice that are situated in district health boards, community and educational environments. The largest proportion of nurses are recorded as working in either surgical (12%) or medical (10%) settings. A very small proportion of registered nurses practice in nursing education (3.3%) or nursing research (0.8%), yet nursing education is the starting point for building the nursing workforce for the future. These figures would suggest that a very small number of registered nurses are working in the field of nursing education.

A further challenge is the ageing of the nursing workforce including the nursing education faculty. The latest workforce profile identifies the registered nursing workforce as being predominantly New Zealand European/Pākehā female, with 41% aged 50 years or older (NCNZ, 2012). There is no 'real' data on the workforce situation for the nurse educator and no plan for how the need for more nurse educators in Aotearoa will be addressed in response to the predicted nursing shortage. There is a need to recruit, develop, and retain the nurse educator workforce based on a sound understanding of the work of nurse educators, to which this research seeks to contribute.

This thesis focuses on understanding the everyday work of the nurse educator in Aotearoa New Zealand. The *State of the World's Nursing 2020* reports on the diversity in the educational preparation of nurses internationally and the lack of a shared focus for nursing education and for the role of the nurse educator. Changing health care and nursing workforce demands have resulted in a complex nurse educator role. The transition from experienced practitioner to novice teacher is well articulated in the literature. Yet the work of a nurse educator is not well understood beyond the transition and novice experience. Neither is the varied role of teacher in the contemporary tertiary setting in relation to teaching methods, pedagogy and identity as an academic. Understanding of the work of the nurse educator as academic is not well articulated and in Aotearoa New Zealand the role of the nurse educator as academic is in an emergent phase. A successful nurse educator is expected to be an expert practitioner, a skilled educator, and involved in research knowledge generation or translation. The nurse educator

needs to be able to evaluate and make links between educational outcomes and patient care quality in a rapidly changing and often stressful environment (National League of Nursing, 2013).

A high-level definition of the work of the nurse educator is presented in the following two sections that outline first the principles of nursing, then the principles of nursing education.

Principles of nursing practice

Nursing work can be described in many different ways. The ICN defines nursing as work that

> encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles. (ICN, 2002 , para 1)

In Aotearoa New Zealand, the NCNZ defines nursing as practice that uses:

> nursing knowledge in a direct relationship with clients; or working in nursing management, nursing administration, nursing education, nursing research, nursing professional advice or nursing policy development roles, which impact on public safety (NCNZ, 2016, p. 34).

My research seeks to understand nursing work as it relates to teaching nursing, so a high-level definition focuses on understanding how nursing is practiced by presenting a model developed by Hesook Suzie Kim (2015), based on her experience of over 30 years as a nurse academic. Her analytic model of nursing practice is based on a threefold philosophy of **therapy**, **professional work** and **care** (Kim, 2015, p. 70). The principles relating to each of these three aspects, taken together, provide an explanation of how nursing is practiced.

Nursing philosophy of therapy: Nursing is described as relationships with people with a focus on health concerns. These health concerns are never viewed independently of the person and are 'treated' in the context of the person experiencing them. Nursing practice often facilitates or enhances the therapeutics or treatment in which the person is engaged. Principles that support the nursing philosophy of therapy are: **effectiveness**, **efficiency**, **individualisation** and **openness to choose** (Kim, 2015, pp. 74-76).

- **Effectiveness** is measured not only by the therapeutic outcomes of nursing actions in relation to the health concern but, more critically, also in terms of the person as a whole.
- **Efficiency** focuses on the processes of nursing actions, and considers the use of resources, including time, and procedural requirements for actions.
- **Individualisation** of therapy is important so that actions are individual-specific rather than technical or mechanistic. This ensures the fitness of therapeutic choices and actions for individual clients.
- The principle of **openness to choose** allows personal preferences to be considered and connects to the perspective of nursing practice as person-centred.

Nursing philosophy of professional work: The structure of nursing practice is configured on its service to people, and its service as professional work, both as core aspects of nursing responsibilities. Professional practice is a form of human action enhanced by human agents who reflect their desires and values and are committed to acting normatively, and ethically in a professional context. Professional nursing work is delineated in relation to the nurse's responsibilities within the institutions of practice, their own nursing practice and in relation to others involved in health care. Professional work involves carrying out responsibilities assigned to the role in specific institutional contexts and is specified by the scope of practice and the type of service this practice has to render. The nursing scope of practice is guided by a set of standards established by the profession itself, as well as social and legal mandates that frame the profession's practice. The NCNZ has authority for setting standards for the registered nurse scope of practice, and the education programmes that lead to registration.

The philosophy of professional work is guided by three principles: **distributive justice**, **competence** and **collaboration** (Kim, 2015, pp. 76-78).

- **Distributive justice** refers to nurses' responsibilities as required by their institutions of health care. Distributive justice involves accountability, prioritisation and selective attention for each and all clients, based on vulnerability and contextual needs.
- **Competence** refers to the requirement for quality of practice both in relation to processes and outcomes. Competency is defined as the behaviour that all nurses must demonstrate and incorporates knowledge, skills and caring into nursing practice (Finkelman, 2019). The goal is for excellence, which is achieved through gains in competence by means of education, experience and reflection.

- The principle of **collaboration** is a critical component of professional work that is needed to coordinate health care for people. Collaboration is based on mutual understanding, sharing, and complementarity, and is made possible through communicative action.

Nursing philosophy of care: includes four principles: **individuality**, **autonomy**, **human integrity** and **human flourishing** (Kim, 2015, pp. 71-73).

- With respect to **individuality**, the nurse focuses on caring actions to gain a deep understanding of the individual with appreciation for the meaning and uniqueness of individuality for persons in health care situations.
- With respect to **autonomy**, nursing practice is based on genuine trust and respect for the individual's capacity for self-determination. This position seeks to correct the power imbalance between the nurse and person, and upholding autonomy means the emancipation of people as well as nurses from power domination.
- Caring is oriented to preserving **human integrity** by maintaining personhood no matter how different or similar the person is from others.
- Caring with respect to **human flourishing** emphasises the nursing responsibility for helping people have better lives with a holistic focus on attending to the person.

Upholding the philosophy of care guides nursing practice to be humane, person-centred, emancipatory and holistic through integration of these four principles.

Taken together, the 11 principles set out above underline the importance of the nurse as a person needing skills and qualities that are linked to forming meaningful relationships. The forming of the person-centred partnership requires both the person and the nurse to develop trust and mutual respect, and to work together to ensure an effective exchange of their relevant knowledge and expertise (Harding et al., 2015).

Principles of nursing education practice

Being able to teach and becoming an academic engaged in research and higher learning are not generally part of the nurse's previous experience and therefore cannot be carried over into the role of the nurse educator. There is a distinct lack of clarity about the professional identity of the nurse teacher/educator (Woods et al., 2016) reflecting role conflict and ambiguity between the disciplines of nursing and teaching (Baldwin et al., 2014; Carr, 2007; Udlis & Mancuso, 2015) and signalling a need to support people to transition from the nurse clinician into the nurse teacher role (Andrew et al., 2009; Boyd & Lawley, 2009; Feldman et al., 2015; Monson, 2014).

The personal qualities of the teacher, their beliefs, and their interpersonal teaching behaviours together form aspects of the teacher's biography that influence how they approach the teaching (Britzman, 2003). It is unclear in the literature, however, how clinical practice experience, professional identity as a nurse and personal biography enables or support the work of the nurse educator.

The principles of how nursing education is practiced are much less well-defined or understood in comparison to the above overview of the principles of nursing practice. The terms educator and teacher are used interchangeably in accordance with the historical context of the literature. Nursing education straddles both a practice discipline and an academic discipline. The principles of nursing are expected to be carried into nursing education. Educators in the tertiary sector become dual professionals: they have expertise in a discipline area and they are teachers (Suddaby, 2019). As the landscapes of practice have become more complex and varied, the nurse educator needs a range of types of knowledge and actions to match the practice environment (Doane & Brown, 2011). The work of the nurse educator is complex in that it requires the nurse to bring together their clinical knowledge, skills and experiences into a contemporary learning environment.

The WHO (2016) names eight domains of practice, each with core competencies, for the work of the nurse educator. Each domain is further categorised with knowledge, skills and attitudes related to learning and teaching. The core competencies highlight the complexity of the role of nurse educator, requiring expertise in teaching and learning, nursing practice, research and providing leadership, to ensure quality and professionalism in developing the nurse of the future. The competencies were developed through a global consensus process and are intended to: help guide the educational preparation of nurse teachers; ensure educational quality and accountability; and, ultimately, contribute to improving the provision of nursing care and outcomes of health services (WHO, 2016, p. 7). The requirements for acquiring the title of nurse educator include having completed a recognised nursing qualification and currently being registered as a nurse. The role also requires recent clinical experience and the completion of a tertiary teaching qualification, either before or soon after employment as an educator.

The AACN (2018) labels the work of the nurse educator as 'scholarship in nursing' by which is meant "the generation, synthesis, translation, application, and dissemination of knowledge that aims to improve health and transform health care" (p. 2). This definition was developed based on Boyer's (1990) principles of scholarship being inclusive of discovery, practice and teaching. Threaded through these three principles is an emphasis on the integration of scholarship across

research, practice, health policy and/or education to advance the practice of nursing and improve health outcomes (AACN, 2018, pp. 2-3).

Scholarship of discovery is largely based on the paradigm of scientific inquiry resulting in new knowledge or expansion of knowledge that is translatable to practice.

Scholarship of practice is aimed at bridging the theory-to-practice gap by applying and integrating evidence to and from practice.

Scholarship of teaching focuses on the transmission, transformation and extension of knowledge through teaching and learning.

The broad definition of scholarship was developed to support the academic contribution of nursing scholars in the American health and education context. The guidelines presented are proposed to support career advancement for academic nursing which generally requires a doctoral level of academic preparation.

In Aotearoa New Zealand, registered nurses working in the tertiary education sector are understood to be practicing nursing within the field of nursing education. The nurse educator needs to meet all NCNZ (2016) competencies under Domain One: Professional Responsibility and Domain Four: Interprofessional Health Care and Quality Improvement. For Domain Two: Management of Nursing Care and Domain Three: Interpersonal Relationships, three different competencies specific to a nurse educator's practice must be met:

1. The nurse educator must demonstrate how they contribute to the management of care through supporting learning for student nurses developing competency and evaluating competency of safe practice.
2. The competent nurse educator must integrate evidence-based theory and best practice into education activities and must keep abreast of current trends and issues in nursing.
3. In meeting competencies for interpersonal relationships, the nurse educator must establish and maintain effective interpersonal relationships with others and communicate effectively with members of the health care team.

(NCNZ,2016, p. 23.28)

The NCNZ (2015) education standards for undergraduate nursing programmes match the WHO (2016) global requirements that nurse educators have a postgraduate qualification, preferably

a master's degree, as well as a teaching qualification. These requirements suggest that experience in higher education and teaching is also valued in nursing education.

The principles of nursing education practice presented by the WHO, the ACCN, the NCNZ and the wider literature highlight the disjuncture in understanding the everyday work of the nurse educator. The complexity of work as a clinician, teacher and academic is evident in the WHO and ACCN principles but the work of the nurse academic is absent in the NCNZ description of the nurse educator. The language and concepts in each definition are built on principles largely from a scientific paradigm of practice. The nurse educator's work is vital to shaping the future nursing workforce. It is unclear how the nurse educator's work is informed by the principles of nursing practice and how the nurse educator should undertake this complex work of forming the nurse of the future.

The research question and rationale

The disjuncture in understanding how the nurse educator should practice leads to my research question, which seeks to understand how the nurse educator works, and what this work does in relation to nursing education. The question investigated in this thesis is:

How do nurse educators in Aotearoa New Zealand form their identity and navigate the competing demands of their roles in bachelor degree nursing education?

The aim of this research is to investigate the work of the nurse educator in supporting the professional formation of nurses within the social world of nursing education. For the purposes of this study, a 'nurse educator' is defined as a registered nurse who teaches on an undergraduate, i.e., bachelor's degree nursing programme, in a tertiary institution. Undergraduate nursing education in Aotearoa New Zealand involves three years of full-time study in a tertiary institution, either a polytechnic or university, to complete a Bachelor of Nursing degree. After completing this qualification and being deemed 'fit for practice', the graduate nurse is eligible to sit the NCNZ state final examination to become a registered nurse.

Researcher positionality

I undertake this project as an insider-researcher since I have over 25 years of experience as a nurse educator and have been a registered nurse for more than 30 years. Most of my nursing career has been spent in nursing education, fuelled by my passion for nursing as a career choice, and my desire to support the professional formation of nurses and, more recently, nurse educators. As an insider-researcher, I mine my own practice in both nursing and education for

data through critically reflecting on my experiences as a learner, nurse, teacher, and researcher/academic.

This research begins with my own practice and experiences in nursing education which lead me to problematise the competing demands and power relationships in the social world of nursing education (see Chapter 5, below). It might be assumed that, with over 25 years of experience in the world of nursing education, I should have a clear position in this world, but it is this lack of clarity that leads me to this inquiry. I come to this research with knowledge about nursing and nursing education that has grown and developed throughout my career. With a duration of nursing experience that has spanned over 30 years and two countries, the context of nursing and nursing education has transformed my knowledge and experiences as a nurse educator. I come to this research as an individual, a woman, a mother, a professional nurse, a child health nurse, a nurse educator, an academic leader, a learner, and a researcher. My research aims to provide some approaches for enhancing the experiences of nurse educators today and in the future. It may also assist in better understanding analogous tertiary educator roles in other human-centred professions.

My research engages with my colleagues as interview participants to create an understanding of the complexity of the social world of nursing education and to contribute to a social and educational vision to direct practice in this area. My approach to inquiry encourages a focus on the nurse educator's everyday experiences in constructing methods of thinking. The purpose of this approach is to explicate the actual social relations in which the lives of the nurse educators are embedded and make these visible to themselves and others. An inquirer is situated in the actualities of their own living, in relation to others as they are (Smith, 1996). This approach seeks to disrupt the ruling relations by taking the everyday world as its problematic and making the ruling relations knowable.

My experience as a nurse and an educator, and my knowledge of the world of nursing education, are a starting point for investigating the research problematic. The term problematic refers to the tensions, contradictions and problems that arise between people and the world they inhabit, influenced by the ways societies are organised and governed (Ng et al., 2017). The research problematic is the tension that motivates the research question stated above. The nature and causes of the problematic are uncovered through documenting my own and others' experiences of working in nursing education, in combination with exploring the evidence available in professional and institutional documentation and research literature. My experience of the field suggests there is a disjuncture within the everyday world of nursing education, and this idea

forms my research problematic and motivates this thesis study. The word 'disjuncture' here refers to the disconnection and separation between the insider experience and the authoritative practices linked to these experiences (Ng et al., 2017).

For the nurse educator, there is a disjuncture as nurse working between the worlds of nursing and education. Using a qualitative research approach informed by postmodern ideas offers the opportunity to gain an understanding that goes beyond what traditional research methods might produce. This approach is based on the belief that people and events are connected in ways that are understood by concepts such as power, knowledge, policy and culture. Examining how these concepts link and connect is critical to understanding the complexity of the social world of nursing education. Bringing consciousness to these relationships creates the possibility of making meaningful change. The capacity to coordinate consciousnesses, to learn to see the world in new ways, makes critical knowledge of the social world possible (Smith, 1987).

Thesis structure and chapter overview

This chapter has introduced the reader to the research topic in context, the researcher, and the research question. It is worth noting that the remaining chapters do *not* follow the normative structuring of a conventional nursing research thesis, which mimics the theoretical principles and checklists of scientific practices (Grant, 2016). The reader may therefore be confronted by what is presented, and what is absent, in what follows. The chapters are written using two major styles or genres, and alternate between the two, in a deliberate writing strategy to disrupt the conventions of qualitative nursing/educational research. Metaphors used for such bi-modal research include to look through two lenses or to walk in two worlds to illustrate the complex aspects of practice in new ways (Richardson & St. Pierre, 2018). The use of two modes of writing, the 'literature review' mode and the 'narrative' mode of writing, equips this small research project to explore this complex topic more adequately than would be possible with a conventional interview research project.

The **literature review mode** of writing aligns with the knowledge criteria of science, in presenting logical arguments supported by reliable evidence. Critical readings of relevant sources assembled for the purposes of this research allow me to investigate my question as far as possible through the extant literature.

The **narrative mode** of writing allows me to combine and recombine experiential data gathered both from my own experiences and from those of others, collected through interviews. Ethnographic fiction (Bruce, 2014) is one label for this method, using the techniques of creative

writing, for processing empirical experiential data, including autoethnographic and interview data, into research narratives (described in detail on the section starting on page 34 below) that capture complex scenarios in a readable, memorable way.

The overall arc of the thesis is as follows:

Chapters 1-3 ground the study, with Chapter 1 providing a contextual introduction to the topic, question and researcher, Chapter 2 a theoretical framework, and Chapter 3 an account of research methodology. To diverge (however slightly) from 'scientific' research conventions makes it more important to first explicate the theoretical underpinnings of the study. Chapter 2 presents a synoptic framework, based on the sociology of Dorothy Smith (1999), used in this thesis for thinking about nursing, nursing education, and nursing education research.

Chapters 4-6 present data from the three main sources, self, literature and interviews. Chapter 4 narrates my own life journey to becoming a nurse educator. Chapter 5 presents synoptic accounts from the literature, that build up an investigation of the research question using extant professional and research texts. Chapter 6 presents research narratives written by fictionalising the combined interview data.

Chapters 7-8 synthesise, analyse, and critique these data in relation to the research question; Chapter 9 summatively responds to the research question; and Chapter 10 concludes with a summary of the key findings of the research, a discussion of its limitations, recommendations and some final thoughts about the significance of this research and the future.

Chapter 2: Theoretical Framework

Nursing education is an important component of nursing practice, alongside nursing traditions and nursing knowledge (Kim, 2015, p. 1). Traditions in nursing education link back to the pioneering work of Florence Nightingale, who first articulated a formulation for the role of the nurse as having "charge of the personal health of somebody", saying that what nursing has to do "is to put the patient in the best condition for nature to act upon them" (Nightingale, 1860, p. 75). Nightingale is recognised as the first nurse teacher, insisting that nurses receive formal training, and the first nurse researcher, who collected health care data from her nursing experience in the Crimean War. She developed nursing education pedagogy de novo, and modelled nursing practice to novices who sought a career in nursing. Aspects of nursing scholarship attributed to Nightingale's work include the development of the first standards of care, and the publication of the first nursing textbook, *Notes on Nursing* (Nightingale, 1860).

Nursing education has developed as women's work from the traditions of Nightingale with the nurse educator situated in the fields of health and education. Nursing education is a product of cultural and societal changes across the fields of health care, science and technology, and other professions (Kim, 2015). Nursing is caught in a complex web of power bases and binaries that need to be examined and understood. The complexity of this web means there is no simple way to understand the different forms of knowledge and social relationships that occur in the world of nursing education.

In this thesis, I am adopting and following the theoretical framework outlined by Dorothy Smith (1999) in her key book *Writing the Social* to help me in understanding, investigating and articulating the nature of the work of the nurse educator in Aotearoa New Zealand. Dorothy Smith is a contemporary Canadian feminist sociologist whose substantial oeuvre is considered revolutionary and important in bringing about, in recent decades, more adequate research into and understanding of the lives of women and other non-elite groups in society (see Smith, 1987, 1992, 1996, 1999, 2003)

This chapter presents a synopsis of Smith's theoretical framework, and how it relates to my research project, under the same three headings as her book, namely *Critique, Theory, and Investigations*. The first section serves to acknowledge the 'big picture' and make clear why it is necessary to adopt a critical form of theory. The second section surveys some of the key theoretical concepts arising from critique that are useful for understanding and investigating

nursing practice and nursing education. The third section examines how these theoretical concepts and frameworks can be used to inform my research methodology.

Critique: An alternative sociology to understand women's work

Smith's alternative sociology aims to explain the social and society as it enters and shapes people's lives and activities. Critique begins with the actualities of people's lives. People's everyday/everynight experiences are as various as people are. The aim is not to explain people's behaviour but to be able to explain the socially organised powers that are embedded in their everyday lives and activities. Smith's approach focused on understanding the work of women in their everyday/everynight world. Smith recognised the need to critique the gender relations, power and forces that organise and shape their work in the world. Critique must examine the embodiment of women's experiences while attending to the primary materiality of the text. This approach involves engaging in reflexive examination and critique of both what we know how to do, and what we do.

Patriarchy and capitalism

Understanding the influence of capitalism and patriarchy on everyday life in contemporary Western societies is a starting point for recognising the gendered organisation of text, language and technology and the effects of these on social relationships. According to Marx's critique of capitalist Western European society, people are organised and depend on one another based on their work. Money and commodities gained through work create material states and structures of privilege and oppression. Production in society is governed by capital accumulation so those who earn may buy the commodities on which others subsist. These structures create a class system based on economic capital value.

Patriarchy developed as part of capitalism, with men's work being privileged due to being linked to business and production. Dominant images of how capitalist society operates still considers men as engaged in intellectual work, and given preference in studying subjects such as philosophy, mathematics and science. Women are considered most suited to engaging in 'people work' and 'body work' that involves caring and serving based on female biological differences including the ability to give birth. Women and those whose work is not linked to business are oppressed in terms of their ability to make economic contributions in a capitalist society. This positions women in work that functions at the lower level of control in the world with men functioning as subjects in charge of governing and decision making.

The position of power that men have in governing and decision-making influences the way that knowledge is created, and culture is formed. The biases of men's perspectives infiltrate all ways of thinking, including in health and education. Men's domination in education influences the way processes were developed to produce knowledge, thoughts and values. Power and authority in the educational process are the prerogative of men. Women in education are largely represented in roles with lesser status and authority, focusing on the practical aspects of education, including classroom teaching. The exclusion of women from positions of influence in the discipline of education has resulted in them being absent in contributing to the theorisation of education.

Smith's understanding of male gender domination and power in academia arose from her experiences as a female academic. She was drawn towards the women's movement that dissented from the ruling relations of patriarchy. Feminism and the women's movement raised awareness of the hidden boundaries, exclusion and positioning that were evident in texts and practice, based on class, gender and racial subtexts arising from the ruling relations of men**.** Academics, as part of the women's movement, were antagonistic to the implied superiority of knowledge derived from the institutional patriarchal dominance of the academy. Women were challenged towards thinking and theories originating outside academic discourse with bases of knowing grounded in experiences of the 'other' and beyond their own. Smith described her own response to working in the world as both woman and academic using the metaphor of dual consciousness. This idea represented her struggles in seeking to be knowledgeable and competent in two different worlds – as both mother and academic. Smith's research aimed to enable female academics to coordinate such dual consciousness, to learn to see the world in ways that make critical knowledge of both worlds possible.

Smith and her colleagues discovered that even with the development of women's studies and feminist theorising, as academics they were still bound by the patriarchally influenced institutional boundaries. As feminism itself became professionalised and as such sets up its own ruling relations, as an institution this movement still marginalised or oppressed certain perspectives**.** This recognition led to understanding the importance of positioning. In particular, the perspectives and privileging of white heterosexual middle-class women was acknowledged as being different from working-class, lesbian, non-white women. A feminist approach was needed to explore and work with differences in a way that does not rely on essential notions and categories of difference (such as race, class, gender, sexual orientation, and age). This approach recognises the complexities of multiple, competing, fluid, and intersecting identities.

Smith's work presents a new way of understanding a contemporary capitalist society that is no longer simply class-based. Patriarchy does not exist purely based on gender but is textually grounded in the ruling relationships formed by the domination of Western European culture values. Knowledge, practices of thinking and theorising, and images of the world are textually grounded through categories such as skill, occupation or industry. Smith's position acknowledges the ruling relations in society that have mediated how these categories are understood. She became an early adopter of the feminist standpoint perspective that stresses the necessity of starting research from women's lives. Feminist standpoint pays particular attention to finding and analysing the gaps that occur when women try to fit their lives into the dominant culture's way of conceptualising women's situation. Smith's views fit within the critical philosophical traditions, including postmodernism.

A postmodernist influence

Smith's postmodernist lens questions the belief that there is one form of knowledge or 'truth' that can tell us how to act in the world in a way that is of benefit to us. An affirmative postmodernist approach is adopted that acknowledges feelings, personal experience and empathy as inherent within all forms of knowledge (Mann & Kelley, 1997). 'Writing as a method of inquiry' develops a form of analysis that is open-ended and reflexive building on the theoretical basis of discourse and language(Richardson & St. Pierre, 2018, p. 819).

Situating nursing in the scientific world

Nursing practice has changed greatly and evolved since its origins associated with Nightingale, but it remains focused on people's health and illness and retains its service and person orientation (Finkelman, 2019). These two aspects of nursing practice are often referred to as the 'science' and 'art' of nursing, each with its own knowledge base: medical science on the one hand, and the authentic care base on the other. Nursing is part of the larger social system traditionally known as medicine but is now considered part of the wider health care system.

Both nursing and medicine are rooted in scientific knowledge. Since the 19th century, modern medical knowledge has been acquired largely through scientific methods. These methods have been described as the medical practitioner's rationale objective scientific gaze (De Sio & Fangerau, 2019). Science provides medicine with a systematic organisation of knowledge about the 'natural world' and its component parts and phenomena. Scientific knowledge is based on principles that verify actions or results. Scientific methods and theories have been developed based on the testing of hypotheses enabling predictive results (National Academy of Sciences,

1992). The philosophies of empiricism and positivism have been key influences in the development of modern scientific disciplinary knowledge. Empiricism emphasises evidence, especially as discovered through testing hypotheses in experimentation. Positivism understands knowledge as being formed based on natural occurrences that can be interpreted through reason and logic. The practice of science has become professionalised and institutionalised as part of Western European society.

Privileging of scientific knowledge as part of nursing knowledge development

Nursing education and research practices have been dominated by scientific philosophy, systems and principles that determine how knowledge is developed and understood. Nursing research practices have been colonised by scientific research paradigms that have resulted in the development of structures that exclude alternative forms of knowledge (Holmes et al., 2006). Early nurse educators, including Nightingale, recognised the value of establishing the profession of nursing based on both scientific and non-scientific knowledge. The initial formation of a nursing science knowledge was based on Nightingale's theory and practice concerning the importance of household hygiene in the prevention of the spread of disease. The use of empirical scientific knowledge was key for Nightingale's establishment of the practice of nursing. She recognised the need to use scientific knowledge to develop nursing education practice through theory development and research.

It is essential that nursing education includes a basis in scientific disciplinary knowledge that deals with the human body and its functions, including biology, chemistry and physics, and the derivative disciplines of medical science such as physiology, anatomy, and pharmacology. For many decades, scientific research in health has sought to identify both physiological and psychological behavioural responses, to help determine the range of normal variations of health, using scientific methods such as direct observation and inspection (Kim, 2015). Reliance on the scientific approach to generate knowledge in nursing is inadequate, however, for dealing with patients as individual human beings. The complexity of the discipline of nursing in the evolving health care environment necessitates nursing knowledge and nursing practice that is informed by both scientific problem solving and human practice orientation.

The work of the nurse educator as diverse knowledge developer therefore needs to incorporate both the scientific and other ways of knowing that operating in the field of human practice requires. Nursing education practice must include multiple ways of knowing, differing discourses and diversity of values, in a manner that honours ambiguity and uncertainty (Stajduhar et al.,

2001). The continued privileging of scientific knowledge creates structures and social relationships that impede the nurse educator's ability to work in this manner. This impedance can be further understood by considering in more detail how the privileging of men's work operates in medical science and academic practice.

The workforce of nursing education is predominantly female (90%) (WHO, 2020). This gendered positioning may be traced back to Nightingale as the first female nurse – a position that was developed to work alongside the (assumed) male position of doctor. In the Western European medical tradition, the scientific work of doctors was considered to be men's work, with the less scientific work of nursing more fittingly undertaken by women. The primary qualifications of medical practitioners (doctors) centre on mastery of highly specialised and technical medical sub-disciplines based on scientific knowledge. The work of nurses, which includes close attention and responsiveness to the person who is the subject (or recipient) of medical procedures and health care, requires a different mix or balance between scientific knowledge and human instinct, known as the art of nursing. Nursing work, as structured by patriarchy as women's work, is appraised with a lesser economic capital contribution based on the emotional and relational aspects of practical work (Apesoa-Varano, 2007).

Many aspects of these two roles can be linked to gendered hierarchical structures formed by the privileging of scientific knowledge and the structures of patriarchy. These structures have created a gendered power relationship that has been described as the doctor–nurse game (Holyoake, 2011). The theory of the doctor–nurse game was proposed by Leonard Stein in 1967 to discuss the relationship between these two health/medical professions as it plays out in everyday practice. The relationship is described as a 'game' because the nurse takes on a subservient role in the presence of the doctor, while taking on a more authoritative role when the doctor is not present. Examples of this game include the nurse standing for the doctor when they enter the ward, the nurse walking behind the doctor on patient rounds, and the nurse remaining silent when the doctor is speaking with the patient. Once the doctor leaves the ward, the nurse resumes authority. The doctor also participates in this game, acknowledging the nurse's authority in the background in running the ward, but outwardly presenting as the decision-maker, especially in front of the patient.

This doctor–nurse game is another term for the habitus that portrays the doctor as the male authority figure with nursing identity equated with the female image of helping and seeking approval from the doctor. The concept of habitus is discussed in more detail in the next section on theoretical concepts. The doctor assumes the patriarchal figure: the female nurse is

conceptualised as the male doctor's handmaiden. These images of doctors and nurses are learned from a very young age through the public images that are prolific in all forms of media. The media portrays stereotypical images of nurses as angels of mercy, the doctor's handmaiden, battle-axe, and sex symbol, all images that suggest a subservient gendered role (ten Hoeve et al., 2014). Nursing's social value is defined by its social contributions through service and relationships with others rather than by empirical scientific truths. Nursing practice in Aotearoa New Zealand has been formed based on Western European worldviews brought by colonisers who settled here in the middle of the 19th century. The impact of these gendered and cultural stereotypes in relation to how nurse educators work needs to be addressed.

Patriarchy and the female academic

The domination of patriarchal structures in academia creates a power differential that marginalises women as academics, even when they form a majority of the workforce, as is the case with nursing. With men as a minority of the workforce in nursing education, it is likely that they are also impacted by the oppression of engaging in women's work. The privileging of scientific knowledge and the privileging of men in academia and medical practice have contributed to a gendered organisation of texts, language and technology that together form the relations of ruling in nursing education. The structures formed by capitalism and patriarchy impact on these relations and the positioning of the nurse educator.

Feminist standpoint in nursing education

A feminist standpoint approach is needed to understand the everyday work of the nurse educator. This approach needs to account for the complexities of multiple, competing, fluid, and intersecting gendered and cultural identities in nursing education practice. Focusing on the standpoint of women in nursing education allows a move away from patriarchal and objective ways of knowing that have arisen from capitalism. A women's standpoint problematises nurse educators' diverse situations as mainly female academics, while attending to the gendered institutions of nursing and education, and the material and historical structures that frame this work.

Theory: Concepts for understanding nursing education practice

This section presents a set of theoretical concepts that derive from the traditions of critique and critical theory outlined in the previous section. The theoretical concepts that are used in my research are mainly based on Smith's method of inquiry for understanding social relations from

a women's standpoint (Smith, 1992, 1999). Taking a feminist postmodernist view, Smith presented an understanding of knowledge and language as it is formed through social relations and social action. From this understanding, Smith built on the concept of discourse and standpoint to explain how people interact and how power relations are structured. Concepts from Bourdieu's theory of practice work together with Smith's emphasis on discourse, social relations and power. The concepts of material artefacts and archetypes are used to understand some of the unique cultural features of nursing education.

The theoretical principles framing Smith's approach can be summarised as follows (Smith, 1992, pp. 92-93):

- The subject/knower is situated within the actualities of their own living, in relationship with others.
- The social is understood as the actual practices of actual individuals and the coordination of activities.
- The standpoint of women locates the subject in both theory and practice by locating them in the lived world. Discourse, concepts, beliefs, and knowledge all happen as ongoing practices and are integral to the coordination of people's everyday lives.
- Inquiry and knowledge are forms of social organisation as ruling relations.
- Texts and text mediation are fundamental in forming and creating meanings. Text is a material object with a fixed form of meaning in actual contexts. This meaning can be read in other settings by other people at the same time or different times. The writing, the text, the reading are always ongoing and in the actual practices and activities.
- Text-mediated relations are forms of power, generated and held in contemporary societies.
- Relations of ruling through the materiality of text can be seen to create language, thought, culture, and organisational structures that can become objects of action or investigation within the text.

Knowledge, language, and objects

People are individuated subjects that imprint their own prejudices and interests on concepts, explanations and theories (Smith, 1999). Objects become what they are based on what people do with them and where, when and by whom they are used. Objects organise people's activities in terms of what it is possible to do with them. Naming produces the object as it is known by participants (Smith, 1999). For example, a nurse's watch is named as an object based on its use

in counting the radial pulse of a patient for whom the nurse is caring. Having a large face that is easily visible; being able to be pinned to the nurse's uniform; and having a second hand are features of a nurse's watch based on its specific use.

Referring is the action that we take to make sense of what we are experiencing and to bring consciousness(es) to it. Referring is based on our own perceptions and 'known in common' language use (Smith, 1999, p. 128). It provides us with a set of instructions to recognise how the object fits in a particular category of knowledge. We imprint our own perceptions and interpretations on concepts and theories based on our own interests, values, and beliefs. The nurse educator comes to their work with perceptions and interpretations that have developed based on their interactions with the multiple forms of knowledge and language that become 'known in common' in nursing practice.

Through referring and perceptions, knowledge can become constructed as norms. Norms are understood as cultural forces that regulate and control our human notions, identity and behaviours (Martinsson & Reimers, 2010). Norms are associated with different feelings and actions and can possess the power to dominate or exclude (Butler, 1993). All aspects of our everyday activities provide opportunities for norm construction and norm critique that is expressed through language. Norms in nursing education are built on the structures and relationships formed by capitalism and patriarchy. These norms have regulated nursing work as women's work and created an identity of the nurse and nurse educator as a white middle-class woman. The behaviours expected of a nurse are associated with service and caring in a subservient position in the health care system.

Materiality of texts: Artifacts and archetypes in nursing

Language is part of historical-material reality that is textual, auditory, electronic and so on (Smith, 1999). Nursing language can be traced to its military and religious roots including terms such as 'doctor's orders' and 'front-line' workers and titles such as Matron and Sister. Military language such as working to a plan, being organised, managing basic skills, being on time, being 'in charge' is known in the common language used in the everyday work of the nurse. This language is also dominant throughout the contemporary business world including professions and disciplines such as nursing education.

Artefacts and archetypes have been produced based on the materiality of text, a relationship recognised in recent traditions of 'new materialisms' (Coole & Frost, 2010, p. 4). The concept of the artefact describes something characteristic that can arise from a period in time. The concept

of the archetype is used to describe a set of characteristics that together form a recognisable identity or image. The stories and images of the nursing profession have been based on the archetype of Florence Nightingale, with both military and religious aspects of the role still evident in the language and image of nursing today. Historical images of nurses portray links to either religious service, resembling nuns with veils and white flowing garments, or in military service, including starched uniforms complete with peaked caps and medals to signify rank and status. The nursing medal is an artefact with a military origin proudly worn by Aotearoa nurses to signify the status of the NZ registered nurse. The nurse's watch is another example of an artefact that has been produced through the materiality of text.

The contemporary archetype of 'nurse' is portrayed as Western European, female, subservient, in uniform, and working in a hospital environment. The language used to describe nursing work is typically feminine and service orientated, such as kind, caring, compassionate, nurturing or helpful, and family-oriented. Men in nursing are often portrayed in technical roles, such as in emergency or intensive care practice, more similar to the medical work of doctors. A superhero archetype of the nurse as 'front line' worker has been produced during the global pandemic of 2020 with the image of nurses wearing personal protective equipment (PPE) including gowns, masks and gloves. Cartoon depictions had these same nurses wearing a superhero cape with their mask.

Education practice produces different realities and language. A graduation ceremony showcases the artefacts of the academy. The flowing black gowns, strange headwear, and colourful silks of regalia signify the discipline and status of the academic. The regalia has strong historical and cultural origins that have been maintained in graduation ceremonies today. The everyday archetype of an academic may no longer be wearing the black robe and mortar board. Instead, a 'professor' may be portrayed as someone who dresses conservatively, wears glasses, and spends time surrounded by books or in front of a computer screen. An archetype of the nurse educator as academic may be less established but could be produced from combinations of textual media representations of nurses and women in academia, who have traditionally been in subservient roles working under the supervision of men in management and higher academic roles.

Taking a postmodern view, truth is never contained in the text or language, but arises through dialogue and recognising what the text itself is, as a product in the world (Smith, 1999). This approach proposes that there is not one way in which these concepts or categories can function; and there is no exact and reproducible correspondence between text and object. The nurse

educator does not need to be defined by these artefacts and archetypes. Dialogical interactions offer the opportunity to appreciate varied versions of the world from multiple positions.

Dialogue, discourse and field

Dialogical interactions of people and objects through language constitute social relations. Social relations are the actual practices and activities through which people's lives are socially organised (Smith, 1999). Through these practices and activities, we establish shared realities that can be understood as discourse. Discourse has its own distinctive set of rules or procedures that govern the production of what is to count as meaningful or truthful. Discourse is always contextual and rule dependent. In understanding discourse, we acknowledge both what the discourse articulates and what the discourse produces (Hook, 2001). Discourse constitutes societal and cultural representations of the world constructed through social relations between people and people's social and personal identities. Therefore, it is not possible to create a unified system of knowledge for understanding the social world and society. Discourse becomes a way of analysing social relations without destination or conclusion; instead, theory builds as it goes on (Smith, 1999).

Discourse is evident through the complexity of social relations in the everyday work of the nurse educator. Interactions with multiple forms of knowledge, language and text that govern the worlds of nursing and education need to be understood. Bourdieu's concept of **field** represents the networks and configurations of relationships between structured interactions and positions (Houston, 2002). Bourdieu refers to the field as the battleground on which a game takes place between domination and subordination. In the game, the curators of culture are those with the power and the creators of culture are those seeking power, struggling for strategic advantage (Houston, 2002).

In nursing and education, fields are shaped by global and national historical and gendered practices stemming from the structures of patriarchy and capitalism. In nursing and education, social relations occur in specific fields including the delivery of nursing, academic settings, allied to other health professions in a variety of industry-based practise sites, and within governing or regulatory bodies such as the NCNZ and the New Zealand Qualifications Authority (NZQA). The effects of the fields shape a professional view of the world, and one that in turn is viewed by the world, as a sensor to allow or disallow different ideas (Houston, 2002). Successful navigation in the fields is based on learning to play the game and understanding the power relationships.

Text-mediated relations and power

Structures of power and authority produced through textually mediated relationships are politically, socially and historically situated (Butcher, 2017). These relationships can be examined using Bourdieu's concepts of **capital** and **agency.** Bourdieu claims that all social phenomena exist beyond the lives of the individual actors who construct them (Houston, 2002). Actors as agents are immersed in a culture that determines their thoughts and actions. Agency is expressed as the willingness and intent to respond to situations or events, to make a difference and to be heard. Agency is viewed as an emergent phenomenon of relational transactions (Biesta et al., 2015). The quality of engagement of the persons within a context is what denotes agency, not the qualities of the persons themselves (Biesta et al., 2015).

Agency in education has been linked to improving the quality of education and is viewed as an important dimension of an educator's professionalism (Biesta et al., 2015). Agency is manifested in the concrete actions or practices that educators employ to establish their space of legitimacy within education (Gonzales, 2014). Agency is constrained or enabled by a number of factors including status, gender, ethnicity, and professional discipline (Gonzales, 2014).

Capital can be economic, social, cultural or symbolic and can be understood as it relates to both individual and collective contexts (Houston, 2002). Economic capital is based on Marx's ideology of capitalism and is associated with money and wealth. Social capital consists of the resources both actual and potential that result from a solid network of institutionalised relationships (Power, 1999). Cultural capital can be in found in three forms: an objectified form, which can be found in cultural goods such as books, instruments, and pictures; an embodied form that exists in a person's mind and body; and an institutionalised form such as qualifications (O'Brien & Ó Fathaigh, 2005). Culture is viewed as a source of domination which serves to reproduce institutional hierarchies or positioning. Culture and power can create the status and social structures that are described as symbolic capital (Houston, 2002).

Inherent in subjects in social relations is the drive to obtain power through strategising. Practice and power are based on the relationship between agency and structure in the context of the dialectical relationship between **habitus** (explained below) and field (Houston, 2002). The value of Bourdieu's theoretical perspective is in the acknowledgement of the range of agency that is constrained or enabled by factors related to status, gender, ethnicity, discipline or institution (Gonzales, 2014). All of these factors are evident in the everyday work of the nurse educator.

Structures and capital in nursing education have developed in a cultural and historical context that has arisen from patriarchy and capitalism. Textually mediated structures of power and authority have arisen from different standpoints that privilege men and scientific ways of knowing in Western European medical and academic worlds. Social practices are formed by the capital that people possess and the field in which they operate (Stokke & Peiris, 2017). Bourdieu conceptualises action or practice as the outcome of interrelationships between field, capital and habitus established at different points of time (Power, 1999).

Standpoint, positioning and habitus

The discourses and relationships in which we participate as intellectuals or subjects constitute the objectified standpoints through which we are related to the world as if we stood outside it (Smith, 1999). Different standpoints produce different knowledges. Bourdieu's concept of habitus is a way of understanding identity in relation to social positioning (Hodkinson et al., 2008). Habitus recognises the regularities in behaviour that are associated with social structures, such as class, gender and ethnicity (Power, 1999). Personal values, attitudes, and perceptions shape an individual's habitus. Through socialisation, an individual's habitus will mirror the social divisions within their own culture and other cultural contexts (Houston, 2002). These divisions may be linked to education, gender relations and social class. How an individual struggles or makes their way through different social divisions influences the forming of one's habitus (Gonzales, 2014).

Habitus recognises the multiple dispositions that develop from our social positions in all aspects of our life, including the subconscious and tacit aspects (Stokke & Peiris, 2017). Habitus is both a product and producer of structures within the social world (Houston, 2002). This premise locates structure within the socio-cultural context, not with the person. The nurse educator is shaped by a habitus as clinician, teacher and researcher. On the one hand, the habitus of the nurse educator creates structures within nursing education; on the other hand, the field of nursing education is structured by the social world. Gendered and cultural identity form social divisions that influence the habitus of the nurse educator. Nurse educators, as mainly women, have been oppressed through their habitus and positioning in the fields of nursing education. By looking at the difference between perspectives, we gain a more complex and theoretically richer set of explanations of the lives of the oppressors and the oppressed.

Investigations: An approach for nursing education research

This final section focuses on how all the ideas presented above inform a theoretical basis for my research in nursing education. The concepts presented above can be put to use in research by choosing a methodology that suits this form of inquiry. The work of the nurse educator is situated in a complex social world that needs to be understood. The scientific paradigm that dominates nursing education practice creates an understanding that nursing work should be based on rational, objective, scientific ways of knowing. Research in nursing education is expected to follow these conventions in order to produce evidence and knowledge that is reliable and valid in informing practice. The practice of nursing is also recognised as having a social mandate that calls for attention to matters of social justice with a concern for human integrity and human flourishing. This form of nursing work requires caring and collaboration with an understanding of the impact of unconscious biases and dominant power relations. As a teacher and academic, the nurse educator moves into a different field of practice and needs to be able to bring together the thinking and knowledge bases from both of these paradigms. Research that addresses the complexities of human experiences and relationships as encountered in nursing education practice requires a methodology that can support this by straddling these paradigms.

This research aims to investigate and articulate the everyday work of the nurse educator by writing and presenting textual material that will engage both the writer and the reader in critique. The methodology for this research draws on two writing modes as a deliberate strategy to traverse the complexity in nursing education work. The research design includes academic writing that presents evidence that follows scientific convention in the form of a literature review and use of the literature to critique. The research also uses the power of the narrative writing mode to capture the complexities of the research question in context, and to bring it 'up close and personal' for the reader. Textual material includes my own stories, research and professional nursing education literature, and the experiences of everyday nurse educators as told through fictionalised narratives, as described in Chapter 3.

Taking this approach represents a deliberate move away from a traditional science-based research method, instead adopting Smith's principles that support a textual method of inquiry. Being flexible with some of the conventions of traditional scientific qualitative research presents an opportunity to theorise nursing education in a different manner, from a women's standpoint. A key to supporting this process is engaging in reflexivity and developing critical consciousness.

Reflexivity

Reflexivity as a theoretical concept and holistic process takes place across all stages of this research. Reflexivity challenges the status quo of scientific inquiry by arguing against the objectivity, detachment, neutrality and universality that are rooted in historical, gendered scientific paradigms (Hesse-Biber & Piatelli, 2014). These paradigms create unequal power relations that impact on social relations in nursing education. A stronger reflexive science becomes one that is able to reconstruct or reorganise the social relations that build knowledge (Smith, 1987). Researchers must reflect the scientific gaze back upon themselves to develop a 'strong reflexivity' in which the researcher's own conceptual framework is the subject of critique (Hesse-Biber & Piatelli, 2014, p. 8).

To practice reflexivity means to acknowledge that "all knowledge is affected by the social conditions under which it is produced and that it is grounded in both the social location and the social biography of the observer and the observed" (Mann & Kelley, 1997, p. 392). Researchers must recognise, examine, and understand how their social background, location, and assumptions affect their research practice. Reflexivity supports the researcher in questioning the structures of power and the authority of knowledge in the social context.

A summary of principles to promote holistic reflexive praxis is presented below (Hesse-Biber & Piatelli, 2014, p. 28):

- *Know your standpoint prior to entering the research process.* This includes self-critical action examining one's own lived experiences and one's own biography.
- *Examine your positionality and role in the field.* The researcher needs to be conscious of the fluidity of the identities of self and others based on different contexts, different knowledge bases, situational issues and organisational culture. This fluidity in positioning means that the researcher can be an insider in one time and place and an outsider in another.
- *Listen to your interview participants and listen to yourself.* Reflexivity is a communal process that requires both the researcher and the interview participants to pay attention to structural, political and cultural contexts and how these might affect the research process and outcomes. Questions for interviews should be crafted to engage the researcher and the participants in thinking about structural advantages and how these have shaped experiences. Listening, editing and writing is part of the reflexive process of translation of texts.

- *Be attentive to difference.* The researcher needs an awareness of power and privilege when working across difference.

Critical consciousness

Sociologically just research that attends to reflexive principles can foster change. In a unique way, we are constantly transforming our environment, shaping the very conditions of our existence and our daily life. This is a never-ending process which Freire expressed as 'beings in the process of becoming' (Crotty, 1998, p. 10). This research aims to coordinate the consciousness(es) of being a nurse educator, which makes critical knowledge of the social world of nursing education possible. Freire understood this process of reflection as 'praxis' with reflection and action that seeks to transform. Praxis is a basic tenet of this type of feminist research that sets it apart from other paradigms of inquiry. ''Feminist praxis builds on the understanding of difference and translates these insights by emphasising the importance of taking issues of power, authority, ethics, and reflexivity into the practice of social research'' (Hesse-Biber, 2007, p. 16). Through praxis, researchers are challenged and supported to act and make research relevant to the actual lives of people who are affected by research and to explore critically and theorise action as it informs research. Action and reflection take place at the same time to become creative. It is praxis that leads to conscientisation, the awakening of critical consciousness which leads to further action (Crotty, 1998). Smith (1987) recognised the need for women to act by grasping their authority to speak through developing consciousness of the external sources of authority such as patriarchy that have made it difficult for women to assert authority for themselves.

My research seeks to engage others in conscientisation through reflection upon the material reality of the everyday work of the nurse educator as an active intervention in the professional formation of the nurse. The intent of my research is to critically analyse and explore the everyday work of the nurse educator as a clinician, teacher and academic in order to understand 'what being a nurse educator means'. The undervaluing of nursing education knowledge perpetuates a view of the nurse educator constructed as academic/non-clinician by the nursing world and as non-academic/non-clinician by the nursing education world. The contributing causes of this issue are found not only in contemporary practices in nursing education that contribute to stereotypical perceptions around the nurse educator role and nursing knowledge, but also in historical and cultural events that have shaped nursing education.

Chapter 3: Methodology

This chapter outlines the methodological approaches used to investigate my research question, including defining what counts as data, method, analysis, and findings. The theoretical framework described in the previous chapter underpins the approaches and decisions made in devising the methodology. This thesis research uses qualitative approaches that see scholarly writing (as in the writing of this thesis) as an integral part of the methods of inquiry into social questions (Richardson & St. Pierre, 2018). Qualitative inquiry involves interpreting the meanings people make of their lives and work. The meanings of qualitative research are carried in the entire text: the "meaning is in the reading" (Richardson & St. Pierre, 2018, p. 819).

"Social inquiry is conducted from within the inquirer's particular way of seeing, hearing, and understanding the social world" (Greene, 2007, p. 67). My inquiry starts from examining meaning in texts drawing on my own knowledge as insider-researcher, then progresses to the literature and interview participants in building up critical sociocultural accounts of the everyday work of the nurse educator. Discourse, power relations and social realities are examined as they are mediated through text. This examination includes how social systems in nursing education serve to marginalise and oppress certain groups of people while privileging others. The gendered and cultural relationships in nursing education are examined from a feminist standpoint.

A metaphor for a researcher who carries out this type of qualitative work is that of a 'bricoleur' in reference to the creation of a work by piecing together diverse available elements (Denzin, 1994). A similar image is seeing the researcher as a maker of quilts, connecting the pieces together to create the whole (Denzin & Lincoln, 2013). The bricolage approach is adopted with awareness of the complexity of the lived world, and the complications introduced by power and privilege, or the lack thereof. It offers a way of investigating what we know and the processes by which we know it. The metaphor of the researcher-as-bricoleur sees tacit nursing knowledge as valuable: a source of know-how passed on from expert to novice and a time-honoured and effective way of enacting that know-how. Bricoleurs draw on the traditional practices of their craft, as well as heuristics and rules of thumb (Rolfe, 2019).

As the 'quilt maker' I have negotiated methodological decisions with flexibility and elasticity. This approach has led me to three different methods of data collection and analysis using writing as method of discovery and inquiry. Textual material forms the data for this research as the backing of this quilt that holds everything together. Textual sources include historical and

current research and professional literature from nursing education practice, my own stories and experiences as a nurse educator, and stories and experiences gained from interviewing other nurse educators. This approach provides the flexibility to piece together a quilt, following possible threads in examining my own work as a nurse educator, as well as examining the influences on and shared experiences of other nurse educators in relation to what is already recorded in the research and professional literature.

Methods of data collection and analysis

A qualitative research process provides a familiar pattern for this research that is situated across science and social science research paradigms. Familiar scientific terminology and structures such as data collection and analysis are used without being bound to the conventions of a scientific qualitative research approach. For example, a review of the literature is an expectation in qualitative research in both justifying the reason for a research topic and for providing an understanding of and context for this research topic. For my research, the literature forms part of the textual data to read and make meaning from. The literature provides some of initial pieces of the quilt informing the development of the research question and the questions that I would use for guiding interview participant conversations. The literature also provides the threads for the theoretical framework that draws together an understanding of nursing practice and nursing education.

Adopting methods of data collection based on storytelling and interviews was a natural decision for this research. I knew that I had my own story and experiences of being a nurse educator for over 25 years and I knew that my story would be part of this research. I also knew that I wanted to hear other nurse educators' accounts of their everyday work to gain a richer perspective. Writing narratives as a method of data collection and analysis is a fitting approach that has transpired in response to the theoretical direction for this research.

The challenge was thinking about how to piece together these different experiences and texts as data in a manner that would provide an understanding of the whole. The blurring of the line between data collection and data analysis, including the perception of literature review work as research in its own right, aligns with a postmodern approach including a leaning towards post-qualitative research. Post-qualitative research is not a methodology, but is an approach that is invented and created differently each time (St. Pierre, 2019). Initially the experience was like putting together my quilt without a pattern or set of instructions to follow. I began with an idea

of what I wanted to produce and needed to find the pattern and pieces that would allow me to put it together.

With a research question that focuses on 'how' the nurse educator works, both the thinking and actions of the nurse educator need to be explored. My theoretical framework and methodology need to be able to address both. I have drawn on several different perspectives discussed in Chapter Two as threads to bring together this understanding – from the work of Smith, Bourdieu, Richardson and St. Pierre. Smith's (1999) approach calls for methods of thinking, of writing text and investigation that expand and extend knowledge of how the everyday/everynight worlds of individual people are put together, determined and shaped by forces and powers beyond our practical and direct knowledge**.** Drawing on postmodern ideas, Smith's approach embraces uncertainty and possesses an openness to exploration and analysis that may provide more questions than answers. Bourdieu's (1977) concepts of agency, habitus, field and capital provide a method of analysis in understanding relationships and practice (Houston, 2002).

Richardson and St. Pierre's (2018) approach of using writing as a method of inquiry provides the necessary threads for pulling together the theoretical concepts in this research. Reading, writing, re-writing, re-wording, removing, rethinking, re-reading, revising, remembering, reflecting, rehearsing: all became part of the writing-as-inquiry process. St. Pierre's (1997, 2013) work addresses concerns about how data is informed by postmodernist ideas. She argues that data can appear in many forms, and that a quest for certainty in relation to data is not possible. Rather than viewing this as a weakness, St. Pierre adopts the stance that multiplicities and subjectivity of data are an opportunity for new understandings and approaches to research. Writing narratives as 'data' follows Richardson's (2001) tips for writing stories in a postmodernist context. She asserts that both the writing itself and the writing process form a method of inquiry that has many benefits. Reflexivity and critical consciousness informed by postmodern thinking are important theoretical principles that support analysis through the research process.

The following sections provide an explanation of the methods of data collection and analysis used in this research. Methods of data collection include readings of the literature, interviews, storytelling and writing narratives. The processes for gathering, writing and interpreting the data is explained. Ethical considerations that are important for this research are addressed.

Critical readings of the literature

In research informed by postmodern thinking, data is collected from the literature, and a literature review is considered research in its own right. Learning from the existing scholarship that represents what is known about this research topic and question is a starting point for piecing together the research quilt. The critical reading and reviewing of historical and contemporary literature from both nursing and education practice focuses on the role of the nurse educator in practice and how the nurse educator teaches. Textually mediated forms of discourse and ruling relations that structure and organise nursing education nationally and internationally are examined. A critique of selected literature marshals a unique set of data to follow a particular thread and counts as research in the sense that it creates a new view on any given topic. Chapter 5 is written using the literature to present an original historical sociocultural account of nursing education as both a context and data for this research.

Semi-structured interview research

Interviewing experienced nurse educators working in undergraduate nursing education programmes enabled me to learn more about the everyday work of the nurse educator from different perspectives. The interviews followed a semi-structured format that allowed a conversational style of dialogue while still addressing the interview questions. The interviews provided an opportunity for the participants to share their stories and also to explore different aspects of their work.

Recruiting interview participants

Initial contact was via an email invitation (Appendix A) that I sent to Heads of Nursing Schools, through NETS for polytechnics, and the Council of Deans for university programmes. I deliberately did not recruit any participants from my own workplace. Heads of Schools and nursing leaders were asked to circulate my invitation, which explained the nature of the study and included a copy of the participant information sheet (Appendix B). Since some potential participants could have been known to me through professional networks, I took care at all stages to ensure that participation was voluntary and confidential.

Potential participants were invited to contact me through a personal email account if they were interested in participating in the study. Several institutions required the study to be reviewed and approved by their own ethics committee before circulating my invitation to nurse educators in their schools. I quickly received a large number of initial responses to my invitation from around the country and from both the university and polytechnic sectors. I responded to each

potential participant and undertook correspondence to ensure their understanding of the research project, confirm their participation, and schedule mutually convenient times and places for interviews. There were several potential participants who I did not interview because they were either unavailable on the day that I visited their institution, or I had already secured interview appointments with a manageable group of participants. I attempted to arrange face-to-face interviews as much as possible and travelled to institutions where I had recruited several participants. The participants arranged a suitable private meeting space at their workplace for the interview. A few participants requested that the interview take place via an online video call.

To maintain privacy, I have kept confidential the identity of the participants and the information they shared with me, securely storing the digital and paper information, using fictional names and removing or fictionalising any identifying details given in the interviews.

Conducting the interviews

As an insider researcher, I had anticipated being acquainted with some of the participants, which turned out to be the case, although many of the participants were previously unknown to me. Ethical considerations regarding voluntary participation and protection of privacy were adhered to as discussed further in ethics section to follow on page 38. I developed a set of semi-structured interview questions based on my initial literature review work (Appendix C). The questions began with the participant's individual nursing story of everyday work as a nurse and nurse educator, then moved to a range of questions about broad competing tensions in nursing education work. Participants chose which stories and experiences they wished to share with me and could decline to answer any questions if they wished (Appendix F). I also collected demographic information, i.e., the participant's gender, ethnicity, country of origin, and length of time living in Aotearoa New Zealand.

Most interviews took place at the participant's workplace, during their work time, and lasted 30–45 minutes, with each interview being digitally recorded. I used a conversational interview format that enabled me to probe further as information was shared, and seek clarification as needed. Given my understanding of the nuances of the work being described by the interview participants, I was conscious of not wanting to lead the interviews, but rather to allow the participant to take the questions into areas that were most relevant to them and their personal experiences. I had a general sense that the participants enjoyed the interview experience, given the ease with which they shared their stories and offered examples of aspects of their work. The

richness of the interview data was evident as participants explored different aspects of the nurse educator's work from their various standpoints.

Interview transcripts

The interview audio files were transcribed by a professional transcriber who signed a confidentiality agreement (Appendix D). I reviewed each transcript carefully against the audio recording to ensure accuracy. I sent each participant a copy of their interview transcript for checking, to review what they had shared, and change or delete anything as they wished. In this process, a few participants asked for some identifying details to be anonymised in the transcripts, which I did, while at the same time reminding them that I would be writing fictionalised narratives rather than quoting from the interview data directly. I did not offer the participants an opportunity to read the fictionalised narratives since the narratives do not represent their individual stories. Participants were offered the opportunity to receive a summary report of my research once it has been completed.

Characteristics of the participant group

This summary of the characteristics of the participant group assumes more importance in this thesis as compared with a more traditional qualitative interview thesis research project recognising the non-standard way that I have treated my interview data. This description of my group of 15 interview participants gives an insight into the typical demographic and career characteristics of the nurse educators of Aotearoa New Zealand. In this sense, this summary shades from data collection into data analysis, hence I have placed it here at the end of this section on the interviews.

Demographic summary

I interviewed 15 participants from 7 different institutions spread across the country as far north as Auckland in the North Island and as far south as Invercargill in the South Island. Twelve participants were from four different polytechnics and three participants were from three different university settings. One participant was male, the rest were female.

The participants mostly began their own nursing education in the polytechnic sector with a small number having completed hospital-based training. One participant trained overseas in one of the first nursing degree programmes. All participants had completed some form of qualification upgrade and further study since obtaining their first qualification as a registered nurse, including bachelor's degrees, postgraduate studies/master's degrees, and adult teaching and learning

certificates. One participant had completed a PhD and four others were enrolled in doctoral studies. Many of the participants described taking time out from their careers to have children; moving jobs because of their husband's career trajectory; and working part-time to accommodate the needs of their family. The need to work in a more family-friendly environment was a reason cited by several participants as to why they moved into nursing education.

The participants moved into their nurse educator roles from a variety of nursing backgrounds and experiences. Some participants described experiences while working as a new graduate and then finding their passion in one area of nursing. Many participants had experience working overseas, predominantly in the United Kingdom or Australia. All the participants spoke fondly about their nursing practice experiences. Participants valued the different experiences that nursing has afforded them, including traveling and working overseas, moving around into different speciality areas and 'climbing the ladder' in their nursing career. No one area of nursing practice seemed to suggest itself as a stepping stone into nursing education. These participants were bringing a breadth of knowledge and experience into their practice as nurse educators.

Most participants described their move into nursing education as unplanned. Participants spoke of how "an opportunity arose" or of "sliding into nursing education" or making a gradual move, starting as a clinical lecturer then later moving into an academic role. It seemed like a natural progression for some participants to take their clinical experience into the classroom. Because this career move was often unplanned, it meant that participants may not have had a good understanding of what the move meant in terms of the work of a nurse educator.

The people I interviewed had a wide range of experience in nursing education. Some were very new to the role (from 4–18 months) while others had been working for 25+ years in nursing education. The participants' roles were varied, with job titles including Nurse Lecturer, Senior Nurse Lecturer, Principal Lecturer, Course Leader, Acting Head of School, Programme Manager, Professional Teaching Fellow, Clinical Lecturer, Module Coordinator and Course Coordinator. Some participants defined their role more specifically based on their discipline or teaching area, for example, teaching science, simulation lead, Year One BN teaching, or clinical teaching.

Storytelling and writing narratives

Storytelling is probably the most basic human mode of organising, storing, and transmitting complex arrays of information sharing and transforming knowing. As humans, people are immersed in telling their own story whilst at the same time listening to and hearing their stories in the stories of others (Sandelowski, 1991). In nursing and nursing education, storytelling is part

of our everyday practice. We listen to the stories of others to gather information and build relationships built on caring and trust. We piece together the stories of people's lived experiences of health and illness to develop with them a plan for nursing care. We tell nursing stories and share our experiences with our students as a method of modelling practice and facilitating learning. We share our experiences with colleagues as a method of sharing the joys and debriefing about the challenging aspects of being a nurse. We write reflective journals and accounts of our practice as a method of improving our practice. The practice of storytelling and writing narratives is part of the actualities of the everyday work of the nurse educator.

As the researcher, I have been responsible for listening to stories and interpreting these stories as data to understand the significance of nurse educators' work in ways that they may not have intended. In collecting nursing education experiences through individual interviews, different knowledge has been expressed based on different standpoints. Not all standpoints are equal. The differing standpoints of the participants who volunteered for interviews in this study were captured when participants were asked initially to share their journey into nursing education. The range of experiences collected signifies a shared positioning of previous nursing practice experience alongside differences related to individual trajectories of experience in nursing education.

How the stories are told and information shared by participants is affected by how they are positioned in relation to the research process and the institutions studied (Norstedt & Breimo, 2016). The researcher needs to recognise their dominant position in making their own interpretations (Grant & Giddings, 2002) as well as the forces of domination that affect the lives of individuals from racial, class, gender, sexual, ethnic and religious backgrounds outside the dominant culture and the outside the worldviews of these persons (Kincheloe et al., 2013). The researcher also needs to be aware that the participants may tell the stories that they want to tell or that they think the listener wants to hear. The way the story is told may differ depending on the listeners and teller, and the context and time when the story is told.

Writing narratives as a method of inquiry has been used for research that is human situated and filtered through human eyes and human perceptions (Richardson & St. Pierre, 2018). Writing narratives is a way of understanding one's own actions and the actions of others; organising events and objects in a meaningful way; and connecting and seeing the consequences of actions and events over time (Chase, 2005). When we use narratives, we are describing something with the voice of our culture, and many voices are heard in what we say. Using narratives in research makes the research accessible for others, bridging the academic and the affective, the head and

the heart. Sharing the stories of experienced nurse educators, including myself, has the potential to support the formation of the identities of those nurse educators new to the academic world.

Writing narratives enables me to piece together ideas from my own experiences, from the experiences of others, and from the historical, cultural and social influences that have created nursing education in Aotearoa New Zealand, as represented in literature and the public domain. My first challenge was to develop confidence in my own voice and positioning in telling and retelling these stories. I want this research to provide an understanding of the everyday work of the nurse educator in a manner that is accessible and meaningful for others. As the person responsible for putting together this quilt of stories of nursing education, I am aware of my own positioning and privilege in being able to tell this story. Beginning with a personal biography encourages me as the researcher to examine how I am situated in the world based on my ideas and frameworks. This approach is undertaken with the awareness that meanings will be filtered by both the researcher and participants through different lenses including language, gender, social class, etc.; stories and accounts of experiences shared by participants will not be offered as full explanations of actions or intentions (Denzin & Lincoln, 2013).

My research includes two different forms of original **narratives** written for this study, an approach that walks the line between data collection and analysis.

(1) As researcher and nurse educator, I write my story as both a personal biography and an autoethnographic account, sharing aspects of my personal professional journey in nursing education.

(2) I also write fictionalised narratives, one from my own experiences and three from the interviews with other nurse educators. Writing these narratives as 'archetypes' of the work of the nurse educator provides a less conventional method of processing the interview data and presenting insights from this work. In the discussion chapter, I write a creative piece that imagines an 'ideal' nurse educator as an avatar, a future-facing identity. This avatar piece is based on the research findings and forms the basis of the discussion chapter.

Autoethnographic narratives

Autoethnography is a research tradition aligned with postmodernism that involves the description and analysis of personal experience as a way of understanding cultural, social and political problems and relationships (Ellis et al., 2010). Writing one's own stories can evoke new questions about self and the topic of inquiry (Richardson & St. Pierre, 2018). A personal

biography surfaces some of the basic set of assumptions that give meaning to thoughts about the way things are, why things are and what things are (Boufoy-Bastick, 2004). Self-questioning in autoethnographic research requires the researcher to be vulnerable, looking outward on social and cultural aspects of personal experience, and then looking inward, exposing a vulnerable self (Ellis et al., 2010).

My story begins with a personal biography explaining my positioning in the world and my experience of becoming a nurse. The next part of my story follows my experience in moving to Aotearoa New Zealand and becoming a nurse educator. The last part of my story narrates my journey towards becoming a doctoral student and developing my identity as an academic. Writing this story allows me to reflect on and share my own experience of working as a nurse educator. This process facilitates insight into my evolving worldview as a person, nurse, and nurse educator.

Fictionalised interview narratives

The second narrative method is a form of collective story-writing or ethnographic fiction. This approach is part of an emerging method that uses fictional writing as part of a research process (Bruce, 2014). Rather than telling the stories of individual interview participants, the stories are formed as a collective story. Textual analysis of the interviews was an iterative process of listening to the digital recordings, reading the transcripts, reviewing relevant documents and literature, and writing on-going reflective notes. As part of a creative analysis process, the researcher must consider how the authors of the stories position themselves as the knowers and tellers of the stories (Richardson & St. Pierre, 2018). Through listening and reading for meaning, the social relations reflected in how participants understood and differentiated their work as nurse educators was detected. Further analysis looked for those moments in the participants' discussions that linked to texts, or concepts which were rooted elsewhere—outside of their direct experience—but that linked in some way to their everyday work. This process blurs the boundaries between data collection and data analysis.

This process led to the development of fictionalised narratives based on the themes and discourses from the interview data. Two of the narratives are written as archetypes that signify important aspects of the everyday work of the nurse educator. Actual text from the interview transcripts was pieced together to create the dialogue in the stories. Sometimes, text is included verbatim and, at other times, text is crafted to fit the essence of the story.

Introducing the research narratives

Chapter 4		
My story of becoming a nurse educator	Personal biography as autoethnography	This narrative tells the story of my journey towards becoming a nurse academic
Semester's end	Fictionalised narrative from my professional experiences	This narrative shares the complexities of roles and relationships between the nurse educator and student at the end of the semester
Chapter 6		
Nova: "We don't know what we're doing"	Fictionalised narrative from the interview data	This narrative tells the story of a new nurse educator
Sophia: "Sometimes it feels like you've literally got four or five windows open in your brain"	Fictionalised narrative from the interview data	This narrative follows the week of an experienced nurse educator
Nursing education forum: "You have to learn the rules of the game"	Fictionalised narrative from the interview data	This narrative shares the dialogue of a group of nurse educators at a nursing education forum
Chapter 9		
Creating Te Kaiako Tapuhi	Creative work drawn from the findings	Two creative pieces imagine an 'ideal' nurse educator for Aotearoa New Zealand

Ethical considerations

Formal ethics approval for conducting the interviews was obtained from AUTEC, the Auckland University of Technology Ethics Committee (Appendix E). Codes of ethics for research that involves collecting information from other people are informed by five key principles: voluntary participation, informed consent, protection of privacy, avoiding deceit, and doing no harm (Tolich & Davidson, 2003). Researchers are urged to "think of New Zealand as though it is a small

town ... New Zealand's smallness makes it relatively easy to identify any institution" (Tolich & Davidson, 2003, p. 77).

Voluntary participation: Potential interview participants were first contacted by means of an email invitation circulated by their programme leaders. Care was taken to ensure there could be no consequences of any kind for volunteering to participate; no information about who responded was given to the managers or employers of the participants. Anyone interested in being interviewed was invited to contact me through a personal email address. I contacted each person who responded to the invitation and corresponded with them to ensure they understood the nature and purpose of the research, before confirming their participation.

Informed consent: In practice, the ethical requirement for informed consent is met by providing potential participants with enough information about the research for them to be able to make an informed choice to respond to the invitation to be interviewed as part of this study. In this case, information about the research was provided as part of the initial invitation, and an information sheet (Appendix B) was provided to each interview participant to ensure they understood the research project, their rights as voluntary participants, the interview process and how their interview data would be used in the research. A signed consent form (Appendix F) was collected from each participant, which included their right to withdraw from the study and the opportunity to review their interview transcript.

Protection of privacy: In undertaking the research, including writing my own narratives, I was drawing on information from within my own workplace and experiences which could involve my work colleagues and management. I needed to remain aware of my position within the 'small town' of nursing education in Aotearoa New Zealand. I did not interview anyone from my own workplace, but given the smallness of the nursing education community, it was inevitable that some interview participants were known to me. It would be impossible to gain voluntary participation and seek consent from all those who may be mentioned in the course of the interview. Therefore, consideration must be given to protecting the privacy and concealing the identity of all interview participants *and* all those people they mentioned in the stories they shared. This was achieved by transforming the interview data into fictionalised stories in the form of the research narratives. By creating fictionalised narratives based on the interview data, I aimed to maintain the anonymity of participants and their workplaces. All information related to the interviews is stored on my personal computer and backed up on personal external hard drives and is kept secure by the use of passwords.

Avoiding deceit and doing no harm: In terms of doing no harm in carrying out this research, I needed to protect both myself and others. A researcher needs to be aware of power relationships in any interview situation and in the writing of stories that may involve others (Adams, 2015). Participants need to understand the possible consequences, both positive and negative, of participating in the research. An important aspect of doing no harm in a small country such as Aotearoa New Zealand is its unique culture and its location in relation to the rest of the world (Tolich & Davidson, 1999). While the uniqueness of Aotearoa New Zealand is part of the focus of this study, I took responsibility for portraying this uniqueness in a manner that is respectful to its culture, society and people.

In setting out to interview fellow nurse educators, I was aware of potential power imbalances between myself as the researcher and the interview participants. I am enormously grateful to the participants for their willingness to share their experiences as nurse educators with me and consider it a privilege to have had the opportunity to hear these stories. While protecting their privacy, I wish to acknowledge the anonymous participants for their contribution to this thesis research, and any subsequent publications or conference presentations. The outcomes of this research have potential to benefit nurse educators and the profession of nursing education, and I will work with professional bodies such as NETS to find opportunities to share the research findings.

Having outlined the methods for data collection, in the following chapters I present the data. The next chapter presents my own story of becoming a nurse educator. This story represents the first set of narrative data, collected by writing selective autobiographical accounts as a form of autoethnography, and based on understanding myself to be the first source of data in my research project. The first fictionalised narrative based on my own experiences as a nurse educator form part of this story.

Chapter 4: My Story of Becoming a Nurse Educator

The worldview I bring to this project as a registered nurse and nurse educator is influenced by my own family culture, values and experiences of being in relationship with others. My story begins with some of my personal biography and experiences that led me to nursing and nursing education. My experience starts in my homeland of Canada and follows my journey to Aotearoa New Zealand. Included in my story is the use of some words from the Māori language, the language of the indigenous peoples of Aotearoa New Zealand. I have chosen to use the bicultural name for this country out of respect for Te Tiriti o Waitangi that is recognised as the founding document for this bicultural nation. In the final pages of my thesis, I have included a glossary for the Māori words used throughout my thesis (see page 174).

Choosing to become a nurse

Both my parents were teachers and I grew up in the world of education. My mother was a primary school teacher; she completed her undergraduate teaching degree at the same time as I was completing my nursing degree. She had returned to teaching when my youngest brother started school, after being a stay-at-home mother for some years. My father was a high school teacher; he began his teaching career as a young single man, following a teacher training programme. He completed 30 years of teaching when he was just 50 years old, and decided to retire while he was still happy in the role. I enjoyed spending time helping my mother with her classroom activities such as developing resources and marking tests. I was a pupil in my father's math classes at high school and was thankful that I learned this subject easily so I didn't have to call on my Dad as my teacher for assistance. A teaching career would have been the obvious and, perhaps, easy choice for me, but I had a desire to do something different from what was, perhaps, expected of me.

So, instead of teaching, after successful completion of high school, I applied for and was accepted into the Bachelor of Science in Nursing (BSN) programme at the University of Saskatchewan, in a city about two hours from my hometown in Canada. Even though I was a shy, quiet, young person, I was eager to undertake further education in this new and exciting field. I had limited experience with nursing and nurses, with the main influence being one of our neighbours who was a nurse in a local rest home. When I was a primary school student, she took

my sister and I to work with her one day, to interact with a young woman who had suffered a brain injury and subsequently become a resident in the aged care facility. I remember finding the whole experience frightening because the environment was so unfamiliar, and the person we were interacting with was so in need of care and support. Somehow, this did not deter me, and I later had a two-day work experience at our local hospital as a high school student. This experience gave me a much better feel for the role of the nurse and, although I found it challenging because of my shyness, I was determined that this was the career choice for me.

I think my formation as a nurse was also influenced by other opportunities I had as a young person in interacting with and helping others. I had several opportunities to work with young people with disabilities, and this increased my confidence in interacting with those who were different from me. I was also involved in activities that formed my values which I would take into my nursing career. This included a Christian upbringing and engagement with church activities, including youth group and teaching Sunday School. I was also actively involved in Girl Guiding, both as a participant and later as a leader. I regularly babysat for families in our neighbourhood, including caring for the children for extended periods of time such as summer holidays and weekends. These experiences helped to develop my passion for working with children and their families. My Christian values and desire to a make a difference in the world developed into an adolescent dream about working with poor children in underdeveloped countries – a dream I have not yet realised.

My own nursing education began in the 1980s at the point in time when nursing education began to move from ‘training’ in the hospital setting to ‘education’ in the tertiary education setting. The rift between clinicians and educators was evident when I was a new graduate, as hospital-trained nurses I was working alongside expressed their concern for the perceived lack of practical skills or ‘work readiness’ of a degree-prepared graduate. I was drawn towards nursing in the community and gained my first full-time role as a public health nurse in a small rural town in the Canadian prairies. From my initial new graduate experience working in a paediatric ward in a city hospital to working in a small rural community, my first years as a nurse gave me the chance to develop my nursing skills, especially in building relationships with others. The desire to travel saw me leave my first permanent job; I embarked on overseas travel with two of my nursing classmates. It was on this trip that I first visited Aotearoa New Zealand, Australia, and other parts of the Pacific, and met my future husband.

Moving to Aotearoa New Zealand

In 1989, when I made the decision to migrate to pursue my relationship with my future husband, I was fortunate to gain a position as a Plunket Nurse in Porirua, an outer suburb area of the greater Wellington region, where I have continued to work for the past 30 years. Porirua has always been described as a 'diverse' community. Analysis of the ethnic population in Porirua City in the latest Census data (2018) shows that, compared to the Wellington Region, there is a smaller proportion of people who identify as European, and larger proportions of people who identify as Māori (22.3%) and as Pacific Peoples (26.3%). The community also has a relatively large number of migrant families, including refugees, for many of whom English is an additional language. Migrants to Porirua have included many peoples from Pacific nations as well as more recent migrants and refugees from Asia and Middle Eastern countries. The community is predominantly in the lower socio-economic brackets, with significant numbers of families who live in state housing and are reliant on the government for economic support.

As a new migrant myself, I was now working in a community that was ethnically and socially different to my previous experiences, and in stark contrast to the affluent inner-city suburb where I was currently living. I found that I could relate to many of the migrants who, like myself, were 'different' from the dominant New Zealand cultural group. I had to learn a new language of 'cots' and 'nappies' instead of 'cribs' and 'diapers'. I felt the need to take an interest in rugby, and learned to adapt to teaching mothers how to care for babies in houses lacking central heating, and where many of the families had no transport options. Despite the cultural and colloquial language differences, I found that my nursing education and clinical experiences had prepared me well, and I was able to use my knowledge and skills in this new environment. Having a tertiary nursing qualification in the late 1980s was somewhat of a rarity in Aotearoa New Zealand, and I was fortunate that my Plunket employers valued my tertiary qualification and overseas experience, giving me the confidence I needed to adapt to nursing in this new social environment.

It was my job as a Plunket Nurse that in the early 1990s led me to seek a career in nursing education at the local polytechnic, teaching within my speciality practice area of child and family nursing. Whilst I loved my nursing role working in the community, I was ready for a new challenge, even though I felt that I knew very little about being a nurse educator. Whitireia Community Polytechnic was established as a local tertiary provider in the Porirua community in 1986, and the Diploma in Nursing programme was one of the first courses offered by this new institution. Whitireia was established in partnership with local iwi Ngāti Toa, and its founding

principles have strong links to Te Tiriti o Waitangi and Māori values and beliefs. Turoa Royal was the founding leader and the first chief executive of a polytechnic who identified as Māori. The culture of this institution was developed based on Royal's philosophy and leadership, which was to ensure Whitireia did things 'differently but well' (Jansen & Scadden, 1996, p. 56). He took pride in being able to walk around the campus and acknowledge staff and many students by name. His leadership gave all the Whitireia staff, including academic staff, a strong sense of purpose, and influenced the philosophy of the programmes of study as well as teaching and learning practices. When the Polytechnic celebrated its 30th birthday in 2016, it was remarkable that over 25 staff members have remained employed with the Polytechnic for 25 years or more. Whilst I was not one of the founding staff members, I, too, have now been a member of the Whitireia whānau for over 25 years.

As a new nurse educator, it quickly became apparent to me that being a nurse educator required an integrated approach, incorporating both practice and academic worldviews. At the time I began teaching, the nursing education programme was being re-developed to meet new sector requirements, shifting from a diploma to a degree qualification. The current nurse educators in the programme were being challenged about their lack of academic knowledge, and their perceived lack of ability to teach nursing at a degree level.

From what I had seen in my previous experience of working in this community, the Polytechnic's ability to be responsive to the needs of the community was an important value for me as a nurse teacher. There are several high schools nearby, but only a few students from these local schools were progressing as school leavers into degree-level tertiary study. Significant numbers of students from the local community, many of them mature women seeking a career (including mothers returning to the workforce), undertook foundation-level studies to gain entry into a qualification for a 'second chance' at education.

I began as a lecturer in the three-year Diploma of Nursing in 1993, teaching a paper on child and family nursing in the third year of the programme. The teaching staff were in the process of applying for accreditation for the new Bachelor of Nursing (BN) degree, having been turned down the year before because of perceived deficits in the proposed programme. To offer degree-level qualifications in the Polytechnic setting was still quite new, and a small community polytechnic such as Whitireia, situated in a lower socio-economic community, was not perceived as having the required academic rigour. The curriculum proposed for the degree was 'different' as it linked the programme philosophy to Te Tiriti o Waitangi, and recognised the emancipatory role of education in people's lives and therefore in the wider community. The philosophy

proposed that education would be relationship-based, with the student at the centre of learning and the teacher supporting the learner (Southwick, 1994). The polytechnic's values upheld the importance of student support through concepts such as manaaki and whakawhanaungatanga.

My previous experience working with diverse populations and in the local community of Porirua meant that I felt right at home in the classroom in terms of the people that I was interacting with and I soon adapted the lesson plans to match my nursing experiences. Beginning my teaching career in a practice-based paper specifically related to my nursing practice experience was certainly an advantage, and helped me to develop confidence as an educator by teaching students using examples from my own practice. I was also expected to teach about child-bearing families, however, and I had little experience either personally or practically for this. I was fortunate to have a mentor with expertise in this area who talked about her experiences with me, and gave me encouragement in teaching this subject. She conveyed her experiences to me and to our students as vignettes as a way of theorising practice. This helped me to see that, whilst personal experience was valuable and important, the art of teaching was being able to engage with the students through both knowledge and practice. The teacher didn't need to know everything, and it was okay to let the learners know that this was the case. Much like my experience in nursing practice, I found that the students appreciated me taking the time to get to know them as a person and as a learner and responded well to my being able to adapt my teaching and the learning experiences to match their needs – what is now called a person-centred approach to learning.

From that first year as a nurse educator more than 25 years ago, I have gone on to teach in many different courses and subject areas across all three years of the BN degree programme. While it hasn't always been smooth sailing, the challenges of teaching and the rewards of being involved in shaping the careers of the future nursing workforce continue to inspire me to work in this area of practice. In my work as a nurse educator, I am afforded opportunities for ongoing education, personal and professional growth, and a flexible workplace. These are some of the benefits of nursing education as my chosen career. I have been able to keep extending my knowledge, skills and expertise: as a nurse, a facilitator of learning, an evaluator, a support for student success, a career guide and a leader who is respectful of diversity and desires to develop a nursing workforce that is responsive to the needs of the community. Little emphasis is given to formally developing and supporting this important professional role played by the nurse educator, who is integral to forming a nursing workforce fit for the health care needs of the future.

When I first started out in nursing education, the questions I asked myself were 'Am I a teacher?' and 'Can I teach?' In my covering letter when I first applied in 1992 for the position of nurse educator at Whitireia, I asserted that I could transfer my nursing experience skills into the classroom. I had some previous experience teaching antenatal classes; and this involved developing lesson plans and teaching resources, and engaging learners in activities. I also had experience working with individuals and families in teaching them about healthy parenting practices. And I had certainly had experience of being taught – from school, from my parents, at church, at university, and on the job; I considered myself an experienced learner.

As I progressed as a teacher and moved from the classroom and clinical setting into roles that involved oversight of curriculum, staff and student progress, I wondered again, 'Now am I a teacher?' 'How do I support students to learn?' and 'How do I support staff in their teaching?' In 2015, I was awarded the Chief Executive's Award for teaching excellence whilst in a senior management role. This led me to reflect even further on what it means to be a teacher and a nurse. 'Am I still an excellent nurse or should I be calling myself a nurse at all given that most of career has been as an educator?' My experience in clinical practice spans less than 10 years, even though it is over 30 years since I first registered as a nurse. When I was a new nurse educator, I continued to do some casual work in the clinical setting, to 'maintain my links to practice' and 'keep up my skills' to retain my clinical knowledge. I wonder about the structures in nursing education that value maintaining technical skills and clinical knowledge as more important than the skills of building relationships with others, in caring, in communication, in the problem solving and decision making that are part of my nurse educator practice every day. I know now that I have more expertise in nursing, including child health nursing, than I ever did when I was 'in practice' as a nurse.

My practice as an educator has enabled me to develop knowledge and skills that surpass my previous skills, but this type of nursing expertise is not readily valued or recognised within the wider nursing profession. My experience of becoming both a nurse and a teacher suggests that the two roles are clearly linked, and that interlinking the skills and knowledge from both roles is important in making a difference in nursing and the future nursing workforce. The narrative below is written as a fictionalised account from my own experiences as a nurse educator. This narrative describes the complexity of the roles of a caring professional and the relationships between the nurse educator and students at the 'end of the semester'.

“Semester’s End”

The end of the semester is such a busy time for the nurse educator. We begin to look back over the progress made by each student. How many students haven’t passed all their work? Who still needs to do clinical make up? We need to remind ourselves to look at who has done well, as we get focused on the fails, the work ahead, the limited time, completing the paperwork. The amount of work can feel overwhelming and both students and teachers are tired and in need of a break.

We organise meetings to discuss students’ results. The academic leader and senior academic staff from each year group are tasked with reviewing students’ progress and making decisions. Who should get a further learning opportunity? How many chances can we give one student? What was their progress this semester? Will they be successful if we give them another chance? Have we done everything we could to support this learner?

As we begin to consider the list, we think about each student and their circumstances. There is the student with dyslexia who has worked so hard writing their assignment, but it just doesn't make sense and we wonder if they really understand the topic. We've already given them lots of support, and so we wonder if they just need some more time to focus on their academic skills.

We feel devastated to see the results for one student, she is just 18 and has come straight from secondary school and has only lived in New Zealand for a few years. She has failed everything, yet she tells you that she will try harder. Her Year One tutors wonder how much she understands as her English language skills are poor. And on top of this, she has shared with her tutor that her parents have moved away, leaving her alone in the family home for the first time. The parent’s business venture has not gone well, and it has affected their relationship. Her parents have now split up and her mother wants her to come and live with her in another city.

There are so many stories that accompany the students that we are considering on the list, and the decisions that we make will have serious consequences for their future in the programme. Final grades, multiple chances, financial considerations, motivation, effort, performance in clinical, attendance, family support – what is most important in the decision-making process? Fairness, second chances, a desire to support success, will they make a good nurse? All these things influence our decision making.

When we come to the end of list, we note that, in most cases, we have granted that second chance, we want to believe that the student can be successful. After all, we accepted them into the programme, we fostered their dream of a profession in nursing, we took their money, we

taught them, we designed the assessment tasks, we supported their learning, we graded their work. We want every student to be successful and to become a nurse.

Or do we? We wonder about one or two students on the list. Why are they not doing well? Are they prepared for this level of work? Have they got the right qualities? Maybe their health issues are too big to enable them to deal with the pressure of this course and this career. Maybe this isn't the right time for them to studying. Maybe they need to mature and gain some insight into being professional and being able to tell the truth.

Once we make the decisions, the next task is to notify the students and prepare the work. Many of the conversations are tough as the students are still coming to terms with failing in the first place and they are stressed and lacking in confidence about trying again. Some of the students show insight into their progress and situation and a period of reflection has helped them to accept their results and motivated them to do better. A few of the conversations require a formal meeting with support people to discuss the decision to not grant a further learning opportunity for some courses. There is anger and there are tears, silence and distress. We all feel the emotions and offer tissues and words of support for the different pathways that their learning journey might take.

When it comes time for the reassessments, the corridors are quiet as a small but solemn group of students gather to sit an exam or deliver a presentation. We are concerned that everything needs to go smoothly so that it will be fair – making sure we have two markers, or a recording of the presentation. We aim to mark the results quickly so as to be able to give the students the results – to relieve their stress, and to get us all a holiday.

There is excitement for the students who do well, in seeing the progress that they have made, and in knowing that they are able to move another step closer to their goal. Sometimes there are no surprises in the results of the second attempt, which is still a fail. We may feel relieved that, while we gave the student a second chance, we also know that they will benefit from another year in the programme. Sometimes, these students are also relieved as they were experiencing stress in trying to manage the level of work. Taking a break from study for six months maybe just what is needed to see them come back and be successful. For a few students, their results may signal the end of their journey toward becoming a nurse. We discuss with them alternative pathways that may be more suitable for them.

Over the matter of a few weeks, the assessment period is over, and we contemplate who is in and who is out. We reflect on the final grades and realise that many students have achieved at

a high level. There is a feeling of satisfaction, exhaustion and relief that the grades are now final, and we can take a few minutes to think about what has been achieved. Who will we need to support in the next semester? Who will be coming back after a semester off? Who is leaving the programme? Who is left? Is anyone going to appeal or make a complaint?

We think back to our philosophy and values and the way that we enacted the policies and processes around assessment. We discuss our results, our experiences and our decisions with other colleagues and our managers. We gather together all the documents that have informed and supported our decision making and make sure that we have stored them safely. We talk and we talk about those who have not achieved.

We care about our students and we want them to succeed.
We care about learning and we want students to have the best opportunities and support for learning.
We care about each other and want to shoulder the burden and responsibility together.
We care about our institution and the reputation of our programme.
We care about nursing and we want our students to become good nurses.
We care about our communities and we want nurses to make a difference.
We are nurses. We are teachers. We care!

The caring professional

The role of the nurse educators in this narrative is linked to their formation of the nurse. Nurses taking on the work of nursing education are often expert nurses with a wealth of practice knowledge and skills. Many aspects of the teaching role mirror the work of the nurse in practice, including being relationship-based and making clinical judgements based on critical thinking. The work of caring is evident in both areas of practice. Teaching and learning practices proposed for transformational learning also mirror nursing practice but the language and meanings attached to these practices are different. For example, caring for their students may require the nurse educator to understand caring that is different from the practice that is familiar to them as a nurse.

As a caring health professional, the nurse educator is challenged in wanting to 'care for' her students while at the same time recognising the power relations inherent in her work, including the need to maintain academic standards. The end of the semester marks a point in time when the student is judged in terms of their achievements in meeting the requirements to progress to the next stage of the programme. Many factors influence the decision making that occurs at

this time. In student-centred learning approaches, the student is encouraged to be 'in charge' of their own learning, suggesting that the power to be successful sits firmly with the student. Through the assessment tasks, the student has the power to demonstrate their knowledge, skills, and understanding from the learning they have undertaken. The student's background, culture and previous learning experiences can influence their ability and their opportunity to be successful. The student's power is enhanced when assessment tasks are fair and reasonable, giving opportunities for different learners to be successful. The balance of power sits with the teacher and the other staff at the institution who have set the tasks including the marking criteria, and who make judgements based on these criteria.

This narrative illustrates the complexity and familiarity of the role of the nurse educator as nurse and teacher. The practice of being a nurse academic sits less comfortably and is less visible within the social world of nursing education. For many nurse educators, the practice of becoming an academic is less established and is represented by a longer journey that traverses the fields of clinical and teaching practice. The next part of my story is a reflection on my experiences of forming my identity as an academic. This story has been a long one that starts with my Bachelor of Nursing education in Canada and continues up to my present doctoral education studies.

The long road of becoming a nurse academic

The undervaluing of nursing education knowledge perpetuates a view of the nurse educator constructed as academic/non-clinician by the nursing world and as non-academic/non-clinician by the education world. The contributing causes of this issue are found not only in contemporary practices in nursing education that contribute to stereotypical perceptions around the nurse educator role and nursing knowledge, but also in historical and cultural events that have shaped nursing education. My personal account of my journey towards becoming a research active academic in nursing education is the starting point for the inquiry presented in this thesis.

In the academic world, graduations are held on a regular basis as part of the process for acknowledging academic achievement. Graduation celebrations are an important part of the academic calendar marking the completion of qualifications and sharing in the success of one's students. I have had the privilege of attending many graduations including two significant experiences when I walked across the stage as a graduate. These experiences mark the many steps I have taken towards becoming an academic in nursing education.

The word ‘graduate’ originates from the medieval Latin word ‘gradus’ which means ‘degree, or step’ (*History of graduation*, 2021). The word ‘graduation’ refers to the completion of the degree requirements. Alongside the words ‘graduate’ and ‘graduation’ sits another term, ‘commencement’, which is used to describe the ceremony to celebrate completing the qualification. The term ‘graduation’ symbolises an ending *and* a transition to a new beginning. Graduation and commencement ceremonies mark important steps in nursing and education. My journey began with my own nursing education.

Becoming a nurse in Canada

The first time I walked across the stage at a degree graduation ceremony was when I completed my Bachelor of Science in Nursing qualification in 1985. I remember the excitement of lining up with my other nursing friends in our black gowns, with our nursing degree hoods held carefully over our arms. As a soon-to-be nursing degree graduate in the 20th century in a North American university, I was participating in historically based practices that create cultural capital in higher education through the use of objects, including the hood and the gown.

The history of the graduation ceremony dates back to the 12th century when early universities were first formed in Europe under the Roman Catholic Church (*History of graduation*, 2021). Universities were required to validate degrees and list the names of scholars who were officially enrolled and were completing qualifications. At the time, there was little heating in the universities and churches where learning often took place and the scholars started wearing long robes with hoods to keep warm. Later these gowns and hoods became the official dress of academics and were black to signify the seriousness of undertaking education. The square academic cap (called a mortarboard because of its resemblance to the masonry tool) was a later addition to academic regalia. It was said to have originated from a biretta worn by scholarly clergy, to signify their superiority and intelligence. The cap became popular in the 14th and 15th centuries and was worn mainly by artists, humanists, students, and all those learned people. The traditions of different hoods – bachelor’s hoods with fur and master’s hoods without fur – originated due to the more senior academics (the masters) being giving places of privilege closer to the fire, which meant they didn’t require fur for warmth. The absence of fur symbolises that their status alone was capable of keeping them warm. In the 15th century the hoods were given distinctive colours and linings, and today the coloured linings are used to identify the qualification received (*History of graduation*, 2021).

We were in a huge auditorium filled with family and friends, university staff and dignitaries. When our name was called, we walked carefully across the stage towards our Dean, who placed the hood over our head as a symbol of our achievement. My parents and grandparents were in the audience and my mother presented me with a dozen red roses. My mother told me that roses were part of the tradition signifying entry into the nursing profession. My mother's youngest sister, my Aunt Sandra, was a nurse and I had seen her nursing graduation photos, wearing her white nursing uniform and cap, and holding a bouquet of red roses.

As degree-qualified nurses, we had two sets of nursing graduation photos taken, in our academic regalia and in our nursing uniform. As well as the graduation ceremony to confer the nursing degree, we had another ceremony that signified our entry into the profession. For this occasion, we wore our white nursing uniforms and nursing caps, and were guests of honour at a breakfast hosted by our nursing professors and nursing colleagues from practice. We were equally as excited to be part of this ceremony, which included inspiring guest speakers and the 'passing on of the light of knowledge'. The traditions of this ceremony date back to Florence Nightingale as the 'Lady with the Lamp'.

This experience represents my entry into the dual worlds of nursing and education. I chose the university pathway for becoming a nurse because I valued the opportunity to gain a higher qualification in nursing. I was eager to embark on this quest for knowledge, not just about nursing but as an education about life and, in particular, life beyond my small hometown. The challenge that we faced was understanding how nursing fitted within the world of academia. My graduation experiences stem from and represent the histories of practice in education and nursing.

Looking back on both experiences highlights the essential duality of consciousness for women in nursing education based on patriarchy in society. As women and nursing students we were situated in the academic world, which is male dominated and oriented towards science in terms of medicine. I found the university an exciting new environment of architecturally grand buildings, with large lecture theatres, science laboratories, and a health sciences library. Nearby was an equally impressive University Hospital with medical and nursing specialists, state-of-the-art equipment and a window into the world of health care and nursing. We moved between classrooms in the new health sciences buildings with students studying a range of health disciplines, and also went to classrooms in the old 'nurses' home' which housed our nursing skills laboratories. These two settings and their contrasting concrete forms represent, in material

form, the dual nature of nursing education, in permanent tension between contrasting forms of knowledge.

We were a group of mainly white, middle-class young women, some of us from the cities and some on our first adventure away from small-town Saskatchewan. We were impressed by our lecturers and professors with their vast knowledge, their research and publications, and their experiences in both the academic world and nursing. Some of our more mature lecturers, however, whilst wise, seemed out of touch with current practice. They didn't look like nurses to us – we rarely saw them in uniform – and some of them had been teaching in the university for a long time!

Studying for a university degree in nursing in the mid-1980s certainly set us apart from nurses in practice. When we ventured across campus into the hospitals, we were often questioned about how we could be learning nursing in such an academic setting. I remember our lecturers teaching us about nursing theorists and expecting us to be able to articulate and apply these theoretical ideas to our practice. When we tried to do this in practice, the nurses were bemused as to how any of that 'theoretical stuff' was going to help us in managing a patient load or completing a procedure. At times we were speaking different languages; it was hard for us to find acceptance in both worlds. Thinking back, I can imagine our lecturers also faced criticism from their nursing colleagues as they walked between the two worlds of academia and practice.

Becoming a nurse educator in Aotearoa New Zealand

Following our graduation and gaining our nursing registration, we eagerly set out on our nursing careers, and my journey soon took me to Aotearoa New Zealand. I found work as a well child health nurse in the community. Having completed a nursing degree was even more of a rarity in this country than in Canada. My arrival and initial work in Aotearoa New Zealand were at the time when national nursing qualifications were moving from diploma to degree level for entry into the profession. As a nurse new to the country, I was encouraged to share my knowledge and experience with colleagues, and I felt that my education had prepared me well for working in such a different nursing environment.

While I enjoyed my work in community nursing, my nursing degree qualification gave me the opportunity to move into nursing education. Once again, I experienced the challenges of nursing being accepted in the academic world. I began working as a nursing tutor in the polytechnic sector, teaching on a recently approved Bachelor of Nursing degree qualification.

In the early 1990s polytechnics were given authority to offer nursing degrees, but the acceptance of this move was still being challenged by university academics who were the decision-makers sitting on the NZQA approval panel. Our proposed Bachelor of Nursing programme was initially declined approval for degree status. The degree approval process was a traumatic experience for the staff involved, who found their capability as educators being questioned. Only two of the teaching team held completed master's qualifications at the time, and they were interrogated in relation to the credibility of their qualifications and educational expertise, on the basis of having studied overseas. The curriculum and its philosophy were challenged on the grounds of purported lack of academic rigour. Ironically, even though the philosophy was moving nursing education away from the binary view that valued scientific knowledge over humanist knowledge and relational learning, the panel expected the nurse educators to write the curriculum in academic language that privileged scientific knowledge.

The challenges faced by our pioneering polytechnic team of nurse educators were not unique. Many of the smaller polytechnics would have experienced similar challenges to prove that the academics teaching on the programmes were equipped for the job of awarding degrees. Nursing research and higher education in nursing was still developing, and the workforce needed to teach in degrees was lacking. Most educators were still upskilling to their master's qualifications; this remains the case today, almost 30 years later.

Being a nurse educator in this new environment was very rewarding. We were encouraged to be innovative in our approaches to teaching and learning, including in our new courses in nursing research and nursing knowledge. We attracted a diverse group of learners into our degrees, including registered nurses who were upgrading their nursing diplomas to degrees. We developed our own graduation experience for our degree graduates that incorporated the rich cultural aspects of the community in which we were teaching. Watching our graduands walk across the stage to receive their degrees was as rewarding as my own graduation. Seeing and hearing their families share in the excitement of their loved ones completing a tertiary level qualification was an emotional experience. Many of our graduates were 'first in family' to complete a degree qualification. Following nursing tradition, our ceremony included both the conferring of the degree and the pinning of their nursing badge – symbols of their achievement in both nursing and education.

The master's and beyond

My own journey as an academic continued in the early 2000s when I was supported to complete my master's qualification. The NCNZ education standards required this qualification as I was now in a leadership role within the programme. But there were no rules about the type of master's qualification required. Some nurses were completing a Master of Arts or Master of Philosophy with endorsements in nursing. A new qualification, the Master of Nursing, had recently been accredited in response to the new scope of practice for registered nurse practitioners. I was now caught in the confusion of trying to work out what qualification I should choose.

Initially, I started along the Master of Nursing pathway, but the learning was not aligned with nursing education practice, so I switched to a more conventional Master of Philosophy programme. My memories of this time are of many ups and downs, juggling family life with the demands of study, the pressure of completing the master's study as a requirement of my work, and learning to be a researcher. Once again my parents were in the audience for my graduation, having travelled from Canada for the occasion. This time I was also supported by my husband and children, who had been part of this journey, enduring many hours and days without me while I was fully immersed in my study. The parade of graduands through the city was a unique experience which I partook in mainly for my parents who were thrilled to be in the streets waving at me as I walked past. The ceremony was much like my bachelor's graduation, in a huge auditorium, but this time the group of graduands I stood with as I waited for my name to be called were mostly unknown to me. My academic journey had been a largely solitary experience, with only one colleague from nursing on the same pathway. I felt a great sense of achievement and relief at getting to this point, with the thought that this would be my last time walking across the stage.

Having completed my master's qualification, I felt that I had achieved what I needed to be an academic in my everyday work. I completed my thesis in 2008 and was supported to publish several journal articles and present my findings at an international health care conference. Being a researcher and an academic was beginning to be a regular part of my role, and our Faculty's vision was to make research part of the everyday work of the nurse educator. The key to this vision was the development of a research culture and leadership and mentorship. One of our leaders was Dr Kathy Holloway, who was the Dean for the Faculty of Health. Holloway had two sayings that she used to motivate us to engage with and be consumers of research. 'With awareness comes choice' was her catchphrase to remind us of the power of knowledge and research. Secondly, she challenged us not to be 'brilliant in a cupboard', encouraging and

supporting us to share our knowledge with others. Holloway's leadership, vision and modelling of academic practice in the polytechnic sector was inspiring, and our school and staff benefited greatly from her contribution to developing a research culture.

While the vision was inspiring, the challenges for the nurse educators making research part of their everyday work were enormous. This issue is more prevalent for educators teaching in degree programmes in the polytechnic sector, where workload allocation is often formulated on non-degree-based teaching requirements. Our Dean recognised that we needed to set aside time for research in our everyday work. This meant we needed to shift our thinking around what we taught, how we taught, and how we could be more flexible in our approaches. This was not an easy shift to make as it brought into question how we perceived our roles as educators, and as nurses. We again experienced the binary between education and nursing, and felt challenged about making ourselves less available to students when, as nurse educators, we valued relational teaching approaches. Was being an academic, and giving more of our time to research, going to have a negative impact on student success?

For many staff, their personal experiences with their master's research were at times lonely, arduous and time consuming, and not something that many were eager to repeat. Positive role modelling of active research practice was needed. As a senior academic and leader, I endeavoured to portray enthusiasm and self-motivation towards academic study and to enact the value of being actively engaged in research. We developed a team approach to research, as we soon learned the value of working collaboratively on our projects and areas of interest. This approach has enabled me to be involved in nursing research projects across a range of topics and supported my development in different aspects of research, including writing research proposals and ethics applications, facilitating focus groups, transcribing and coding interview data, writing for publication, and presenting research at conferences. Being research active is an enriching part of my role, especially when working closely with colleagues in education and practice.

My journey in nursing and education has now spanned over 35 years. Yet my journey towards being an academic is not yet complete and some might say it has not yet begun. In many academic institutions both nationally and globally, a doctoral qualification marks the beginning point of an academic career. Instead, with almost 30 years working in nursing education, seeking to complete a doctoral qualification is another step in a long journey in nursing education.

My experience of being a doctoral student has continued to be one of growth, development, and opportunities for new beginning. Undertaking this journey in yet another educational institution, this time in the Faculty of Culture and Society – Te Ara Kete Aronui, has been an enriching learning experience. I chose an educational doctorate as I have spent most of my nursing career in education. Sitting in classes with doctoral students and academic colleagues from a range of different disciplines has been both an enriching and challenging experience. Working together with the daunting, seemly impossible task of developing our research proposals, one of our lecturers took us back again to the graduation experience to give us encouragement. “Picture yourself walking across the stage at your graduation being confirmed with your doctoral degree”. These words were designed to give us an image of the potential for our success. Making that walk across the stage became a visual picture as motivation towards achieving yet another goal in an academic journey. I have again been fortunate to be supported both financially and personally by my employer, my manager, colleagues and supervisors. My family, including my parents and siblings, my husband and children (now young adults), and many friends, have maintained an enthusiastic interest and understanding in supporting my study – even if they do not fully appreciate what is involved. We all look forward with anticipation to my ‘final’ walk across the stage – and the new beginnings that await.

Recording my own personal history and my experiences, values and beliefs around relationships and identity formation in both nursing and teaching is the first set of data. Data presentation continues in the next chapter with a critical review of the research literature that pertains to the research question, as far as possible using relevant existing scholarship. The mode of writing in this next chapter oscillates from the more personal narrative voice to a more neutral academic ‘literature review’ voice (see previous discussion on pages 10 and 25).

Chapter 5: A Historical and Socio-Cultural Context

This chapter examines textually mediated structures and social relationships in the everyday work of the nurse educator as informed by its history and socio-cultural context. This chapter begins with a critique of the significant discourses that can be identified in nursing education historically, both in Aotearoa New Zealand and globally. These trends include the move of nursing education away from a strictly biomedical focus with a shift from training hospitals to education facilities. The second section of this chapter examines the discourses in the work of the nurse educator as nurse, teacher and academic against the literature. The analysis seeks to understand the interdependence of historical, cultural and daily features of the everyday work of the nurse educators that form field, habitus and capital as part of the nurse educator's practice. The final section examines the structures of power and authority that influence agency formation of the nurse educator.

From hospital training to nursing education

The nursing profession as we see it today is a product of various historical strands and stages of development and change. These stages reflect changes that have come about in culture and society at large as well as within certain sectors of society, such as health care, science and technology, and other professions (Kim, 2015). The shift of nursing education in Aotearoa New Zealand from the medically based hospital training to a tertiary level education, followed by the shift from a diploma to a degree-level qualification, are two significant stages of development for the nursing profession and are my starting point in this research. The Carpenter report (1971) recommended the shift of nursing education to the tertiary environment. Just over 20 years later, in 1992, nursing programmes were transitioned from a three-year diploma to a three-year degree-based qualification following the move to comprehensive nursing registration.

Wilson (2001) studied the positioning of Aotearoa New Zealand nurse educators who moved from the health sector into the education sector to establish and develop comprehensive programmes during this period. Her study revealed much about the relative power, knowledge and authority this academic group contributed to nursing and nursing education at this time.

Structural and political changes to nursing education are outlined in the timeline below (Wilson, 2001).

Table Two: Timeline of significant changes in nursing education in Aotearoa New Zealand

1964	**Curriculum Planning Committee of the Nurses' and Midwives Board Recommendations** Reorganisation of nursing preparation to include three main streams: Degree programme, General three-year programme, Community nurse programme.
	Need for specialist preparation for future nurse educators and for nursing research.
1965	**Alma Reid Report**
	To assess the desirability and feasibility of university-based nursing education both for entry to practice and post registration.
1966	**WHO Expert Committee on Nursing Education**
	Established universal criteria for preparation level of nurses for health and advocated for higher education.
	International Council of Nurses (ICN) proposed First Level Nurse category.
1969	**Review of Hospital and Related Services**
	Critical review of hospital-based nursing training. Recommended shift to comprehensive three-year technical institute-based programme.
1971	**Carpenter Report**
	Recommendation to transfer nursing education from the hospital sector to tertiary education sector.
	Recommended development of university level post registration courses.
	Nurses Act 1971
1972	**'Operation Nurse Education'** Members of the New Zealand Nursing Association lobbying Members of Parliament to enact the recommendations of the Carpenter Report.
1973	**Pilot Programmes** Two technical institutes in Christchurch and Wellington.
	Financial support began to shift from Vote Health to Vote Education budget to support these initiatives.
1974	**The National Advisory Committee on Nursing Education Recommendation** Professional nursing services should be provided by nurses registered under the Nurses Act 1971.
1975	**Amendment to the Nurses Act 1971** Registration of comprehensive nurses from three-year courses.
1977	**Legislation Changes for two-tiered Nursing Education System** Introduction of 18-month Enrolled Nursing programme.
1980	**Nursing Education Research and Advisory Committee** established. Replacing the National Advisory Committee as forum between key players in nursing education.
	Commitment to transfer of funding from Vote Health to Vote Education Full responsibility to the education sector for nursing education standards.
1981	**A.J. Taylor Evaluation Report on Comprehensive Nursing Programmes**

	Favourable reports of success.
1986	**Review of Preparation and Initial Employment of Nurses**
	National Action Group formation to work alongside the Nurses' Association.
	Promoted the advancement of nursing and nursing education within the context of the rapidly changing health and social sector.
1987	**Labour Relations Act and State Sector Act** Directed education services towards managerial and accountability foci. Removal of the 'special status' for education which had been upheld by the previous social democratic mandate.
1988	**Cultural Safety in Nursing Education** Hui in Christchurch Formulated the principle of cultural safety.
1988.89	**Hawke report's Post Compulsory Education and Training** Introduction of user pay practices and management culture throughout the tertiary sector
1989.91	**Final RGON (General and Obstetric) nurses** were registered from hospital-based programmes. **Final RPN (Psychopaedic) nurses** were registered from hospital-based programmes.
1990	**Cartwright Report on the "Unfortunate Experiment"** Contributed to the development of ethics committees.
1990	**Nurses' Amendment Act** Independent practice for midwives.
1990	**Study Right and NZQA** were established.
1992	**Nursing Council of New Zealand Education Standards** Formally adopted cultural safety as a compulsory component of nursing education curriculum.
1992	**Development of Degree Level Qualifications** From previously diploma level three-year comprehensive programmes.
1993	**Formation of New Zealand Nurses Organisation (NZNO)** Amalgamation of the New Zealand Nursing Association and New Zealand Nurses Union.
1993	**Nurse Educators in the Tertiary Sector** Established as a group for Heads of Schools from nursing education providers.
1994	**Nursing Council of New Zealand Code of Conduct** In response to public debate about confidentiality of patient information.
1994	**Todd Report on Restructuring Tertiary Education** Students to contribute up to 50% of course costs.

Note. Timeline complied based on Wilson (2001, pp. 42-52).

This timeline shows how nursing leadership was responding to the political and structural changes that were taking place. The nursing leaders in the 1960s had a vision for nursing education that recognised the need for specialist support for educators, including research. The Carpenter report provided the support needed to move away from hospital training into tertiary level education. Nursing leadership groups during this time included the National Advisory Committee, and later the Nursing Education and Research Advisory Committee and the newly amalgamated New Zealand Nurses Organisation (NZNO) and Nurse Educators in the Tertiary

Sector (NETS). NCNZ had a key role throughout this period in setting the required standards for the changes, so as to uphold their mandate of keeping the public safe. The nurse educators in Wilson's study who moved from the health sector into the education sector to establish and develop comprehensive programmes were challenged in their positioning in this new environment. Within the polytechnic environment the new nurse educators were viewed as 'outsiders' who had moved into the tertiary sector from the distant health sector. Additionally, the new educators were quickly viewed as 'outsiders' by the health sector as they took on their new identity as educationalists. This proved to be enormously challenging for the educators, as evidenced by participants in Wilson's study. Three key discourses are evident during this time that constrain or enable capital and agency in the world of nursing education and the practice of the nurse educator.

The impact of neoliberalism in the tertiary environment

For many years, tertiary education was mainly centred in the university setting, with vocational training and apprenticeships being more prevalent in community polytechnic settings. In 1990, the deregulation of tertiary education and the formation of the New Zealand Qualifications Authority (NZQA) under the Education Amendment Act led to the recognition of nursing as an academic discipline offering undergraduate and postgraduate study. This shift to include the polytechnic sector improved access to education at this level for a more diverse population.

The changes in funding in education heralded the societal shift towards Western European-based neoliberalism. Neoliberal discourse advocates reduced government intervention in running the economy, making way for an expanded role of the private sector (Grant, 2014). This approach supports open markets, privatisation, and deregulation with a repositioning of power away from the state. The adoption of a neoliberal approach to tertiary education in response to the Todd Report (1994) (McLaughlin, 2003) moved the sector to a user-pays approach with students contributing up to 50% of course costs. The adoption of neoliberalism and its emphasis on individualism and economic growth resulted in a focus on preparing graduates for the labour market (Bruce et al., 2014). This position was in conflict with nursing programmes that were fostering graduates who were focusing on inquiry and critical thinking in preparation for recognising the wider effects of the socio-cultural influences and contexts of the social world of health and education (Tomm-Bonde, 2012). The focus on work-ready graduate preparation created an anti-intellectual rift, with clinicians valuing pragmatic skills-based knowledge over the abstract thinking that is favoured in the academic environment.

The health care sector has also been impacted by neoliberalism through a focus on operating under a market-driven business model based on economic capital. Government funding for clinical learning experiences moved from healthcare budgets (Vote Health) into education budgets (Vote Education). Ironically, most of this funding is subsequently paid back to the health sector for access to clinical learning. This shift was meant to give full responsibility for nursing education to the tertiary sector. With the health care sectors as the 'purchasers' of the product of nursing education (the graduates), their market interest and control of the education sector remains significant.

Acknowledging indigenous rights and cultural worldviews in health and education

A second discourse evident during this timeframe was the acknowledgement of the importance of indigenous rights in health care. This awareness led to the adoption of cultural safety as a compulsory component of nursing education. Globally and in Aotearoa New Zealand, how we think about and understand the knowledge of people, science, health and education has been dominated by Western Eurocentric cultural views. Nursing education has inherited and adopted an understanding of nursing as it has developed through colonisation. The impact of colonisation worldwide has resulted in the privileging of the Western European paradigms while, at the same time the non-dominant culture views of the indigenous peoples have been marginalised and devalued. This methodological positioning in society, named as 'Whiteness', is still prevalent in academic practices today (Stewart et al., 2020, p. 2).

Developing cultural awareness and an understanding of cultural safety is part of nursing education's journey and part of the journey that Aotearoa New Zealand is on in response to and recognition of breaches to Te Tiriti o Waitangi. In 1990, the country acknowledged 150 years since the historic signing of Te Tiriti o Waitangi, the founding document of New Zealand society. The 1988 Royal Commission Report introduced the principles of partnership, protection and participation as a way of making Te Tiriti o Waitangi current and applicable to all Aotearoa New Zealand citizens (Richardson, 2010). Cultural safety was developed as concept for nursing to educate and address the need for attitude change and an awareness of power in health relationships with Māori (Richardson, 2010). The NCNZ commissioned Irihapeti Ramsden to develop guidelines for nurses in working in a culturally safe manner (NCNZ, 2005/2011). The guidelines became incorporated into NCNZ regulations as part of the competencies that all nurses must meet to be fit and safe to practice as registered nurses.

Nursing education curricula were revised to include these guidelines and the teaching of concepts of cultural safety, social justice, equity and disparity, particularly in relation to Māori health outcomes. With these structures and changes being implemented in the world of nursing education over 30 years ago, the expectation might be that we have now developed sufficient cultural capital such that Te Ao Māori is normalised as part of Aotearoa New Zealand society including in nursing education. The reality is that society is just beginning to acknowledge the ongoing impact of institutional racism, discrimination and inequities that impact on the health and education systems with a profound impact on indigenous peoples. Māori nurse educators are still underrepresented in the nursing education workforce. Three indigenous nursing curricula have been developed and approved for preparing Māori nurses; however, the majority of nursing education curricula are structured around Western cultural views. The cultural capital associated with the indigenous peoples of Aotearoa New Zealand has yet to be recognised and valued in society and in the fields of nursing education practice.

Establishing a place for nursing research: A feminist standpoint

The third discourse evident during this time was the move to degree-level preparation for registered nurses. The nurse educator as an educational professional now had the opportunity to establish a place for nursing education research. Nurse educators at this time mainly held qualifications and research expertise gained from other disciplines. In the United States, nursing scholars were emerging from doctoral degrees in areas such as psychology, sociology and biology (Kim, 2015). Empirical research in nursing based on mainstream scientific methods was frequently used to guide nursing curricula and nursing practice processes. When nursing education began to move towards non-scientific knowledge bases including relational, aesthetic and ethical knowing, different research methodologies were needed. Attention was given to ethical issues when conducting research that involved human subjects using scientific research approaches, especially in relation to gender.

The development of research ethics systems in response to the 1988 Cartwright report contributed positively to nursing and health research practice. The Cartwright report focused on what became known as the “Unfortunate Experiment” that involved research on women with cervical cancer without their informed consent (Bunkle, 2014). The findings from this report identified scientific misconduct in this research study that was undertaken by research academics and medical practitioners. The Aotearoa New Zealand Government undertook reforms in relation to bioethics and patient rights that were considered innovative by international standards of the time. The Cartwright reforms successfully addressed the

imbalance between institutional and personal power that arose from this research (Bunkle, 2014). The reforms provided legal and enforceable processes for safeguarding patients' and research subjects' rights, especially in relation to informed consent (Paterson, 2010) and improved relationships between research institutions and health professionals. These reforms supported the development of nursing research processes which predominately involve human subjects.

The Cartwright report and subsequent reforms continue to be debated, with some claiming that the inquiry was manipulated by anti-male feminists who undermined the clinical and academic freedom necessary for scientific investigations (Bryder, 2009). This discourse is significant for nursing education because it represents the dominant view that favours an experimental approach to the construction of scientific health knowledge, with alternative approaches being branded as unscientific. This discourse also resulted in the academics taking a feminist standpoint in relation to research and gender issues. This standpoint surfaced further discourse in relation to power relations and research. This debate questions the power imbalance that is still evident between medical researchers and their subjects. This power imbalance is linked to the academic freedom in the publication of opinion and differences in the interpretation of knowledge. Bunkle (2014) argued the need for organisational systems in the academic world that investigate and adjudicate alleged ethical breaches and improprieties whilst upholding the defence of academic freedom. This example represents the symbolic capital that has been afforded to scientific research as a basis for legitimate authority within the field of academia. It also highlights the oppression that can occur in research based on patriarchal principles and domination from medical and scientific paradigms.

The field of nursing education today

Nursing education in Aotearoa New Zealand and internationally continues to transform alongside the changes in healthcare. The move to from hospital-based training to educational institutions led to the separation of theory and practice in nursing education which has generated a struggle that continues today. Nursing education is taught in polytechnics and universities situated in the main cities on both the North and South Islands. The regulatory body for nursing, the NCNZ (2015), sets the requirements for nursing education programme standards. These standards determine the academic focus for nursing education as well as the practice requirements deemed necessary for public safety. This includes the requirement that at least one-third of the nursing programme (1100 hours) being devoted to clinical learning and

practice in the workplace. At the time of writing, these education standards were being reviewed.

Tertiary education in Aotearoa New Zealand is now governed by the Education and Training Act 2020. This Act gives authority to institutions, namely universities, wānanga and Te Pūkenga – New Zealand Institute of Skills and Technology, to offer tertiary education. New Zealand Qualifications Authority (NZQA) is the body primarily responsible for quality assurance matters in the tertiary education and vocational education and training sectors, apart from the universities where the Vice-Chancellors Committee is the body primarily responsible for quality assurance matters (Education and Workforce Committee, 2020). Most Bachelor of Nursing programmes are situated across 13 Polytechnics with three universities offering degree nursing programmes and one programme situated within a wānanga setting.

The Act sets out parameters for institutions that may offer tertiary education programmes such as nursing. Universities are defined as having all the following characteristics while other tertiary institutions have one or more of them:

> (A) they are primarily concerned with more advanced learning, the principal aim being to develop intellectual independence
> (B) their research and teaching are closely interdependent and most of their teaching is done by people who are active in advancing knowledge
> (C) they meet international standards of research and teaching
> (D) they are a repository of knowledge and expertise
> (E) they accept a role as critic and conscience of society
> (Education and Training Act 2020, pp. 168-169).

A university is further characterised by a "wide diversity of teaching and research, especially at a higher level, that maintains, advances, disseminates, and assists the application of knowledge, develops intellectual independence, and promotes community learning" (Education and Training Act 2020, pp. 168-169). The characteristics of the university setting follow a traditional hierarchical structure linked to patriarchy, including privileging a scientific approach towards the development and advancement of knowledge, including research.

A wānanga is characterised by teaching and research that maintains, advances, and disseminates knowledge and develops intellectual independence, and assists the application of knowledge regarding ahuatanga Māori (Māori tradition) according to tikanga Māori (Māori custom) (Education and Training Act 2020, p. 169). The wānanga model seeks to fulfil the

government's commitment to establish and regulate an education system that honours Te Tiriti o Waitangi through the advancement of Māori-led and mātauranga-informed solutions (Tertiary Education Commission/Te Amorangi Matauranga Matua, 2020). The authority, including funding for these institutions remains with the government, which continues to create a power differential that marginalises the people it is intending to support.

The newly established Te Pūkenga – New Zealand Institute of Skills and Technology now incorporates all other polytechnics and private training institutions that offer tertiary education. The structures and culture of this new institution are still being developed and are discussed further in the next section on vocational reform. Nursing programmes, both undergraduate and postgraduate, are established and positioned within each of these types of institutions. The subtle difference in focus for each of these tertiary education providers has resulted in a range of nursing programmes and curricula.

Review of vocational education – responding to inequality?

Organisational structures and cultures in these different learning institutions have developed based on the interpretation of meaning from the Act. Ongoing transformation within the tertiary sector has seen both polytechnics and universities undergoing changes in management structures including leadership team structures, responsibilities for programme oversight, and how programmes are organised within centres, faculties, or schools. These changes are based on neoliberal and gendered practices that impact on how nursing programmes and staff are organised and run.

The polytechnic system has traditionally had a focus on vocational education with the current political strategy to support 'earn as you learn' education. This strategy seems to be steering the polytechnic sector away from academic learning towards learning that focuses on skills acquisition and the preparation of the work-ready graduate. Rolfe (2012) suggested that the shift in the late 20th century from a Newmanesque 'education for its own sake' ethos to an applied 'education for specific and specialist jobs' model facilitated the entry of nursing into the academic world in the first place (p. 103).

The New Zealand Productivity Commission (2016) review of new models of tertiary education identified a number of issues related to the role of the teacher and the student-teacher relationship. Issues to be explored include understanding the teachers' role as researcher and how this might contribute to teaching practice; how tertiary teachers are prepared and supported to become effective educators; and understanding the complexity of issues in terms

of the funding and management of the tertiary environment using a business model. This review has prompted a government review of vocational training, alongside a proposal to reform how vocational education is provided in the tertiary sector (Ministry of Education, 2019a).

This reform proposed the establishment of a single entity for providing vocational education across Aotearoa New Zealand with regional Centres of Excellence for different industries. Te Pūkenga was created following a national review of vocational education. The establishment of Industry Skills Bodies is proposed to have oversight of the setting of educational standards, moderation and assessment, and curriculum design. Within a nursing context, it is unclear whether this body would be the NCNZ.

This government-led review resulted in a new tertiary education strategy that would seek to substantially change the organisational culture of the polytechnic sector. With a unified system for learners, the vision is to create vocational education system that is more responsive to the unique needs of all learners including those who have been marginalised such as Māori and Pacific peoples. A more upfront focus on upholding and enhancing Māori-Crown partnerships is part of the organisational culture change proposed (Hipkins, 2020). The impact of the reforms and the restructuring in tertiary education is happening during the time of writing this thesis so the impact of these reforms cannot be fully understood.

The National Nursing Organisations' report to Health Workforce New Zealand (2014) signalled a need to work purposefully towards a workforce that matches the population. This means that an improvement is needed in the employment of Māori and Pacific nurses to match the population and significant health needs for this demographic. Decision-making needs to include a nursing education voice that is able to advocate for nursing curricula and programmes that produce the nursing workforce that is representative of the local population's needs. Culturally specific Māori and Pacific undergraduate programmes have proven a successful strategy for recruitment, retention and success for growing this workforce (NNO, 2014). An increase in the employment of Māori and Pacific nurse educators is needed to support these programmes and to support the development of an organisational culture that fosters a more culturally diverse workforce.

It is within this context that this research is undertaken. Nursing education continues to undergo reform and transformation in response to the changes in the education and health environment. These changes impact on the everyday work of the nurse educator. This next section evidences the historical and socio-cultural discourses that influence the formation of the nurse educator's

habitus. Habitus formation results from the multiple dispositions that develop from the social relations both personal and professional that the nurse educator engages with.

The nurse educator's habitus

The discourse around the nurse educator's habitus begins by examining identity formation. Learning how to teach involves learning new skills, examining different forms of knowledge and understanding pedagogy. Research literature has continued to signal a lack of clarity around the identity formation of the nurse educator. The nurse educator role is poorly described, undervalued and complex (Woods et al., 2016). It is unclear how the combination of clinical practice experience, a post graduate qualification and a teaching qualification enable or support the formation of the nurse educator. The formation of the nurse educator can be understood as a "process of becoming: a time of formation and transformation, of scrutiny into what one is doing, and who one can become" (Britzman, 2003, p. 31). The notion of 'becoming' helps in understanding that identity formation can change and/or reinforce what is learned as well as changing and or reinforcing the habitus of the person. "In this way, a person is constantly learning through becoming and becoming through learning" (Hodkinson et al., 2008, p. 41).

The nurse educator as clinician

The process of becoming a nurse educator begins with the process of becoming a nurse. A seminal model for understanding the nurse's way of being in the world is Parse's (2004) human becoming theory. Nursing is a journey involving both art and science that results in a process of coming to know the world of human experience (Parse, 2004). Becoming a nurse involves making true connections with others and developing relationships in true presence (De Natale & Klevay, 2013). Becoming and being a nurse requires competencies related to leadership, facilitation, clinical excellence and critical thinking skills in order to deliver quality person-centred nursing care (Harding et al., 2015). Some believe that the personal qualities of the nurse are just as important as their knowledge and skills. These qualities can be described as the nurse's presence evoking their personal identity into their practice. Nurses need to reflect on, absorb and internalise what person-centred nursing care means for themselves and others. The nurse educator needs to consider their own identity, relationships and context as role models for their learners (Brown & Doane, 2007).

As an experienced clinician, the nurse educator brings experience of building and working in relationships with others. The work of the nurse as organised through nursing knowledge and nursing practice is imprinted on the nurse moving into practice as an educator. They bring their

clinical skills and expertise, their nursing knowledge and philosophical understanding, and their identity and way of being as a nurse. Being person centred and being in social relationships with others is part of everyday practice for the nurse. The transition to nurse educator should be simple with the nurse already having the relational skills needed to teach. Whilst the work of the nurse educator mirrors the work of the nurse utilising many of the same skills and much of the same knowledge, the transition to teaching and the change in identity poses challenges.

The ambiguity for the nurse educator in combining dual identities of nurse and educator needs to be understood (Boyd & Lawley, 2009; McArthur-Rouse, 2008; Summers, 2017). Monson (2014) explored the experiences of expert nurse clinicians moving to the role of faculty educators in Aotearoa New Zealand. Lack of preparation for the role, lack of clarity around the expectations of working in an academic environment and lack of practical teaching skills influence the nurse's development of their identity as a teacher. The experience of 'transition shock' related to the differences in the values, social norms and ideology in the academic world may contribute to role confusion. Uncertainty about what is a 'good teacher' and how to fulfil this role is also challenging to identity formation (Monson, 2014). Uncertainty in their new role can lead the new nurse educator to hold on to their previous identity. Workplace support is important for understanding the shift in role and identity of the nurse educator (Boyd & Lawley, 2009).

The nurse educator as teacher

The nurse educator's identity is formed by their experiences as a nurse and as a teacher. Their personal qualities, beliefs and interpersonal teaching behaviours together form their teacher biography which influences how they approach and experience the teaching role (Palmer, 1997). The teacher needs to understand their own stories or narratives as well as the stories of others in the education experience to model this practice for their learners (Britzman, 2003; Brown & Doane, 2007).

The nurse educator also brings their personal experiences as a learner and of being taught. The experiences of learning from someone and being taught can be radically different (Biesta, 2013, p. 53). The nurse educator's own experiences as a learner may have been largely teacher led. Traditionally, teaching practice in nursing education was based on the transfer of knowledge with the nurse educator sharing professional knowledge and expertise in a clearly organised fashion from teacher to learner (Pratt & Paterson, 2007). The new nurse educator may have very little knowledge or understanding of curriculum, pedagogy and teaching/learning processes. The

starting point for the nurse educator is their own practice. Nurse educators look intentionally at how they are living and enacting nursing knowledge through their teaching practices in order to support the student in being the nurse (Doane & Brown, 2011).

The discourse of the nurse educator as teacher has focused on the transition from the clinical setting into the education environment. The transition experience includes adapting to organisational and situational differences, a new work environment, new technologies, and relationships that are unique to nursing education (McArthur-Rouse, 2008; Paul, 2015). Teaching preparation, orientation and support are needed during the transition period (McArthur-Rouse, 2008; Summers, 2017). The role of managing students' learning is seen as the most difficult part of the transition, requiring flexible teaching approaches, building connection with learners and being able to accommodate diverse learning needs (Summers, 2017).

Mentorship and collegial support are viewed as critical in the transition from clinical nurse to nurse educator (McArthur-Rouse, 2008; Monson, 2014; Paul, 2015; White et al., 2010; Wilson et al., 2010). Building faculty relationships with effective communication and connections is important (McArthur-Rouse, 2008) yet challenges are recognised in the mentorship relationship. These include lack of time, the power imbalance between the mentor and mentee, and the mentor knowing how to share wisdom (Wilson et al., 2010). The need for more practical functional guidance in the form of both formal and informal orientation and support for colleagues and the institution is also acknowledged (White et al., 2010).

The nurse educator as academic

Being an experienced clinician and teacher and holding a higher educational qualification does not automatically prepare the nurse to work as an academic. The role of nurse academic responsible for knowledge generation or translation can be a daunting role for the new nurse educator (National League of Nursing, 2013). Principles of academic scholarship include discovery, practice and teaching (Boyer, 1990). The scholarship of discovery links to the more traditional notion of scholarly activity being research based. This aspect of the role is valued highly in terms of being 'an academic'. Teaching in a bachelor's programme requires the nurse educator to be actively engaged in applied and/or theoretical research (Education and Training Act 2020). The scholarship of practice is an important role of the nurse academic for its impact on advancing nursing practice and improving health outcomes (Carter, 2009; Diekelmann, 2001; Peterson & Stevens, 2013). The integration of scholarship across research and practice has especially been prevalent in discipline-based education such as nursing. The scholarship of

teaching, the space in which academics spend the most time is the penultimate scholarly activity and seems to receive the least recognition (Boyer, 1990).

The historical view of teaching in academia was that a good researcher would develop teaching skills by carrying out good research practice (Attard et al., 2010). Most nurse educators in Aotearoa New Zealand engage in doctoral studies as experienced educators rather than in preparation for entry into this role. Nurse educators who gain the title of 'doctor' may struggle to reconcile their cultural identity as 'doctor' and 'nurse'. This career pathway means that the nurse educator may have little experience or preparation in the scholarships of discovery or application. The requirement for the nurse educator to hold a higher tertiary qualification is set to support their forming as an academic. What is not clear is how this requirement contributes to the quality of the work of the nurse educator as academic.

These discourses around the nurse educator's habitus highlight the complexity of the nurse educator's identity formation. Most of the literature focuses on the transition period. The nurse educator's work can be further understood by examining the discourses around capital and patriarchy that dominate the everyday work of the nurse educator. Forms of capital in nursing education can afford power and relations of ruling can create organisational and cultural structures that can support or marginalise the everyday work.

Forms of cultural and social capital in the field of nursing education

Structures and institutionalised relationships in both nursing and education have influenced how social and cultural capital is formed. Some of these structures have developed based on historical capitalist principles that included patriarchy as discussed in Chapter 2. Nurse educators, mainly women, form part of the social capital resource in tertiary institutions. Cultural capital is formed by structures, objects including artefacts, archetypes, and text from the disciplines of nursing and education. Cultural capital together with power has the potential to create symbolic capital and to support agency development. Since moving into the tertiary education environment, it has been difficult to develop symbolic capital for nursing education in Aotearoa New Zealand based structures and processes in the academic world.

Nursing knowledge development and nursing curricula contribute to both social and cultural capital. The genealogy of nursing knowledge development evidences attempts to build pluralism as a form of unique cultural capital in nursing education. Curricula have been structured based on knowledge development creating an opportunity for the formation of symbolic capital that values nursing education. The impact of patriarchy is invisible in the discourses except when the

work of the nurse educator is linked to caring. It is at this point that the impact of gendered and cultural biases is first evident.

Nursing knowledge development as cultural capital: Supporting pluralism

Disciplinary knowledge in areas such as nursing is made up of facts, concepts and ideas that have been developed through logical and formal procedures and practically conceived knowledge learned and developed through practice. Additionally, there is an ethical or moral dimension to disciplinary knowledge focusing not only on what to do but what it is right to do. The genealogy of knowledge development has been influenced by the dominance of patriarchal and capitalist structures and principles and the resulting privileging of scientific knowledge.

The discipline of nursing and education have followed similar trajectories in moving from industry-based training to education in tertiary institutions. Discourse has arisen around how theory, knowledge and evidence are represented. In nursing education, discourse has been between a medical, scientific focus on knowledge and the valuing of relationship-based knowledge and caring. Different nursing theories, models of practice and pedagogy have developed in response to the diverse knowledge bases. In the 1950s and 1960s, the profession moved towards self-determination with nursing leaders emphasising the uniqueness of nursing as a role different from medicine (Kim, 2015). Knowledge development focused on the uniqueness of the nurse-patient relationship and the recognition of patient problems that the nurse must attend to. This focus led to the development of nursing-based scientific theories paving the way for moving nursing training into educational institutions.

The move into degree-based education required the establishment of academic programmes that emphasised science, theory and research to validate a core body of knowledge in order to gain institutional recognition (Apesoa-Varano, 2007). This move saw the development of grand theories of nursing and the adoption or translation of other disciplines' theories to address nursing questions. Empirical research in nursing based on mainstream scientific methods was frequently used to guide nursing curricula and nursing practice processes. From the mid-1980's to the end of the 20th century, nursing knowledge development began to make a more deliberate shift to include alternative philosophies for nursing work that embraced non-scientific forms of knowledge. Carper's (1978) seminal work identifies foundational patterns of knowing as relational, aesthetic and ethical. A more holistic nursing approach formed as nurses embraced different ways of knowing.

Nurses recognise the importance of relational knowledge in forming their responses to people in different contexts (Brown & Doane, 2007). Aesthetic knowledge combines with attributes such as caring and compassion is valued as part of 'being a nurse' (McAllister, 2015). Unspoken in this discourse is the linking of these attributes of caring and compassion to 'women's work'. The nurse's own personal knowing or skilled 'know how' is linked to aesthetic knowing (Benner et al., 2010). Ethical knowing that includes relational attributes such as trust, empathy and respect was acknowledged as critical for understanding issues of social justice, equity and ethics (Hartrick Doane & Varcoe, 2005). Nursing practice was now described as this complex mixture of knowledges that were often contingent on understanding specific contexts. This more human response to practicing nursing acknowledges and respects diversity and difference and makes nursing practice less able to be explained by scientific theories and causal explanations alone (Rehg & SmithBattle, 2015). The changes in nursing education during these decades can be seen as involving a change in the culture capital associated with being a nurse.

Different approaches for studying nursing knowledge began to develop as nursing began to emerge with its own approaches to research. Nurse educators began to study nursing phenomena and engage in postmodernist questioning of the fallibility of knowledge and the role of language and power in knowledge development. Nursing scholars embraced a more interpretative/constructivist worldview based on qualitative research approaches. To maintain a scientific approach, nursing research adopted an evidence-based practice (EBP) approach that advocates questioning practice through critical reflection. This interpretive approach was considered to have a feminine underpinning reflecting the female dominance in the nursing profession in comparison with the masculinity of the positivist approach more common in medical and scientific professions (Artless & Richmond, 2000). The move towards EBP linked to the neoliberal political force of 'costing out' aspects of patient care and with the perceived need to developing nursing-specific therapeutics (Kim, 2015). EBP supported the continued dominance of scientific research methods for evaluating and developing nursing knowledge and practice. Common discourse during this period included a focus on globalisation versus local needs, nursing science versus nursing art, health versus illness, and quality control or standardisation versus creativity (Kim, 2015).

Twenty-first century knowledge development has seen nurses focusing on both bio-behavioural and bio-psycho-social perspectives. These approaches recognise the need for nursing knowledge and nursing practice to encompass both scientific problem-solving orientation *and* the human practice orientation (Kim, 2015). This pluralist form of nursing

scholarship is valued as the way for nursing to make a difference in a global community of health that is informed by multiple lived realities (Georges, 2003).

Whilst nursing education literature has documented the changes in knowledge development, there is a lack of consciousness of how these changes in cultural capital formation have impacted on nursing education practice. A review of American nursing education curricula noted a lack of reference to nursing philosophies and theories including multiple ways of knowing and nursing EBP, but an emphasis on scientific knowledge from other disciplines such as medicine continued to be more prevalent (Smith & McCarthy, 2010). Nursing education curricula lack attention to disciplinary knowledge linked to becoming a nurse. The invisibility of discipline-specific nursing knowledge might be due an undervaluing of the breadth of nursing knowledge or an assumption that nursing knowledge is implied without needing to be named.

Current nursing education may leave the future nursing workforce without a clear direction for adopting a pluralist nursing perspective. Failure to adopt a diverse perspective may impact the valuing of nursing practice within the interprofessional team. Cultural capital can be enhanced through the development of nursing curricula and pedagogy that adopts a postmodern approach. Nurse educators need to take a leadership role in curriculum development that is informed by an understanding of pedagogy.

Knowledge capital in nursing education curriculum and pedagogy

One of the prominent discourses for novice nurse educators is understanding curriculum and pedagogy and knowing how to teach. Novice nurse educators identify challenges in understanding curriculum and learning to teach and learning to give feedback (Paul, 2015; White et al., 2010). Since the curriculum in a broad sense is the primary tool by means of which the human subject is guided in their learning, one could say the curriculum is the 'mechanism' for the process of education (Osberg & Biesta, 2010). A pedagogy that supports creativity is an important foundation for learning and teaching nursing (Brown & Doane, 2007). Some significant changes have occurred in 21st century nursing education teaching and learning practices.

Diekelmann was one of the first nurse scholars who theorised teaching nursing with an approach that supports the shift of focus from knowledge acquisition to the application of thinking in practice (Diekelmann & Schulte, 2001). She developed a relational narrative pedagogy that encourages the teacher and the student to learn by interpreting their lived experiences from a

variety of perspectives. Narrative pedagogy has been adopted by several American nursing schools. Teachers described the difference in preparing for classroom teaching which involving creating thought-provoking experiences to enable students to practice thinking (Ironside, 2003). Students noted the shift from focusing on problem solving and 'doing', to valuing 'hearing' and listening' (Ironside, 2003, p. 514). Students expressed being uncomfortable with the idea that there is no one right answer particularly when this approach was mismatched with tertiary education structures such as testing or assessing best practice through examinations. Teachers were striving to engage the learner in different kinds of thinking, including thinking about questions that could not be easily answered or are perhaps were unanswerable. Teachers were challenged to reflect on what influenced their own knowledge and ways of thinking, considering both meaning and significance to practice. Both students and teachers reported shifts towards postmodern thinking and reflecting on what is uncertain and unknown (Ironside, 2003).

Another significant advancement in nursing curricula and pedagogy has been led by Dr. Patricia Benner. In 2010, Benner led a research project that studied five professional fields including nursing. This study determined three high-level apprenticeships (cognitive, practice and ethical comportment) that are linked to developing professional practice (Benner et al., 2010). The word 'apprenticeship' is used metaphorically and signals the need to integrate learning with practice. The cognitive apprenticeship focuses on the academic and theoretical knowledge base modelling the capacity to think in ways that are important to the profession. The practice apprenticeship focuses on learning clinical reasoning and clinical practice 'know how' to enable students to think and solve problems in actual clinical situations. Learning to make clinical judgements is the process that includes both conscious decision-making and intuition. Intuition is a form of thinking that nurses develop over time by putting together scientific knowledge and clinical expertise. Formation and ethical comportment involve teaching and learning about ethical standards and the roles and responsibilities of the profession. Through this learning, the novice is introduced to the meaning of integrated practice which considers all dimensions of the profession (Benner, 2015).

Benner's research determined that the apprenticeships work best when they are taught together in a situated way and signalled the need to shift pedagogies in nursing education. The researchers called for a radical transformation in the way nursing is taught with a move to deep rather than superficial learning, integrating knowledge acquisition and knowledge use. The need to focus on how to use knowledge was also identified as being equally as important as the knowledge itself (Benner, 2015). This type of transformative learning treats the learners as

critical agents who have the potential to move beyond binary thinking in becoming agents of change (McAllister, 2015). A pluralist approach values scientific and relational knowledge, values-based learning and aesthetic knowing in developing attributes such as caring and compassion.

Caring in nursing education practice

Caring is an important aspect of nursing relationships that is built on respect for individuality and autonomy and is orientated to preserving human integrity and promoting human flourishing (Kim, 2015). Students benefit from learning about being cared for and caring for others (Spadoni et al., 2015). The discourse that nurse educators encounter is understanding how to teach caring and how to model caring as part of nursing education.

Many nurse scholars have explored the notion of the ethic of care as being fundamental to nursing relationships. Caring involves attending to patients or clients as human persons in their totality and has a relationship orientation. Caring is most often linked to compassion or concern for one another. In nursing, caring also involves doing for others what they cannot do for themselves. Caring has a medical perspective which recognises caring as an intervention using nursing expertise. Caring is also linked to competency with nursing practice being measured based on providing 'proper care in the proper way and time' (Mustard, 2002, p. 37). Caring is an important component in both patient-centred care and the overall quality of care.

Nursing practice is described as relational caring when considering the unique human experiences and histories of the people being cared for. To learn to practice caring, the nurse needs to explore the nature and meaning of their own reality and the reality and the relationships of the people that they are caring for. Nurses engage in 'intentional caring' through human sharing, interacting and connecting with people's humanity (Kim, 2015). The model of being person-centred by recognising people as psychological and social beings and upholding the term 'person' rather than patient or client is now viewed as critical when considering the ethics and goals of health care (Harding et al., 2015). The qualities of caring that include being present and understanding wholeness and humanness guide nurses to build relationships based on partnership, presence and shared meaning (Smith & McCarthy, 2010).

A focus on caring has been part of the history of nursing practice including debate about whether caring is an innate feminine characteristic and/or whether it can be taught. Nelson and Gordon (2004) expressed concern that caring in nursing is sentimentalised without acknowledgement of the skill and knowledges involved in nurses' relational work. A different

perspective proposes that the concept of caring is multi-faceted and linked to specific forms of knowing. Aspects needed to be competent in caring include: the *intellectual* aspect that is informed by nursing knowledge; the *psychological* aspect that involves the nurse's feelings and emotions; the *spiritual* aspect that seeks to answer the questions why or what is the meaning of this; and the *physical* aspect of caring that uses nursing skills and abilities (Scotto, 2003, pp. 290-291). The discourse around caring as a part of nursing practice is based on the Western European values that have dominated the field of nursing. An indigenous worldview to caring as cultural safety, adopted in Aotearoa New Zealand, offers an alternative perspective that seeks to address marginalisation based on difference.

Cultural safety arose from te reo Māori concept of kawa whakaruruhau developed through the work of Irihapeti Ramsden, a Māori nurse educator. The original premise for kawa whakaruruhau was intended to address colonisation and inequity in health outcomes for tangata whenua as indigenous peoples of Aotearoa New Zealand (Roberts, 2019). Learning to practice in a manner that is culturally safe requires the nurse to have an understanding of their own culture, the historical, social and political influences on health and the ability to develop relationships that engender trust and respect (NCNZ, 2005/2011). In Aotearoa New Zealand, cultural safety is linked firstly to developing trusting and respectful relationships with Māori that uphold the principles of Te Tiriti o Waitangi. It is the person who is receiving nursing care that determines whether the nurse's practice is culturally safe. The understanding of cultural safety has been expanded to include other aspects of culture apart from ethnicity including age, gender and sexual orientation. The nurse needs to understand their own way of being in the world and the impact that this has in their relationships with other. This includes understanding the concept of privilege that may result from being part of a dominant cultural group. Cultural safety as a concept for caring offers an opportunity for addressing privilege and practices that may oppress.

The ethic of caring has developed as a central construct of nursing education teaching practice (Sawatzky et al., 2009). Excellence in teaching practice should include caring as part of teaching scholarship and leadership. Caring for the learner includes emotional support to promote self-esteem and confidence (Pratt & Paterson, 2007). Helping the student to develop proactive factors and build resiliency are also advocated as part of the ethic of care. Teaching/learning relationships that mirror nursing relationships by providing emotional support, building confidence and developing the protective factors of the person enable the student nurse to develop the ethic of caring that is fundamental to nursing. A relational model supports reflective

thinking, critical thinking and fosters connections in a manner that values a humanist approach built around the ethic of care. The nurse educator must dialogue practice to convey or teach values to support the learner in developing skilled 'know how' in understanding how caring and compassion should be expressed in different nursing contexts (McAllister, 2015). The student nurse learner needs to appreciate that not all practice can be empirically observed and measured or can be evidence based. A pluralist approach in nursing curricula and pedagogy represents a shift in cultural capital from reliance on the scientific paradigm. These approaches require the nurse educator to engage in teaching and learning through more interactive integrated approaches.

Dialoguing practice: The apprenticeship perspective

Nursing education has adopted a relationship-based teaching approach that incorporates attention to relationships both with others and with the world. The student-teacher relationship that is person centred provides an opportunity for modeling a person-centred approach for nursing practice. Applying a relational lens to learning should be central in nursing education focusing on "how people, situations, contexts, environments, and processes are integrally connecting and shaping each other" (Hartrick Doane & Varcoe, 2005, p. 51). The nurse educator's role is to support the student nurse in translating the complexity of knowledges gained through this type of inquiry. A teaching/learning approach is needed that can interpret meaning that is based on subjectivity and the contexts of different situations in the context of broader ideologies, norms and practices. The student nurse needs to be skilled in relational comportment and knowing-in-action (Hartrick Doane & Varcoe, 2005). As a coach, the nurse educator needs to be "asking what the students are paying attention to and how they understand what they are seeing" (Benner et al., 2010, p. 187). This approach can be described as dialoguing practice.

Nursing education needs to include opportunities for the learner to practice and engage in thinking processes such as reflection, wondering, discussing, feeling, critiquing, challenging, and creating (Benner et al., 2010; Brown & Doane, 2007; McAllister, 2015). It is important that students develop consciousness as part of the learning process which leads to a greater sense of creativity and freedom in their learning. A key aspect of the teacher's role is to create a trusting environment that promotes cooperative and authentic learning with meaningful assessment of the learning process. Student motivation is crucial, and the teacher has a role to play in fostering a relationship with sensitivity to understanding the student's needs.

A dialogical relationship with the student is open ended and circular, with spaces for responsiveness and learning for both the student and the teacher (Osberg & Biesta, 2010). The nurse educator poses questions and encourages the engagement of students to facilitate learning through making connections and interconnections with groups of students. The nurse educator must also understand the practical and embodied nature of learning which, for nursing, is crucial to 'becoming' the nurse.

The apprenticeship perspective of teaching nursing is a hallmark of nursing education. Learning is based on authentic tasks in real settings of application or practice with an experienced practitioner (Pratt & Paterson, 2007). This perspective has gained new support and understanding in terms of the complexity of this form of experiential learning and the importance of the relationship between student nurse and nurse teacher relationship in this clinical learning approach (Benner et al., 2010). Nurse educators have long recognised nursing as a practice-based discipline, and as such, nursing cannot be learned from or taught by textbooks and lectures based on theoretical principles alone (Harding et al., 2015). Teaching in a practice-based discipline requires an understanding of the relationship between learning and practice. Learning is viewed as an ongoing process that, in its simplest form, includes training, rule following and imitating role models (Hager, 2012). When practice becomes more complex, then simple rule following is not possible because of the uncertainty in the practice context. The learner needs to make judgements about how to apply the rules in a given situation. Ongoing learning through continual interpretation and reinterpretation of the rules is essential to good practice. Practice-based learning is viewed as emergent in the sense that is grows out of the dynamic nature of practice and through reflexivity and transformation (Hager, 2012).

Experiential learning has been part of history of nursing education dating back to Nightingale. Learning occurs through acts of problem solving involving relational transactions and interactions within the social context (Doane & Brown, 2011). Learning involves thinking in action to help the learner understand possible relations between actions and consequences (Biesta, 2007). Exploring and reflecting on real experiences through narrative storytelling and through simulated learning are practice-based approaches that develop critical thinking and actions to enhance nursing practice.

This model requires experienced clinicians who know how to support learners by articulating the embodied knowledge of practice. The relationship with the nurse educator needs to change as the learner develops and requires less direction and takes on more responsibility particularly in the practice-based learning environment. The clinician teacher needs to be able to articulate

to the learner both *how* to do things as well as *why*; while recognising that is it often more difficult to put into words the intuitive or tacit knowledge that the experienced nurse often possesses (Pratt & Paterson, 2007).

The nurse educator in a teaching role may have the most contact with the student yet often they are not seen by students as their most influential role model (Baldwin et al., 2014). The modelling of professional nursing behaviours is recognised as part of the hidden or informal curriculum. Students professional conduct is influenced by the manner in which the nurse educator engages with students, including how the educator provides feedback. The nurse educator who models enthusiasm for nursing and demonstrates a positive attitude towards nursing through teaching and learning practices, will have a more positive impact on the student nurse's professional conduct (Baldwin et al., 2014).

The success of the apprenticeship approach is influenced by the learning environment and context. Nursing students need learning environments that allow them to learn to make connections, particularly when in practicum experiences (Parse, 2004). Parse's model of humanbecoming has been used to develop teaching/learning processes that support students learning to connect with others (De Natale & Klevay, 2013). Building trust and active listening are the basic tenets of connecting with others. When relationships are the focus of learning in the practicum experience, students are better able to make connections and more at ease in making them. Learning to be with people requires practice, supervision and much reflection (De Natale & Klevay, 2013). The student needs to begin with self-development to support the forming of meaningful nursing relationships with others.

Inquiry and self-development: Facilitating learning

The discourse around adult learning practices, including nursing education, has arisen with the shift to being learner focused or person focused (Allen, 2010; Doane & Brown, 2011). Using the language of being person-centred gives meaning to the student as person with their own history, and social and cultural experiences as individual habitus. Adult learners as people benefit when they are able to take initiative and be self-directed in constructing their own meaning. The social aspects of learning including the learner's own self-concept, their accumulated life experience and their self-motivation, impact on their learning experience (Harper & Ross, 2011).

A person-centred approach focuses on the learner developing knowledge through active inquiry. Effective person-centred learning fosters the student's intrinsic motivation for learning with an emphasis on cooperation in the form of team learning, problem based learning and active

learning (Attard et al., 2010). Using student-focused learning outcomes shifts the teaching approaches to what the student is able to achieve and understand rather than what the teacher is able to teach. Shifting the focus from content to concepts and contexts enables the teacher and learner to investigate, analyse and evaluate nursing phenomena in deeper and more meaningful ways (Mitchell et al., 2016).

The discourse suggests that the role of teacher is more complex, with the teacher needing to engage with the learner to guide person-centred learning. The importance of the student-teacher relationship in organising inquiry and knowledge development needs to be understood. The teacher can be described as coach, guide, gift-giver, facilitator, listener, knowledge builder. Each of these descriptions bring different meanings and approaches for the nurse educator in the teaching/learning relationship. The teacher takes the role of 'coach' in guiding the student through the learning process instilling practices of collaboration and cooperation (Attard et al., 2010). Biesta (2013) uses the metaphor of teaching as a gift, or an act of gift giving, to describe a person-centred approach. The teacher brings something new to the educational situation through the encounter between the teacher and learner. The power of teaching forms through the interaction and requires giving authority to the teacher/learner relationship. To receive the gift of teaching requires giving authority to the relationship between the teacher and the learner. Some educators view this practice as making the role of the teacher as more passive and of lesser importance in the learning environment.

As facilitators of learning, the teacher must acknowledge the cultural, psychological and political complexities of learning and the way in which power permeates all human relationships (including those between students and teachers). This means that the teaching/learning relationship is never power-neutral. The teacher must recognise and acknowledge the perspectives or biases that they bring to the learning context. Recognising biases and developing strategies that are responsive to the learner are important aspects of the teacher's role in developing a balance of control (Pratt & Paterson, 2007).

The teacher's role is as the active listener who is able to pitch learning at the student's level, whilst allowing the learner to construct knowledge and to be challenged in their ways of understanding (Pratt & Paterson, 2007). There is a significant role for the nurse educator to support intuitive knowledge development. The teaching/learning relationship needs to nurture curiosity as a part of development of intuitive knowing (Brown & Doane, 2007). The teacher needs to understand how to guide learning but not control, how to share knowledge but not necessarily state, how to use dialogue without providing the answer and how to follow students

on their self-directed learning trail (Horsfall et al., 2012). Some educationalists critique this focus on the student-teacher relationship in learning processes, instead advocating for a restoring of the focus onto praxis learning which emphasises the connection between the learner and the world (Biesta, 2013).

A facilitation approach to inquiry and self-development requires the nurse educator to let go of authority and to trust that, when learners are supported in a community with teachers, learning will occur (Mitchell et al., 2016). Whilst this shift may be daunting for the nurse educator, teaching can be far more stimulating when teachers are open to surprise, to the collective consciousness of the group, and to the diversity of views and possibilities (Mitchell, Jonas-Simpson, & Cross, 2012). The nurse educator working in this manner not only shapes the practice of the learner but also shapes their own knowledge and understanding of nursing practice.

Structures of power and authority in nursing education: Formation of agency

Building the social and cultural capital that supports nurse educator agency is important. Research literature positions teacher agency as critical to improving the quality of education by building positioning that can respond to issues of power and authority. Teacher agency is viewed as a configuration of influences from the past, including the teacher's personal and professional biographies; from the present, in terms of practical cultural, structural and material resources; as well as from the future, focused on both short-term and long-term projections (Biesta et al., 2015). The importance of teacher agency in nursing education needs to be understood as an active contribution to shaping their work and its conditions for overall improvement. Teacher agency is influenced by teachers' beliefs and factors outside of their immediate control (Biesta et al., 2015). Teachers' beliefs may be assimilated to external messages without necessarily changing their personal beliefs.

The nurse educator's role is to act as an agent of change to bridge the gap between academia and theory. The nurse educator needs an agentic role in order to understand the changing health care environment and how it is influenced by social, political and community forces (Stanley & Dougherty, 2010). Teacher agency is highly dependent on the personal qualities the teacher brings to their work. A focus on long-term goals including the overall quality of education, results in a stronger agentic response (Biesta et al., 2015). An understanding of practice, learning and change intertwined with theory creates a place for change to emerge from practice (Hager, 2012). Learning is viewed as transactional in that it changes both the learner and the context. The nurse academic's role as change agent can be realised through their work as an academic.

The patriarchal structures that continue to dominate in the field and habitus of nursing education need to be understood for any real change to be realised. Discourses around institutional and programme structures impact on leadership, resourcing and academic development. An understanding of the structures and power relationships is critical to the development of the social and cultural capital that supports a nurse educator's agency as a nurse academic.

Programme structures and leadership

The leadership of nursing programmes must be delegated to a registered nurse with a current practicing certificate. The head of a nursing programme provides oversight of the programme with specific responsibilities related to ensuring that applicants entering the programme and graduates completing the programme meet NCNZ requirements for registration (NCNZ, 2015). Oversight and 'sign off' of nursing student graduates for meeting clinical competency means that nurse educators need to have both clinical learning expertise as well as hold a higher academic qualification. Having recent clinical nursing experience is often listed as a requirement for a job as a nurse educator in a tertiary education setting in Aotearoa New Zealand. These requirements the provide cultural capital for nursing education leaders to set the direction for nursing education. These structures build a strong base of capital that is predominantly controlled by nurses.

The size of a nursing programme may provide significant economic capital for the institution. Nursing programmes are often seen as the flagship programmes for the polytechnic as they make the largest capital contribution of both students and revenue. Nursing programmes vary in size with new intakes once or twice year. The size of the programme determines the number of nurse educators working in the programme. In the polytechnic sector, staffing requirements have been benchmarked for degree-level programmes which has resulted in most programmes being staffed at a 1:18 to 1:25 staff to student ratio. A significant social network of nurse educators can be formed within a polytechnic institution that has a large nursing programme. The culture capital of the polytechnic is often formed based on the credibility of the nursing and health related programmes which often have strong links to the community and industry.

Qualifications and status

Cultural capital is gained through the qualifications and status that the nursing education workforce might hold. There is a lack of clarity and consistency regarding the qualification requirements for working in nursing education. Differing qualification requirements result in

differing forms of cultural capital in different organisations nationally and globally. Both the NCNZ and the qualification authorities have requirements that educators teaching at a degree level must hold a higher qualification, at least a post graduate certificate but preferably a master's degree. The master's qualification may have research, practice, or education focus. In the university sector, it is expected that nurse educators hold a doctoral qualification to meet research obligations that are encompassed in this sector.

Some countries also have requirements regarding a teaching qualification. In the United Kingdom and Aotearoa New Zealand, nurse educators are required or recommended to undertake an approved teacher preparation programme (NCNZ, 2015; Summers, 2017). In the United States, higher education at doctoral level is required for the work of a nurse educator but a teaching qualification is not; and many doctoral programmes do not include preparation for teaching (National League of Nursing, 2013). There is a lack of direction both nationally and globally in developing a specific qualification that supports the work of a nurse educator.

While the doctorally prepared nurse educator may hold a higher qualification and status, their positioning with their institutional setting may differ dependent on whether they are in a university or a polytechnic. Within the university setting, nursing schools may be situated in faculty with a broader non-discipline-specific focus such as health or health sciences. Nursing programmes in these settings are often high in student numbers and may be taught as part of a wider health sciences suite of programmes with some courses taught by educators outside of the nursing faculty. Shared authority for these programmes may limit the autonomy and academic freedom for nurse academics. Doctorally prepared nurse educators may be perceived as holding a lesser status linked to the types of research that they engage in. Scientifically based research is afforded higher cultural and economic capital. Nurse educators whose research sits outside of this field may be marginalised and positioned differently in this setting.

Doctorally prepared nurse educators and nurse educators with research experience in the polytechnic sector may be a minority within the range of qualifications that nurse educators may bring into the sector. Even though there may be a significant social network of nurse educators in the polytechnic sector, there may a lack of leadership and support for research and career advancement. Although the polytechnic system currently permits the offering of postgraduate qualifications, the nursing sector itself has been divided in terms of the place for advanced nursing education beyond the undergraduate degree.

The cultural and economic capital for nurse academics in these settings is determined by their smaller contribution to the wider academic research environment. Structures used to allocate staffing and release time for research may not be responsive to the additional needs of the nurse educator to have oversight of clinical teaching practice.

Social networks: Promoting civility in the workplace

The formation of supportive social networks in nursing education is dependent on nurse educators being able to find a common field in nursing education. The different qualifications, titles, and structures can make it difficult for nurse educators to form cohesive collegial relationships. The gendered structures and culture in academic institutions may marginalise the position of nurse academics in forming social networks across the wider tertiary institution. Men are more likely to be in positions of management and power, with women in roles with lesser status and an expectation to 'do more for less' (Glass, 2003). Significant research shows that these structures contribute to an academic culture that includes incivility and bullying. Incivility is described as behaviours such as exclusion, lack of support, rudeness, gossip, and use of profanity in the workplace (Clark, 2013). Bullying includes an actual or perceived sense of power of one over the other. Women nurse academics from four countries (Australia, New Zealand, United Kingdom and the United States) revealed experiences of workplace violence and vulnerability (Glass, 2007). The stories told by female academics in her study revealed some deeply disturbing patterns of incivility and bullying in the workplace that she likened to a violent game. Strategies identified for dealing with the negative consequences of poor collegial relationships include quality mentorship, career professional development support, and the management of workload (Singh et al., 2020). An organisational commitment to a culture of civility is essential (Lasala, Wilson, & Sprunk, 2016).

The next threads to follow…

Multiple discourses are evident in the literature that reveals the social relations that make up the everyday work of the nurse educator. Nursing work has been mediated by nursing traditions that can be traced back to Florence Nightingale, who is recognised as an 'archetype' of nursing. The nurse educator's habitus formation is influenced by dual identity formation. Social relations and power can be understood as forms of capital. The incorporation of both scientific knowledge and other ways of knowing are forms of cultural capital. Teaching in nursing education has been mediated by traditions from both nursing and education theoretical frameworks. Caring work sits across clinical and teaching practice and comes from the historical underpinnings of nursing

as women's work. For many nurse educators, the practice of being an academic, results from a longer journey that incorporates both clinical and teaching practice. The work of the nurse educator in research and knowledge development is the area of practice that has unrealised potential for the development of symbolic capital and agency.

The next chapter presents fictionalised research narratives based on individual interviews with 15 nurse educators as another form of data about the everyday work of the nurse educator.

Chapter 6: Narratives of Nurse Educators

The narratives in this chapter have been compiled by blending together the experiences shared by the interview participants and my own experiences and observations as a nurse educator. These are 'archetypal' narratives in that they present fictionalised but typical views from the field of nurse education. Each narrative is followed by some commentary and analysis.

The first narrative records experiences of nurse educators in their first year in the role. Nurses come into nursing education first and foremost as nurses; and as learners with varied experiences of teaching or being taught. Most nurse educators in Aotearoa New Zealand move into the role after several years of practice in a clinical environment. Recent clinical nursing experience is often listed as a requirement in job advertisements for nurse educators in tertiary settings. The archetypal character of the new nurse educator is named Nova, derived from the Latin 'novus' or new. Nova's story illustrates the rewards and challenges for the new nurse educator, including identity formation.

The second narrative is compiled from interviews with more experienced nurse educators, using the name Sophia for the archetypal character, which refers to the wisdom that comes from experience, and who is navigating the competing demands of being a teacher, clinician and researcher.

The third narrative is compiled blending interview participants shared experiences of dealing with the structures, policies and power relations in the wider field of nursing education. This narrative is presented as a dialogue that takes place at the forum discussing areas for improvement in nursing education policies and management systems. Characters are created to depict difference perspectives of nurse educators who are participating in a national nursing forum discussion.

Nova's Story: "We don't know what we're doing"

There is a lot to be learned in your first year as a nurse educator. And one of the biggest challenges is that you often won't know what you need to learn until you are suddenly given the responsibility to do it. Nova is married with three children and had been working part time in the hospital for the past ten years. The flexibility of shift work enabled her to be at home while her children were young. Now that her youngest child has started primary school, it seems the perfect time for Nova to change roles and move away from shift work. Initially Nova "slipped

into the nurse educator role" by working casually as a clinical tutor. Nova loves supporting students in their clinical learning experiences and teaching them "basic nursing skills". Nova moved to working 0.8 full-time equivalent (FTE) at the local polytechnic since the start of the school year.

Nova is fitting in well with her nursing colleagues and has been amazed at the huge range of staff working within the nursing school. She joined a staff of about 30 people many who have 15 or more years' experience in nursing education. Nova's immediate manager was away when she started but she was assigned a mentor as part of the orientation process. Both Nova and her mentor seemed unsupported and unclear about the mentor-mentee arrangement. Fortunately, a colleague seated near to Nova in their open office space, offered her support and advice. Nova was grateful for the support: "She was friendly and smiled at me over the top of the computer. She said, if you've got any problems, just come and ask. We went out for coffee and I became part of her group."

Nova describes the experience of "stepping out of the clinical environment into the academic environment [as being] like chalk and cheese". Even in noting this difference, Nova feels that you can't separate educating others from the nursing role. "I'm very well versed and appreciate that teaching, mentoring, and supporting others is inherently part of the registered nurse role both in the education and clinical settings. But it's different standing in front of a classroom or a lecture theatre or supporting students in their newly developing beginning practice."

Nova found the whole experience of teaching 100 students in a lecture hall very daunting. "I can't understand how (school) teachers do three years of education and are observed, watched and assessed; and yet we're literally just told to go and teach." She had a genuine fear of public speaking and was surprised that she was expected to be able to do this after just a few weeks in the job. Especially when she realised that she was expected to talk for three hours! "In my first teaching session, I was a neurotic mess. I hadn't slept the night before. I was in the toilet in tears. I was just beside myself. I taught two classes on that first day and no one was there watching or giving feedback or helping with the technology. I did find that odd." She soon realised that she knew more than she thought and was able to use her stories and experiences in her teaching.

Working in the clinical environment supporting students has been an easy part of the transition for Nova, especially when she has been seeing students working in areas where she has practiced herself. "I love clinical, because I can go and see the students and kind of get my ward fix, but then come back and teach." This combination of clinical and classroom teaching helps

Nova feel comfortable and confident in her role. While Nova values her role in education, she is also conflicted with wanting to keep links with her clinical self. “I can see that experienced educators who perhaps have been in this academic world for a long time might experience a bit of a disconnect between academic and clinical realms. I’m cognisant of making sure that I keep connected to clinical practice and I am thinking about how I do that going forward.”

One of the most common experiences for nurses new to education is moving from being an expert practitioner to a novice educator. Nova experienced this when she felt unrealistic expectations from colleagues for managing new tasks. “I think at times if you appear to be quite capable and experienced in nursing, then people felt that I should be doing okay. But inwardly maybe I haven’t been. I’ve learnt a few lessons about reaching out sooner, rather than just putting on a brave face and appearing to be coping.”

Another challenge for many new nurse educators is the need to complete a master’s qualification. Luckily, Nova has completed some post grad courses supported by the District Health Board (DHB) and she only needs to complete two more courses to gain her master’s qualification. She hoped that this would be easier when she was employed by the polytechnic, especially as they promised to pay her course fees and give her study time. She didn’t realise that she would also need to complete an adult teaching and learning certificate. However, after just four months in the role, Nova recognises that she needs to learn and understand the world of education. “If you’d asked me what the word ‘pedagogy’ meant two years ago I wouldn’t have been able to tell you. It’s a whole different language and a whole different kind of mindset. I’ve actually chosen to do two papers this semester just because I feel like it’s really useful. Although it’s added more work, at least it is helping me every day.”

Nova wasn’t prepared for the challenge of working regular hours when she was used to doing shift work. “I didn’t realise how hard it was going to be. Just the tiredness, and the mental exhaustion. It’s just been unbelievable.” Nova recognises that some of the physical tiredness is related to needing to take work home. “I do find I take a lot of my work home, in terms of my actual physical work. When I was a nurse on the ward, I would take my work home, but it was all in my mind. Whereas this is a lot of physical work and I have found that a lot of my weekends are being tied up with trying to get a lesson planning sorted, because I’m new and fresh at it so I’m really slow.” Nova attributes the mental exhaustion to being both the teacher and the learner. “You’re teaching and learning at the same time. I feel like although I have the basics and I remember what I was taught, but it’s like I’m re-learning it again.”

Beside learning how to teach, Nova finds that she is sometimes stuck even understanding the basic policies and structures. She describes this process as “needing to manage the step into the academic world, into a new position; and learning the culture of the environment and the culture of the organisation.” “It’s like, we don’t know what we’re doing. For example, I didn’t even know how you were meant to request annual leave. We were told it had to be in by March for the whole year, but I don’t even know when I’m teaching next semester.” Nova explains that she has been encouraged to be proactive and ask questions. But she explains “if you don’t know what to ask it’s very difficult to ask questions until the situation occurs and then it’s like, well now what do I do?”

Understanding how to manage her workload and competing demands is also challenging with a lack of direction. Nova shared an experience when she was left to make her own decisions about competing demands on her work calendar. She describes “feeling like you’re not in the right place at the right time, because you didn’t realise, and you’re not told that this meeting was more important than that meeting, and you were meant to be there”. She also feels that she needs more support in judging the time needed for different work. “Even working out your timetable and your diary. I wasn’t really given much direction in the beginning. I don’t know how much time marking’s going to take.”

Equally challenging is Nova’s desire to want to do everything as it all seems new and exciting. “My biggest challenge has come with saying no. When you’re a capable person and when you’re also a team player and a bit of a ‘yes’ person, people will tap into that. I’ve needed to learn some strategies about just managing my own time, where my focus or priorities need to remain; and then if time permits, I’m happy to look outside of that. It’s actually practicing what you preach. I would say to my students- don’t wait until you’re struggling before you reach out for help – and yet that’s exactly where I was at.” She appreciates when colleagues have supported her to set realistic timeframes for completing unfamiliar tasks. “My colleagues have now been saying what type of work requires more time. So that’s kind of given me a heads up to put a little bit more time into that work.”

Even with all these strategies for managing competing demands, Nova looks forward to when the work will become more familiar. “I think next semester will be so much easier because I’ve gone through the papers and I have a basic idea. I will know how everything works. You’re trying to learn about all the systems, the computer programmes, everything as well as the paper that you’re teaching and then you’ve got your own study as well.”

Nova is happy and full of enthusiasm as she reflects on her first term working as a nurse educator. She describes this role as “probably one of the jobs I’ve enjoyed the most, even though I feel like I have no idea what I’m doing”. She is excited about the different opportunities that the role will offer. “I just feel like there’s so many roles in nurse education and because you can teach in so many different papers and areas, I don’t believe I’ll get bored. There’s so much scope for me too, to do further education, to learn to teach properly or to look at a PhD. I just think the opportunities are amazing.”

Nova describes the work as “an extreme privilege” and explains that this is not just a catchphrase. “I honestly do feel really privileged to be here. It's a really lovely way for me to be able to give back to the profession that’s been extremely kind to me. I’ve had the most incredible career to date. It’s lovely to come back to where it all began for me. I do find it helps me to be able to really relate to what the students are going through, and I think that’s the key.”

Nova appreciates her relationships with students and the learning that she gains from the students themselves. “Actually, I never underestimate student lived experiences and their own life experiences and what they bring to their learning. I’m learning from them so it’s kind of that teaching/learning, it’s not just one way, which is really exciting. That’s part of the privilege for me. You get to a place where they share some pretty wonderful life experiences and stories of their own, which opens my eyes to a different world as well.”

Nova envisions herself staying in this role because of the additional opportunities for research. “This is my first role that I’ve felt really supported to look at research. Even though we’re held accountable to that in our clinical practice, I don’t know that nurses on the floor have the same access or acknowledgement of the importance that research can play in developing your practice. I think that it is a real privilege, to have dedicated space, the hours and a place to do research.”

Coupled with the opportunities, Nova has already experienced moments where she knows that she is making an impact with her students. “You know those lightbulb moments, some ah-ha moments. I’ve had a couple of those when I get that validation that I’m helping, I’m doing my job. That’s been the coolest thing so far and fun because I think no amount of money can buy that feeling. So far in my very limited nurse educator career, that’s been my driver. I mean it’s been only four months, but I really enjoy the challenge and I’ve really enjoyed working with the students because one day they will be my colleagues.”

Commentary on Nova's story: Identity formation

Nova's story focuses on how she is navigating competing demands as she transitions to the role of nurse educator. One of the challenges evident in Nova's story is the lack of understanding of the 'big picture' or the wider context of nursing and education. Her transition into nursing education is linked to the formation of her identity in this new role. The nurse educator brings to the role their values, beliefs and experiences both as a person/learner and as a nurse/teacher. These factors influence their approach to learning and to the learner, their understanding of the role of education as well as their understanding of their role as teacher. Teacher identity is formed by the person's biography and by understanding their own stories or narratives as well as the stories of others in the education experience (Britzman, 2003). For Nova, her biography includes her identity as a nurse, a woman and a mother. Nova is comfortable and confident in her role as nurse and mother, and upholds her personal values for maintaining a work–life balance. These personal qualities and experiences influence her approach to learning and to the learner, and her understanding of the role as educator. She values her own experiences in nursing and wants to share that positive experience with the learners.

Nova 'slipped into nurse educator role' suggesting that is a simple and natural transition. Yet like many new nurse educators Nova found this transition challenging and confusing. Nova experienced the feeling of being unprepared for the new role of teacher, in the unfamilar world of education. These experiences of uncertainty, lack of preparation, including practical teaching skills, and lack of role clarity in the academic environment are well documented in the literature (Boyd & Lawley, 2009; McArthur-Rouse, 2008; Monson, 2014; Paul, 2015). Nova sought to maintain her links with her clinical identity by returning often to her familiar ward setting where she had developed into an expert practitioner. In this setting, Nova felt confident both as a nurse and a teacher. She recognised and was able to use some of her nursing skills and knowledge in her new role as educator. New nurse educators like Nova hold on to their familiar clinical identity to counter the experiences of 'transition shock' that occur because of the different values, social norms, and ideology in the academic world (Monson, 2014).

Nova was given little orientation to her new role in the classroom and was expected to seek out her own support and ask for help when needed. This lack of support and Nova's lack of confidence in classroom teaching resulted in a very traumatic first teaching experience. This unforeseen and unanticipated struggle to meet the expectations of an academic role is also reported by Australian nurses moving into more permanent teaching roles (McDermid et al.,

2013). Their stories revealed similar experiences as new nurse academics being overwhelmed with the demands of the role.

Fortunately Nova had strong self efficacy in the more familiar role as clinical teacher and this helped her in developing her confidence in other less familiar areas of teaching. Some new nurse educators reported resorting to over-preparing for teaching and learning as a strategy to mitigate their lack of confidence in the new role (McDermid et al., 2013). This strategy can become an exhausting and stressful process motivated by a fear of failure or a questioning of the nurse educator's credibility. New nurse educators need preparatory experience, sufficient time and resource for practice and evaluation to confidently adopt new teaching practices (Robinia & Anderson, 2010).

Role ambiguity is considered a problem for many new academics and clear expectations, guidelines and policies are required for understanding how developing practice will be supported and evaluated (Summers, 2017). Summers concluded that a formal orientation and mentorship process is needed when nurse educators are first appointed into academic roles. Nova's story and the literature illustrate that there is a need for peer support, mentorship and socialisation to support the formation of the identity of nurse educator.

The identity of the nurse as organised through the way that they think and act as a nurse is imprinted on the nurse moving into practice as an educator. Nova recognises that her own nursing knowledge and stories were valuable in teaching and supporting student nurses' learning. Recognising the nurse educator role as knowledge worker supports the transfer of a wide range of skills including critical thinking, reflective thinking, clinical reasoning and judgement and sensemaking in applying knowledge to practice (Benner et al., 2010; Finkelman, 2019). Nova uses critical thinking and clinical judgement to form her practice as a new educator. This includes using her judgement and time management skills to help her in setting priorities for both her work and family commitments. She may not be conscious of the transferability of these skills into her practice as a nurse educator.

A key aspect of Nova's role as a nurse educator and in her identity as a nurse is working in relationships with others. The importance of collegial relationships includes the desire to belong with the team and within the new environment. Nova describes her vulnerability as a new educator wanting to get things right, to appear to be coping, and sometimes being overwhelmed by the whole experience. The importance of belonging, mentorship and collegial support is evident in both Nova's story and in much of literature that has investigated the transition

process (Kenny et al., 2004; McArthur-Rouse, 2008; Roberts et al., 2013; Singh et al., 2020; White et al., 2010).

This abundance of literature that has promoted mentorship for the past 20 years has not resulted in much improvement in the transition process (Hunter & Hayter, 2019). Hunter and Hayter recommended that a plan for a prolonged period of mentorship including the adoption of an ongoing reflective process, is needed to support integration and career progression. This process should include support for developing a new collegial network that links the nurse educator to more experienced colleagues. An ongoing focus on identity development and revisioning of their new role as academic should also be part of the career plan. A commitment to regular professional supervision is also recommended as part of this approach. The success of this type of plan is reliant on skilled nursing leadership and supportive organisational structures including resourcing (Hunter & Hayter, 2019).

The next narrative is based on typical work week for Sophia, who is a more experienced nurse educator. Sophia's narrative reveals the challenges of navigating the competing demands of her work week.

Sophia's Story: "Sometimes it feels like you've literally got four or five windows open in your brain"

It's Friday afternoon and Sophia is looking at her calendar of work for next week. Managing a busy workload is not new to Sophia, who has been a registered nurse for over 15 years, including working as a nurse educator for the last 10 years. Sophia remembers with a smile how she initially came into nursing education. She was newly married and settled in her job, working in an acute hospital setting after spending a few years travelling and working overseas. She was enjoying her work as senior nurse and as a preceptor, which involved looking after nursing students during their time on the ward. She felt she was giving back to the institution where she was once a student and enjoyed teaching the students in the clinical setting.

One day she was asked by the clinical tutor from the polytechnic to be an actor in a simulation learning experience on campus. After speaking with some of the nursing tutors that day, she was encouraged to pick up some casual clinical tutor hours. Sophia had already been thinking about making a shift into an educator role. "I would have been quite happy to work as a nurse educator within the hospital setting, but the roles for educators or nurse specialists in that setting are really limited. People get into these roles and they don't want to leave. Then the DHBs go through cycles of cutting back some of these roles. It's really hard for younger nurses

to try and get into those roles." So, when a part time position was advertised at the polytechnic, Sophia decided to apply.

Now, as the mother of two school-aged children, Sophia works 80% of a full-time job, with Friday off each week. But she still checks her emails daily for any student matters that might require her attention. She's trying to learn to switch off at the weekend but being accessible by phone and email 24/7 makes this challenging. "I got a text from a student on Sunday saying: 'I've uploaded some work, I'd love some feedback.' But it is Sunday night and I've got to put my kids to bed. I'm trying to get the message through to students that I'd really love to mark their work, but I can't always do it when they want it. It's only certain times in my weekly schedule where I'm going to be able to read their work."

Sophia recognises this as part of the dilemma of being the nurse and the teacher. "You want to be there for the students. You want to be available and as a nurse you are a caring, kind, compassionate person and you want to role model that to your students. However, students have an infinite need for your time, so you need to balance the role of the being the caring nurse with being professional and needing to get other work done". Sophia links balancing the role of caring as part of her ethical obligation for self-care. "I was reading ICN code of conduct, and it talks about caring for yourself as an ethical obligation. I think that motivated me because I want to be an ethical nurse educator. I must look after myself. I'm a bit more mindful of that in the last few months."

Sophia is trying to maintain work–life balance, valuing her family time on the weekends. But she still finds herself doing work around her family life. "I will write an email at night but put the delayed delivery on it so that the student doesn't get an email from me at 10 o'clock at night. Because late night emails indicate that I am available 24/7, and I'm not. We try to encourage all staff to do that. If you've got one staff member that continually replies no matter what the time of day, or over the weekend, we get different student expectations about response times. They need to know that we don't work weekends."

Sophia finds it challenging at times to set priorities and manage the various competing demands of her job – classroom teaching, marking, visiting students in clinic, attending meetings and being involved in research. She is looking forward to visiting Year Three students in clinical on Wednesday and Thursday this week, but she is wondering how she will juggle the rest of her workload. She is scheduled to teach a three-hour workshop for a Year One praxis course on Monday morning.

The topic is something she's taught many times before, but she still wants to review the lesson plan and her power point slides sometime over the weekend. She wants to be prepared and make sure that her resources are all up to date. She wonders if she needs to contact ICT services to make sure that the technology in the classroom is working, because she intends to show the students a YouTube video clip. Sophia is not always confident in using technology in the classroom but knows that younger students are more engaged if different types of learning activities are included. Sophia always stays in the classroom after a session to be available for students needing additional support. This often means that missing out on a lunch break and eating lunch at the desk while checking emails.

Sophia uses nursing management skills to prioritise the workload. "I think it's partly who I am. As a nurse I was highly structured, every shift I worked had a plan for everything that needed to be done, it was all documented, but it also didn't stop me from being flexible. The plan is there but I can adapt and bend as needed. It's part of who I am."

Sophia has blocked out Monday afternoon for starting to mark an assignment. She has been allocated thirty 3,000-word essays, and the marking needs to be completed within the next two weeks. Sophia finds it difficult to mark in the shared office space, but she hopes if she puts on her headphones, she can get two or three marked today without too many interruptions.

Sophia values the flexibility in her role and is planning to work from home on Tuesday as it is her 'non-teaching day'." She will take the opportunity to go for a swim in the morning after she drops the kids at school and then catch up on emails, other paperwork and marking. Her calendar looks 'blank', but Sophia has a big 'to do list' that she wants to get on with. "That list generally might look this big, and then may look substantially bigger by the end of the week with a few ticks. I highlight stuff that must be done, and stuff that can wait, and some of that gets carried over. Sometimes you end up with everything highlighted and I just go right this week is going to be busy. I'm just going to get these things done." Sophia labels this work as administration. "So, a lot of email, a lot of filling in forms, doing your own photocopying or filling in HR (Human Resources) forms or request forms or applying to student queries. She also needs to engage regularly with the students' online classroom activities, checking in daily to respond to students."

On these admin days, Sophia sets some parameters for her work to make her day more efficient. For example, "limiting when I look at emails. Sometimes I don't look at emails when I first start work because then there's just lots of distractions. So, if there is something that I really want to

focus on, I'll do that. Then at morning teatime, I'll open my email. Because I think if it's absolutely urgent someone will phone me anyway. And then I will close my email, putting it to the calendar mode so it is blocked, and then later in the afternoon, I'll look at email as well. Otherwise, I feel like you can just get swallowed up with email, particularly within an organisation where you're getting emails from all different departments. A lot of them don't necessarily need your response, but they're just a distraction."

As a senior academic staff member, Sophia is also a course leader which means she must find time to oversee the timetabled teaching, check on student progress including attendance, and identify and support students at risk or needing extra support. Sophia draws on her negotiation skills around clinical problem solving for managing competing demands from students: "doing it in a way that doesn't say we're right and you're wrong; but it says let's work together to find a solution that's going to work for both of us. Really focusing on a win/win rather than this is how it's got to be."

Sophia is expected to take on a leadership role in the School, including being involved in academic committees and supporting more junior staff members. She finds this additional responsibility quite draining. "Sometimes newer staff don't have the confidence to go and make the hard decisions themselves. They often feel that they need to check decisions, so I'm constantly needing to be available for staff." She recognises the importance of teamwork but doesn't always find it easy to share the workload. "I guess it's still that classic managing- what's urgent? and what's important? and then thinking what things I could delegate to someone else? Sometimes there doesn't seem a lot of people around to delegate to. There's lots of things to think about. Sometimes it feels like you've literally got four or five windows open in your brain."

Sophia often feels conflicted in managing her own needs with the needs of the job. She worries that some of her colleagues who don't have children resent the fact that she is not always able to stay late or work on the weekend. She has a team meeting scheduled from 3 – 4 pm to catch up with colleagues about any student concerns or workload issues. Sophia hopes everyone arrives on time for the meeting, because there is always lots to discuss. She needs to get away at 4 pm to pick up her children from their after-school activities.

Sophia is a bit intimidated by one of her colleagues, Ann, who is a long-serving member of staff. Ann has an emergency department nursing background, and she uses her crisis management skills when dealing with workload issues. Ann has some strong opinions as to how the team should manage competing demands. Ann has a more dogmatic approach that includes rules

such as: “keep the show running; don’t air any issues to the student group; keep everything ticking along in front of the students; and then deal with things later.” Ann will often work late or come in on the weekends to get things done. She has been quick to point out colleagues over the years who become stressed or overwhelmed by workload because they choose not to work extra hours. “That’s fine if they choose to do that, but then they become stressed out and shouting and that is winding everyone else up. I think it is worth it to spend a bit of extra time to finish that task. Finishing putting results into the system, finishing writing those memos after meeting with students, so that it’s not there when you come back. Otherwise, it causes unnecessary cumulative stress. I like to try to be ahead because you never know what’s going to happen; emergency nursing taught me that.”

On Wednesday morning, Sophia puts on her clinical tutor uniform in preparation for visiting students in the local hospital. Being a nurse is at the heart of her daily work and wearing her uniform including her nursing medal is an important part of her identity. Sophia feels fortunate to be able to follow students in clinical and maintain her contact with patients and with the nurses in some of the wards where she used to work. According to Sophia, her clinical teaching role involves “lots of pastoral care and then touching base with their preceptors to check that the students are on track. It’s about helping them make that link between theory and practice; and being able to articulate what they do and link it to what they’ve been taught. Then alongside that, I spend a lot of time reading their portfolio work, and giving them feedback: what’s good, what could be improved, have you thought about saying this instead? how does this link with what you were taught? I give lots of written feedback for formative and then the final summative assessment. So, I’m either face-to-face with my learners or reading their work. That is the bulk of my clinical time.”

Sophia heads home to pick up her kids from school and make dinner for her family before returning to the hospital to visit a student who is working the afternoon shift (3–11pm). As she reflects on her own busy schedule, she thinks about her current student cohort, and the overwhelming complexity of their lives. “We have students with very complex mental health needs, who may be absolute academic stars on paper, but we need to work with them to manage their own health needs. We’ve got to ensure safety to practice which means we need to ensure that students have the capability to be safe with the public.”

Sophia would like to see more evidence that she is making a difference for nursing practice, given what she sees in the clinical or classroom setting. “What is really worrying is that students go out into clinical placement and come back and tell me about appalling nursing practice,

absolutely horrendous. Nurses hiding medications and not telling patients what they are giving them and using patient restraint without consent. Some really awful practice happens out there. I wonder why I am doing what I'm doing, if those sorts of practices are going to happen. I tell my students that they need to remember that those nurses were once sitting in a classroom telling the same stories. While I am not condoning what these nurses are doing, the students need to think what has happened to make nurses practice in that way. How are they going to protect themselves so that they don't turn out like that nurse? And I remind students that there are good stories to tell as well." Sophia worries about whether her contribution through nursing education is making practice better. She is heartened when she gets former students walking across the road to tell her about the positive impact that she has had on their nursing practice. "That is the positive reinforcement that you are actually doing a good job and that you are making a difference."

Sophia feels the constant gap between the clinical and academic spaces that she inhabits and thinks about how she can bridge the gap. She acknowledges that "our students spend more time in the clinical setting than they do at the polytechnic. All their teachers in both spaces want them to succeed in becoming nursing colleagues and graduate nurses." She believes that this perceived gap between theory and practice has caused her to struggle with coming to terms with her own identity as a nurse educator. "My professional background, my values, everything was in nursing and now is in teaching. Over the years there has been a dilemma for me, do I want to be clinical? Do I not? Where does the balance fit? It's understanding what we do and where do we sit in nursing education. I think it has taken me the last few years to value that we have in teaching. Now I can proudly say 'I'm a registered nurse!' It's interesting because when I fill in a form and it says employment; registered nurse is what I put down. I don't put down nursing educator, because registered nurse is my title for want of a better word. Registered nurse is what enables me to do all of this stuff. I guess that's where my loyalty lies, to protection of the public. I could lose my registration if I didn't do that and I'm not keen on that road (laugh)."

Friday morning finally arrives, and Sophia is grateful to have time to catch up on some household chores before the weekend. She is meeting up with a nursing friend for a coffee in the afternoon before school pick up. Sophia and her friend who works in community health nursing have an informal supervision session comparing their working weeks. Sophia describes her work to her friend as both rewarding and demanding. "I don't think people realise how hard it actually is. I think some people see it as the soft option. That we come out of practice and it will be this

wonderful Monday to Friday, nine-to-five job, which it is not. At least I have not found it to be a nine-to-five job. There's always something different happening every day, which I love."

Sophia recalls this similar feeling when working in a clinical role. "As a nurse, every day was different, because you were looking after different patients every day; even if it's the same surgical procedure, it's still different people. It's a bit like that here. Every semester we get a new bunch of students. Some of them are the same (laugh) but it's still different. Every day is different, and you can feel the cycle. In the 15 years I've been here I would say no two semesters have ever been the same. Even if I've been in the same papers and done the same teaching and marked the same assessments, no two semesters are ever the same, which is great because it means that I'm constantly having to think and grow and develop and push my own boundaries."

Sophia explains to her friend that she believes that being a nurse academic fits with her personality. "I guess because I've always naturally been an academic and liked reading and writing and thinking, that has always been a part of who I am. So really, this role suits my temperament and my personality. I love to read my students' work and give them feedback and see them one-to-one. These are the best bits of my job."

Sophia loves being in an environment where she feels she's learning: "I feel like I can keep learning from them and their experiences. That can be invigorating. I like being with young people, it helps me not feel so old (laugh) and so that's exciting. I like being on the wider campus. I think I've got a lot of varied interests, even as a nurse I've worked in a range of places, so I don't have just one small niche that I'm really interested in. Being a nurse educator helps me keep those broad interests as well." Both friends reflect on the value that their everyday work as nurses adds to their lives. Even with all the competing demands, this is work that they love. "I think what I really enjoy about this role is that there is room for change and my scope of practice can grow. There is so much opportunity here and I feel very fortunate."

Sophia sees the opportunity to support the students into a nursing career as her way of giving back to the profession and the public. "I think it's a sector where you can give something back to nursing and make a difference. I entered nursing because I wanted to make a difference, but I didn't know what that difference was going to be. I guess I had all the clichés – caring about people, wanting to make a difference, wanting to help people. I think that's what I'm actually living because I'm making a difference to students' lives and staff lives; and arguably that therefore leads to making a difference for patient outcomes."

Commentary on Sophia's story: Competing demands

Sophia's story is from the perspective of an experienced educator who is more secure in her identity as an educator and as a nurse. She recognises the value of her nursing skills and knowledge, and she has adapted this discipline knowledge to her work in education. Her story shows that she feels competent in her teaching skills and moves easily from the classroom into the clinical setting. Sophia experiences many challenges as a nurse educator who is seeking to manage the competing demands of her everyday work. Sophia uses the metaphor of navigating many tasks on her computer when she describes her work as having 'many windows open at the same time'. This image illustrates the complexity of the everyday work that requires Sophia to navigate between education and practice. The biggest challenge for Sophia is managing her work as an academic.

In Sophia's story, navigating her daily tasks is visualised as a computer screen having four or five windows open at once. We can imagine each window representing the organisational values, strategic direction, government strategies, financial responsibilities, and other political agendas. This description depicts the systems and structures that may be in the forefront or hidden competing for attention or recognition. Becoming familiar with organisational structures including processes such as meetings, report writing, and monitoring student achievement provides the experience needed to manage the complex decision-making processes and power structures. Gaining this experience gives the nurse educator a great sense of control over day-to-day tasks.

In the period of a week, Sophia is engaged in classroom teaching, pastoral care for students and meeting with academic and clinical colleagues. Each of these encounters requires Sophia to draw on relational approaches to teaching and learning. In the classroom, Sophia uses technology and flexibility to ensure she connects with her learners. In her support for students, she draws on her well-developed interpersonal skills in building relationships that facilitate learning. With her academic colleagues, she takes on a leadership and mentorship role showing the flexibility and adaptability that is important for teamwork. Sophia loves the opportunity to coach students in their clinical learning as this is the area where she feels most comfortable in bringing together the worlds of education and practice.

Educationalists like in Sophia's story have adopted teaching/learning approaches that focus on active, integrated learning approaches built on student-teacher relationships. Sophia seeks to be in relationship with students using different forms of communication including face-to-face

interactions and emails to support the learning process. This relational lens recognises not just the relationship between people but with knowledge and within the learning context (Hartrick Doane & Varcoe, 2005). Sophia is motivated to being in relationship with students, staff and others because of her ethic of care and desire to a make a difference in education and in health care. Nurse educators are expected to know how to convey and/or teach caring in the student-teacher relationship to support the learner in developing skilled 'know how' in expressing caring and compassion in different nursing contexts (McAllister, 2015). The context of nursing education is a complex environment for Sophia to enact professional caring and compassion as a nurse academic.

Sophia feels conflicted in the teacher/student relationship when she is managing the competing demands of being a caring nurse and making judgements as an academic. She recognises her personal commitment to caring for others but struggles with maintaining professional boundaries between her roles as academic and nurse. Establishing and maintaining professional boundaries in the tutor-student relationship is a complex task for the nurse educator (Gardner & Lane, 2010). The relationship between the student nurse and the nurse educator may include pastoral care, teaching and guidance that is not dissimilar to the work of a nurse. While engaging in this work may be useful in modelling nursing practice, the nurse educator needs to be careful not to become 'the nurse' for the student in this relationship. Critical reflective practice is essential for all practitioners working in relationship with others, however, the strategies needed to make this meaningful for the educator are unclear (Benade, 2015). A model for reflective practice that develops the nurse educator as academic could be warranted.

Sophia feels most comfortable when she puts on her uniform and enters the clinical learning environment. In this setting, Sophia is able practice as a nurse educator using her nursing skills, knowledge and experience in a manner that mirrors her practice as a nurse. Sophia values working in an academic environment but is less comfortable in knowing how to 'bridge the gap' between education and practice. The nurse educator needs to understand the relationship between academic and theoretical knowledge as well modelling the capacity to think and solve problems in actual clinical situations (Benner et al., 2010). As well as these important encounters and relationships in her everyday work, Sophia is in a relationship with theoretical knowledge marking student assignments, planning for upcoming lessons and courses, and managing academic responsibilities to ensure programme quality and favourable student outcomes. Sophia recognises and values both her clinical and her academic work; she finds it difficult to manage and prioritise the competing demands of this workload and to bridge the gap.

Integrated approaches to learning seek to address the theory-practice gap that concerns Sophia in her work. The competing demands of student and teacher expectations and the structures of the education systems seem at odds with these approaches. Sophia's story mirrors the challenges the learners identified in Ironside's (2003) study as she struggles with problem solving and the 'doing' in her everyday work whilst striving to engage in the 'thinking' work of an academic. Whilst the relational model is a familiar role for Sophia as a nurse and a clinical teacher, it is very different from the traditional 'sage on the stage' teaching role (Stanley & Dougherty, 2010) expected in many tertiary institutions. The contemporary 'guide on the side' role indicates a more active rather passive role (Stanley & Dougherty, 2010). Sophia's story suggests that she is comfortable in using this approach in her clinical teaching, but, like many teachers, she feels compelled to portray the role of expert (sage) in the academic environment, especially with her academic colleagues.

The complexity of an interactive teaching/learning approach signals the need for the nurse educator to understand the learning environment. Sophia recognises that she is working with a diverse group of learners and that her approach to teaching needs to reflect their learning needs. Sophia uses technology to support learning and in creating learning opportunities suitable for a diverse range of learners. As the teacher, she is expected to be the manager of the learning experience, including supporting and scaffolding learning, with the teacher sometimes being the learner themselves. Sophia loves being a learner alongside her students and feels that this is an important in keeping her connected to practice. Sophia does not verbalise the pedagogy or teaching philosophies that inform the approaches that she uses, and this may suggest that she lacks the language to articulate this aspect of her work.

Even if Sophia was able to verbalise a contemporary teaching philosophy, adopting a more active and flexible approach may not fit neatly into the systems and structures that Sophia works with, particularly in the academic environment. Sophia might feel challenged, unsupported and unprepared to engage with more contemporary teaching practices within the current structures of the tertiary education environment that has created expectations as to how an academic should perform. The relationship between the teacher and learner is governed by the authority of the institution that sets timetables, assessment dates, quality review processes and grading standards. Sophia's practice is also governed by the standards for nursing registration. These standards and processes are focused on outcomes for the student, the institution and for public safety in the health care setting. Sophia recognises their importance but wonders if they are at times limiting her in the teaching process.

The literature signals the need for a change in learning culture that supports risk taking (McCabe & O'Connor, 2013; McCormack et al., 2014) and trialling different approaches (Fletcher & Meyer, 2016; Liu, 2011; Mitchell et al., 2016), with time available for deep learning. Learning is more effective if the approaches used and the learning culture are acting in synergy (Hodkinson et al., 2008). New learning approaches are being developed with new learning modalities such as simulation, virtual communities of learning and the use of technology as part of the changing learning culture. Sophia's story shows that she is conflicted between being a clinical educator, teaching in the classroom and seeking to meet the expectations of being an academic. Sophia is adopting contemporary teaching and learning practices but the systems and structures within the institutions create competing demands making her question her capability.

Situational factors such as collegial support and organisational structures can influence this learning culture. Sophia describes different collegial relationships within her everyday work. In some situations, she is in a leadership role supporting others within her department. She values engaging with colleagues in the broader organisation but has little opportunity to do this. Organisation structures that can create resistance to changing the learning culture include policies and procedures within the tertiary institution, current personnel who value traditional approaches and lack of professional development to support change (Johnson et al., 2009). The nurse educator needs to be aware of these systems and structures and needs power to support change.

Sophia describes conflict with a senior colleague who seeks to work with a more traditional approach. This colleague refers to teaching as a performance in the classroom with the adage that teachers must 'keep the show running'. Much of Sophia's everyday work is linked to the business of education – managing her calendar, doing administration work, completing tasks, attending meetings, adhering to processes. Managerial and collegial support is needed for both teachers and students in adapting to different learning cultures. The importance of a faculty community of practice was identified by several researchers as being critical for developing a positive learning culture (Johnson et al., 2009). Sophia's description of her working week makes no reference to her own professional development or work as a research scholar. The absence of this work is significant for both Sophia in her own career development, for the institution and their responsibilities in providing quality degree-level education programmes and for nursing and nursing education as a whole.

The final narrative is presented as a dialogue from a nursing education forum where contributors are sharing their experiences of dealing with the structures, policies and power relations in the wider field of nursing education.

Nursing Education Forum: "You have to learn the rules of the game"

Contributors at the forum have been asked to sit in mixed table groups with people from different institutions. The discussion below is the conversation which takes place at one table. The group of fictional characters depicting different nurse educator perspectives include:

- Marcus, senior lecturer at a large university
- Polly, Head of School at a rural-based polytechnic
- Sam, senior academic staff member and doctoral student
- Jo, principal academic staff member with 30 years' teaching experience
- Kim, newly appointed Programme Manager for a polytechnic nursing programme
- John, senior advisor at the Ministry of Health

John has been appointed to facilitate the group discussion. Sam has been volunteered to be the scribe. Contributors introduce themselves in relation to both their nursing background and their teaching experience. These introductions are important in establishing their identity and credibility as nurse educators in the group. Most of the forum contributors are female and from a Western Eurocentric cultural background. It is possible that several of the contributors may be internationally qualified nurses. The representative indigenous nurse educators who are part of the forum group do not balance the dominance of Western Eurocentric cultural perspectives.

The group has been asked to discuss how policies and management systems influence their work as nurse educators. Whilst this narrative has been structured in an orderly manner, it is more likely that a discussion of this nature would have been somewhat chaotic. People at times would be talking over one another, with incomplete sentences or thoughts and with conscious or unconscious body language that reflects the engagement of the different contributors. Some group members were probably distracted during the conversation, reading their phones, looking around the room at what others are doing, or doodling on paper. Their inner thoughts about the topic may not have been fully expressed in a group of people they may have only just met. They may be thinking about the different positions and power relations within the group and the different institutions that they each represent. They may self-edit their contributions to what they believe is socially acceptable and expected by individuals, the group and the facilitator. John, the senior advisor at the Ministry of Health, begins the conversation:

John: Okay guys, so our question is about how we think policies and systems work in nursing education. You're all educators here, so don't be shy, just start throwing out some ideas and Sam will capture them for us on our paper.

Polly: Hang on John, I think we need to introduce ourselves first before we begin. My name is Polly and I am the Head of School for Nursing at a rural-based polytechnic.

Sam: Kia ora koutou, my name is Sam and I'm from the city. I'm a senior academic staff member teaching in our undergraduate and postgrad courses. My background is in mental health nursing. I'm also studying at the moment – doing my doctoral studies.

Jo: Mōrena everyone, I'm Jo and I'm one of the oldies here today. I've been working in nursing education for over 30 years and I love it. I teach professional nursing topics and my background is in child health nursing.

Kim: Hi everyone, I'm Kim and I have just taken up the role of Programme Manager for our nursing programme. I've been working at the polytechnic for about 15 years now. My background is ED (emergency department).

Marcus: Cheers everyone, I'm Marcus and I'm a senior lecturer at the university. I'm interested in nursing education research. My nursing background was in acute care nursing many years ago.

John: Okay, and as you know, I'm a senior advisor for the Ministry. Our discussion question is about how we think policies and systems work in nursing education. Now let's get started with that brainstorm and Sam, our creative one, can create a mind map for us to present back to the wider group. We've got about 20 minutes so let's get going.

Polly: Okay, I'll start. Policies are something that nurses must follow.

Jo: Yeah, it's about being accountable and being audited. We adhere to policies to protect the public, "do no harm" and to meet our audit requirements.

Kim: That's right, the Nursing Council (NCNZ) standards trump NZQA because of public safety.

John: Are you talking about NCNZ audit requirements or academic requirements?

Jo: Both, but nursing standards come first before education.

Marcus: Maybe, but in the university environment, the rigour and credibility of our programmes is equally important.

Polly: I think you learn to know what you can push and what you can't with both Council and NZQA.

Kim: What's important to me is ethics and values. I have to work with policies in a manner that is ethical and that values the ethos of nursing. But there seems to be some gaps in the guidelines as to how we apply academic policies within a nursing context. That's what I'm noticing when I'm needing to make decisions about students' progress.

Marcus: Kim, you have to learn the rules of the games, and I don't think they are written in the policies or guidelines. I agree that we use our nursing experiences to guide our decision making in enacting the policies. But in my experience, our judgement isn't always valued in the big machine of the university.

Jo: That's been my experience in the polytechnic too, sometimes we just get directed by management. Nurses are used to being much more autonomous.

Kim: Sometimes it feels quite dictatorial. Even when you are in a management position, you are micromanaged by others who may not have the same understanding of our discipline.

John: Sam, we haven't heard much from you. What do you think?

Sam: I think it is important to learn to see the big picture. I've learned so much from my doctoral studies by researching different aspects of education. With the current government review and proposed reforms, it is important that all nurses take an interest in understanding the politics at play both in nursing and education.

Polly: I've experienced a lot of challenges over the years with a misalignment between nursing and education practices and policies. The student as consumer is viewed as being always right and, sometimes, we need to act to keep ourselves safe in this environment. That can be tough in a smaller community where everyone knows one another. You can be made to feel personally responsible for a student who is not successful, and you may get challenged by a family member during your weekly trip to the supermarket.

John: So let's just summarise what we have so far. We have policies in nursing and education which are both important but sometimes misaligned. You sometimes feel challenged between your nursing values and responsibilities and your responsibilities as educators. You have identified several different groups here having influence including the government, and the politics that go with this, our own institutions and management and our stakeholders especially our students.

Anything else we can think about in terms of policies and systems?

Sam: Yeah, I want to add in something here about the research requirements and how these impact on our work. I'm currently studying, trying to achieve some research outputs on top of my teaching. Whilst I have a supportive manager, there are so many hoops you have to jump through to get any support in terms of study leave, resourcing for research work including attending conferences etc. Everything is so complicated and requires lots of form filling, levels of approval, and this can be daunting and unachievable for many of my colleagues. I'm lucky because I haven't got lots of outside commitments so I can use my time of the weekends to make my way through all the systems and requirements, but I do really worry about how others can manage this.

Jo: That's a problem at our institution as well, and they seem to keep changing the processes and the rules which makes it even more confusing.

John: When you say 'they' – do you mean management?

Jo: Yes, that's right.

Kim: We've been under huge financial constraint for the past two years and so research has really taken a hit.

Marcus: In the university if you're part of a research team you've got to bring in money. And research in topics related to nursing education … it's not likely to bring in money. I've been hearing for many years we're going to set up a research team that focuses on clinical education or health education or something, and I don't really see that developing any further. I just think it's been given lip service because there isn't any funding in those areas.

Sam: I do have a few fears around once I graduate with my doctorate there's going to be expectations on me to produce research and writing. How am I going to do that if

there isn't a team that I can fully immerse myself within? And what value will it be given if it doesn't bring in the money that everyone's looking for? There is a real gap in terms of people who have that experience of getting in that funding or just even setting up research projects. In our institution, there's one named person as a mentor for everybody and if you don't particularly see eye to eye with that person or their way of working isn't quite how you would work, there are some problems around that as well.

Kim: That's right Sam, I think the issue of mentorship is a real problem. In our institution, there aren't enough people to mentor everybody, basically, and we are quite a young group of people all embarking on the same journey at the same time. There's a few people that have joined us recently that are a little bit more advanced, but they're still at the beginning phases of their research journey, so it is quite difficult in that regard.

Polly: I would say the other big challenge I will have faced over my time in our institution, is just the culture. When I first started, there was definitely a culture that ... it's a bit like school, there was the in-crowd and there was the out-people. I moved into the community from the city, so I was immediately seen as an outsider. And if you were one of the out-people you were definitely 'outed'. And as a newcomer and outsider, if you critiqued the practice of others, if you weren't happy with their standard of practice, then you were seen as being a threat.

Jo: Sometimes I wonder if it's all worth it. No offence John and Marcus, but it's the blokes in the organisation who get all the leadership roles anyway, so why even bother to complete a doctorate. Nursing may be a female-dominated profession, but it's the males who get the positions of power.

Marcus: I can understand your point Jo, however often I am the odd one out particularly in a nursing context. Look around the room here today. There are only a handful of us 'blokes' here. It's true, when I'm in my university environment, I tend to be in the majority at the senior management level. I'm not sure how our policies or systems contribute to that.

Polly: It's interesting thinking about those power dynamics, because we are the biggest school in our polytechnic, "the cash cow", but we don't have any more power within the organisational structure.

Jo: I feel that it's the same with our industry partners in clinical and the DHB. They don't see us as 'real nurses' and we aren't given credibility because we are working in education.

Kim: Yeah, I worry about losing my professional identity as a nurse, it's like we have to give these up to be a teacher, and then I wonder, where do I sit? Am I nurse or teacher?

John: Well that may be where we have to leave this, because our time is up. Thanks everyone for your contributions and thanks Sam for capturing it all on paper. It will be interesting to hear if other groups had similar opinions as this group.

Marcus: Thanks John, it's been good to have the opportunity to have this discussion. I hope that the powers-that-be will take on board our insights when they are considering the future for nursing education.

Commentary on the Nursing Education Forum: Structures and power relations

This narrative depicts some of the structures and cultural contexts as 'rules of the game' in Aotearoa New Zealand. The dialogue including the language used detects discourse that nurse educators navigate when considering the current issues in nursing education. Text mediated material such as policies and regulations are articulated as ruling relations that dominate and coordinate nursing education practice. The dialogue also reveals some of the unheard or unsaid discourse that results from the structures and systems that dominate or marginalise.

The forum aims to engage the nurse educators in discussion about policies and management systems beyond their own programmes and institutions. The contributors' responses to this discussion reveals different understanding and perspectives on power relations. Structural and cultural differences may be experienced because of the different institutional settings where nursing education may sit. The forum contributors expressed concern that they were not able to work as autonomously in education practice as they have in their clinical nursing experiences. The nurse educators voice concern that some of the conflict with management and systems relates to a lack of understanding, at the management level, of nursing discipline responsibilities. The dialogue portrays a feeling of powerlessness for the nurse educator in the academic setting. Some contributors identified the need to adapt their practice to work with policies and systems in the academic environment. This adaptation was labelled as 'learning to play the game'.

The forum contributors illustrate some shared understanding of the power relations between nursing regulations and practices and educational standards and practices. The contributors in the forum immediately identified two regulators at work in nursing education – the NCNZ, which is the regulating body for the profession and for public safety; and the education qualification authorities (NZQA and the Academic Quality Agency, AQA) which set the standards for tertiary education. Both of these bodies are appointed by the Government and are ruled by government policies and political strategies.

The forum discussion illustrates how the nurse educator may navigate the power relations between these two authorities. The discussion regarding NCNZ standards linked to public safety signals the importance that the nurse educators place on their own nursing practice. Some contributors feel that these regulations are more important than education quality assurance requirements. Navigating these regulations may result in the nurse educator feeling conflicted in responding to the requirements of both public safety and academic integrity. The nurse educators' work is dominated by the NCNZ standards. Nurse educators' work that is similar to nursing work in the clinical environment is more easily managed by drawing on nursing skills and attributes. This was evident in Nova and Sophia's stories. The education policies present a different form of authority that is either unfamiliar to the nurse educator or conflicts with their professional and societal responsibility for nurturing and caring. The nurse educator may feel less power when navigating education regulations.

Piecing together the quilt

The two modes of 'writing as inquiry' from the literature and the research narratives reveals a disjuncture between the understanding of the everyday work of the nurse educator and the structures or practices linked to these experiences. The nurse educator engages in social relations straddling across the two worlds of clinical practice and teaching practice. The work of caring is evident in both areas of practice. Nurses taking on the work of nursing education are often expert nurses with a wealth of practice knowledge and skills. Many aspects of the teaching role mirror the work of the nurse in practice, including being relationship based and making clinical judgements based on critical thinking.

The teaching and learning practices proposed for transformational learning also mirror nursing practice but looking through two lenses results in different language and meanings attached to these practices. For example, caring for their students may require the nurse educator to understand caring in a different manner from the practice that is familiar to them as a nurse.

For many nurse educators, the practice of being an academic and engaging in the wider world of nursing education is less established. It is represented by a journey that traverses the fields of clinical and teaching practice. The practice of being a nurse academic sits less comfortably within the social world of nursing education. The structures and practices linked to this work are less familiar to nursing practice and the journey to becoming an academic is long, with few tangible rewards. These discourses are examined in depth in the next two chapters.

Chapter 7: Am I a Teacher? Can I Teach? Becoming a Nurse Educator

"When I first started out in nursing education, the question for me was 'Am I a teacher?' and 'Can I teach?' In my cover letter applying for the job of nurse educator, I asserted that I could transfer my nursing skills including teaching into the classroom. I had some classroom experience in teaching antenatal classes. I had developed lesson plans, teaching resources and classroom sessions and had been successful in engaging learners in activities. I also had experience working with individuals and families teaching them about healthy parenting practices and ways to support their children in normal growth and development. And I had certainly been taught – from school, from my parents, at church, at university and on the job so I felt that I was an experienced learner." (My story)

My own journey in nursing education has spanned nearly 30 years with a myriad of disruptions, struggles and experiences that have brought me to this research. From nursing practice, to teaching, to motherhood, to nursing education leadership and novice researcher, becoming a nurse educator has been a long journey. This chapter discusses the struggles experienced in forming the nurse educator's identity, drawing on the theoretical principles of Smith and Bourdieu. Examining knowledge, language and social relations in nursing education from a feminist standpoint illuminates the discourses and underlying power struggles within this social context. The data collected as literature explored aspects of the everyday work of the nurse educator as nurse, teacher and academic. One of the major themes from the research narratives is that the identity and work of the nurse educator is the identity and work of a registered nurse.

The value of 'being a nurse' is the contribution that the nurse educator makes to the professional formation of the nursing workforce and to improving health outcomes. The practice-based work of the nurse educator can be linked to nursing history and traditions traced back to Florence Nightingale. The incorporation of both scientific knowledge and other ways of knowing are evident in clinical nursing practice and in the work of the nurse educator. But how is this cognitive work valued or understood?

The research narratives highlight how nurse educators struggle to value their contributions to nursing through our work as nurse educators. So why would others see the value in this role? For many nurse educators, including myself, this journey begins from our own practice knowledge and experience. When we investigate the work of the nurse educator, many describe this role as moving away from nursing or transitioning to a new role. The valuing of the work of nurses is prominent in the media. Nursing is situated on the forefront of health care and during

the global pandemic of 2020, nurses were given 'superhero' status. Interestingly, this status given to essential workers saw nurses situated alongside supermarket workers, delivery truck drivers, and other people providing services that were considered essential for our health and wellbeing. Hairdressers were also elevated to this status when restrictions were lifted, and people were able to move out of their home environments. In this respect, society sees nurses as people (mainly women) who provide a service, people who do things to support the health and wellbeing of others.

The research narratives show that 'doing' work linked to clinical practice and 'practice knowledge' is what is valued in forming the nurse educator's positive self-image and building a satisfying career. But there is so much more to 'being a nurse' than working 'on the floor' in that very visible hands-on role. Nursing has transformed from servanthood images of 'angels of mercy' to health care leaders and innovators of practice who use specialist nursing knowledge to work autonomously and collaboratively in the ever changing and expanding world of health care practice.

In this chapter, I explore two key themes that emerge from the discourses in the narratives and literature. The first theme relates to the 'thinking' work of the nurse educator and the disconnection between practice and tacit knowledge on the one hand and academic and discipline knowledge on the other. The cognitive/thinking work places many nurse leaders, including nurse educators, behind the scenes with the tangible capital contribution they are making to improving health outcomes being less visibility. The second theme relates to the development of professional identity as a nurse academic. Identity as an academic is formed through their 'thinking' work including teaching and valuing different forms of knowledge.

How does the nurse educator 'think' nursing?

A key to understanding the habitus of the nurse educator is understanding how nursing is theorised. This 'thinking' work includes making visible the perceptions that underpin how knowledge and language is used in the way we refer to subjects and objects in the social world of nursing. The nurse educator brings both private and public knowledge of nursing to their work in nursing education (Kim, 2010). Each nurse educator possesses and generates private knowledge based on their personal and clinical experiences. They bring this knowledge with them into their work as nurse educators. In Chapter Five, this was identified as practice-based knowledge. The nurse educator needs to be able to dialogue practice by posing questions and

facilitating learning to support the learner in deep thinking (Mitchell et al., 2016; Osberg & Biesta, 2010).

In the narratives, both Nova and Sophia were comfortable in their own practice knowledge base, especially when they had the opportunity to be in the clinical setting with their students. Practice-based learning recognises the importance of the learning context and relationships (Benner et al., 2010). Nova and Sophia's stories illuminate discourse in knowing how to think and transfer their knowledge base into their work as teachers and academics. The nurse educator needs to be able to articulate to the learner both how to do things as well as why, putting into words their intuitive or tacit knowledge.

Learning the language, the norms and the processes of nursing education present challenges for both Sophia and Nova. This knowledge can be understood as the public knowledge of the discipline of nursing (Kim, 2010). Nursing education knowledge includes theoretical knowledge, curriculum models and professional standards developed over time through consensus informed by research. This type of knowledge expands building from the nurse's personal experiences and reflection. Knowledge of self, including one's cognitive work, influence how discipline knowledge is understood. It is this relationship of private and public knowledge that supports growth and shapes nursing education practice.

The literature and the research narratives make evident the following discourses concerning private and public knowledge development and how this is understood in nursing education practice. Challenges include the privileging of clinical and scientific knowledge, the valuing of doing over thinking, the valuing of safety over risk taking, and the valuing of the caring teaching role over the academic leadership role. These discourses impact on how the nurse educator thinks; how they teach students to think and how they develop academic thinking. This in turn impacts on their identity formation as a nurse educator/academic.

Clinical practice as private knowledge

The private knowledge that we bring to nursing education is largely formed from our clinical nursing experiences. Clinical nursing as the dominant norm has been perpetuated by the Florence Nightingale archetype of the nurse working in hospitals at the bedside. The term 'clinical practice' generally refers to practice that involves direct patient care, with non-clinical practice referring to practice not involving patients. In the narratives, Nova and Sophia refer to their 'clinical' practice as a nurse as forming their knowledge base. They draw on their knowledge and language from their clinical experiences and use the term 'clinical' in an all-

encompassing way to depict their private knowledge. Nursing practice has always involved both thinking and doing but more emphasis has been given to the 'doing' work that involves specific skills and completing tasks in an often very busy clinical environment. We often hear nurse educators talking metaphorically about 'losing their skills' when they are working outside of the practice space and equating this to losing their knowledge of practice. In this context, 'skills' seems to be a more acceptable or 'normal' way of referring to nursing practice knowledge. The research narratives show that nursing education practice embraces many forms of knowledge, but the dominance of valuing clinical knowledge is prevalent.

Taking nursing outside of clinical, into an education setting for example, can be viewed as disconcerting and even abnormal for the new nurse educator. The research narratives tell of concerns about being disconnected from their knowledge of practice as they move into the academic world. These concerns may explain why new nurse educators may work part-time in education to 'remain in practice' by also doing clinical work.

Privileging scientific knowledge as public knowledge

The public knowledge of undergraduate nursing education in Aotearoa New Zealand has been gained through the local, historical and global development of theory, research and professional nursing education standards. Nursing education practices have been dominated by scientific philosophy, systems and principles. In my own institution's first nursing degree in 1992, the curriculum was scrutinised and critiqued based on the academic principles that have arisen from a scientific basis. Our curriculum philosophy, which had shifted to a more social science focus with a lesser bio medical focus was viewed as being less relevant and academically sound for a nursing education programme. Scientific principles including how knowledge should be developed based on scientific research methodologies, were viewed as critical to gaining academic acclaim. Additionally, the academic qualifications and credibility of the staff was questioned including a critique of the 'type' of master's qualification achieved by some of the nursing academics.

Since the 1990s, nursing education has moved to develop a diverse knowledge base but it is still dominated by scientific and medical knowledge. The nurse educator's valuing of scientific knowledge is closely linked to their valuing of clinical knowledge. Nurses working in highly medicalised and scientifically focused settings such as emergency departments and intensive care units are often seen to be more knowledgeable and highly skilled nurses. This perception is based on their advanced scientific knowledge and their technical clinical skills. By comparison,

nurses working in areas such as community health or mental health practice may have a different specialist knowledge base that is viewed as lesser because of the social science focus on forming therapeutic relationships, professional communication and caring. The valuing of 'doing' work and the privileging of scientific knowledge may be linked to the positioning of nurse educators as mainly women doing 'women's work'.

Dual consciousness: Doing women's work in nursing and academia

From Dorothy Smith's perspective, the work of female academics can be understood using the metaphor of duality of consciousness based on socio-historic roots and patriarchal structures in society (Hart & McKinnon, 2010). Women historically have struggled to be viewed as professionals due to the patriarchal order that devalues their work in both nursing and academia. Nursing has been positioned in society as women's work, compounded by the stereotype and stigma that it is a caring occupation; caring being associated with mothering and nurturing as essentially female biological traits (Goffman, 1963). These gender influences focus on nursing as 'women's work with an emphasis on 'doing'. Traditionally, the male role of doctor was viewed in the higher role of 'thinking' and decision making, with the female nurse as the handmaiden or doctor's assistant assigned the 'doing' work. Language such as 'doctor's orders' that stipulate the work that the nurse must complete continues to reinforce the higher status of the doctor. While gender roles may have changed over the years, some aspects of nurses' work remain 'doing' work. Nurses continue to focus on their 'clinical' knowledge and skills discussed previously as the visible and hands-on 'doing' work that is traditionally attributed to their identity as nurses. This 'doing' work also includes caring, supporting and being in relationship with others.

Similarly, gender has influenced how the discipline of higher education was structured, favouring academic work as men's work with early universities and higher learning institutions set up specifically for men (Witz, 1992). Historically, women's work was to support men by caring for children in the home, and 'doing' work that maintained the home environment. When women were permitted to engage in higher education and academic learning, the role of teacher was viewed as the 'doing' work more fitting for women. The woman as educator and mother needs to create a dual consciousness that establishes two modes of knowing and experiencing of their worlds. The nurse educator's understanding of how knowledge is privileged will provide some understanding of the duality of consciousness inherent in their role.

With most nurse educators being women, the management of their personal life, family responsibilities and children is evident in the career pathways for nurses and nurse educators. Nova and Sophia, as female nurse educators described managing their roles as educators and mothers. They were conscious of wanting to balance their work and portray an image that honoured their identity as women and as nurses both with roles of caring. This dual consciousness of managing nursing work and family life leads the new nurse educator to embrace the 'doing' work in education which includes classroom teaching, marking, responding to emails, attending meetings, writing feedback, planning classes, visiting students in clinical, completing paperwork. The thinking work of the nurse educator is not so easily expressed or valued as part of their identity, possibly due to the separation of thinking work from practice.

A theory-practice gap?

When nursing education shifted from hospital-based training to degree-based education in the tertiary education setting, a shift was needed in the way that nursing was taught. This shift resulted in a separation of teaching theory and practice. Theory classes are taught on campus with practical learning occurring off campus. By segmenting the education and clinical components of learning, student nurses were socialised to different versions of nursing work – the education way and the clinical way (Melia, 1987). This challenge continues today and is often referred to as the theory- practice gap.

In the research narratives, the relationship between the nurse educator's private and public knowledge is disrupted as they seek to connect their practice experiences with the pedagogy, curriculum, theory and assessment principles that they encounter through academic study and engagement. The new nurse educator needs to build on their understanding of the public knowledge of nursing education, recognising that that knowledge they bring from practice will continue to grow and develop. They do not leave behind their practice knowledge when they 'leave' the clinical environment, it comes with them. How the nurse educator experiences this gap may be related to how they understand and value different forms of knowledge. There are several different discourses for understanding the theory practice gap and why it may exist.

Objectivity and subjectivity: Finding a middle ground

For the past three decades, some nursing education scholars have contributed to a shift in theoretical focus with a stronger inclination towards a human practice orientation. Teaching practice that includes an understanding of ethics, values, morality and other aspects of the human world has been incorporated into curriculum. Bevis (1988) was one of the first nursing

academics who emphasised the role of the teacher in nurturing the learner: nurturing ethical ideals, the caring role, the creative drive, curiosity, assertiveness and the desire to advocate for caring. This more humanistic approach to teaching focuses on seeing the student as a person with dignity and acknowledging their worth and intelligence. This shift in focus in the nursing curriculum creates competing tensions between the soft skills of nursing which include caring (subjectivity), and the technical skills of nursing that link to patient safety and competence (objectivity) (Stajduhar et al., 2001). This shift in focus cannot be adopted in a binary sense by favouring subjectivity in place of objectivity. Both forms of truth need to be embraced in the complexity of nursing practice. A philosophical 'middle ground' must be established to create practice where both general and particular forms of knowledge are foundational to theorising nursing practice (Stajduhar et al., 2001). This approach recognises that in the postmodern world, the terrain is constantly shifting.

Differend: Acknowledging cultural worldviews

An alternative way to explain the theory- practice gap is by applying the postmodernist notion of the 'differend' which signifies cultural differences in understanding between two or more worldviews (Lyotard, 1988). Described as incommensurate worldviews, knowledge and truth are understood differently as we experience the world differently and live in different worlds. The worlds of nursing and education create a 'differend' which could be perceived as a theory practice gap. The impact of colonisation as a dominant worldview in both nursing and education contributes to a theory- practice gap. The domination of a Western Eurocentric, patriarchal worldview and the marginalisation of indigenous and gender diverse worldviews has resulted in the privileging of specific forms of knowledge. Understanding nursing education from a feminist standpoint that accounts for multiple, competing, fluid and intersecting forms of knowledge and practice is needed to find a philosophical middle ground.

Bridging the gap

Some author's question whether the theory-practice gap exists in nursing, or whether this theoretical 'disconnect' is a symptom of a difficulty in expressing identity or ways of 'being' (Zieber & Wojtowicz, 2020). This explanation, which is based on Heidegger's theoretical perspective, uses the metaphor of building a bridge. Heidegger describes the bridge as the physical reality as well as conscious representation of the connection between two banks of a river. By focusing on this physical connection, the gap almost disappears or becomes less meaningful. Using the concept of a bridge, nursing theory and nursing practice are viewed as

intimately connected in that they inform and create meaning for each other. Rather than this relationship between theory and practice being viewed as a gap, the concept of the bridge respects the gap and provides a way to approach it. There is value for the new nurse educator in recognising and being able to 'use' their existing nursing skills and knowledge as a 'bridge' in academic settings. Transferring these nursing skills supports their growth in the role of nurse educator and supports student learning across the theory- practice gap.

Each of these perspectives provides an understanding of how different ways of thinking might create a theory- practice gap. Instead of focusing on one truth, the concept of a bridge allows for multiple connections in keeping with the complexity of the nurse educator's work. Socio-historical traditions and perspectives continue to influence our nursing identity and work. Understanding the gendered and cultural influences from traditional roles and values is needed to support the growth of the nurse educator. Moving to a philosophical 'middle ground' in nursing education will help nurse educators to make connections between theory and practice, valuing the many forms of knowledge and truths that must be considered in nursing education practice. Acknowledging the differend in the contexts of nursing education in Aotearoa New Zealand is critical in creating nursing education practice that reflects diversity in our world. The nurse educator can contribute to knowledge development that bridges theory and practice and informs nursing education pedagogy. Bridging the gap has implications for teaching practices and the professional identity formation of the nurse educator.

How does the nurse educator teach students to 'think'?

"I do not pretend to teach her how, I ask her to teach herself, and for this purpose I venture to give her some hints" (Nightingale, 1860, preface).

Teaching nursing has been mediated by traditions and norms from both nursing and educational theoretical frameworks. From the simple traditions of Nightingale, an understanding of teaching and learning in nursing education is informed by experiences of being taught, and of teaching others in through nursing practice. One of the biggest challenges identified in the literature and the research narrative of the new nurse educator is understanding curriculum pedagogy, knowing how to teach and learning to give feedback. Whilst the concepts of person-centred learning and relationship-based learning are familiar to the nurse educator, the work of the nurse educator in teaching students to think is less familiar. The nurse educator must work from a diverse knowledge base with an understanding of 'thinking' work, to support the learner in their development and understanding of knowledge construction. Teaching nursing requires the nurse educator to let go of authority and to trust that the learning will occur. The nurse educator

working in this manner not only shapes the practice of the learner but also shapes their own knowledge and understanding of practice. This approach facilitates the learning needed to prepare the future nursing workforce.

The research narratives reveal that the new nurse educator is most focused on learning how to teach. We can imagine a new educator like Nova standing on the bank of the river, ready to cross the bridge into nursing education. Carrying both her private and public knowledge with her, Nova tentatively starts across the bridge with the confidence that this knowledge will provide her with the foundation for teaching nursing. For Nova, the bridge may seem a bit unstable, and the moving water underneath may seem to be moving too quickly. Initially she may hold onto the railings to keep her safely within the confines of the structure that has been built to support her moving to the other side.

Nova gains stability in her initial teaching practices by using her intuition and tacit knowledge that informs how she thinks about nursing. She brings her own clinical knowledge and experiences, and interprets these into learning experiences for her students. Teaching has been part of her nursing practice, but she is standing on new ground, taking her nursing into the classroom. She is aware that the public knowledge base of nursing education is also unfamiliar terrain with a different organisational culture.

Nova's story illustrates that the work on the other side of the bridge is complex and, like many nurse educators, she feels unprepared and unsupported. Making time for 'thinking' work like reading and research is not a priority in their everyday work, and this is noticeable in the research narratives. Giving more value to the 'doing' work may influence how the nurse educator portrays the value of 'thinking' work to the learner. Nurse educators need to understand nursing education practice as knowledge work taking their critical thinking, clinical reasoning and sensemaking into their practice. The language used in the research narratives to describe nursing education practice shows evidence of the transferability of this knowledge, even if the educators themselves lack awareness of how this occurring. The new nurse educator needs to build self-efficacy to help them develop confidence, capability, and opportunities in developing their practice as knowledge workers. Confidence is built by understanding learning processes and pedagogy that foster student inquiry and problem-posing to facilitate thinking. The nurse educator does not need to provide the knowledge; rather, they need to support the learner to become self-directed and capable of producing their own knowledge.

Reductionism versus holism?

Teaching students to think requires examining discourses around scientific and behavioural teaching practices that favour reductionism and integrated teaching practices that support a holistic approach. Nursing education in the 1990s began to move away from the traditional curriculum that compartmentalised teaching based on scientific knowledge using behaviourist approaches to learning. The genealogical influences of the discourse of nursing science discussed in Chapter 5 provided some understanding of the power relations that have supported this dominant discourse. The supreme valuing of scientific knowledge that favoured reductionist-type curricula often had issues with content saturation, repetition, and fragmentation of learning (McGrath, 2015). Teachers took personal responsibility for ensuring that content was covered, with the belief that it they didn't teach it, the students wouldn't learn. Reductionism may have given the learner a strong scientific understanding of a topic, but the separation of learning across many courses and the separation of clinical and theoretical learning contributed to a theory- practice gap.

The power of the reductionist approach in both health and education has been difficult for nursing curriculum to move past. New curricula using integrated approaches to learning were proposed to focus on contextualising knowledge with an emphasis on multiple ways of knowing (Benner et al., 2010). Some of these new curricula are influenced by the introduction and spread of postmodernism as a discourse in nursing (Georges, 2003). At the time American based nursing curricula were focused on knowledge related to the diagnosis and treatment of disease with little focus on the disciplinary knowledge of nursing characterised by humanised health care practices (Smith & McCarthy, 2010).

Nurse educators' work needs to include developing pedagogy that is relevant to the disciplinary knowledge of nursing (Smith & McCarthy, 2010). Instead, nursing education has focused on teaching practices and technical skills that support learning rather than focusing on the knowledge needed to support humanistic health care practice. This work is not visible in the research narratives, suggesting that it is not part of the nurse educator's consciousness. The nurse educator needs to be an aware of the potential to privilege, either consciously or unconsciously the reductionist approach based on their own experiences as a learner and as a nurse. Even more experienced educators may not readily dialogue about their practice in a holistic manner. The nurse educator needs to understand the different ways that they perceive and use both scientific and human practice knowledge in their everyday work. This

consciousness is essential for creating a common ground that models the application of knowledge to practice, and of inquiry into practice, and the creation of new knowledge.

A pluralist form of nursing scholarship that values nursing knowledge from both within the discipline of nursing and from other disciplines and ways of knowing is essential (Georges, 2003). The term 'epistemic diversity' has been used to express the discursive bridge needed to bring together the dominant discourse in nursing as 'science' with the marginalised discourse of postmodernist nursing scholarship that favours other ways of knowing (Georges, 2003, p. 50). A feminist standpoint approach creates a possibility for the dialoguing of practice where the freedom to speak from one's own individual traditions would be honoured. The speakers in this dialogue must take responsibility for questioning the authority of their own analysis and not privileging one form of knowing over another (Georges, 2003). This requires the use of critical thinking.

Critical thinking

Postmodernist nursing curricula and practice engage both teachers and learners in critical thinking. Simulation learning is one of the key learning modalities used to develop critical thinking skills that can connect theory and practice (Erlam, 2015). Teaching nurses to think requires a shift from a 'problem-solving approach' based on 'facts and rules' to a learning process guided by critical reflection (Ford & Profetto-McGrath, 1994). Simulating practice in a safe environment allows the learner to problem solve *and* critically reflect on how to manage and think about different nursing practice scenarios. Creating realism using actors and storytelling is an important aspect of this learning modality as it supports the learner in understanding the different contexts within practice. Disciplinary-specific knowledge, philosophies and theories should guide reflective practice. Critical thinking needs to include an understanding of socio-political, historical and economic contexts in order to understand power relations.

A critical thinking approach to examining knowledge may support the nurse educator in addressing the privileging of scientific discourse in nursing (Ford & Profetto-McGrath, 1994). Balancing the perspectives of science, human practice knowledge and critical thinking may not be valued or understood by those engaged in teaching practice in current nursing curricula and by the wider world of academia (Stewart, 2017). Stewart recognised this issue as a 'perpetual paradox' when critical thinking is encouraged or even mandated but is constrained within the profession and organisations for the benefit of political and organisational interests.

Educated caring

Teaching about the caring work of nursing is one aspect of the humanistic nursing curriculum that continues to challenge nurse education. Nursing work has traditionally been viewed as caring work that is mainly undertaken by women (Holstein & Gubrium, 2011). The importance of forming caring relationships is part of the genealogy of nursing and the work of nurses including nurse educators. These relationships spread across the everyday work as teacher, student, colleague, mentor, family member and mother (Hunter & Hayter, 2019). In "Semester's End", the nurse educators recognise the complexity of relationships with students that are built on a concept of caring. The nurse educators expressed caring as discourse that impacted on their teaching/learning practices with their students.

The literature around caring and nursing practice provides several arguments for consideration in relation to teaching/learning practices. Care work is conceived as the antithesis to professional work (Apesoa-Varano, 2007). As a professional, the nurse educator is expected to be objective, disengaged, and rational in providing untainted professional opinions and arriving at expert judgments in relation to student learning. "Semester's End" signals the discourse between caring for students and the professional work of supporting learning and making professional judgements. The nurse educators felt the need to set firm boundaries with students to ensure that their relational role as teacher was understood as being different to that of the nurse. Caring was still a strong focus of their practice as nurse educators however, they felt conflicted when professional judgements such as grading were needed. They also expressed conflict in moving from the subjective caring role into what they perceived as a more objective academic role as a nurse educator.

An understanding of caring and its relationship to professional socialisation and formation of the professional identity of the nurse is not prominent in the literature and the research narratives. When nurse educators participated in a study on how to teach caring, caring was viewed as part of what makes a professional nurse, but the educators could not agree on what caring is and how or whether it can be taught (Apesoa-Varano, 2007). Nurse educators assumed that students knew how to perform caring work and were unaware of their gendered assumption arising from the dominance of female students and educators. The archetype of the nurse upholds caring as performing uneducated tasks such as wiping bottoms, making beds and cleaning bedpans. This public perception of nurses' caring is linked to the work that they are visibly seen doing. Caring work that is related to thinking and clinical decision-making is less visible and therefore not easily identified as part of the professional identity of the nurse.

‘Educated caring’ is the language used to describe the professional craft that nursing students develop that acknowledges caring work as both thinking and doing (Apesoa-Varano, 2007, p. 264). Acting in an empathic and person-centred, caring manner is regarded as an obvious way for the nurse educator to achieve the goals of supporting the professional formation of the caring nurse. Nurse educators also need to practice and teach caring that models actions of social justice, fairness and respect to enable the learner to see a way of respecting others (Tengelin & Dahlborg-Lyckhage, 2017). The nurse educator needs to be able to critically reflect on the power relationships, and the assumptions held in the caring relationship to create a positive learning experience and to model professional caring. The nurse educator needs to practice ‘educated caring’.

In “Semester’s End”, taking an ‘educated caring’ approach when making professional judgements enables the nurse educators to express the discursive bridge between caring and professionalism. Their reflection demonstrates person-centred caring as they consider the circumstances of different learners. An awareness of fairness and respect for all learners is also in their minds as they make professional judgements about student progress. The discourse of caring creates tension for the nurse educator when judgements around safety to practice are concerned. This is discussed further in the next section.

Educated caring practice may be influenced by the quality of the nurse educator’s relationships with professional colleagues. In my own experience, collegial relationships and a sense of belonging have nurtured me both personally and professionally in my work and these relationships support me in educated caring practices with learners. When I have been faced with making difficult decisions about student progress, I have known that I have the support of my colleagues who value my professional judgement. In the research narratives, the nurse educators’ experiences highlighted the important of mentorship, positive collegial relationships and developing belonging. The literature supports the need for positive mentorship and critical reflection. Nurse educators without this support have reported feeling bullied and suffering from occupational stress. A sense of belonging and mentorship is also key to identity development for the nurse educator. The process of identity formation will be discussed further in the final section of this chapter.

Safety to practice

The caring discourse can create tension for the nurse educator in relation to their legislative requirements as a registered health professional and the discourse of ‘safety to practice’. The

nurse educator must maintain their annual practicing certificate by making a self-assessment and declaration that they are meeting the competencies required as a registered nurse. For all nurses, this includes "demonstrating knowledge and judgement and being accountable for own actions and decisions, while promoting an environment that maximises health consumer safety, independence, quality of life and health"(NCNZ, 2016, p. 4). The competencies recognise that the nurse educator may not be involved in direct patient care and the competency requirements in *Domain Two: Management of Nurse Care* and *Domain Three: Interpersonal relationships* reflect this. For nurses in education, it is their responsibility to promote an environment that supports the student in developing and being evaluated against the competencies using evidence-based theory and best practice (NCNZ, 2016). These responsibilities that link to the safety of the public and the promotion of health and wellbeing are paramount in the work of the nurse educator. Of note here are the feelings and sense of responsibility that the individual nurse educator experiences as expressed in the narratives.

One issue that can arise from this discourse has been labeled as 'failure to fail' (Dobbs, 2015). This study revealed tensions between 'being-in the world of nursing' as well as 'being-in the world of education' that contributed to the nurse educators' discourse around safety, risk and assessment of student competency. The clinical nurse educator uses the phenomenon of care for the health consumer to make a judgement of a student's competence. The threat of the student appealing a failed grade inhibits the less experienced nurse educator from failing students. The power relationships between that health and education systems that contribute to this discourse are discussed further in the next chapter.

How does the nurse educator become a knowledge developer and thinker?

It is through an active relationship with knowledge by way of research and engagement with others that the nurse educator continues to form and shape their practice. The discourse about the legitimacy of nursing as an academic discipline continues to prevail and consequently detract from a clear career pathway for the development of nursing academia and academic leadership (Andrew et al., 2009). The process for gaining both knowledge and recognition as a nurse educator is by undertaking higher level study with a theoretical and philosophical education focus. The rewarding aspects of the nurse educator's work is in shaping the nurse of the future, sharing knowledge and experience and informing nursing practice through knowledge development (Hunter & Hayter, 2019). Yet, this work has been separated into the thinking work of nursing and is often side-lined and given less value and priority in the everyday work of the

nurse educator. The previously discussed discourses all contribute to the norm that clinical knowledge and leadership is valued above academic leadership.

The research narratives reflect the challenges in the everyday work to become research active, to develop and sustain a research culture, and to give value to the contributions that being a nurse academic makes to nursing. Globally and locally, the work of the nurse educator as academic is not well articulated or addressed. Several versions of nurse educator competencies have been developed to describe the different aspects of the work. The World Health Organization (2016) competencies highlight the complexity of the role of nurse educator in requiring expertise in teaching and learning, nursing practice, research and providing leadership, and ensuring quality and professionalism for the developing the nurse of the future. A literature review by European authors delineates different competencies for nursing education work (Zlatanovic et al., 2016). The category of academic competency focuses more on academic practice than academic knowledge development. Academic practice includes gaining a higher qualification (PhD) and gaining status as an academic through publishing output. Academic practice focus is often directed towards the nurse educator's area of clinical expertise, not towards theoretical knowledge development. Research expectations in nursing education are mainly linked to the perceived usefulness in improving health care and practice (Dupin et al., 2015) with a lesser focus on pedagogical practice. The preference for this type of research is also linked to the nurse educator's own understanding of research requirements and their development of research practice (Zlatanovic et al., 2016).

Low-quality research approaches are common in nursing research because it is not a viewed as a research-based discipline (Zlatanovic et al., 2016). Research projects undertaken by nurse educators lack theoretical frameworks with little use of interaction data that addresses institutional and educational processes and contextual and cultural differences (Zlatanovic et al., 2016). While the conclusions from these authors may be valid, their own judgements are made based on a traditional scientific approach to research which they are suggesting needs to be critiqued. The challenges presented in nursing research mirror the challenges discussed previously in relation to nursing curricula. The dominance of the discourse of nursing science is fixed in the systems and structures that support nursing research funding and development. Scholarly achievement and funding for research is more readily accessible if the research has a scientific focus and uses traditional scientific methods (Georges, 2003). Research that has a postmodernist approach is marginalised in nursing academia. The organisational and

institutional power relations that impact on this discourse are discussed further in the next chapter.

How does a nurse educator develop their professional identity?

Professional identity develops when a member of a profession adopts the attitudes, beliefs and standards that support their professional role with a clear understanding of their responsibilities (Higgs, 1993). Professional identity development in higher education is described as a way of being and a lens for evaluating, learning and making sense of practice (Trede et al., 2012). Identity can be viewed as the way a person is similar to and different from others. These similarities and differences enable us to identify with a particular category of people. As professionals, identification includes similarities in knowledge, skills, values and ways of being that are shared by members of the profession. Even with these similarities, further differences can emerge that result in the formations of one's own professional identity/ies (Lawler, 2008).

The journey of becoming

How we value and create knowledge is one of the discourses that impacts on our professional identity formation as a nurse educator. The discourse around how knowledge is developed and privileged influences the everyday work of the nurse educator and how they perceive their work. Clinical knowledge, including intuition, is valued as part of our nursing identity. For the nurse transitioning to nursing education, there is a strong desire to hold on to that identity and the knowledge linked to forming that identity. This was evident in the literature and the research narratives in the way that nurse educators refer to their practice.

Identity changes occurred when nurse educators moved from hospital-based training into the polytechnic environment (Wilson, 2001). The new nurse educators were viewed as 'outsiders' who had moved into the tertiary sector from the distant health sector. Before long, the new educators were also viewed as 'outsiders' in the health sector, as they took on a new identity as educationalists. This proved to be enormously challenging for the educators as evidenced by participants in Wilson's study. Thirty years later, a disconnect between these two environments continues to create tensions for the nurse educator's identity formation. This rift, and the lack of understanding of the diversifying knowledge base needed for preparing the graduate nurse for the future, is evident in the discourses discussed previously. Nurse educators continue to be confused about their professional identity, as they work across the disparate worlds of health and tertiary education. Nurse educators who display or voice a disconnect between theory and

practice are reinforcing this disconnect for students, for nurses and for other colleagues that they are working with.

The transition of clinicians to nurse educators is described as 'becoming', acknowledging a strong connection between identity and practice (Boyd, 2010, p. 156). Nurse educators come to the role of teaching as experienced, often expert, nurses with their identity and understanding of teaching/learning formed from their own experiences and practices. Some literature describes the loss of one identity, and the search for a new one, as part of the process of becoming and 'owning' the identity of an academic (Hunter & Hayter, 2019). As the nurse educator's habitus develops through learning, what is learned can be modified as it becomes part of their identity. Rather than viewing identity formation as a process to be reconciled with the loss of one identity, the process of becoming suggests that process of identity formation is ongoing and continuous, a never-ending journey. My own stories of graduations and commencement – endings and new beginnings – symbolise this ongoing journey of becoming.

Boyd (2010) presented points of identity formation as the nurse moves into education that are useful in understanding the processes of becoming. The new nurse educator feels a perceived *loss of status* as they move away from the clinical role (Boyd, 2010, p. 159). Learning to teach by drawing on clinical knowledge is an important step in identity formation. Nova's story illustrates the similar identity challenges of a new nurse educator as she develops credibility in her teaching practice. The title of Nova's story, "We don't know what we are doing?", represents her initial feelings of uncertainty and lack of confidence in her ability to teach. She soon realises that valuable teaching and learning can be built around the sharing of her own knowledge through storytelling and through remaining connected with her familiar clinical environment. She relishes the opportunity to be a learner herself and she values the collegial support and mentorship opportunities that support her identity formation.

The nurse educator seeks *credibility and recognition* through their knowledge development (Boyd, 2010, p. 159). Gaining credibility and recognition for the work of nurse academics and researchers was part of never-ending journey evident in my journey and the research narratives. Even experienced nurse educators like Sophia question their contribution to nursing practice when they have been 'out of practice' since moving to work in nursing education. Sophia seeks to embrace the identity of the academic, but she feels comfort in being in the clinical environment where she wears her uniform and is 'seen' as a nurse. The realisation that working in nursing education is nursing practice is evident in the narratives although, for many nurse educators, it takes many years to develop a consciousness and confidence in this identity.

Support through mentorship is highly valued in developing professional identity (p. 160). Mentorship is an important part of the socialisation process. Credibility and recognition may also be linked to identity formation in relation to status. The status of being a registered nurse and working in a clinical environment is a valued part of identity for many nurse educators. It is common practice for nurse educators, including myself, to continue to identify themselves by their clinical background as that is the area of expertise that holds most credibility. The title nurse educator signals to the nurse a move away from practice, and the title of nurse academic does so even more. The discourses discussed previously around the privileging of clinical knowledge provide some explanation as to the dominance of this discourse and its impact on identity formation. Perhaps even more significant are the power relations associated with job titles and status. These power relations are discussed fully in the next chapter.

Forming the student nurse identity

The nurse educator's development of their own professional identity is critical for modelling positive professional behaviours for students. Key aspects of the nurse educator's identity formation can be linked to supporting learning (Baldwin et al., 2017). Creating a context for learning supported by effective communication and a suitable learning environment is paramount. This context creates the opportunity for the nurse educator to use authentic practice experience (both positive and negative) and an opportunity for students to learn from the nurse educator's mistakes. Authentic teaching and learning experiences support the nurse educator to project the professional image of nurse, with the intent that the student can learn from this process (Baldwin et al., 2017). The nurse educator needs to have credibility and confidence in their identity as a nurse educator. The research narratives reveal that the nurse educators felt most confident in this identity when they were able to remain close to practice. This suggests that identity formation of the student is optimised when the nurse educator is able to build a bridge that supports learning between the practice setting and education.

Professional socialisation: Becoming a nurse academic

Primary socialisation is a process that begins in childhood in the development of socially constructed human behaviours through interactions with the immediate environment (Mackintosh, 2000). Secondary socialisation is broader, and concerns processes that construct ways of working within the culture of different organisations. Both forms of socialisation have shared purposes of transmitting norms and values that maintain or develop society and organisations (Mackintosh, 2000). Becoming a nurse educator involves a professional

socialisation process that leads the individual on a journey, either moving from one organisation to another, or sometimes spanning two organisational cultures, clinical and educational (Andrew et al., 2009). As discussed in the previous section, this process is not as seamless we might either expect or claim. The socialisation process involves the duality of the role perceived as 'doing two jobs' (Findlow, 2012, p. 127) and as duality in cultures — the culture of the nursing profession and the culture of the academic discipline of nursing (Shriner, 2007).

The socialisation process in nursing education can also be described using the metaphor of dual consciousness (Smith, 1996). The work of the nurse educator is coordinated across the worlds of nursing and education with professional standards and organisation standards intersecting with the philosophical practices, values, and beliefs of the individual. Smith proposed the need for critical reflection or praxis to learn to see the worlds in new ways. The research narratives make conscious the indiscernibility of the everyday work of the nurse academic in Aotearoa New Zealand. Rather than transitioning to the role of nurse educator, support for growth and socialisation into the role is required to expand the nurse educator's work to that of an academic.

In Aotearoa New Zealand, the least familiar and formed aspect of the work and identity of the nurse educator is as an academic. The research narratives revealed a lack of consciousness and an absence of authority in the socialisation process that supports identity formation particularly in relation to the discourses and competing demands of the institution of nursing education. The research narratives reveal high levels of uncertainty and concern for the undervaluing of academic work. While more nurses are now completing postgraduate studies as part of their nursing journey, this academic advancement is often related to nursing speciality practice. There is no clear academic pathway in Aotearoa New Zealand to support the nurse to develop as an academic even though the completion of a higher qualification is a requirement for all nurse educators. My decision to study a doctorate in education was informed by desire to strengthen my own understanding of this area of my practice. The academic pathway that includes advanced study in the practice of education is less common for most nurse educators.

Tensions around academic knowledge development have arisen between academic and clinical leaders and are linked with academic identity formation (Jackson et al., 2011). Sophia's story illustrates this struggle as she reflects on the competing demands in her role as registered nurse, teacher and researcher. As an experienced educator, Sophia is comfortable in her role as a teacher, but she is still developing her identity as an academic. 'Being an academic' is viewed as distinct from being a teacher (Logan et al., 2015). The next generation of academic nurse

educators need to be both researchers and teachers. What is lacking in this discourse is the development of the nurse academic as leader.

Academic leadership: Being a nurse educator

Nurse educators show low self-confidence and agency in their ability to lead, bring about change, contribute to quality improvement, advocate for nursing in the political arena, and achieve a balance between teaching, scholarship and service requirements in their everyday work (Ramsburg & Childress, 2012). This issue can be compounded by a focus on hierarchy that results in 'them and us' thinking about those with and without formal leadership roles and titles (Thompson & Clark, 2018, p. 996). My own journey has been long (over 25 years), and I am continuing to develop as an academic leader. While I have been fortunate to be supported and mentored throughout this process, the uncertainty and struggles in developing the nurse academic role can be linked to lack of mentorship, career direction and agency development. A lack of understanding and undervaluing of the nurse educator's work as academic contributes to negative behaviours and experiences, including workplace stress, incivility and bullying (LaSala et al., 2016). Ongoing mentorship, critical self-reflection, identity formation and career guidance is needed to create a supportive academic culture (Hunter & Hayter, 2019).

The links between these multifaceted dimensions of academic practice (educational preparation, identity, research and leadership) are not well developed. The fragmentation of the nurse educator's knowledge base and practice translates into fragmentation in the preparation of the future nursing workforce. Nurse educators need to value their own contributions as diverse knowledge developers and back themselves in leadership roles in this area. The metaphorical split of consciousness may create a stumbling block stopping the nurse educator from progressing on their journey. The separation of nurse educator's work between clinical and education practice reinforces the undervaluing of nurse educator's contributions to knowledge development and research, particularly in relation to education.

A holistic interdisciplinary team approach is proposed to foster the collaborative work of nursing education (Zlatanovic et al., 2016). Too often, nursing is seen as weaker and less credible by those in other disciplines and nurses in academia themselves perpetuate this by not seeking leadership roles outside nursing (Clark & Thompson, 2015). The key to developing academic leadership and agency is understanding the dialogical interactions, norms and discourses that dominate and oppress the everyday work of the nurse educator. The next chapter analyses the

competing demands in the social world of nursing education that the nurse educator encounters as part of this journey.

Chapter 8: Navigating the Competing Demands in Nursing Education

The field of nursing education is complex, with the interrelationships between the habitus of health professionals, health consumers, academics and students, and the forms of capital that coordinate and interconnect in the fields. The previous chapter focused on the habitus of the nurse educator and the discourses that influence professional socialisation to the role. The nurse educator understands their identity as a registered nurse but needs to develop credibility and confidence in their role as a nurse educator. The shift in identity formation is particularly difficult in relation to becoming a nurse academic and was described in the research narratives as 'struggling against the norm'. This chapter examines the ruling relations as the structures in the field that produce a form of social control or power linked to capital and habitus. Illuminating these relationships brings awareness of their existence, enabling action against structures that dominate or marginalise the work of the nurse educator.

Interrelationships between public habitus, capital and field

Public habitus is understood as the habitus that expands from the nurse educator's own experiences and perceptions. This habitus constructs how the nurse educator is positioned and portrayed in nursing education. Genealogical influences, including gender bias, textually mediated material and archetypes, have contributed to a gendered positioning of nursing that has formed this habitus. These influences, discussed in Chapter 5, shape the nurse educator as clinician, teacher and researcher.

The Nursing Education Forum narrative in Chapter 6 provides understanding of the power relations that further influence the formation of the public habitus of the nurse educator. The nurse educators contributing to the forum dialogue are experienced nurse educators who portray different positioning through their discussion. Textually mediated relationships evident in this dialogue and the other research narratives portray the discourse that has arisen from genealogical influences, structures and forms of capital. Most evident is the discourse that has mediated gender biased relationships in nursing education. This discourse can be understood by examining the structures in the wider field of nursing education. These structures influence how the nurse educator is positioned to navigate competing demands and power relations.

Discussion begins by examining the governmental and academic structures that mediate nursing education practice.

Government regulations: NCNZ trumps NZQA

Government strategies and policies in both health and education set the agenda for nursing education. The research narratives voiced an understanding of the different structures and regulations that are part of the nurse educator's everyday work. What is not voiced is the understanding of the power dynamics that arise through organisational values, governmental strategic direction, and political agendas.

The political philosophies and priorities of the government in power determine the direction for this agenda. Neoliberal ideology has continued to permeate across both left- and right-facing political approaches. In the current Aotearoa New Zealand governmental structure, the Ministry of Health and the Ministry of Education provide strategic direction for the business of nursing education. The Ministry of Health sets strategies and policies for health care across a range of health disciplines and, traditionally, medicine has been dominant in setting the agenda in this space. The Ministry of Education provides oversight from early childhood education through primary and secondary schooling into the tertiary environment. Government-funded universities and polytechnics sit within the tertiary setting alongside wānanga, industry training organisations and private training establishments. Both ministries cover a broad range of disciplines, and each works with its own philosophical underpinnings, priorities, values and culture.

Two different regulatory authorities are in place in health and education. NCNZ is the government appointed regulatory body that sets regulations for nursing practice. The NZQA and the AQA are the educational regulatory bodies that set the academic standards for degree qualifications in the polytechnic and university sectors. These bodies must ensure that the direction set by the Ministry is enacted in manner that ensures public safety in health care and academic quality in education practice. Each of these authorities operates with different structures and policies that need to be understood in the context of nursing education in different settings (see previous discussion on page 65).

The policies and regulations of the academic world require lateral thinking and sensibility in how they are interpreted and applied within a nursing education context. In the research narratives, the Nursing Education Forum contributors expressed a strong opinion that NCNZ authority 'trumps' academic authority when it comes to decision making about safety to practice.

Operating nursing education under these different authorities contributes to the discourse about how programmes are structured and how they function.

Negotiating academic structures: The journey 'up the ranks'

Academic structures vary, based on the type of institution, organisational values and culture, and the education models and philosophies. Nursing education programmes are often the largest degree programmes in polytechnics. As degree-based programmes, they often make a significant contribution to the institution's academic cultural capital. Degree-level requirements support the robust development of quality assurance and research processes that benefit the wider institution. NCNZ education standards endorse the development of locally influenced programmes through strong stakeholder engagement. These systems and structures afford polytechnic-based nursing education programmes autonomy in developing unique curricula that meet the needs of local communities.

Academic and regulatory structures set staffing and resourcing requirements in the polytechnic sector. Nurse educators may be full-time, part-time or casual academic staff members whose work includes teaching in the classroom, online and in the clinical environment, as well as being engaged in scholarly activity including research. This workforce creates a substantial resource of both social and cultural capital for the nursing programme and the institution. The workforce in the polytechnic sector tends to be relatively stable in successful nursing programmes and institutions, and my journey 'up the ranks' from lecturer to programme manager is not unusual. Nurse educators and other degree-based academics in polytechnic settings often move through the ranks into leadership positions within their own institution or by moving to neighbouring institutions. In the research narratives, the tertiary education environment (especially in the polytechnics) is perceived as family friendly and supportive for part-time workers, requiring less shift work. This culture supports women managing the competing demands of motherhood and career.

University-based nursing programmes are often structured as part of a wider suite of health-science-related programmes resulting in different forms of social and cultural capital. Nursing education staff in universities may include a higher proportion of non-nursing academics, with subject experts teaching areas such as science, social science and research. Nurse educators working in this sector are less likely to be also teaching in the clinical learning space, and more like to have part of their workload allocated to research. Nursing leadership in universities may be subsumed into a specialist health practice field, with a greater focus on academic practice

including research. Nursing academics, especially women, in university settings have experienced being marginalised with teaching contracts and positions that are not regarded as having the same significance as research active academics (Glass, 2007). For these women, career aspirations may need to be managed alongside managing families. This more competitive process for career progression based on individual outcomes and status maybe be less familiar or comfortable for the nurse educator.

These governmental and organisational structures impact on the public habitus of the nurse educator and influence their position in the field. Examining textually mediated relationships using the concepts of economic, cultural, and social capital provides further insight into how the nurse educator navigates the power relations inherent in the business model of nursing education.

The power of economic capital: Nursing programmes as the 'cash cow'

One of the biggest challenges for nurse educators is understanding how to navigate the business of nursing education. The institutions of both health and education are managed using business models based on the principles of capitalism and neoliberalism that construct education outcomes as products. Governments invest significant money in health and education budgets and expect a good return on this investment. Language which frames people as health care 'consumers' and tertiary students as 'customers' is now commonly used in these two sectors. Nursing education produces the future nursing workforce, and this workforce makes up a significant resource in the health sector.

Nursing programmes in the polytechnic sector provide much needed steady revenue for the institution with predictable enrolments every year. A centralised business model of management puts nursing education leaders into management positions with little control over budgets. Centralised financial control could result in decision making on important aspects of the programme, including staffing ratios, being made by non-nursing management without an understanding of the nature of nursing education work. The recent review and restructuring of vocational education has yet to provide a clear direction for how degree-level study such as nursing sits will be managed in the organisational structure of one national polytechnic. Clarity is needed in understanding the value of the cost saving and other benefits that could be achieved by the national Tertiary Education Strategy priorities that may favour a single national nursing education curriculum (Ministry of Education, 2019b). Equally, understanding is needed about what may be lost in a 'one-size-fits-all' approach. The less visible forms of social and cultural

capital gained through engagement with stakeholders, including the community, may be lost if a standardised approach is adopted.

Schools of Nursing situated in the university environment face different financial pressures, with the funding of academic staff often directly linked to research outputs through the Performance Based Research Fund (PBRF). Academics, including nurse academics, are ranked according to the number and quality of their research outputs (TEC, Tertiary Education Commission/Te Amorangi Matauranga Matua, 2020). This ranking is used to determine how government research funding is allocated to different institutions. Nursing academics have traditionally struggled in being measured against predominantly scientific measures, resulting in a lower ranking with less funding (Glass, 2007). The ranking system is often based on research publications, with science-based research gaining the highest status. Nurse educators are disadvantaged by this structure that marginalises nursing education knowledge and the thinking work of nursing as cultural capital.

A monetary valuing of the 'essential' work of the nurse educator

The undervaluing of women's work is evident as a discourse between the business model of education described above and nursing ethics and values. The work of nursing is highly valued and identified as 'essential' work in public opinion, yet it is difficult to put a monetary value on the nurse educator's contribution to this work. In the Nursing Education Forum narrative, the nurse educators understand the business model that names the student and patient as consumers. The forum contributors express their concern that this language changes the focus of the nurse educator's work, putting a capital value on education and caring. For example, the financial contribution that the nursing education programme makes as the 'cash cow' for the institution needs to be reconciled with contributing to the wider good of society. The work of research is also linked to financial gains through funding and brings a competitiveness to the work that may be unfamiliar and uncomfortable in the nurse educator's habitus. The nurse educator wants to be doing work that makes a contribution to the nursing and health care workforce. An understanding of the impact of the monetary contribution that the 'business' of nursing education makes on health outcomes may help the nurse educator to reconcile this discourse.

Nursing education's return on investment has been measured in terms of the health care benefits, services and outcomes supported by the nurses formed through nursing education (Kowalski & Kelley, 2013). This notion puts nurse educators at the top of the essential health

care sector workforce "supply chain" (p. 71). Using this American model, nurse educators are viewed as investments in human capital with a set of assets including the nurse educator's knowledge. One nurse educator could produce six new nurses per year which in turn supports at least $704,000 in health care services. Using different analyses of variables and assumptions of costs and benefits, the predicted investment from nurse educators ranges from 350% to 1,330%, depending upon the different underlying assumptions (Kowalski & Kelley, 2013).

Whilst the results from this American study provide a means for quantifying the human capital value of nursing education, the authors recognised the complexity of the world of nursing education that could not be explained by economic means only. Education, management, regulation, community and health care leaders have a stake in nursing education work and therefore need to have a role in developing and supporting solutions (Kowalski & Kelley, 2013). An interprofessional approach that focuses on the potential for all forms of capital gain through nursing education would be valuable in addressing the power relations.

Struggling for recognition: Building cultural capital

Nursing education has struggled to be recognised based on cultural capital. The possession of cultural capital in nursing education is determined by several competing factors. Individual cultural capital refers to "knowledge, attitude and behaviour that promotes social mobility" (Andrew et al., 2020, p. 2). The possession of individual cultural capital is often unquestioned as it is recognised as carrying authority that is reinforced through institutions such as education or the workplace (Royal, 2012). Nurse educators, as women, are often reluctant or uncomfortable in promoting their individual cultural capital.

Cultural capital can be objectified as textbooks, research publications, and qualifications. The shift to a degree qualification resulted in higher cultural capital for the profession. The objectified capital associated with nursing education research and publications is perceived as lesser cultural capital because of the way that nursing knowledge and nursing work is understood. Different forms of institutional cultural capital are associated with perceived differences between universities and polytechnics in the quality of education.

The struggle to be recognised and build cultural capital is linked to structures and power relations inherent in nursing education as women's work. One of the challenges of Bourdieu's theory on the possession of capital is that it endorses the dominant culture and therefore acts as a deficit model. Bourdieu argued that knowledge associated with upper and middle classes have been given the highest cultural capital value in hierarchical societies (Yosso, 2005). These

embodied forms of cultural capital are linked with dominant culture, devaluing the cultural capital or minority cultures or those who are gendered differently. Nursing education has been formed by dominant Western European cultural worldviews which afford nurse educators from the dominant culture a higher cultural capital. As a discipline, nursing education is gendered as women's work, which results in a lower level of cultural capital. The impact of lesser forms of cultural capital is evident when examining forms of symbolic capital and the impact on leadership development.

Symbolic capital: Job titles and status

Symbolic capital is a significant form of cultural capital in tertiary education. This form of capital results from the way in which other forms of capital are perceived in social structures (O'Brien & Ó Fathaigh, 2005). Status is the capital product of education that is given most value in the academic setting. The status associated with titles, qualifications, publications, and institutions of learning impacts on how nursing education is perceived in the fields of health and education. Status, particularly in the university sector, equates to a form of power. The need or desire to gain status places high expectations on Aotearoa nurse academics to complete their doctoral studies, and to produce research outputs and publications.

The status of the nurse educator is reflected in the variety of job titles used to describe the work. The Nursing Education Forum contributors introduced themselves using their job titles. Titles describe the work that the nurse educator does, their position, or status. These titles are shaped by the habitus of the nurse educator as well as the fields where the work is situated. The diversity in the titles for and interpretations of the role across a variety of settings and sectors is evident in material text pertaining to teaching and the role of a teacher. Teachers are described as facilitators, guides, coaches, mentors, change agents, mediators, and pioneers, reflecting changes in the world of education (Attard et al., 2010; Horsfall et al., 2012; Osberg & Biesta, 2010).

In Aotearoa New Zealand, more traditional titles such as 'nurse lecturer' or 'nurse tutor' may still be used because of the established understanding of the terms. The title itself may no longer be accurate, since the nurse educator is doing much more than just 'lecturing' students. A lecturer is defined in the Education and Training Bill (Education and Workforce Committee, 2020) as a person who is employed by a university, the New Zealand Institute of Skills and Technology (NZIST), or an NZIST subsidiary to teach or instruct students in these tertiary education settings. A range of other titles is used in different tertiary settings to fit the

institutional requirements for the role. For example, the university setting might use an academic title including ‘professor’ or ‘fellow’ linked to achievements in research and representing prestige within the academic world.

The title ‘nurse educator’ is also used beyond the tertiary education institution to describe the role of a registered nurse who works in a clinical setting (usually a hospital) providing education support to nurse colleagues working in that area. The ambiguity and variability of titles for the work of the nurse educator contributes to the difficulties the nurse experiences in developing their professional identity as a nurse educator. Many nurse educators will include their area of clinical expertise in their description of their work. This area of practice is an embodied form of cultural capital gained as part of their professional identity formation. Many of the Nursing Education Forum contributors included their area of clinical expertise when introducing themselves to the group.

Social relationships and cultural capital are influenced by the power implied in title and status. For example, the term ‘nurse lecturer’ may position the nurse educator in authority as the ‘lecturer’ title implies a power relationship that imparts knowledge to the learner. The title of ‘facilitator’ or ‘guide’ may portray a more balanced power relationship for both the learner and the educator. Completion of doctoral studies is often viewed as the starting point for establishing an academic status, yet for many nurses (including myself) this achievement may occur much later in the span of their nurse educator career. The status associated with a doctoral qualification may represent further confusion in the nurse educator’s job title with the cultural capital that is represented as both doctor and nurse.

The academic title of professor may be held by a person with an advanced level of knowledge and academic achievement. This title may not portray a person with the advanced clinical knowing that might be necessary in preparing the future nurse. Even though the person holding the title and status may be well equipped to traverse the breadth of the nursing and academic worlds, and what lies between them, their title may carry symbolic capital without the other forms of capital needed for managing the complexity of the professional and clinical work. A rethinking of how status and titles are bestowed in nursing education is needed to represent the nurse educator who embodies all the forms of capital needed for preparing the future nursing workforce.

Professional stance as nurse academic

The work of the nurse educator as researcher and knowledge developer is an unrealised form of cultural capital. It is from this knowledge base that the professional stance of the nurse academic should be formed. The discussion in Chapter 5 critiqued the ways in which nursing education's knowledge base could be perceived as a lesser form of cultural capital due to its less scientific focus. Academic structures that support research and knowledge development marginalise these opportunities for the nurse academic. The possession of cultural capital being linked to patriarchy creates a gender bias in academia that contributes to structures that favour male-led initiatives and disciplines that are linked to male-dominated subject areas such as science and technology. Science-based research is favoured in many national and international health research funding strategies (Glass, 2007). A recent international report funded by the Nursing Now campaign recommended that the legitimacy of the status and profile of nursing needs to be elevated through an international strategy promoting nursing as a STEM (science, technology, engineering, math and medicine) profession (Newman et al., 2019). If this approach favours the legitimacy of scientific knowledge *over* nursing knowledge, it risks moving nursing education backwards rather than forward.

Educational research funding strategies offer little to support nursing education research. There is also a lack of social capital in the form of mentorship and academic networks within and across institutions to support the emergent nature of the developing nursing academic workforce (Glass, 2007). Nurse academics need to be supported towards a pluralist research perspective that makes visible discipline-specific nursing education knowledge development.

A career pathway for nurse educators is needed that recognises the complexity of this work. In Aotearoa New Zealand, there is no shared vision for preparation and advancement in a career as a nurse educator. The NCNZ and NZQA both support preparation at a master's level but there is no specific or general pathway to support a career as a nurse academic. Master's and doctorate qualifications range across clinical, general philosophy or arts, education, professional or scientific domains. Career direction is mostly gained either through mentorship or institutionally sanctioned directives that may be linked to funding, perceived status or convenience.

Globally, the AACN has a vision for nursing education that includes three levels of academic preparation. A generalist nurse is prepared at the baccalaureate level; the advanced generalist is prepared for clinical leadership at the master's level; and an advanced specialty nurse is

prepared with a practice doctorate, Doctor of Nursing Practice (DNP) qualification. The research-focused doctorate, the Doctor of Philosophy (PhD), is the pathway for a nurse academic or researcher (Smith & McCarthy, 2010). This pathway lacks any specific reference to the practice of nursing education. From this vision, the relevant pathway and qualification for work as a nurse educator could be at a master's advanced generalist level, the advanced speciality practice doctorate or the research-focused doctorate. The lack of a shared understanding of the status and professional stance of the nurse educator is compounded by the gendered and cultural structures that position nursing education as 'women's work'.

The invisible ceiling for female academics

The continuation of the gender bias that favours men and hinders women in their careers, including in nursing, has resulted in a power imbalance and lower forms of social and cultural capital for nurse educators. The doctor–nurse game discussed in Chapter 5 described gender bias based on the subservient positioning of nurses as women in relation to men as doctors. When nursing moved into higher education, an opportunity arose to gain cultural capital and change nursing's perceived lower status. Stein concluded that the doctor–nurse game no longer existed because nurses were no longer willing to play (Holyoake, 2011). Holyoake argued that the game still exists and is driven by competing discourses and professional values that substantiate the game. Nurses taking on roles or tasks that were previously viewed as doctor's work are still playing the game as doctors willingly give up these tasks. What Stein may not have considered is whether changes in educational preparation alone would afford the changes needed to disrupt the deeply embedded power gradient that has developed in the world of health care. The research narratives illustrate a continued valuing of medicine-based tasks or skills as part of clinical nursing identity. Leaving clinical or giving up these tasks results in a perceived lowering of cultural capital that is built on scientific and medical knowledge. The nurse educator's positioning is lowered by moving into the field of nursing education.

These same biased perceptions impact on the positioning of the nurse academic. Traditionally, Western Eurocentric society privileged men for roles of knowledge acquisition and knowledge development gained through academic dialogue and research. Men were considered to be more capable of higher-level thinking and were encouraged to go to university. This gave men the control of the development and production of knowledge which had far-reaching control of many aspects of society. Smith's research links this positioning to Western patriarchal influences in relation to the knowledge work. When women were finally accepted into the university

environment, the influences of patriarchal beliefs remained, and women were believed to better suited for roles as knowledge translators through teaching and learning practices (Smith, 1996).

Few leadership positions in health are held by nurses or women. There is evidence of a gender-based pay gap, as well as other forms of gender-based discrimination in the nursing work environment (WHO, 2020). Female nurses, together with other women in the health workforce, face more barriers at work than their male colleagues. These include:

> biased perceptions of women's roles in caregiving, social gender norms, gender bias and stereotyping, all of which undermine nurses' ability to obtain good working conditions, receive fair pay and equal treatment, participate in decision- making, and become leaders within health care. (WHO, 2020, p. 30)

The impact of gender bias for women in nursing education means there are fewer opportunities for leadership due to the constraints of an invisible 'glass ceiling' (Newman et al., 2019). A study of leadership barriers and facilitators in nursing described not only a 'glass ceiling' for women, but also a 'glass elevator' for men, who hold a disproportionately high number of senior nursing roles (Newman et al., 2019, p. 6). The 'glass ceiling' for women represents the invisible barrier that inhibits women from progressing into leadership positions. Conversely, for men in nursing, their ability to progress is supported by an invisible 'glass elevator' that propels them up the ranks with more speed.

The Nursing Education Forum contributors were predominately women and leaders. They positioned themselves based on their work as either clinicians, their job titles or academic achievements. When introducing themselves in the forum, the nurse educators were seeking to present a credible image so that their contribution would be valued. Whilst the group was made up of mostly females, the men in the group were assigned leadership roles including the group facilitator and the scribe. The forum contributors described men as being leaders in academic institutions, including being in positions of power, signalling an acceptance of the positioning of men in authority.

A female profession: We must apologise for the pay!

Working in nursing education comes at another cost for most nurse educators. The gendered gaps for women academics in rank, promotion and pay are evident in material text. In Australia, women remain concentrated at the bottom of the academic hierarchy, making up only 20% of professors and associate professors (Carrington & Pratt, 2003). The lack of nurse educators

holding doctoral qualifications also affects the ability of the profession to conduct the research needed to develop evidence to inform practice, and to assume leadership roles in academic and health care sectors (Gazza, 2009).

The research narratives did not reveal any discourse regarding remuneration but there is evidence of a significant pay drop for clinicians on moving into nursing education in Aotearoa New Zealand. The value for the nurse educator in making a contribution to nursing and to society as a whole is voiced in the narratives as a valuable reward for this type of career. My own experience of recruiting nurse educators has resulted in feeling the need to 'making an apology' for the lower pay. Based on the Tertiary Education Union (TEU) collective agreements, a beginning nurse educator may be offered a salary of around $75-94k per annum including benefits (TEU, 2019). The salary range is due to variations in collective agreements across the university and polytechnic sector. A senior nurse salary based on the DHB collective agreement is at least $10,000 higher (without the inclusion of penal rates) than a beginning nurse educator (NZNO, 2019). An American study reported pay differences of 25-50% in favour of clinical careers over academic careers (Gerolamo & Roemer, 2011). New academics may face the additional costs of both time and money in acquiring higher degrees. Faculty working conditions were reported to be increasingly unattractive to young professionals who want a better work–life balance (Gerolamo & Roemer, 2011). The silence in the research narratives around remuneration does not make this situation any less significant.

On top of these pay differences are the gender and ethnicity pay gaps that have resulted from capitalist and patriarchal principles. In Aotearoa New Zealand, the average wage gap between men and women is 12% (Pacheco et al., 2017). The 'glass ceiling' effect described in relation to academic leadership is also perceived to create gender pay gaps that increase as women move up the career ladder, with wider gaps of 18–21% at the top of the scale. Explanations for the gender pay gap include the difference in occupational structure for men and women, with males more likely to be in management and trades roles and women more likely to be in professional and services role. Women are also three times more likely to work part time. Educational differences are less likely to be a contributing factor, with educational attainment having risen for women (Pacheco et al., 2017). The gender pay gap is even more pronounced for Pasifika (25.4%) and Māori women (22%) when compared to Pākehā men (Black, 2020).

In academic settings, including nursing education, both the gender and ethnic pay gap are noteworthy and have been studied recently in the Aotearoa New Zealand context. Brower and James (2020) compared the PBRF scores of men and women and found that even when women's

research career trajectories resembled men's, they still got paid less than men and were ranked lower (associate or full professor) than men. This research determined that the academic gender pay gap could only be partially explained by observable variables such as age, research score and discipline. Even if research scores were similar, women were not promoted similarly, resulting in a 30- 60% gender pay gap. Higher expectations of women academics for teaching and service impeded their research opportunities creating a 'double whammy' effect that meant they were under-rewarded as well as underpaid (Brower & James, 2020, p. 8).

The 'double whammy' effect is evident the research narratives as the nurse educators navigate the competing demands in their everyday work. The expectations of being clinician and teacher have impeded the nurse educator in forming, as a research academic, the work that will afford them more opportunity for status and monetary rewards. Policies that address the undervaluing of women's work and gender and ethnic bias are needed.

Building social capital: Embracing diversity

Social capital is the strongest form of capital evident in the everyday work of the nurse educator. This is also the form of capital that the nurse educator has most potential to influence and control. Social capital develops from shared beliefs and values within the public habitus of the nurse educator. Different types of social capital are formed based on relationships and networks with this habitus (Ling & Dale, 2013). At an individual level, nurse educators are working with structured social networks that connect them. Professional identity and belonging are important concepts in building positive social networks (Xu et al., 2020). The professional socialisation of the nurse educator as discussed in Chapter 7 is a complex process that requires mentorship, leadership and a supportive academic culture.

Connections are strengthened when nurse educators are working from a shared knowledge base and when the sharing of knowledge is valued (Hofmeyer, 2013). The shared knowledge base for the nurse educator is nursing knowledge. Connections that build trust and foster shared understandings create powerful feelings of belonging and shared purpose which provide motivation for cooperation, collaboration and the building of knowledge (Claridge, 2020). These relational networks are needed to develop and maintain social capital for the nurse educator. Textually mediated relationships in the research narratives portray the potential for social capital built on social networks and trust.

Social networks can include both bonding relationships that are structured within a group or community and bridging relationships that span social groups (Putnam, 2000). New nurse

educators like in Nova's story, bond strongly to social networks within the clinical practice settings where they have built credibility and trust. The public nurse educator habitus is less familiar, and this may create a discourse with relationships that span different social groups and levels of experience. The new nurse educator needs to feel valued for what they contribute to the relationship with a respect for diversity and difference (Xu et al., 2020). Reciprocity in the relationships indicates a willingness to provide mutual support without the need for formal rewards or recognition. Nova experienced bonding relationships as a new nurse educator as she learned to value her own contribution and gained trust in seeking support from colleagues. Building cohesive social networks supports public habitus formation and the potential for building social capital. Bridging relationships are needed to create ties between being a nurse and an academic, and to support civility in the workplace.

Bridging relationships develop across different faculty groups within an institution, and with other social networks in which nurse educators may engage. Both formal and informal relationships exist at personal and institutional levels, as evident in the Nursing Education Forum narrative. Outside of their immediate work environments, nurse educators can build their own social capital through networking and influencing shared goals that will support nursing education policy development. The social connections outside of the workplace are less established, with weaker levels of trust and less potential for social capital. At this level, individuals may be described as social actors with different influences, power, beliefs and values that are linked to routines and institutional practices (Claridge, 2020).

Linking capital is offered by the government representative who connects the Nursing Education Forum contributors to the wider education community. Linking capital provides the capacity to promote ideas and information beyond the social network to more formal institutions (Ling & Dale, 2013). Control over how information shared at the forum is formally communicated sits with the government official and organisers of the forum. It is possible that the contributors in the group have other linking capital that enables them to share this information, but this places the control with the individual rather than the collective. The potential for change from the Nursing Education Forum discussion is limited as much of the control sits outside of the relationships formed by the contributors.

Institutional networks exist with different relationships formed within the polytechnic and university sectors. Government and societal structures and legislation discussed previously produce degrees of control. This level of power means that change occurs more slowly. Linking and vertical social capital in nursing education have the most potential to afford change, but

also are the most difficult to develop and sustain. Vertical social capital connects people with power, both politically and financially (Ling & Dale, 2013). Cohesive nursing education leadership is needed to exert influence in the wider institutions of health and education.

How social capital is both conceived and utilised within these different social networks must be understood in relation to social exclusion and diversity. Contextual features such as poor educational achievement or lower socioeconomic status contribute to social exclusion (O'Brien & Ó Fathaigh, 2005). The diversity of social and cultural capital is illustrated in the narrative of the Nursing Education Forum. Different forms of capital are linked to the forum contributors, based on the institutions that they represent, their professional status, their gender and culture. Individuals have different levels of opportunities and control that enable them to build their reputation, status and power. The potential for incivility and bullying was evident in the literature when social networks were absent or dysfunctional. The impact of incivility and bullying discussed in the critical reading of the literature is discussed further in relation to the potential impact on career pathways (see discussion on pages 85 and 163).

Bourdieu's concept of social capital recognises how social capital operates as a tool of cultural reproduction (O'Brien & Ó Fathaigh, 2005). Inequality and differences in opportunity can be reproduced through different social groups, different regions, and different social strata. The value of diversity must be acknowledged and embraced to build social capital and academic leadership.

An undetectable academic leader

The struggle to gain social and cultural capital for secure positioning in nursing education has resulted in an undetectable academic leader role. An archetype of a nurse educator is less defined by some of the features that dominate society's image of nursing. The research narratives present stories of a gradual entry into nursing education following a successful career as a clinician. Nova and Sophia were drawn to nursing education based on their desire to give back to the profession, or for a more flexible work environment without shift work. Nova and Sophia are both portrayed as female and mothers, with their professional identity formation mostly attributed to their work in clinical practice. The Nursing Education Forum contributors are portrayed as mainly women of various ages with a Western Eurocentric background. They are likely to be middle class and middle aged, and to come from a position of privilege having gained a tertiary level qualification and a leadership position in nursing education. They portray

themselves in a friendly professional manner through the language that they use in the forum discussion.

It is difficult to detect a new archetype image of these nurse educators as academic leaders. At times, the nurse educator may don either the uniform of the nurse clinician or the regalia of an academic. Taking off the uniform and putting away their nurse medal can signal a loss of identity, in the absence of a new image to fulfil the new identity of nurse educator. Nurse educators are often more comfortable with this Nightingale archetype, as this fits the picture of nursing they have formed for themselves as part of their own nursing identity. Nursing education texts shaped by generations of nurses and nurse educators have embodied a deeply conservative message of the 'good' nurse that re-affirms popular beliefs about the nature of women and their role in society (Walker & Holmes, 2008). The nurse educator may cling to this familiar image of the 'heroine' making a difference in health outcomes.

The familiarity of this image may explain why some nurse educators feel uncomfortable and like they are outsiders when imagining themselves in the academic work of the nurse educator. The archetype image of the academic in regalia does not represent the everyday work of the nurse educator. Putting on academic regalia from time to time may help the nurse educator in being comfortable with their new identity but conversely it may also reinforce the falseness of this image in conjunction with their everyday work. The authentic power that the nurse educator feels when wearing their uniform and nursing medal is not experienced when donning the less familiar garments of patriarchal academic regalia. The graduation ceremony provides the nurse educators with an opportunity to be recognised by colleagues and the public in their academic roles, but their everyday work is not evident in this ceremonial event.

Cultural bias also contributes to the undetectable nurse educator archetype. The Aotearoa New Zealand image of the nurse is strongly influenced by the history of colonisation taking on the Western worldview. This has resulted in the dominant view of the nurse as of Western European descent although the workforce is becoming more diverse with the arrival of internationally qualified nurses. Indigenous and non-European nurse educators may find no familiarity or comfort in the images that reinforce the domination of one cultural worldview. The history and cultural practices of indigenous Māori nurses are not evident in the nurse educator archetype, further marginalising indigenous leadership and cultural worldviews. More recently the use of te reo words such as kaiako (teacher) and tapuhi (nurse) have begun to be used as more accurate terms for indigenous persons in this role. The underlying dominance of institutional racism makes these practices difficult to embedded in the public habitus of the nurse educator.

The absence of authentic academic leadership as part of the public habitus of the nurse educator may impact on the developing social and cultural capital needed to manage the power dynamics at work in the wider field of nursing education. These power dynamics need to be understood in relation to the structures that dominate nursing education practice.

Disempowerment and unmet expectations

Uneven power differentials and the resulting costs for the female academic are evident in the research narratives and literature across different local and global contexts. Some nurse educators trade their autonomy and authority as nurses to balance their commitments as women and mothers. In the research narratives, the nurse educators expressed feeling undervalued and powerless, and feeling that they have a lack of clarity in their professional identity. The impact of gender in both nursing and education was acknowledged with reference to the female domination in nursing and teaching roles, and the male domination in education management and leadership roles. Nurse educators' social networks are less developed in the academic work environment. The nurse educators in the forum narrative were seeking to be engaged in social relations and decision making that might afford them some power in their everyday work. Power in this context was linked to management and the systems and processes that management controlled.

The research narratives portray feelings of powerlessness arising from being managed by others, especially as a new academic. The nurse educator role is seen to be less visible in the wider institution and this lack of visibility is equated to a lack of power. The language used to describe management in the research narratives included managers being 'dictatorial', and nurse educators feeling 'micromanaged' and being 'managed by outsiders'. The culture of the organisation was also described as impacting on the nurse educator's relationship with power. This relationship included being seen as an outsider when new to the organisation or being seen as a threat when more experience and status has been gained. The nurse educators recognised the need to understand the wider social world of nursing education and the politics at play in it. Students and stakeholders are identified as consumers of education with different expectations. A sense of powerlessness is evident, with the nurse educators showing awareness of the issues but lacking strategies for support from others.

The discourse of *how* the nurse educators learn to play the 'academic game' remains unarticulated. Significantly, there was an absence of dialogue on the nursing education scholarship that is required to do this work. Ruling relations derived from government

regulations and academic structures create forms of power and authority that have the capability to privilege and oppress. The rules and expectations around research and the development of the nurse academic role were identified as key concerns in relation to policies and systems. The contributors in the Nursing Education Forum voiced feeling disempowered when seeking to develop as research-active academics. They expressed concerns about the lack of control in the process in regard to management oversight, financial constraints, and competition for research funding. A lack of mentorship support was also identified as being a concern for contributors. The responsibilities of 'producing research' and 'gaining funding' to support the institution seemed to be at the forefront of the discussion. Similar findings are evident in Australian research on the experiences of female nursing academics. Institutional oppression and competing university directions were very powerful opposing forces that were consistently evidenced in the workplace (Glass, 2003). Competitiveness within nursing schools is manifested by lack of support for professional development and, as a consequence, a growing isolation experienced by female academics (Glass, 2007).

The fields of nursing and education present a range of competing demands that impact on the nurse educator's everyday work. The aim of the present research is to provide some approaches that support nurse educators and other human-centred health professionals in their everyday work. Social and cultural capital and agency are concepts that support actions to effect social change (Ling & Dale, 2013). Networks can build social capital, but agency is needed at both individual and collective levels to mobilise the social and cultural capital. Agency has the ability to affect events outside of the immediate sphere of influence (see previous discussion on pages 23 and 82). Adopting a postmodern view offers nursing education an opportunity to appreciate the varied views of the world that come from multiple positions in managing the complex power dynamics in nursing education. The building of agency and social and cultural capital are discussed in the next chapter as postmodernist approaches that can support nurse educators and other human-centred professionals in their everyday work.

Chapter 9: Discussion: Te Kaiako Tapuhi

This chapter draws on all the previous chapters to discuss and address the research question:

How do nurse educators in Aotearoa New Zealand form their identity and navigate the competing demands of their roles in bachelor degree nursing education?

This chapter is slightly unusual by comparison with most conventional thesis discussion chapters. The discussion begins with the creation of an agentic Aotearoa avatar drawing on Aotearoa New Zealand's context and Māori wisdom to embody the 'ideal' nurse educator playing the game in the 'real' world of nursing education. Whereas earlier chapters invoked an 'archetype' for describing historical or usual practice, the avatar is a future-facing embodiment of a person which may be new, unexpected or revolutionary (Merriam-Webster, 2021). In the digital world, a person can choose or create an electronic embodiment. The identity formation of the agentic nurse educator might be thought of as somewhat analogous to creating an avatar in the world of gaming.

An Aotearoa avatar of nursing education: Te Kaiako Tapuhi

The Aotearoa avatar is named Kaiako Tapuhi. Kaiako is a Māori word meaning 'teacher/educator' and Tapuhi is a Māori word meaning 'nurse' that is used adjectivally and hence following the noun ('educator') in this phrase, according to the syntax of te reo Māori, the Māori language. The use of te reo to name this avatar signifies the cultural capital from a Te Ao Māori worldview, as part of an intention towards normalising te reo Māori within the process of envisioning an 'ideal' nurse educator in Aotearoa New Zealand. The Nurse Educators in the Tertiary Sector (NETS) have now included te reo Māori in their organisation name: 'Te Rōpu Kaiako Tapuhi' (literally, The Nurse Educators Group).

The Kaiako Tapuhi avatar represents the identity/habitus of the Aotearoa undergraduate nurse educator, with some of the unique characteristics, attributes and experiences of our local context. The value of viewing Kaiako Tapuhi as somewhat like an avatar in an electronic medium is its inherent ability to change and be modified and enhanced as it grows and experiences different opportunities in the changing fields that it may encounter. Ideas for building agency and capital are needed in nursing education to support Kaiako Tapuhi to work collectively in a

manner that will see nursing education flourish in the future. The following section describes this avatar as I envision it.

Creating Kaiako Tapuhi (KT)

Building an avatar begins with a blank canvas. In this case, we begin with a nonbinary body form. Starting with the face, we consider the eyes, nose, lips and ears.

KT's eyes are an important window looking inward to their thoughts and outward to the world around them. There is a shared vision that KT holds for nursing education.

The nose represents breathing and provides life. The ability to control breathing can provide a sense of calmness, peace and wellbeing. Sometimes it is necessary for KT to breath quickly, to take action, to feel the emotions that get their heart, mind and spirit racing. Other times KT can breathe slowly and quietly, giving their body and mind an opportunity to rest and sleep.

KT's lips provide the opportunity for a voice. KT has a strong authentic voice that has the gift of being able to speak in a language that is universally understood. There is an awareness of the power in their voice, their language, their words, and in the silence and unspoken words. KT has a thirst for learning new behaviours and language.

KT's ears are also open and ready to listen. Ears with an ability to hear and reflect on what is said and what is not said. KT's ears can hear both joy and sorrow, the good and the bad. It is difficult to hear the struggles, the unkindness, the pain of those who are marginalised and mistreated. KT seeks the listening ears of others and keeps their ears open to the possibilities in this work.

Inside our avatar lies their heart, mind and soul. KT's heart is firmly focused on being a nurse. KT embraces the privilege of making a difference through caring for others. KT's heart is huge with a capacity for giving and serving others. At times, this heart feels the pain of others.

KT's heart and mind work together, always thinking about what they are seeing, hearing, saying, and doing. A thirst for knowledge, for understanding, for inquiry, for learning means that KT's mind is always growing. Their heart provides the energy and the drive that enables their mind and body to work together. Their soul provides the stillness, the inner strength, the wisdom to be authentic and vulnerable.

Our avatar's hands provide KT's heart and mind with the means for providing physical care, for providing a gentle touch, for completion of technical skills, for writing , for examining, for feeling.

Outside, KT's body is clothed for warmth, comfort and protection. KT carefully chooses clothing that represents their identity and professionalism. KT is enveloped in a cloak that wraps around for support. The cloak represents KT's aspirations that maintain hopes and dreams supported through a cloak of mentorship.

KT is standing firmly on the middle ground between nursing and education. The environment has a familiarity about it and KT feels a sense of belonging – a connection to the whenua on which they stand. There are connections through whānau, history and language. KT is not alone in this space; there is a strong network of people connected through whakapapa with a shared vision for nursing education.

Being in this space gives KT the opportunity to explore the intersections of race, gender and status. KT gains strength and mana as forms of resistance from being in this space. It is a safe place where critical dialogue about oppression and privilege in nursing education can occur.

KT is aware of their own positioning in this space. If this is a position of dominance and power, KT seeks to take steps towards moving in this space to a place that honours the positioning of others.

KT is able to traverse into unfamiliar places that may be uncomfortable, and to develop new skills. KT's journey in this space is the unfolding of narratives that inform their views of the world.

Being in this space offers the opportunity for experiences that create capacity for leadership and the development of wisdom. With resilience and optimism, KT is able to look forward and see a future breaking through the glass ceiling that has previously confined this space. It is a place of legitimacy for the thinking work of nursing education.

An artist's impression of Te Kaiako Tapuhi

Title: Hands, heart, mind and soul of Te Kaiako Tapuhi (Pool, 2021)

The remaining sections of this chapter use the agentic Kaiako Tapuhi avatar to address the research question, beginning with revisiting the power of agency.

Understanding Kaiako Tapuhi agency

My research illustrates the complexity of the context of nursing education practice. Kaiako Tapuhi need to understand this complexity to support them in enacting an agentic response. Agentic responses are evident in Nova and Sophia's stories, both of whom are motivated towards making a difference through their nursing education work. Their responses and actions are constrained by structural influences within the discipline of nursing and the wider societal

influences of patriarchy and colonisation. These structures have created a Kaiako Tapuhi habitus in a manner that oppresses agency and voice.

My research signals the need to build Kaiako Tapuhi agency as a force for social action within nursing education. Kaiako Tapuhi need to establish their legitimacy in tertiary education to enable an optimal collective and holistic response. The Nursing Education Forum narrative illustrates the possibility of collective agentic responses giving voice to the issues with a willingness and intent to take action. Absent from this narrative is robust professional discourse about actions and long-term visioning on the future of nursing education practice. Transformational leadership and self-efficacy have come to be seen as important factors that are linked in increasing agency (Polatcan et al., 2021). Professional development that builds agency and focuses on wider sector issues is needed. Kaiako Tapuhi need targeted professional development and leadership that support agency development in nursing education.

Towards building a strong identity for Kaiako Tapuhi in Aotearoa New Zealand

There are many challenges that Kaiako Tapuhi encounter as they seek to form their identity and navigate the competing demands of their roles in the field of undergraduate nursing education. Many of these challenges are similar to those faced by nursing academics globally. An understanding and development of a habitus for Kaiako Tapuhi may assist in identity formation and developing an agentic response. Building agency begins with Kaiako Tapuhi and the knowledge and identity resources that they bring to their relationships with others. A shared vision provides a reason to act fuelled by individual and collective motivation (Ling & Dale, 2013).

Critical to building agency is the presence of connectors with an openness to new ideas or people (Ling & Dale, 2013). The discussion in Chapter 7 shows that building positive connections from the habitus of nursing to the habitus of nursing education support authentic identity formation and professional socialisation.

Kaiako Tapuhi needs to feel a connection and sense of belonging to stand firmly on the middle ground of nursing education. More work is needed in making connections that support Kaiako Tapuhi to traverse the constraints of gender and cultural bias. Building cultural capital for minority and marginalised groups is essential for working towards equity. The rethinking of status and titles in nursing education will support the creation of Kaiako Tapuhi who embody what is needed for nursing education in the future. Authentic role models and ongoing mentorship are important in building the connections that will support agency.

Negotiating academic structures and processes present ongoing challenges for Kaiako Tapuhi in their identity formation. Developing agentic voice and social capital as networks for responding to power and conflict issues is vital for a strong agentic identity that will lead change through action. Together, social capital and agency create a 'virtuous cycle' for change (Ling & Dale, 2013). Kaiako Tapuhi have the potential to build both agency and social capital towards strong identity formation through their everyday work. Authentic identity formation builds a voice that creates the potential for an agentic response.

Authentic identity and voice

Kaiako Tapuhi as an avatar embodies authentic identity and voice. Kaiako Tapuhi works from their knowing as a registered nurse. This way of being and thinking brings authenticity to their work as a nurse educator. The concept of authenticity was first employed by Heidegger (1962) to describe a person's relationship with the world with the internal motivation to live in a way that is true to oneself. Being authentic may mean taking a more difficult or arduous path that is ultimately more rewarding and genuine (Starr, 2008). The concept of authentic identity makes sense as a relative not absolute concept. The nurse educator is not described in an objective binary of being either authentic or inauthentic. Rather, an authentic identity as Kaiako Tapuhi will develop and change as they seek to know their own authentic self. Te Kaiako Tapuhi can be conceptualised as an agent with unfolding narratives that inform their views of the world and the actions that they take to navigate in it.

Te Kaiako Tapuhi understands their authentic identity as nurse/tapuhi and educator/kaiako. Authentic educators strive to develop self-awareness so that they may be authentic in their behaviours and words (Starr, 2008). For Kaiako Tapuhi this means learning new behaviours and language for congruence in their relationships as nurse, teacher and academic. Self-awareness is important in choosing language and behaviours that bridge the gap between education and practice. These practices give authentic voice to the value of their contribution to nursing practice as diverse knowledge developers and educated carers.

The struggles of Kaiako Tapuhi in identity formation contribute to their vulnerability. Authenticity and vulnerability are viewed as critical in forming trusting relationships (Daniel, 1998). Being vulnerable in a relationship results in sharing the authenticity of what it is to be human. The vulnerability that the new Kaiako Tapuhi experiences is in developing authenticity as a teacher and academic. Sharing this vulnerability in relationships with learners and colleagues enables Kaiako Tapuhi to develop an authentic voice in a variety of contexts. Critical

thinking, ongoing professional development and learning, scholarly activities and research all contribute to the development of an authentic Kaiako Tapuhi voice. Vulnerability is a necessary part of this journey, not something that should be avoided or hidden; rather, it should be embraced.

Alongside vulnerability, authenticity can also require a person to be unknowing (Munhall, 2004). To be authentic, a person needs to seek to know their authentic self by situating themselves in the unknowingness of being 'other' (Porr, 2005). Kaiako Tapuhi need to be able to dialogue about practice in a manner that honours the knowing of the 'other' with a self-awareness of the authority and privileging of dominant worldviews. To develop authenticity as Kaiako Tapuhi, the impact of gender and cultural bias on knowing the 'other' must be understood.

Incorporating intersectionality

The dominant and normative identity of nurse is portrayed and positioned as gendered female with a cultural identity formed by Western European attributes, values and language. The way nurses dress and speak, their titles, their roles, and images of nursing are generalised based on these stereotyped dominant 'brands' in the marketplace of identity. Both dominance and subordination are associated with these images alongside privilege and oppression. A solution might be to create Kaiako Tapuhi as an avatar that is nonbinary or gender/culturally neutral. However, it is not just about choosing a range of different attributes, clothing, skin colour and language to represent Kaiako Tapuhi in a different manner. An understanding is needed of the societal norms that have resulted from the discourses that connect Kaiako Tapuhi identity and attributes to gender and culture. A feminist standpoint approach is needed to understand the impact of gender and culture on Kaiako Tapuhi identity.

Intersectionality offers an approach to viewing intersections of difference such as gender and culture. It was first adopted as a feminist approach focused on understanding the effects of race, class and gender on women's identity, experiences and struggles with power (Davis, 2008). It has value both in understanding individual experiences of identity formation as well as in examining intersections of social structures and cultural discourses. Exploring the intersections of race, gender, and status is critical for examining issues of justice and equity for those who are marginalised (Pauly et al., 2009). It prompts policy makers and researchers to think beyond gender and culture to look at broader social forces such colonisation and oppression (Clow et al., 2009).

An intersectionality approach begins with examining how people identity themselves, how they are seen with others and how they interact with others. For many Kaiako Tapuhi, this requires personal reflection on the privilege of being white and middle class, and recognising the struggle for minority populations who are marginalised and oppressed. Part of the challenge of this reflection is understanding how one's own identity contributes to these normative discourses (Van Herk et al., 2011). Processes of norm awareness and norm criticism may be a beginning process to help to deconstruct, destabilise, and question dominant societal norms by scrutinising the power structures that create unequal relationships (Tengelin et al., 2020). Thinking about how gender pronouns are used and other language biases that privilege or oppress are simple approaches to deconstructing and creating a more authentic identity of Kaiako Tapuhi.

Social location or the amount of privilege and oppression that an individual possesses on the basis of their specific identity must also be considered as an integral part of an intersectionality framework (Hulko, 2009). Kaiako Tapuhi who are socially located in positions of privilege due to different educational opportunities and socio-economic factors, and those who come from a position of oppression due to the impact of colonisation and institutional racism will experience their identity as Kaiako Tapuhi differently. Intersectionality attempts to account for the overlapping and interrelated aspects of an individual's identity and their social location that is influenced by historical relationships and power (Hulko, 2009).

Nursing education provides a powerful socialisation experience in the identity formation of the nurses of the future, shaping both who will be nurses and how they will nurse (Van Herk et al., 2011). The voices of Kaiako Tapuhi need to be shared and heard without the gendered portrayal that has created expectations, structures or actions based on the stereotyped attributes of a dominant or marginalised gender. Kaiako Tapuhi need to critically dialogue about oppression and privilege in nursing education and the impacts that it has on the profession, on nursing practice and on health outcomes. An intersectionality paradigm can also be used to appraise and create more inclusive and equitable policies and structures in nursing education (Van Herk et al., 2011).

Claiming the middle ground

An authentic and vulnerable identity and voice will support the formation of Kaiako Tapuhi as nurse academics with a habitus that is comfortable occupying the middle ground. Nursing education must lead the building of this terrain in a way that is responsive to changes in how

knowledge is perceived and understood at different times and in different contexts. On a philosophical middle ground, Kaiako Tapuhi can build understanding of critical thinking, caring, safety to practice and professionalism to support the formation of the nurse of the future. Developing a nursing education philosophical approach that supports pluralist forms of nursing scholarship is required. Transformational nursing education that is able to respond to the changing fields of health and education must continue to be developed and critiqued. It is on this middle ground that the legitimacy of the identity of Kaiako Tapuhi as academics can be realised.

Kaiako Tapuhi want to make a difference to health outcomes and to the formation of the nursing workforce. The work of Kaiako Tapuhi offers this opportunity through engagement in nursing education research. The competing demands in the everyday work mean that Kaiako Tapuhi often feel pulled from habitus that on both sides of the bridge that spans the middle ground. Moving to the other side of the bridge into the field of the academy is perceived as a move away from practice including teaching.

The discussion in Chapter 8 illustrates the struggles for Kaiako Tapuhi to be comfortable and confident on the middle ground. Kaiako Tapuhi struggle to navigate competing demands, balancing their practice across nursing and education. The work of the Kaiako Tapuhi as nurse academic in this space was not visible in the research narratives and my own experiences reveal the long journey towards becoming an academic. When I first began this journey, I pictured myself moving to the other side of the bridge into the field of the academic. However, the authentic identity and work of Kaiako Tapuhi need to stay situated in the middle ground that links education and practice. Instead of traversing to the other side of the bridge, the legitimacy of the thinking work and research that can occur on this middle ground needs to be valued.

The analysis contends that valuing the legitimacy of thinking work as nursing education scholarship needs to first come from within the profession itself. The nursing profession continues to struggle to develop a collective professional stance that builds on the cultural capital of nursing knowledge and practice. It is vital that nurses individually and collectively realise their worth as holders of unique knowledge and practice (Walter et al., 2001). Kaiako Tapuhi need to build nursing education knowledge and address the power relations that impede the value of this form of capital. The focus needs to be shift to academic knowledge development rather than on academic practice (Glass, 2007). Rather than focusing on producing outputs that gain status, Kaiako Tapuhi need to focus on diverse knowledge development. Standing firm in this space requires a level of resilience and optimism that will grow from positive

experiences of working in this space. Positive role models, mentorship and career support needs to focus on developing the nurse academic on this middle ground.

A new habitus for the nurse academic

Building cultural capital and claiming the status of Kaiako Tapuhi as nurse academics requires a postmodern approach. While Bourdieu's concept of cultural capital acknowledges inequality, it offers nothing in the way of how to understand cultural capital from the view of minority cultural groups. A strengths-based approach to understanding the cultural capital associated with minority and marginalised cultural groups offers another viewpoint (Yosso, 2005). This model introduces new dimensions of capital including aspirational, navigational, familial, resistant and linguistic. Yosso described aspirational capital is the ability to maintain hopes and dreams even when facing barriers. Navigational capital refers to the skills that enable an individual to manoeuvre through unfamiliar environments outside of their cultural experiences. Familial capital is the emotional and practical support from family. Resistant capital is the knowledge or skills used to overcome inequity, and linguistic capital refers to the communication and social skills developed through linguistic interactions (Yosso, 2005). An additional notion of experiential capital is added by O'Shea (2016) that considers the acquired wisdom or personal attributes that can be accrued through life experiences. These concepts are discussed below as strategies for building the habitus of Kaiako Tapuhi as nurse academics.

Aspirational mentorship and support

Aspirational capital is evident in the research narratives as a driving force for a career in both nursing and nursing education that is fuelled by the desire to make a difference. Nursing education work requires positive mentorship for both students and nurse educators that is aspirational in the formation of the nursing workforce. Women in nursing are often recognised as being aspirational in their commitment to nursing and to serving others, including their families and communities. The 'superhero' status of the nurse as an essential worker during the global pandemic illustrates the power of aspirational work. Kaiako Tapuhi can draw on their aspirational capital as motivation and support for their work.

Aspirational collegial support and mentorship are important for both new and experienced Kaiako Tapuhi as they seek to develop in their academic careers. New Kaiako Tapuhi will benefit from having a mentor to support them in developing a sense of belonging and understanding of the nurse educator habitus. Mentorship that builds relationships and resilience, and addresses inequality across the institution and the wider sector of nursing education, is needed at this

level. Ongoing mentorship and career pathway support are needed for retention and growth of experienced Kaiako Tapuhi.

Career pathways in a supportive work environment

Kaiako Tapuhi need navigational skills to develop a career pathway for Kaiako Tapuhi into nursing education. My research reveals that the career pathway towards becoming a nurse academic is not clearly marked. The initial pathway may be relatively straightforward with the requirements of clinical expertise, a teaching qualification and master's degree. Choices need to be made to determine which type of master's to complete, alongside other professional development needs to support Kaiako Tapuhi in this new environment. Beyond the master's, Kaiako Tapuhi need to develop skills for navigating the competing demands in the field. Ongoing mentorship and a supportive work environment are crucial for helping Kaiako Tapuhi find their way.

Various staffing models have been proposed locally and globally to develop different career pathways and address the workforce demand for Kaiako Tapuhi. American professional bodies have been focused on expanding funding opportunities for nurses to undertake master's and doctoral studies to meet the requirements for an academic nursing career (AACN, 2020). Even with additional support for starting a career as an academic, issues around remuneration and heavy workloads continue to make this career pathway unattractive and the faculty shortage remains.

Local models to support permanent full-time staff to work as nurse academics have been developed to include a mix of sessional or casual, clinically focussed, non-academic staff. Research reports on a similar model in Australia found that, instead of relieving workload issues, the employment of these non-academic staff creates an additional burden for permanent staff, who are required to mentor and support new staff and their students(Peters et al., 2011). Some university models have post-doctoral and tenured academic staff whose work does not include clinical teaching, and they report having better workloads and a better work–life balance (Smeltzer et al., 2015). None of these models are fit for purpose for developing a career pathway and model for nursing education in Aotearoa New Zealand. A model consisting of academic and non-academic staff has the potential to reinforce the gap between clinical and education practice. Urgent attention needs to be given to addressing this issue with a collective response that supports a career pathway and model for nurse academics working comfortably and confidently on the middle ground.

In developing an attractive and sustainable career pathway, attention must be given to addressing the workload issues encountered on the middle ground. Occupational stress and burnout have been identified in the literature as issues for novice nurse educators transitioning to the academic work environment (Singh et al., 2020). The research narratives illustrated the potential for conflict that may result from the challenges of decision making regarding student progress, competition between peers in achieving academic outputs and difficulties with management when the work of Kaiako Tapuhi is perceived to be at odds with the requirements of the organisation. The stress and burden of the work is underplayed in the research narratives in favour of the rewards and privileges that the work affords. However, cumulative stress resulting from the demanding workload and an unclear career pathway are evident in the narratives, even if it is not readily voiced. In some situations, this may lead to incivility and bullying as has often been reported in nursing education literature.

Incivility and bullying are attributed to the competitive and hierarchical nature of the academic world and the stress of heavy workloads (Clark, 2013). Often, the stories of incivility and bullying are 'unsaid' or 'hidden' stories in nurse educators' experiences (Glass, 2003). Kaiako Tapuhi may not voice the feelings of stress and personal anguish due to an emotional habitus that they have adopted as nurses and women. As caring professionals, nurses have developed emotional rules that enable the carer to manage emotional demands internally, often by putting their own feelings aside (Malak Akgün, 2018). Instead of voicing concerns about incivility and bullying, nurses may be using their own nursing practice philosophy of healing and hope to manage the vulnerabilities that they are facing (Glass, 2007). While this strategy may support Kaiako Tapuhi in their everyday work, a collective response towards building a positive organisational culture is needed to support career development.

Creating a whānau-centred organisational culture

Organisational culture in disciplines such as nursing that involve human interaction is primarily influenced by collegial relationships as social capital. The research narratives emphasise the importance of collegial relationships within the field of education, and with industry partners in the clinical field. A new sense of shared belonging is beginning to develop across the country's 14 different nursing programmes through the formation of Te Pūkenga, the newly formed national vocational education provider. There is an awareness that the different entities within this one institution are not yet on a level playing field, with financial constraints and local issues creating inequity in the opportunities for development in some areas. Competition between programmes has not been eliminated as decisions will soon be made recognising Centres of

Excellence for different disciplines. This process may give authority to one Te Pūkenga nursing programme in shaping how nursing education is structured and enacted in the future.

A shift of focus from individualism and status to a collective network built on trust and shared understanding is needed to support a career pathway for Kaiako Tapuhi as nurse academics. The building of familial, resistant and linguistic capital can support a more equitable and diverse nursing education habitus. Kaiako Tapuhi familial cultural capital could be enhanced by adopting the approach of Te Ao Māori to relationships. Whakapapa is a central concept in Māori culture that signifies the connections and relationships between humans and other living and non-living things (Stewart, 2021). Drawing on emotional and practical support from whānau (family) is central in Māori culture and recognises the importance of whakapapa (Taonui, 2005). Kaiako Tapuhi who embrace this philosophical approach could gain a strong sense of cultural capital that comes from such a collective worldview. Viewing other Kaiako Tapuhi as whānau and recognising nursing and education whakapapa connections in the local and global world of nursing education offers the opportunity to strengthen and bridge relationships. This philosophical approach is built on a cultural understanding of the connections that people have based on land, language, heritage, history.

My career progression as a Kaiako Tapuhi has been largely supported by working in a supportive whānau-centred organisation. A commitment to shared values and beliefs that seek to provide both emotional and practical support to learners has been integral to my journey in nursing education and forms a strong part of my cultural capital kete. Working as a human-centred professional in a world of diversity and inequality, I find this approach affords strength and mana in ways that money or financial rewards cannot.

Addressing inequality and exclusion

My research identifies a need to address gender and cultural bias and negative perceptions of nursing education as a career choice. The research narratives are missing any substantive dialogue that addresses experiences of gender and cultural bias. The Nursing Education Forum contributors briefly address the gender imbalance in nursing and nursing education with reference to ‘blokes’ in leadership positions and senior management roles. The silence or unspoken acceptance of these biases in nursing education is not unexpected. The lack of voice regarding these issues signals the absence of resistant and linguistic capital to address these issues. The research report commissioned by the Nursing Now campaign recognised gender

discrimination, bias and stereotyping inhibit opportunities for female nurses as leaders as decision makers (Newman et al., 2019).

Kaiako Tapuhi need to lead by example, as they play a significant role in the formation of a nursing workforce that is able to address these issues. Gender-transformative and culturally safe education needs to address education and health policies and programmes in a manner that positively promotes the position of women and girls, as well as other marginalised groups (Newman et al., 2019). Kaiako Tapuhi need to develop an authentic way of being in the field of nursing education that embraces approaches to actively address inequality and to communicate and use language in a manner that supports diversity, inclusiveness and equality. Leadership and wisdom are needed. People who have experienced inequality and oppression should be supported as leaders who can offer an authentic voice to this discourse.

Although the literature paints a picture of the challenges of a career as Kaiako Tapuhi with potential issues of occupational stress, incivility, bullying, gender bias and poor remuneration, this picture was not overtly expressed in my research. The overarching premise of hope and positivity found at the end of each of the research narratives suggests that a different focus can be taken. These research results must be understood as coming from the dominant cultural perspective. Building on the concepts of capital and agency, with attention to addressing inequality and exclusion, offers potential for understanding these results from a perspective of diversity. The outcomes of positive, inclusive social networks in the workplace include healthy behaviours and higher job satisfaction (Xu et al., 2020). Other benefits include the retention of staff, and improvements in organisational and professional outcomes through knowledge sharing. The possibility of social exclusion due to strong over-bonding among nursing staff positioned in a dominant culture must be recognised and addressed. A whānau-centred approach is proposed to create and support connections in an inclusive manner that is respectful of diversity. The benefits arising from positive collegial environments can extend beyond the workplace to yield better quality outcomes for patients (Xu et al., 2020). Fulfilling career pathways for Kaiako Tapuhi can be built based on aspirational mentorship offered in a supported workplace environment. Kaiako Tapuhi need collective leadership to thrive in an academic career that offers more than economic reward or status.

Authentic leadership in nursing education

Authentic academic identity formation that supports Kaiako Tapuhi to situate themselves with legitimacy on middle ground is a starting point but it is not enough to afford change. While

individual agency and capital is valuable, it is the collective mobilisation of the nursing education workforce that will result in meaningful action and change. Nursing history and nursing education literature show evidence of strong female nursing leadership in Aotearoa and globally. Grace Neill is considered the first Chief Nursing Officer in the world and she was instrumental in passing the Nurse Registration Act in 1901, making Aotearoa the first country to establish a professional register for nurses (New Zealand History).

Dr Irihapeti Ramsden, an indigenous nurse educator of Ngāi Tahu/Rangitāne descent, is recognised for leadership in education that is respectful of indigenous peoples and that upholds society's responsibilities to working in health care in a manner that is empowering of others (see previous discussion on pages 62 and 77). Ramsden held various international positions over the years, including being the New Zealand representative to the International Bioethics Board (Ellison-Loschmann, 2003).

Nursing education has been led by local leaders each who have developed nursing education practice in response to the societal needs of this country. In my own journey in nursing education, I have been fortunate to gain experience from nationally recognised female nursing education leaders whose individual contribution to nursing education has been exemplary. What is missing is the collective impact of leadership in the fields of nursing education nationally and globally.

The Office of the Chief Nursing Officer (OCN) for the Ministry of Health in Aotearoa New Zealand recently released a leadership narrative for change. This narrative is written in response to the 2016 New Zealand Health Strategy with its vision for a fit-for-purpose, responsive health workforce and systems (OCN, 2018). The narrative has a strong focus on nursing care and models that are responsive to diverse health needs. Nursing educators as leaders are hidden in this narrative, with reference given to opportunities for advanced education without a clear link to leadership. Kaiako Tapuhi need a collective voice that has them at the front of strategies that support nursing leadership development. Kaiako Tapuhi need to connect as leaders across the sector in a more meaningful way.

The global Nursing Now leadership report identified that female nurse leadership is hampered by two significant challenges that also impact on leadership in nursing education. The first challenge for female leaders in nursing is the ongoing perception of nursing as a "soft science," thereby less rigorous and inferior to medicine or other science-based disciplines (Newman et al., 2019). Instead of striving to make nursing education more science-based, authentic nursing

education leadership needs to build on the cultural capital of nursing knowledge that embraces both science-focused *and* relationship-focused practice that will address inequity and disparities in health outcomes. The second significant challenge for female nursing leadership is in regard to the gender stereotypes that favour men in leadership positions and the perceived lower status of nursing as a female-dominated society. Globally, this challenge is more significant in some countries were patriarchy and male dominance in leadership and power is more indoctrinated into society.

Both of these challenges are identified in the context of my research. Nursing education in Aotearoa New Zealand needs to embrace the opportunity for developing nursing education scholarship that includes both science-focused and relationship-focused practice. My research seeks to contribute as an example of nursing education scholarship that sits in this space. The issue of gendered stereotypes is beginning to be recognised but these stereotypes are part of nursing habitus and need to be challenged and addressed by all nurses. Authentic leadership will seek to use inclusive language and voice gender-neutral policies and positions. Kaiako Tapuhi need to build self-efficacy and collective voice that seeks to disrupt the structures and power relations that support this culture.

These challenges require leaders to engage in risk-taking to consider how best to introduce and implement organisational and educational change (Pardue et al., 2018). A prerequisite for building social capital is developing mutual respect across leaders, the creation and development of social networks to support newcomers, building connections and assisting nurses to reach common goals, and valuing all members (Materne et al., 2017). Kaiako Tapuhi in Aotearoa New Zealand have the potential to realise the capital needed to achieve these goals.

The avatar of Kaiako Tapuhi could be viewed as a fantasy, an ideal or even an impossibility. With all the challenges Kaiako Tapuhi face, it would be reasonable to think change will be difficult to achieve. The concept of the avatar brings consciousness to the possibility of being a change agent. The characteristics and attributes that Kaiako Tapuhi possess are the traits of human beings. There are no magical powers needed to play in the world of nursing education, and being authentic and vulnerable is a good starting point. The power of Kaiako Tapuhi comes from within and from the connections they make in the world. Connections as whānau, firmly situated on common ground and in inclusive language, will go a long way in influencing how we speak, think, act and be as Kaiako Tapuhi. Collective leadership and voice will give Kaiako Tapuhi the strength and wisdom needed to realise their full potential in their everyday work. Being Kaiako Tapuhi will be what nurses aspire to become, with recognition for the value of this work.

Chapter 10: An End and a Beginning

The year 2020 was designated the Year of the Nurse in honour of Florence Nightingale's 200th birthday. For a year beforehand, plans both globally and locally were being made to recognise the work of nurses and take the opportunity to promote the further development of the profession. Nurses look forward to celebrating International Nurses Day on 12 May, but 2020 was going to be different – we had a whole year to celebrate and promote nursing. Little did we know, then, that it would be a year like no other in recent times. The world has been challenged by a global pandemic as the result of a new virus, COVID 19. As expected with any major health event, nursing has been at the forefront of this experience. Nurses around the globe have been working tirelessly to support those who are ill, to develop strategies to prevent spread of the illness and promote health, and to educate society about good health practices. Once again, hand hygiene was at the forefront and nurses led the way in teaching others how to wash hands and to sanitise effectively. It has been a challenging time for nursing and nursing education, but these challenges have also afforded us opportunities to rethink nursing education and the future of nursing.

Nursing education has been influenced by history, culture and language. There are many aspects of the contemporary nurse educator role that Nightingale and her students would recognise from their experience as nurses, nurse educators and researchers. How we understand nursing education knowledge has influenced how we teach and how we support the learner to become a nurse. How nursing education is organised and structured has changed significantly from its beginnings. We have moved away from teaching in hospitals and working in an apprenticeship model to learning in educational institutions that is supported with a range of learning modalities. Whilst this move has taken nurse educators out of clinical environments, we strive to remain at the forefront of nursing practice. This has required us to be expert clinicians, teachers and researchers – not an easy job, but not unlike how Nightingale pioneered nursing practice in the first place.

The archetypal image of the Nightingale nurse remains strongly linked to the practices established 200 years ago. Nurses proudly wear uniforms and take pride in presenting themselves in a professional manner. Many of our nursing skills and language can be linked to practices from military influences, including accurate timekeeping, planning and documentation. These skills have been transferable into our practice as nurse educators and

enable us to work confidently and competently in many different practice settings. The female image of the nurse has also continued to dominate our profession with characteristics of helping and caring still viewed as key aspects of the work. We tend to put forward an image that focuses on the positive aspects of the role of helping people to be healthy. We talk less about the difficult aspects of the work like people dying or needing to see, touch, smell or deal with aspects of illness that are unpleasant. Similarly, in nursing education we are happiest when students are learning and being successful, and we shy away from dealing with failure or difficult behaviours or situations. These aspects of nursing mean that learning to be professional includes knowing how to manage our emotions, our reactions, our voices; it includes knowing when to speak and when to be silent, knowing when to act and when to stop and think, knowing when to take charge and when to stand back.

Modelling nursing practice remains a powerful teaching tool. This means that the work of the nurse educator can never be replaced by a textbook or technology. No matter how advanced nursing education becomes, it can never replace the value of the nurse sharing their stories and experiences with learners. New practice ideas develop through scholarship and research and facilitating learning, as the nurse educator continues to grow and learn themselves. Nursing education has a huge responsibility in setting the curriculum and pathway for learners who want to take this journey. The everyday work of the nurse educator sets the pathway for the future of nursing. This research has enabled me to examine many different perspectives across the fields of nursing and education, each of these perspectives adding to my understanding. My research is pragmatic in seeking to learn from experiences and take action for change. I have taken a theoretical approach in examining the knowledge, language, structure and meanings that influence actions.

Critical readings of the research literature identified the complexity of the nurse educator's role. There was a prevalent lack of clarity about nurse educators' identity, with role conflict and ambiguity, especially for the new nurse educator. Mentorship and career development support are crucial for growing the nurse educator workforce. Recruitment, retention and development of the nurse educator workforce globally and in Aotearoa New Zealand must be addressed, including issues of fair remuneration, career progression especially for women, and clear career pathways into nursing education.

One of the biggest challenges identified in the literature is that nurse educators frequently experience occupational stressors and burnout. Increasing workloads, poor collegial

relationships, and a competitive and sometimes toxic work environment are detailed in the literature. Strategies to address these issues include building resilience and addressing hierarchical structures and environments. Accepting these issues as part of the culture and environment that the nurse educator needs to build resilience towards offers little in the way of change. The competing demands in the workplace create an organisational culture where these issues are likely to occur.

My research has brought attention to the complexity of the everyday work of the nurse educator in Aotearoa New Zealand. This work encompasses how we 'think' about nursing, how we teach students to think about nursing, and how we develop nursing education knowledge and scholarship. The nurse educator's practice is positioned firmly on the middle ground between nursing and education. This research seeks to contribute to the formation of an authentic nurse educator identity, which will be required to enable nursing education to find its place of academic authority in scholarship.

Limitations (and strengths)

This research is situated in Aotearoa New Zealand. Although a global context is included in this research, the findings may be limited to a local context. The strength of focusing on the local context is that this research can thereby contribute more to local professional practice, while also adding a unique Aotearoa New Zealand perspective on nursing education to the international research.

My positioning in this research as an experienced nurse educator is both a limitation and a strength. In regard to my experience as a limitation, I am conscious of how my own ideas and experiences have shaped what I was hearing from the interview participants and reading in the literature. As a strength, my experience has been essential to being able to conceptualise the project, guide the research questions, find, read and interpret the interview data into the research narratives. I acknowledge that the stories that I have written and told in this thesis come from a position of privilege. Whilst I have tried to be attentive to bias, including gender and cultural bias, my positioning means that my stories are told from a dominant cultural perspective.

Situating this research outside of the traditional scientific paradigm of nursing required strong reflexivity in critiquing conceptual frameworks for nursing education research. Without a traditional "medical research" structure, my research findings could be seen as limited on account of being non-scientific. An unfolding research approach enabled me to follow the

threads of discourse from different data sources, with each source of data being presented in different ways. The use of semi-structured interviews as a key source of data provided some familiarity, and balanced the uncertainty of using the literature and my own experiences as other forms of data. My thesis research uses scholarly writing as a methodology, and I have struggled to develop my ability to write in a manner that does justice to this approach. Use of this type of methodology is relatively new in nurse education literature. This research seeks to provide an example of how this form of inquiry can contribute to nursing education research.

Findings

One of the most rewarding aspects of engaging in research is reflecting on what has been learned and knowing that the learning will not stop when the project ends. Different perspectives, different contexts, and different people engaging in nursing education mean that there will always be more to learn – an infinite, never-finished beginning. The key findings are presented with an awareness that this list is not definitive, nor complete. A desired outcome from this research is to raise consciousness and provide new learning and understanding of the ever-changing, everyday work of the nurse educator. Three key findings are presented and briefly discussed below.

1. **The work of the nurse educator is viewed from a position of privilege. Kaiako Tapuhi need to reflect the diversity and culture of society.**

It is a privilege to be a nurse and to do work that supports nursing and the wellbeing of others. This finding is not unexpected but it is good to be reminded of the privilege inherent in this work. The Year of the Nurse and the global pandemic both highlight the significant and specialist role that nurses have in health care and in society as a whole. Nurses continue to be viewed as one of the professions held in highest regard and nurses themselves are committed to upholding the professionalism that nursing and society expects.

With privilege comes responsibility, and nurses have a responsibility to portray and position nursing through dialogue that addresses gender and cultural biases. This does not mean that nursing needs to discard the images and traits that are cherished as part of nursing identity. Kaiako Tapuhi need to make visible and promote all aspects nursing work, including the ability to think critically and make decisions that impact on health outcomes.

Nursing education has a responsibility to recognise the power of the social positioning of nursing. Recognition must be given to understanding relationships of dominance and

oppression. Having a mainly Pākehā middle-class workforce, nursing education is dominated by Western European culture and values. This cultural heritage and values have shaped the discipline of nursing education and have given people who are from the dominate culture opportunity and advantage over those who belong to a minority culture.

It is not enough to acknowledge a position of privilege. Kaiako Tapuhi need to be both strong and authentic in recognising power and positioning, and vulnerable in embracing diversity. Actions need to be directed towards equity and giving voice to those who are marginalised. Vulnerability needs to be embraced rather than hidden, and Kaiako Tapuhi need to embrace the 'unknowing' and the experiences of being 'other'.

Kaiako Tapuhi need to reflect the diversity and culture of our society. Valuing and giving voice to indigenous cultural capital begins to normalise Te Ao Māori as part of nursing practice. Kaiako Tapuhi need to actively address institutional racism and practices that marginalise indigenous peoples. Adopting Kaiako Tapuhi as a title is a small step towards giving value and voice to indigenous ways of being. Kaiako Tapuhi need professional development and support for engaging with the wider issues in the field of nursing education. Targeted development that forms Kaiako Tapuhi as change agents is need.

2. **Kaiako Tapuhi need to claim their space as scholars in the middle ground between education and practice. Building a cohesive, connected nursing education workforce in this space has the potential to develop an authentic voice for improving health outcomes.**

Academic scholarship in nursing education involves educating people to become nurses *and* developing nursing education knowledge and practices. The value of 'being a nurse' is the contribution that Kaiako Tapuhi makes to the professional formation of the nursing workforce and to improving health outcomes. An authentic identity situated in the public habitus of nursing education must be formed to gain authority in this space. Standing firm in this space requires a shared vision, a collective voice and the optimism that will grow from positive experiences.

Adopting pluralist approaches to knowledge and inquiry will take nursing education forward into the post-qualitative and postmodernist space. Producing diverse knowledge through academic scholarship will make nursing education's contribution to nursing and health care visible and accessible. The use of non-traditional research methods, including dialogue and narratives, has the potential to surface the unsaid and hidden stories that marginalise or oppress. Critical reflection on these stories raises consciousness and creates a platform for voicing change.

Kaiako Tapuhi as nurses are familiar with working in an environment that requires agility in being responsive to change. Kaiako Tapuhi need to be actively engaged as policy makers and researchers in creating the organisational culture and habitus for nursing education. A legitimate career pathway is needed to promote academic scholarship.

3. **Nursing education should be highly valued as a career choice. Nursing education offers opportunities for learning and making an impact on nursing practice every day.**

A career pathway for nurse educators should focus on healthy collegial relationships, shared vision and values, equity in opportunity, and mutual respect. Kaiako Tapuhi need to connect as whānau and develop shared values and vision for the future of nursing education. Building the workforce of indigenous Kaiako Tapuhi must be a priority for Aotearoa New Zealand. Authentic role models and leaders who represent the gender and cultural diversity in our society are needed.

Final thoughts

This research offers both reassurance for the work that Kaiako Tapuhi are doing and some direction for the future. Nursing remains a popular and worthwhile career opportunity and the experience of the pandemic has reinforced the importance of nursing work that includes both science and caring. This research has examined the everyday work of Kaiako Tapuhi and the transformation that has occurred over the past 30 years across two different centuries. Reflecting on this work as a journey encourages looking back on what has been accomplished and looking forward to what might be ahead. The completion of a doctoral qualification is another step in the journey, an experience that offers an opportunity for growth, personal and professional development and opportunities for a new beginning.

This research evokes hope and new beginnings for the next generation of Kaiako Tapuhi who will develop new ways of thinking and new ways of being. Nursing education history, culture, knowledge and relationships form as Tapuhi and Kaiako Tapuhi provide the social and cultural capital needed to prepare the workforce for the future. Valuing what nursing education has to offer as academic scholarship will enhance nursing education practice and provide the recognition needed in moving towards a positive career pathway. A collective voice is needed to focus on developing opportunities for both Tapuhi and Kaiako Tapuhi as leaders in their practice.

Glossary of Māori words

As used in this thesis (*Māori dictionary*, 2021)

Āhuatanga	Elements or characteristics
Aotearoa	A Māori name for New Zealand
Iwi	Large kin group
Kaiako	Teacher
Kawa whakaruruhau	A Māori concept used to describe cultural safety in nursing
Kete	A traditional Māori basket
Mana	Prestige, authority, status
Manaaki	To support, show respect, care for others
Ngāi Tahu/Rangitāne	South Island iwi
Ngāti Toa	Local iwi in Porirua area
Pākehā	Non-Māori (White) New Zealander
Tapuhi	Nurse
Te Ao Māori	Māori worldview
Te Ara Kete Aronui	Faculty of Culture and Society, AUT
Te Kaiako Tapuhi	The nurse educator
Te Pūkenga	A Māori name for the New Zealand Institute of Skills and Technology
Te reo	The language
Te Rōpu Kaiako Tapuhi	A Māori name for Nurse Educators in Tertiary Sector (NETS)
Te Tiriti o Waitangi	The Treaty of Waitangi
Tikanga Māori	Māori custom
Wānanga	A Māori form of tertiary institution (modern meaning)
Whakapapa	Genealogy, descent
Whakawhanaungatanga	Process of establishing relationships
Whānau	Family (extended or metaphorical)

Appendices

Appendix A: Email invitation to participate

Invitation to Participate

To: *Heads of Schools, Nursing*

From: *Leanne Pool, AUT Doctor of Education Candidate*

Subject: ***The everyday work of an undergraduate nurse educator in Aotearoa New Zealand***

Tēnā Koe

My name is Leanne Pool and I am a nurse educator currently employed at Whitireia New Zealand. I am currently undertaking a research project, as part of a Doctor of Education (EdD) degree. My research seeks to interrogate the nature of the work of a nurse educator, with the aim to support the professional formation of nurses into this role. I am writing to seek your help in recruiting participants for individual interviews as part of this research.

I seek volunteers who are currently working as undergraduate nurse educators in the tertiary sector and hope to recruit participants working in both university and polytechnic settings. A range of backgrounds and experiences is sought to give richness to the results.

I am seeking your support in sharing this opportunity with nurse educators working within your organisation. I would like to interview participants, either in person or via a video call, in an individual interview that will last up to approx. 60 minutes. The interview will include questions related to the participant's experience working as a nurse educator. All identifying characteristics about the participant, including their place of work, will remain confidential and will not be disclosed in the findings.

Please could you distribute this invitation to nurse educators working in your undergraduate nursing programmes. Those interested are asked to contact me to discuss being part of this study using the details below:

Contact Leanne Pool by email: leannegpool@gmail.com or by telephone: 04 237 3103 ext 3729

Approved by the Auckland University of Technology Ethics Committee on type the date on which the final approval was granted AUTEC Reference number type the AUTEC reference number

Appendix B: Participant information sheet

Participant Information Sheet

Date Information Sheet Produced:

20 June 2018

Project Title

The everyday work practices of an undergraduate nurse educator in Aotearoa New Zealand

An Invitation

My name is Leanne Pool and I am a nurse educator currently employed at Whitireia New Zealand. I would like to invite you to participate in a research project, which is being undertaken as part of a Doctor of Education (EdD) degree. Participation in this project is voluntary and based on informed consent. You have the right to withdraw from participating in the project at any time prior to the completion of data collection.

What is the purpose of this research?

This study will seek to add to the knowledge base about the everyday work of the nurse educator. Internationally and nationally, the work of a nurse educator is not well understood beyond the transition and novice educator experience. Nurse educators come to the role of teaching as experienced, often expert nurses, with their understanding of teaching and learning formed from their own experiences and practices. For most nurse educators, their experience in teaching begins after a period of clinical practice in either hospital or community settings. My research will examine the nature of the work of a nurse educator in order to support the professional transition of nurses into this role.

The results from this research will be written in the form of a doctoral thesis and the findings may be shared through journal articles and conference presentations nationally and internationally.

How was I identified and why am I being invited to participate in this research?

I am seeking volunteers who are currently working as undergraduate nurse educators in the tertiary sector by contacting Heads of Nursing Schools or School Administrators. Participants working in both university and polytechnic settings are desired as participants for this study. A range of backgrounds and experiences is sought to provide representation of the field of nurse educators in Aotearoa New Zealand.

How do I agree to participate in this research?

You will contact me if you are interested in being a participant. You agree to participate by completing the Consent Form when we meet for the interview. If we are completing the interview by video, I will send you the consent form to complete prior to the interview. Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You may withdraw from the study at any time up to one month after being sent the interview transcripts for checking. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

We will meet either face to face or via a live video platform for an interview that will last up to 60 – 90 minutes. You will be given the opportunity to share stories and experiences around the work of a nurse educator. The interview will be audio recorded and transcribed by a professional transcriber who has signed a confidentiality agreement. You will be invited to review and approve the transcript for inclusion in the study.

What are the discomforts and risks?

The interview will involve discussion around work experiences and you may feel discomfort if you are discussing challenging or difficult experiences. You can choose the stories or experiences that you wish to share and this will limit the discomforts and risks.

How will these discomforts and risks be alleviated?

You can ask to stop the interview if you experience any discomfort at the time. If you experience discomfort following the interview you are encouraged to seek support from your employee support services.

What are the benefits?

This research has the potential to benefit you by assisting you to reflect on your work as a nurse educator. The interviews are part of my doctoral thesis research project and will help develop my knowledge of research. This

research will also deepen my own knowledge about nurse education to enhance my teaching. This research offers wider community benefits in adding to the knowledge base about nurse education in Aotearoa New Zealand.

How will my privacy be protected?

Your identity will remain confidential to the researcher and your contact details will be stored securely in order to maintain privacy. If the interview takes place at your workplace, we will discuss using a neutral and private meeting space, away from your office and team spaces, in order to seek to keep your participation confidential. The possibility must be acknowledged, however, that others at your workplace may become aware that you are being interviewed. Care will be taken to ensure that your identity cannot be determined from any information you share. The transcript from the interview will be sent to you for checking and you may request any information that you wish to be deleted.

All data will be kept securely, and consent forms will be stored separately, so that data cannot be associated with specific individuals. The transcriber will sign a confidentiality agreement.

What are the costs of participating in this research?

The interview will take up between 60-90 minutes of your time. As the researcher, I will seek to conduct the interview at a time and setting that is convenient for you. If you are required to travel to the interview, I will make a contribution to travel costs.

What opportunity do I have to consider this invitation?

Please consider this invitation for up to two weeks from the time of receiving this Information Sheet. I may make a follow-up phone call to the Head of School or School Administrator, if no response has been received within this time frame. If you would like to consider participating in the study, please contact me at the email address or telephone number below at your earliest convenience. I am happy to discuss any questions you may have by email or telephone before you agree to participate.

Will I receive feedback on the results of this research?

At the completion of the study, I will make a written report available to all participants. If you choose to have a copy of this report, your details will be collected on the Consent form.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr Georgina Stewart, email g.stewart@aut.ac.nz; telephone 09 921 9999 ext 7231.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, email *ethics@aut.ac.nz* , telephone 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Leanne Pool; leannegpool@gmail.com ; 04 237 3103 ext 3729

Project Supervisor Contact Details:

Dr Georgina Stewart, g.stewart@aut.ac.nz; 09 921 9999 ext 7231

Professor Eleanor Holroyd, e.holyroyd@aut.ac.nz; 09 921 9999 ext 5298

Approved by the Auckland University of Technology Ethics Committee on *3 July 2018* AUTEC Reference number *18/253*.

Appendix C: Interview questions

The everyday work of an undergraduate nurse educator in Aotearoa New Zealand

Interview questions

1. Background information about the participant:
   Tell me a bit about yourself and your work as a registered nurse
   - Number of years working as nurse

2. Working as a nurse educator
   Tell me about your experience of becoming a nurse educator
   - Number of years working in nursing education.
   - Place of work – university or polytechnic
   - Primary role – classroom teaching, clinical teaching or both

   Who are the main people that you work with?
   (students, administrators, other educators, support services staff, preceptors, etc)

   What are the main tasks that occupy your time at work?
   (Might include classroom teaching, marking, clinical teaching, research, industry engagement, pastoral support, dealing with management, etc.)

3. Examples or tell me some stories about some of these aspects of your work
   Tell me about the something that stands out as positive that has happened for you in your work as a nurse educator?

   Tell me about the something challenging or negative that has happened for you in your work as a nurse educator?

4. Give me some examples of the competing demands on your time at work
    - Why does this occur?
    - How do you manage these competing demands?
    - How do you establish priorities?

5. What are some of the policies, structures and/or management systems, in your work as a nurse educator?
    - Are these policies or management systems related to the health system?
    - To the education sector?
    - To other groups or organisations?
    - Which are most important and why?

    How do the policies or management systems you deal with impact on your work as a nurse educator?

    How do you think it could be improved or work better?

6. Is there anything you would like to tell me about your work as a nurse educator?

Appendix D: Transcriber confidentiality agreement

Confidentiality Agreement

Project title: ***The everyday work of a nurse educator in Aotearoa New Zealand***

Project Supervisors: ***Dr Georgina Stewart,***

Researcher: ***Leanne Pool***

O I understand that all the material I will be asked to transcribe is confidential.

O I understand that the contents of the tapes or recordings can only be discussed with the researchers.

O I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature: .....

Transcriber's name: .....

Transcriber's Contact Details:

.....

.....

.....

.....

Date:

Project Supervisor's Contact Details:

Dr Georgina Stewart
School of Education, Faculty of Culture and Society, AUT University, g.stewart@aut.ac.nz, 09 921 9999 ext 7231.

Approved by the Auckland University of Technology Ethics Committee on 3 July 2018 AUTEC Reference number 18/253

Note: The Transcriber should retain a copy of this form.

Appendix E: AUTEC Ethics approval

Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

3 July 2018

Georgina Stewart
Faculty of Culture and Society

Dear Georgina

Re Ethics Application: **18/253 The everyday work practices of undergraduate nurse educators in Aotearoa New Zealand**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Subcommittee (AUTEC).

Your ethics application has been approved for three years until 3 July 2021.

Standard Conditions of Approval

1. A progress report is due annually on the anniversary of the approval date, using form EA2, which is available online through http://www.aut.ac.nz/researchethics.
2. A final report is due at the expiration of the approval period, or, upon completion of project, using form EA3, which is available online through http://www.aut.ac.nz/researchethics.
3. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form: http://www.aut.ac.nz/researchethics.
4. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.

Please quote the application number and title on all future correspondence related to this project.

AUTEC grants ethical approval only. If you require management approval for access for your research from another institution or organisation then you are responsible for obtaining it. You are reminded that it is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard.

For any enquiries, please contact ethics@aut.ac.nz

Yours sincerely,

Kate O'Connor
Executive Manager
Auckland University of Technology Ethics Committee

Cc: leanne.pool@whitireia.ac.nz; Eleanor Holroyd

Appendix F: Participant consent form

Consent Form

Project title: ***The everyday work of an undergraduate nurse educator in Aotearoa New Zealand***

Project Supervisor: ***Dr. Georgina Stewart***

Researcher: ***Leanne Pool***

O I have read and understood the information provided about this research project in the Information Sheet dated 20 June 2018

O I have had an opportunity to ask questions and to have them answered.

O I understand that notes will be taken during the interview and that the interview will also be audio-taped and transcribed. I will be sent the transcript of the interview for checking and can ask for anything to be deleted or changed.

O I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time up to 4 weeks following receipt of the transcript without being disadvantaged in any way.

O I agree to take part in this research.

O I wish to receive a summary of the research findings (please tick one): YesO NoO

Participant's signature: .....

Participant's name: .....

Participant's Contact Details :

.....

.....

.....

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on 3 July 2018 AUTEC Reference number 18/253

Note: The Participant should retain a copy of this form.

References

Adams, T. E., Holman Jones, S., & Ellis, C. (2015). *Autoethnography*. Oxford University Press.

Allen, S. (2010). The revolution of nursing pedagogy: A transformational process. *Teaching and Learning in Nursing, 5*(1), 33-38. https://doi.org/10.1016/j.teln.2009.07.001

American Association of Colleges of Nursing. (2018). *Defining scholarship for academic nursing* Retrieved May 13, 2021 from https://www.aacnnursing.org/News-Information/Position-Statements-White-Papers/Defining-Scholarship-Nursing

American Association of Colleges of Nursing. (2020). *Fact sheet: Nursing faculty shortage*. Retrieved April 25, 2021 from https://www.aacnnursing.org/news-information/fact-sheets/nursing-faculty-shortage

Andrew, L., Robinson, K., Dare, J., & Costello, L. (2020). Widening the lens on capital: Conceptualising the university experiences of non-traditional women nurse students. *Higher Education Research & Development*, 1-17. https://doi.org/10.1080/07294360.2020.1815663

Andrew, N., Ferguson, D., Wilkie, G., Corcoran, T., & Simpson, L. (2009). Developing professional identity in nursing academics: The role of communities of practice. *Nurse Education Today, 29*(6), 607-611. https://doi.org/10.1016/j.nedt.2009.01.012

Apesoa-Varano, E. C. (2007). Educated caring: The emergence of professional identity among nurses. *Qualitative Sociology, 30*(3), 249-274. https://doi.org/10.1007/s11133-007-9069-6

Artless, E., & Richmond, C. (2000). The art and science of orthopaedic nursing. *Journal of Orthopaedic Nursing, 4*, 4-9.

Attard, A., Di Ioio, E., Geven, K., & Santa, R. (2010). *Student-centered learning: An insight into theory and practice*. https://www.esu-online.org/wp-content/uploads/2016/07/2010-T4SCL-Stakeholders-Forum-Leuven-An-Insight-Into-Theory-And-Practice.pdf

Baldwin, A., Mills, J., Birks, M., & Budden, L. (2014). Role modeling in undergraduate nursing education: An integrative literature review. *Nurse Education Today, 34*(6), e18-26. https://doi.org/10.1016/j.nedt.2013.12.007

Baldwin, A., Mills, J., Birks, M., & Budden, L. (2017). Reconciling professional identity: A grounded theory of nurse academics' role modelling for undergraduate students. *Nurse Education Today, 59*, 1-5. https://doi.org/10.1016/j.nedt.2017.08.010

Benade, L. (2015). Teachers' critical reflective practice in the context of twenty-first century learning. *Open Review of Educational Research, 2*(1), 42-54. https://doi.org/10.1080/23265507.2014.998159

Benner, P. (2015). Curricular and pedagogical implications for the Carnegie study, educating nurses: A call for radical transformation. *Asian Nursing Research, 9*(1), 1-6. https://doi.org/10.1016/j.anr.2015.02.001

Benner, P., Sutphen, M., Leonard, V., & Day, L. (2010). *Educating nurses: A call for radical transformation*. Jossey-Bass.

Biesta, G. (2007). Why ''what works'' won't work: Evidence-based practice and the democratic deficit in educational research. *Educational Theory*(57), 1-22.

Biesta, G. (2013). 'This is my truth, tell me yours'. Deconstructive pragmatism as a philosophy for education. *Educational Philosophy and Theory, 42*(7), 710-727. https://doi.org/10.1111/j.1469-5812.2008.00422.x

Biesta, G., Priestley, M., & Robinson, S. (2015). The role of beliefs in teacher agency. *Teachers and Teaching, 21*(6), 624-640. https://doi.org/10.1080/13540602.2015.1044325

Black, A. (2020). *Women working for free*. PSA. Retrieved January 5, 2021 from https://www.psa.org.nz/media/resources/women-working-for-free/

Boufoy-Bastick, B. (2004). Auto-interviewing, auto-ethnography and critical incident methodology for eliciting a self-conceptualised worldview. *Forum: Qualitative Social Research, 5*(1). http://www.qualitative-research.net/fqs/

Bourdieu, P. (1977). *Outline of a theory of practice* (R. Nice, Trans.). Cambridge University Press. https://doi.org/10.1017/CBO9780511812507

Boyd, P. (2010). Academic induction for professional educators: Supporting the workplace learning of newly appointed lecturers in teacher and nurse education. *International Journal for Academic Development, 15*(2), 155-165. https://doi.org/10.1080/13601441003738368

Boyd, P., & Lawley, L. (2009). Becoming a lecturer in nurse education: The work-place learning of clinical experts as newcomers. *Learning in Health and Social Care, 8*(4), 292-300. https://doi.org/10.1111/j.1473-6861.2009.00214.x

Boyer, E. (1990). *Scholarship reconsidered: Priorities for the professoriate.* The Carnegie Foundation for the Advancement of Teaching.

Britzman, D. P. (2003). *Practice makes practice* (rev. ed.). State University of New York Press.

Brower, A., & James, A. (2020). Research performance and age explain less than half of the gender pay gap in New Zealand universities. *PloS One, 15*(1), e0226392. https://doi.org/10.1371/journal.pone.0226392

Brown, H., & Doane, G. H. (2007). From filling a bucket to lighting a fire: Aligning nursing education and nursing practice. In L. E. Young & B. L. Paterson (Eds.), *Teaching nursing: Developing a student centered learning environment* (pp. 97–118). Lippincott Williams & Wilkins.

Bruce, A., Rietze, L., & Lim, A. (2014). Understanding philosophy in a nurse ’s world: What, where and why? *Nursing and Health, 2*(3), 65-71. https://doi.org/10.13189/nh.2014.020302

Bruce, T. (2014). A spy in the house of rugby: Living (in) the emotional spaces of nationalism and sport. *Emotion, Space and Society, 12*, 32-40. https://doi.org/10.1016/j.emospa.2013.12.002

Bryder, L. (2009). *A history of the 'Unfortunate Experiment' at National Women's Hospital*. Auckland University Press.

Bunkle, P. (2014). Publishing ethics, research integrity and error in academic research: Whose responsibility? *New Zealand Sociology, 29*(1), 98–114.

Butler, J. (1993). *Bodies that matter: On the discursive limits of ‘sex’*. Routledge.

Carpenter, H. M. (1971). *An improved system of nursing education for New Zealand; Report by Helen Carpenter*. Deptartment of Health.

Carper, B. (1978). Fundamental patterns of knowing in nursing. *Advanced Nursing Science, 1*(1), 13-23.

Carr, G. (2007). Changes in nurse education: Being a nurse teacher. *Nurse Education Today, 27*(8), 893-899. https://doi.org/10.1016/j.nedt.2006.12.006

Carrington, K., & Pratt, A. (2003). *How far have we come? Gender disparities in the Australian higher education system*. Department of the Parliamentary Library. https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/Publications_Archive/CIB/cib0203/03CIB31

Chase, S. E. (2005). Narrative inquiry: Multiple lenses, approaches, voices. In N. K. Denzin & Y. S. Lincoln (Eds.), *The handbook of qualitative research* (3rd ed., pp. 651–679). Sage Publications Inc.

Claridge, T. (2020). Social capital at different levels and dimensions: A typology of social capital. *Social Capital Research*. https://www.socialcapitalresearch.com/social-capital-at-different-levels-and-dimensions/

Clark, A. M., & Thompson, D. R. (2015). "But how many papers should I write?": Making good choices about quality, quantity and visibility of academic publications. *Journal of Advanced Nursing, 71*(8), 1471– 1473.

Clark, C. M. (2013). National study on faculty-to-faculty incivility: Strategies to foster collegiality and civility. *Nurse Educator, 38*(3), 98-102. https://doi.org/10.1097/NNE.0b013e31828dc1b2

Clow, B., Pederson, A., Haworth-Brockman, M., & Bernier, J. (2009). Rising to the challenge. In B. Clow, A. Pederson, M. Haworth-Brockman, & J. Bernier (Eds.), *Rising to the challenge: Sex and gender-based analysis for health planning, policy and research in Canada*. Atlantic Centre of Excellence for Women's Health,. http://pwhce.ca/pdf/RisingToTheChallenge.pdf

Coole, D., & Frost, S. (2010). Introducing the new materialisms. In D. Coole & S. Frost (Eds.), *New materialisms : Ontology, agency, and politics*. Duke University Press.

Crotty, M. (1998). *Foundations of social research: Meaning and perspective in the research process*. Allen & Unwin.

Daniel, L. E. (1998). Vulnerability as a key to authenticity. *Image: the Journal of Nursing Scholarship, 30*(2), 191-192. https://doi.org/10.1111/j.1547-5069.1998.tb01279.x

Davis, K. (2008). Intersectionality as buzzword. *Feminist Theory, 9*(1), 67-85. https://doi.org/10.1177/1464700108086364

De Natale, M. L., & Klevay, A. M. (2013). The humanbecoming connection: Nursing students find meaning in the teaching-learning processes. *Nursing Science Quarterly, 26*(2), 125-129. https://doi.org/10.1177/0894318413477148

De Sio, F., & Fangerau, H. (2019). The obvious in a nutshell: Science, medicine, knowledge, and history. *Berichte zur Wissenschaftsgeschichte, 42*(2-3), 167-185. https://doi.org/10.1002/bewi.201900001

Denzin, N. K. (1994). Romancing the text: The qualitative researcher-writer-as-bricoleur. *Bulletin of the Council for Research in Music Education,*(122), 15-30. http://www.jstor.org/stable/40318652

Denzin, N. K., & Lincoln, Y. S. (2013). Introduction. In N. K. Denzin & Y. S. Lincoln (Eds.), *The landscape of qualitative research* (4th ed., pp. 1-42). Sage Publications Inc.

Diekelmann, N., & Schulte, H. D. (2001). Narrative pedagogy: Heideggerian hermeneutical analyses of lived experiences of students, teachers, and clinicians. *Advanced Nursing Science, 23*(3), 53-71.

Doane, G. H., & Brown, H. (2011). Recontextualizing learning in nursing education: Taking an ontological turn. *Journal of Nursing Education, 50*(1), 21-26. https://doi.org/10.3928/01484834-20101130-01

Dobbs, S. (2015). *When two worlds collide: a Heideggerian interpretive phenomenological study into the experience of assessing 'failing' nursing students within clinical practice* [Doctorate thesis, Massey University]. Theses and Dissertations,. http://hdl.handle.net/10179/10179

Dupin, C. M., Larsson, M., Dariel, O., Debout, C., & Rothan-Tondeur, M. (2015). Conceptions of learning research: Variations amongst French and Swedish nurses. A phenomenographic study. *Nurse Education Today,, 35*(1), 73-79.

Education and Training Act 2020. https://www.legislation.govt.nz/act/public/2020/0038/latest/LMS170676.html

Education and Workforce Committee. (2020). *Education and Training Bill*. House of Representatives. Retrieved May 19,2021 from https://www.parliament.nz/en/pb/bills-and-laws/bills-proposed-laws/document/BILL_93294/education-and-training-bill

Ellis, C., Adams, T. E., & Bochner, A. P. (2010). Autoethnography: An overview. *Forum: Qualitative Social Research, 12*(1). http://www.qualitative-research.net/

Ellison-Loschmann, L. (2003). Irihapeti Ramsden. *BMJ: British Medical Journal, 327*(7412), 453. https://doi.org/10.1136/bmj.327.7412.453

Erlam, G. D. (2015). *Improving pedagogical practices with undergraduate nursing students in high-fidelity simulation* [Doctoral thesis, Auckland University of Technology]. Tuwhera. http://hdl.handle.net/10292/9260

Feldman, H. R., Greenberg, M. J., Jaffe-Ruiz, M., Kaufman, S. R., & Cignarale, S. (2015). Hitting the nursing faculty shortage head on: Strategies to recruit, retain, and develop nursing faculty. *Journal of Professional Nursing, 31*(3), 170-178. https://doi.org/10.1016/j.profnurs.2015.01.007

Findlow, S. (2012). Higher education change and professional-academic identity in newly 'academic' disciplines: The case of nurse education. *Higher Education, 63*(1), 117-133. https://doi.org/10. 1007/s10734-011-9449-4

Finkelman, A. (2019). The essence of nursing: Knowledge and caring. In A. Finkelman (Ed.), *Professional nursing concepts: Competencies for quality leadership*. Jones & Bartlett Learning.

Fletcher, K. A., & Meyer, M. (2016). Coaching model + clinical playbook = transformative learning. *Journal of Professional Nursing, 32*(2), 121-129. https://doi.org/10.1016/j.profnurs.2015.09.001

Ford, J. S., & Profetto-McGrath, J. (1994). A model of critical thinking within the context of curriculum as praxis. *The Journal of Nursing Education 33*(8), 341-344.

Gardner, L. D., & Lane, H. (2010). Exploring the personal tutor-student relationship: An autoethnographic approach. *Journal of Psychiatric and Mental Health Nursing, 17*(4), 342-347. https://doi.org/10.1111/j.1365-2850.2009.01527.x

Gazza, E. A. (2009). The experience of being a full-time nursing faculty member in a baccalaureate nursing education program. *Journal of Professional Nursing, 25*(4), 218-226. https://doi.org/10.1016/j.profnurs.2009.01.006

Georges, J. M. (2003). An emerging discourse toward epistemic diversity in nursing. *Advances in Nursing Science, 26*(1), 44-52.

Gerolamo, A. M., & Roemer, G. F. (2011). Workload and the nurse faculty shortage: Implications for policy and research. *Nursing Outlook, 59*(5), 259-265.e251.

Glass, N. (2003). Studying women nurse academics: Exposing workplace violence in Australia: Part 2. *Contemporary Nurse, 14*(2), 187-195. https://doi.org/10.5172/conu.14.2.187

Glass, N. (2007). Investigating women nurse academics' experiences in universities: The importance of hope, optimism, and career resilience for workplace satisfaction. *Annual Review of Nursing Education, 5*, 111-136.

Goffman, E. (1963). *Stigma*. Prentice Hall Publishers.

Gonzales, L. D. (2014). Framing faculty agency inside striving universities: An application of Bourdieu's theory of practice. *The Journal of Higher Education, 85*(2), 193-218. https://doi.org/10.1080/00221546.2014.11777324

Grant, A. (2014). Neoliberal higher education and nursing scholarship: Power, subjectification, threats and resistance. *Nurse Education Today, 34*(10), 1280-1282. https://doi.org/10.1016/j.nedt.2014.06.004

Grant, A. (2016). Researching outside the box: Welcoming innovative qualitative inquiry to nurse education today. *Nurse Education Today, 45*, 55-56. https://doi.org/10.1016/j.nedt.2016.06.018

Grant, B. M., & Giddings, L. S. (2002). Making sense of methodologies: A paradigm framework for the novice researcher. *Contemporary Nurse, 13*(1), 10-28. https://doi.org/10.5172/conu.13.1.10

Greene, J. C. (2007). *Mixed methods in social inquiry*. Jossey-Bass.

Hager, P. (2012). Theories of practice and their connections with learning: A continuum of more and less inclusive accounts. In *Practice, learning and change* (pp. 17-32). https://doi.org/10.1007/978-94-007-4774-6_2

Harding, E., Wait, S., & Scrutton, J. (2015). *The state of play in person-centred care: A pragmatic review of how person-centred care is defined, applied and measured,featuring key contributors and case studies across the field.* http://www.healthpolicypartnership.com/wp-content/uploads/State-of-play-in-person-centred-care-full-report-Dec-11-2015.pdf

Harper, L., & Ross, J. (2011). An application of Knowles' theories of adult education to an undergraduate interdisciplinary studies degree program. *The Journal of Continuing Higher Education, 59*(3), 161-166. https://doi.org/10.1080/07377363.2011.614887

Hart, R. J., & McKinnon, A. (2010). Sociological epistemology: Durkheim's paradox and Dorothy E. Smith's actuality. *Sociology, 44*(6), 1038-1054. https://doi.org/10.1177/0038038510381609

Hartrick Doane, G., & Varcoe, C. (2005). *Family nursing as relational inquiry. Developing health promoting practice.* Lippincott Willams & Wilkins.

Hesse-Biber, S. N. (2007). *Handbook of feminist research: Theory and praxis*. Sage.

Hesse-Biber, S. N., & Piatelli, D. (2014). The feminist practice of holistic reflexivity. In S. N. Hesse-Biber (Ed.), *Handbook of feminist research: Theory and praxis* (pp. 557-582). Sage Publications, Inc. https://doi.org/10.4135/9781483384740

Higgs, J. (1993). Physiotherapy, professionalism and self-directed learning. *Journal of the Singapore Physiotherapy Association*(14), 8-11.

Hipkins, C. (2020). New Zealand Institute of Skills and Technology- Letter of Expectations.

History of graduation. (2021, 2021). In Wikipedia. Retrieved April 16, 2021 from https://en.wikipedia.org/wiki/Graduation#Historyofgraduation

Hodkinson, P., Biesta, G., & James, D. (2008). Understanding learning culturally: Overcoming the dualism between social and individual views of learning. *Vocations and Learning, 1*(1), 27-47. https://doi.org/10.1007/s12186-007-9001-y

Holmes, D., Murray, S. J., Perron, A., & Rail, G. (2006). Deconstructing the evidence-based discourse in health sciences: Truth, power and fascism. *International Journal of Evidence-Based Healthcare, 4*(3), 180-186. https://doi.org/10.1111/j.1479-6988.2006.00041.x

Holstein, J., & Gubrium, J. (2011). Institutional ethnography: Using interviews to investigate ruling relations. In J. Holstein & J. Gubrium (Eds.), *Inside interviewing* (pp. 368-394). Sage Publications Inc. https://doi.org/10.4135/9781412984492

Holyoake, D.-D. (2011). Is the doctor-nurse game still being played? *Nursing Times, 107*(43), 12-14.

Hook, D. (2001). Discourse, knowledge, materiality, history. *Theory & Psychology, 11*(4), 521-547.

Horsfall, J., Cleary, M., & Hunt, G. E. (2012). Developing a pedagogy for nursing teaching-learning. *Nurse Education Today, 32*(8), 930-933. https://doi.org/10.1016/j.nedt.2011.10.022

Houston, S. (2002). Reflecting on habitus, field and capital:Towards a culturally sensitive social work. *Journal of Social Work, 2*(2), 149-167. https://doi.org/10.1177/146801730200200203

Hulko, W. (2009). The time-and context-contingent nature of intersectionality and interlocking oppressions. *Affilia: Journal of Women and Social Work*

24(1), 44-55. https://doi.org/10.1177/0886109908326814

Hunter, J., & Hayter, M. (2019). A neglected transition in nursing: The need to support the move from clinician to academic properly. *Journal of Advanced Nursing, 75*(9), 1820-1822. https://doi.org/10.1111/jan.14075

International Council of Nurses. (2002). *Definition of nursing*. Retrieved April 25, 2021, from https://www.icn.ch/nursing-policy/nursing-definitions

International Council of Nurses. (2021). *International Council of Nurses policy brief: The global nursing shortage and retention*. https://www.icn.ch/sites/default/files/inline-files/ICN%20Policy%20Brief_Nurse%20Shortage%20and%20Retention.pdf

Ironside, P. (2003). New pedagogies for teaching thinking: The lived experiences of students and teachers enacting narrative pedagogy. *Journal of Nursing Education, 42*(11), 509-516.

Jackson, D., Peters, K., Andrew, S., Salamonson, Y., & Halcomb, E. J. (2011, 2011/05/01/). "If you haven't got a PhD, you're not going to get a job": The PhD as a hurdle to continuing academic employment in nursing. *Nurse Education Today, 31*(4), 340-344. https://doi.org/10.1016/j.nedt.2010.07.002

Jansen, A., & Scadden, T. (Eds.). (1996). *Whitireia conversations: Our first ten years 1986-1996*. Whitireia Community Polytechnic.

Johnson, A., Kimball, R., Melendez, B., Myers, L., Rhea, K., & Travis, B. (2009). Breaking with tradition: Preparing faculty to teach in a student-centered or problem-solving environment. *Primus, 19*(2), 146-160. https://doi.org/10.1080/10511970802409164

Kenny, G., Pontin, D., & Moore, L. (2004). Negotiating socialisation: The journey of novice nurse academics into higher education. *Nurse Education Today, 24*(8), 629-637. https://doi.org/10.1016/j.nedt.2004.08.002

Kim, H. S. (2010). *The nature of theoretical thinking in nursing* (3rd ed.). Springer Publishing Company.

Kim, H. S. (2015). *The essence of nursing practice: Philosophy and perspective*. Springer Publishing Company.

Kincheloe, J. L., McLaren, P., & Steinburg, S. R. (2013). Critical pedagogy and qualitative research: Moving to the bricolage. In N. K. Denzin & Y. S. Lincoln (Eds.), *The landscape of qualitative research* (4th ed., pp. 339-370). Sage Publications Inc.

Kowalski, K., & Kelley, B. M. (2013). What's the ROI for resolving the nursing faculty shortage? . *Nursing Economics, 31*(2), 70-76.

LaSala, K. B., Wilson, V., & Sprunk, E. (2016). Nursing academic administrators' lived experiences with incivility and bullying from faculty: Consequences and outcomes demanding action. *Nurse Educator, 41*(3), 120-124. https://doi.org/10.1097/NNE.0000000000000234

Laurencelle, F. L., Scanlan, J. M., & Brett, A. L. (2016). The meaning of being a nurse educator and nurse educators' attraction to academia: A phenomenological study. *Nurse Education Today, 39*, 135-140. https://doi.org/10.1016/j.nedt.2016.01.029

Lawler, S. (2008). *Identity: Sociological perspectives*. Polity Press.

Ling, C., & Dale, A. (2013). Agency and social capital: Characteristics and dynamics. *Community Development Journal, 49*(1), 4-20. https://doi.org/10.1093/cdj/bss069

Liu, S.-H. (2011). Factors related to pedagogical beliefs of teachers and technology integration. *Computers & Education, 56*(4), 1012-1022. https://doi.org/10.1016/j.compedu.2010.12.001

Logan, P. A., Gallimore, D., & Jordan, S. (2015). Transition from clinician to academic: An interview study of the experiences of UK and Australian registered nurses. *Journal of Advanced Nursing, 72*(3), 593-604.

Lyotard, J.-F. (1988). *The Differend: Phrases in dispute*. Manchester University Press.

Mackintosh, C. (2000). "Is there a place for "care" within nursing?". *International Journal of Nursing Studies, 37*(4), 321-327. https://doi.org/10.1016/S0020-7489(00)00011-0

Malak Akgün, B. (2018). The field of care work and habitus. *Journal of Psychiatric Nursing, 10*(2), 143-148. https://doi.org/10.14744/phd.2018.19971

Mann, S. A., & Kelley, L. R. (1997). Standing at the crossroads of modernist thought: Collins, Smith and new feminist epistemologies. *Gender & Society, 11*(4), 391-408.

Māori dictionary. (2021). Retrieved May 28, 2021, from https://maoridictionary.co.nz/

Martinsson, L., & Reimers, E. (Eds.). (2010). *Norm-struggles: Sexualities in contentions*. Cambridge Scholars.

Materne, M., Henderson, A., & Eaton, E. (2017). Building workplace social capital: A longitudinal study of student nurses' clinical placement experiences. *Nurse Education in Practice, 26*, 109-114. https://doi.org/10.1016/j.nepr.2017.07.007

McAllister, M. (2015). Exploring transformative learning and the courage to teach a values based curriculum. *Nurse Education in Practice, 15*(6), 480-484. https://doi.org/10.1016/j.nepr.2015.01.007

McArthur-Rouse, F. J. (2008). From expert to novice: An exploration of the experiences of new academic staff to a department of adult nursing studies. *Nurse Education Today, 28*(4), 401-408. https://doi.org/10.1016/j.nedt.2007.07.004

McCabe, A., & O'Connor, U. (2013). Student-centred learning: The role and responsibility of the lecturer. *Teaching in Higher Education, 19*(4), 350-359. https://doi.org/10.1080/13562517.2013.860111

McCormack, B., McGowan, B., McGonigle, M., Goode, D., Black, P., & Sinclair, M. (2014). Exploring 'self' as a person-centred academic through critical creativity: A case study of educators in a school of nursing. *International Practice Development Journal, 4*(2), 1-18. https://doi.org/10.19043/ipdj.42.003

McDermid, F., Peters, K., Daly, J., & Jackson, D. (2013). 'I thought I was just going to teach': Stories of new nurse academics on transitioning from sessional teaching to continuing academic positions. *Contemporary Nurse, 45*(1), 46-55. https://doi.org/10.5172/conu.2013.45.1.46

McGrath, B. (2015). The development of a concept-based learning approach as part of an integrative nursing curriculum. *Whitireia Nursing and Health Journal, 22*, 11-17.

McLaughlin, M. (2003). *Tertiary education policy in New Zealand*. Ian Axford (New Zealand) Fellowship in Public Policy. https://www.fulbright.org.nz/wp-content/uploads/2011/12/axford2002_mclaughlin.pdf

Merriam-Webster. (2021). *Avatar*. In Merriam-Webster.com dictionary. Retrieved April 3, 2021, from https://www.merriam-webster.com/dictionary/avatar

Melia, K. (1987). *The occupational socialisation of nurses.* Tavistack London.

Ministry of Education. (2019a). *Reform of vocational education -Consultation discussion document*. https://www.education.govt.nz/assets/Uploads/11-Reform-of-Vocational-Education-Consultation-Discussion-Document.pdf

Ministry of Education. (2019b). *Shaping a stronger education system with New Zealanders*. https://doi.org/10.1007/978-94-011-5194-8_1

Mitchell, G. J., Pilkington, B., Jonas-Simpson, C. M., Daiski, I., Cross, N. L., Johnston, N., O'Grady, C. P., Peisachovich, E. H., & Tang, S. Y. (2016). Nursing education and complexity pedagogy: Faculty experiences with an e-learning platform. *Journal of Nursing Education and Practice, 6*(5). https://doi.org/10.5430/jnep.v6n5p60

Monson, T. (2014). *An exploration of the experiences of expert nurse clinicians moving to the role of faculty educators in a New Zealand setting: A qualitative descriptive study.* [Master's thesis, Auckland University of Technology]. Tuwhera. http://hdl.handle.net/10292/7828

Mustard, L. W. (2002). Caring and competency. *JONA's Healthcare Law, Ethics, and Regulation, 4*(2), 36-43. https://doi.org/10.1097/00128488-200206000-00006

National Academy of Sciences. (1992). Scientific principles and research practices. In *Responsible science: Ensuring the integrity of the research process* (Vol. 1). National Academies Press. https://www.ncbi.nlm.nih.gov/books/NBK234526/

National League of Nursing. (2013). *A vision for doctoral preparation for nurse educators*. Retrieved May 20, 2021, from http://www.nln.org/docs/default-source/about/nln-vision-series-%28position-statements%29/nlnvision_6.pdf?sfvrsn=4

National Nursing Organisations. (2014). *Report from the National Nursing Organisations to Health Workforce New Zealand*. https://www.nzcmhn.org.nz/files/file/707/23%20May2014_%20NNO%20paper.pdf

Nelson, S., & Gordon, S. (2004, 2004/09/01/). The rhetoric of rupture: Nursing as a practice with a history? *Nursing Outlook, 52*(5), 255-261. https://doi.org/10.1016/j.outlook.2004.08.001

New Zealand History. (2020). *World's first state-registered nurses*. Ministry of Culture and Heritage,. Retrieved May 18, 2021, from https://nzhistory.govt.nz/page/worlds-first-state-registered-nurses

New Zealand Nurses Organisation. (2019). *Collective agreements*. Retrieved May 13, 2021, from https://www.nzno.org.nz/support/collective_agreements

New Zealand Productivity Commission. (2016). *New models of tertiary education: Issues Paper*. www.productivity.govt.nz/inquiry

Newman, C., Stilwell, B., Rick, S., & Peterson, K. (2019). *Investing in the power of nurse leadership: What will it take?* https://www.who.int/publications/m/item/investing-in-the-power-of-nurse-leadership

Ng, S. L., Bisaillon, L., & Webster, F. (2017). Blurring the boundaries: Using institutional ethnography to inquire into health professions education and practice. *Medical Education, 51*(1), 51-60. https://doi.org/10.1111/medu.13050

Nightingale, F. (1860). *Notes on nursing: What it is, and what it is not*. D. Appleton and Company.

Nursing Council of New Zealand. (2005/2011). Guidelines for cultural safety , the Treaty of Waitangi and Maori health in nursing education. http://www.nursingcouncil.org.nz

Nursing Council of New Zealand. (2012). *The New Zealand nursing workforce*. http://nursingcouncil.org.nz/Publications/Reports

Nursing Council of New Zealand. (2015). *Education programme standards for the registered nurse scope of practice.* https://www.nursingcouncil.org.nz/Public/Education/Standards_for_programmes/NCNZ/Education-section/Standards_for_programmes.aspx?hkey=52a51787-905a-481b-a4f7-4007742cbdbe

Nursing Council of New Zealand. (2016). *Competencies for registered nurses*. https://www.nursingcouncil.org.nz/NCNZ/nursing-section/Registered_nurse.aspx

O'Brien, S., & Ó Fathaigh, M. (2005). Bringing in Bourdieu's theory of social capital: Renewing learning partnership approaches to social inclusion. *Irish Educational Studies, 24*(1), 65-76. https://doi.org/10.1080/03323310500184509

O'Shea, S. (2016). Navigating the knowledge sets of older learners: Exploring the capitals of first-in-family mature age students. *Widening Participation and Lifelong Learning, 18*(3), 34-54. https://doi.org/10.5456/WPLL.18.3.34

Office of the Chief Nursing Officer. (2018). *Nursing leadership narrative for change*. Retrieved April 6, 2021, from https://www.health.govt.nz/our-work/nursing/nursing-leadership/nursing-leadership-narrative-change

Osberg, D., & Biesta, G. (2010). The end/s of education: Complexity and the conundrum of the inclusive educational curriculum. *International Journal of Inclusive Education, 14*(6), 593-607. https://doi.org/10.1080/13603110802530684

Pacheco, G., Li, C., & Cochrane, B. (2017). *Empirical evidence of the gender pay gap in New Zealand*. Ministry for Women,. Retrieved January 6, 2021 from https://women.govt.nz/sites/public_files/EmpiricalevidenceofGPGinNZ-Mar2017_0.pdf

Palmer, P. J. (1997). The heart of a teacher: Identity and integrity in teaching. *Change, 29*(6), 14-21.

Pardue, K. T., Young, P. K., Horton-Deutsch, S., Halstead, J., & Pearsall, C. (2018). Becoming a nurse faculty leader: Taking risks by being willing to fail. *Nursing Forum, 53*(2), 204-212. https://doi.org/10.1111/nuf.12244

Parse, R. R. (2004). A human becoming teaching-learning model. *Nursing Science Quarterly, 17*(1), 33-35. https://doi.org/10.1177/0894318403260549

Paterson, R. (2010). The Cartwright legacy: Shifting the focus of attention from the doctor to the patients. *The New Zealand Medical Journal, 123*(1319), 6-10.

Paul, P. A. (2015). Transition from novice adjunct to experienced associate degree nurse educator: A comparative qualitative approach. *Teaching and Learning in Nursing, 10*(1), 3-11. https://doi.org/10.1016/j.teln.2014.09.001

Pauly, B., MacKinnon, K., & Varcoe, C. (2009). Revisiting "Who gets care?": Health equity as an arena for nursing action. . *Advances in Nursing Science,, 32*, 118-127. https://doi.org/10.1097/ANS.0b013e3181a3afaf

Peters, K., Jackson, D., Andrew, S., Halcomb, E. J., & Salamonson, Y. (2011). Burden versus benefit: continuing nurse academics' experiences of working with sessional teachers. *Contemporary Nurse, 38*(1-2), 35-44. https://doi.org/10.5172/conu.2011.38.1-2.35

Polatcan, M., Arslan, P., & Balci, A. (2021). The mediating effect of teacher self-efficacy regarding the relationship between transformational school leadership and teacher agency. *Educational Studies*, 1-19. https://doi.org/10.1080/03055698.2021.1894549 (Advance online publication.)

Pool, D. (2021). *Hands, heart, mind and soul of Te Kaiako Tapuhi,* [Digital media created using images from https://www.deviantart.com/danni-chan15/art/Tree-Tattoo-337899515, https://collections.tepapa.govt.nz/object/980500, http://free-extras.com/images/fern_maori_tattoo_new_zaeland-17488.htm, and https://i.pinimg.com/originals/08/89/3b/08893bec964d77d906926f9daf3ddd90.jpg]. Property of author.

Porr, C. (2005). Shifting from preconceptions to pure wonderment. *Nursing Philosophy, 6*, 189–195.

Power, E. M. (1999). An introduction to Pierre Bourdieu's key theoretical concepts. *Journal for the Study of Food and Society, 3*(1), 48-52. https://doi.org/10.2752/152897999786690753

Pratt, D. D., & Paterson, B. L. (2007). Perspectives on teaching: Discovering BIASes. In L. E. Young & B. L. Paterson (Eds.), *Teaching nursing: Developing a student centered learning environment* (pp. 56–77). Lippincott Williams & Wilkins.

Ramsburg, L., & Childress, R. (2012). An initial investigation of the applicability of the Dreyfus skill acquisition model to the professional development of nurse educators. *Nursing Education Perspectives, 33*(5), 312–316.

Rehg, E., & SmithBattle, L. (2015). On to the 'rough ground': Introducing doctoral students to philosophical perspectives on knowledge. *Nursing Philosophy, 16*(2), 98-109. https://doi.org/10.1111/nup.12077

Richardson, F. I. (2010). *Cultural safety in nursing education and practice in Aotearoa New Zealand* [Doctoral thesis, Massey University]. Theses and Dissertations. http://hdl.handle.net/10179/2411

Richardson, L. (2001). Getting personal: Writing-stories. *International Journal of Qualitative Studies in Education, 14*(1), 33-38. https://doi.org/10.1080/09518390010007647

Richardson, L., & St. Pierre, E. (2018). Writing: A method of inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *Sage handbook of qualitative research* (5th ed., pp. 818–939). Sage Publications Ltd.

Roberts, J. (2019). Kawa whakaruruhau -Has its intent been lost? *Kai Tiaki Nursing New Zealand, 25*(11), 14-15.

Roberts, K. K., Chrisman, S. K., & Flowers, C. (2013). The perceived needs of nurse clinicians as they move into an adjunct clinical faculty role. *Journal of Professional Nursing, 29*(5), 295-301. https://doi.org/10.1016/j.profnurs.2012.10.012

Robinia, K. A., & Anderson, M. L. (2010). Online teaching efficacy of nurse faculty. *Journal of Professional Nursing, 26*(3), 168-175. https://doi.org/10.1016/j.profnurs.2010.02.006

Rolfe, G. (2012). Cardinal John Henry Newman and 'the ideal state and purpose of a university': Nurse education, research and practice development for the twenty-first century. *Nursing Inquiry, 19*(2), 98-106. https://doi.org/10.1111/j.1440-1800.2011.00548.x

Rolfe, G. (2019). Big ideas: New metaphors for nursing (2): The nurse as bricoleur. *Nurse Education Today, 74*, 97-98. https://doi.org/10.1016/j.nedt.2018.10.017

Royal, J. (2012). Evaluating human, social and cultural capital in nurse education. *Nurse Education Today, 32*(5), e19-22. https://doi.org/10.1016/j.nedt.2011.10.018

Sandelowski, M. (1991). Telling stories: Narrative approaches in qualitative research. *Image: Journal of Nursing Scholarship, 23*(3), 161-166. https://doi.org/10.1111/j.1547-5069.1991.tb00662.x

Sawatzky, J. A., Enns, C. L., Ashcroft, T. J., Davis, P. L., & Harder, B. N. (2009). Teaching excellence in nursing education: A caring framework. *Journal of Professional Nursing, 25*(5), 260-266. https://doi.org/10.1016/j.profnurs.2009.01.017

Scotto, C. J. (2003). Faculty forum. A new view of caring. *Journal of Nursing Education, 42*(7), 289-291.

Shriner, C. (2007). The influence of culture on clinical nurses transitioning into the faculty role. *Nurse Education Perspective 28*(3), 145-149.

Singh, C., Cross, W., Munro, I., & Jackson, D. (2020). Occupational stress facing nurse academics - A mixed-methods systematic review. *Journal of Clinical Nursing, 29*(5-6), 720-735. https://doi.org/10.1111/jocn.15150

Smeltzer, S. C., Sharts-Hopko, N. C., Cantrell, M. A., Heverly, M. A., Jenkinson, A., & Nthenge, S. (2015). Work-life balance of nursing faculty in research- and practice-focused doctoral programs. *Nursing Outlook, 63*(6), 621-631. https://doi.org/10.1016/j.outlook.2015.04.008

Smith, D. E. (1987). *The everyday world as problematic: A feminist sociology*. Northeastern University Press.

Smith, D. E. (1992). Sociology from women's experience: A reaffirmation. *Sociological Theory, 10*(1), 88-98. https://doi.org/10.2307/202020

Smith, D. E. (1996). The relations of ruling: A feminist inquiry. *Studies in Cultures, Organizations and Societies, 2*(2), 171-190. https://doi.org/10.1080/10245289608523475

Smith, D. E. (1999). *Writing the social : Critique, theory, and investigations*. University of Toronto Press.

Smith, D. E. (2003). Making sense of what people do: A sociological perspective. *Journal of Occupational Science, 10*(1), 61-64. https://doi.org/10.1080/14427591.2003.9686512

Smith, M., & McCarthy, M. P. (2010). Disciplinary knowledge in nursing education: Going beyond the blueprints. *Nursing Outlook, 58*(1), 44-51.

Southwick, M. (1994). Making the Treaty count: A new curriculum for the Whitireia Nursing Centre of Learning. *Whitireia Nursing Journal, 1*, 7-16.

Spadoni, M., Doane, G. H., Sevean, P., & Poole, K. (2015). First-year nursing students - Developing relational caring practice through inquiry. *Journal of Nursing Education, 54*(5), 270-275. https://doi.org/10.3928/01484834-20150417-04

St. Pierre, E. A. (1997). Methodology in the fold and the irruption of transgressive data. *International Journal of Qualitative Studies in Education, 10*(2), 175-189. https://doi.org/10.1080/095183997237278

St. Pierre, E. A. (2013). The appearance of data. *Cultural Studies ↔ Critical Methodologies, 13*(4), 223-227. https://doi.org/10.1177/1532708613487862

St. Pierre, E. A. (2019). Post qualitative inquiry, the refusal of method, and the risk of the new. *Qualitative Inquiry, 27*(1), 3-9. https://doi.org/10.1177/1077800419863005

Stajduhar, K. I., Balneaves, L., & Thorne, S. E. (2001). A case for the 'middle ground': Exploring the tensions of postmodern thought in nursing. *Nursing Philosophy, 2*(1), 72-82. https://doi.org/10.1046/j.1466-769x.2001.00033.x

Stanley, M. J. C., & Dougherty, J. P. (2010). A paradigm shift in nursing education: A new model. *Nursing Education Perspectives, 31*(6), 378-280.

Starr, S. S. (2008). Authenticity: A concept analysis. *Nursing Forum, 43*(2), 55-62. https://doi.org/10.1111/j.1744-6198.2008.00096.x

Stewart, A. (2017). *Critical thinking in nursing: A critical discourse analysis of a perpetual paradox* [Doctoral thesis, Auckland University of Technology]. Auckland. Tuwhera. http://hdl.handle.net/10292/10838

Stewart, G. T. (2021). *Māori philosophy: Indigenous thinking from Aotearoa*. Bloomsbury Publishing Plc.

Stewart, G. T., St. Pierre, E., Devine, N., & Kirloskar-Steinbach, M. (2020). The end of the dream: Postmodernism and qualitative research. *Qualitative Inquiry*. https://doi.org/10.1177/1077800420971867

Stokke, K., & Peiris, P. (2017). Public opinion on peace as a reflection of social differentiation and politicisation of identity in Sri Lanka. *PCD Journal, 2*(1). https://doi.org/10.22146/pcd.25719

Suddaby, G. (2019). *Professional standards for tertiary teachers: A synthesis of recent work and initiatives.* Ako Aotearoa. https://ako.ac.nz/knowledge-centre/synthesis-reports/professional-standards-for-tertiary-teachers/

Summers, J. A. (2017). Developing competencies in the novice nurse educator: An integrative review. *Teaching and Learning in Nursing, 12*(4), 263-276. https://doi.org/10.1016/j.teln.2017.05.001

Taonui, R. (2005). *Tribal organisation - The significance of iwi and hapū*. http://www.TeAra.govt.nz/en/tribal-organisation/page-1

ten Hoeve, Y., Jansen, G., & Roodbol, P. (2014). The nursing profession: Public image, self-concept and professional identity. A discussion paper. *Journal of Advanced Nursing, 70*(2), 295-309. https://doi.org/10.1111/jan.12177

Tengelin, E., & Dahlborg-Lyckhage, E. (2017). Discourses with potential to disrupt traditional nursing education: Nursing teachers' talk about norm-critical competence. *Nursing Inquiry, 24*, 1-11. https://doi.org/10.1111/nin.12166

Tengelin, E., Dahlborg, E., Berndtsson, I., & Bülow, P. H. (2020). From political correctness to reflexivity: A norm-critical perspective on nursing education. *Nursing Inquiry, 27*(3), e12344. https://doi.org/10.1111/nin.12344

Tertiary Education Commission/Te Amorangi Matauranga Matua. (2020). *The tertiary education strategy*. Retrieved April 26, 2021, from https://www.tec.govt.nz/focus/our-focus/tes/

Tertiary Education Union. (2019). *Collective agreements*. https://teu.ac.nz/collective-agreements

Thompson, D. R., & Clark, A. M. (2018). Leading by gaslight? Nursing's academic leadership struggles. *Journal of Advanced Nursing, 74*(5), 995-997. https://doi.org/10.1111/jan.13399

Tolich, M., & Davidson, C. (2003). Collecting the data. In C. Davidson & M. Tolich (Eds.), *Social science research in New Zealand: Many paths to understanding* (pp. 121–153). Pearson Education Australia.

Tomm-Bonde, L. (2012). The naïve nurse: Revisiting vulnerability for nursing. *BMC Nursing, 11*. https://doi.org/10.1186/1472-6955-11-5

Trede, F., Macklin, R., & Bridges, D. (2012). Professional identity development: A review of the higher education literature. *Studies in Higher Education, 37*(3), 365-384. https://doi.org/10.1080/03075079.2010.521237

Udlis, K. A., & Mancuso, J. M. (2015). Perceptions of the role of the Doctor of Nursing Practice-prepared nurse: Clarity or confusion. *Journal of Professional Nursing, 31*(4), 274-283. https://doi.org/10.1016/j.profnurs.2015.01.004

Van Herk, K. A., Smith, D., & Andrew, C. (2011). Examining our privileges and oppressions: Incorporating an intersectionality paradigm into nursing. *Nursing Inquiry, 18*(1), 29-39. https://doi.org/10.1111/j.1440-1800.2011.00539.x

Walter, R., Glass, N., & Davis, K. (2001). Epistemology at work: The ontological relationship between feminist methods, intersubjectivity and nursing research-a research exemplar. *Contemporary Nurse, 10*(3-4), 265-272. https://doi.org/10.5172/conu.10.3-4.265

White, A., Brannan, J., & Wilson, C. B. (2010). A mentor-protégé program for new faculty, part I: Stories of protégés. *Journal of Nursing Education, 49*(11), 601-607. https://doi.org/10.3928/01484834-20100630-04

Wilson, C. B., Brannan, J., & White, A. (2010). A mentor-protégé program for new faculty, part II: Stories of mentors. *Journal of Nursing Education, 49*(12), 665-671. https://doi.org/10.3928/01484834-20100730-08

Wilson, D. S. (2001). *Transforming nursing education: A legitimacy of difference* [Doctoral thesis, University of Canterbury]. UC Research Repository. http://hdl.handle.net/10092/1845

Witz, A. (1992). *Professions and patriarchy*. Routledge.

Woods, A., Cashin, A., & Stockhausen, L. (2016). Communities of practice and the construction of the professional identities of nurse educators: A review of the literature. *Nurse Education Today, 37*, 164-169. https://doi.org/10.1016/j.nedt.2015.12.004

World Health Organization. (2016). *Nurse educator core competencies*. https://www.who.int/hrh/nursing_midwifery/nurse_educator050416.pdf

World Health Organization. (2020). *State of the world's nursing 2020: Investing in education, jobs and leadership.* https://www.who.int/publications/i/item/9789240003279

Xu, J., Kunaviktikul, W., Akkadechanunt, T., Nantsupawat, A., & Stark, A. T. (2020). A contemporary understanding of nurses' workplace social capital: A response to the rapid changes in the nursing workforce. *Journal of Nursing Management, 28*(2), 247-258. https://doi.org/10.1111/jonm.12914

Yosso, T. J. (2005). Whose culture has capital? A critical race theory discussion of community cultural wealth. *Race Ethnicity and Education, 8*(1), 69-91. https://doi.org/10.1080/1361332052000341006

Zieber, M., & Wojtowicz, B. (2020). To dwell within: Bridging the theory-practice gap. *Nursing Philosophy, 21*(2), e12296. https://doi.org/10.1111/nup.12296

Zlatanovic, T., Havnes, A., & Mausethagen, S. (2016). A research review of nurse teachers' competencies. *Vocations and Learning, 10*(2), 201-233. https://doi.org/10.1007/s12186-016-9169-0