Emotional Intelligence in Undergraduate Nursing Education: The Essential Extra

A Critical Analysis of Emotional Intelligence Discourses in New Zealand Undergraduate Nursing Education

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Abstract

Driven by the need to understand how nursing education shapes the development of EI in nursing students, this study investigated the impact of the dominant discourses operating within undergraduate nursing education in New Zealand. Examining how these discourses construct, position and influence EI development provided insight into their influence and potential role in promoting or hindering EI development. This illuminated existing challenges in the development of EI in nursing students so as to guide future efforts.

A critical discourse analysis methodology, informed by the work of Fairclough (1995) and Huckin (1997), was used to examine five influential documents that impacted the education and development of undergraduate nursing students. The documents included the professional competency requirements for nurses, the undergraduate nursing curricula from three tertiary institutions, and a widely used nursing textbook within New Zealand undergraduate programs. The documents were selected based on their privileged position in guiding the development of undergraduate nursing knowledge and competencies, which gives them authority and influence within nursing theory and practice. A thematic approach was used for the analysis at a textual and discourse practice level. Critical and social constructionist theory was then used to provide a contextualised interpretation of the powerful discursive forces impacting the inclusion of emotional intelligence development within undergraduate nursing education.

Paradoxically, while the study found undergraduate nursing students were discursively positioned as needing to develop emotional intelligence to become nursing professionals, explicit requirements for emotional intelligence development were found to be conspicuous by its absence within undergraduate nursing education. The various discourses within the analysed texts and the broader nursing context were found to both promote and hinder the development of emotional intelligence. In addressing this, the study argues for explicitly including emotional intelligence development requirements within undergraduate nursing education in preparation for the emotional realities of nursing. Additionally, incorporating specific emotional intelligence-related competencies within the Nursing Council of New Zealand

Competencies for Registered Nurses document would promote the standardisation of emotional intelligence development for all future nurses.

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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.

31 March 2024

Signed: Elizabeth Dianne Carroll-Thom Date

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Chapter 1 Introduction and Overview

Nurses are expected to provide emotional support and solace to patients and families during periods of heightened vulnerability and profound emotional distress; this includes an expectation to understand and manage complex human emotions resulting from pain, discomfort, and sadness. During such times, the emotional work of the nurse can be extensive. It requires expressing compassion, empathy, and hope while often experiencing and contending with their own emotions of fear, helplessness, and sadness (Freshwater & Stickley, 2004).

The combination of recognising, understanding, managing, and regulating one's own emotions and those of others is commonly known as emotional intelligence (EI) (Boyatzis et al., 2000; Goleman, 1995b; Salovey & Mayer, 1990). The literature overwhelmingly emphasises the importance of EI in helping nurses navigate their work's emotional demands (Choudary, 2010; Codier, 2021; Codier et al., 2013; McQueen, 2004; Rankin, 2013; White & Grason, 2019). However, despite studies highlighting the benefits of integrating EI development in undergraduate nursing education in preparing graduates for the emotional complexities of nursing practice, it is not yet routinely included (Batmaz et al., 2022; Cleary et al., 2018; Freshwater & Stickley, 2004; Hurley et al., 2020).

This first chapter introduces the study by providing the background to the development of the concept of EI and its relevance to nursing, particularly in undergraduate nursing education. A personal reflection is presented to share one of the catalysts that motivated me to research this topic, both personally and professionally. Next, the research aim and questions are presented. Finally, the chapter concludes with a summary of this work's eight chapters.

Topic Overview

For decades, the primary measure of human intelligence relied on a single cognitive ability known as the intelligence quotient (IQ) score. However, the emergence of EI reflects a shift towards acknowledging the existence of multiple independent intelligences operating simultaneously (Gardner, 1993; Sadiku & Musa, 2021). The social aspects of EI can be traced back to the psychology-based work of Edward

Thorndike (1920), who focussed on 'social intelligence'. This concept encompassed emotional awareness and understanding others' feelings and motivations, laying the foundation for recognising EI as a distinct form of intelligence. This notion was further reinforced by Howard Gardner's groundbreaking theory of multiple intelligences (1983), which incorporated emotional and social aspects under the umbrella term of 'personal intelligence'. This challenged the traditional IQ-centric view, replacing it with a more multifaceted understanding.

EI is now recognised as one of many distinct forms of human intelligence. While the concept became popular in the 1990s, reflecting a shift in perspectives, the term 'emotional intelligence' was used prior to this in a doctoral thesis by Wayne Payne (1986). Payne conceptualised EI as opposing 'emotional ignorance' but did not provide a specific definition of EI or connect it to a theoretical framework. Psychologists Peter Salovey and John Mayer (1990) are credited with introducing the first comprehensive model and definition of EI. Drawing on psychology, cognition, and neuroscience, their model conceptualised EI as a mental ability and offered a structured framework for its understanding, study, and measurement. They identified four key components of EI: emotional perception, understanding, use, and regulation. Salovey and Mayer (1990, 1997) argued that recognising and utilising one's own and others' emotional states through the use of EI is linked to effective problem-solving, behaviour management, and a more fulfilling life.

Building on the work of Salovey and Mayer (1990), Daniel Goleman (1995a, 1995b; 1998a) expanded the focus on EI to include its broader impact on both personal and professional success. He offered an alternative model of EI with five components: self-awareness, self-regulation, motivation, empathy, and social skills. While not the first to explore EI, Goleman popularised EI through his groundbreaking book, *Emotional Intelligence: Why it Can Matter More Than IQ (Goleman, 1995b)*. The book's success can be attributed to several factors. It offered practical applications through anecdotes and stories that could resonate with a broader audience. It also encouraged self-improvement and translated academic research into understandable information relevant to real-world situations like education, relationships, and leadership. However, while Goleman's definition is widely known and adopted, it attracted

criticism from some, like Mayer and Cobb (2000), who argued that the model was too broad because it included aspects such as personality traits.

As research on EI continues to evolve, its application extends beyond its initial boundaries. Researchers in fields such as education, business, healthcare, and leadership are contributing to a growing body of knowledge, expanding on existing EI theories and identifying new areas for study. Nursing actively participates in this evolving landscape, contributing new and valuable insights.

EI in Nursing and Undergraduate Nursing Education

Goleman (1998b) proposed that individuals possess a base level of EI, which can be developed and improved. This concept is firmly established in nursing, as evidenced by extensive research documenting its benefits and advocating for its development in this field. The literature consistently highlights the positive effects of EI on nurses, including enabling them to demonstrate greater compassion towards patients (Adams & Iseler, 2014; Codier, 2015; Maillet & Read, 2021). This is argued to directly translate to improved communication, stronger therapeutic relationships, and, ultimately, higher-quality, patient-centred care. Further research suggests that EI strengthens nurses' conflict management skills and fosters collaborative relationships with patients, families, and colleagues (Raeissi et al., 2019; Soriano-Vázquez et al., 2023). These positive impacts contribute to stress reduction and burnout prevention among nurses (Karimi et al., 2014; Kheirmand et al., 2016; Mazzella-Ebstein et al., 2021), resulting in a more resilient and sustainable workforce better equipped to deliver quality care over time.

Recognising these benefits, a growing number of studies explore EI development within undergraduate nursing education, acknowledging its potential impact on future practitioners. Notably, EI offers specific benefits to students themselves. Skills like self-awareness and emotion regulation are seen as critical in helping nursing students manage stress, anxiety, and burnout, all of which are common in demanding healthcare environments (Por et al., 2011). Furthermore, research links EI to lower dropout rates and higher completion rates in nursing programmes, attributed to students' ability to manage challenges, navigate interpersonal conflicts, and maintain motivation (Benington et al., 2020; Marvos & Hale, 2015). Therefore, the focus on EI in

nursing students benefits their well-being and academic success, ultimately contributing to a future generation of nurses equipped to provide more compassionate, effective, and safer patient care.

Calls for integrating EI development into undergraduate nursing curricula have continued (Codier, 2021; Ireland, 2022). Research by Foster and McCloughen (2020) highlights that existing tertiary healthcare education primarily focuses on the fundamentals of professional communication, which may not adequately prepare students to manage challenging or emotionally charged situations in healthcare settings. However, despite strong support for its inclusion, the Nursing Council of New Zealand (NCNZ) does not currently mandate explicit requirements for the teaching of EI within undergraduate nursing education. This lack of mandate reflects a concerning gap between what is proposed as best practice and the current content of undergraduate nursing education.

Emotional Intelligence: Theory to Practice Gap

While some limited studies have discussed attempts to incorporate aspects of EI into undergraduate nursing education, there is a scarcity of research that focuses on examining the challenges that may hinder this. Some general challenges identified within the literature are the focus on technical skills in nursing practice, the absence of an agreed nursing definition of EI and the lack of standardised EI nursing assessment tools (discussed further in Chapter 2). However, of the studies undertaken, none were found to have examined the discourses operating within nursing and undergraduate education to establish how these may shape and, therefore, promote or adversely impact EI development within undergraduate nursing education.

A significant discrepancy exists between the extensive research supporting the benefits of EI in nursing and its actual implementation in practice (Dugue et al., 2021). This was reflected in my experience teaching in a Bachelor of Nursing programme, where several students expressed feeling unprepared for the emotional demands of the clinical environment. One instance involved a second-year student who, visibly distressed during a meeting, shared their anxieties and doubts about their emotional readiness, stating:

> "I am not sure I have what it takes to be a nurse. I constantly think about patients even when I am away from the ward. Staff told me to 'toughen up' and not get so involved, or I would not make it as a nurse. I really wish I could learn to care less and be less emotional."

The student's words prompted me to question how effectively students are supported in developing the skills to become emotionally intelligent and manage their own and others' emotions. The student's desire for instruction on suppressing emotions revealed a troubling contradiction related to the notion of care. Although embarking on a journey to learn how to care, this student seemed to want instruction on learning how to emotionally detach rather than developing stronger emotional intelligence.

The nurses' use of colloquial language like "toughen up" in the example above can be confusing and misleading, especially for students lacking relevant experience. The phrase lacks clarity and can, therefore, lead to multiple interpretations. While the more experienced nurse's advice may have intended to encourage the student to focus on setting healthy relationship boundaries and building emotional resilience, the lack of clarification resulted in the student interpreting a need to ignore or hide their emotions. This, in turn, could hinder the ability to provide compassionate and effective care.

Most undergraduate students in New Zealand complete first-year coursework on professional boundaries and relationships. However, this example highlights the challenge of applying professional expectations and theoretical knowledge to real-world clinical settings. Recognising the potential of EI to equip students with the necessary skills in such situations, I began thinking about how undergraduate nursing education fosters EI development and how this may be hindered by pressures within both the context of nursing and undergraduate nursing education.

Research Problem

Many studies highlight the benefits of EI development in undergraduate education, leading to calls for its inclusion due to its vital role in nursing practice (Ireland, 2022). Most undergraduate nursing education programmes in New Zealand require three years of full-time, degree-level study to prepare students to become registered nurses.

However, within the Nursing education standards for programmes leading to registration as a registered nurse, there are currently no explicit requirements for undergraduate nurses to develop EI (Nursing Council of New Zealand, 2022b). While the ambiguity surrounding EI definitions and conceptualisations (discussed further in Chapter 2) presents a potential challenge to its inclusion, no identified studies have examined the impact of discourses within nursing education and the wider sociocultural context on EI development in undergraduate nursing programmes. Therefore, having identified this gap in the literature, my research aimed to explore the discourses impacting EI development, seeking to reveal and understand the forces affecting its inclusion in undergraduate nursing education in New Zealand.

Research Aim

My study aimed to analyse the discourse surrounding EI in nursing education in New Zealand, investigating how language and social factors construct and maintain the perceived disconnect between the valued concept of EI and its actual implementation. By exploring the power dynamics and dominant discourses, this study sought to uncover underlying barriers that may hinder its full integration into nursing education and practice. To achieve this, the study identified how discourses operating within undergraduate nursing education construct, position, and impact EI development. The overarching goal was to identify and analyse how dominant discourses impact the development of emotional intelligence in undergraduate nursing programmes in New Zealand. Understanding these challenges is a prerequisite to developing effective strategies to foster EI development in undergraduate nursing students and, thus, ultimately, improving future patient care.

Research Questions

In meeting the research aim, the following research questions were asked:

1. How is the language used to construct the meaning of EI within undergraduate nursing curricula, theory, and clinical practice?
2. How do the discourses operating within undergraduate nursing education influence the positioning and inclusion of EI?
3. How does the sociocultural context impact the discourses and influence EI's positioning and inclusion within undergraduate nursing education?

Overview of the Thesis

This thesis is presented in eight chapters. Chapter 1 introduced the topic and included an introduction to EI and its importance in nursing practice, with a reflective account of the major influences on topic selection. The chapter concludes by presenting the study's research problem, aim and questions.

Chapter 2 reviews the literature on EI in nursing and undergraduate nursing education. In doing so, the origins of EI are presented. Additionally, recognising that multiple definitions exist for some key terms central to the research, the different models of EI and its interdependent relationship with emotional competency are explored and defined.

Chapter 3 introduces and explains critical discourse analysis as the methodology chosen to address the research questions. It also discusses the philosophies influencing the thesis and justifies the choice of a social constructionist approach. Additionally, the chapter outlines the analytical methods used to examine and analyse the relevant documents, including the rationale for their selection.

Chapter 4 presents synthesised findings from the analysis to uncover how language is used with the first two selected documents, the *Competencies for Registered Nurses* (NCNZ, 2012b) and *Potter and Perry's Fundamentals of Nursing* textbook (Crisp et al., 2017).

Chapter 5 continues the presentation of the synthesised findings from the analysis of nursing curricula from three different tertiary institutions delivering degree-level undergraduate nursing programmes within New Zealand.

Chapter 6 discusses the dominant discourses and analysis of findings, answering the first two research questions related to the language used to construct EI within undergraduate curricula, theory, and clinical practice and how the discourses influence the positioning and inclusion of EI within undergraduate nursing education.

Chapter 7 provides a contextualised discussion of clinical practice examples in addressing the third research question: How does the sociocultural context impact the

discourses and influence EI's positioning and inclusion within undergraduate nursing education?

Chapter 8 provides the final discussion and recommendations with a review of the findings and a discussion of the study's limitations. The importance of EI development in undergraduate nursing education and the potential consequence of its absence is reinforced.

Chapter Summary

This first chapter outlined the importance of EI in nursing and the widespread support for its inclusion in undergraduate education. It identified and outlined the research problem as a disconnect between the established value of EI and its implementation in undergraduate nursing education in New Zealand. Consequently, the study aimed to understand how discourses within undergraduate nursing education influence EI development. Research questions were designed to explore how EI is constructed within nursing education, the impact of these discourses on its inclusion, and how the broader sociocultural context shapes EI's positioning and development. A personal reflection illustrated the catalysts for this research. The chapter concludes with a summary of the study's eight chapters. The following chapter critically reviews the literature, introducing and defining EI and related concepts and showing how EI is positioned within the field of nursing.

Chapter 2 Review of the Literature

This chapter presents a review, evaluation, and synthesis of literature related to EI within nursing and undergraduate nursing education. It distinguishes between EI and Emotional Competence (EC), acknowledging the potential confusion surrounding these terms while emphasizing their interconnectedness. In addition, various EI models are presented, and their strengths, limitations, and implications for EI measurement are discussed. The significance of EI in nursing is discussed, highlighting its potential benefits for patients, nurses, and student nurses. Finally, the chapter pinpoints a gap within the literature and explains how the current study contributes to the body of knowledge in this area.

Emotional Intelligence (EI) and Emotional Competence (EC)

It is important to note that some terminology relating to EI research can be ambiguous and misleading. The conceptualisation of EI and EC is particularly challenging as these terms are often used interchangeably in the literature, with little or no information to differentiate them. Some authors even claim they are synonymous (Brasseur et al., 2013). However, when a distinction is made, EI commonly represents the fixed, underlying capability to recognise and use emotions, forming the foundation for EC, which is considered the learned capability built upon the EI foundation (Goleman, 1998b, 2001; Salovey & Mayer, 1997). Therefore, EC can be seen as the practical application of EI-informed behaviours that individuals with EI can learn and improve (Mikolajczak et al., 2014).

Vaida and Opre (2014) highlight the symbiotic relationship between EI and EC. They define EI as "a set of skills that support the identification, processing, and management of emotions" and see it as a foundation for EC, which ultimately leads "to performance" (pp. 26-27). They also note the absence of EC in many studies, which is one reason why the term EI was chosen over EC in this study. This absence may also contribute to the emergence of the alternative hybrid term of "emotional intelligence competencies" (ECI), which linguistically reflects the interrelationship between EI and EC (Goleman et al., 2002).

While the lack of universally agreed-upon definitions for EI and EC in nursing may seem like an obstacle, it arguably fuels the field's intrigue and enduring research interest. Studies continue to explore various aspects of EI, including its impact on clinical performance (Christianson et al., 2021; Kim, 2022; Mi Sook & Sue Kyung, 2019), compassion (Im & Jun, 2021), clinical competency (Dehnavi et al., 2022), safety (Shokry et al., 2023), resiliency building (Chikobvu & Harunavamwe, 2022), and of particular interest to this study, its inclusion within undergraduate education (Dugue et al., 2021; Hamad & Gurbutt, 2023).

Models of EI

Attempting to define EI and EC aims to reduce ambiguity in research. However, achieving consensus on whether EI is considered personality-based, ability-focused, or a combination of both remains challenging. These contrasting approaches have led to the development of three main theoretical frameworks: ability EI, trait EI, and mixed EI.

Ability Model of EI

The Mayer-Salovey-Caruso Emotional Intelligence Test (MSCEIT) is a prominent example of the ability model. It draws inspiration from ability-based IQ tests and focuses on the skills related to perceiving, using, understanding, and managing emotions (Mayer et al., 2008; Petrides et al., 2007; Salovey & Mayer, 1997). Unlike trait EI, ability EI relies on objective problem-solving performance measurement tests rather than self-reporting and self-perception (Mayer et al., 2003).

The MSCEIT is considered a leading ability EI assessment tool (Papadogiannis et al., 2009), demonstrating cultural adaptability (Karim & Weisz, 2010) and supported by theoretical and empirical evidence supporting its reliability and validity in measuring EI (Mayer et al., 2008, 2012; Mayer et al., 2003).

Supporters of the ability model argue that it is theoretically more robust than trait EI due to its emphasis on objective measurement and link to predicting outcomes like job performance and academic achievement (Mayer et al., 2012). However, the model is criticised for being limited in scope and time-consuming due to the extensive number of questions required for a comprehensive assessment (Connor et al., 2019).

Trait Model of EI

In contrast to the ability model, trait EI focuses on personal disposition and personality-related traits. These are measured primarily through self-reporting, capturing an individual's perceptions of how they typically behave in specific situations (Salovey & Mayer, 1997). One commonly utilised tool is the Trait Emotional Intelligence Questionnaire (TEIQue), which assesses emotion-related behavioural dispositions such as self-control, self-motivation, assertiveness, self-esteem, and happiness (Petrides et al., 2007).

Critics argue that the pure trait EI model faces challenges due to its close association with personality, raising concerns about its inability to be objectively measured and its overall validity (Andrei et al., 2016; Dulewicz et al., 2003; Landy, 2005; Locke, 2005). This criticism is related to its reliance solely on self-reporting, potentially duplicating existing personality studies (Andrei et al., 2016). However, supporters of the trait EI model argue that assessment tools like TEIQue are able to predict differences beyond personality and can improve validity if required by utilising additional information sources (Andrei et al., 2016; Petrides et al., 2016).

Mixed Model of EI

The mixed model of EI aims to bridge the gap between ability and trait EI, viewing EI as a combination of learnable skills and personal traits. This more comprehensive model encompasses cognitive abilities and personality, offering a valuable tool for understanding behaviour in complex and emotionally charged environments like nursing.

Mixed model tools, like Bar-On's Emotional Quotient Inventory (EQ-i), assess a broad range of personal, emotional, and social abilities, reflecting its measurement of emotional-social intelligence (ESI) (Bar-On, 2006). Similarly, Goleman’s (1998) Emotional Competence Inventory (ECI), combines mental capacity and personality traits, including assessments of real-life application of that knowledge to situations. The ECI combines self-report measures with 360-degree feedback from others related to five key areas of self-awareness, self-regulation, motivation, empathy, and social skills, and associated emotional competencies like self-confidence, emotional self-control, and conflict management (Boyatzis et al., 2000).

Although popular, mixed models face criticism for lacking a clear theoretical foundation and potential ambiguity in disentangling the contributions of learned skills and personality traits during measurement (Mayer et al., 2012). Despite these issues, mixed models remain valuable tools for understanding EI's complexities. Their comprehensive framework explains individual differences in EI and its impact on personal and professional success, which holds particular relevance in nursing studies.

There is, therefore, no single model of EI that can be recommended for use in nursing. All three main types of EI models have been used in various nursing-related studies. The choice of model in nursing research typically depends on the specific research question and what aspect of EI researchers aim to examine. Additionally, some studies may use multiple models for comparison or to gain a more comprehensive picture. Furthermore, research on EI in nursing is still evolving, and there's no single agreed-upon definition thereby presenting challenges to the assessment and measurement of EI.

Measuring EI

The conceptualisation of EI as either a trait, ability, or mixed model is crucial for selecting an appropriate tool and ensuring the chosen assessment aligns with the chosen EI construct. O'Connor et al. (2019) emphasise the importance of EI assessors possessing a strong foundation in psychological assessment principles, particularly reliability and validity. Additionally, they note that specific EI tests like the ESCI, MSCEIT, and EQi 2.0 require specific certifications for administration. Despite the abundance of nursing studies on EI, there is no single, universally accepted definition or measurement for the construct. This challenge is further increased by the overlap between EI and emotional competence (EC). For instance, Goleman's ECI assessment tool, designed for EC assessment, incorporates both self-reported emotional knowledge, which is associated with the assessment of EI, in addition to the ability to apply that knowledge in real-life situations, which is associated with EC (Boyatzis et al., 2000; Gowing, 2001; Mayer et al., 2001).

In summary, while the recommendations from many studies include recommendations for the universal adoption of EI development in undergraduate nursing, challenges remain around the concept definition, the number of available measurement tools

(O'Connor et al., 2019), and the reliability and validity of the tools used to measure the impact of such EI-related education (Michelangelo, 2015). However, despite this lack of consensus, efforts to understand, define, assess, measure, and develop both EI and EC in nursing continue.

The Emotional Requirements of Nursing

Therefore, the emotional work of nursing requires understanding, regulating, and managing both one's and others' emotions. This necessitates developing EI to enhance professionalism, performance, intuition, and compassionate care-related skills (Kılıç et al., 2023). The recognised emotional demands within the nursing profession continue to contribute to the global interest in EI research within healthcare settings. Studies have demonstrated the positive impact of EI on nurses' performance across diverse clinical settings. For example, Dehnavi et al. (2022) found that higher EI in nurses working in special care units translated to higher self-reported clinical competence. Similarly, enhanced autonomy, quality of care and well-being were self-reported by nurses and other health workers caring for older adults when their EI levels increased (Karimi et al., 2020). Celik (2017) also found EI positively correlated with increased awareness and utilisation of emotions, leading to greater empathy for patients, improved care, and higher patient satisfaction in surgical settings.

EI in Nursing Education

Multiple studies support integrating EI development into undergraduate nursing education in response to the significant benefits for nurses associated with EI development. Studies have demonstrated the crucial role of EI in meeting the emotionally demanding nature of nursing practice, enhancing students' ability to manage their emotions and facilitating therapeutic relationships with patients (Dugue et al., 2021). Moreover, EI has also been positively linked to improved academic performance (Beauvais et al., 2014), improved clinical skills (Foster & McCloughen, 2020), and greater resilience (Cleary et al., 2018). This positive role of EI in student success is associated with enabling students to navigate challenges, resolve conflicts, and maintain motivation, leading to lower dropout rates and higher completion rates (Benington et al., 2020; Marvos & Hale, 2015). These findings collectively highlight the significant benefits of incorporating EI development into nursing curricula.

Communication, Compassion and Conflict

Studies consistently point to the positive impact of EI on nurses and patient care (Celik, 2017; Dehnavi et al., 2022; Kılıç et al., 2023). This includes fostering compassionate attitudes towards patients, which are associated with higher-quality, patient-centred care (Adams & Iseler, 2014; Maillet & Read, 2021). Studies also suggest that higher EI enables nurses to connect more effectively with patients and families, further strengthening compassionate care (Codier, 2015).

EI-related improvements in communication are associated with improved clinical performance and work-related outcomes for nurses through the ability to navigate such complex and challenging situations (Beckham & Riedford, 2017; Choudary, 2010). Erkayiran and Demirkiran (2018) also highlight the benefits for student nurses in fostering EI for positive and collaborative work environments through stronger interpersonal relationships.

EI can also lead to better communication, thereby supporting de-escalation and conflict resolution in emotionally challenging situations (Al-Hamdan et al., 2019). Similarly, Soriano-Vázquez et al. (2023) highlighted the positive impact of EI on communication skills, particularly in managing high-pressure, emotionally charged situations. All of these positive effects realised from enhanced EI are also directly associated with improved patient safety and positive healthcare outcomes (Shokry et al., 2023).

Critical Thinking Requirements of Emotional Intelligence

Early literature suggested that critical thinking (CT) was a prerequisite to EI due to the need for self-analysis and the understanding of emotions (Elder, 1997). However, more recent studies (Hutchinson et al., 2018; Mousavi et al., 2023) position EI as necessary for nurses to think critically due to the requirements of emotional awareness and emotional processing in informing the nurse's moral and ethical decision-making. Therefore, based on this assumption, developing CT in nursing students would first require them to develop or strengthen their EI. EI supports reflection on emotions and feelings, which supports self-awareness and consideration of how their bias and values impact and inform their thoughts. Student nurses are therefore required to have or

develop EI in support of being able to think critically, reflecting their joint importance for nursing success (Christianson, 2020).

Intriguingly, one study by Christodoulakis et al. (2023) investigated the mediating role of EI in the relationship between the learning environment and CT skills of mainly first-year nursing students. While a positive learning environment was not found to directly improve CT, it was suggested that CT was positively affected and can positively influence student EI, which, in turn, leads to enhanced CT. This suggests that by integrating EI into the core of tertiary teaching, education has the potential to nurture future healthcare professionals with improved critical thinking abilities, ultimately leading to better patient care.

Resilience, Well-being and the Retention of Nursing Staff

Beyond its association with patient-centred care, higher EI offers nurses significant benefits for nurses by fostering improved personal well-being. This, in turn, positively impacts the quality of patient care and contributes to retaining valuable nursing staff. Studies by Bittinger (2020) and Mazzella-Ebstein et al. (2021) highlight the crucial link between EI and effective coping mechanisms, enabling nurses to process emotions constructively and reduce burnout through enhanced resilience. Moreover, the increased coping strategies of the nurse associated with higher EI can help reduce the personal detrimental effects of stress related to the emotionally challenging work of the nurses and prevent severe consequences like burnout (Karimi et al., 2014; Kheirmand et al., 2016) thus empowering nurses to better manage the demanding and often stressful healthcare environment.

Some studies purport that nurses are vulnerable to workplace challenges that can deplete their coping ability, leading to stress and burnout, for which EI can help build a nurse's resilience (Liu & Boyatzis, 2021). Nurses with higher EI demonstrate greater awareness of their surroundings and manage their emotions effectively, leading to positive emotions, motivation, and, ultimately, reduced workplace stress (Badu et al., 2020). A study by Chikobvu and Harunavamwe (2022) in South Africa reinforces this connection, showing that both EI and work engagement significantly predicted nurses' resilience. This research showed that supporting the development of such resilience through cultivating EI-related competencies can equip nurses to handle demanding

work environments effectively. It aligns with the understanding that nurses with EI are adept at managing their emotions, leading to positive feelings and motivation. These positive emotions fuel work engagement, foster a more positive work environment, and further strengthen resilience. Chikobvu and Harunavamwe (2022) advocate for nurturing its development as a strategy to enhance nurse resilience and recognise its potential to benefit individual well-being and workplace performance.

Furthermore, Codier et al. (2009) suggest that developing nurses' EI could assist in staff retention by encouraging them to remain in the profession longer. They attribute this to nurses with higher EI being better equipped to understand and manage their own and others' emotions. Given the known challenges in nursing workforce recruitment and retention, incorporating strategies to develop EI within nursing education and professional development programmes becomes increasingly important. This is particularly beneficial in strengthening the healthcare workforce, especially in areas facing persistent nursing job vacancies.

Challenges to Implementing EI in Undergraduate Nursing Curricula

The literature highlights the important role of EI in nursing practice. While studies have shown that a nurse EI can be developed in the workplace (Codier et al., 2013; Kozlowski et al., 2018), Bellack (1999) stated that EI is both "desirable and necessary" (p. 3) and proposed integrating EI-related competencies into curricula. She proposed integrating EI-related competencies into curricula to measure their development in a similar way to the way that other skills are assessed. A more recent study by Erkayiran and Demirkiran (2018) echoed this call, emphasising the benefits of fostering EI for positive and collaborative work environments through stronger interpersonal relationships. Incorporating EI development within undergraduate education is suggested to offer both long-term and specific benefits for undergraduate nurses, such as enhanced academic performance and sustained engagement (Beauvais et al., 2014).

However, despite ongoing advocacy and documented positive outcomes, incorporating EI into undergraduate curricula consistently faces challenges. One factor noted by Hamad and Gurbutt (2023) is the relative newness of the concept in nursing education. They argue that insufficient research has been completed and that nursing often refers to outdated studies. Additional challenges to including EI within curricula can be seen

in the different ways in which EI is perceived. For example, Beauvais et al. (2011) proposed that minimal revisions would be required to incorporate EI components into mental health-related courses within existing undergraduate nursing curriculum content. However, Foster et al. (2015) suggest a broader range of approaches, encompassing educational strategies, EI skill and ability measures, screening and assessment, and learning and teaching methods.

Studies do link EI training to positive outcomes for undergraduate nursing students, including enhanced stress tolerance and resilience, potentially improving academic performance (Foster et al., 2018; McCloughen & Foster, 2018; Yildirim-Hamurcu & Terzioglu, 2022). Additionally, research by Marvos and Hale (2015) and Pence (2010) connects EI training to nursing students' improved stress management and coping mechanisms, resulting in increased student retention in undergraduate nursing programmes. However, despite widespread acknowledgment and support for including EI development in undergraduate nursing education, further work is recognised as needed for successful implementation to occur (Foster et al., 2015; McQueen, 2004; Wilson & Carryer, 2008).

Much of the literature related to EI in undergraduate nursing education recommends that further research be undertaken to understand and reduce the challenges that hinder the implementation of EI development in this field. These challenges include the lack of universally agreed-upon definitions and conceptualisations for EI, curricula content, and consensus on best teaching practices (Dugué & Dosseville, 2018; Dumitriu et al., 2014; Faralli, 2009).

Critical Discourse Analysis (CDA) Studies in Nursing

While the literature consists of many studies utilising a myriad of methodologies to research many aspects of EI in nursing and nursing education, no studies were found to explicitly examine the discourses that may impact and influence EI development (or not) within undergraduate programmes. This gap in CDA research can be seen to be attributed to two factors. Firstly, the relatively recent emergence of EI (Hamad & Gurbutt, 2023), and second, the use of CDA in nursing research remains less common than other methodologies (Smith, 2007).

CDA has, however, been used within nursing to examine various topic areas, including critical thinking (Stewart, 2017), aged care (Foster et al., 2022), child development (Einboden et al., 2013), home nursing care (Martínez-Angulo et al., 2023), social justice (Valderama-Wallace, 2017), spirituality (Cooper et al., 2022), health promotion (Dahl et al., 2014), education (Ahmadreza et al., 2017), and research (Crowe, 2005). CDA goes beyond analysing existing practices; it aims to uncover underlying power dynamics, ideologies, and assumptions embedded within the discourse. It is particularly useful in examining complex issues like educational policy, where diverse stakeholders with conflicting interests and perspectives might be involved. For example, while educational policies are often presented as neutral and focused on solutions, CDA can assist in identifying hidden power dynamics and biases within these policies (Rasti, 2023). CDA can, therefore, help identify hidden assumptions or biases potentially hindering the acceptance or implementation of EI development within nursing education.

The Literature Gap

The literature has reflected a significant interest in understanding how EI has been, or could be, developed further in undergraduate nursing education, accompanied by calls for more evidence and further review (Christianson, 2020; Dugue et al., 2021). A particularly relevant study, conducted over a decade ago by a New Zealand nursing lecturer (MacCulloch, 2011), utilised CDA to critically examine nursing-related texts concerning EC. While MacCulloch's study focused on EC rather than EI, it is important to note, as discussed at the beginning of the chapter, that these terms are often used interchangeably and are intrinsically linked. EI represents the knowledge and abilities, while EC represents the application of that knowledge, making EI a prerequisite for EC. Although MacCulloch's study did not focus on undergraduate nursing education, he specifically endorsed its inclusion stating "nursing education needed to ensure it was effectively incorporated in nurse training programmes"(MacCulloch, 2011, p. 12).

While the growing body of evidence supports the principle that all nurses require EI, and much of it promotes integrating its development within undergraduate nursing education, literature exploring this topic within the context of New Zealand is limited. One of the most recent New Zealand studies related to both emotional competence and undergraduate nursing education is by Wilson and Carryer (2008), which aimed to

understand New Zealand nurse educators' perspectives on assessing emotional competence in New Zealand nursing students, highlighting the importance of emotional competence for practising nurses in effective communication. Their findings called for a New Zealand definition of emotional competence in nursing and for educators and practising nurses to role-model emotionally competent communication. However, no further New Zealand studies were found to have built on this work or tried to address these issues. There is, therefore, a notable gap in the literature related to exploring EI in undergraduate nursing education in New Zealand. Other key areas for further New Zealand research related to EI in nursing include the examination of the intersection of EI and the Māori culture to ensure culturally safe strategies for EI development and integration. Also, another broad area worthy of investigation is the specific impact of EI on patient outcomes within the New Zealand healthcare system.

Existing EI-related nursing studies often examine EI in broader nursing contexts or focus on specific countries, hindering direct comparisons and insights into the unique challenges and opportunities in New Zealand. This study acknowledges these challenges and seeks to provide insights beyond the complexities of definition and conceptualisation. While factors hindering successful EI implementation have been identified within the literature, as discussed in the previous section, none were found to have examined the discourses influencing and impacting EI development within undergraduate nursing education. As already established, CDA goes beyond simply analysing the surface meaning of texts and examines the underlying power dynamics, ideologies, and assumptions embedded within the discourse (Fairclough, 1995). The identified gap in the research presents an opportunity for this study to contribute to the existing knowledge by employing CDA to understand the factors influencing the inclusion or exclusion of EI within undergraduate nursing curricula.

Based on this gap in the literature, the focus of this study shifted away from exploring 'how' EI development is or could be implemented. Instead, it aimed to identify and reveal previously unknown and hidden challenges that may hinder its inclusion and implementation. Therefore, this research focuses on uncovering the impact of discourses on the development (or lack thereof) of EI within undergraduate nursing education.

Chapter Summary

This chapter has discussed the numerous benefits of EI for nurses, including enhanced communication skills, compassion, resilience, and critical thinking. It is clear from the literature that where EI underpins nursing practice, it is linked to improved patient care, increased job satisfaction, and reduced stress levels for nurses. Furthermore, the chapter has highlighted the potential benefits of integrating EI development programmes within undergraduate nursing education, cited in the literature. Studies have shown that such integration can lead to enhanced interpersonal skills, improved stress management, and better academic performance, ultimately contributing to a more competent and effective nursing workforce. Finally, the chapter has concluded by identifying a significant gap in the literature regarding the discourses surrounding EI development in undergraduate nursing education. This gap presents an opportunity to utilise Critical Discourse Analysis (CDA) to understand the factors influencing the inclusion or exclusion of EI for development within undergraduate nursing education.

The following chapter discusses the philosophical underpinnings of the selected CDA methodology before outlining the data collection and analysis processes.

Chapter 3 Methodology & Methods

This chapter begins with the positionality and motivation for this CDA study, then describes the study's philosophical underpinnings, focusing on the relevance of social constructionism and critical theory. Next, it details the CDA methodology followed by the study's research approach taken in examining how dominant discourses impact EI development within undergraduate nursing education in New Zealand. This includes an explanation of the chosen research methods, the rationale for decisions made regarding the research design (e.g., document selection), and the analytical methods used to answer the research questions. Finally, the chapter discusses measures taken to promote trustworthiness and rigour within the study.

Positionality and Motivation for the Study

As a nurse and nurse educator actively engaged in undergraduate nursing education, I have observed and experienced first-hand the value and importance of EI in contemporary nursing practice alongside the detrimental effects of its absence. These personal experiences and professional insight drove my interest in exploring the factors that influence the integration of EI into undergraduate nursing education. A CDA approach was chosen as the aim was to uncover the power dynamics and social factors positively or negatively influencing the prioritisation and implementation of EI within nursing education. By identifying and critically examining dominant discourses, this research sought to understand how these factors may promote or marginalise the inclusion of EI within undergraduate nursing education.

Philosophical underpinnings: Social Constructionism

The chosen philosophy for any research study is important as it influences all decision-making and acts as a foundation for how the study is structured and undertaken. Clarifying the philosophical underpinnings of a study also assists in understanding and establishing which underlying beliefs the researcher holds (Bradbury-Jones, 2007). The researcher's justification of decisions to adopt or reject philosophy also benefits the decision-making process as it informs the process and informs what is appropriate for a study’s design, methodology, and analysis (Ryan, 2018).

In describing what social constructionism represents, Lock and Strong (2010) provided encompassing principles, namely that it is "concerned with meaning and understanding as the central feature of human activities" (p. 6), of which the iterative process of understanding language is an example and links to the premise that "meaning and understanding have their beginnings in social interaction" (p. 7). Thus, a social constructionist view of knowledge is that it is created through social interactions and interpretations of reality and constructed from experience, perspective and interaction rather than being a fixed truth waiting to be discovered (Berger & Luckmann, 1967; Crotty, 1998). Therefore, social constructionism does not seek to establish a single truth but rather what might be considered the truth based on the circumstances at the time (Gergen, 2015). Social constructionism, therefore, suggests that what is considered true is in fact developed from agreed or shared meanings within a specific social context.

The significant influence that culture has on how individuals construct reality must also be recognised and encompassed because it strongly influences what is considered within or outside of normal parameters or societal norms (Crotty, 1998). From a critical perspective, social constructionism challenges researchers to look at what is considered a normal part of reality and the reasons why. For example, the British tradition-informed idiom 'keeping a stiff upper lip', assumes that the correct response to feeling upset is to suppress all physical indications of emotional upset, whereas in other cultures, this lack of physical reaction to being upset could be interpreted as bizarre, inappropriate, disrespectful, or wrong. This example reflects how the constructed reality and 'truth' for one society may differ from another even when related to the same concept, such as 'the correct response to being upset' with neither being right nor wrong, just different. From a social constructionist viewpoint, reality is subjective and constructed through cultural influences, social discourse, and interactions, reinforcing the alignment of social constructionism within a relativist construct. Reality is constructed from our sense of it and how we understand the world. It is also influenced by historical and sociocultural elements, making it challenging to think differently from what we consider is 'normal' (Burr, 2015; Crotty, 1998). Social constructionism, therefore, argues that language plays a central role in shaping our reality and that our knowledge, values, and beliefs are constructed

through social interaction and historical processes. In acknowledgement of the role of power in shaping social realities, there is an acceptance that some groups are dominant over others, thereby having a more significant influence and marginalising the perspectives of other, more minority groups.

Critical Theory

Critical theory, influenced by theorists such as Karl Marx, Immanuel Kant, Theodor W. Adorno, Herbert Marcuse, Walter Benjamin, Jürgen Habermas, and Max Horkheimer, exposes and counteracts challenges that are embedded within societies such as exploitation, repression, and alienation (Bronner, 2017). In explaining societal structures and problems, critical theory examines social practices to assist in understanding and enhancing individual freedom and social justice, enabling practical solutions to be found (Horkheimer, 1982). As a function of critical theory, the critique of society and culture draws from knowledge across the social sciences and humanities. This interdisciplinary or transdisciplinary approach is a core tenet in analysing complex social problems and their application across different social, political, and cultural phenomena (Fairclough & Wodak, 1997; Unger, 2016; Weiss & Wodak, 2003).

Critical theory, therefore, promotes the analysis of power structures and underlying assumptions embedded within society and culture. As Crotty (1998) states, critical theory acknowledges that the reality is that "some people have dominant power; others have far less power; most have no power at all" (p. 63). This power imbalance leads to oppression, manipulation, and coercion, which critical theory seeks to unveil and dismantle. Driven by the ideal of social emancipation and freedom, critical theory strives to empower marginalized voices, dismantle unjust systems, and ultimately create a more equitable and just society (Browne, 2017).

The critical part of CDA reflects a solid philosophical relationship with critical theory. It seeks to identify what is wrong in society and promote positive change (Macaraan, 2015). Fairclough (2010), whose CDA three-dimensional framework was used for this study, stated that the critical part of his CDA framework is within the analysis, where systematic exploration of discursive practices, events, texts, and broader social and cultural structures occurs. The analysis also includes the examination of relationships

and processes to show how practices, events and texts are ideologically shaped and arise through their connection with power. Therefore, the critique does not focus on precise details or isolated instances. Instead, it views them as part of a broader social system with the more minor specific details considered part of the "underlying character of the social system within which they exist" (Dant, 2003, p. 7). It challenges reductionism by not taking things for granted, revealing complexity, dogmatism, and dichotomies, encouraging the researcher to apply reflexivity to assist in making opaque structures of power relations more apparent through these processes (Wodak, 2001). It supports the premise that to improve or better inform current situations, a critique of the existing assumptions in discourses is required alongside a focus on the holders of power. Critical theory, therefore, requires that social and historical forces be included in the critique because most critical theorists agree that they influence the creation of assumptions (Howell, 2013).

Critical theory supports social transformation by uncovering ideologies underpinning dominance. It seeks the empowerment of people through exposing and challenging the social relationships existing within a society's culture. Critical theory operates through its critique of society by exposing "ideas, understanding, reasons, images, writing and other modes of expression that accompany the material dimension" (Dant, 2003, p. 156). Therefore, in relating theories of language to theories of society, CDA seeks to identify issues related to ideology, power, and inequality. CDA relies on social theories to develop a critically contextualised approach that assists in understanding through analysing the socio-cultural context within which the discourse exists (Fairclough, 2018). In this study, critical theory and social constructionism formed the basis of an analysis that was carried out to better understand the influences on the sociocultural context of nursing and, more specifically, the emotional development of undergraduate nurses in relation to their practice.

Critical Discourse Analysis

Critical Discourse Analysis (CDA) emerged in response to limitations within critical linguistics, which were perceived to neglect the broader socio-cultural context (Blommaert, 2005). CDA goes beyond just studying language itself; it looks at how language shapes knowledge and understanding, the consequences of its use, and, importantly, how it exerts power and social influence (Lock & Strong, 2010). By

incorporating the socio-cultural context, CDA offers an alternative to traditional scientific approaches to studying social issues. It embraces subjective and interpretive methods, applying a critical lens to social issues by prioritizing critique and social transformation over detached objectivity (Howell, 2013).

CDA is a well-established field within social sciences that reveals the relationship between language and the social world, illuminating the existence of power, injustice, and inequity within society (Fairclough et al., 2011). Moving beyond just understanding the meaning of words, CDA can assist researchers in exploring how language reflects and shapes social realities (Fairclough & Scholz, 2020). CDA scrutinises discourses by examining discursive practices, encompassing linguistic elements (e.g., speech and written text) and non-linguistic social practices (e.g., diagrams and pictures). This analysis considers how language is presented and how sociocultural factors and societal power relations affect it. The critical aspect of CDA distinguishes it from discourse analysis (DA) by focusing on power, exploitation, manipulation, and social inequities. Drawing from various theoretical perspectives, such as critical theory, CDA establishes links between social practices and underlying assumptions embedded within the discourse.

According to German philosopher Wittgenstein (1980), language shapes how we perceive the world. Rather than a neutral reflection of reality, language can restrict our understanding. Selective use of language can foster limited views. CDA assists in uncovering these hidden or non-obvious restrictions by illuminating how dominant societal forces influence reality through language. By revealing taken-for-granted assumptions within texts and meaning-making processes, CDA exposes how social discourses are impregnated by dominant discourses projected from sources of power. (Van Dijk, 1998). The understanding gained from this can provide insight into covert ways in which language is used to influence or restrict understanding.

The Origins of CDA

CDA began as a direction of work in the 1980s amid concerns that critical linguistics had omitted the consideration of social hierarchy and power. In addition to literacy studies, CDA borrows from sociolinguistics, communication, and culture studies to support the interrogation of discourse for ideologies and power relations, drawing on

the work of scholars such as Karl Marx, Antonio Gramsci, Louis Althusser, Jürgen Habermas, Michel Foucault, and Pierre Bourdieu (Catalano & Waugh, 2020). By 1992, CDA had developed into a movement spearheaded by a group of text-focused linguists, including Norman Fairclough, Gunther Kress, Teun van Dijk, Theo van Leeuwen, and Ruth Wodak, who continue to be instrumental in its development (Catalano & Waugh, 2020; van Leeuwen, 2006). Their focus shifted towards understanding language as a form of social practice and analysing how societal power relations are established and reinforced through language. The scholars engaged with social questions relating to power and ideology as an extension of their linguistic analysis, with the *critical* part of CDA aiming "to help reveal some of these hidden and 'often out of sight' values, positions and perspectives" (Paltridge, 2012, p. 186).

Understanding the effects of power on political and social change enables an understanding of what influences people, what is considered to be acceptable ethically, what is possible in practical terms, and what is reasonably thinkable (Blommaert, 2005). CDA studies aim to systematically explore the causal relationships between discursive practices, events, texts, and the broader social and cultural structures. Fairclough (1995) describes this goal as helping examine "how such practices, events and texts arise out of and are ideologically shaped by relations of power and struggles over power" (p. 132). Wodak (2001) emphasises that CDA is "fundamentally concerned with analysing opaque" and "transparent structural relationships of dominance, discrimination, power and control as manifested in the language" (p. 2). This reinforces the notion that reality is changeable and emphasises that ideas, facts, and knowledge are not static but alterable as the discourse changes (Williamson et al., 2018). The assumption, then, is that reality is constructed through interaction and mediated by the use of language and increased understanding of factors such as power, domination, or discrimination, leaving reality open to change, potentially for the better (Huckin, 1997).

The foundation of CDA lies in embracing multiple realities constructed by individuals through experiences and knowledge within each unique socio-cultural context. CDA is, therefore, congruent with a relativistic ontology and the social constructionist standpoint whereby multiple realities are accepted as possible rather than a singular

phenomenon constructed by people based on their experiences and knowledge within a socio-cultural context.

Fairclough's CDA Methodology

Fairclough's CDA methodological approach was selected as it supported the analysis of written text analysis and had also been successfully used within nursing research. The approach to CDA promoted by Fairclough (1995) met both of these criteria, with examples of nursing studies having been undertaken using his methodology, including topics of critical thinking (Stewart, 2017), older adult immigrant patients in hospitals (Vestgarden et al., 2023), home-care nursing in primary health care (Fjørtoft et al., 2022), and spirituality and standards for practice (Cooper et al., 2022).

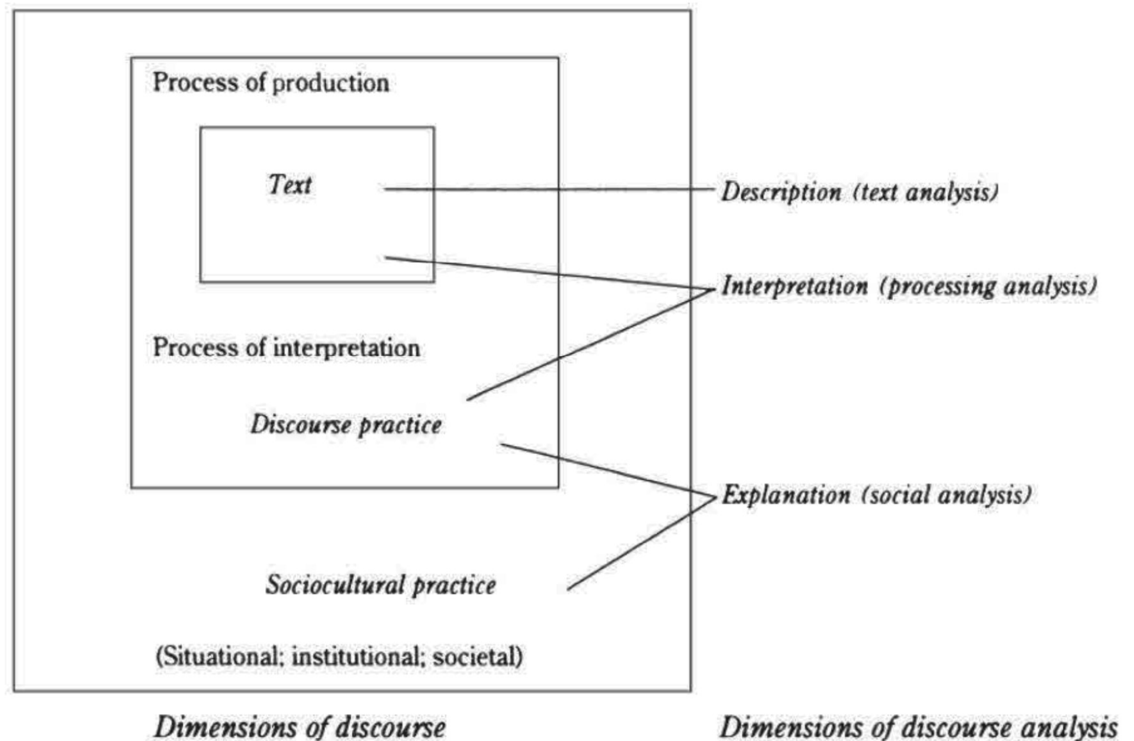
Fairclough is considered one of the founders of CDA's textually oriented approach, which systematically examines relationships of causality and determination between discursive practices, events, and text on the basis that power dynamics shape social situations (Fairclough, 1995, 2001, 2005, 2010). It is informed by Foucault's discourse theory, which posits that power is everywhere and is maintained and understood through accepted knowledge (Fairclough, 2015). Michel Pecheux's Althusserian approach to language and ideology and the critical linguistics work of Roger Fowler and Gunther Kress are also identified as among some of the early influences on Fairclough's approach. Other early influencers include "Basil Bernstein, Pierre Bourdieu, Michel Foucault, Jurgen Habermas, Stuart Hall, Ernesto Laclau, Marx, and Chantal Mouffe" (Fairclough & Scholz, 2020, p. 114).

The approach promoted by Fairclough (2010) is based upon the premise that the concept of discourse or any discursive event can be viewed simultaneously as operating three-dimensionally within (i) a language text that can be either spoken or written, (ii) discourse practice (text production and text interpretation), and (iii) sociocultural practice (how it is embedded in sociocultural practice). Fairclough viewed

any given text as able to be interpreted across these three levels of analysis and offers a 3-dimensional framework for CDA to illustrate his approach (see Figure 1).

Figure 1

Fairclough's Model of the Interrelationships Between the Dimensions of Discourse and Dimensions of Discourse Analysis Provides a Framework for CDA (Fairclough, 2010, p. 133).



Fairclough's model of the interrelationships between the dimensions of discourse and discourse analysis provides a framework for CDA. The innermost part of Fairclough's framework for CDA (Figure 1) represents the textual analysis that is required in examining text at a descriptive level. The next level is the discourse practice, wherein processing analysis requires the interpretation of the text. The questions asked during this part of the analysis are how the text is produced, who has access to it, who is the intended reader, and what discursive practices are being used to influence the reader. The final level is the social analysis part of the framework, which requires an explanation of the relationship and interaction of the discursive content and the sociocultural context practice within which the text is embedded. It requires identifying and examining the social events and activities within the society that the

discourse represents, examining what may influence and impact the text. As purported by Fairclough (2015), this third level of analysis requires a good understanding of the society being studied and how the discourses operate within it so that critique and explanations can be made within that specific social reality. Without this understanding, the opportunity for any positive change may not be recognised or revealed. Therefore, my being a lecturer within undergraduate nursing education is seen as not just an advantage but a necessity for the knowledge, insight, and understanding that I bring to this research. The level of involvement, however, comes with a responsibility to ensure that rigour is applied to the study through reflexivity as a tool to reduce the risk of biases and assumptions impacting claims and findings (Cheek, 2000; Darawsheh, 2014; Peddle, 2022).

Consistent with social constructionist Fairclough's (1995) three-dimensional framework provided an overarching guide to the analysis in this study, directing the first level of analysis to investigate how EI is represented within the texts (description), followed by the identification of which discourses were influencing how EI is expressed within the text (interpretation), and, finally, understanding the impact of the dominant discourses within the socio-cultural context of undergraduate nursing education, including the impact of the context upon the discourses (explanation).

Research Methods

As has been established, CDA is not a simple study of language alone; instead, congruent with its social constructionist and critical theory underpinnings, it considers how language is used and shapes knowledge and understanding, what results from its use and, most importantly, how it exerts power and social influence (Lock & Strong, 2010). As a nurse and teacher of undergraduate nursing students, I am actively engaged within the 'society' being studied, and it is through my experience within that society that the motivation for the research question was founded, as shared earlier. Bloor and Bloor (2007) stated that the research question, the nature of the social problem, and the disciplinary background of the researcher all play a part in selecting a CDA methodology. As this study required the examination of written text, a CDA methodology that specifically supported the critical analysis of the language used in written documents was selected. While the selected methodology for the study was a Critical Discourse Analysis (CDA) based on Fairclough's (1995) model of CDA, the CDA

methods employed were based on that designed by Huckin (1997), which requires engaging with the text in an uncritical and then analysing the text critically and draw attention to how language mediates and controls meaning.

Discourse

Defining discourse is important because the term holds various definitions depending on the context and disciplines involved (Burr, 2015). Therefore, establishing a clear understanding of discourse is also fundamental to ensuring rigour and clarity. French philosopher Michel Foucault (1971) conceptualised discourse as a system of rules and practices that shapes permissible ideas and expressions within a society. Discourse, therefore, also extends beyond language, encompassing non-verbal communication such as gestures, images, and sounds (Fairclough, 2010). Additionally, interpreting and making sense of these discursive practices requires cognitive effort to grasp the embedded meanings which are influenced by factors like power, purpose, and context (Van Dijk, 2016).

Discourses can be viewed as part of social practice (Fairclough, 2015), wherein discourse constructs identities, relationships, and knowledge systems. Discourses can provide structure and influence what is considered acceptable and usual behaviour based on the rules constructed within that discourse. They can also be transformed into practice as assumptions taken for granted, invisible, or assumed (Bloor & Bloor, 2007).

Discourses both shape and reflect society. The discourse of a particular group in society can reflect a shared sense of what society considers normal. It can also exert control over groups through manipulating and influencing the promotion or undermining of knowledge to influence and control behaviours and shape the values, beliefs, and interactions with that society. Therefore, discourse can represent and influence society through ideas, concepts, or a patterned way of thinking from which a particular set of practices, physical and social realities, and ideologies can be reproduced and provide meaning (Hajer, 1995).

When speaking about discourses, Fairclough (2015) emphasises that discourses are inherently value-laden and reflect a group's prevailing ideologies, belief systems, and

social practices. They can also be seen as assumptions shaping reality and concealing power dynamics embedded within language (Fairclough, 2015; Orlowski, 2012). This power is not evenly distributed, with individuals or groups holding varying degrees of influence over how discourses are developed and interpreted (Somerville, 2002).

Discourses are, therefore, a dynamic construct. Building upon the concept of "orders of discourse" from Foucault (1971), Fairclough (1995) connects discursive practices with social institutions and their power dynamics. This approach highlights how individuals with power shape the social order and reveals the hidden and explicit power embedded within discourses. Furthermore, Fairclough emphasises the role of discourse in facilitating the transmission of practices, meanings, values, and ideologies, ultimately shaping our understanding of ourselves and our relationships within the social context (Fairclough, 2001, 2010).

Discourses can be seen as “socially and culturally produced patterns of language, which constitute power by constructing objects in particular ways”, with recognition required that “discourses are not fixed, but change over time as the social institutions which produce them change” (Francis, 2000, p. 21). While some discourses hold more significant influence than others, they all reflect a fluid and subjective representation of social institutions and their power dynamics while also receiving influence from the society they represent. This complexity highlights one of the key challenges faced in selecting a methodological approach and design capable of encompassing the critical analysis of all these factors that is rigorous and trustworthy.

Document Selection

In order to analyse the discourses informing and impacting the development of EI in undergraduate nursing education, I needed to establish and select appropriate data sources. The selection of documents containing the text for analysis was a critical decision as part of the research design. The rationale and justification for selecting the specific documents for analysis were based on the requirement to examine the discourses influencing the development, or otherwise, of the EI of undergraduate nursing students in New Zealand. The documents needed to contain enough relevant text to complete the textual analysis and answer the research questions. They needed

to be influential in the development of undergraduate nursing students' EI and be likely places where EI development might be expected to appear.

The exclusive focus on selected written texts is a recognised, legitimate, and common way to employ CDA to identify where persuasive language can distort the truth in subtle ways (Bloor & Bloor, 2007). While the social construction of reality and identification of influential discourses can also be externalised through physical and verbal social practices, this CDA research focused purely on written text contained within existing influential documents related to the undergraduate education of student nurses. The documents selected for the study all contained text that had been purposefully produced in written form as opposed to written text that has resulted from other sources (e.g., a transcription of spoken words into written form). This distinction is important to note because written text usually follows established conventions in how the words are presented in sentences, which would differ if used in conversation. They also differ in format because of the many different conventions followed. For example, a report and a textbook have distinctly different ways of presenting information. Another significant difference inherent in written text is that it is read, in most cases, in isolation from the author/s who is/are absent. For example, textbooks are written, produced, and then read by others without the author/s presence. Thus, it is the words of the writer that are presented for interpretation, and only through the text can the author(s) attempt to exert influence or manipulate how the text is interpreted. However, the final interpretation is left to the reader. Therefore, in using a CDA to examine the documents, it is not just which words are chosen and the way words are presented but also the order and characteristics all contribute to the privilege or priority of specific discourses, influencing what is accepted as the truth. Consistent with its critical theory underpinnings, CDA attempts to reveal the truth by examining and identifying any manipulations within the text, intentional or not, that exert power and influence over the reader.

The current study was developed in response to a lack of understanding as to the extent to which the discourses within New Zealand undergraduate nursing education influence the inclusion and teaching thereof of EI development. The content of five documents considered influential in the education of undergraduate nurses was examined and analysed to assist in identifying the dominant discourses impacting upon

the development of EI in undergraduate nursing education. The five documents selected for analysis included the *Competencies for Registered Nurses (Nursing Council of New Zealand, 2012b)*, a textbook commonly used in New Zealand undergraduate nursing education (Crisp et al., 2017), and three different tertiary institutes' undergraduate nursing degree curricula (see Table 1).

Table 1 Documents Selected for Analysis

	Author of document	Document title	Purpose of document
1	NCNZ / Te Kaunihera Tapuhi o Aotearoa (2012b)	*Competencies for Registered Nurses*	Professional document with a regulatory function
2	Crisp, J., Douglas, C., Rebeiro, G., & Waters, D. (Eds.). (2017)	*Potter & Perrys Fundamentals of Nursing* (5th ed.)	Textbook
3	Tertiary Institute 1	Undergraduate nursing curricula 1	
4	Tertiary Institute 2	Undergraduate nursing curricula 2	Educational and Professional documents with an informative function
5	Tertiary Institute 3	Undergraduate nursing curricula 3	

The first text selected was the *Competencies for Registered Nurses* by the professional regulatory body NCNZ / Te Kaunihera Tapuhi o Aotearoa. It is an important professional document that mandates the requirements for registered nurse competence and is publicly available through the NZNC website. The competencies are prescriptive of how registered nurses should behave and perform as professionals and have direct links with the education of nurses because all programmes delivering nurse education must have a structured curriculum that enables students to achieve the NCNZ's *Competencies for Registered Nurses* as stipulated in *Appendix 4: Education*

Programme Standards for the Registered Nurse Scope of Practice in the *Handbook for Pre-registration Nursing Programmes* (NCNZ, 2012b; 2021b, 2022a).

Next, a general nursing textbook that multiple New Zealand tertiary institutions used to supplement undergraduate nursing education was selected. Selecting and analysing a widely utilised general nursing textbook allowed for broader trends and challenges in nursing and nursing education to be identified and to identify how EI was (or wasn't) represented, defined or conceptualised as part of nursing practice across the breadth of nursing and nursing education. The textbook selected was on the recommended reading list for the three tertiary institutes whose curricula were examined, supporting the textbook editors' claims that it is the most successful fundamentals text ever published for nursing students across Australia and New Zealand (Crisp et al., 2017). Therefore, the content was considered more likely to reflect the dominant discourses and professional and knowledge frameworks commonly used in undergraduate nursing education for those tertiary institutes' whose curricula were also being examined. It was also chosen as the most suitable of the textbooks considered, as unlike the others, it adapted global nursing knowledge to New Zealand-specific cultural and socio-economic contexts. Therefore, this meant that it was more likely to reflect the dominant discourses and knowledge frameworks within New Zealand nursing, and specifically undergraduate nursing education. The textbook was analysed to provide insight into how information and discourse are shaped, promoted, and presented to the nursing profession concerning EI skills development. The analysis was completed to uncover discourses and their influence within undergraduate nursing education and determine whether EI development was promoted explicitly, implicitly, or absent.

Including three undergraduate nursing curricula as the final set of selected documents to be examined was a logical choice. Curricula are both professionally and educationally influential texts that reflect what is being delivered at a tertiary institutional level. The purpose and content of a curriculum for a profession such as nursing can be described as being:

> implemented with the intention that learning will occur and student potential will be unlocked… there is a written plan that usually contains philosophical statements and goals or outcomes… [it also] indicates some selection,

> organisation, and sequencing of subject matter and learning experiences and integrates evaluation of learning. (Iwasiw et al., 2020, p. 24)

All undergraduate nursing curricula in New Zealand are developed based on nationally mandated educational and professional requirements stipulated within the *Registered Nurses Education Programme Standards* (NCNZ, 2021b). All tertiary institutes delivering undergraduate nursing education programmes were contacted via email and requested to provide their curricula for analysis. Three institutes provided their complete curricula documents, and several declined to participate in the study. A second attempt was made with the tertiary institutions who had not replied however, no further curricula were obtained. Reasons for declining participation in the study included that they considered the content of their curriculum to be commercially sensitive or that the curricula were about to be reviewed and/or changed, and so they did not believe it should be examined as part of the study. The institutes that provided a curriculum included two polytechnics and one university. The institutes were from the North and South Islands of New Zealand and included regional and city-based programme delivery. Each of the institutes expressed keenness to see the completed findings. While the curricula documentation format differed between the institutes, documentation was sought from each tertiary institute to include the programme philosophy, graduate profile, theory and clinical course paper outlines and assessments of each paper taught within the full-time 3-year Bachelor of Nursing Degree programme. The programme philosophy and graduate profile contributed significantly to the positioning and understanding of the curriculum context as presented in the course paper outlines.

As the study examined documents that were all available to the public, and no human participants or personal data was involved in the study, ethics committee approval was not required.

Two-stage Analysis of the Text

The research methods for this study are the tools and techniques used to collect and analyse the data based on the CDA methodological requirements and the research questions (Crotty, 1998; Fairclough, 2010). The analysis focused on the identification of discourses rather than the pure linguistics of the text, which Huckin (1997) highlighted

does not require exhaustive details of the text but instead looks for where textual manipulations occur to serve “non-democratic purposes” (Huckin, 1997, p. 80). The analysis focussed on how EI development was represented within the selected documents, including any direction for it to be taught as part of the education of undergraduate nurses and any assumptions or expectations that the student nurse should already possess EI. The analysis did not rely on ‘keywords’ to assist in the identification of text relevant to the broad concept of EI; rather, its conceptualisation, as discussed in Chapter 2, informed what was deemed relevant. This involved identifying text that was related to a requirement of EI, through it being spoken about, alluded to or implied as being required. For example, in the second document analysed, the statement was that “it is the role of the nurse to deliver care in a way that the patient deems culturally safe” (Feo et al., 2017, p. 35). Therefore, whilst EI is not explicitly mentioned, in being culturally safe, nurses are required to have and utilise EI to assist in being able to understand their own biases, manage their emotions, communicate effectively, and empathise with patients from diverse backgrounds so that they can provide culturally sensitive and effective care.

The CDA method employed followed the two-stage process for analysing text developed by Huckin (1997) based on Fairclough's CDA framework model, which reflects the interrelationships between three dimensions of discourse (Fairclough, 2010). The analysis varies in granularity, ranging from focusing on single words, sentences, and phrases to the textual examination of the text as a whole. Huckin advised that during the first of the two analytical stages, the researcher only notes salient features of the text because this stage aims to reveal the higher-level concepts. It also includes discursive processes and broader contextual factors that may conceal manipulations and are considered by Huckin as especially pertinent to the abuse of power. Following completion of this high-level analysis of the whole text, the second stage commences, moving through the levels of text from phrase to sentence and then individual word analysis, and repeating as necessary (Huckin, 1997). Huckin referred to the first of these two stages as the ‘uncritical stage’ of analysis of the text, which must be completed fully before moving on to stage two, the ‘critical stage’ of analysis. This systematic two-stage analytical approach was applied to all five selected documents and is outlined later in the chapter.

Huckin (1997) highlighted six important features considered specific to CDA. The first is that texts are not produced in isolation with a single meaning but are consumed in a real-world context. Thus, the context contributes to both the production and consumption of the text, making it highly context-sensitive. Therefore, in examining the texts in this study, it was important to take into account socio-cultural and historical contexts so that a deeper understanding could be gained as to how they shape nursing knowledge and practice. For example, how much government policies and healthcare reforms can be seen to have influenced language, terminology and content.

The second feature specific to CDA is that it is a highly integrated form of discourse analysis that aims to reveal the interrelationships between the different levels of analysis; namely, the aforementioned textual analysis, processing analysis, and social analysis from Fairclough's (2010) CDA framework. The third feature specific to CDA is that it includes both the immediate environmental context and larger cultural and political societal context, as is reflected in the sociocultural practice level of Fairclough's framework where social analysis occurs. For example, a nursing textbook may focus on technical skills and knowledge, prioritising biomedical approaches. While it may acknowledge the importance of patient-centred care, it may inadvertently downplay the importance of emotional intelligence and interpersonal skills, considered essential for effective nursing practice. The fourth feature is that an ethical stance is typically taken by CDA practitioners, drawing attention to power imbalances and social inequities, which brings in the critical part of CDA in that it is explicitly critical of practices where the influence of power can be seen rather than simply highlighting its existence. For example, building on the previous example, where the CDA practitioner exposes power imbalances and social inequities by highlighting the limitations of a purely biomedical approach and advocating for a more holistic model of care that prioritises patient-centeredness, empathy, and social justice.

The fifth feature is that CDA assumes a social constructionist view of discourse with post-structural philosophies followed by an assumption that people's notions and ideas are mainly constructed through interaction with others and with reality being open to change, potentially for the better. CDA tries to illuminate how versions of reality that are constructed by dominant forces benefit themselves and their own

agenda; for example, within nursing, one of the driving discourses for EI development in nurses is the managerial discourse that focuses on keeping staff emotionally well and able to fulfil their occupational and professional duties thus avoiding burnt out, or needing to be off work through sickness. The illumination of such practice can enable resistance against the forces. It can change the narrative to support EI development being prioritised to support personal and professional health and well-being as part of the employer's responsibility to nurses rather than the nurse's responsibility to the employer and profession.

Finally, the sixth feature is the resistance against "scholarly jargon" and unnecessary complication of what is presented; avoiding "convoluted syntax" (Huckin, 1997, pp. 78-79) even if this impacts a loss of precision in the analysis. CDA is purposively clear in what it articulates because it tries to illuminate hidden practices, such as textual manipulations that are "serving a non-democratic purpose" (Huckin, 1997, p. 80), meaning they are not neutral but rather 'carry weight' that is attempting to influence the way the text is interpreted. For example, the use of medical jargon without explanation or rationale in a nursing textbook can create a sense of authority and expertise while also excluding some nurses or student nurses unfamiliar with these terms.

Stage One – Uncritical Stage

Huckin (1997) described the first stage of analysis as requiring the uncritical reading of the text as a whole. It requires the reader to establish the target readership where it is not explicitly stated to assist in the 'role-play' of a typical reader consuming the text; that is, "how an intended reader might read and react to the given text" (Huckin, 2002, p. 158). In preparing for this first stage, the background and history of each text was established to establish the purpose and support the development of a 'typical reader' profile by building on what was explicitly stated within the text and asking questions such as "Who is the target audience for this text? What sorts of interests and background knowledge might such readers have in common? What is the purpose of this text?" (Huckin, 2002, p. 158). This process assists in understanding what the author may have intended to convey to its 'intended reader'. While appearing straightforward, this uncritical stage is regarded as extremely important to understand what the author intends for the reader to receive. In this first uncritical stage, the

reader notes only what stands out as being communicated. It provides information to be considered during stage two of the textual analysis, contributing to the detection of any manipulations of the reader that are being used within the text.

Stage Two – Critical Stage

The second stage moves from the uncritical to the critical analysis of the text where the reader steps back from the text to examine it more thoroughly to assist in questioning and comparison (Huckin, 1997). The initial step in stage two required a critical examination of the text as a whole and my initial reaction to it, acknowledging and considering what was noted in the uncritical review. I was mindful that this step supports the appreciation and identification of where, in the presentation, any manipulation occurs. Huckin (1997) also advised consideration of identifying characteristics such as agency, presuppositions, insinuations, connotations, register, and modality, as outlined below. This second stage requires revisiting the text for characteristics such as genre, framing, foregrounding, and omissions. It involves looking for manipulations at the word/phrase level and sentence/utterance level in a critical way and asking questions of the text about what is (and is not) presented, how it is presented, and the influences on why it is presented the way it is (the socio-cultural context within which it exists).

When moving from large (text level) to small (word level) and comparing it to other related texts, Huckin (1997) warned not to lose sight of things noted in the uncritical stage because this supports the identification of features that may be “misleading the unwary reader” (p. 81) and will need critical analysis during stage two. As part of identifying relevant data in stage two, the textual characteristics of excerpts considered to be associated with emotional competence were explicitly looked for at the word/phrase level, sentence/utterance level, and the whole text level. Huckin’s approach helped to identify specific characteristics to be examined. Their ascribed meaning and application are provided in the next section.

Word/Phrase Level Analysis

According to Huckin (2002), at the word/phrase level, the concepts include classification, connotation, metaphor, lexical presupposition, modality, and register.

The following characteristics were looked for in the texts and examined with a focus on how they were applied to EI.

Classifications and Connotations

Classification refers to the labelling of things from which the writer's stance can be positioned. Huckin (2002) provided an example with the word 'abortion', as virtually impossible to refer to in entirely neutral terms (e.g., opponents of abortion are labelled pro-life by sympathisers and anti-choice by opponents). In addition, Huckin noted that certain words and phrases (lexis) carry additional, special meanings (or connotations) derived from the frequent use of a word or phrase in a particular type of context and refers to the associations and nuances of meaning that go beyond a word's dictionary definition. A nursing-related example is use of the word 'appropriate', which assumes that the nurse or student nurse is aware of what is required or expected to be done in each of its applications.

Metaphors

A metaphor is a word or phrase used to refer to something that highlights a direct similarity between the word or phrase and the described thing, such as 'the patient got cold feet and refused the operation'. The understanding is provided through understanding the thing used to represent it and comparing the two. Huckin (2002) noted that writers commonly use metaphors to assign meaning to what is being said (Huckin, 2002). An example was found in the second document in the phrase, "The bottom line is that the process of clinical reasoning is the basis for your practice as a registered nurse" (Douglas & Crisp, 2017, p. 54). The bottom line is a financial metaphor related to the final line of a financial statement showing net profit or loss and is used to indicate the essential essence of the point being made. This usage suggests the statement is the most important, emphasising the authority claimed by the 'expert' authors in their provision of knowledge.

Presuppositions

Huckin (1997) described presuppositions as notoriously manipulative because they are difficult to challenge when presented as facts without question. These are words or phrases that assume the truth without providing any validation; for example, 'caring nurses'. While the trait of caring may be true for a great majority of nurses, it certainly

cannot be guaranteed as absolute truth. Caring is also a term used in relation to EI as it communicates that there is emotional understanding and management by the nurse. Presuppositions can also be used as part of sentences/utterances. For example, the sentence 'the patient was thankful for Jane and the other kind nurses on the ward' presupposes that all the nurses, including Jane, are kind.

Modality

Huckin (2002) described modality as referring to the tone of statements and the degree of certitude in which they are delivered. Examples include modal verbs words and phrases like 'it is possible', 'may', 'might', and 'could' have a lesser degree of certainty than words such as 'will' and 'must' or phrases such as 'without a doubt' or 'inarguably'. Huckin highlighted that modal verbs and phrases can convey an air of heavy-handed authority or attitude while, at the opposite end of the spectrum, a tone of deference. Modality can, therefore, have a similar impact to presupposition in that the forcefulness of tone conveyed can communicate that what is being proposed is beyond question. For example, in the sentence, "All nurses should always try to provide emotionally competent care" the modal verbs "should" and "try" softens the directness of the command and instead suggest obligation and possibility rather than absolute necessity. This can be interpreted as a way of constructing nursing as a profession that is both caring and pragmatic.

Register

Register refers to the 'linguistic style' of discourse and can communicate the level of formality or informality of a text, including the subject and related technicality. For example, Huckin (2002) alerted the reader to attempts by writers to deceive readers by using a "phoney register" (p. 160), as is sometimes used in advertisements to invoke a misplaced trust through employing a friendly conversational register or an authoritative expert register. For example, the way nurses communicate in written patient records differs significantly from their verbal interactions with colleagues. For instance, the formal and precise language used in documentation contrasts with the more informal and conversational style of verbal handover reports.

Sentence/Utterance Level Analysis

Huckin (2002) highlighted that the most useful analytical concepts to be used at the sentence/utterance level are “transitivity, deletion, topicalisation, register, politeness, presupposition, insinuation, and intertextuality” (p. 160).

Transitivity

Transitivity relates to the relationship of “who is doing what to whom?” (Huckin, 2002, p. 160) and where the sentence’s primary semantic agent (or actor) could be depicted as having more or less power or importance. Examples include how the teacher is positioned concerning the student in the following two statements: ‘the teacher was *helping* the student to understand’ or ‘the teacher *warned* the student of the risks associated with …’. In both examples, the teacher is implied as possessing more knowledge than the student through the requirement to transmit information in a ‘helping’ or ‘warning’ way. The teacher is seen as the holder of more knowledge and power than the student when examining the relationship of ‘who is doing what to whom’.

Deletion and Omission

Deletion refers to the deliberate omission of information. The exertion of power or dominance can favour some text (foregrounding) and/or omit others (an extreme form of backgrounding). Uncovering the effect of the omission assists in revealing the nature or intended purpose of the omission. For example, the legal name for the new institute that represents New Zealand’s merged Institutes of Technology and Polytechnics (ITPs) and Industry Training Organisations (ITOs) across Aotearoa New Zealand is Te Pūkenga – New Zealand Institute of Skills and Technology. In introducing the new name on the governmental website, Te Pūkenga’ s Chief Executive, Stephen Town, is quoted as saying: “A name that uses both te reo Māori and English highlights the organisation’s commitment to partnership under the Treaty of Waitangi” (New Zealand Government, 2020). However, New Zealand Institute of Skills and Technology is omitted from the webpage and logo, and only appears where the institute’s legal name is required (i.e., in government legal documents). This deliberate omission can be seen as a purposeful branding strategy. It is explained within the website that the name *Te Pūkenga* is a “new permanent unifying name” that “reflects our new tertiary

institute's commitment to New Zealand's unique heritage and our relationship with tangata whenua" (New Zealand Government, 2020), something that that was being promoted throughout the policies of the then Labour-led government.

Register

While register has been noted as being affected at the word/phrase level, Huckin (2002) contended that the syntactic and lexical differences in the sentence structure also affect the register and include different speaking and writing styles. At the sentence and utterance level these shifts occur to how the phrases are structured (syntactic differences) as much as to the individual words used (lexical differences).

Politeness

Politeness is closely related to the register used. Positive politeness can be seen as a way of establishing solidarity with the person on the receiving end. It can be as simplistic as including the use of words such as please or acknowledgement statements. In contrast, Huckin (2002) highlighted that *negative* politeness can create a barrier and maintain privacy and independence from the receiver.

Insinuation

Insinuations are devious comments or unpleasant hints that Huckin described as slyly suggestive and difficult for readers to challenge because they typically have double meanings. If challenged, the writer can claim innocence, pretending to have only one of these two meanings in mind. Huckin noted that this is similar to what Hodge and Kress call an ideological complex (Hodge & Kress, 1988; Huckin, 1997, 2002). An example in nursing could be that the statement 'a professional nurse finishes their shift on time', on the one hand, can be claimed to be valuing the time management of the professional nurse in the completion of their duties; on the other hand, the insinuation could be seen that if the nurse does not finish on time, they are being labelled as not being professional even though it may be unavoidable (due to poor staffing levels, for example).

Text Level Analysis

Huckin (2002) referred to text-level concepts as including “genre, heteroglossia, coherence, framing, extended metaphor, foregrounding/backgrounding, omission, and auxiliary embellishments” (p. 161).

Genre

Fairclough (2001) described genres as encompassing the different ways in which people are required to behave and act as part of ‘producing social life’ and may include “everyday conversation, meetings in various types of organisation, political and other forms of interview, and book reviews” (Fairclough, 2001, p. 123). Therefore, genre is important because it frames how the audience should comprehend the text. As a characteristic within discourse analysis, it can be used to manipulate the consumer of the text. The discourses present information in a particular way with a style relating to the framing and positioning of the text for the consumer. Examining these characteristics supports looking at how similar aspects of the world can be appreciated and understood from different perspectives or positions, as expected from a social constructionist stance.

Establishing the text’s genre requires an examination of the text to see if it complies with associated conventions and what is expected to be present but omitted. For example, a document may be presented as a strategic plan which would require it to be future-focused; however, if it omits to provide strategic goals, for example, it would be omitting an essential part of the strategic plan genre conventions and must therefore be including something in its stead (e.g., reporting on what has already happened rather than providing the expected future-focused goals). Genre manipulation can be seen as a deliberate act of influencing the reader. Huckin (1997) proposed understanding the genre as enabling the analyst to detect and interpret deviations critically, with Fairclough (2010) advising the researcher to examine for manipulation of the genre and where the text goes beyond its normal boundaries. For example, a nursing textbook might include patient case studies that include narratives that evoke an empathetic and emotional response. By adding the humanising element of the patient experience, it could be argued that the nursing textbook has gone

beyond the traditional role of imparting factual knowledge and is encouraging the development of empathy and compassion.

Coherence

Textual coherence requires cues such as consistent verb tense and active interpretation on the reader's part, drawing on their background knowledge. Examining a text's coherence is suggested by Huckin (2002) as having the purpose so that the "critical discourse analyst can see what kind of background knowledge the text is evoking" (p. 161).

Framing

Framing is considered a significant part of both text production and interpretation. It is how the text is brought together and presented as a unified whole, influencing the narrative. Huckin (2002) also alerted to visual aids as a powerful way of framing. These can include photographs, sketches, and other visual embellishments. Huckin warned of the power at the author's disposal through framing, stating that "the ability to cast a story in a certain light is one of the most powerful weapons at an author's disposal" (Huckin, 2002, p. 161).

Extended metaphor

Huckin (2002) noted that as part of manipulating the text, extended or sustained metaphors that continue beyond a simple metaphor, usually only a single sentence long, may be used. In education, an example could be that the student is described as being on a *journey* and will encounter many *crossroads* where they will need to decide *which way to turn with s*ome *roads* leading to an oasis, thus linking extended metaphor to framing and textual coherence.

Foregrounding/Backgrounding and Omission

Huckin (2002) drew particular attention to observing where the author emphasises or de-emphasises information. Giving text prominence is known as foregrounding and includes placement at the front of the text or using a larger font. Conversely, backgrounding can be done through physical placement nearer the text's end and a smaller font size. The ultimate form of backgrounding is omission or leaving relevant

information out of a text, as shown in the previous section on sentence/utterance level. Backgrounding can also result in the 'other' text being foregrounded.

Auxiliary Embellishments

Huckin (2002) highlighted the manipulative potential that auxiliary embellishments can have as non-linguistic aspects of a text, including things such as graphics and sound effects. For example, in written texts, pictures and diagrams may be included to highlight, reinforce, and foreground certain aspects of the text, as is discussed within the findings of the textbook analysed in this study. Auxiliary embellishments can be used to draw the reader's attention to what the author wishes the reader to focus upon within the text.

Discursive Closure

Discursive closure is a powerful way of distorting communication by actively or intentionally shutting down opposing views, inhibiting open discussion or excluding alternative opinions. It is important in critical studies such as the current study (Prasad, 2018). In addition to delegitimising alternative positions or dismissing, undermining, or minimalizing debate or discussion, discursive closure can also be seen as foregrounding specific text because it privileges certain discourses. Discursive closure was observed within the texts I analysed and is discussed within the findings chapters regarding privileged discourses that dominate others.

Thematic Analysis

As stated earlier, the text contained within each of the five selected documents was analysed using Huckin's (1997) two-stage approach to enable the noticing of linguistic methods employed in the discursive construct of EI and its development within undergraduate nursing education. Firstly, excerpts were identified from each text based on their relationship to EI development and themes were assigned. Themes are more than simple and commonly identified words and phrases appearing in the text or a data summary. They comprise underlying patterns that tie analytical observations such as language, meaning and experience to a common or central organising concept.

Critical and social constructionist theory underpinned the contextualised interpretation of the themes and discourses because they did not simply emerge from

the data or are present naturally. They reflected observations and interpretations that were captured and combined into a meaningful whole (Clarke & Braun, 2018; DeSantis & Ugarriza, 2000, p. 362). After the excerpts were collected, themes assigned and collated, they were examined again to establish the discourses constructing and influencing their application (see Appendix B). Once all the discourses found to be in operation were identified, it was possible to identify the dominant discourses present within the individual texts and across all five documents. The dominant discourses were those that exerted power and had the most influence on how EI was constructed within and across all the texts.

The thematic analysis criteria developed by Owen (1984) were applied in identifying these dominant discourses. The criteria consist of 1) recurrence, 2) repetition, and 3) forcefulness, and together, provided greater specificity when identifying both themes and discourses associated with the concept of EI within the text. The first criterion of *recurrence* required that at least two parts of the text reflected the same idea, perspective or meaning, even if different words were used. For example:

Sentence 1: Nurses should act in a culturally safe way.

Sentence 2: Nurses must be considerate of other people's backgrounds, values, and beliefs.

While both sentences relate to the nurses' application of cultural safety in their practice, different words are used. In the second sentence, the concept of culture has been deconstructed into the components of backgrounds, values, and beliefs without explicitly using the word culture. This difference reflects the requirement for the analysis to be completed in an informed way, to ensure the identification of the recurrence of discourse so as to determine its dominance. The analyst is required to be 'knowledgeable' on the topic area being analysed because the interpretation requires more than the simple identification of keywords demonstrating the application of the principles of critical and social constructionist theory. It enables assumptions to be challenged and a better understanding of power relations and differences to, in turn, challenge and change current practice.

The second criterion of *repetition* refers to the consistent reiteration of specific keywords or phrases, helping identify discursive patterns that reinforce certain

viewpoints and increase the dominance of the discourse. The third and final criterion, *forcefulness*, can present as being evident in a written text through actions such as underlining, circling, highlighting, or where specific forceful language is used to assert ideas and persuade and influence a specific understanding or narrative through the increase in its prominence and strength (Owen, 1984). It is closely linked to what Huckin (1997) would consider foregrounding, as discussed earlier in the chapter. An example that meets the criteria for both forcefulness and foregrounding would be the phrase ‘the primary issue here’. The word ‘primary’ contributes to increased force and emphasis on the issue to which it is linked in the sentence.

Applying Owen’s (1984) criteria provided insight into the main ideologies, values, and beliefs promoted within the texts by identifying a high recurrence of specific words and key concepts and the forceful presentation or prominence related to specific viewpoints. This assisted with identifying the underlying power within the discourses and which were most dominant and, therefore, most likely to influence the actions and thinking within undergraduate nursing education.

The dominant discourses were then presented and discussed (see Chapter 6), and practice examples, interpreted within the sociocultural context of nursing education, are provided in Chapter 7. They focus on the dominant discourses’ power, impact, and influence to complete a contextualised interpretation of the dominant discourses relating to EI within the socio-cultural context of nursing.

Reflexive Requirements of Qualitative Researchers

Professional doctoral research plays a vital role in bridging the gap between theoretical knowledge and its practical application, aiming to drive quality improvement and advance professional knowledge (Cashin et al., 2017). In partaking in qualitative research as part of the professional doctorate, reflexive action is essential to help acknowledge personal connections to the research topic and gain conscious awareness of views, values, and beliefs and how these can impact the research (Burnard, 2016). This awareness, in turn, enables qualitative researchers to challenge inherent biases, interpretations, and limitations, ultimately leading to more informed conclusions (Cashin et al., 2017; Servage, 2009).

CDA Rigour and Trustworthiness

> CDA is primarily ethical. Its aim is to transform action and values such that the social scene becomes increasingly equal, more democratic, less victimising. It has more in common with law than grammar; less in common with semantics than rhetoric. (Graham, 2018, p. 202)

The research approach and analysis were completed in a way that is congruent with CDA's critical social theory and social constructionist underpinnings, wherein the interpretation of the texts offers 'meaning' rather than 'truth'. Rigour was sought by employing a systematic CDA approach and applying thematic criteria alongside an explanation and evidence of any statements or conclusions drawn. Consultation with my supervisors, who are nurses experienced in CDA and qualitative research, assisted in sense-checking the research design and approach and in confirming the credibility of the meanings contributing to the findings.

Reflexivity is particularly relevant to qualitative nursing studies where the research is often highly interpretive. Reflexivity was therefore employed as a tool during the analysis as it can assist in reducing the influence of beliefs and assumptions impacting the findings (Darawsheh, 2014; Finlay, 2002; Peddle, 2022; Probst, 2015). This added rigour to the analysis which was an iterative process of moving back and forth between experience and awareness so that the data obtained reflected "what I knew and how I knew it" (Finlay, 2002, p. 533) and, therefore, actively constructed rather than achieved through detached scrutiny.

Reflexivity and Research Rigour

Jamieson et al. (2023) highlight that researchers engage in reflexivity through self-reflection, examining themselves to understand their identities, values, experiences, and beliefs. This practice also entails acknowledging the influence of personal views on the research, including recognising both biases and how subjectivity shapes decisions and interpretations made throughout the research process. Reflexivity is an iterative process because researchers' understanding of the world both shapes and is shaped by their research (Jamieson et al., 2023; Wilkinson, 1988).

As the researcher, my close proximity to nursing education and interest in the topic of EI necessitated ongoing reflexive practice throughout the study. This involved

journaling my thoughts and beliefs to heighten awareness of pre-held assumptions about EI (Lumsden, 2019). Doctoral supervision further supported reflexivity by providing a space for sharing thoughts, challenging assumptions, and understanding how these views impacted research completion and data analysis (Cheek, 2000). Engaging with supervision acknowledged my existing perspectives while demonstrating a willingness to consider and potentially challenge them through openness to new knowledge and perspectives.

Benefits of Reflexivity

Gergen (2015) and Lumsden (2019) outline several benefits of critical reflexivity to research rigour and trustworthiness. This includes raising awareness of researcher bias and how their viewpoints, values, and beliefs can impact the research and encouraging them to be open to other viewpoints and interpretations. It can also lead to a more meaningful research endeavour through engaging with personal connections to the topic, ultimately fostering passion and leading to a more meaningful research project (Darawsheh, 2014).

My Values and Beliefs

Examining the relationship between EI and undergraduate nursing education demanded critical self-reflection. This included my prior experiences as a nurse, lecturer, and student (albeit 30 years ago) and my understanding of EI and emotionally competent care, which personal and professional experiences have shaped.

My research was influenced by preexisting beliefs, which included that:

- Nursing is an emotionally demanding profession.
- EI benefits nurses both personally and professionally.
- Undergraduate nursing education may not adequately prepare future nurses for the emotional demands of the profession.
- Undergraduate nursing education includes theory and clinical practice, and EI development may occur in either, both, or neither.
- A concerning disconnect between theory and practice may exist, where students believe that suppressing emotions demonstrates or assists them in coping with emotional situations.

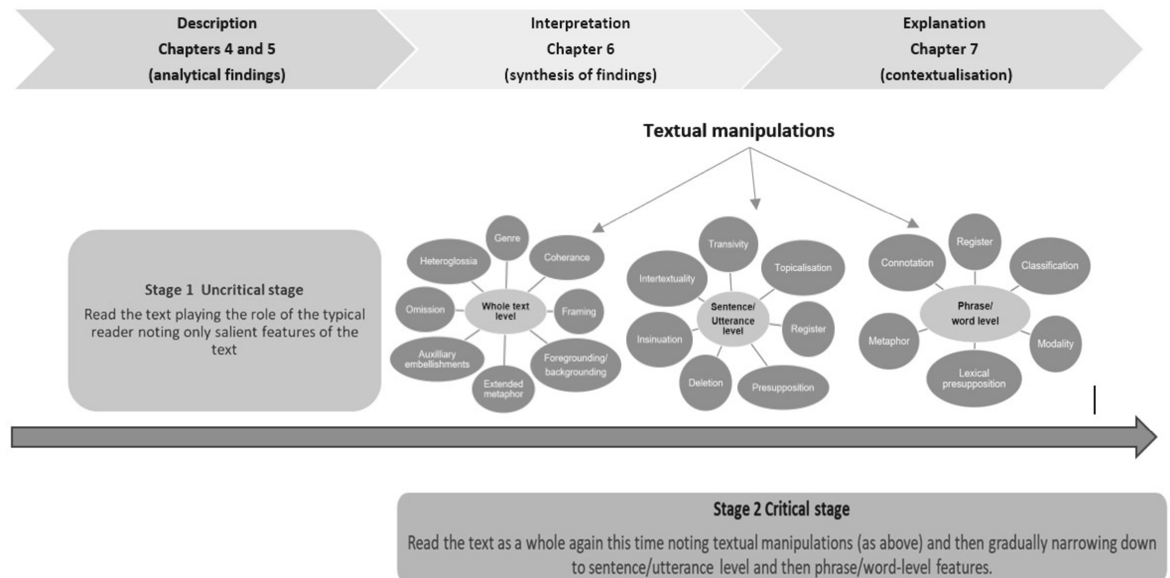
Methodology Summary

The purpose of analysing the five selected documents was to reveal the discursive practices surrounding EI and the dominant discourses impacting upon its inclusion to support the aim of identifying personal, professional, social, cultural, and institutional constraints to the development of EI within undergraduate education. The intention was that such information would assist in the reduction of constraints.

Figure 2 provides a diagrammatic representation of the CDA-based methodological process followed in this study—Huckin's (1997) CDA approach based on Fairclough's (1995) 3-dimensional framework for CDA.

Figure 2

Diagrammatic Representation of the CDA-based Methodological Process Followed in this Study.



The two stages of analysis based on Huckin's CDA approach were completed on each document, including uncritical and critical analysis to examine each document for how EI was constructed within the texts. Particular attention was paid to the characteristics present, as described in the previous section, to reveal where power was being exerted or where the text was being manipulated in an attempt to influence how it was received and perceived by the reader. These findings are presented in Chapters 4 and 5.

Chapter Summary

This chapter has outlined the study research design, underpinning epistemology and the theoretical perspectives drawn upon to inform the selected CDA approach and thematic analytical methods used to generate themes and discourses in order to answer the research questions. The rationale for document selection and research design decisions has been provided with issues of rigour and trustworthiness addressed both through the systematic use of CDA and thematic criteria to identify the discourses dominating the construction of EI within the selected nursing texts. Employing reflexivity assisted in reducing the risk of bias and assumptions impacting claims and findings (Cheek, 2000; Darawsheh, 2014; Peddle, 2022). Chapters 4 and 5 present a detailed textual analysis of the five selected documents, revealing how EI features within the texts and is constructed through discourses.

Chapter 4 Research Findings Part A

This chapter presents the synthesised research findings that sought to identify how EI is constructed and positioned within the discourses and the sociocultural context of undergraduate nursing education, thus revealing hidden elements of powerful influence. Five documents were chosen for their relevance and significance in undergraduate nursing education. They were analysed using a two-stage CDA approach designed by Huckin (1997) based on the 3-dimensional CDA framework by Fairclough (2010). The two stages of analysis included an uncritical and critical review of the language and textual characteristics constructing EI, as outlined in Chapter 3. Thematic analysis of the discourses was employed to support the identification of the dominant discourses. Support is given to the findings and associated claims by sharing excerpts from the selected documents related to the inclusion, omission, or manipulation of the text related to the development of the EI of undergraduate nurses, demonstrtaing the Intertextual properties across discourses.

The synthesised findings are presented across two chapters to support a manageable volume and logical order in order to enhance reader understanding. Chapter 4, Part A, contains the synthesised findings from the analysis of the first two documents analysed: 1) *Competencies for Registered Nurses* (NCNZ, 2012b) and 2) *Potter & Perrys Fundamentals of Nursing* (Crisp et al., 2017). Chapter 5, Part B, presents the findings from the analysis of curricula from three New Zealand tertiary institutions.

The presentation of the findings for each document begins with an overview of the historical context and background, supporting the necessary contextualisation advocated by Crowe (2005) and including the purpose for the creation of the document. This information is further used in Chapter 7 to inform the completion of the contextualised analysis, the third and final dimension of Fairclough's (1995) CDA framework.

Part A Document 1

Competencies for Registered Nurses (NCNZ, 2012b)

Historical Context and Background

Te Kaunihera Tapuhi o Aotearoa/NCNZ is the responsible authority governing nurses' practice under the Health Practitioners Competence Assurance (HPCA) Act 2003 with the principal purpose of protecting public safety through mechanisms ensuring "health practitioners are competent and fit to practise their professions" (HPCA Act 2003, s3(1)). The Act was primarily developed in response to public examples of medical error and lobbyist demands to ensure health professionals respected healthcare consumers' rights and were held more accountable. It also simplified bureaucratic processes by bringing multiple health professional groups under one piece of legislation (New Zealand Nurses Organisation, 2014). The HPCA Act calls for competent health practitioners; however, does not define competence. Instead, this is left to each of the individual regulatory bodies. As the regulatory body for nursing, the NCNZ defines nurses' competence by setting standards. It requires all nurses to demonstrate competency as stipulated in Document 1, *Competencies for Registered Nurses* (NCNZ, 2012b).

During their undergraduate education, nursing students are assessed against the NZNC competencies on an ongoing basis to meet the entry criteria of the registered nurse scope of practice upon completion of their programme. In addition, the NCNZ provides standards for undergraduate nursing programmes and governs all accreditation processes for nursing programme delivery in New Zealand. Therefore, the *Competencies for Registered Nurses* document holds an important and necessary influence over curriculum content and delivery. This document was selected for examination to reveal the overt and implied EI requirements for nursing registration.

Uncritical Review

As guided by Huckin (1997), the first stage review was completed uncritically to obtain the obvious and intended meaning of a typical reader to notice features within the writing that "have the potential of misleading the unwary reader" (p. 81). As both a registered nurse and educator, I am familiar with the content of the documents that guide and influence professional behaviour and clinical practice. While the NCNZ

produced the Competencies for Registered Nurses document, the people authoring the document would likely have included experienced nurses working within the NCNZ, integrating feedback from stakeholder consultation before the competencies were published. The competencies consist of four domains that registered nurses are required to meet as evidence of safety to practise: professional responsibility, management of nursing care, interpersonal relationships, and interprofessional healthcare and quality improvement. They are written in a professional language familiar to me as a registered nurse and nurse educator. The text begins by setting out the registered nurse's scope of practice, stating the purpose of the competencies as "describing the skills and activities of registered nurses" (NCNZ, 2012b, p. 2).

The information in the document is presented in a structured way. It uses a professional format, explaining the nurse's scope of practice, the domains, competencies, and indicators before presenting each competency numbered and allocated to each of the four domains. Each competency has indicators that provide exemplars of competent performance for evidence in support of each competency and are purported to be neither exhaustive nor comprehensive. Instead, the indicators provide relatable examples of the knowledge or skill that could be demonstrated as evidence of meeting the competency.

Critical Review

Process for Claiming Authority

The document text was examined to identify the processes used in claiming its authority. One of the explicit ways in which authority was evident in the text was through the statement which foregrounds its legislated responsibilities for public safety on the front cover of the document:

> Te whakarite i nga mahi tapuhi kia tiakina ai te haumaru a-iwi
> Regulating nursing practice to protect public safety. (NCNZ, 2012b)

The statement foregrounds its powerful 'regulator' and 'protector' roles related to nursing practice and public safety, which comes from the authority delegated to it by the New Zealand Government through the HPCA Act 2003. Nursing is one of the 22 health professions regulated in New Zealand by the Act, which stipulates under section

16 that professionals must meet relevant competencies to protect the public's safety (Ministry of Health, 2003). In section 16 of the Act, NCNZ has mandated the responsibility to regulate nurses and keep the public safe with delegated authority over the competency of nursing professionals. The document, therefore, reinforces that its authority is derived from the transmission of its legislated responsibilities for public safety and is met through the provision of competency evidence by the registered nurse.

While NCNZ has delegated legal power and responsibility through the HPCA Act 2003, it is not explicitly mentioned in the body of the document. The only reference is contained in the glossary at the end of the document, reinforcing its responsibility as an authority:

> **Nursing Council of New Zealand** The responsible authority for nurses in New Zealand with legislated functions under the Health Practitioners Competence Assurance Act 2003. (NZNC, 2012b, p. 13)

The backgrounding of the responsibility and accountability of the NCNZ to the Act sits in contrast to the foregrounded accountability of the nurse which is made explicitly clear within the first few pages of the document:

> Registered nurses are accountable for ensuring all health services they provide are consistent with their education and assessed competence, meet legislative requirements and are supported by appropriate standards. (NZNC, 2012b, p. 2)

The competencies also assert power within undergraduate nursing education because they are required to be used to inform curriculum design and assessment. Undergraduate student nurses have explicit requirements to achieve competency through assessment against all NCNZ (2022b) competencies on an ongoing basis throughout their education. Further assertion of power can be seen in the delegation of responsibility to registered nurses to guide and support student nurses, new graduates, and new members of teams in competency 4.1:

> Provides guidance and support to those entering as students, beginning practitioners and those who are transferring into a new clinical area. (NZNC, 2012b, p. 11)

NCNZ authority in this area is reinforced through another important NCNZ authored document, the *Code of Conduct for Nurses* (2012a). The Code provides information to both nurses and the public about the expectations of a nurse in their professional role and provides a basis for evaluating the conduct of nurses. The Code reinforces the expectation that nurses work respectfully and "support, mentor and teach colleagues and other members of the health care team, especially students and those who are inexperienced" (p. 28). This reinforcement of authority through other NCNZ documents can be seen through the expectation for nurses to read and apply the content to their practice from other documents that it produces as directed in the explicit requirement within the competencies:

> Indicator: Practises nursing in accord with relevant legislation/codes/policies and upholds health consumers rights derived from that legislation. (NCNZ, 2012b, p. 5)

This explicit requirement within the competency document, which further directs nurses to practice under relevant legislation, codes, and policies, encompasses numerous documents, such as the aforementioned HPCA Act (2003) and *Code of Conduct for Nurses* (NZNC, 2012a), the *Guidelines for Cultural Safety, the Treaty of Waitangi*, and *Māori Health in nursing and Midwifery Education and Practice* (NZNC, 2011), *Guidelines: Professional Boundaries* (2012c) and *Registered Nurse Education Programme Standards* (NZNC, 2021).

The NCNZ establishes authority throughout the competency document directing the registered nurse on what they need to do and how to behave. It extends its reach by referring to the requirement for nurses to practice in accordance with other documents, standards, and guidelines. One such important document referred to within the competencies is the founding document of New Zealand, Te Tiriti o Waitangi/The Treaty of Waitangi, which requires nurses to read and interpret to apply the principles in practice:

> 1.2: Demonstrates the ability to apply the principles of the Treaty of Waitangi Te Tiriti o Waitangi to nursing practice. (NZNC, 2012b, p. 5)

However, as a seminal document within New Zealand legislation, it is not academically referenced. Instead, it is included within the document's glossary:

> Treaty of Waitangi The founding document for Aotearoa/New Zealand signed in 1840 by the Māori people and the British Crown. (NZNC, 2012b, p. 14)

The only document specifically referenced in the main section of the competency document directs registered nurses involved in management, education, policy, and research to the *Guideline: Expanded Practice for Registered Nurses* (NZNC, 2010) "available on our website:www.nursingcouncil.org.nz" (2012b, p. 12). This is in contrast with generic requirements of nurses to identify, interpret, and comply with relevant legislated requirements and professional and ethical standards to inform competent practice as made explicit in the document:

> meet the standards of the professional, ethical and relevant legislated requirements. (NZNC, 2012b, p. 5)

Therefore, despite not naming specific documents, there is an explicit expectation that the content of other professional documents, standards, and guidelines have been read and could account for some of the variability in detail within some competency statements. For example, competency 2.9 which assumes the knowledge and concept of professional development are known to the nurse, exemplifies a generalised statement:

> Competency 2.9 Maintains professional development. (NZNC, 2012b, p. 8)

In contrast, other competencies combine generic and specific written direction, with the nurse left to interpret what 'acts appropriately' means when in unexpected circumstances:

> Competency 2.5 Acts appropriately to protect oneself and others when faced with unexpected health consumer responses, confrontation, personal threat or other crisis situations. (NZNC, 2012b, p. 8)

Constructing EI Within Competencies for Registered Nurses Document

The explicit wording 'EI' was omitted from the document; however, the requirements of nurses related to its presence were evident. Thus, the examples in Table 2 (Appendix B) do not reference EI but contain specific aspects of EI required for registered nurse competency. For example, the management of threats or a clinical crisis requires an appreciation and understanding of both the personal emotions of the others involved in the situation and one's own emotions, before implementing an appropriate and informed response professionally, safely, and within the nurse's scope of practice. Therefore, there are expectations for the nurse to possess emotional competencies to fulfil such requirements despite it not being explicitly stated.

Other references to where EI is required but not named in the document include cultural safety, critical thinking, understanding consumers' values and beliefs, forming therapeutic relationships, and managing emotionally charged situations. EI is constructed within these examples as part of the discourse of professional care and safety, promoting the requirements for nurses to manage their own and others' emotions, both of which require emotional self-awareness and social awareness. Nurses are also required to develop and manage therapeutic relationships, keeping the patient safe and engaged through applying professional nursing behaviours and conduct as directed by professional guidelines and standards. These are both referred to and implied as compliant with competencies 1.1 and 1.2. The competencies related to relationship management, cultural safety, and relationship boundaries exist within the professional, safety, legal, and ethical discourses (NCNZ, 2011; 2012a, 2012c).

Literary Tools to Drive the Message

The document is dated December 2007. It was reprinted in 2012, amended in 2016, and reformatted in June 2022. The 'Competencies for registered nurses' are presented as a professional document, A4 size and 36 pages. Published by the NCNZ, it is publicly available for download as a PDF document from the NCNZ website. Each competency and accompanying indicators has its own page within the document, apart from the last two. This deviation would seem to relate to the competencies' length and that they have only two indicators each. They fit on one page together, and there appears to be no other significant reason for the deviation from one page per competency. The

front cover has at the top, next to the *Te Kaunihera Tapuhi o Aotearoa Nursing Council of New Zealand,* the digitally created NCNZ logo used on many documents as part of their branding. In recognition of the Treaty of Waitangi, the indigenous language pre-empts English translations with te Reo wording Te Kaunihera Tapuhi o Aotearoa and the English translation NCNZ beneath. However, this is not a bilingual document. Another grass-like digital image at the bottom of the page appears throughout the document and aligns with the branding of other NCNZ documents.

The instant recognition and familiarity with the digital logo and images provide clear communication of ownership of the document. It could also be seen to communicate assurance of the professional quality of the content because the author is the registering body for nursing. Ownership of the document is apparent throughout, with each page brandishing alternatively one of the two graphics mentioned above. The authority of the NCNZ is reinforced by the clear and prescriptive language used to direct nurses as to the areas of competence required, thus reducing misinterpretation or deviation from the requirements. The words are specific and direct the nurse to what is required for each competency. For example, each competency begins with one of the following verbs: ‘accepts’, ‘demonstrates’, ‘promotes’, ‘practises’, ‘provides’, ‘undertakes’, ‘ensures’, ‘acts’, ‘reflects’, ‘maintains’, ‘establishes’, ‘communicates’ ‘collaborates’, ‘recognises’.

The style in which the document is written, known as the genre, reflects the authority that the NCNZ hold as a regulatory body and provides professional direction as part of its governance responsibilities. Authority is reinforced through statements within the document related to legislative requirements needing to be met, such as stipulating nurse accountability for ensuring all health services provided by them are consistent with their education and assessed competence:

> Registered nurses are accountable for ensuring all health services they provide are consistent with their education and assessed competence, meet legislative requirements and are supported by appropriate standards. (NZNC, 2012b, p. 2)

The document presents its information factually in line with the governing genre of a professional regulatory document. The document lists and describes the competencies required to register as a New Zealand nurse. It provides the information using

professional language familiar within the global nursing context. The NCNZ is responsible for mandating the minimum regulating competency standards required to ensure public safety. Therefore, they require nurses to understand these requirements to demonstrate compliance. Some competencies have a generic nature because NCNZ recognises that nurses work in a myriad of settings:

> Registered nurses may practise in a variety of clinical contexts depending on their educational preparation and practice experience. (NZNC, 2012b, p. 2)

Competency specificity could hinder registered nurses' ability to demonstrate competence, which would mean being unable to obtain a practising certificate and work in New Zealand as a nurse. Presenting competencies in generic terms allows a broader range of evidence that meets the criteria to be provided. For example, competency 2.9 simply states, "Maintains professional development" (NZNC, 2012b, p. 8). Each competency has indicators that provide various examples of how the nurse would demonstrate competence in clinical practice; however, these, too, can be unspecific and generic.

In contrast to the above competency that relies upon the indicators to provide examples of application, some competencies are more specific; for example, competency 2.5:

> Acts appropriately to protect oneself and others when faced with unexpected health consumer responses, confrontation, personal threat or other crisis situations. (NZNC, 2012b, p. 8)

This competency provides examples of different consumer responses within the competency statement, specifically instructing registered nurses to protect themselves and others from unexpected responses and circumstances. In contrast, the indicators supporting the competency are open to interpretation and refer to the nurse's understanding, taking action, and implementing responses to procedures and protocols.

When generic wording is used, the nurse must interpret the meaning. An example is evident in competency 2.5. where the instruction is that nurses "*Act[s] appropriately to…*" requiring the nurse to decide what is 'appropriate' based on their knowledge of

legislation and professional standard requirements as instructed in the competency document. While there is variation across the document in the specificity of the competencies and accompanying indicators, the professional language is familiar to nurses and, thus, does not mislead or confuse the reader.

Authored by the NCNZ, the competency document could be viewed as unlikely to contain manipulations because it is associated with the profession of nursing and, therefore, considered synonymous with traits such as trustworthiness, honesty, and integrity. This is an example of where the consumer of the text may be influenced by the author of the text. Because NCNZ is the regulator of the nursing profession and in a position of authority over the profession, they must be trustworthy. While this may be true, it is an example of a presupposition based on the text's authorship. An associated presupposition could be that because it is created by trustworthy, highly knowledgeable, and influential persons, it is beyond the realm of being questioned. This latter presupposition reveals the discourse of professionalism and the societal influence and power that the NCNZ holds. It permeates understanding and beliefs related to the text's integrity and reliability and how it should be received even before reading commences.

Positioning Subjects

Huckin (2002) draws attention to the agent-patient relationship being present in sentences that include "who is doing what to whom" with "the semantic agent (or actor) in a sentence is depicted as having more power than the patient" (p. 160). He also noted that the consistent use of the same agent from sentence to sentence may reflect a perspective favouring that agent's status. The nurse's agency is communicated through the activities required to achieve competency, as outlined by the four competency domains of professional responsibility, management of nursing care, interpersonal relationships, and interprofessional healthcare and quality improvement (NZNC, 2012b, pp. 4-5). While the text does not use the term 'nurse' within the competencies, the registered nurse is the primary consumer of the document and is directed within the competencies as the primary agent of action with responsibilities unequivocally set out in terminology such as 'demonstrates', 'provides', 'ensures', 'acts', and 'establishes'. Although not explicitly named, the nurse

is seen to be activated as the 'social actor' where the author enacts their capacity for 'agentic action' as above (Fairclough, 2005).

The document's title explicitly states that they are *Competencies for Registered Nurses*; however, there is a paragraph included early within the document that places the nursing student as also being required to meet all competencies "for entry to the registered nurse scope of practice at the completion of their programme" (NZNC, 2012b, p. 4). Student nurses are also referred to in the text but primarily as a 'recipient' of supervision through the delegated responsibilities of the registered nurse because they are "expected to be supervised in practice by a registered nurse when the competencies relate directly to an undergraduate nursing student" (NZNC, 2012b, p. 4). This statement reflects these competencies' relevance from the day students begin their nursing education until they terminate their nursing career.

While the NCNZ's (2012b) responsibility for "regulating nursing practice to protect public safety" (p. 1) is declared on the document's cover page, it is not mentioned again within the document. Instead, the nurse is assigned accountability and responsibility in the document, positioning the nurse as the agent of action required to comply with the document's instructions. The competency document tells the nurse what to do but does not provide a rationale. Instead, it relies on other professional documents, such as the NCNZ *Guidelines: Professional Boundaries*, to provide professional guidance, legislative details, and rationale. The NCNZ makes the legal and professional requirements explicit concerning the registered nurses' practice, including additional accountability for directing, monitoring and evaluating when delegating to others:

> Registered nurses are accountable for ensuring all health services they provide are consistent with their education and assessed competence, meet legislative requirements and are supported by appropriate standards. (NZNC, 2012b, p. 2)

Uncovering the Discourses

This research aimed to uncover the discourses to provide insight and understanding of the influences promoting and hindering the inclusion and development of EI within undergraduate nursing education. In doing so, the study focussed on how language is used in constructing EI within the text. Phrases were extracted due to their connection

in constructing the concept of EI within the NCNZ Competencies for Registered Nurses document and provided as excerpts alongside their thematically identified discourses in Table 2 (Appendix B). The multiple themes and discourses identified for each excerpt demonstrate the interconnectedness of the discourses used to construct emotional competence within the document.

Azemian et al. (2021) described professionalism in nursing as a multidimensional concept comprising a broad number of personal characteristics: “self-regulation, professional values, striving to acquire and enhance professional expertise, professional interactions, social, professional, and legal responsibility, and creation of a sense of belonging, and professional development” (p. 327). Self-regulation requires both self and social awareness, and professional interactions require developed interpersonal and communication skills that require EI. Professionalism was a prevalent discourse throughout the document. Throughout the text (NZNC, 2012b) nurses are positioned as requiring “professional knowledge” (p. 2), “professional responsibility” (p. 3), contributing to “interprofessional activities” (p. 3), making a “professional judgement” (p. 4), use “professional standards” (p. 5), complete “professional development” (p. 8), participate in “professional activities” (p. 9), while being aware of the impact of culture on “professional practice” (p. 13). The presupposition is that a competent nurse is a professional nurse and, conversely, a professional nurse is a competent one.

Registered nurses are regulated under the HPCA Act (2003) and are accountable for ensuring their care is consistent with their education, competence, and scope of practice. In addition, they are required to uphold professional standards of nursing practice, such as those outlined in the *Standards of Professional Nursing Practice* (New Zealand Nurses Organisation, 2012) and the NCNZ (2012a) *Code of Conduct for Nurses*. This regulatory responsibility for public safety was evident, as much as could be reasonably expected from a document developed to ensure that the nurse meets the professional and regulatory competency standards required for registration. Therefore, the professional discourse of nursing is interconnected with (public) safety and legal responsibility-related discourses.

Connection and relationship building are strong themes throughout the document, with an entire domain dedicated to them: *Domain three: Interpersonal relationships* competencies. Therapeutic interpersonal relationship building is part of the professional discourse on how nurses interact with others. The safety discourse is brought into play alongside the legal discourse with the requirement for separate guidance provided by NCNZ on professional boundaries to be consumed by the nurse. Although this is expected, it is not made explicit within the document. The guidance aims to inform the nurse's behaviour through interpretation and decisions about appropriate behaviour, keeping the consumer safe from harm. The consequences of such would also protect the nurse, keeping them 'safe' from disciplinary action resulting from any unprofessional behaviour. It also links to the legal discourse due to the required adherence to legislated boundaries as directed by the NCNZ (2012c) Guidelines: Professional Boundaries document. The guidelines direct that nurses:

> …must be aware of their professional responsibility to maintain appropriate personal, sexual and financial boundaries in relationships with current and former health consumers and their families. (NCNZ, 2012c, p. 3)

The NCNZ *Code of Conduct for Nurses* further reinforces professional boundaries when working with health consumers and others:

> 7.13 Maintain a professional boundary between yourself and the health consumer and their partner and family, and other people nominated by the health consumer to be involved in their care. (NCNZ, 2012a, p. 33)

After the above excerpt, the document has a footnote that directs the reader back to the *Guidelines: Professional Boundaries* document for detailed guidance and explanation, reinforcing its importance. The competency document requires the nurse to collaborate " with other health professionals …in partnership with individuals, families, whānau and communities" (NCNZ, 2012b, p. 2). Professional interactions, professional relationships, team collaboration, and therapeutic relationship building are competency expectations. In addition, there are safety expectations related to cultural safety. There are also obligations stated within Competency 1.2 of the document requiring the nurse to understand and apply the principles of the Treaty of Waitangi/Te Tiriti o Waitangi to their nursing practice (NCNZ, 2012b, p. 5).

Professionalism, therefore, requires the nurse to work with others collaboratively, build relationships, provide high-quality care, respect consumers' values and beliefs, and behave responsibly.

Professional behaviours also require nurses to be self-aware and motivated. The competency document's use of 'self' in self-reflection, self-awareness, and self-direction (motivation) provides three examples wherein the nurse's emotions and feelings must be examined, understood, or used. The competency-related extracts below also require the nurse to use introspection to understand behaviour in context, the identification and management of threats to take protective action, and to self-assess competence and internalise what others are saying to learn from that feedback and improve practice:

> Competency 1.5. (Indicator 6) Reflects on his/her own practice and values that impact on nursing care in relation to the health consumers' age, ethnicity, culture, beliefs, gender, sexual orientation and/or disability (p. 6);
>
> Competency 2.5 Acts appropriately to protect oneself and others (p. 8);
>
> Competency 2.6. (Indicator 3) Reflects on health consumer feedback on evaluating nursing care and health service delivery (p. 8);
>
> Competency 2.8. (Indicator 1) Identifies one's own level of competence and seeks assistance and knowledge as necessary (NZNC, 2012b, p. 8).

In addition to professionalism, self-motivated awareness requires the nurse to adhere to legal and ethical responsibilities concerning maintaining professional boundaries when building therapeutic relationships. For example, in the requirements of the nurse in Competency 3.1 (indicator 2):

> Incorporates therapeutic use of self and psychotherapeutic communication skills as the basis for nursing care for health consumers with mental health needs. (NZNC, 2012b, p. 10)

The above indicator requires self-disclosure of personal information in the use of self. Therefore, the nurse must know what and how much to share when building a therapeutic relationship. EI is required to achieve an emotional understanding of

themselves and the health consumer, and subsequently to support appropriate levels and types of self-disclosure. Such EI can also reduce over-sharing, over-involvement, and other relationship boundary violations.

Despite the promoted use of 'self' in clinical practice, New Zealand registered nurses are not professionally mandated to participate in clinical supervision to support ongoing competency building once formal training has ceased. Instead, responsibility is left to the individual nurse to decide what professional advice, assistance, and debriefing they require as part of Competencies 2.8 (Indicator 3) "Accesses advice, assistance, debriefing and direction as necessary" (p. 8); and 2.9 (Indicator 3) "Takes responsibility for one's own professional development and for sharing knowledge with others" (NZNC, 2012b, p. 8).

Part A Document 2:

The Fundamentals of Nursing Academic Textbook (Crisp et al., 2017)

Historical Context and Background

The *Fundamentals of Nursing* textbook is over 1500 pages and is available as a hardback and eBook. The rationale for selecting this textbook was that most tertiary institutes in New Zealand that deliver an undergraduate nursing degree programme use it across multiple papers within their curriculum. It is an adaptation of an international nursing fundamentals text for the Australasian market. In its welcome preface to students, the editors claim the textbook as the most successful fundamentals text ever published for nursing students across Australia and New Zealand. The claims are supported by the fact that it is in its fifth edition and appears on the required textbook reading list for most nursing education institutes in New Zealand. Therefore, it holds a prime position of influence as a core textbook for nursing practice, providing written information on what it refers to as fundamental nursing knowledge and skills. The book is divided into eight parts, containing a total of 41 chapters (Crisp et al., 2017).

Uncritical Review

The picture on the textbook's cover appears to be a magnified picture of a silver-coloured metal frame with many different-sized spherical shapes haphazardly

asymmetrically hanging/attached. There are tiny beads of what appear to be water on the frame, suggesting each sphere may contain the same clear liquid, as the central part of each spherical shape is distorted as if filled with water. The picture is lighter in the top half. The bottom half of the picture progressively gets darker with shadows cast from the frame. Each of the book's eight parts begins with this same full-page picture. The part's name and number are printed centrally within the top half of the picture, with each chapter number, name, and page number printed on the right-hand side of the bottom half. There is no explanation provided or credit to explain what the picture depicts. It is unique, distinct, and easily recognisable as the fifth edition Potter and Perry textbook cover picture.

The consistent use of a unique picture could be present to depict the book's reinforcement of authorship. However, the cover picture changes with every edition released and is more likely to represent both the authorship and edition. Booklists for each nursing programme usually recommend that the student has the latest edition of a textbook, which results in sales of the textbook and reduces the saleability of used textbooks when new versions are released. The unique imagery for each new version provides easy recognition of textbook editions. However, with the introduction of online textbooks, imagery has become less evident and increases the likelihood that the student will use a more recent addition.

The book is written in an easy-to-understand format providing information at the students' level with supporting references, photographs, and diagrams. It also has boxes highlighting points and providing examples to reinforce the information presented. A comprehensive range of topics is included within the text; for example, information on nursing practice concerning the healthcare environment, professional responsibility and accountability for safe and effective care, regulatory frameworks, teamwork, culture, communication, and many other nursing knowledge, understanding, and practice.

Donna Waters wrote the preface for the text on behalf of the textbook's editorial team. She is the Dean of the Faculty of Nursing and Midwifery at the University of Sydney and holds a position as a respected figurehead within nursing education. The preface begins with a subheading of 'To the student'. Thus, the text begins as a

greeting directly to the student in a friendly, informative, letter-writing conversational tone, declaring its success confidently in the first paragraph:

> Welcome to the fifth edition of the most successful fundamentals text ever to be published for students of nursing across Australia and New Zealand. (Crisp et al., 2017, p. xxi).

The textbook lists over 50 Australian and New Zealand and over 30 United States, contributors to the textbook in addition to 13 Australian and New Zealand reviewers, all of whom are cited by name, followed by their academic qualifications (minimum of a master's degree), their occupational title and place of employment. The contributors and reviewers support the positioning of the textbook as both academically and clinically credible, which is emphasised in the text through the mention of new members with expert and contemporary knowledge contributing to the *experienced* writing team:

> In this edition, we welcome a number of academics and clinicians to the experienced writing team and acknowledge their expert contemporary knowledge and contribution to perspectives on health and health care. (Crisp et al., 2017, p. xxi)

Credibility is enhanced further through the textbook's call on research and authors considered dependable within the nursing profession. As expected from a textbook supporting degree-level study, academic references are provided throughout the text to substantiate and provide the evidence base behind the theory and practice assertions.

As an educator and nurse, I like the clinical examples provided throughout the textbook and have used them within my role as a nurse educator. They demonstrate how some nursing knowledge and skills could be applied in practice and what development was likely required for this to happen. The clinical examples were plausible and therefore relatable, and the authors utilised emotive language at times to emphasise potential consequences and the importance of not having sufficiently developed knowledge and skills to underpin decision-making and prioritisation of skills, for example:

> When working in acute care settings, encouraging patients to mobilise may be a low priority compared with meeting their other needs. Yet, for the patient with impaired physical mobility, the resultant inactivity may lead to life-threatening complications, such as a pressure injury, deep vein thrombosis or pulmonary infection as well as longer-term decreased functional ability. (Willets, 2017, p. 845)

The subtext of the above example is that the nurse can indirectly cause the death of a patient through poor decision-making and poor prioritisation of patients' needs. While a frightening thought, it is a genuine risk. Therefore, I believe its inclusion was necessary and appropriately presented because it also provided a rationale that highlighted the potential consequences. Keeping with the uncritical review added to my feeling that this textbook portrayed nursing practice in real terms, including the benefits of best practice and not ignoring the risks associated with any deficits in care provision.

Because the focus of the current study is the development of undergraduate nurses' EI, Chapter 12 of the book presented particular relevance. It included a section on EI, signalling that it is considered 'fundamental' to nursing, as the book titled *Fundamentals of Nursing* suggests. It was therefore noted as requiring particular attention within the critical review. I was also drawn to the paragraph within the preface stating that in this edition of the textbook, self-awareness and reflective skills are reiterated and linked to the importance of personal attributes in the delivery of quality care:

> We also re-emphasise the importance of self-reflection and awareness as important personal fundamentals for delivering quality care to the increasingly diverse populations we work with. (Crisp et al., 2017, p. xxi)

This recognition early in the textbook suggests that it focuses on more than just knowledge and skills and is reinforced later in the textbook, stating that the "commitment to developing as a reflective practitioner – being critical and learning from practice – is the essence of good nursing" (Douglas & Crisp, 2017, p. 59). The text supports the notion that more than clinical knowledge and skills are required by

nursing professionals and indirectly levels a challenge to the new student nurse to aspire to be intelligent, agile and creatively competent:

> It is the intelligent, agile and creatively competent nurse working across all sectors – including in community and primary healthcare – who will make a difference to keeping people well and cared for, more often in their own homes in the future. (Crisp et al., 2017, p. xxi)

The uncritical review was completed on the textbook as a whole. As with Document 1, the critical review then commenced and focused on how the document constructs the development of EI in undergraduate nursing education. Excerpts and associated discourses were identified and recorded in Table 3 (Appendix B).

Critical Review

Process for Claiming Authority

The textbook was examined to identify the processes used in claiming its authority. The first began with the claims from the editors regarding the expertise of the contributing authors and the success of the textbook with terms such as 'most successful', 'experienced writing team', and 'expert contemporary knowledge' used to establish it as a text providing an authoritative voice of knowledge at the forefront of nursing education in New Zealand and Australia:

> Welcome to the fifth edition of the most successful fundamentals text ever to be published for students of nursing across Australia and New Zealand… In this edition, we welcome a number of academics and clinicians to the experienced writing team, and acknowledge their expert contemporary knowledge and contribution to perspectives on health and health care. (Crisp et al., 2017, p. xxi)

Within the text, nursing experts are positioned as dealing with complexity, making decisions on incomplete information, and accepting that it was the best decision at the time, even if it is later shown to be incorrect. In contrast, the nursing novice challenges relate to decision-making and are spoken of in terms of deferring to others, even when they suspect that the others are wrong. This suggestion is because they have minimal experience performing the tasks consequent to their decision, resulting from

rationalising against what they think is correct, which can have significant implications for patient safety (Douglas & Crisp, 2017). The implication is that the negative emotions experienced alongside uncertainty due to the limited knowledge base are likely to result in the novice going against what they suspect is correct and deferring to the perceived expertise of others. Because EI is linked to reducing or avoiding such challenges or conflict, it could be argued that a novice who is emotionally competent would be less likely to ignore their suspicion that the 'expert' is wrong despite not yet having developed expert-level critical thinking skills. However, it is the knowledge, skills, and attitudes of the 'master' that feature as the solution with emotional requirements embedded within, such as "embodies intellectual humility" and "accepts uncertainty" (Douglas & Crisp, 2017, p. 57), and using adaptive expertise to toggle between fast, instinctive, and emotional thinking, and slower more deliberate and logical thinking.

The textbook presents a table of a consensus list of critical thinking skills and sub-skills proposed by the American Philosophical Association. Scientific terminology includes interpretation, analysis, evaluation, inference, explanation, decoding significance, examining ideas, analysing arguments, querying evidence, drawing conclusions, stating results, justifying procedures, and presenting arguments. In contrast, while the EI requirement is not specified in the table, one of the six skills and sub-skills listed includes EI-related characteristics of "self-regulation, self-examination and self-correction" (Crisp et al., 2017, p. 57). Therefore, the development of critical thinking can be seen to be constructed as requiring aspects of EI. Like EI, the development of critical thinking is described as able to be developed through experience and observation rather than through explicit instruction and was accompanied in the text by the concerning assertion that some "never master this skill" (Douglas & Crisp, 2017, p. 58).

Literary Tools to Drive the Message

The textbook is arranged in a logical order. It provides background and underpinning information on the health system related to ageing populations, chronic disease, health expenditure and reform, nursing workforce, and professional development and regulation. It conforms to the genre of an education textbook, providing information at the students' level with supporting references, photographs, and diagrams. It also uses

a conversational tone, talking to the reader as a friendly expert providing information on broader issues such as political and social concepts affecting healthcare:

> Good health is at the core of human wellbeing, a prosperous society and good economic progress. The healthcare system is a critical component in ensuring and maintaining the health and wellbeing of populations. (Hughes et al., 2017, p. 6)

When examining the nursing text, Crowe (2005) advised that it involves an examination of “the linguistic strategies that the text uses to construct a particular way of thinking about and acting in clinical practice” (p. 58). The textbook positions itself as an expert, with the author/s talking directly to the nursing student and imparting knowledge to support the development of knowledge and skills. It is pitched at explaining to a novice and offers guidance and direction, with a comprehensive reference list at the end of each chapter reinforcing the notion that the content is evidence-based. Relevant academic references are used to further understand from a theoretical and clinical perspective. However, I noted one apparent deviation when the voice of the German-born theoretical physicist Albert Einstein was used without academic reference. His words reinforced the need for the discovery of more innovative healthcare solutions “We cannot solve our problems with the same thinking we used when we created them” (Hughes et al., 2017, p. 6). It is curious that a textbook about nursing written predominantly by and for nurses uses the voice of Albert Einstein. As a well-known scientist and Nobel Prize awardee, Einstein is highly regarded for his scientific discoveries and can be seen as holding considerable authority and weight. The use of words by such an intelligent and influential man can be seen to be used to reinforce the notion that the book contains important information.

Authority can also be claimed by the authors in the way they present information. For example, there were instances where the author wrote unequivocally:

> The bottom line is that the process of clinical reasoning is the basis for your practice as a registered nurse. (Crisp et al., 2017, p. 54)

The bottom line is a financial metaphor related to the final line of a financial statement showing net profit or loss and used to indicate the essential essence of the point being made. It suggests that the statement is irrefutable and that there is no need for further discussion or opportunity to question. Despite a lack of referenced support for this statement, it emphasises the authority claimed by the 'expert' authors in their provision of knowledge.

Positioning Subjects

Discursive practices are used to position people within the text. While this can be done subtly, implied, or not at all, in this textbook the student is directly addressed within the preface, positioning them as the intended recipient to engage with the text. Engagement with written text can only ever be one-way, with the reader interpreting what they read without the author present; thus only able to reflect what the author wrote at that specific time. In this textbook, the authors position the content as provided by experts and establish authority by including contributors' and reviewers' names, qualifications, and occupations, stating that they have also consulted with experts regarding the content, adding to its credibility. The text uses several linguistic approaches, such as informing, instructing, and guiding through providing clinical information and advice. It also uses an inspiring approach through the continued highlighting of how to improve practice, which is reflected in the first chapter's title, "Creating a proactive and dynamic nursing profession" (Hughes et al., 2017). The text also warns students of "both intended and unintended consequences" (Conroy et al., 2017, p. 17) of the clinical risks that exist within nursing practice, discursively positioning the student as the recipient and, therefore, novice. There is no specific consideration of previous knowledge because this textbook states that its purpose is to speak to the student nurse and does so even though they knowingly rely upon other consumers of the text, such as the educators within undergraduate nursing programmes, using the textbook as a resource.

The agency of the student nurse is communicated through the direct addressing of the student by the authors. As mentioned, the book's preface subheading of 'To the student' communicates that the textbook wishes to address the nursing student directly. Thus, the text places the student nurse as the primary consumer of the textbook. Furthermore, the student is spoken to throughout the text, directly

addressing the student using ‘you’ and ‘your’. The novice student’s agency to become a nurse within healthcare is directly linked to the consumption and completion of tasks as directed by the textbook. The students’ implied responsibility for ensuring they attain the ‘mastery of content’ is associated with each chapter’s bullet-pointed learning outcomes. The specificity of the words reinforces the authority of the textbook, and presupposition is used to direct the student that they will be able to achieve all learning outcomes through reading the text and completing all the requirements to ‘master’ the content. For example, each learning outcome begins with verbs such as “understand”, “recognise”, “explain”, “appreciate”, “identify”, “list”, “differentiate”, “describe”, “relate”, “define”, “discuss”, “identify”, “distinguish”, “recognise”, “list”, and “differentiate” (Stein-Parbury, 2017, p. 209; Welch, 2017, p. 444). Thus, the student is positioned as a recipient of expert knowledge with the ultimate goal of ‘mastering’ the content.

Mastery requires them to practice with the knowledge imparted, such as explain, recognise, or relate. In this sense, the student is to progress from novice and passive recipient of valuable knowledge to the position of ‘expert’ by knowing what the ‘expert’ author does and completing what is advised to be done. Congruent with the Document 1 *Competencies for Registered Nurses* (NCNZ, 2012b), the terminology of ‘health consumer’ is used frequently throughout the textbook in the form of “consumer needs” (Crisp, 2017, p. 105), “consumer rights” and “health consumer records” (Johnstone, 2017, p. 142 & 144). As identified in the *Competencies for Registered Nurse*s (NCNZ, 2012b), ‘consumer’ terminology can be linked back to the HPCA Act 2003. It is also related to the neoliberal ideology discussed in Chapter 5.

The use of ‘basics’ and ‘fundamentals’ and ‘building blocks’ (as shown below) in the preface implies a widely agreed foundation and purpose for the nursing profession:

> We retain an emphasis on the very important basics – the fundamentals of care that are the building blocks on which professional nursing practice is built. (Crisp et al., 2017, xxi)

The textbook seeks connection and relationship building through direct communication with the student placed centrally in its dialogue. It is claimed that the

core format of the text resulted from student feedback, with further claims stating that it is easy to navigate:

> we have maintained the core format of a fundamentals text that you have told us you enjoy and find easy to navigate. (Crisp et al., 2017, p. xxi)

The authors' self-referencing terminology of 'expert' and explicitly referring to the student nurse as a 'novice' reinforces the knowledge difference between the two, and the authority held over the reader as a 'novice'. Furthermore, the author refers to the textbook as providing the fundamental nursing knowledge required to move the student from their novice status, implying that it is possible to move the student from novice to mastery of content through its consumption.

Citing only small parts of other authors' work within the textbook seeks to add content and may increase credibility for the nurses reading this text. However, in doing this, there are risks of misinterpreting the original author's meanings to the reader by omitting other parts of the original text. The author can also manipulate the reader by only presenting certain parts of information (foregrounding) and thereby backgrounding other information.

Manipulation is exemplified by the extracted table of an educational model about clinical reasoning by Levett-Jones et al. (2010 as cited in Douglas and Crisp, 2017 p. 48). It states that it is being used to demonstrate how a novice nurse needs to be active in learning, seeking support, and knowing when and where to seek support to meet patient needs. The table presents the experienced nurse as having 'a way of being' and 'instantly knowing' after 'scanning' the patient:

> Have a way of 'being with a patient' and instantly knowing the patient after scanning him/ her; they know what to pay attention to and what questions to ask. (Douglas & Crisp, 2017, p. 55)

The textbook provides a limited context compared to the original text from which the educational model is taken and simplifies advanced nursing, reinforcing the message that the novice-level student nurse has limited knowledge and a lot to learn. This simplification could motivate the novice to engage with the original text to acquire

such knowledge; however, there is also a risk that the novice will be left wondering if they could ever achieve such skills.

The text cross-references its content and calls on professional documents to strengthen its instructional legitimacy, such as the Australian Code of ethics for nurses in Australia and the Code of professional conduct for nurses in Australia and New Zealand standards for practice for nurses and professional codes of ethics and conduct (Nursing and Midwifery Board of Australia, 2008a, 2008b; and NCNZ 2012a, 2012b; Stein-Parbury, 2017).

There is an implied appreciation that work is actively being carried out to increase patient-centred care; however, in the textbook excerpt below, the healthcare system, rather than the individual healthcare professional, is portrayed as the active agent in achieving patient-centred care. This reduces individual responsibility and replaces it with institutional responsibility for reform:

> Current efforts in healthcare systems reform are aimed at making communication, and care itself, more patient-centred. (Newell & Jordan 2015 & van Dulmen 2011, as cited in Stein-Parbury, 2017, p. 213).

The authority exerted by the textbook is reinforced by the wording selected for the title *Fundamentals of Nursing,* suggesting its contents are essential, necessary, and important. There is also a *Fundamentals of Care Framework* and a *Fundamentals of Care Practice Process* that are developed by some of the book's contributors. These are extensively referred to within some chapters of the textbook, accompanied by claims such as:

> The Fundamentals of Care Framework shows the need to establish a trusting relationship with the patient and to incorporate and address a patient's physical, psychosocial and relational needs. (Conroy et al., 2017, p. 28)

> The Fundamentals of Care Practice Process demonstrates how the Fundamentals of Care Framework is the intersection of your working hypothesis, relevant theories and the clinical reasoning process. (Conroy et al., 2017, pp. 28-29)

> in using the Fundamentals of Care Practice Process you will develop the skills of critical reflection and evaluation of the impact your actions have had on your patient – both intended and unintended consequences. (Conroy et al., 2017, p. 17);

> The Fundamentals of Care Framework illustrates how a positive and trusting nurse-patient relationship is integral to maintaining patients' physical, psychosocial and environmental safety. (Feo et al., 2017, p. 43)

Uncovering the Discourses

Following the same process completed for identifying themes and discourses as for Document 1, Table 3 (Appendix B) presents selected excerpts from the critical analysis of the textbook alongside the themes or discourses identified in the construction of EI. As with the analysis of Document 1, each EI-related excerpt for the textbook had multiple discourses contributing to its construction, again demonstrating the interconnectedness between them. The professional, safety, and legal discourses related to self-awareness, cultural safety, relationship development, and management of boundaries in the Document 1 were also evident in the textbook discourses. The managerial discourse appears in the text and is closely aligned with the professional discourse, encompassing the responsibilities expected of nursing employees to have the appropriate knowledge, skills, and training to perform their duties, including maintaining their emotional health and well-being, to support reducing the chance of any detrimental effects such as burnout. In addition, managerial discourse expects a collegial work ethic to be employed by the nurse. This interconnected working of the discourses can be seen across the following examples which reflect the foregrounded professional responsibility of the nurse to establish therapeutic relationships within both personal and cultural boundaries, guided by policy and collaboration:

> Communication is the means by which nurses meet their professional obligation to form therapeutic relationships with clients. (Stein-Parbury, 2017, p. 232);

> It is the role of the nurse to deliver care in a way that the patient deems culturally safe. (Feo et al., 2017, p. 35);

> Patients and their family members should feel as though they are integral members of the healthcare team, that they are engaged, involved and informed, and that their preferences and expertise are considered rather than dismissed. (Feo et al., 2017, p. 37);

> The qualities, behaviours and communication techniques described characterise professionalism in therapeutic relationships with clients and collaborative relationships with colleagues. (Stein-Parbury, 2017, p. 210)

The expectation is that the nurse is both self and socially aware and decides what constitutes 'safe' boundaries and parameters of such relationships, including how much to share of themselves, and to avoid unsafe care delivery when managing connections with both consumers and colleagues. This is evident in the following excerpts:

> Statements reflecting empathy are highly effective because they tell the person that the nurse heard the feeling content, as well as the factual content, of the communication. This results in clients feeling accepted and valued, thereby facilitating the therapeutic relationship. (Stein-Parbury, 2017, p. 228);

> Sharing emotion makes nurses seem more human and can bring people closer. It is appropriate to share feelings of caring, or even cry with others, as long as the nurse is in control of how those feelings are expressed and does so in a way that does not burden the client. (Stein-Parbury, 2017, p. 228)

> Nurses consider many contexts and factors influencing communication when making decisions about what, when, where, how, why and with whom to communicate. (Stein-Parbury, 2017, p. 232)

Constructing EI

EI was explicitly referred to within the textbook, in Chapter 12, reinforcing its requirement for the fundamentals of nursing practice, synonymous with the title of the textbook. The text explicitly states that "emotional intelligence is required for effective and skilled communication in the healthcare setting" (Stein-Parbury, 2017, p.

232). While the inclusion of EI clearly indicates recognition of its requirement for nursing practice through its inclusion, the text only contains information about the origins, requirements and benefits of EI and not how the student nurse might further develop it. The chapter cites seven different contributors when presenting the application of EI as unequivocally required in nursing, supporting its assertions as being commonly supported by others and, therefore, evidence-based rather than only reflecting the author's viewpoint.

The textbook refers to the nurse's unequivocal ‘need’ to be able to manage their own and others' emotions. It reinforces the expectation that nurses should have or acquire EI to ensure they are skilled in managing and understanding their and others’ emotions, yet it does not guide what the student nurse might do to foster such development. The requirement for the nurse to have EI is again reinforced later in the textbook in Chapter 37 concerning the nurse managing stress in the workplace. It states that a nurse's high level of EI can protect against stress.

Chapter Summary

This chapter has presented the synthesised research findings from analysing the first two of five documents. The analysis followed a two-stage process and supported the identification of how language and textual characteristics are used to construct EI and establish authority. The discourses identified across the two documents included professional, management, safety, and legal discourses related to self-awareness, cultural safety, relationship development, and the management of boundaries. Chapter 5 presents the synthesised findings of the remaining three documents in the same format with a concluding textual analysis of all five documents.

Chapter 5 Research Findings Part B

Chapter 4 (Document Analysis Part A) presented the findings derived from the first two selected documents. Chapter 5 now provides the synthesised findings of the remaining three documents, each of which is a nursing curriculum. The analytical approach was identical to the one used in Chapter 4 and utilised Huckin's (1997) two-staged approach based on Fairclough's (1995) 3-dimensional CDA framework. Each document was critically analysed for EI-related content as outlined in Chapter 3, and thematic analysis was employed to support the identification of the themes and dominant discourses within the texts (Owen, 1984).

Historical Context and Background for the Three New Zealand Nursing Curricula Documents

The NCNZ is the statutory regulatory body that functions under and administers the HPCA Act 2003 to protect public interest by being accountable to the public for maintaining standards of registration of nurses (Ministry of Health, 2003). As part of its statutory obligations and responsibility to public safety, NCNZ requires every institute delivering a nursing programme to undergo extensive ongoing review for accreditation and all are required to provide evidence as part of mandated desk audits and monitoring visits. In addition, all persons placed on the nursing register are required to be deemed fit for registration. The curriculum documents, alongside other documents such as the academic regulations and calendar, programme regulations, academic review reports, and student handbooks, enable tertiary institutes to provide the required information in line with the professional accreditation and monitoring audits of the NCNZ (2015). The terms nursing curriculum and nursing programme are sometimes interchangeable; however, within the current study, the nursing programme encompasses the overarching role of the tertiary nursing education department, within which the nursing curriculum exists (Iwasiw et al., 2020). A curriculum can be seen as a pedagogical action plan consisting of documents that guide learning within a programme of studies and can result in attaining academic qualifications (Iwasiw et al., 2020; Jonnaert & Therriault, 2013).

To support its statutory legislative role, the NCNZ (2021a) provides a handbook of education programme standards to guide each of the 17 institutes offering Bachelor of

Nursing programmes in New Zealand. The transfer of nursing education from hospital-based training to tertiary education-based programmes by the 1990s was followed in 1996 by the regulatory body mandating that all registered nurses required a minimum of a bachelor's degree level qualification. This signalled the end of the practical caregiving vocational model of nursing education to a model of education that emphasised preparing nurses for a dynamic theory, research, and evidence-based practice profession (Jacob, 2019, p. 20).

The current standards require that the programme is delivered with the resources required to support learning. This means that all institutions must employ academic staff who either hold or plan to complete a relevant master's level degree within 4-years. In contrast to specificity in terms of qualifications, staff must also demonstrate 'currency' of theory and practice knowledge appropriate to their teaching responsibilities. Exactly what that currency is, is not specified or elaborated upon in the document NCNZ (2021a).

Each tertiary institute's structured curriculum must enable students to achieve the programme outcomes and the NCNZ competencies for the registered nurse scope of practice. While the *Competencies for Registered Nurses* document was not produced until 2007, New Zealand undergraduate nursing education has required the principles of the Treaty of Waitangi/Te Tiriti o Waitangi and cultural safety to be applied to nursing practice within the curriculum since 1991 (Ramsden, 1993). The Treaty of Waitangi/Te Tiriti o Waitangi must be read, understood, and implemented in practice to demonstrate NCNZ Competency 1.2.

All three of the curricula analysed complied with the standards written in July 2010; however, these standards have since been updated in 2021 by NCNZ (2021a). Each of the documents provided by the selected tertiary institutes included course descriptor papers containing each paper's aims, learning outcomes, indicative content, and assessment requirements. These curriculum documents have multiple functions in reflecting and shaping the content taught to nursing students seeking to qualify as registered nurses in New Zealand. They provide a contextualised understanding of how the curriculum has been developed, its considerations, and specific details of the content taught and assessed within each course/paper.

Generic Naming of Nursing Curricula Course Papers

Each institute used a unique naming convention for its course papers. Therefore, each course paper was allocated to a generic group dependent on its content to assist in linking and comparing the three selected institutes' curricula.

Course Paper Generic Group

- Sociology/Psychology
- Māori Health Studies
- Evidence-based Practice/Research
- Mental Health Theory/Clinical
- Hospital/Acute Nursing Theory/Clinical
- Primary/Community Nursing/Chronic Disease Management Theory/Clinical
- Biology/Pathophysiology/Pharmacology

Part B Document 3:

Undergraduate Nursing Curriculum 1

Historical Context and Background

The tertiary institute for whom this curriculum document was written is one of five nursing schools based in a large city. It was established in 1895 and has offered nursing education since 1975, commencing a degree programme in 1992 as a polytechnic and became a university in 2000. The curriculum was updated in 2019 with 16-course descriptor papers at NZQA levels 5, 6, or 7, each worth 15, 30, or 45 credits. The author/s were senior registered nurse/s with teaching/research/clinical/managerial experience and/or responsibility in the nursing programme.

Uncritical Review

The read-through of the first curriculum document was again guided by Huckin's (1997) methodological process to establish the text's purpose and meaning at face value and note initial observations, feelings, and thoughts. The language used within the curriculum document was familiar to me as an educator and a registered nurse. It was lengthy, 71-pages, and very comprehensive. The first 17 pages presented the background and history of the institute and its nursing programmes before providing

information on the underpinning philosophy, pedagogy, teaching and learning strategies, latest restructure changes, clinical model, and references with the actual paper descriptors included as the first of four appendices.

The document's content conveyed the primary purpose of providing evidence of compliance with requirements of nursing programme education and clinical content, informing the reader of the updated curriculum details and providing evidence and rationale for changes made to improve quality. During the uncritical read-through, one specific part of the curriculum document that drew my attention due to its unmistakable relationship to EI was where it focused on the nurses' well-being and resilience. Key stakeholders had raised this as an issue during the curriculum consultation phase resulting in it being identified as a key theme to be addressed. Because this was significant to the study, it was noted for further examination within the critical part of this review:

> The personal well-being and resilience of the nurse was also a key theme to emerge from the consultation. (Curriculum Document 1, 2019, p. 10)

In addition to conveying compliance with the requirements of nursing programme content, the paper descriptors were informative. The language used in the document was familiar to me as education or professional-related terminology. While this is not a student-facing document, Appendix A's paper descriptors would be particularly relevant to students and are most probably disseminated to students as standalone documents. They contain information about the course paper learning outcomes, content, learning and teaching strategies, assessment processes and methods, and learning resources. In addition, although not explicit, the document provides a comprehensive overview of the programme to be used as supporting evidence for reports and audits, particularly for the NCNZ and relevant educational governing bodies demonstrating what, how, and why the curriculum is how it is.

Critical Review

Process for Claiming Authority

The document text of the first curriculum was examined to identify the processes used in claiming its authority. Formal professional language was used to provide information on the academic content of the nursing educational programme, conforming to both professional and educational genres. There was a tone of authority and certainty in using familiar educational terms such as the student will 'apply', demonstrate', and examine', with the text written using prefixing positive focussed words such as 'will' that assumes the success and achievement of the student.

The document's appendices include all course paper descriptors, an overview of all papers, and how the content of the four NCNZ domains and competencies for registered nurses map to the paper descriptors. The content aligns with the evidence required by the NCNZ (2015) as part of their mandated desk audit and monitoring of programmes. The course paper descriptors encompass educational and professional genres using educational and professional language to meet academic, theoretical, and clinical requirements. They are written predominantly in the third person, speaking on behalf of the nursing school; for example:

> The integrated nature of the current clinical papers was considered a strength and thus many of these have been retained. (Curriculum Document 1, 2019, p. 10)

Academic references were used to strengthen selected statements, as might be expected of a tertiary educational institute. The references support the assertion of authority by the institute through the provision of an evidence base for the content, reducing the chance of challenge and reinforcing its educational credibility:

> A mixed model approach to providing clinical supervision to BHSc (Nursing) students is based on recommendations from an independent review … (Mueller, 2015) as well as taking into consideration stakeholder feedback and a preference by some for joint appointment arrangements. (Curriculum Document 1, 2019, p. 12)

An air of showcasing was also noted in parts through the use of language related to ‘first class’ education, producing the ‘future experts and leaders’, the student’s pursuit of ‘excellence and quality’ clinical experiences:

> The Department of Nursing strives to deliver first class education.” (p. 4)
>
> Our goal is to produce academically capable graduates who are the future expert nurses and nurse leaders. (p. 4)
>
> The programme is delivered with integrity, respect and compassion to enable students to pursue excellence and to be creative, curious and critical enquirers. (p. 5)
>
> work collaboratively with three District Health Boards (DHBs) and numerous Nongovernment Organisations (NGOs) to maximise student access to quality clinical experiences. (Curriculum Document 1, 2019, p. 10)

This strong air of authority can be seen to reflect the confidence the institute has in its compliance with the NCNZ regulatory body requirements for the curriculum. Another reason for likely positioning within the tertiary institute market for nursing programmes is the significant local competition in the region for both students and the clinical placements within which to place students, for which quality could be an influencing factor. The document claims authority for the tertiary institute as being held in high esteem amongst its peers, foregrounding its world-class status:

> ranked in the top 2% of the world’s universities (QS World University Rankings). It is one of the world’s top young universities (16th) and the top New Zealand university for international outlook. (Curriculum Document 1, 2019, p. 4)

Moreover, it positions the nursing school in the top 100 schools globally with the addition of an official award for World University Rankings. An orange, black, and white logo is presented underneath, comprising six lines of the document’s text in height and width:

> In 2018 the Department of Nursing was ranked in the top 100 Schools of Nursing in the world (QS World University Subject Rankings). (Curriculum Document 1, 2019, p. 4)

The institute also claims authority through its repeated assertion of quality regarding "quality clinical experiences" (p. 10), "quality care" and "quality assurance practices" (p. 41), and with "quality improvement" included in the learning outcomes of six of the course paper descriptors (Curriculum Document 1, 2019, pp. 32, 34, 36, 37, 39, 41). The word 'quality' communicates high standards of practice and is consistent with the professional language used in NCNZ documents, such as the *Competencies for Registered Nurse*s that speak of the quality of life, quality improvement, and quality practice (NCNZ, 2012b).

As previously highlighted, NCNZ requires tertiary institutes delivering nursing programmes to provide a structured curriculum that enables students to achieve the programme outcomes and the NCNZ (2017) competencies for the registered nurse scope of practice. While the document does not state a primary purpose, the comprehensive and structured nature of the content and the document's report style genre suggest one function is as part of an audit report for the NCNZ in compliance with the responsibilities that the NCNZ has under sections 12, 16, 45(4)(5), and 118 of the HPCA Act (2003). The curriculum document does not mention the regulatory responsibility of the NCNZ, simply that:

> The Nursing Department complies with the legislative requirements under the HPCA Act (2003) as an educational institution offering healthcare professional programmes at entry to practice and postgraduate levels. (Curriculum Document 1, 2019, p. 4)

The above statement reflects a direct relationship between the nursing department and HPCA Act, missing out the regulatory role of the NCNZ. It also claims further authority at the beginning of the statement through the use of presupposition, where it states compliance with legislative requirements; whereas it is, in fact, NCNZ that has the authority to determine its compliance with the legislation.

Appendix 3 of the NCNZ handbook for pre-registration nursing programmes provides the guidelines for the accreditation of institutions seeking to establish a school of nursing. It stipulates that "each paper/course/unit should indicate to which of the Council's standards and guidelines it contributes" (NCNZ, 2013, p. 52). The institute complies with this through the inclusion in the curriculum document of Appendix C:

NCNZ indicators mapped to papers, and Appendix D: *Content matched to threads/domain*s provides clear evidence of compliance for NCNZ. Thus, the curriculum also aligns with the NCNZ C*ompetencies for Registered Nurses* four domains of competence by renaming these as *curriculum threads*:

1. Professional responsibility
2. Management of nursing care
3. Interpersonal communication
4. Interprofessional health care and quality improvement

The course papers were presented logically with an alphanumerical code made up of four letters and three numbers in addition to the name of the course paper. The course paper code was followed by the paper title, which used familiar nursing terms that were informative of their content (e.g., Long-Term Care and Pharmacology for Professional Practice). Some course papers related to biology/pathophysiology/ pharmacology and Māori health are delivered on an interprofessional basis, meaning that health studies students, other than those in the nursing programme, are enrolled. The remaining nurse-only course papers are all integrated theory and clinical practice whereby reflection seemed to be the means whereby clinical and theoretical learning are integrated, based on the NCNZ competencies for registered nurses; for example, requiring the student to reflect on their practice and values as directed in the sixth indicator in NCNZ Competency 1.5:

> Reflects on their own practice and values that impact on nursing care in relation to the health consumers age, ethnicity, culture, beliefs, gender, sexual orientation and/or disability. (NCNZ, 2012b, p. 6)

Reflective practice was noted as playing a significant role in students' assessed expectations in providing evidence for their practice, commonly required in the forms of competency portfolios and reflective diary evidence. Students are required to reflect and then analyse their clinical experiences to provide what the institute terms reflection-on-action, facilitated by journaling and interaction with clinical lecturers and educators. Reflection requires self-assessment and, depending on the competency attempting to be achieved, will influence how and what is shared. Furthermore, and

importantly, reflection requires the EI of self-awareness to reflect fully on experience and receive feedback and observations from others. The level of reflection is dependent on the individual and is necessary to link practice to learning, with the institute claiming that: “doing and reflecting lead to becoming” (Curriculum Document 1, 2019, p. 7).

Literary Tools to Drive the Message

The genre of curricula reflects many characteristics of a report and meeting with general educational content requirements. For example, the cover page for Institute 1’s curriculum has the institute’s logo occupying nearly a third of the A4-sized document and is copyrighted to the institute. It has a table of contents and provision of information in a factual report style and is written concisely and predominantly in the third person. Huckin (1997) cautioned to be mindful of purposeful deviations or manipulations when examining the text. One deviation noted was from use of the third person with ‘our’ in the first person which often denotes where belonging and potentially ownership/alliance is being portrayed. I noted that the word ‘our’ was evident in the curriculum document concerning our bicultural nation, our goal, our philosophy, our mission, and our clinical partners:

> The Department of Nursing acknowledges our bicultural nation ... Our goal is to produce academically capable graduates. (p. 4)
>
> Our Philosophy… Our Mission. (p. 5)
>
> supports closer engagement with our clinical partners that will positively impact student learning. (Curriculum Document 1, 2019, p. 12).

Using ‘our’ when referring to clinical partners could be seen as the institute fostering a partnership-type relationship. Health services are essential in providing clinical placements in areas the institute will provide future nursing personnel. The fact that five city-based nursing programmes compete for clinical placements in this region could also be a driver for fostering allegiance and alliance. Although District Health Boards are important stakeholders and clinical partners, they are unlikely to read the curriculum document. Therefore, it could be assumed that the use of ‘our’ is meant to convey confidence to the NCNZ that students will be able to complete the mandated

minimum of 1100 clinical hours during their programme, despite competition for placements. Interestingly 'our' is never used in relation to the students enrolled in the institute's programme. They are always referred to in third person. One reason could be that the relationship with the student is time-limited rather than ongoing. Alternatively, it reflects a power dynamic, with the student being the recipient and the institute the knowledge holder, further communicating their position of authority. References about the student were noted to include what the institute prepares the student to be able to do while acknowledging the diverse sources of teaching and learning, including peers, academic staff, health professionals, and the recipients of care:

> Bachelor of Health Science (Nursing) prepares the next generation of nurses …is delivered with integrity, respect and compassion to enable students to pursue excellence… Learning and teaching occurs in active partnerships with peers, academic staff, health professionals and care recipients in a variety of healthcare environments. (Curriculum Document 1, 2019, p. 5)

Active partnership is key to the students' learning; therefore, engagement with key stakeholders is essential. As identified in the uncritical review, recent consultation had resulted in the personal well-being and resilience of the nurse being identified as needing to be addressed within the curriculum. While identifying EI-related content is welcomed, because it foregrounds changes to the curriculum, it was disappointingly backgrounded by being last in the list of recommended key themes. Furthermore, it did not include the recommended integration into the curriculum and better student preparation associated with the other key themes. The theme of personal well-being and resilience is only explicitly featured in one level 5 clinical paper worth 45 credit points completed in the programme's first year. The fact that important EI-related content, such as well-being and resilience, was recognised and that the recommendation has been carried forward is a positive move. However, the emphasis dissipated compared with other key themes that also had context and rationale included.

The stakeholder themes identified the reason why they were beneficial to the student in terms of preparing the nurse, better preparation of the student, or opportunities for

interprofessional learning. In contrast, there was no elaboration as to why well-being and resilience positively contribute to preparing the student for their future work environment (as proposed for the use of information technology, for example). This reduces the power the theme carries in comparison with the others:

> Key themes that needed to be addressed within the new curriculum included a focus on the patient/client/service user journey within the full continuum of care and an increased emphasis on primary health care and the preparation of nurses for working in the community. Stakeholders also recommended the integration of mental health concepts through the curriculum, increased use of information technology to better prepare students for the future work environment and more opportunities for interprofessional learning. Personal well-being and resilience of the nurse was also a key theme to emerge from the consultation. (Curriculum Document 1, 2019, p. 10)

While there was only one explicit inclusion within the curriculum of personal well-being and resilience, knowledge and skills related to other emotional competencies was found in several paper descriptors. These EI-related examples are detailed in Appendix B as part of Table 4 excerpts extracted from the document.

Positioning Subjects

Discursive practices can be used to position people within the text. It is clear from its report style and evidence that the curriculum document provides a comprehensive, authoritative outline of its current nursing curriculum programme and demonstrates its position of compliance with NCNZ requirements for nursing programmes. However, while being a curriculum for nursing students, it is not written with the student as a reader in mind. The course paper descriptors are students' most relevant parts of the curriculum document. Each course paper descriptor contains information, as previously detailed, that would provide the student with an overview of the programme's content and what is assessed.

The requirement for nurses, as health professionals, to draw on legislation to inform their practice and meet professional standards was explicitly clear in the document.

The Professional regulation, responsibilities, and legislation explicitly identified in the document included:

- HPCA Act (2003)
- New Zealand Public Health and Disability Act (2000)
- Medicines Act (1981) *and relevant regulations*
- Medicines Amendment Acts 1990, 1999 & 2013
- Misuse of Drugs Act (1975) and relevant regulation
- Health and Disability Commissioner Act (1994)

Specific references to relevant policy and guidance documents such as the *Code of Conduct for Nurses* and *Guidelines: Professional Boundaries* were not cited within the document but are still required to be read and understood as part of meeting NCNZ registered nurse Competency 1.1 wherein the nurse:

> Accepts responsibility for ensuring that his/her nursing practice and conduct meet the standards of the professional, ethical and relevant legislated requirements. (NCNZ, 2012b, p. 5)

and supported by the competency indicator stating:

> Demonstrates knowledge of, and accesses, policies and procedural guidelines that have implications for practice. (NCNZ, 2012b, p. 5)

The requirement for compliance with the NCNZ's *Competencies for Registered Nurses* is reinforced and foregrounded in the first bullet point of the graduate profile within the institute's curriculum document stating that graduates will:

> Meet Nursing Council of New Zealand competencies for entry to the Register of Nurses. (Curriculum Document 1, 2019, p. 6)

Uncovering the Discourses

The same analytical process was followed to identify themes and discourses for the first curriculum document as used for Documents 1 and 2. This process enabled excerpts related to the construction of EI to be identified alongside their associated themes and discourses (see Table 4, Appendix B). Each EI-related excerpt for

Curriculum 1 (Document 3) had multiple discourses identified as participating in its construction, thus demonstrating the interconnectedness of the discourses. Consistent with the analysis of Document 1, professional, safety, and legal discourses related to self-awareness and cultural safety were identified, in addition to themes related to the management of boundaries and therapeutic relationship development and management. One of the main reasons for this similarity is that all tertiary institutes delivering undergraduate nursing programmes must align their curricula with Document 1, *Competencies for Registered Nurses* (NCNZ, 2012b). Therefore, the content of the curriculum reflects the requirement to develop undergraduate nursing students to be able to meet the professional, ethical, cultural, and clinical-related competencies to be able to maintain public safety and meet legislative requirements as part of the HPCA Act (2003) which includes requiring professionals to be regulated.

Included within the appendices of Institute 1's curriculum document are the NCNZ competency indicators mapped to each of the course paper descriptors learning outcomes. Therefore, the themes and discourses that influenced the positioning of EI within Document 1 were also found within the curriculum document and included the professional, legal, safety, and cultural safety discourses. The learning outcomes within the course papers were seen to reflect the content of Document 1 directly, with learning outcomes repeated and reinforced across multiple papers. For example, learning outcome three across four of the course paper descriptors directly linked to Competency 3.1:

> Establishes, maintains and concludes therapeutic interpersonal relationships with health consumers. (NCNZ, 2012b, p. 10)

This repetition and recurrence meets two of Owen's (1984) three criteria in thematic analysis, with forcefulness communicated through its use of unequivocal and direct language, making it clear that it is a non-negotiable requirement.

Constructing EI

As already established, the *Competencies for Registered Nurses* (NCNZ, 2012b) document has a powerful professional and legislative influence on the content of the undergraduate curriculum. EI has emotional self-awareness requirements that are fundamentally required to enable understanding and management of emotions.

Reflection, therefore, plays a key role in self-awareness within the curriculum, supporting the student's knowledge development through insight and self-awareness of emotions as indicated by the focus on the student gaining confidence in 'who they are' as a person rather than simply 'what they are' (e.g., a nursing student). The curriculum document cites Daley (2001) in supporting reflection on experience as a central pedagogy within the curriculum because "it is through reflection on clinical experiences that nurses gain maturity and confidence in their abilities and in who they are (p. 53)" (Curriculum Document 1, 2019, p. 7). The document also cites Ewing and Smith (2008) in the recognition that as an individual the student will have a personal life, prior experience and knowledge requiring consideration and that 'who they are' and 'what they are' cannot be detached from one another:

> Practice cannot be divorced from the practitioner as a person with life experience: the doing is the being. (Ewing & Smith, 2008, p. 27). (Curriculum Document 1, 2019, p. 7)

Therefore, EI is predominantly featured as part of the experiential learning focus of Institute 1's undergraduate curriculum to assist students in integrating knowledge into practice. As part of that experiential focus, reflective practice requirements feature throughout the curriculum and are referenced within the document to add weight to the claim that it contributes to improving professional knowledge and abilities and how the nurses understand and feel about themselves:

> Ruth-Sahd (2003) identifies other positive outcomes of a reflective practice such as enhanced self-esteem, acceptance of professional responsibility, a sense of empowerment, increased social and political emancipation, improvement of practice through greater self-awareness, and expanded clinical knowledge and skills. (Curriculum Document 1, 2019, p. 7)

Part B Document 4:

Undergraduate Nursing Curriculum 2

Historical Context and Background

The second curriculum document examined (Document 4) was written and produced by a New Zealand tertiary institute based in South Island that has been offering a

nursing programme since 1984. The curriculum course descriptors are dated 2018, and the curriculum is constructed of clinical and theory course papers and taught exclusively to the Bachelor of Nursing students. The course descriptor papers are worth 15, 20, or 40 credits and equate to 120 credits per year, 360 credit points in total at NZQA levels 5, 6, and 7. As with Institute 1 (Document 3), the author/s are likely to be senior registered nurse/s with teaching/research/clinical/managerial experience and/or responsibility in the nursing programme to support a clear understanding of the programme delivery and audit requirements.

Uncritical Review

As already noted, curriculum documents have several purposes. They provide information for both educational and professional monitoring and quality assurance purposes. Therefore, while each curriculum document is unique, they contain similar information such as programme philosophy, graduate profile, teaching and learning strategies, and course paper descriptors. Thus, the second curriculum was similarly lengthy and comprehensive. Differences were noted in that this document did not include the institute's background and/or history as had the previous curriculum document.

This document's opening section began with a personal summary statement from the Head of the School. The 'Programme Philosophy' section continued, written in the first person in a conversational style, sharing the School of Nursing's team decisions and views using 'our' and 'we' to indicate a collective view. It seemed to be designed to engage readers personally with the document and ensure they were aware of the shared decision-making process through reference to team discussions that had taken place:

> Given that the school holds the position … our choices have been many... we have moved to a position;
>
> The School of Nursing has had several discussions about changing the school philosophy. (Curriculum Document 2, 2018, p. 1)

I found the philosophical discussion on the first page of the document engaging and relatable because it is congruent with my own philosophical leanings. It states that the

school believes that knowledge is socially constructed and that there is multiple worldviews. This global inclusivity would likely appeal to the range of cultural groups who now make New Zealand their home and support the favourable positioning of the institute to international students. It also stated that the philosophy for the new review of their curriculum was built on a sustainable model of practice that nurses will embrace. I was intrigued to find out what the institute meant by these words, having previously linked sustainability more with environmental issues than as an underpinning premise of health education. In line with Huckin's methodological process of first reading the text uncritically to establish the text's purpose and meaning at face value, recording initial observations, feelings, and thoughts, I made a note to revisit sustainability as part of the critical part of my review. I needed to understand its relevance to EI.

The document contained statements that I would expect to see related to nurses being accountable in an applied discipline with caring and partnerships, working both independently and in collaboration across the lifespan in multiple settings. However, a statement that drew my attention related to the assumptions underlying curriculum development. It resonated because it spoke to the invisibility of nursing, acknowledging that nursing is complex and can be undervalued due to the taken-for-granted nature of its practice:

> Much of nursing practice is invisible, which means that nurses, the public, and other health professionals can undervalue the complexity of nursing practice. (Curriculum Document 2, 2018, p. 1)

While not explicitly mentioning or expanding on what aspects of nursing practice are invisible, EI undoubtedly falls within this category. The understanding, reasoning, and skill required to manage the complexities inherent in emotive clinical situations is not visible in the same way as is the application of physical nursing tasks. Nurses' emotional work can be undervalued by the public and other health professionals, as well as by nurses themselves. I found it reassuring that the institute was overtly aware of this taken-for-grantedness, making it more likely that the development of EI would feature as part of the taught curriculum content.

Critical Review

As noted for further analysis in the uncritical review, sustainability is featured in the document's first line and highlighted as a thread throughout the curriculum, with such foregrounding signalling that it may be considered significant. This tertiary institute was the first in New Zealand to join the Climate Leaders Coalition. Reflecting this impact is the explicit requirement mandated by the institute on its main website for the inclusion of sustainability in all its courses, not just nursing, adding that sustainability is for the decision-makers and leaders of change. It provides a key example of where the socio-political environment is explicitly impacting the curriculum's language use, discourse, and content. Although the inclusion of sustainability in the curriculum could be viewed as driven by the institute's membership in the Climate Leaders Coalition, there are also professional drivers for sustainability to be included in the nursing curriculum.

The New Zealand Nurses Organisation (NZNO) *Strategy for Nursing Advancing the Health of the Nation 2018-2023* promotes a model of care that encompasses sustainability. They call for investment in nursing to support the delivery of universal health coverage and progress the United Nations Sustainable Development Goals to ensure better health for everyone (New Zealand Nurses Organisation, 2018). NZNO is the leading professional nursing association and union for nurses in New Zealand. Thus, it is influential and in a position of power supported through nursing membership. The organisation promotes improving the model of care away from nurses being seen as units of production and progressing to nurses being viewed as a solution to sustainable, high-quality health services (NZNO, 2018). Therefore, sustainability can be viewed as driven by two separate influential and powerful sources, reinforcing and strengthening its significance within this curriculum document.

Sustainability

The institute further raises the profile of sustainability by linking it with the future of nursing: "Environmental awareness and sustainability are attributes that are important for the future of nursing" (Curriculum Document 2, 2018, p. 4.). It also states that by including it within the learning outcomes of every course descriptor paper, it ensures

that sustainability is: “recognised as a key concept embedded within a multitude of areas of nursing practice” (Curriculum Document 2, 2018, p. 4.)

The following statement is included in every course descriptor paper learning outcome:

> Students will develop an understanding of sustainable nursing practice and its application to health in Aotearoa New Zealand.

The consistent repetition of sustainability throughout the course papers can be seen to reinforce the significance of the concept. However, a caution with this approach is that it could also result in desensitising the reader to the concept with a ‘cut and paste’ feel. One of the assessments related to sustainability requires self-awareness, social awareness, and conflict resolution, thus linking clearly to EI:

> understanding of the complexity of addressing environmental, social/cultural and economic aspects of sustainability in a range of nursing contexts; developing the capacity to make links between personal, community and global issues and the recognition and integration of multiple and divergent points of view to solve problems and resolve conflict in cooperative and proactive ways. (Curriculum Document 2, 2018, p. 4)

Sustainability is given a privileged place within the curriculum through its inclusion under the subheading of professional responsibility in line with NCNZ competencies, alongside safe, legal, and ethical practice in the first clinical practice course paper. Furthermore, the indicative content of this course paper links sustainability practice to self-care, reinforcing that the self-care of nurses is a professional responsibility, with the students required to “‘demonstrate knowledge of safe, sustainable, legal and ethical clinical practice” and “sustainable practice and self-care”. Self-care is also included in the two of the Hospital/Acute Nursing Theory course descriptor papers (level 6, 30 credits and level 7, 20 credits), where the student is directed in both papers to “identify and develop strategies to enhance self-care and sustainability of own practice”. Self-care is a component of emotional resilience building in nurses and can contribute positively to sustainable practice.

Process for Claiming Authority

The curriculum document text was examined to identify the processes used in claiming its authority. This document provides both informative and comprehensive information on the development of the curriculum and the curriculum itself. Thus, it is evident that it serves multiple purposes, including providing information for professional and educational monitoring and audit requirements, teaching staff and students. While the document is unlikely to be available to students in its entirety, the curriculum course descriptor papers provide essential information on the content of each taught course and would be relevant to students.

Discursive differences were noted within the text. For example, there was a shift from a conversational voice of sharing the team's journey during the curriculum review to a voice of authoritative and expert register in the following statement suggesting that nursing can foster sustainability:

> The contribution that nursing can offer to the field of sustainability is modelling less exploitative and more sustainable health care practices in order to support people and their communities. (Curriculum Document 2, 2018, p. 4)

Literary Tools to Drive the Message

The tertiary institute uses a report-style genre to present the curriculum information confidently. In keeping with a report, the language used is factual and explanatory to reduce doubt and conflicts, and includes educational and nursing-related terminology. Each course descriptor paper follows the same format and informs the reader of the aim, content, learning outcomes, and assessment expectations. Also included are moderation, extensions, attendance requirements, specials policy, and course failure information. The format of each course outline within the curriculum is similar. The use of the word 'will' in the course descriptor papers communicates certainty in relation to expectations, authority, and confidence in the outcome:

'Students will maximise learning opportunities...'

'Students will participate…'

'Students will be able to…'

Authority is consequently reinforced in cases where the emphasis is given to words in the text through bold font. Bold font can emphasise specific words bringing the emphasis to the foreground. Below are several examples from the course descriptor papers where one word in bold suggests that whatever is written before or after the word in bold is of greater importance or significance to the student:

> ‘To pass this course a student **must**…’
> ‘sit all four theory week tests **and**…’
> ‘gain a minimum cumulative mark of **50%**’
> ‘**No** Special will be offered in this course’
> ‘One resubmission opportunity **may** be available’

When looking at other manipulations of the text, Huckin (1997) also speaks of omissions or deletions in terms of words being missing from the text and words being left for the reader to work out using existing knowledge. An example is where, as noted in the uncritical review, the institute highlights an undervaluing of the complexity of nursing practice due to its invisible aspects:

> Much of nursing practice is invisible, which means that nurses, the public, and other health professionals can undervalue the complexity of nursing practice. (Curriculum Document 2, 2018, p. 1)

The absence of clarity can lead to misinterpretation because it leaves the reader to decide what ‘invisibility’ represents. Drawing on my knowledge and experience as a nurse, I interpreted it to include EI. Highlighting the ‘invisible’ parts of nursing contributing to its complexity, even though they are not defined, refocuses attention from what is obvious and visible.

That said, the following page of the document then strongly foregrounds parts of nursing that are ‘visible’ such as the scientific underpinning to nursing practice, stating that “the relationship between nursing science and practice is paramount” (Curriculum Document 2, 2018, p. 2), thereby reducing some of the previous statements force by bringing forth science as more important than anything else. Having a strong science focus is appropriate within nursing and needed within all curricula considering the increasing clinical practice complexities. The concern, however, is the lack of reference to the other essential aspects of nursing practice, such as those considered softer

skills. While it is accepted that nursing education should include the teaching of nursing theory, bioscience, and practical clinical skills, there is a recognised and growing concern resulting in continued calls for nursing education to extend its curricula and emphasis of what is often termed softer skills, such as EI, to improve student nurses' emotional understanding, self-awareness, self-control, and management (Ireland, 2022; Ranjbar, 2015; Waite & McKinney, 2016).

Positioning Subjects

Discursive practices can be used to position people within the text. As with Institute 1, there were elements of showcasing present where the institute was portrayed in terms of professing a quality programme and providing internationally accepted education alongside high personal and professional integrity expectations of students congruent with their graduate profile:

> The programme provides quality, undergraduate degree level, internationally accepted education. (p. 3);
>
> Have excellent personal and professional integrity. (Curriculum Document 2, 2018, p. 7)

An international focus is reinforced through this institute's global focus which states on the website 'Our people make a better world'. Raising the institute's profile regarding the opportunity for international nursing is, in part, driven by the neoliberal marketing that now exists in tertiary education where funding is based on the number of full-time equivalent (FTE) students enrolled in a course. International students provide a revenue stream for educational institutions, making an international approach economic sense.

The positioning of the student as being capable of adapting to an unfamiliar culture and working outside of New Zealand is also made explicit within the course papers. The student is positioned as being prepared not just for nursing within New Zealand but 'internationally'. The expectation for international working capability is included in several of the clinical course descriptor papers' learning outcomes requiring that the student employ self-awareness and reflection to support understanding how to adapt,

form relationships, and behave in a new and unfamiliar socially and culturally diverse environment is a necessity:

> The ability to critically reflect on their own practice, the practice of others and the socio-political influences on health care in both the New Zealand and international contexts. (Curriculum Document 2, 2018, p. 24)

The international focus of this curriculum may be the reason that a singular philosophy is not articulated in the same way it was in Document 3. Instead, the focus is on underpinning beliefs of the learning and teaching environment, referring to a unifying construct that encompasses the different perspectives that inform the programme.

Uncovering the Discourses

Excerpts related to the construction of EI were identified alongside their associated themes and discourses and are provided in Table 5, Appendix B. As was established with Curriculum 1, there is a strong requirement for curricula to reflect the NCNZ competencies for registered nurses, and this was evident throughout the course papers, influencing the same discourses to be present within the document of professional, legal, safety, and cultural safety discourses.

The educational process in the learning and teaching of Curriculum 2 is purported to be structured to allow for critical, reflective practice, and personal and professional growth. Students are expected to demonstrate critical, conceptual, and reflective thinking capacity, with capable graduates positioned as self-aware, reflective, and future-focused. They are presented in the graduate profile as able to "base today's decisions and actions on long-range goals" (Curriculum Document 2, 2018, p. X). Such wording implies being able to use long-term visioning to delay the requirement for gratification.

There is also a growing body of research linking delayed gratification to emotion regulation, suggesting they are related because both reflect an individual's more general self- regulation ability (Cohen & Lieberman, 2010; Heatherton & Wagner, 2011 as cited in Luerssen & Ayduk, 2014, p. 119). Long-term visioning can also be seen as thinking strategically, utilising traits such as sacrifice, self-control, and willpower. However, rather than a specific skill set, or task, delayed gratification and strategic

thinking are positioned as specific ways of thinking and reacting to stressors suggesting that this can be variable from person to person and challenging to articulate as a specific skill set. It was, therefore, difficult to identify how this featured in the curriculum.

Constructing EI

As with Curriculum 1, the requirements of EI were evident within the document; however, the explicit wording of EI was omitted. The excerpt examples in Table 5 (Appendix B) do not include any specific reference to EI; instead, contain specific aspects of EI required to meet the academic and professional requirements to become a registered nurse. For example, the curriculum document claims that professional nursing courses, nursing practice courses, theory for practice courses, and behavioural science courses have a focus that will facilitate its graduates to be "self-aware and reflective, adaptable, autonomous, self-managing, and accepting of responsibility and value diversity and effectively work with others" (Curriculum Document 2, 2018, p. 8). This implies that the curriculum delivers content that ensures the students are developed in areas of EI related to self-awareness, understanding and control of emotions which includes self-management and the culturally safe management of relationships. Because the curriculum is purposefully aligned to the *Competencies for Registered Nurses*, it is understandable and appropriate that the professional, safety, legal, and ethical discourses are used to construct EI. Requirements within the *Competencies for Registered Nurses document* related to relationship management, cultural safety, and relationship boundaries were also evident in the curriculum documents. The curriculum is designed to facilitate the development of a competent registered nurse (NCNZ, 2011; 2012a, 2012c).

The relevance of sustainability to EI in Curriculum 2 is also evident through an explicit link within the programme philosophy section of the document where it states that sustainability includes emotional sustainability:

> Within the programme it is recognised that sustainability encompasses social, cultural, economic, and emotional sustainability. (Curriculum Document 2, 2018, p. 4)

Despite this statement, little else is written specifically about emotional sustainability in the document. However, the concept of emotional sustainability can be viewed in terms of emotional resilience implying that it is required to carry out the ongoing challenges inherent in nursing. Nurses who have competencies such as emotional resilience have been shown to have less work-related stress and increased job satisfaction, which can result in higher performance and greater job retention (Codier et al., 2009). Therefore, emotional sustainability could improve nursing staff recruitment and retention, reducing staffing costs and allowing for healthcare monies to be saved or spent elsewhere. In this way, emotional resilience can also contribute to economic sustainability within healthcare.

The development of EI skills to prevent the above attrition could be sensibly sought to be included within the curriculum of a nursing programme. Examples reflecting the requirement for the application of EI are evident in the examples below. Specific mention is made of micro-skills, self-awareness, and communication requiring reflection and assertion in the management of communication between individuals and within groups:

> Demonstrate an ability to appropriately apply communication micro skills;
>
> Increase their self-awareness and effectiveness as communicators with individuals and within groups;
>
> Demonstrate effective use of assertive communication.

Part B Document 5:

Undergraduate Nursing Curriculum 3

Historical Context and Background

The third tertiary institute Bachelor of Nursing programme was first developed in 2002, replacing their previous Bachelor of Health Science programme. The document identifies the local population demographics as one of the fastest-growing in New Zealand with one-third Māori, poorer health, an increasingly ageing population, and a high proportion of deprivation in a large geographical area.

Uncritical review

As with the others, analysis of the third curriculum document was completed using Huckin's methodological process. Tertiary Institute 3 did not have a curriculum document like the other two institutes. Instead, it had a *Programme Approval and Accreditation Document* containing similar content to the first two institutes' curricula. The title of this document reinforced its stated purpose on the first page (i.e., that it had sought and received programme approval and accreditation from the Academic Committee and the NCNZ). It included information about the institute's mission, philosophy, organisation, and structure; and the Bachelor of Nursing programme review process, philosophy, and graduate profile. The 'Programme Structure and Descriptors' were referred to in the main document as an associated document explaining that "each descriptor provides detailed information about the course aim, learning outcomes, indicative content, assessment methods and events, clinical competencies, and learning and teaching strategies" (Curriculum Document 3, 2002, p. 17). Thus, these two documents represented the curriculum document for Institute 3, with the main document containing the introduction, philosophy, and graduate profile; and the second containing the structure and course descriptors.

The title of the document was consistent with the content. The document's primary purpose of compliance with accreditation requirements was reflected in the formal report layout and structure of the document's content. It provided information in factual statements informing the reader what to think. The mission statement for the nursing department was "To be at the leading edge in providing quality education in the fields of science, health and humanities, in an environment that values people" (Curriculum Document 3, 2002, p. 6). I noted this reflected prioritisation of the quality of education in addition to a leadership role, using an all-encompassing valuing of 'people'.

Critical Review

Process for Claiming Authority

The document text was examined to identify the processes used in claiming its authority. Both formal professional and academic language were used to provide information in the document, with the student referred to throughout in the third

person. While the accreditation part of the document was not written for the nursing student to read, students would be one of the consumers of the course descriptors. The document's fundamental purpose is to inform the reader of the high quality of the programme to attain approval and accreditation by demonstrating compliance with programme requirements. The document presents its narrative in a way that suggests it is trying to convince the reader that it meets all accreditation requirements; hence, the sense of authority demonstrated throughout is understandable. The programme is portrayed as having been modernised and "better" than before. It talks of replacing the previous Bachelor of Health Science, having been driven by local and national stakeholders seeking a high-quality, locally designed and locally owned undergraduate degree:

> When local and national stakeholders sought a high quality, locally designed and locally owned undergraduate degree. The Bachelor of Nursing replaced the Bachelor of Health Science (Nursing). (Curriculum Document 3, 2002, p. 11)

In addition, there was a sense of not just meeting the requirements but positioning the institute ahead of other institutes, with a strong sense of leadership authority. The document states that the previous nursing programme required a new framework and, in the same sentence, positioned itself at the "leading edge" (Curriculum Document 3, 2002, p. 6); thus ahead of others alongside a "commitment to promoting excellence, lifelong holistic learning and research, cultural safety and team concepts" (Curriculum Document 3, 2002, p. 8).

Literary Tools to Drive the Message

The document's information is presented logically and has 41 A4 pages of comprehensive information about the programme content, delivery, and format. The contents list covered two and a half pages, detailing each subheading consistent with the purpose of demonstrating compliance. Thus, it is aligned with accreditation and approval requirements in a format that is easily cross referenced. The style conforms to professional and educational genres. The course descriptors, as the associated document, continue to use a formal format and, like Curriculum 2, provide information confidently and factually using the same words for all the learning outcomes for the

papers (i.e., “On successful completion of this course, the student will be able to”) followed by the specific outcomes for that specific course paper.

While the language used provides specific direction to the student concerning learning outcomes; for example, “identify”, “classify”, “describe”, “demonstrate”, “discuss”, “apply”, and “present”, there were some more general statements requiring interpretation such as “Managing Nursing Council Competencies at the level of a Unit 1 nursing student” (p. 9) or “demonstrate an understanding of communication in a health care context” (Curriculum Document 3, 2002, p. 10). For assessment purposes, this would require both the student nurse and the lecturer to have a mutual understanding of what each represents within the course descriptors.

Other papers, such as the science-based ones, provided more specific direction of expectations, such as: “identify the fundamental organisation of the human body at a chemical, cellular, and tissue level” (Curriculum Document 3, 2002, p. 14), requiring little or no additional information. The main document also contained nebulous examples where numbers or percentages would have been more helpful; for example, “maintaining the Māori student participation rate at an appropriate level” (p. 6); “to ensure appropriate Tikanga Māori within courses of the programme”; “implement appropriate nursing care” (p. 14); and “appropriately evaluate the learning outcomes” (Curriculum Document 3, 2002, p. 35). Lack of specificity may be to avoid committing to targets, lack of confidence in delivery and/or because the aspirations are difficult to quantify; however, it requires the reader to gauge what is meant.

An example of the use of presupposition as a literary tool was noted within the document where challenge to the authority held would be difficult. It was seen in the assertion that the programme was developed through guidance from leading theorists and researchers in nursing theory, practice, and education. Authority was reinforced by the inclusion of academic references, confirming the voice of authority and reinforcing that it has a solid evidence base.

A section of the document that provided considerable detail about its development was the institute’s newly developed curriculum programme. It stated that it was envisioned as a series of five core processes. These were presented in a digitally constructed picture consisting of five separate tāniko strands on the left-hand side

becoming braided and tied together as the diagram moved to the right-hand side before continuing in closer proximity, but still as separate strands. The continuation is stated as reflecting that learning for the professional nurse is a lifelong process. The diagram is referred to as the raranga weave and the tying together represents "the strengthening and development of theory and practice, culminating in the knowledge required to practice as a beginning nurse within contemporary health care settings" (Curriculum Document 3, 2002, p. 13). It states in the document "a diagrammatic representation of these five core processes is shown on the cover of the programme approval document, and below" (Curriculum Document 3, 2002, p. X). This type of foregrounding suggests that the diagram is important, and the author wants to emphasise further the significance that it represents. The reframing of the core processes into the raranga weave reflects a connection of the curriculum to Māori culture and emphasises that partnership with Māori has taken place, a requirement by the educational programme standards of the NCNZ. Contemporary curricula development requires the involvement of stakeholders and partnerships with Māori are explicitly called for:

> The nursing education provider has strategic and functioning partnerships with iwi, hapū and Māori, clinical learning providers, external representatives of the nursing profession, consumers of healthcare and other relevant stakeholders. (NCNZ, 2021, pp. 9-10)

There was a strong emphasis on engagement with Māori during the development and review process for the Bachelor of Nursing programme. In addition to the engagement stated above, the document stated that all lecturers in the programme were involved, including academic and clinical nursing advisers. The document also states explicitly that endorsement was gained from the Māori Academic Committee to ensure appropriate Tikanga Māori within the programme courses. Emphasis was given to the fact that this had happened before through addition of the phrase 'was again endorsed', indicating that this is usual practice for the institute and implying that it is always done as if without question:

> The Bachelor of Nursing programme was again endorsed by the Māori Academic Committee on 3 August 2011 and on-going input from stakeholders

> identifying as Māori is taken into account during any review. (Curriculum Document 3, 2002, p. 14)

While meeting NCNZ requirements, endorsement strengthens the level of authority carried by the work in demonstrating compliance, consultation, and engagement with stakeholders, and adds the voice of others to the authority of the document. Another example of partnership working is the development of a “framework, which emerged from regular discussions, forums, and workshops over a period of nine months” (Curriculum Document 3, 2002, p. 13). The institute also declared that they reviewed other curricula, which can be seen as looking outwards to improve itself and acknowledging others as potential experts rather than positioning itself as either experts or the leading institute. Equally, it could be seen as positioning themselves as stronger than they were previously, having acknowledged the strengths and weaknesses of other programmes and their previous curricula: “Reviewing external curricula to gain insight into strengths and weaknesses of other programmes” (Curriculum Document 3, 2002, p. 10).

The document also made use of naming associated documents. These have the effect of adding a professional voice to what is being said by the nursing programme and included four NCNZ documents:

- *Code of Conduct for Nurses* (June 2012)
- *Direction and Delegation* (May 2011)
- *Guidelines for Cultural Safety, the Treaty of Waitangi and Māori Health in Nursing Education and Practice* (March 2009)
- *Clinical Competencies for Registered Nurses* (2012)

The document is presented in a formal report format, referring to individuals and groups in the third person. Exceptions were in the use of the word ‘our’, used twice in reference to the nursing programme personnel:

> The Nursing programme’s strategy is to focus on the values that underpin our mission statement
>
> Be creative in our challenges. (Curriculum Document 3, 2002, p. 7)

The term ‘our’ can communicate inclusion, cohesiveness, teamwork, and strong relationships. By including the word ‘our’, the first example suggests that the personnel in the nursing programme agree and are committed to the mission statement. Therefore, the content is implied as based on what the team values. While it may reflect the reality, this literary technique of presenting the information as if written by the team is often used to get staff ‘buy-in’ and compliance by suggesting that it is based on ‘their’ ideas. It can also be used to portray a cohesive team to outside readers and thereby exemplify assurance quality.

Positioning Subjects

Discursive practices can be used to position people within the text. While the student is the primary participant and consumer of a curriculum, this document is explicitly written to demonstrate compliance and achieve approval, with the student nurse as the subject rather than the consumer of the text. While there is no dialogue with or directly aimed at the student, the course descriptors focus on the student and the requirements needed to graduate. The course descriptors are, therefore, the most relevant part of the curriculum document for students because they hold information, as previously detailed, on the taught content and assessment expectations of the programme. Claims within the accreditation document are that its teaching approaches are “student-centred” (Curriculum Document 3, 2002, p. 17); however, the student is referred throughout the whole document in the third person.

As with the other two curriculum documents, the graduate profile is based on the assumption or expectation that students will succeed in the programme. The graduate profile states that the key aim of the programme is to produce nurses competent to fulfil a number of requirements, including to “empower the client”, “utilise thorough assessment skills and clinical reasoning”, “critique and utilise best evidence to inform and continually develop own nursing”, and “manage nursing practice safely within multiple contexts” (Curriculum Document 3, 2002, pp. 14-15). As with the previous two curricula, the graduate nurses are positioned as being prepared for both a local and international platform of nursing work. However, a greater focus on developing nurses to meet the local requirements was noted for Curriculum 3 with explicit emphasis on the programme being a “locally designed and locally owned undergraduate degree” (Curriculum Document 3, 2002, p. X).

Uncovering the Discourses

As was established with undergraduate nursing curricula 1 and 2, there is a mandated requirement for New Zealand graduates to meet all competency requirements within the *Competencies for Registered Nurses* document (NCNZ, 2012b). Demonstrating this requirement, each course descriptor paper within the document has a subheading of 'Clinical competencies/Tohungatanga' and includes a table consisting of the four domains and listing the NCNZ *Competencies for Registered Nurses* considered to have been achieved upon successful completion of the course. Once again, the discourses identified as related to EI in the NCNZ *Competencies for Registered Nurses* document are also present in these curricula documents. Thus, the discourses identified were consistent with those found to be evident in the construction of EI in the NCNZ *Competencies for Registered Nurses* and those identified in the previous two curricula documents. They included professionalism, cultural safety, and legislation, with evidence-based practice presenting as would be expected in an academic institute curriculum for degree-level study.

Excerpts related to the construction of EI were identified alongside their associated themes and discourses and are provided in Table 6, Appendix B. They demonstrate how multiple discourses are used to construct EI with their interconnectedness shown through the multiple discourses presented in each excerpt. Consistent with the previous two curricula, the discourse within the course descriptor document relating to safety is linked to a variety of aspects requiring very different skillsets and knowledge; for example, cultural safety and the safe administration of medicines. The links with legislative requirements were also linked to Te Tiriti o Waitangi and the legislated professional requirements via the NCNZ (2012b) *Competencies for Registered Nurses*.

The cross-referencing to the NCNZ *Competencies for Registered Nurses* indicates compliance with NCNZ educational requirements. However, it fails to provide information on the taught content of the courses to assist the development of knowledge and skills to meet the competencies. Therefore, it is unclear whether EI is taught within the curriculum or expected to be attained and/or demonstrated within the clinical setting.

Constructing EI

Like the previous documents analysed, EI was not explicitly named within the documents; although elements of EI, as defined in Chapter 2, were mentioned as underpinning the thinking and behaviours required for nursing registration. When read in conjunction with the indicative content, some of the learning outcome statements implied a requirement for EI skills. However, this cannot be assumed because the way in which EI development is facilitated was not articulated. For example, the learning outcome of one theory course descriptor paper stated: "explore cultural safety from a Māori perspective" (Curriculum Document 3, 2002, p. 32). To do this, students must first understand their own and others' emotional perspectives concerning culture. Theoretical exploration and learning do not necessarily ensure the acquisition of clinical skills; however, like the previous curricula, assessment of culturally safe practice occurs within the clinical environment against the *Competencies for Registered Nurses*. Therefore, the theory is assumed to precede or be taught alongside the clinical course papers, connecting theory with clinical practice. The way in which this is done, however, is not clear from the curricula documents (NCNZ, 2012b).

The mental health theory paper within Curriculum 3 requires that students develop the skills, knowledge, and attitudes necessary for effective nursing practice when working with a person experiencing mental illness and/or addiction. The indicative taught content of the course paper includes therapeutic communication, therapeutic relationship building, and culturally safe nursing care, all of which require the student to self-reflect and assess their own emotions and understand the emotions of others, in addition to managing that relationship with the health consumer. The indicative content does not explicitly indicate the development of EI is part of the taught content. However, there is a requirement for the student to have demonstrated EI to fulfil the course paper's requirements. As with the previous two undergraduate curricula, EI can be seen to be required and, therefore, only indirectly assessed within the clinical practice environment as part of its requirement in meeting NCNZ (2012b) *Competencies for Registered Nurses* related to culturally safe nursing care, therapeutic communication, and therapeutic relationship building. The responsibility for assessing the students' EI sits predominantly within the remit of the registered nurse within the

clinical environment as part of the clinical placement competency assessment, which is completed firstly by the student as a self-assessment.

Concluding Summary of Findings Chapters

This chapter concludes the presentation of the two-part synthesised findings, Part A in Chapter 4 and Part B in Chapter 5. Five influential documents within undergraduate nursing education were examined to identify discursive influences, themes, and discourses that influence how EI was constructed. The process included establishing how authority was claimed within the documents and how literary tools were employed in the manipulation of how the text was interpreted. Several discourses were identified in the construction of EI across the five documents.

Owen's (1984) thematic approach was then used to identify which of these discourses were most dominant both within and across the documents, and these will be discussed in Chapter Six. They include legal, professional, and management discourses that encompassed and are related to each other; and other discourses related to competency, cultural safety, relationship development and management, emotional boundaries, and health and well-being.

Chapter 6 Examination of the Discourses

Chapters 4 and 5 presented the description and analysis of five documents considered influential in undergraduate nursing education. The analysis supported the identification of several discourses influencing how language is used to construct the meaning of EI within New Zealand undergraduate nursing education theory and practice. This chapter examines and presents those discourses in more detail, highlighting how they connect with other discourses influencing nurses' practice and the meaning and positioning of EI for the undergraduate nurse. In discussing these synthesised findings, the following two research questions for this study are addressed:

1. How is the language used to construct the meaning of EI within undergraduate nursing curricula, theory, and clinical practice in New Zealand?
2. How do the discourses operating within undergraduate nursing education influence the positioning and inclusion of EI?

The term EI was not used in the professional document *Competencies for Registered Nurses* or any of the three curricula. Instead, text consistent with the meaning of EI or its requirement was identified and presented in Appendix B, alongside the discourses operating in each example construction. The tables reflect how several discourses operated simultaneously to influence how the language constructs EI and the positioning of its requirements within nursing.

The discourses were identified within the texts examined based on their influence on the thinking around EI within undergraduate nursing education, including how it is understood and applied in practice. Where one discourse dominates over another, this signifies the influence of social power that is embedded within the discourse, which can also impact thinking and actions. However, determining the most influential discourses was challenging due to their interconnected nature. Owen's (1984) three criteria of recurrence, repetition, and forcefulness were applied to identify which discourses were more dominant in their influence on the construction of EI within the documents. The three dominant discourses identified were legal, professional, and

management, with each of these containing several other important discourses recognised as increasing their influence and reach.

Furthermore, three dominant discourses were interconnected through some of the associated discourses, thus enabling them to be discussed as part of more than one discourse. For example, expectations related to the discourse of professional competency concerning the emotional development of the undergraduate nurse were included as part of the ‘legal discourse’ due to legislative and regulatory requirements for nurses to be competent in their clinical practice in the protection of public safety. EI expectations were also evident within the ‘professional discourse’, where professional nursing practice expectations are that nurses must employ evidence-based practice to fulfil the professional competency requirements in developing and managing therapeutic relationships within professional boundaries. The ‘management discourse’ connects with the EI expectations of the undergraduate nurse in promoting the emotional well-being of the nurse as an employee, for which EI has been shown to influence positively. It also connects to the legal discourse for the legislated health and safety of the nurse and ensures the nursing workforce is fit for purpose in the protection of public safety.

In managing the discussion of the synthesised discourse findings, each dominant discourse is defined and discussed in the following order, highlighting where they connect, compete, or contradict each other. The interrelated and interconnected discourses are within the brackets following the dominant discourse, as illustrated below:

1. Legal discourse (authority, regulation, public safety, professional competency, accountability, and responsibility)
2. Professional discourse (evidence-based practice, care, therapeutic relationships, and cultural safety)
3. Management discourse (well-being, sustainability, and resilience)

This chapter focuses on the three dominant discourses and their construction and interaction with other lesser discourses and explores and identifies their significance to the construction of EI. The discussion will also link the findings to the literature and

illustrate how the EI development positions the undergraduate nurse in a particular way. Crowe (2005) summarised this process as:

> Specifying what discourse types are drawn on; describing the discourses it is linked to and the interpretative implications of this; and identifying the social practices of text production and consumption. (p. 62)

The Legal Discourse and the Discourse of Competence

The discourse of competence in nursing is seen to be enacted through the legal discourse, as NCNZ regulations require all nurses to provide competent care in support of public safety. NCNZ regulates nursing practice by requiring the individual nurse to provide evidence that they possess the ethical, cultural, and clinical competencies stipulated in the *Competencies for Registered Nurses* (Document 1), which NCNZ considers to be the minimum professional skills and activities required to enable the nurse to provide care. The accountability expectations of the nurse within the professional competency document require that the nurse employ self-regulation to ensure that the health services they provide are consistent with their education and assessed competence (NCNZ, 2012b). In addition, nurses are also mandated by the NCNZ, as part of their registration requirements, to provide evidence of meeting professional competency as part of upholding the legal requirements for the protection of public safety as part of the legislative discourse (Krautscheid, 2014; NCNZ, 2012b). The legislated and professional accountability and responsibilities of the individual nurse are made explicit and further reinforced on the NCNZ website, specifically the webpage for *Continuing Competence* by the personalisation of the final two words, ‘you are’ in the following statement:

> As a nurse you are professionally responsible for meeting these requirements. Your employer may provide you with opportunities for professional development or competence assessment, but is not accountable to the Nursing Council – you are. (NCNZ, n.d)

While there is no specific use or reference to the term EI within the requirements of the *Competencies for Registered Nurses* or the curriculum documents, EI is a fundamental requirement in attaining many of the competencies and meeting

educational learning outcomes. These include competencies related to the development and management of therapeutic interpersonal relationships in the provision of patient-centred care, which is professional, legal, ethical, and culturally safe, and is discussed as part of the discussion later in this chapter as part of the construction of EI within the professional discourse of nursing (NCNZ, 2012b). EI is, therefore, a pervasive and important underpinning of nursing competence.

The Discourses of Authority, Regulation, and Public Safety

In New Zealand, like many other countries, registered nurses have a scope of practice and defined roles that give them the authority to perform specific tasks and make decisions within those boundaries (Nursing Council of New Zealand, 2023). This authority is established through professional education, policies, registration, and a code of conduct (Nursing Council of New Zealand, 2012a).

The NCNZ (2012b) are "the responsible authority for nurses in New Zealand with legislated functions under the Health Practitioners Competence Assurance Act 2003" (NCNZ, 2012b, p. 13). As the regulatory body for nursing practice, the authority held by NCNZ was observed to operate throughout all the documents as part of the legal discourse because part of NCNZ's responsibility is to ensure nurses are generally competent in their nursing practice. This claim of authority as the government-level legislated regulator of nursing is done so for the protection of public safety and is stated on the front cover of the *Competencies for Registered Nurses*, Document 1: "Te whakarite i nga mahi tapuhi kia tiakina ai te haumaru a-iwi Regulating nursing practice to protect public safety".

One of the ways Document 1 enacts authority is by requiring nurses to provide evidence of meeting the competencies which NCNZ equates to the nurse being competent and fit to practise (Ministry of Health, 2003; NCNZ, 2012b). In addition, NCNZ holds individual nurses accountable for ensuring their level of care and general competence:

> Registered nurses are accountable for ensuring all health services they provide are consistent with their education and assessed competence, meet legislative requirements and are supported by appropriate standards. (NCNZ, 2012b, p. 2)

Therefore, the skills and activities described and expected of registered nurses within Document 1 rely upon the nurse to self-regulate as part of the regulation responsibilities of the NCNZ delegated to the individual nurse. Self-regulation and actively pursuing the enhancement of professional expertise are common expectations of nursing professionalism (Azemian et al., 2021), connecting the legislative discourse to the discourse of professionalism. The legal discourse, therefore, operates within this recognised expectation of nurses as professionals and informs all the documents through the direct influence of the NCNZ as the appointed regulatory body for nurses. The competencies in Document 1 represent what the NCNZ consider to be the minimum requirements from day one of becoming a registered nurse. Therefore, as reflected within Documents 3, 4, and 5 (examples of undergraduate nursing curricula), there is a requirement for student nurses to provide incremental evidence of meeting the NCNZ competencies as they progress towards registration. The NCNZ requirements of nurse accountability were observed to be made explicit within the three curricula through their requirements to facilitate the student attaining the required level of professional competency for nursing registration. As stipulated in Document 1, meeting professional competency is an essential requirement underpinning professional nursing practice.

Accountability and Responsibility

As previously discussed, NCNZ holds authority concerning the professional conduct of nurses in New Zealand. As part of this authority, NCNZ holds registered nurses individually accountable and responsible for ensuring they are competent to deliver safe care in compliance with legislation, policy, and guidelines. This requirement is made explicit within the NCNZ (2012b) *Competencies for Registered Nurses* (Document 1), where nurses are responsible for "ensuring all health services they provide are consistent with their education and assessed competence, meet legislative requirements, and are supported by appropriate standards" (NCNZ, 2012b, p. 2).

The requirement to operate within policies and guidelines, legislation, codes, and scope of practice is further reinforced in Professional Competency 2.1 (Document 1), related to the 'management of nursing care' concerning the administration of medication and care-related interventions, with the fifth indicator requiring that the nurse "administers interventions, treatments and medications (for example

intravenous therapy, calming and restraint) within legislation, codes and scope of practice; and according to authorised prescription, established policy and guidelines" (NCNZ, 2012b, p. 7).

The interventions of calming and restraint are offered as examples in the above professional competency, both of which indicate that the nurse must employ emotional understanding and managerial skill. The intervention of calming requires the nurse to engage emotionally with the consumer to positively influence their behaviour and de-escalate tension-filled situations as part of the provision of professional discourse of care. Document 2 (textbook) is seen to discourage restraint, particularly in the care of confused older people as it is considered "a significant infringement of one's personal space and liberty" (Chiarella & Adrian, 2017, p. 189). Document 2 engages the legislative discourse in its discouraging words to the nurse for its use, highlighting it as an acceptable intervention but only where there are significant safety concerns, such as protection from harm or to protect others from harm (Chiarella & Adrian, 2017).

The Professional Discourse

In another section of Document 2, the professional discourse is engaged in presenting the restraint as an absolute failure to deliver the necessary and appropriate professional care if the person is a confused older person. It declares that such restraint is "inappropriate and that with proper nursing care and adequately designed facilities, it is much safer not to restrain people in any way" (Chiarella & Adrian, 2017, p. 189). As a textbook used extensively by undergraduate nurses, this provides an example where advice on professional care may appear conflicting. Restraint requires the nurse to take action that limits physical movement and, therefore, also constitutes the physical removal of someone else's liberty, requiring the nurse to make a judgement that attempts to balance patient rights with patient safety. The tension between the nurse intervention of restraint in the pursuit of making a situation safer and keeping in step with an ethical and legal framework provides a clear example of where this can challenge what is considered to be appropriate within the professional discourse of care. The textbook authors position restraint as an undesirable and mainly unnecessary nursing intervention as part of professional care but with the nurse's

agency to act sanctioned through the legislative and managerial discourse in maintaining public and personal safety.

While all three curricula require the undergraduate nurse to meet Professional Competency 2.1, the specific development of calming or restraint is not mentioned within the taught content of any of the curricula. Instead, generic terminology is used within each mental health course paper of all three curricula, which implies the students' requirement to become competent in managing such experiences. For example, Curriculum 1 (Document 3) requires the student to consider knowledge, regulations, risk assessment, ethical considerations, and legal clinical safety. Curriculum 2 (Document 4) requires the student to demonstrate safe clinical practice, including identifying and managing legal, ethical, and physical risks; and Curriculum 3 (Document 5) similarly requires the student to perform mental health status assessments and complete assessments of risk while considering legal and ethical concepts related to mental illness. The legal discourse can be seen to be constructing clinical practice within the curricula for the undergraduate student nurse, where the management of emotionally charged clinical situations prioritise legal and ethical considerations in decision-making related to risk and safety, and with the health consumer presented as the potential source of the risk. The student is required to make professional judgements focussed on the potential threat or danger the health consumer poses to themselves, the nurse, or others; again requiring the nurse to assess and understand emotions before taking appropriate nursing interventions or actions informed by policy and legislation.

Professional Competency 2.5 (Document 1): "Acts appropriately to protect oneself and others when faced with unexpected health consumer responses, confrontation, personal threat or other crisis situations" (NCNZ, 2012b, p. 8) is another example wherein the nurse must make judgements in complex and emotionally charged circumstances that present potential safety issues for all. The nurse must also be able to understand and respond to the emotions of others whilst understanding, processing, and managing their own emotions.

The decision-making responsibility is again placed upon the nurse within Professional Competency 2.5, with the added requirement of discerning what acting 'appropriately'

is within unexpected and highly challenging circumstances. In deciding which action to take in emotionally charged situations, the responsibility is explicitly placed within the remit of the nurse alongside the additional responsibility of having the skills and competencies to ‘act appropriately” and successfully manage the situation. In such circumstances the nurse is required to apply emotional competencies in understanding the emotions of the health consumer to assist in making clinical and professional judgements in line with legislative and professional policy in risk assessment. Of equal importance is that nurses understand their own emotions and how these may impact their assessment of and interaction with health consumers. Yet, specific mention of emotions and feelings is absent.

The discourse of professionalism in nursing can be seen to reflect compliance with expected general social practice and behaviours such as being autonomous, providing care in a kind and caring manner, and utilising professional knowledge and skills in carrying out such caring duties. Professional practice can be seen to include both personal and professional characteristics, including mannerisms, behaviour, and attitude, alongside legal and professional responsibilities, professional values, self-regulation, and self-motivation for continuous professional development to develop expertise based on evidence-based practice (Altiok & Üstün, 2014; Azemian et al., 2021; Lehna et al., 1999; Tanaka et al., 2014; Wilkinson et al., 2009). EI expectations related to the professional practice of nursing were implied within all of the documents in the requirements for the student nurse to develop abilities in providing patient-centred compassionate care and developing and managing therapeutic relationships that encompass the principles of cultural safety, based on evidence and research.

Professional Discourse of Evidence-Based Practice

Evidence-based practice (EBP) in nursing fits into both the professional and managerial discourses. As part of the professional discourse, EBP is essential in providing the basis for effective, high-quality nursing care. EBP equips nurses to make decisions based on the best available research, thereby reducing the use of purely traditional or personal experience. EBP, therefore, requires clinical reasoning skills and, therefore, critical thinking.

In undergraduate nursing education, the discourse of evidence-based practice (EBP) and EI, while separate, can be mutually reinforcing when incorporated into nursing education. The connections include those already discussed in Chapter 2 concerning the connection between critical thinking and EI. The discourse of EBP reinforces the importance of critical appraisal in identifying the best available evidence to inform patient care. EI skills such as self-awareness are important within this process in identifying bias and the emotional impact of nursing interventions

The nursing profession has embraced evidence-based practice; however, barriers to its implementation by individual nurses include prioritising their previous experience, trends, out-of-date knowledge, or advice from other nurses over evidence-based information (Trinder, 2000).

One of the professional expectations of nurses is that they contribute to the development of an evidence base on which to base their care:

> Nurses' involvement in gathering evidence to support safe, quality nursing care is essential for the future growth of the profession and, most important, to the patients receiving the care they deserve. (Boswell & Cannon, 2023, p. 567)

Understanding how people view and interact with the world contributes to an evidence base that is considered essential to developing nursing practice and improving care (Kornhaber et al., 2015; Porter, 2010; Ravitch & Mittenfelner, 2016). Qualitative research importantly provides a wide range of methodologies that assist in the 'meaning-making' of people's experiences. Reflecting this requirement, the *Competencies for Registered Nurses* (Document 1) includes requirements for creating and using nursing knowledge and evidence-based research. For example, in Professional Competency 2.2, the nurse is required to apply "relevant research to underpin nursing assessment" (Indicator 3) (NZNC, 2012b, p. 7). In Professional Competency 4.3, the nurse must review policies, processes, and procedures "based on relevant research" (Indicator 1) and recognise and identify "researchable practice issues" (Indicator 2), in addition to distributing relevant "research findings" where changes to practice are required (Indicator 3) (NZNC, 2012b, p. 11).

The use of evidence-based practice to provide rationale for changes in healthcare practice based on achieving quality, efficiency, and financial savings exemplifies the connection of the professional discourse with the managerial discourse. The evidence-based rationale for nurses being emotionally competent includes improved consumer satisfaction, fewer complaints, higher retention levels, reduced time is taken off work by nursing staff, and reduced incidence of emotional burn-out. However, the value of evidence-based practice is not without controversy. While it provides up-to-date, valid, and reliable research findings, supporting efficient use of resources and 'best practice', it can also be used as an evidence base to over-simplify things and hinder nurses' autonomy in decision-making or covertly ration resources (Trinder, 2000). It is essential, therefore, to consider the influences and drivers when implementing evidence-based practice to ensure that the focus remains on health outcomes rather than serving a managerial agenda related to financial constraints while recognising that these are not mutually exclusive:

> The core argument is that the emergence and rapid expansion of evidence-based practice must be understood against a background of increasing preoccupation with managing risk, critiques of science and professionalism and the emergence of managerialism and consumerism. (Trinder, 2000, p. 3)

Professional Discourse - Biomedical Focus in Nursing

Building on the discussion of EBP and critical thinking, it is important to recognise the complex relationship between nursing's professional discourse and EBP. This complexity stems from the historical emphasis on "hard" sciences (chemistry, physics, biology) in healthcare, education, and research. This focus on objectivity, measurable data, and empirical methods aligns with the traditional biomedical model, which has significantly influenced the development of nursing practice.

This dominant approach has resulted in the 'softer' sciences like sociology and psychology being less utilised despite offering valuable insights into human behaviour and emotions (Shapin, 2022). While this historical preference for the positivist paradigm has lessened within nursing research, it is still seen to dominate, particularly in areas related to disease, diagnosis, and pharmacological interventions. Nursing continues to have a necessary alignment with biomedical sciences, as reflected in

Document 1, *Competencies for Registered Nurses,* where it states twice within the first four pages that nurses require "**substantial scientific** and professional knowledge" (NZNC, 2012b, pp. 2, 4).

This biomedical focus within undergraduate nursing education in New Zealand has actively lessened with the introduction of specific models of care where the human needs of patients can be seen as , particularly in areas where disease processes, diagnosis and interventions such as surgery are taught, can sometimes contribute to neglecting the more emotional aspects of the patient's care, such as fear, anxiety, and cultural influences on health behaviours.

Furthermore, clinical research has the propensity to focus on expanding knowledge linked to the prevention, detection, or cure of disease and prolonging life (Cassel & Field, 1997; Dahl et al., 2014). One of the reasons for this focus can be associated with the ease of assessment and measurement of the 'hard' sciences as objective information when compared with the assessment and measurement of subjective data, which involves interpretation. However, the dominance of biomedical knowledge may be reserved for the educational setting in nursing because, within the clinical setting, concern has been raised that the application of bioscience is diminishing despite its requirement as essential for "safe and effective practice" (Fell et al., 2016, p. 2703).

Therefore, while both 'hard' and 'soft' sciences underpin nursing theory and practice, the fundamental premise that underlies this issue is the importance and prominence given to the biomedical sciences in undergraduate nursing curricula. Practical clinical skills are highly valued and assessed in clinical settings, while the softer social and emotional skills suffer from being more challenging to assess or measure. While it is recognised that nurses need to have scientific knowledge and technical skills, "patients and their families also expect nurses to be caring, compassionate, and communicative" (Palos, 2014, p. 247). These qualities are considered part of the 'art' of nursing and should not be forgotten or considered of lesser value than the 'hard' scientific knowledge and skills. Hence, the importance that, in times of biomedical and technological advancement, there is also a need to develop the essential 'art' of nursing with skillsets such as EI supporting the emotional protection of individual

nurses when providing safe care (Barker, 2016; Barley, 2016; Heron, 2001). The assessment and measurement of EI continue to be examined across different healthcare settings in nursing and is carried out differently, usually influenced by how EI is conceptualised as either a trait EI model, an ability EI model or a mixture of the two, as outlined in Chapter 2.

The pursuit of professional autonomy in nursing has seen a progression of nursing into higher education and a move towards a patient-centred model of nursing care. Nursing encompasses patient-centred care and the psychosocial aspects of health through a holistic approach to wellness as part of the social and behavioural sciences, supported by a partial move away from the dominant biomedical model underpinnings (Chandler, 1991; Magdalena & Magda, 2021). However, Chandler (1991) posited that the biomedical model was able to bring more "intellectual consensus" (p. 86) than the behavioural and social sciences because it "generates harder 'facts' with its positivist methodology" (p. 86). While this viewpoint has lessened over time, a paradoxical relationship can still be seen to exist between the autonomous professional status of nursing and the biomedical model of care; with the *pre*-autonomous days of nursing viewed as restrained by its adherence to a biomedical model. However, upon becoming an autonomous profession, nursing is now, at least in part, seen as constrained through its move towards the social and behavioural sciences and greater use of qualitative research.

Therapeutic Relationships

Professional discourse is associated with nursing practices such as building therapeutic relationships through professional interactions and promoting the qualities of cooperation (Altiok & Üstün, 2014). The formation of therapeutic relationships enables patient-centred care to be provided and tailored to meet health consumers' needs. The process of developing, understanding, regulating, and managing safe therapeutic relationships requires the nurse to be aware of their feelings, thoughts, values, and beliefs to understand and manage how these may impact their practice (NCNZ, 2011; 2012b). Levett-Jones (2022) connected EI with having a central role in forming and managing such therapeutic relationships, assisting in understanding needs and feelings, empathising, and delivering effective nursing care. Professional requirements of nurses in forming therapeutic relationships were evident in all the documents

examined. While not explicitly mentioned, EI was implied through the emotional requirements of the nurse being able to understand, connect, and develop therapeutic and culturally safe relationships with consumers, establish rapport and trust, show empathy and be respectful (NCNZ, 2012a; 2012b, 2012c).

All five documents reflected the professional expectation that nurses must be able to develop and manage therapeutic relationships. Therapeutic relationships are presented as essential to nursing practice and explicitly required as part of Domain three: Interpersonal relationships within the NCNZ *Competencies for Registered Nurses* (Document 1). Competency 3.1 requires the nurse to form, manage, and end therapeutic relationships: "Establishes, maintains and concludes therapeutic interpersonal relationships with health consumers" (NCNZ, 2012b, p. 10)

In supporting students to developing the above professional competency, all three curricula have taught content that requires the student to develop an understanding of the value and principles of therapeutic communication and therapeutic relationship-building. In doing so, students must ensure that the care provided through these trust-based relationships is culturally safe. The discourse of cultural safety similarly requires that all such relationships incorporate self-reflection and actively respect cultural differences.

Professional and Emotional Boundaries According to NCNZ

As the regulatory body for nursing in New Zealand, the NCNZ sets clear expectations for practice through guidance and standards (2012a, 2012b, 2012c), which they expect all nurses to incorporate within their practice, ultimately aiming to ensure safe and effective patient care. The documents provide a framework for safe and responsible nursing practice to protect public safety and maintain standards of professional practice. The NCNZ (2012c) *Guidelines: Professional Boundaries* is one such document designed to provide specific guidance alongside the NCNZ (2012a) *Code of Conduct* document. These assist nurses in navigating professional boundaries to promote patient safety, prevent abuse of power or position, and cover, to some extent, where boundaries can overlap with the nurses' personal lives. According to these guidelines, the example provided in Chapter 1 demonstrated signs of over-involvement in the nurse-health-consumer relationship wherein the (student) nurse frequently thinks of

the health consumer when away from work. This was evident when the student nurse, as catalyst, stated, “I am thinking about the patients when I am away from the ward”. Although a clear transgression of professional boundaries on the part of the student, the advice subsequently given by ward staff to “toughen up” could equally be seen as transgressing the boundary wherein under-involvement is exemplified by disinterested and neglectful care. Interestingly, NCNZ gives less attention to under-involvement in the boundary guidance, choosing to focus more on a tendency towards over-involvement, and stating that:

> Under involvement lies to the left side of the continuum; this includes distancing, disinterest, coldness and neglect. These behaviours can be seen also as boundary issues but they are not discussed here in detail as the focus of the document is on the over-involvement end of the continuum. (NCNZ, 2012c, p. 7)

Under-involvement in a nurse-health-consumer relationship, therefore, receives less emphasis in the documents through the purposeful reduction of attention and detail given in the document. In addition, no similar guidance exists for under-involvement, thus promoting the ideological view that emotional under-involvement is a lesser boundary transgression and professional concern than over-involvement.

As an undergraduate nursing educator, I share responsibility with my work colleagues for supporting the development of undergraduate students to become beginning practitioners upon graduating. Therefore, my concerns for this student and others reporting similar emotional challenges within the clinical setting were about their understanding that the issue should not be about correcting being ‘too emotional and caring too much’ but how they could be better emotionally prepared to manage such situations. It also reinforced to me how potentially damaging such advice can be both personally and professionally.

The Discourse of Cultural Safety

EI is essential in meeting professional competency requirements such as building therapeutic relationships, developing rapport and trust, reflecting on consumer feedback to improve the quality of care, and providing culturally safe care to

consumers (NCNZ,2012b). Cultural safety, originating in New Zealand nursing education, has become a significant discourse within nursing. Developed in response to the rising mortality and morbidity rates among the Māori population, it aimed to improve health outcomes (Ramsden, 1990, 1992, 2002). However, cultural safety has evolved into a broader healthcare concept, emphasising respectful and responsive care that acknowledges patients' cultural backgrounds, beliefs, and values. Document 2 (textbook) reaffirms that cultural safety centres upon how society responds to and treats its people due to their diversity or differences rather than specifically on their culture (Cox & Taua, 2017).

The legal discourse interconnects with the discourse of cultural safety through the regulatory requirements for nurses to provide culturally safe nursing practices to support public safety (NCNZ,2012b). The discourse of cultural safety connects with the discourse of professionalism because it pervades all aspects of professional nursing care provision and relationships. Thus, the expectation that nurses behave in a culturally safe way is intrinsically linked to consumer care and clinical safety. This was evident across all five documents examined.

Document 2 introduced concepts and perspectives related to cultural safety, highlighting the professional requirement “to effectively address the interaction between culture/s and nursing care” (Stein-Parbury, 2021, p. 261). Additionally, the document emphasised the importance of obtaining the consumer’s trust, both in terms of the professional requirement of care and in delivering culturally safe care. The ability to establish trust between the student and a consumer is positioned within Document 2 as “an essential prerequisite to negotiating and maintaining culturally safe care” (Stein-Parbury, 2021, p. 261). However, only the consumer can determine whether they trust the nurse or determine if the care they receive is culturally safe

Professional nursing actions suggested to facilitate nurses building trust are included in Principle 7 of the NCNZ *Code of conduct for registered nurses* (Nursing Council of New Zealand, 2012a) and centre around honesty and integrity. However, the complexity in developing trust with consumers is noted within Document Two (textbook), where it states that “there is no checklist for developing trust - it will grow as relationships

grow" (Cox & Taua, 2017, p. 282), reflecting its connection to EI through the requirement of communication and relationship development.

Cultural safety became a nursing registration requirement in New Zealand in 1992. Therefore, the *Competencies for Registered Nurses* (Document 1) reflect Ramsden's call for consumer empowerment, requiring that nurses, as part of professional responsibility, "practise nursing in a manner that the health consumer determines as being culturally safe" (NCNZ, 2012b, p. 6). Unlike cultural competency, where the nurse is deemed to gain cultural knowledge, theory and practice expertise, Ramsden (2002) argued that cultural safety enables consumers to speak out when they do not feel culturally safe within the health service. Ramsden also successfully promoted the adoption of cultural safety-based educational strategies within all New Zealand nursing curricula. Currently, curricula are required to include content that meets the Cultural Safety Learning Outcomes stipulated in the NCNZ *Guidelines for Cultural Safety, the Treaty of Waitangi, and Māori Health* that requires student nurses as part of their education to:

> (a) examine their own realities and the attitudes they bring to each new person they encounter in their practice;
>
> (b) evaluate the impact that historical, political and social processes have on-the health of all people; and
>
> (c) demonstrate flexibility in their relationships with people who are different from themselves. (NCNZ, 2011, p. 6)

The NCNZ (2011) *Guidelines for Cultural Safety* reinforce the importance placed on delivering culturally safe care in New Zealand. Cultural safety content was evident within each of the curricula examined. Students are required to self-assess and reflect on their own culture, including significant personal and cultural values and biases, to enable consideration of the way these can influence how care is provided for consumers and carers with diverse cultural beliefs, practices and identities (Papps & Ramsden, 1996).

Competency 1.5 of the *Competencies for Registered Nurses* (Document 1) requires that the nurse:

> Reflects on their own practice and values that impact on nursing care in relation to the health consumer's age, ethnicity, culture, beliefs, gender, sexual orientation and/or disability [and] practise[s] nursing in a manner that the health consumer determines as being culturally safe. (NCNZ, 2012b, p. 6).

The NCNZ cultural safety competency requirements were included across multiple course papers in the three curricula. For example, Curriculum 2 (Document 4) highlighted the social-emotional aspect in requiring students to "demonstrate understanding of culturally and clinically safe effective nursing practice that is supported by nursing knowledge, research and practice which reflects relevant legislation and ethical accountability" and "develop attitudes commensurate with culturally safe practice" (Curriculum 2, 2018, p. X). Document 2 (textbook) provides extensive information on culture in the context of Australia and New Zealand in a chapter dedicated to "Understanding and applying cultural safety: philosophy and practice of a social determinants approach" (Cox & Taua, 2017, p. 260).

Cultural safety encompasses cultural awareness and sensitivity, with some researchers arguing that cultural safety has a stronger focus on the causes of inequality (Thompson & Taylor, 2021). While cultural competence and cultural safety both require self-reflection, culturally safe practice is determined by the recipient of care and focussed on the consumer's experience rather than relying on nurses' judgement of this ability. Therefore, unlike other NCNZ competencies, assessing whether the nurse has successfully achieved the goal of delivering culturally safe care purports to rely upon the consumer. However, none of the analysed documents provide specific information or guidance on how this would be enacted and/or how often.

Although cultural safety does not explicitly call for the nurse to acquire EI, it is an essential prerequisite for providing culturally safe care. Nurses must understand their own and others' values, beliefs, and assumptions and be able to manage their behaviour and emotions accordingly. New Zealand nurses must be emotionally competent in order to meet the professional requirements mandated by the NCNZ relating to culturally safe care.

The discourse of cultural safety interconnects with the legal and professional discourses that require the nurse to have emotional self-insight and to use this to inform the establishment of culturally safe consumer relationships. While cultural safety is an absolute requirement within NCNZ documents and the undergraduate curricula, competing priorities and complex factors must be considered in the clinical setting. These include the transgression of boundaries with actions such as disclosure of self potentially being limited by such factors as experience and knowledge base. The requirements for therapeutic relationships that are culturally safe require the nurse to be emotionally aware, able to understand and manage their emotions and to do the same concerning their consumer. The professional discourse encompasses the behaviour of the nurses and the responsibility they have as a professionals to act and behave in a certain way. While expected to engage with consumers as part of developing therapeutic and culturally safe relationships, there are legal, professional, and personal boundaries that sometimes conflict or contradict each other. This provides the nurse with the dilemma of selecting the information on which to base decisions concerning how much or how little emotional engagement and sharing they should commit to the care they are providing and where the boundaries are placed. This issue is discussed further in Chapter 7.

Management Discourse

The standard conceptualisation of management functions includes planning, organising, directing, and controlling (DuBrin, 2019). The management discourse in nursing reflects the institutionalised ways in which the organisation and management of nursing work can be understood through the language used. Management terms commonly used within healthcare relate to clinical and cost-effectiveness, the measurement of health outcomes, and health consumer satisfaction that reduces health consumer complaints. In addition, the discourses of efficiency can be seen to be cost-effectiveness, driven by lower staff ratios and the performance of minimum interventions to save money. Conversely, nursing efficiency can be constructed as linked to adequate staff ratios, high-quality nursing care, technology use, competent standard care and ethical clinical practice, and effective communication and relationship building (Khomami & Rustomfram, 2019). This highlights how efficiency can be constructed through a professional or managerial discourse, changing its

emphasis and meaning; therefore, "words are not seen as being in opposition to action or practice; rather, it is through language that meaning is constructed, and the possibilities of practice emerge from that meaning" (Rhodes, 2015).

The Discourse of Well-being

As discussed earlier, the managerial discourse connects closely with evidence-based practice in the construction of EI through its influence on the areas of healthcare that require changes in practice. The managerial discourse also connects to the professional discourse in that nurses are expected to be competent to practice and identify when this is not the case. Therefore, nurses are positioned as responsible agents for the profession's corporate reputation, not just for themselves. This positioning is enabled through the professional responsibility that NCNZ places upon the nurse and connects it with both the professional and management discourse through the responsibility to maintain emotional well-being as an employee and responsible nursing professional. This responsibility is explicitly placed on the individual nurse by NCNZ. Nurses must be aware of the requirements to maintain their health and well-being and address any issues that affect their "ability to practise safely" (NCNZ, 2012a, p. 38).

The profile of emotional well-being is presented in Document 2 (textbook), Chapter 3, in relation to the health consumer, as equally important to physical safety, in recognising that the consumer has a "range of psychosocial needs, including emotional, cultural, and psychological needs" (Feo et al., 2017, p. 36). However, in requiring the nurse care for the consumer's emotional well-being, Document 2 (textbook) Chapter 20, reinforces the requirement of EI in the premise that nurses must first understand their own emotions before being able to care for others appropriately:

> self-awareness is critical in initially understanding and accepting others, and nurses must understand themselves before they can understand their effects on others. (Jack & Smith, 2007, as cited in Welch, 2017, p. 455)

The benefits associated with caring for the consumer's emotional well-being are presented in Document 2 (textbook) *Chapter 3: Engaging patients and keeping them safe* as part of the professional discourse of care, and include helping the health consumer to "feel safe, reassured and less isolated and overwhelmed" (Feo et al.,

2017, p. 36). While the documents reflect a focus on public safety and the care of the health consumer and their family, concern related to the health and well-being of individual nurses can be seen to be constructed using a managerial discourse in informing the language representing concern for the nurse with regards to ‘fatigue’, ‘stress’, and ‘quality of life’ (Todaro-Franceschi, 2013; Waddill-Goad, 2016). Such wording presents the nurse as ‘a risk’ or being ‘at risk’ of being unable to fulfil their duties rather than requiring the same level of care and nurturing of the health consumer despite their symbiotic nature and, therefore, being of equal importance.

While nursing is sometimes presented as altruistic in its selfless concern for the well-being of others (Çiftçi et al., 2022), there is a prerequisite for self-care and the building of emotional resilience if nurses are to continue providing quality care, especially in times of challenge. For example, in the recent COVID-19 global pandemic, the requirement for self-care initially appeared self-indulgent and of lower priority. However, this perception changed noticeably as the pandemic became an ongoing challenge. It developed from a narrative of the nurse as a self-sacrificing healthcare hero (Mohammed et al., 2021) into an explosion of existing and new strategies for self-care to combat the negative consequences of burn-out (Clancy et al., 2021; Fontaine et al., 2021; Lewis et al., 2022). It is now widely acknowledged that a global nursing shortage and workforce issues of burn-out and compassion fatigue have negatively impacted workforce numbers and the quality of patient care (Jarrad & Hammad, 2020).

Research undertaken during the COVID-19 pandemic has helped raise the profile of self-care, well-being and mindfulness as predictors of nurses’ ability to continue to provide compassionate care (Kam et al., 2022; Tolouian et al., 2022; Yıldırım & Çiriş Yıldız, 2022). Activities associated with EI and competencies, such as self-awareness, self-knowledge, and self-development, are strongly linked to the ability of nurses to provide compassionate care, long recognised as a public expectation and core health professional value (Alquwez et al., 2021; Bray et al., 2014; Duarte et al., 2016; Halldorsdottir, 2012; Şenyuva et al., 2014).

The World Health Organization (2019) officially recognises burn-out as a syndrome rather than a medical condition resulting from chronic workplace stress and, therefore,

an occupation-related phenomenon. The typical features of this syndrome include exhaustion, negative feelings or cynicism related to one's job, and reduced professional efficacy. Document 2 (textbook) describes burn-out in nurses as considered to be "a state in which the nurse is no longer able to manage the emotional and psychological demands of nursing" (Kravits et al., 2010, as cited in O'Brien, 2017, p. 1485). Burn-out is directly associated with emotional labour (defined and discussed further in Chapter 7) and work-related stress that negatively impacts the nurse's health and quality of life, job satisfaction, performance, and quality of care provided to consumers (Afriyie, 2021).

None of the curricula (Documents 3, 4, 5) make reference to preventing burn-out; however, Document 2 (textbook) includes burn-out and constructs it using managerial and professional discourses associated with the inability of the nurse to function competently as a nurse. Burn-out is discursively constructed within this text as a severe adverse physical, emotional, and mental deterioration related to coping with workload pressures. Responsibility for preventing burn-out is positioned within the text as being within the remit of the individual nurse as part of their professionalism. Doing so, foregrounds the nurse's responsibility, positions them as the agent responsible for implementing preventative measures, and backgrounding external factors such as support, resourcing, and staffing levels. The individual nurse is discursively positioned as the agent responsible for preventing burnout, and backgrounding the employer's responsibility.

Document 2 (textbook), which offers practical self-care strategies to reduce stress and burn-out, reinforces that these are the individual nurse's responsibility. The authors identify stressors and suggest coping mechanisms for eliminating or reducing them. They suggest that individual nurses maintain realistic expectations of themselves, set realistic goals, ask for help, continue their education, learn to say no, and look for new challenges. They also include suggestions such as "take a holiday or leave of absence" or "change your job" (Rosenberg, 2017, p. 527), all of which would result in nurses removing themselves from the work environment.

Document 2 (textbook) also encourages students to "get in touch" with themselves to help self-understanding and reminds them, in a nurturing way, that "Taking care of

others requires you to respect and care for yourself" (Rosenberg, 2017, p. 527); thus linking the addressing of stress to personal well-being. It suggests that the student examines significant influences in their life, the characteristics of the culture in which they were raised, and the values that underpinned it. Such self-awareness raising is aimed at supporting personal development. Self-care is thus essential to a student nurse's continued development and requires awareness of their emotional state and well-being. In addition, neglecting basic self-care requirements, such as breaks for personal needs and meals in clinical practice, significantly contributes to professional burn-out (Dossey & Keegan, 2016). Responsibility for preventing burn-out is constructed within the textbook as lying with the student, thereby diminishing the responsibility held by others in relation to external factors such as workload and workplace culture.

Nowhere does the *Competencies for Registered Nurses* (Document 1) explicitly mention self-care, instead relying on nurses to do what is required to ensure they are competent to practice and "Acts appropriately to protect oneself and others when faced with unexpected health consumer responses, confrontation, personal threat or other crisis situations" (NCNZ, 2012b, p. 8). In this example, the legislative discourse is called upon to reinforce the nurse's professional responsibilities in protecting public safety. It also instructs the nurse in attending to their own personal health and safety responsibilities, revealing a connection to the discourse of well-being.

Managerial Discourse of Sustainability and Resilience

The emphasis on resilience within the documents can be seen as contributing to the individual nurse's safety as part of providing professional care. It promotes the notion that graduate nurses are 'work-ready' upon qualifying and able to sustain the professional challenges they are likely to face. As part of the professional discourse of care, the nurse must also develop strategies to assist in coping with emotionally charged situations. Building resilience aims to ensure that nurses can deliver care without negatively affecting their well-being. While the NCNZ *Competencies for Registered Nurses* (Document 1) does not explicitly mention well-being and resilience, both are referred to within Curriculum 1 (Document 3), where "reflective practice and resilience" are directly linked to contributing positively to the "personal well-being" of the student nurse.

Document 2 (textbook) suggests that nurses will benefit from using the same stress-management techniques they teach consumers (Maslach, 2003, as cited in Barkway, 2017). In addition, Document 2 promotes the identification of stressors and the engagement and support gained from other nurses as positively impacting the nurses' ability to "maintain a caring attitude towards clients, their families or communities" (2007, as cited in Barkway, 2017, pp. 1384-1385). Aburn et al. (2016) referred to resilience in nurses as what enables them to cope with the most stressful and sustained challenging situations, such as workload and staff shortages, making it a concept increasingly referred to in professional, developmental, research, and policy literature.

However, while stakeholders identified resilience as something needing to be addressed within Curriculum 1 (Document 3), Document 2 (textbook) presents resilience as something that all nurses possess innately, stating that "nurses continue to provide care with resilience and versatility, often with minimal resources and organisational support" (Hughes et al., 2017, p. 7). While such assumptions can lead to resilience being seen as being required as part of undergraduate nursing curricula, it could also lead to omissions if viewed as an innate personal quality held or self-developed by those who become nurses. This statement also represents a presupposition that normalises the lack of organisational support and resources as part of the managerial discourse and places the professional responsibility on the nurses to be resilient and versatile.

Historically, the building of resilience was incorrectly seen as developed through the survival of hardship, whereas the opposite is, in fact, more correct. O'Brien (2017), in Document 2 (textbook), noted that the emotional challenges experienced by the nurse can contribute to reduced job satisfaction and disengagement, resulting in a reduced ability to look to the future positively, especially when managing care for consumers with mental health issues. The value of the nurse using emotional competencies to avoid developing maladaptive strategies, such as emotionally distancing themselves, is discussed in more detail in Chapter 7.

While EI was not explicitly present in any of the documents, discussion of the dominant discourses has reflected an implied requirement for the development of EI

as a necessary part of nursing practice. The discourses reflect professional and social practice expectations of the nurse as able to understand, process, and manage their own and others' emotions in delivering evidence-based, therapeutic, and culturally safe care that complies with legislated requirements for public safety. In addition, the management discourse reflected the significant personal benefits to be gained by nurses achieving EI as part of maintaining well-being and building the resilience required to manage the many challenges they will face.

Chapter Summary

This chapter has separately discussed the three dominant discourses—legal, professional, and management—using examples from the documents to show how each can potentially impact the development of the undergraduate nurse's EI-related theory and practice. In addition, the interconnectedness of the discourses highlights the ways in which the discourses compete, complement, and/or contradict each other. In addressing the first two research questions, this chapter provides insight into how the dominant discourses of legal, professional, and management discourse influence the construction of EI within the five selected documents. Chapter 7 will complete the contextualised interpretation of the study findings, where interpretation and explanation at a sociocultural level answers the third and final research question using contemporary examples from clinical practice.

Chapter 7 Contextualisation of the Discourses

This chapter moves the analysis from understanding how the discourses within the documents construct EI development to understanding how the discourses operate within the socio-cultural context of nursing practice. It focuses on how the discourses operating within the social practice of nursing influence the positioning, inclusion, and development of EI within undergraduate nursing education. This level of analysis is an essential feature of CDA, distinguishing it from other forms of discourse analysis because it goes beyond description and interpretation of the texts to include an explanation, critique, and criticism of the relationship between the text and its interaction within the social context (Fairclough, 2001, 2010; Huckin, 1997).

The findings, thus far, reveal that the dominant discourses impacting EI development within undergraduate nursing education are legal, professional, and managerial, with additional discourses such as accountability, competency, cultural safety, and well-being identified as either diminishing or adding to their influence, reach, and power. This final part of the analysis assists in exemplifying the findings in relation to contemporary clinical scenarios. The discussion of which assists in the recognition of the ways social practices influence and are influenced by dominant discourses and ideologies.

The Value of Contextual Analysis

As claimed in the third and final dimension of Fairclough's (2010) CDA framework, contextualised interpretation explains how the different discourses operate in the clinical practice setting through social practice. Thus, no single construct of society exists. Instead, society is seen to be constructed in many ways and influenced by both systematic and general theories of society (O'Mahony, 2023).

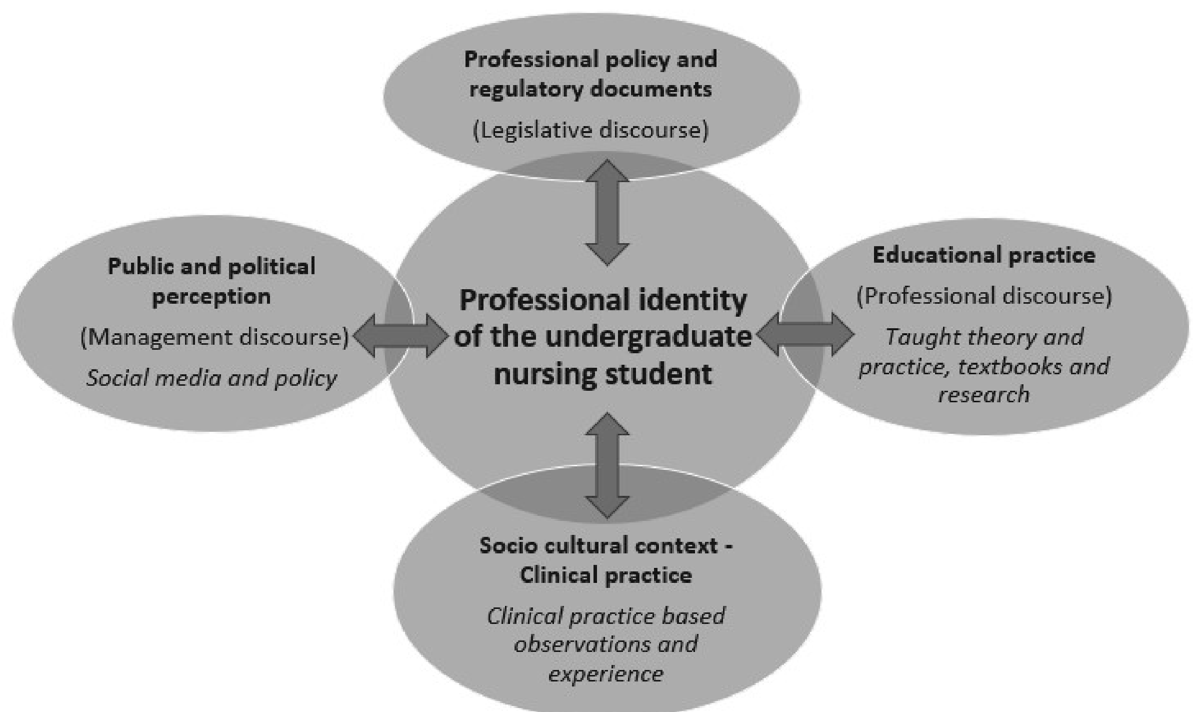
The Formal and Hidden Curriculum Constructing Professional Identity

In addition to consolidating theory and practice learning attained within the educational setting, the clinical setting provides an environment within which the student nurse learns new knowledge and skills. Some of these are outside the formal pedagogical plan and are considered part of an 'informal' or 'hidden curriculum'. Raso et al. (2019) describe a hidden curriculum as learning that is made up of unintended or

unplanned lessons that are culturally acquired and can be seen to contribute to the internalising of professional values, learning of unwritten rules, and developing a professional identity. Multiple sources contribute to the development of the undergraduate student nurses' professional identity, as shown in Figure 3.

Figure 3

Discursive Influences Upon the Construction of the Undergraduate Nursing Student's Professional Identity



The content of Figure 3 was inspired by Fealy et al. (2018), who examined discursive constructions of the professional identities of nurses and midwives, and Raso et al. (2019), who examined the influences and construction of the hidden curriculum. The purpose of Figure 3 is to illustrate the discursive influences found in the current study that impact the professional identity of the undergraduate nursing student. This conscious awareness of how ideological positions assign identities assists in revealing how discourses shape identities, influence public and political opinion, and, in the process, can shape public policy and impact clinical practice (Fealy et al., 2018).

The undergraduate nursing student's professional identity is shown in Figure 3 as being impacted and influenced by four areas of discursive influence, with discourses

identified as playing a role within the documents examined and perceptions of others across professional, public, political, educational, and clinical practice areas. The central part of Figure 3 represents the professional identity of the undergraduate nurse with two-way arrows connecting it to each discursively influential area. The arrows illustrate the interrelationship between the discursively influential areas and the professional identity of the undergraduate nursing student. The beliefs, assumptions, behaviours, and values of the undergraduate nursing student's professional identity are influenced by all of these; however, dependent on which is the more powerful, the professional identity of the undergraduate student nurse also has some discursive influence through the decisions and choices made by them as to which discourses are called upon and enacted through their clinical practice.

The examples discussed in this chapter highlight how discursive influences within the sociocultural context can be particularly powerful in informing the professional identity of the undergraduate nurse and are impacted by public and societal opinion and expectations (see COVID-19 example p. 148 and patriarchal influence p. 150). In the context of clinical practice, the managerial discourse of efficiency is prioritised over the professional discourses of patient-centred care (see the surgical versus palliative care example p. 140, and busyness and sitting down in clinical practice setting examples p. 145).

The Language, Discourses, and Sociocultural Context

This study assumed that student nurses in the socio-cultural clinical practice setting would also encounter the legal, professional, and managerial discourses identified within the documents influencing EI development in undergraduate nursing education. This expectation was built on the premise that the clinical setting extends and merges the learning environment into the 'real world' environment, integrating theory into practice and providing an important opportunity for the student nurse to develop knowledge and practise clinical skills while under supervision in preparation for entry into practice (Hickey, 2010; Öhman et al., 2016; Woo & Li, 2020). However, the multitude of different clinical practice settings, and the differing socio-cultural practices within each, can result in differing discourses being enacted. For example, related to the management discourse of efficiency, the 'conveyor belt' approach to

surgery is recognised as contributing to the conflict between the discourses of "new nursing," focusing on holistic and individualised nursing care, and "scientific management" (Wigens, 1997, p. 1116) through focusing on efficiency and cost constraints (Fox, 1993; Wigens, 1997, p. 1116).

Therefore, in time-limited relationships with consumers, such as those within a day-case surgical ward setting, meaningful emotional engagement with consumers may be deemed less necessary due to the limited time for interaction. The impact is a devaluing of EI skills related to relationship building. Priority is given to neoliberal values of productivity and efficiency rather than qualitative measures such as the level of engagement required in delivering person-centred care (Buss & Arnold, 2023; Dillard-Wright et al., 2020; Krol & Lavoie, 2014; Watson, 2008). Furthermore, the principles of Habermas' (1987) hegemonic or dominating economic and administrative systems reinforce technical interests, such as outputs and rule-following, and are prioritised to maintain the status quo. Technical interests work against practical emancipatory and communicative knowledge interests, nullifying the nursing implementation of EI. Reflecting the dominant management discourse, greater value is placed on meeting metrics to manage waiting list times and ensure operations run to schedule. Therefore, the dominant managerial discourse of efficiency influences students learning within such an environment. This discourse communicates that a higher value is placed upon efficiency and can devalue care provision requiring time, engagement, and understanding (Wigens ,1997).

In contrast to this surgical example, in a palliative care clinical setting where the clinical focus is on the consumer's symptom management rather than curative medicine, the importance of throughput and technical skill is lessened through a focus upon person-centred and holistic approaches which prioritise individual needs and value the contribution of consumers and their families in decision-making and planning (Nolan et al., 2004; Slater, 2006). Metrics reflecting a dominant professional care discourse associated with end-of-life care provision are likely to include quality-of-life measurements such as minimising distress and pain, where patience and quality of time would be of higher priority than time efficiencies and routines.

Therefore, the critical relationship between the discourses and socio-cultural context can be seen to be reflected within the conundrum that language and discourses contribute to the development of practices within the socio-cultural context while, at the same time, social practice also influences the development of language and discourses. This continuously iterative process of reshaping is described by Fairclough (1992) in terms of discursive practice contributing to reproducing society and its identities, relationships, belief systems, and knowledge, as well as to its transformation. This perspective is consistent with a social constructionist approach to language and discourses. Both are central to constructing and communicating an emphasis on one thing over another, constraining what we perceive and can and cannot express (Gergen, 2015).

The Emotional Development of the Student Nurse in the Clinical Setting

As shown in Figure 3 (p. 138), discursive influences of clinical practice on the professional identity of the undergraduate nursing student include clinical observations and experiences. The preceptor has an important role in building nursing students' confidence, promoting knowledge and skill acquisition, and supporting the professional socialisation of the student nurse in the clinical practice setting (Happell, 2009). However, McCloughen et al. (2020) claimed that students are not routinely offered structured emotional support within the clinical setting. They blame this on deficits in preceptors' abilities related to areas such as reflection, reframing, being calm, and expressing emotions appropriately. The risk to the student is that they may be advised, guided, or supervised by a preceptor who does not model the required emotionally competent behaviours in clinical practice, making it unlikely that students' EI development will be fostered. Suliman and Warshawski (2022) share these concerns and suggest that preceptors and educators should pay particular attention to supporting students' development.

Directed by the NCNZ (2012a) *Code of Conduct*, New Zealand registered nurses have delegated professional responsibility to assist in the learning and development of others and, "especially students and those who are inexperienced" (NCNZ, 2012a, p. 28). Despite these requirements and concerns, the NCNZ regulatory body for nurses only requires that preceptors have "undertaken formal structured education programmes that include the curriculum, assessment and relationships with education

providers" and with the clinical assessment of students "undertaken collaboratively between the nursing education provider, clinical learning provider and the student" (NCNZ, 2022b, p. 14). This requirement reflects the foregrounding of preceptors' contractual rather than professional practice qualities, constructed as part of the managerial discourse within nursing education. The prioritising of managerial over professional requirements and the absence of explicit requirements jeopardises the development of EI within the clinical environment.

EI and Conflict Management

Despite the absence of explicit requirements for emotional competencies within the professional discourse, one of the expectations of nursing care provision is that the nurse is equipped to manage conflict within the clinical setting. Conflict management is considered an essential skill to be developed for both nurses and nursing students, alongside the prerequisite EI to be able to do so (Chan et al., 2014; Morrison, 2008). This expectation is explicit in the *Competencies for Registered Nurses* document (NCNZ, 2012b). Nurses are required to respond "appropriately to protect oneself and others when faced with unexpected health consumer responses, confrontation, personal threat or other crisis situations" (p. 8).

In such situations, as part of the legislative discourse of responsibility for public safety and the managerial discourse of personal safety, nurses are required to manage their emotions while focusing on the health consumer's requirements and concerns. The combination of the discourses reinforces their importance and places the nurse as required to decide how to respond accordingly.

However, literature attests that where such confrontations involve threatening or verbally abusive patient behaviours, the negative affect on the nurse's perception of the health consumer results in nurses withdrawing emotionally from the provision of care in order to manage work-related stress (Değirmenci Öz & Baykal, 2022; Levett-Jones, 2022; van Zyl & Noonan, 2018). On the one hand, this could be seen as part of the professional discourse and compliant with NCNZ (2012b, 2012c competency expectations of nurses protecting themselves and creating safe emotional boundaries. On the other hand, such behaviour hinders professional requirements that the nurse understands the emotional context in which people exist as part of culturally safe care

(NCNZ, 2011). While most nurses need to suppress their emotions on occasions, it is the continued suppression of emotions within the clinical setting that is directly linked to psychological ill health, reducing performance, attendance, and increasing the risk of emotional burn-out (Delgado et al., 2017; McCloughen et al., 2020; Nguyen et al., 2016; Schmidt & Diestel, 2014). Faking or suppressing emotions in compliance with the requirements of the nursing role and professional rules is commonly referred to as emotional labour (Grandey, 2000 ; Morris & Feldman, 1996).

Emotional Labour as Part of the Managerial Discourse

Emotional labour, described initially in Hochschild's (1983, 2012) social theory of emotions, refers to the requirement to induce or suppress feelings and has evolved to being considered a market commodity (McClure & Murphy, 2007). It includes the effort, planning, and control required to express the externally observable organisationally desired or sanctioned emotions as an essential part of an individual's work (McClure & Murphy, 2007; Morris & Feldman, 1996; Wharton, 1999). Unlike EI, which is the ability to understand, control, manage, and regulate emotions regardless of setting (Goleman, 1995b), emotional labour recognises the emotional requirements of performing duties within the workplace to adjust and/or change natural emotional responses to comply with organisational rules and regulations (Guy & Lee, 2015). The framing of emotions as able to be directed and managed constructs emotional labour as a commodity within health care and, as such, is part of the managerial discourse where exhibited emotions are expected to meet organisational expectations of behaviour in line with guidance and policy (Hochschild, 2012; Weiss et al., 2002).

In providing an emotional response to consumers, the nurse is guided by professional expectations and must decide what emotions are appropriate to be expressed. Therefore, on occasions, the nurse's feelings and emotions may not concur with what is seen to be professionally expected. Clinical situations may include where the nurses have felt threatened or verbally abused by a consumer or their family, as discussed earlier, negatively affecting the nurse's perception and emotions toward the consumer. In such cases, the nurse must project emotions that do not align with their real feelings, forcing them to be inauthentic and suppress undesired emotions to meet organisational demands. When authentic emotions cannot be expressed, nurses

employ emotional labour to orchestrate the outward portrayal of the required emotions (Bolton, 2000; Riley & Weiss, 2016). In such instances, the nurse experiences emotional dissonance due to discrepancies between their true feelings and emotions and what they are expected to display to conform with professional and managerial policies and guidelines (Zapf, 2002). The adverse effects on nurses' health, manifest as anxiety, stress, depression, fatigue, or burn-out (Grandey, 2000 ; Kenworthy et al., 2014; Nielsen et al., 2023). Acquiring EI can, therefore, support a reduction of emotional dissonance through the constructive understanding, processing, and management of emotions rather than their suppression.

Emotional Dissonance Requiring Surface-Acting or Deep-Acting

According to Hochschild (2012), confronting emotional dissonance as part of emotional labour requires two strategies: surface acting or deep acting. In simple terms, surface acting requires faking the emotions displayed, with no attempt being made to change the felt emotion. In contrast, deep acting requires that the person reflect and review their internal feelings more positively in an attempt to modify the emotional state to be more consistent with the 'expected' or appropriate emotion and to assist in the 'appropriate' emotion being displayed, even if not entirely congruent with their own true feelings, thus reducing dissonance. While surface acting could be seen as the less involved and, therefore, less harmful strategy to be employed, it is more detrimental to the person's well-being because emotions are being ignored and suppressed (Grandey & Gabriel, 2015; Judge et al., 2009; McCloughen et al., 2020). In this way, the increased emotional labour erodes the nurse's sense of authentic selfhood (Ashforth & Humphrey, 1993; Erickson & Ritter, 2001; Erickson & Wharton, 1997).

The suppression of emotions seems inherent in the managerial discourse expectations of clinical practice despite the resultant emotional dissonance being recognised as energy-draining and adversely affecting individual well-being. Codier (2021) proposed an alternative approach to suppressing emotions and encouraged embracing the energy that emotions generate as part of an emotionally intelligent response. This is supported by Liu and Boyatzis (2021), who argued that full engagement of emotions through applying EI contributes positively to developing competencies, such as resiliency building. McCloughen et al. (2020) also proposed that such learning can

support the development of EI-related skills, including self-development strategies, such as self-regulation, reflection, and social connection, to enhance their ability to manage workplace stress. Emotionally competent nurses are, therefore, expected to identify and process their emotions to manage emotional dissonance and avoid negative emotional consequences to their health and well-being, such as burnout. The nurse needs to spend time with the consumers to identify and process the consumer's and the nurse's own emotions. Restriction of such contact reduces the opportunity for EI to be employed.

Time 'Sitting Down' in the Clinical Setting

Time spent at the bedside is often colloquially referred to as 'sitting down'. As part of clinical practice expectations, nurses are required to be emotionally competent to establish rapport, show empathy, and develop therapeutic relationships in providing care as directed by underpinning care-related theories that support authentic, nurturing, ethical, and humanistic nursing care (Basford & Slevin, 2003; Boore et al., 1999; Boykin et al., 2003; Leininger, 1985; Watson, 2008; Wei & Watson, 2019). The literature reinforces the importance of time spent with health consumers for its contributions to improving care quality, communication, experience and outcomes for the consumer (Golden et al., 2022; Lidgett, 2016). The professional document NCNZ (2012b) *Competencies for Registered Nurses* also reinforces time spent as part of professional practice within the indicators for Competency 3.3, which articulates the requirement of the nurse to provide "adequate time for discussion" (NCNZ, 2012b, p. 10). When time spent with consumers is limited due to factors such as workload, meaningful nursing interactions with health consumers are also limited. In such circumstances, managerial discourses of efficiency and throughput are again prioritised over professionally related discourses, diminishing quality care priorities such as time spent with consumers. This scenario places undergraduate nurses at risk in two ways. First, the student has less time to develop and practice emotional competency within the clinical setting. Second, they are less likely to observe emotional competency in action because the environment does not encourage their preceptors to role model such practice.

The Managerial Discourse of Efficiency

The literature suggests that insufficient time spent by nurses sitting at the health consumer's bedside is part of a broader issue within health care contributed to by the complexity and competing priorities within clinical environments (Cleary, 2004; Cleary et al., 2012; McAndrew et al., 2014; Terry & Coffey, 2019). A known phenomenon contributing to this normalising of reduced time spent with health consumers is the valuing of the busyness of the nurse constructed as part of the discursive construction of efficiency as part of the managerial discourse and reinforced by the normalising of nursing practice expectations that nurses are 'on their feet' all day (Evans, 2010; Jividen, 2022; Nagington et al., 2013; Terry & Coffey, 2019).

Perceptions of what represents efficiency in health consumer care can differ and are influenced by the discourses operating within the clinical setting. For example, on the one hand, the professional nurse may view efficiency as resulting from adequate staffing levels that allow for high-quality, person-centred and emotionally engaged nursing care. This professional viewpoint sees efficiencies gained through reducing the number of hospital stay days and the resulting cost savings. On the other hand, hospital managers may view controlling costs through reduced staffing costs with a focus on increasing productivity in terms of throughput as contributing to efficiencies at the expense of clinical quality (Khomami & Rustomfram, 2019). This dichotomy reveals nursing being "dominated by neoliberal values embedded in technocratic and bureaucratic ideologies" (Krol & Lavoie, 2014, p. 112) with commodification and the need for efficiency replacing nursing principles of providing "equitable, person-centred care to practice loving kindness in the caring process" (Buss & Arnold, 2023, p. 1; Dillard-Wright et al., 2020; Watson, 2008).

Furthermore, technological advancement can mean that the time nurses spend with consumers is diminished by the use of equipment. This is because it can create a physical barrier between the consumer and the nurse and, therefore, may result in negative consumer experiences (Alasad, 2002; Almerud et al., 2008; Bennett, 2011). The consumer can interpret this barrier as disrespectful and depersonalising(Alasad, 2002; Almerud et al., 2008; Bennett, 2011; Krol & Lavoie, 2014, p. 115). Once again, it signals a conflict between human considerations, technologies, and bureaucratic

structure, wherein managers prioritise the completion of administrative tasks and can physically observe the busyness of the nurse rather than time spent with the consumer (Atashzadeh-Shoorideh et al., 2021).

Nursing practice is person-centred, focusing on building trust through genuine caring (Stein-Parbury, 2021). This fosters effective interactions and allows nurses to better understand consumers' values and preferences (Barros et al., 2017; Doona et al., 1999; Watson & Woodward, 2010). Sitting down with consumers has been shown to contribute to health consumers' feelings of receiving respect and courtesy. Consumers perceive that nurses are actively listening when time at the bedside is spent sitting rather than standing (Lidgett, 2016; Merel et al., 2016). Conflict with health consumers is more likely where the busyness of the nurse, associated with increased workload and time constraints, prevents the nurses from having time to sit down and be present with consumers (Simpson-Collins et al., 2023; Thompson et al., 2008). Campaigns to increase the presence of nurses and meaningful time spent with health consumers include 'commit to sit' and 'grab a seat'. Such strategies were developed to actively encourage health staff, including nurses, to sit down with health consumers and point to the need to counteract constraining factors (George et al., 2018; Lidgett, 2016; Orloski et al., 2019).

Despite campaigns and supporting evidence reinforcing the positive impact of sitting with health consumers for the purpose of interaction (Crisp et al., 2016; George et al., 2018; Lidgett, 2016; Orloski et al., 2019), the managerial discourse of efficiency undermines the influences of such professional discourses. This undermining is reinforced by the premise that sitting down with consumers is representative of nurses not being busy. Health consumer perceptions reinforce such a notion when consumers report that nurses act in a 'rushed' way and then justify the inadequate care they receive with the assumption that being a 'good' nurse aligns with being an observably 'busy' nurse (Evans, 2010; Nagington et al., 2013). Thus, when the managerial discourse is prioritised and constructs busyness as contributing to and representing efficiency in clinical practice, the professional discourse is constrained, even when health consumer expectations reinforce the latter. This restriction on meaningful engagement and time spent with health consumers within the socio-cultural context of clinical practice also negatively affects students' development. They are denied

opportunities to develop EI both through a lack of observation and time to practice interactions that enable refinement of the skills of EI.

Having drawn on a time-honoured and long-debated example of sitting at the bedside, I will now use a more recent COVID-19-related scenario to exemplify and reinforced the complex interaction of discourses impacting the development of EI.

Novel Coronavirus (COVID-19) Pandemic

The COVID-19 pandemic is a contemporary example of the impact that the socio-cultural context has upon the discourses operating within the clinical setting.

In January 2020, the World Health Organization declared a Public Health Emergency of International Concern (PHEIC) in relation to COVID-19; and by March 2020, as the number of people affected worldwide continued to grow exponentially, a global pandemic was declared (World Health Organization, 2024). As a result, health services were put under extreme pressure from under-resourced staffing levels and overburdened services, causing large-scale disruption to healthcare delivery (Trentini et al., 2022; Xiao et al., 2021). The resulting emotional demands drew significant media attention to nurses' emotional health and well-being. Clinical settings were likened to war zones, with photographs showing exhausted nurses with skin damage and bruises to their faces from the continual wearing of masks. The required personal protective equipment (PPE) was even reported as causing 'battle wounds' (Dean, 2022; Ford, 2021; Robinson et al., 2023; Sky News, 2020).

During the height of the pandemic, media reports positively positioned health professionals working through 'lockdowns', having to manage their emotions and the associated stress, both personal and professional. While professional expectations, as directed by the *Code of Conduct for Nurses* (NCNZ, 2012a), require that nurses seek assistance when health concerns threaten their ability to practise safely, discursive positioning by public media portrayed the nurse as a 'hero', enduring significant challenges and making personal 'sacrifices'. However, these heightened expectations unwittingly had the effect of silencing nurses' ability to advocate for their own safety (Boulton et al., 2022; NCNZ, 2012a, p. 38). Despite the adverse effects of exhaustion and burn-out on nurses' emotional health and well-being resulting from COVID-19, the

discourses positioning nurses as ‘self-sacrificing saviours’ placed them in the invidious position of feeling unable to voice their concerns because this would go against the practice expected within the socio-cultural context at that time. It did, however, result in an increased value being placed on the emotional competencies of the nurse, particularly in developing emotional resilience and reinforcing its necessity as part of nurses’ knowledge and skillset (Galanis et al., 2021; Jiménez-Fernández et al., 2022; Jose et al., 2020; Safiye et al., 2022; Zhang et al., 2021).

This discursive positioning of the nurse’s professional responsibility in managing and maintaining their emotional health intersects with the managerial discourse on nurses’ occupational duty requirements. The inability to meet the emotional requirements of their role becomes a risk to care provision and, thus, a safety concern as part of the managerial discourse relating to nurses’ ability to provide health services. Moreover, the increased expectation of nurses' emotional capacity to become heroes when required implies that nurses are appropriately prepared to do so. This discursive positioning of the nurse exemplifies how both discourses reinforce the necessity for nurses to be emotionally competent and that undergraduate nursing education programmes facilitate such development in preparation for the actual and potential challenges of the ‘real world’ of clinical practice.

The following section focuses on the discursive positioning of the nurse’s professional responsibility to manage and maintain their emotional health. It reflects the complexity inherent in the interactive nature of the dominant discourses where professional expectations are placed upon personal well-being.

Health and Well-being Responsibilities

In chapters 4 and 5, the examination of the documents identified the protection of public safety as an important part of the dominant legislative and professional discourses. While remaining a priority within the clinical setting, the interconnection with the nurse’s health and well-being can be seen to increase in focus, driven by challenges encountered in clinical practice that call for greater inclusion of the nurse’s health as an associated priority. EI is an essential and fundamental skill in supporting personal health maintenance and strengthening professional practice (McCloughen & Foster, 2018; McCloughen et al., 2020). Therefore, fostering EI development as part of

social practice could be expected in the clinical setting; however, the findings do not provide direction as to what this may entail. The lived experience of the undergraduate nursing student within the clinical practice setting reveals different discourses and ideologies being employed to construct meaning. Some are conflicting, and others differ in interpretation and application in practice. For example, the discourse of risk as part of the safety discourse is present in relation to the vulnerability of the nurse's health in delivering care. It connects to the nurse's well-being as part of professional care provision and is more dominant when an emotional challenge to the health and well-being of the nurse is experienced.

Standard 8.7 of the *Code of Conduct* for nurses, places responsibility upon the nurse for maintaining and reporting any health concerns related to their safety to practice:

> You have a responsibility to maintain your health and well-being, and to seek assistance if your health threatens your ability to practise safely. (NCNZ, 2012a, p. 38)

Therefore, nurses are professionally and legislatively required to identify and take action against any things that negatively impact their emotional well-being. In the clinical setting, the managerial discourse related to the personal safety of the nurse is also active, related to the nurse's ability to perform the occupational requirements of being a nurse. Managerial objectives also require nurses to cope with emotional challenges and stress, supporting clinical and cost-effectiveness by reducing absence from work through stress-related conditions such as 'burn-out', thus improving staffing levels and efficiencies (Badu et al., 2020; Bittinger, 2020; Karimi et al., 2014).

The Pervading Patriarchal Discourse

Patriarchy describes a social system wherein masculinity is associated with power and contributes to patriarchal-driven dichotomies and 'truths', such as men being rational versus women being emotional (and therefore less rational) (Blangsinga et al., 2021; Connell, 1994; Millett, 2000). It is through the normalising of behaviours associated with the male gender that the construction of understandings concerning masculinity and femininity impacts socially prescribed behaviours (Gott et al., 2020). Social constructionism and critical social theory assist in understanding society because they

connect by reflecting on the origins of knowledge and considering how dominant theories perpetuate and highlight oppressive societal inequities (Price & Reus-Smit, 1998). The strengthening of stereotypes linked to the feminisation of nursing can also be observed where female nurses are associated with basic rather than technical aspects of care, handling sensitive information and communication (Carlsson, 2020). Therefore, social constructionism and critical social theory theories can be utilised to examine patriarchy as a sociological and ideological construct by illuminating how its dominance and oppression are constructed.

New Zealand academic and politician Marilyn Waring (2018) highlighted an example of patriarchy as undervaluing and ignoring the economic value of women's caring work, with society promoting the ideology that caring is a 'natural' role for women (Gott et al., 2020; Waring, 2018). While this example can reflect an issue of concern for women's unpaid, undervalued, and under-recognised caring work, such ideological-based expectations also devalue the effort required in providing professional nursing care, in which EI plays a significant role and so is ultimately minimised. Reverby (1987), highlights this dilemma in American nursing, stating that there are prescribed requirements for all nurses to care, yet the society within which it operates "refuses to value such caring" (p. 5). The patriarchal ideology that caring is an innate and natural ability of women devalues the complexity of knowledge and EI required and fails to recognise the inner ethical values of caring, being reflective and reflexive, self-aware, attentive, open, and respectful (Karlsson & Pennbrant, 2020).

Some have suggested that parts of modern nursing, based on Florence Nightingale's 19th-century model of nursing, with its accepted norms of devotion to duty, obligation, and obedient service, are still prevalent today (Reverby, 1987; Sumner & Danielson, 2007). While Nightingale's ideologies can be seen to reflect female privilege, linking empathy and feelings uniquely to the female nurse and reflecting their suitability for a caring role as part of the professional discourse of care, they can also be seen conversely to reinforce patriarchal views linked to gender stereotyping. In highlighting the gendered nature of nursing and nurses' work within a patriarchal culture, such influences also encourage men to hide their emotions and vulnerabilities, thus giving greater value to being unemotional (Becker, 1999). The patriarchal view can, therefore, be seen to construct emotionality with being unprofessional, portraying

females as over-emotional, prone to being emotionally unstable, fragile, weak, irrational, and unreasonable (Evers, 2009; Grady et al., 2008).

Patriarchy is ever-present and invisible in the socio-cultural context of nursing practice. It pervades every part of managerialism and professionalism, yet its power is neither acknowledged nor addressed in relation to its impact on emotional competency. The pervasive nature of the patriarchal discourse renders it 'hidden in plain sight' within nursing practice. This significantly devalues EI skills concerning communication and relationship building.

Therefore, from a social constructionist viewpoint, nurses are positioned within the socio-cultural context of nursing as natural caregivers. The perceived and constructed emotionality of females in nursing is contributed to and reinforced by the fact that nursing is predominantly a female workforce. As already identified, the clinical setting profoundly impacts student nurses' opportunity to develop and consolidate EI behaviours through the effects of the discourses and ideologies at play within the complex setting of the 'real world'.

Conclusion

Professional expectations within the clinical setting reflect an expectation that the nurse is capable of managing highly emotionally charged situations. The nurse is also responsible for ensuring their practice is evidence-based and that maladaptive strategies, such as emotional avoidance or distancing from health consumers, are not employed. Such practices require nurses' continual self-management, understanding, and management of others' emotions. Nurses are also expected to maintain their health and well-being by meeting professional and occupational requirements. The public expectations of nurses have further developed to include the expectation that they rise to challenges like a global pandemic. Thus, it is abundantly clear that learning to be emotionally competent is essential during nurses' undergraduate preparation.

Chapter Summary

This chapter's discussion of the impact of different discourses within the clinical practice setting illustrates how the social context and ideological perspectives impact student nurses' ability to practice and develop emotional competency. The nurse's

legal, professional, managerial and public expectations are shown to be influential in the positioning of the nurse, with a pervading patriarchal discourse influencing the positioning of care and EI expectations within the clinical setting. Conflicted feelings and the inability to take the time to engage with consumers at the bedside and/or to voice concerns about their own emotional health and well-being also cause angst for student nurses and limit opportunities to engage with consumers on an emotional level. Thus, becoming emotionally competent can be seen as a double-edged sword in that the emotionally competent nurse is aware when they are not addressing the emotional needs of the health consumers, and the emotional dissonance that results from such awareness can harm the nurses' well-being. The next chapter discusses the findings of the current study. It provides practice recommendations and possibilities for future research and highlights the study's limitations.

Chapter 8 Discussion and Recommendations

This chapter reviews and discusses the understandings drawn from completing the CDA of EI development within undergraduate nursing education. Attention is focused on the continuing ambiguities that exist around defining EI and related terms and the continued absence of explicit EI development requirements within undergraduate nursing curricula. The articulation of the insights gained and supported by the literature will be followed by the chapter's final section, which provides recommendations for future nursing practice, support for EI inclusion within undergraduate nursing curricula, and greater utilisation of EI within the clinical setting. It also includes suggestions for further research and addresses some of the study's limitations.

This study set out to answer the following research questions:

1. How is the language used to construct the meaning of EI within undergraduate nursing curricula, theory, and clinical practice?
2. How do the discourses operating within undergraduate nursing education influence the positioning and inclusion of EI?
3. How does the sociocultural context impact the discourses and influence EI's positioning and inclusion within undergraduate nursing education?

The motivation to address these questions grew from a personal concern that the development of knowledge and competency in managing the emotional side of nursing seems to receive little attention in nursing education compared to other nursing knowledge. It was further inspired by the feeling that undergraduate nursing education does not do enough to support the EI development of undergraduate nursing students in preparation for the emotional challenges that are faced within the nursing role.

The literature supports all nurses' development of high levels of EI, as it is shown to contribute significantly to a more positive and effective healthcare environment. Nurses' strong communication skills and ability to connect with patients lead to higher-quality, patient-centered care. EI also equips nurses to manage stress and navigate

conflict effectively, fostering a safer environment for patients and staff. A more resilient and well-equipped nursing workforce ultimately translates to better healthcare outcomes. EI is, in the main, seen as a vehicle to enhance the nurse's connection to consumers, help maintain their health, and strengthen the professional practice of students and registered nurses to improve the quality of care they provide (Codier et al., 2009; McCloughen et al., 2020). The expectation that nurses have EI to be able to understand, regulate, and manage their emotions and to meet the demands of nursing work, as promoted through the literature, can also be seen within the nursing discourses. Those expectations extend to undergraduate student nurses as part of their undergraduate nursing education, where they are required to demonstrate professionalism, compassionate quality care, clinical decision-making, attention to personal well-being, and resiliency. Before completing this research, I was unsure exactly how much and how EI development occurred within undergraduate nursing education in New Zealand. A review of the literature identified significant evidence relating to the importance of EI being integral to nursing and the benefits for both consumers and the personal health and well-being of the nurse.

Conversely, it also highlighted the associated detrimental effects that result from an absence of EI, e.g. work-related stress and burnout. The literature contained many calls for including EI development within undergraduate nursing education; yet, apart from some individual institutes worldwide taking on such work, the literature provides no single clear answer as to why such content has not been universally adopted. Through examination of the selected documents in this current study, it is clear that EI was *required* to fulfil many nursing responsibilities, but *how* it was developed was not clearly articulated. The discourses dominating and hindering EI development in nursing education were identified and discussed, thus providing an essential first step in awareness of this impact and influence to provide the insight required to begin addressing this deficit.

Ambiguity of the Definition of EI

Part of the challenge to EI development can be seen to be associated with the ambiguous and interchangeable definitions associated with EI and its use, as discussed in Chapter 2. A frustrating contradiction also exists. On the one hand, there is a resounding call for nurses to be emotionally competent; on the other hand, no single

solution or agreement of approach has been mandated, offered, or adopted within undergraduate nursing theory or practice.

The Essential Extra

This research reinforces the concept of EI as an "essential extra" in nursing. While not explicitly required for development or demonstration as a separate competency, as has been shown, EI is implicit in the requirements for emotionally informed care, such as conflict management, critical thinking, and culturally safe care. Nurses need to manage their own emotions and those of others to avoid unhealthy coping mechanisms that can negatively impact patient care and job satisfaction. Examples include ignoring or repressing feelings and failing to engage with patients fully.

Therapeutic relationship building and cultural safety are two fundamental areas of nursing practice that rely heavily on EI. Both require nurses to engage in purposeful self-reflection and appreciate the complex emotions of others to build culturally safe and therapeutic relationships.

Nursing curricula must reflect more than knowledge and technical skills. New Zealand needs a future nursing workforce of highly knowledgeable and skilled nurses capable of managing the complexity of the clinical environment and being resilient against current and future challenges. As was demonstrated during the COVID-19 pandemic, EI is essential for the workforce to continue coping and delivering quality care to consumers amidst new and complex challenges.

There is strong consensus in the literature, supported by this study's findings, that explicitly integrating EI development into undergraduate nursing education is essential (Dugue et al., 2021; Foster et al., 2018; McCloughen & Foster, 2018). While further research is warranted to ensure all curricula address EI development, a first step would be for the Nursing Council of New Zealand (2012b) to explicitly articulate the emotional competencies expected of all registered nurses in its *Competencies for Registered Nurses* document. Aligning the NCNZ Nursing Education Standards with this revised document would then require undergraduate nursing programme leading to registered nurse registration to include content and assessment methods that ensure

graduates are supported in their development of EI and and can demonstrate emotional competence (NCNZ, 2022b).

Prioritising Public Safety but Neglecting Emotional Well-being

The legislative discourse in nursing prioritises public safety, emphasising that consumers have the right to safe care from competent registered nurses (NCNZ, 2012b). This focus inherently includes self-awareness, which is aligned with the legal requirement for self-regulation. Nurses must understand and implement professional guidelines and legislation, reflecting a neoliberal emphasis on individual responsibility. However, this framework positions the nurse as solely responsible for mitigating stress and preventing burnout, even in situations beyond their control, such as staffing shortages or pandemics.

The Emotional Demands of Nursing

The NCNZ (2012b) *Competencies for Registered Nurses* outline care provision expectations, including developing therapeutic relationships with patients. This necessitates emotional engagement and the ability to manage challenging situations. However, undergraduate students are not guaranteed to be explicitly taught or encouraged to practice emotionally informed care. Several factors within clinical settings may hinder student development, including the emotional intelligence of educators, resource limitations, staffing shortages, and time constraints.

Workplace Stress and Nurse Retention

Nurses are facing unprecedented workplace stress, particularly in the wake of the COVID-19 pandemic. This stress is compounded by workload challenges, uncertainty, and fear, impacting not only practicing nurses but also student nurses entering the profession (Clancy et al., 2022; Dos Santos et al., 2022). This growing complexity of workplace stress for nurses and students is further exacerbated by existing factors within the managerial discourse of healthcare. Chronic underfunding, resource limitations, staffing shortages, and recruitment and retention issues all contribute to a more pressured work environment. Additionally, the inherent emotional demands of caring for patients are a well-known contributor to workplace stress, potentially leading to burnout when workloads and emotional burdens become overwhelming.

These combined factors create a significant challenge that demands immediate attention to ensure the well-being of nurses and the future of the nursing workforce.

The Untapped Potential of Emotional Intelligence

A New Zealand study examining why nurses leave the profession early identified work-related stress and poor work-life balance as key factors (Walker & Clendon, 2018). Research suggests that strong EI could help mitigate these issues. Another New Zealand study on the role of the workplace in nurse burnout concluded that EI is essential for the emotional demands of nursing but "not always taught well" (Tabakakis et al., 2020, p. 15). This aligns with international studies showing new graduate nurses experiencing burnout and leaving the profession within two years due to inadequate skills and knowledge, compounded by high workloads (Codier, 2021; Ulupinar & Aydogan, 2021). These findings highlight the unpreparedness of some undergraduate nurses to cope with the realities of professional nursing.

The Hidden Hindering of Discourses

This study reveals hidden forces that limit EI development and opportunities for student nurses to practice and develop these skills. Discourses can subtly or dramatically influence social practice. While legislative, managerial, and professional discourses were shown to influence practice priorities demonstrably, the patriarchal discourse within the sociocultural arena was also shown to devalue emotional care in favour of technical or bureaucratic aspects of nursing. The combined impact of these and other discourses relegates EI development to being an “essential extra” and failing to translate into mandatory development and assessment requirements for all undergraduate nursing education programmes.

The Dissonance Between the Ideal and Reality

This thesis investigated how discourses within selected texts and the broader social context influence how undergraduate nursing students develop EI. A key finding was the surprising absence of the term "EI" from all three undergraduate nursing curricula and the Nursing Council of New Zealand (2012b) Competency for Registered Nurses document. The absence is significant as not naming it reduces the value seen to be placed upon its requirement.

The analysis revealed a duality in the way the documents address emotional intelligence. On the one hand, they emphasise a compliance-oriented EI, focusing on nurses' ability to *respond* to emotions in a way that adheres to professional regulations and guidelines. This translates to managing how stress is *manifested* in their *behaviour*, how conflict is actually physically managed, and how emotions are expressed (or suppressed, aligning with professionalism, relationship boundaries, and patient safety, all of which are focussed on the *observable* behaviours of the nurse.

In contrast, the analysis also found requirements for the philosophical aspects of EI embedded within the documents. These aspects focus on the nurses' self-awareness and emotional processing capabilities. This involves a nurse's ability to recognise their own emotions and understand their impact on thoughts and behaviours. This self-awareness allows for better decision-making self-care and aligns with self-reflection and resilience concepts in complex and challenging situations. Unlike the outward behaviours of compliance-oriented EI, this approach emphasises the required complex cognitive processing of emotions to inform such responses.

While both aspects are required for compliance with the professional requirements of nurses with respect to competency-related areas such as critical thinking and cultural safety, the argument presented is that the current focus on EI in nursing practice, as reflected in the documents, prioritises compliance with guidelines and expected social norms related to emotional behaviour (or the suppression of emotional behaviour/emotions). While this can be seen to foster a baseline of professionalism, it does not equip nurses with the full range of EI skills, placing the benefits of such EI processing at risk, related to the *not readily* or immediately observable areas, such as the personal well-being of the nurse.

Recommendations and Further Research

Therefore, the discussion concludes that a more philosophical approach to EI in nursing education would be beneficial. This would encourage students to reflect on their own emotions, values, and beliefs, and how these influence their interactions with patients and colleagues. By incorporating philosophical inquiry into the curriculum, students can develop a deeper understanding of themselves and their role as a nurse.

Practical applications of this could include mindfulness and meditation instruction and practice to help students develop self-awareness and emotional regulation skills. Focused reflective Journaling encourages students to reflect on their experiences and particularly their emotions so as to deepen their understanding of themselves and their interactions with others. This approach would better prepare student nurses to manage their well-being and navigate emotionally challenging situations during their education by fostering emotional processing, self-awareness, and regulation. This, in turn, would support achieving other professional competencies and ultimately lead to a more resilient and emotionally intelligent nursing workforce, fostering improved patient care and well-being.

Future research could also explore how educators interpret and integrate EI development within their teaching practices. This could include investigating their understanding of EI, identifying any challenges in incorporating it into the curriculum and identifying innovative and practical strategies that could be used. This would support the development of more standardised and effective approaches being integrated into curricula.

Policy recommendations

The principal recommendation of this study is that the NCNZ (2012b) *Competencies for Registered Nurses* document be revised to include specific emotional competencies to reflect the specific requirements of EI development. EI would then become a mandated requirement to be taught and developed within undergraduate nursing education through the requirement that all curricula include content that enables undergraduate nurses to meet all NCNZ Competencies for Registered Nurses' requirements upon graduating.

The New Zealand Competencies for Registered Nurses are currently being reviewed, for which feedback on the proposed changes ended at 5 pm Monday, 12 February 2024. Part of the rationale provided for the development of new RN competencies by the NCNZ is that they are to be more future-focused to reflect the context of providing care in New Zealand and be more measurable and assessable. Examples of ways in which EI competencies could be included as specific and measurable competencies could be requiring self-awareness as a crucial component of emotional intelligence, enabling nurses to recognise and understand their own and others' emotions. This

includes accurately identifying and labelling emotions such as stress, frustration, or joy. Assessing competencies could be done by various methods, including self-reflection, peer assessment, direct observation, and simulated clinical scenarios.

While this study's significant call is for EI to be given the attention it deserves and become a mandated requirement by the Nursing Council of New Zealand, it is also acknowledged that further research is required into effective, practical and innovative ways for educational institutions to prepare undergraduate nurses for clinical practice.

Practice Recommendations -Clinical Simulation

One area that warrants further research is how clinical simulation hours could be used in developing emotional competency as a structured alternative to clinical practice. Undergraduate nurses could experience simulation-based learning that provides opportunities for students to practice managing specific complex emotional situations, helping them gain experience, competence and confidence in developing and using EI skills in a safe and controlled environment. This would remove some of the pressures experienced in clinical practice, such as real consequences and time pressures, and provide the space to facilitate and support de-briefing and reflection. This approach could enhance student nurses' capacity to manage their emotions and provide role-modelling opportunities to build emotional intelligence. Furthermore, research into how simulation can be used for ongoing staff development of registered nurses could also be a worthwhile endeavour to support increasing EI capabilities in the existing workforce.

There is already exciting and new interest in exploring how artificial intelligence and digital technologies can support the development of emotional intelligence and its associated competencies by developing pedagogical tools such as Virtual Reality (VR) games (Hack-Polay et al., 2022; Oliveira et al., 2021). This research area holds the potential for creating immersive and interactive learning experiences that can further enhance the development of emotional intelligence in both student and registered nurses.

Considerations and Limitations

This research has provided new insight into how discursive positioning within key documents shapes the development of EI in undergraduate nursing education. The analysis reveals how the discourses operating within nursing theory and practice and the documents influence what students are encouraged to learn, develop and prioritise as they prepare for professional practice.

While CDA is a powerful tool for examining power dynamics in texts, it is a relatively new and evolving methodology. This study employed a specific CDA approach focusing solely on written texts. This decision, while strategic, acknowledges a limitation in that the selected documents cannot capture the full spectrum of professional discourse that shapes and is shaped by registered nurses. The sheer volume of data analysed also presents the possibility that some discursive influences might have been missed or connections overlooked due to the study's scope.

However, the study tried to address this limitation by instilling rigour into the research through the use of reflexive practice and by carefully selecting methods and documents that aligned with the research questions, time constraints, and overall scope. It is important to acknowledge that limitations are inherent to qualitative research methods as interpretations made by the researcher "are always subjective and reflect the researcher's own beliefs and values" (Crowe, 2005, p. 62).

In addition, this study was limited due to the availability of specific tertiary institute curricula documents; however, while this constraint may have impacted the depth and breadth of the analysis, this was seen to be accounted for by the fact that the three curricula analysed were from across the both north and south island of New Zealand and from both polytechnic and university tertiary education institutes. At the outset of the study, a decision was made that if not enough quality data was available to be retrieved from the available curricula, alternative texts would be considered for examination.

While this study may not directly address how educators can integrate EI development into their practices, it offers valuable insights into the discursive landscape within the sociocultural context of nursing. It reveals how these discourses prioritise certain

aspects of professional practice over others, and these insights can help inform actions that counteract powerful, yet often hidden, influences that shape healthcare practice (Todic et al., 2022).

Conclusion

This study highlighted discourses' hidden power and influence within nursing theory, practice, and the broader socio-cultural context and how these factors can promote or hinder EI development and utilisation within undergraduate nursing education and practice. The analysis revealed the complex ways discourses shape EI development for undergraduate nursing students and overt and covert influences on students' EI-related professional identities and practices.

The critical approach adopted in this research acknowledges the limitations of current research on EI in undergraduate nursing education. It also recognises the need for further studies to support the implementation of some of the recommendations. In addition, on a broader scale, there is a requirement for systemic challenges within the healthcare system, such as chronic understaffing, to be addressed, which can hinder the development of such EI initiatives.

This thesis contributes critical insights into how discourses influence, connect, and impact EI development in undergraduate nursing education. The findings and discussion presented aim to motivate further research by raising the profile of EI. This, in turn, could lead to the development of EI as a requirement in undergraduate nursing education in New Zealand and other countries. Ultimately, this research also aims to stimulate a broader understanding of how discourses can both empower and hinder progress in undergraduate nursing education, as recognising such hidden power and influence can reveal opportunities to facilitate necessary change.

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Glossary

Fairclough (2011, p. 96) helpfully provides the following summary of some of the terms used in connection with his three-dimensional CDA framework:

Discourse	***(abstract noun) where language use is conceived as social practice***
Discursive event	*An instance of language use, analysed as text, discursive practice, social practice*
Text	*The written or spoken language is produced in a discursive event*
Discourse practice	*The production, distribution and consumption of a text*
Interdiscursivity	*The constitution of a text from diverse discourses and genres*
Discourse	*(count noun) Way of signifying experience from a particular perspective*
Genre	*Use of language associated with a particular social activity*
Order of discourse	*Totality of discursive practices of an institution and relations between them*

Appendices

Appendix A: Textual Characteristic Questions used for examining texts based on Thomas Huckins approach to CDA (1997)

Genre/Authorship /Audience/ Agency:

- What 'type' of text is it?
- What are its features and purpose?
- Does it conform to what it is?
- Who is the author, and how does this genre serve the author's purposes – is it a person or organisation? What are their qualifications/ professional affiliations?
- Who is the audience/intended reader?
- Does the genre fit the audience that it is intended for? If yes, why/why not?
- How are the subjects positioned within the text? Do they identify themselves, or are they presented as 'other' or 'the authority'?
- Who is initiating the action?
- Who is it informing? Educating? Accusing?

Framing:

- How does the author wish this to be received by the reader? What is the general position, style, and perspective?
- What visual aids are being used to frame it?
- Is there a precise angle of the document? Are some things presented more favourably?
- Is it purposefully framed in a way to influence the reader- are there intentional metaphors used? e.g. good versus bad?

Foregrounding and backgrounding:

- Are there any visual embellishments such as photographs, sketches, diagrams, or larger or bold text to bring particular text to the foreground?
- Is prominence given to particular text? If yes, how?
- Are certain parts of the text given less emphasis or prominence? Are there fewer words about certain parts? Is the text smaller or at the end of a document?
- Is there an order of significance? Is greater importance, for example, given to text appearing earlier in a section as 'headlines' with the latter part being the non-essential details?

Omission or deletion:

- Before reading the text, what do I expect to be there?
- Is there any information that I would have expected to be there but is missing?
- Are specific words left to the reader to work out with their existing knowledge? Why? Has it been done purposefully to draw less attention to it and/or focus more on what is explicitly being said (foregrounding)?
- Are there any gaps in the text? Why? Is it left for the reader to decide? Do they assume the reader should already know? Is it on purpose? Is it to draw less attention and a severe form of backgrounding so it cannot be scrutinised or have questions raised?

Presupposition:

- Are certain ideas presented as fact and without an alternative?
- Are there instructions within the text that you should not do (or not do) something, presupposing that you may do this otherwise?
- Is something presented as fait accompli that is actually not already complete e.g. talking about what will happen at the next stage before the previous stage is successfully navigated through?

Insinuation:

- Is there an implied judgment?
- Is there a comparison to something else intending to make it more or less favourable? Does the comparison present it as a simple fact, or is it implying something?

Connotations:

- What are the words used, and how do they differ and why? e.g. Student, pupil, learner, novice or patient, client or the disease name used in place of a person.
- Are there words used to imply something? e.g. the subjects being depicted using words that imply something else e.g. military, animals and animal behaviour – inferring justice/power/irrational non-thinking etc.…?
- Are metaphors used?

Discursive differences & register:

- Is there more than one style of discourse or register? Is it being used to manipulate e.g. showing authority and expertise?
- Are there words/phrases being used to affect the level of informality or formality? e.g. technical, conversational or authoritative (expert) register

Sequencing:

- Is there a natural order to how they should be presented, or does the discourse deviate from this? If so why? To influence? Change focus?

Modality:

- Is there a tone of certainty in the words and phrases indicating authority e.g. will or should? Alternatively, is there and air of uncertainty e.g. can, could, may, might or possibly?
- What is the indicative mood e.g. past tense, current or future focused?
- Does it report a series of actions in a highly factual tone or have a trace of uncertainty?
- Are there any instances of conditional, hypothetical, or subjunctive modality in this text?
- Is the discourse closed to discussion or negotiation?
- Is there an ineffectual ritual feel than a meaningful clash of ideas?

Contextualised interpretation:

- What does the analysis show? Does the text paint a picture favouring something specific? Or emphasise something specific? (what do the discourses say)
- Is it congruent with the fundamental premises of a democratic society: equal justice for all, basic fairness, individual freedoms (within reason), guarantees of human rights etc…? (what do the discourses influence)

Larger Sociocultural considerations:

- Are the hot topics currently in the world featured in the text e.g. for nursing/tertiary education/emotional intelligence/competence developments – what are the links to this from the text? e.g. sustainability / tertiary sector reforms
- How does this impact the discourses found in the text

Appendix B: Emotional Intelligence Examples From Textual Analysis of the Documents

This table lists statements from the documents that draw on various discourses to define and impact emotional intelligence requirements in nursing theory and practice as determined in the literature in Chapter Two.

Table 2 Emotional intelligence examples from document 1 (professional document): Competencies for registered nurses (NCNZ, 2012b)

Examples of excerpts from the text: Characteristic of emotional intelligence linked to emotional self-awareness, self-regulation, motivation, empathy, and social skills	Discourse
"They practice independently and in collaboration with other health professionals…" (NCNZ, p. 2).	Professional (relationships)
"Recognises the impact of the culture of nursing on health consumers care and endeavours to protect the health consumer's wellbeing within this culture" (NCNZ, p. 6).	Professional Management (Well-being) Safety (cultural)
"Practises in a way that respects each health consumer's identity and right to hold personal beliefs, values and goals" (NCNZ, p. 6).	Professional Legal Safety (cultural)
"…in partnership with individuals, families, whānau and communities" (NCNZ, p. 8).	Professional Safety (cultural)
"in collaboration with the health consumer and other health care team members" (NCNZ, p. 8).	Professional
"Acts appropriately to protect oneself and others when faced with unexpected health consumer responses, confrontation, personal threat or other crisis situations" (NCNZ, p. 8)	Legal (public safety) Professional Management (personal safety)
"Practises nursing in a negotiated partnership with the health consumer where and when possible" (NCNZ, p. 10).	Legal Professional Management
"Implements nursing care in a manner that facilitates the independence, self-esteem and safety of the health	Professional (care) Legal (safety and partnership principles)

Examples of excerpts from the text: Characteristic of emotional intelligence linked to emotional self-awareness, self-regulation, motivation, empathy, and social skills	Discourse
consumer and an understanding of therapeutic and partnership principles" (NCNZ, p. 10).	
"Communicates effectively with health consumers and members of the health care team" (NCNZ, p. 10).	Management (effectiveness &efficiency)
"Uses a variety of effective communication techniques" (NCNZ, p. 10).	Professional
"Collaborates and participates with colleagues and members of the health care team to facilitate and coordinate care" (NCNZ, p. 11).	Professional Management
"Provides guidance and support to those entering as students" (NCNZ, p. 11).	Professional Management
"Collaborates with the health consumer and other health team members to develop plan of care" (NCNZ, p. 11).	Professional Management
"Collaborates, consults with and provides accurate information to the health consumer and other health professionals …" (NCNZ, p. 11).	Legal Professional Management (collaborate & consult)

Table 3 Emotional intelligence examples from document 2 (textbook): Potter and Perry's Fundamentals of Nursing (Crisp et al., 2017).

Examples of excerpts from the text: Characteristic of emotional intelligence linked to emotional self-awareness, self-regulation, motivation, empathy and social skills	Discourse
"Communication is the means by which nurses meet their professional obligation to form therapeutic relationships with clients". (Stein-Parbury, 2017, p. 232).	Professional
"It is the role of the nurse to deliver care in a way that the patient deems culturally safe". (Feo et al., 2017, p. 35)	Professional Safety (cultural)
"Patients and their family members should feel as though they are integral members of the healthcare team, that they are engaged, involved and informed, and that their preferences and expertise are considered rather than dismissed". (Feo et al., 2017, p. 37)	Professional Management (Well-being) Safety (cultural)
"The qualities, behaviours and communication techniques described characterise professionalism in therapeutic relationships with clients and collaborative relationships with colleagues" (Stein-Parbury, 2017, p. 210).	Professional Management
"The healthcare system is a critical component in ensuring and maintaining the health and wellbeing of populations" (Hughes et al., 2017, p. 6).	Legal Professional Management
"The Fundamentals of Care Framework illustrates how a positive and trusting nurse-patient relationship is integral to maintaining patients' physical, psychosocial and environmental safety" (Feo et al., 2017, p. 43).	Professional Management Safety
"Have a way of 'being with a patient' and instantly knowing the patient after scanning him/ her; they know what to pay attention to and what questions to ask" (Douglas & Crisp, 2017, p. 55).	Professional
"embodies intellectual humility"; "accepts uncertainty";	Legal Professional Management

Examples of excerpts from the text: Characteristic of emotional intelligence linked to emotional self-awareness, self-regulation, motivation, empathy and social skills	Discourse
"self-regulation, self-examination and self-correction" (Crisp et al., 2017, p. 57).	
"commitment to developing as a reflective practitioner – being critical and learning from practice – is the essence of good nursing" (Douglas & Crisp, 2017, p. 59).	Professional Management
"Current efforts in healthcare systems reform are aimed at making communication, and care itself, more patient-centred" (Newell & Jordan 2015 & van Dulmen 2011, as cited in Stein-Parbury, 2017, p. 213).	Professional Management
"Statements reflecting empathy are highly effective because they tell the person that the nurse heard the feeling content, as well as the factual content, of the communication. This results in clients feeling accepted and valued, thereby facilitating the therapeutic relationship" (Stein-Parbury, 2017, p. 228).	Professional Management
"Sharing emotion makes nurses seem more human and can bring people closer. It is appropriate to share feelings of caring, or even cry with others, as long as the nurse is in control of how those feelings are expressed and does so in a way that does not burden the client" (Stein-Parbury, 2017, p. 228).	Professional Management
"Nurses consider many contexts and factors influencing communication when making decisions about what, when, where, how, why and with whom to communicate" (Stein-Parbury, 2017, p. 232).	Professional Management
"In nursing, emotional intelligence is required for inter¬ personal competence" (Powell et al., 2015, as cited by Stein-Parbury, 2017, p. 232).	Professional Competency Management
"It is for this reason that nurses need to be skilled in managing their emotions as well as understanding others' emotions. This ability is termed 'emotional intelligence'…(Adams & Iseler 2014)" (Stein-Parbury, 2017, p. 232).	Professional Management
"Cultural safety is also about trust, being trustworthy and the way trust is constructed personally, culturally and institutionally; it requires the dominant culture to be accountable for the access and delivery of appropriate health care to all cultures" (Cox & Taua, 2017 p. 267).	Professional Competency Management Safety (cultural)

Table 4 Emotional competence examples from Document 3 (curricula): Undergraduate nursing curricula 1 (Tertiary Institute 1)

Examples of excerpts from the text: Characteristic of emotional intelligence linked to emotional self-awareness, self-regulation, motivation, empathy, and social skills. In addition to the examples in document 1 (NZNC, 2012b).	Discourse
"The personal well-being and resilience of the nurse was also a key theme to emerge from the consultation" (p. 10).	Professional Management Well-being Resilience
"Apply principles of interpersonal relationships to clinical practice in order to facilitate appropriate and therapeutic relationships with clients"	Professional Management
"doing and reflecting lead to becoming" (p. 7).	Professional Management
"it is through reflection on clinical experiences that nurses gain maturity and confidence in their abilities and in who they are (p. 53)" (p. 7). "Practice cannot be divorced from the practitioner as a person with life experience: the doing is the being (Ewing & Smith, 2008, p 27)". (p. 7)	Professional Management
"Ruth-Sahd (2003) identifies other positive outcomes of a reflective practice such as enhanced self-esteem, acceptance of professional responsibility, a sense of empowerment, increased social and political emancipation, improvement of practice through greater self-awareness, and expanded clinical knowledge and skills". (p. 7)	Professional Management
"Demonstrate behaviours which reflect professional, ethical and legal requirements of a first year student nurse"; "Personal wellbeing • Reflective practice • Resilience (p. 47).	Professional Management Wellbeing
"Be confident, adaptable, resilient, committed to ongoing learning and understand the wider healthcare context" (p. 6).	Professional Resilience Management
"Practice safe, competent and effective nursing that is responsive to peoples' needs and reflects current knowledge, research and best practice" (p.6).	Professional Competency Management

Table 5 Emotional competence examples from Document 4 (curricula): Undergraduate nursing curricula 2 (Tertiary Institute 2)

Examples of excerpts from the text: Characteristic of emotional intelligence linked to emotional self-awareness, self-regulation, motivation, empathy, and social skills in addition to the examples in document 1 (NZNC, 2012b)	Discourse
"Much of nursing practice is invisible, which means that nurses, the public, and other health professionals can undervalue the complexity of nursing practice" (p.1).	Professional Management
"Environmental awareness and sustainability are attributes that are important for the future of nursing…recognised as a key concept embedded within a multitude of areas of nursing practice". (p. 4.)	Professional Management Resiliency
*The following statement is included in every course descriptor paper learning outcome:	Professional Management
"Students will develop an understanding of sustainable nursing practice and its application to health in Aotearoa New Zealand"	Resiliency
" … understanding of the complexity of addressing environmental, social/cultural and economic aspects of sustainability in a range of nursing contexts; developing the capacity to make links between personal, community and global issues and the recognition and integration of multiple and divergent points of view to solve problems and resolve conflict in cooperative and proactive ways". (p. 4)	Professional Management Resiliency Conflict management Safety (cultural)
"The contribution that nursing can offer to the field of sustainability is modelling less exploitative and more sustainable health care practices in order to support people and their communities" (p. 4).	Professional Management Resiliency
"Have excellent personal and professional integrity…" (p.7).	Self-awareness
"The ability to critically reflect on their own practice, the practice of others and the socio-political influences on health care in both the New Zealand and international contexts".	Self-awareness /reflection Professional Management Resiliency

Examples of excerpts from the text: Characteristic of emotional intelligence linked to emotional self-awareness, self-regulation, motivation, empathy, and social skills in addition to the examples in document 1 (NZNC, 2012b)	Discourse
"Within the programme it is recognised that sustainability encompasses social, cultural, economic, and emotional sustainability". (p. 4)	Professional Management Safety (cultural) Resiliency
"Demonstrate an ability to appropriately apply communication micro skills";	Professional Management
"Increase their self-awareness and effectiveness as communicators with individuals and within groups"; "Demonstrate effective use of assertive communication".	Competency Self-awareness /reflection

Table 6 Emotional intelligence examples from Document 5 (curricula): Undergraduate nursing curricula 3 (Tertiary Institute 3)

Examples of excerpts from the text: Characteristic of emotional intelligence linked to emotional self-awareness, self-regulation, motivation, empathy and social skills in addition to the examples in document 1 (NZNC, 2012b).	Discourse
"Critical thinking and reflection and their role in nursing" (p. 12).	Professional Managerial
"To introduce students to theoretical, ethical, cultural and professional concepts relevant to contemporary nursing, including the role of research and evidence-based practice" (p. 12).	EBP Professional Managerial
"Clinical teacher support; Weekly clinical tutorials; Reflective log writing" (p. 25).	Self-awareness/reflection Professional Managerial
"Psychology concepts (personality, memory, learning, emotion)" (p. 8).	Professional EBP
"Cultural conflict (ethnocentrism, stereotypes, prejudice, discrimination)" (p. 8).	Professional Managerial Safety (conflict) Safety (cultural)
"Leadership and management issues in nursing – includes leadership and management theory, patient management systems, change theory and management, delegation, conflict management" (p. 43).	Professional Managerial Safety (conflict)
Interpersonal Relationships	Professional
Interpersonal Health Care and Quality Improvement (p. 45)	Managerial Safety (conflict)
"Therapeutic communication skills" (p. 4).	
Professional nursing relationships Elements of professional communication	

Examples of excerpts from the text: Characteristic of emotional intelligence linked to emotional self-awareness, self-regulation, motivation, empathy and social skills in addition to the examples in document 1 (NZNC, 2012b).	Discourse
Communication with clients with special needs (p. 6).	
Intersectoral and interprofessional communication (p. 31).	
Therapeutic communication, therapeutic relationship and associated theorists	EBP Professional