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Privileged Pioneering in the Peripheries: an ethnographic study of Research Capacity Building in the emerging academic disciplines of Irish Nursing and Midwifery.

A thesis presented to the University of Dublin, Trinity College
for the
Degree of Doctor in Philosophy

By

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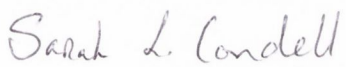

Sarah L. Condell

Title: Privileged Pioneering in the Peripheries: an ethnographic study of Research Capacity Building in the emerging academic disciplines of Irish Nursing and Midwifery.

Summary

Background

Research Capacity Building (RCB) was a term often used in research policy literature, including that emanating from nursing and midwifery. However, its meaning was obscure, lacking conceptual and empirical clarity. An initial concept analysis produced an interim definition of the concept of RCB but absent in the literature was any evaluation of the process (as opposed to the product) of RCB or theoretical underpinning of the concept. The literature also lacked any critical comment on RCB from an Irish perspective. Concurrently, an Irish research funding agency, the Health Research Board offered the Clinical Nursing and Midwifery Fellowship scheme aimed at building research capacity and employed a Nursing Research Advisor (NRA) as part of a joint appointment role. The scheme funded experienced nurses and midwives to undertake a PhD that the literature showed was an international benchmark of RCB.

Aim

The overall aim of this ethnographic study was to examine the development and create a substantive theory of research capacity building in the emerging academic disciplines of nursing and midwifery in Ireland.

Method

Following academic and organisational ethical approval, using a longitudinal ethnographic approach, I, the NRA collected data in two fields over 28 months and maintained a reflexive researcher diary. The Field of the Fellow had 16 participants from a total population of 17 Clinical Nursing and Midwifery Fellows (CNMFs) funded to undertake doctoral research. The CNMFs were observed or interviewed in 48 episodes generating 84 hours of data. The Field of the Funder had 114 fieldnote entries recorded by the NRA of the funding agency and 28 reports and newsletters were analysed in addition to subsidiary texts. From there, a modified Glaserian grounded theory analysis of the data was undertaken.

Results

The substantive theory of *privileged pioneering on the peripheries* emerged as the core variable to explain RCB in Irish nursing and midwifery on their entry to the academy. One periphery refers to the place of Irish nursing and midwifery research in health research culture, at policy, academic and individual levels. A second periphery refers to the distance between many of the CNMFs and any formal research culture. A third periphery experienced by some CNMFs was the peripheral disciplinary nature of their chosen topics. Privileged pioneering is the activity and behaviour of 'elite' nurses and midwives (the CNMFs and the NRA) in the two fields within the specific temporal context. For CNMFs being funded to undertake their doctorates on a full-time basis gives public knowledge of their privilege with resultant tensions on the legitimacy of their labour and imposed obligations; for the NRA, privilege consists of the uniqueness of the role at operational and strategic level. Pioneering behaviours include taking risks, initiating new ventures, identifying opportunities and acting as role models. The nature of pioneering means that tenacity and resilience is shown in the face of contestation, negotiation and the

isolation from being marginalised. The pioneers, with varying degrees, struggle to forge a space in health research that is already occupied by others and which, to the new and somewhat naïve entrants, is unknown or 'strange'.

Supporting this core were the dynamic and inter-connected subcategories of '*resourcing' the research*', '*labouring the doctorate*' and '*transitional identities*'. In '*resourcing' the research* the pioneers attain funding, gain time and construct a space. Attaining funding means undergoing or, in the case of the NRA, supporting a competitive process. This requires preparation and performance in which the CNMFs displayed resilience and tenacity. It gains for the CNMFs the mythical 'luxury' of a bounded 'flexible' time 'being off' that they have to guard against loss. Constructing a space in which to labour means identifying the optimal environment and equipping this, not just with labour tools, but also with motivational visual prompts and scholarly symbols. In both fields, space is often contested requiring negotiation. In *labouring the doctorate* the CNMFs work through the processes and practices of the PhD to develop an understanding of, and achieve the PhD as a product, all the while labouring ethically and struggling with the unknown and strange. It entails developing the skills required and attempting to keep on track, building new routines and managing pace. The CNMFs have to champion the work in and out-with formal rites of passage. In *transitional identities* the pioneers have multiple identities of self as CNMF, as doctoral student, as nurse or midwife and as person, and the NRA as nurse, researcher, visitor or HRB agent. They manage these identities saliently with the pertinent identity to the fore in differing contexts. They build confidence and assemble credibility in the identities by 'doing', sometimes overcoming feelings of 'impostorship'. The identities are in transition requiring adjustments such as 'letting go', 'not belonging' and 'contemplating the future'.

Conclusions

The theory exposes five key issues for nursing, midwifery and health research in Ireland. These are the individualistic, solitary and competitive PhD labour due to a lack of research culture and tradition within Irish nursing and midwifery; the meaning of identity within RCB with that of nurse or midwife being the strongest as opposed to the CNMF identity as the weakest; the valuing of nursing and midwifery research(ers) and what it may mean for the future, the optimal positioning of the NRA within the HRB and the challenge for dominant models of RCB and doctoral education. Eighteen recommendations are made to address these issues and include fostering collaborative alliances and offering greater guidance to HRB Fellows; strengthening identification with the HRB; promoting the contribution and translation of nursing and midwifery research into practice and areas for further research and monitoring.

This is the first empirical study of RCB in Ireland. It was conducted at an opportune time when the concept of RCB was emerging and dynamic and it contributes to the corpus of work internationally. Through its methodology, it uniquely combines data from two fields and shows similarities in processes and nuances across the levels of RCB. The substantive theory emerging from the data supported the initial concept analysis of RCB but, by empirical examination, expands its attributes. The theory has policy and practical relevance and will assist individuals, organisations and policy-makers to optimise RCB by showing all the substantive areas that should be considered in operationalising the concept beyond a 'product' focus so that what can be expected and how best to respond is explicit.

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List of Abbreviations

AFMO	Academic Family Medicine Organisations
ANP/AMP	Advanced Nurse Practitioner/Advanced Midwife Practitioner
CEO	Chief Executive Officer
CNMF	Clinical Nursing and Midwifery Fellow(ships)
CSA	Chief Scientific Advisor
DoHC	Department of Health and Children
HEI	Higher Education Institute
HoD	Head of Division
HRB	Health Research Board
HSE	Health Services Executive
HSR	Health Services Research
IRCHSS	Irish Research Council for Humanities and Social Sciences
IRCSET	Irish Research Council for Science, Engineering and Technology
JAN	Journal of Advanced Nursing
MKWfH	Making Knowledge Work for Health
NAPCRG	North American Primary Care Research Group
NCNM	National Council for the Professional Development of Nursing and Midwifery
NRA	Nursing Research Advisor
OECD	Organisation for Economic Co-operation and Development
PhD	Doctor of Philosophy
PRLTI	Programme for Research in Third Level Institutions
R&DfH	Research and Development for Health Division.
RAE	Research Assessment Exercise
RCB	Research Capacity Building
RDO	Research Development Officer
RFPD	Research Funding and Policy Division
RSNMI	Research Strategy for Nursing and Midwifery in Ireland
SFI	Science Foundation Ireland
UK	United Kingdom
UKCGE	United Kingdom Council of Graduate Education
UKCRC	United Kingdom Clinical Research Collaboration
UN	United Nations
US(A)	United States (of America)
WHO	World Health Organisation

Chapter 1: Situating the Study.

1.1 Introduction to the chapter

This study is concerned with research capacity building (RCB) in the emerging disciplines of Irish nursing and midwifery. The initial chapter introduces the reader to key elements from which the study itself emerges. Such an action situates the study within the policy, professional, educational and temporal contexts that inform its production and introduces the reader to the concept under investigation. The chapter commences with an introduction to myself as the ethnographer[1] who conducted the study. Outlines of the study context and its policy foundations then follow, before an initial exploration of the RCB concept.

1.2 Introduction to the researcher

At the outset of this study, I was a nurse of 25 years, with the latter 12 years spent in nurse education including the academic setting. My experience included conducting research as a part-time post-graduate student and supervision of research projects for taught Masters programmes. Since 2002, I have held a joint appointment between two national statutory agencies: as research development officer (RDO) in the National Council for the Professional Development of Nursing and Midwifery (NCNM) and as nursing research advisor (NRA) in the Health Research Board (HRB). The role of the NRA was one of advising the HRB on nursing and midwifery issues within its operations and acting as a communication conduit with the professions. The NRA also represented the HRB on relevant committees and implemented government policy through the HRB. Other aspects included providing guidance and advice on research training, funding opportunities and research careers to all nurses and midwives. Elements of the NRA role are found in descriptions of research developmental roles in the literature (Elliott, 1997; Thompson, 1999; Bateman & Kinmonth, 2001), although these contain neither an operational and strategic functional mix, nor have the 'cultural brokering' attributes[2] (Jezewski, 1995; Raiwet et al, 1999) of the role. The NRA spent 1-2 days per week in the HRB setting.

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[1] Within ethnography, the researcher is the research instrument (Hammersley & Atkinson, 1995)

[2] For Raiwet et al (1999) a cultural broker mediates between two cultures to which they belong in order to enhance a service to a marginalised or minority group.

For ten years[3] the HRB offered the scheme entitled Clinical Nursing and Midwifery Fellowships (CNMF) that aimed to build research capacity, from the provision of ring-fenced funding by the Department of Health and Children (DoHC). The establishment of the scheme was heralded by the HRB Chief Executive Officer (CEO) in the Annual Report of 1999[4] and with a press release (appendix 1.1). The 'Fellows' (CNMFs) become full-time researchers with their institution of registration for the duration of the award. This fulfils one element of the dominant global policy model of 'traditional' PhDs (Evans, 2002; Barnacle & Usher, 2003; Evans & Kamler, 2005), although paradoxically CNMFs' degree of experience marks a difference to the 'early career stage' policy assumption (Miller & Brimicomber, 2004). Whilst the NRA could act as a point of contact for Fellows, there was no formal power relationship with them.

1.3 The context

The CNMF initiative occurred at the outset of the assimilation of Irish nursing and midwifery to the health research culture. The Commission on Nursing (Government of Ireland, 1998) found a dearth of published Irish nursing and midwifery research. Condell (2004:146) suggests that "this reflected the low level of research activity and support structures, the neophyte position of nursing and midwifery within the Irish higher education sector and the lack of specific publishing opportunities." Subsequent policy initiatives addressed the issue; for example, since 2002 degree level education afforded nurses and midwives an academic career with inherent research capacity. However, the CNMF scheme was aimed at experienced nurses and midwives whose socialisation had been embedded primarily in practice (appendix 1.2). In other words, the CNMFs already knew how to 'do' nursing or midwifery and 'be' a nurse or midwife. The fellowship allowed them to learn how to 'do' nursing or midwifery research and 'be' a nurse or midwife researcher. Thus the CNMFs underwent an additional socialisation process into an academic culture in which nursing and midwifery themselves were noviciates. The CNMFs now had to learn the craft of research (Newell, 2004) and the 'cultural competences' (Delamont et al, 2000) of the academy. In doing so, not only is nursing or midwifery knowledge produced but the social identity of the nurse or midwife researcher is also formed. White (2005) contends that competitive, time-out schemes, such as the CNMF, assist in building a critical mass of research talent and, like in the United Kingdom (UK)

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[3] 1999-2008

[4] This included a photograph of the first awardees with the Chief Nurse, HRB CEO and the then NRA.

(Delamont et al, 1997a), the CNMFs had highest status funding for PhD in Ireland because it was awarded by the HRB. However, there is a tension in having such a bracketed, ring-fenced scheme as it marks nursing and midwifery research as a particular case and may marginalise or subordinate its contribution to health care research (Davies, 2004; White 2005). Additionally, the establishment of such a fund is recognised as part of a much longer process (Rafferty et al, 2002) to develop nursing and midwifery research as an influential contributor to the health services, and therefore requires sustainability.

The academic context in which the CNMF initiative occurred was the move of Irish[5] pre-registration education into the academy – a move from vocational training to professional education (Treacy, 2005). Elsewhere, comparable contemporary policy shifts have been highly contested (Meerabeau, 2001, 2004), as much because of an anti-intellectualism in the professions themselves (Walker, 1997; Mead & Moseley 2000; Thompson & Watson, 2001; Miers, 2002; Yam 2005). Some speculate that an anti-intellectual undertow also exists in Irish society (White, 2001) and McNamara (2005) shows just such an attitude in the general public's reaction to the Irish nurse education developments. Research is associated with intellectual activity which may result in clinical nurses', midwives' and managers' attitudes to research being problematic in the context of policy and professional drivers for its greater utilisation (Hicks, 1995a, b, c; Hicks, 1996a, b; le May et al, 1998). Normand (2004) implies that capacity will build when a demand is created for good evidence for practice. Thus Irish nursing and midwifery research needs to show its contribution and value to those within and without the professions themselves. Yet, "given the small amount of evidence nursing has compared with the vast amount of care that it provides the research agenda for the profession is enormous" (Bishop & Freshwater, 2003:405).

The Irish universities, themselves, had been mainly teaching institutions with a very strong vocational focus (White, 2001). Historically, this has meant a long and deep relationship between medicine and the Irish universities with, despite one exception[6], large percentages of the student corpus registered for medicine in the 20th century (White, 2001). The entry of nursing and midwifery continues such a vocational tradition with these professionals now educated in the same culture as those they

[5] Here, the term Irish denotes the Republic of Ireland. Northern Ireland, which is part of the UK has two universities with academic schools of nursing and midwifery established for some years.
[6] University of Dublin, Trinity College.

practice alongside. However, the path may be far from smooth. In addition to changing power relations between themselves and medicine that academic establishment brings, Irish nursing and midwifery, being a predominantly female group, enters at a time of dramatic increasing admission rates (O'Connell et al, 2006) with undergraduate female participation already exceeding that of males (OECD, 2004) although vertical segregation exists. Whilst the Universities Act (1997) and the Education Act (1998) encase gender and equality development, White (2001) gives results of a press survey of 2000 showing that only 13% of higher level academics (senior lecturer and above) were women. Thus, the pre-dominantly female professions of nursing and midwifery will develop a research base in a milieu that is male orientated[7] and where research has been under-resourced until the last decade.

1.4 Relevant Irish policy and its agents

1.4.1 General research policy

Governmental recognition of the value of education for economic expansion (OECD, 2004) from the 1960s has gradually shifted to the value of research for economic expansion. Although the level of investment remains below the OECD and EU averages (OECD, 2004) since 1998, there has been an increase in research funding; firstly with the founding of the Programme for Research in Third Level Institutions (PRLTI), quickly followed by the establishment of three additional funding agencies, the Irish Research Council for Humanities and Social Sciences (IRCHSS) in 1999, Science Foundation Ireland (SFI) in 2000 and the Irish Research Council for Science, Engineering and Technology (IRCSET) in 2001.The funding available to the HRB also increased dramatically from the late 1990s. Whilst this public investment had a background of low research activity (OECD, 2004) it appears that a policy driven investment wave had been initiated. In addition, governmental policy led to a concerted effort to increase the number of doctoral students with particular emphasis on science areas[8] including health. This was against a background of low overall postgraduate numbers in comparison with other European countries (OECD, 2004) but increasing numbers graduating with PhD awards (IUA, 2004). It raises the question as to the level of preparedness of nursing and midwifery to benefit from the investment surge given their professional and disciplinary circumstances.

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[7] Glass (2001a, b) critiques the Australian university for its impact on women nurse academics and particularly the vulnerability it generated.

[8] Brew (2001) claims that science has been particularly adept at aligning its discourse with that of research funding and so dominates Australian government research funding.

Funding agencies act as "quasi government bodies" (Brew, 2001:114) that influence and implement national policy on research funding. Such 'co-opted elites' (Kogan & Hannay, 2000:38) also "create hierarchies of resource and esteem in their own domains" and protect dominant concerns by 'interpreting' policy (Henkel, 2005). So the HRB is not just an organisational work setting with a tradition and culture – it can be viewed as an agent in the production of knowledge of health. In contrast to the newer funding agencies, the HRB had been in existence for over twenty years, being established in 1986 from the amalgam of the Medico-Social Research Board (MSRB) and the Medical Research Council (MRC) with the latter formed in the 1930s. The different foci of the original bodies were acknowledged as potentially problematic at the outset[9] pointing to the dilemma of using the rhetoric of 'health research', that Pearson (2004) claims is a proxy for medical research.

Other key stakeholders engaged with this emerging policy agenda; for example the Irish Universities Association hosted a number of events in 2004-2005 focusing on research careers. There was a recognition that the changing context meant that researchers were engaging in "new activities in which the ground rules and relationships of authority, status and career are still ill defined" (IUA, 2005:4). The IUA (2004, 2005) acknowledged the divergent disciplinary milieu for researchers at all levels, as well as their continuous evolution and shifting disciplinary boundaries. It contended that the size of the Irish university system and its units point to a need for greater co-operation and a focus on interdisciplinary work (IUA, 2004). Internationalisation was seen as another challenge, as was the divergence arising from 'ownership' of the PhD with students, supervisor, industry and funding agencies all bringing their own values to the process and product. Professionalisation of the research career across its trajectory was called for (IUA, 2004, 2005).

1.4.2 Health research policy

Whilst governmental policy meant an increase in research funding across the total research spectrum, there were two key governmental strategy documents at the commencement of this study dealing with health research RCB. In Making Knowledge Work for Health (MKWfH) (DoHC, 2001), two pillars of support were identified. 'Science for Health' had a broad scope from basic and applied sciences to

[9] First Chairman's statement for the initial Annual Report (HRB, 1987).

social sciences. As a funding stream[10] MKWfH acknowledges it had well developed procedures through its length of establishment but a prior consultation exercise had criticised the HRB's level of funding to some of the sciences within the health research 'family' such as primary care or professional practice issues. There was also acknowledgement that such science developed in academic environments, with links to health settings where appropriate. The second pillar of 'Research and Development for Health' focused on research for and within the health service and thus contained some of the sciences within the first pillar with no clear demarcation[11]. This pillar had no historical presence in Ireland but MKWfH did outline some supporting policy initiatives including the process of the development of the Research Strategy for Nursing and Midwifery in Ireland (RSNMI) (DoHC, 2003). Interestingly, the specific discipline highlighted as in need of RCB in MKWfH is epidemiology with medical research consultants and research scientists also singled out for special mention from the term 'health professional'. This reflected the earlier alleged bias towards science and medical disciplines in funding and the majority of HRB board membership to 2002.

The HRB traditionally assisted in doctoral level education through two types of funding schemes from RFPD – project grants and fellowships. The former 3 year grants were awarded to Principal Investigators who then employed PhD students to undertake the projects and the latter were awarded to individuals who registered their own study with an academic department. At commencement of this study an evaluation of the Project grants was complete (O'Donovan & McCafferty, 2004) and an evaluation of the Fellowship schemes was about to commence. Regardless, there were anecdotal reports of problems with both schemes. In an effort to address some of the issues, a third mechanism, PhD Training sites[12], were piloted in 2004 with further rollout in 2006. This consisted of funding for 4 years with the aim of broadening the training and creating a critical mass of doctoral students.

The second pertinent strategy, the RSNMI (DoHC, 2003), developed as a uni-professional, focused strategy and was an outcome of a broader professionalizing

[10]The Research Funding and Policy Division (RFPD) was created in 1999 with the appointment of Head of Division (HoD). The documentary analysis showed its origins as being in the MRC.
[11] The Research and Development for Health Division (R&DfH) was created in 2002 as a result of this strategy.
[12] This common usage of this title is interspersed with PhD Scholar Programmes.

drive initiated by the Commission on Nursing (Government of Ireland, 1998)[13]. The twenty one recommendations spanned the continuum from research generation to research utilisation with funding and career development seen as critical for capacity building at the level of the individual. This strategy also recommended the representation of nurses and midwives on governmental funding bodies. Interestingly, whilst discussing a research culture, it appears to apply the concept solely to practice, with an assumed presence of such a culture within the newly established nursing and midwifery academy. A similar scenario occurred in UK nursing policy at the same time (Meerabeau, 2005).

Whilst these strategy documents underpin the development of RCB in Irish health research, their usage of the concept varies. For example, MKWfH presumes an understanding of the meaning, offering no explanation of the term, and focusing solely at an individual level. For RSNMI, explanations for both 'research capacity' and 'capacity building' are given and the concept is applied across a number of levels.

1.5 The initial concept

To clarify the concept of RCB, a literature review was conducted. Within this, a systematic analysis of the concept was undertaken (Condell & Begley 2007) (appendix 1.3) and showed that the usage of the concept 'research capacity building' implied a funded, dynamic, intervention operationalised through a range of foci and levels to augment ability to carry out research or achieve objectives in the field of research over the long-term with aspects of social change as an ultimate outcome. Given the limitations of this initial analysis and the evolutionary stage of the concept, the statement was not viewed as a fixed definition but as a useful reference for further debate and critical thinking. A number of issues arise from the conceptual analysis and its synthesis with other key literature generated from additional short searches conducted on the databases Ebsco, British Education Index, ISI Web of Science with included Social Sciences Citation Index, the Science Citation Index Expanded and the Arts and Humanities Citation Index. The discussion that follows has two parts: the first addresses the activities of RCB as outlined in the literature and the second examines underlying themes from the literature.

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[13] Research is lauded as a professionalizing strategy (Mulhall, 2001; Styles, 2005) as it "specifically forms part of the political and cultural project to establish nursing as a profession" (Mulhall, 1995:577)

1.5.1 Research Capacity Building Activities

In practice, twenty five years ago capacity building had a narrow focus on institutions that has since expanded to incorporate contextual variables (UN Secretary General, 2002; Nuyens 2005). Such a broad perspective, Panday (2002) claims goes beyond the narrow development foci that are traditionally funding based and can fail to produce the necessary results. The implications are that a broad integrated approach is more likely to achieve development goals. The literature acknowledged that RCB activities occurred at multiple levels (Sitthi-amorn & Somrongthong, 2000; Farmer & Weston, 2002; Thompson 2003; Larisang & Dennis, 2004). Nevertheless, it tended to focus on the lower levels or 'bottom up' approach of individuals and organisations, although some literature looked at broader 'top down' approaches or policy, both at national and international levels. A useful starting point for some of the description on RCB was the identification of influencing factors including barriers (Cooke & Green, 2000; Farmer & Weston, 2002; Del Mar & Askew, 2004; Hazelkorn, 2004; Rafferty & Traynor, 2004; Grange, 2005). This acknowledged contextual complexity, yet produces differing meanings and emphasis in RCB to stakeholders (Gordon, 2005).

The literature focus on RCB at the level of the individual discussed training for skills deficiency[14] (Albert & Mickan, 2002; Farmer & Weston, 2002; Reading & Nowgesic, 2002; Smith & Edwards, 2003; Taylor et al, 2005; Pirkis et al, 2005). Some of this training was doctoral awards (Proctor, 1997; Wall, 2000; Williamson, 2001; Nchinda, 2002; Hyder et al, 2003). It is noted by some that the term capacity building is still used as a euphemism for individual training (Paul, 1995; Potter & Brough, 2004) as this is one of its main tools (UN Secretary General, 2002). Additionally, at the level of the individual there was debate about research career development (Proctor, 1997; Wilson-Barnett, 2001; Bishop & Freshwater, 2003; Haas, 2004; Pearson, 2004; Grange et al, 2005; Gordon, 2005) including recruitment and retention into such careers (Sitthi-amorn & Somrongthong, 2000; Wall, 2000; Nchinda, 2002; White,

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[14] For example: A documentary analysis of the newsletter titled '*Building* Research Capacity' (2002-2004) produced by the funded network established to support a UK ESRC programme called Teaching and Learning Research Programme (TLRP) was available from www.cardiff.ac.uk/socsi/capacity. The aim was to inform the readership of TLRP activities and other relevant issues such as familiarisation with different methodologies, debate on key issues and an emphasis on the use of technology in research design and project management. As such building research capacity was a technical skills deficit that the Network aimed to fill. Not until Issue 7 of 8, was this concept challenged and the complexity of building research capacity acknowledged. However the critique (Boyask et al, 2004) was limited to the differing theoretical perspectives and inherent difficulties underpinning research approaches and so failed to identify contextual complexities of capacity building.

2002; Hyder et al, 2003; Lansang & Dennis, 2004) and the development of individual research leadership (Meyer et al, 2003; Nchinda, 2002) or facilitator roles (Stephenson & McCreery, 1994; Bateman & Kinmonth, 2001; Crossley & Holmes, 2001; Grange, 2005; Darbyshire et al, 2005).

A focus at organisational level (Cooke & Green, 2000; White, 2002; Hazelkorn, 2004; Macfarlane et al, 2004) was also evident within the literature. Where such organisations were geographically or professionally isolated, networks of individuals or organisation were the unit of interest (Sitthi-amorn & Somrongthong, 2000; Thomas et al, 2001; Boon & Verhoef, 2002; Farmer & Weston, 2002; Nchinda, 2002; Stillman et al, 2005; Pirkis et al, 2005) and in some cases these bridged the academy and practice (Thomas & While, 2001; Gillibrand et al, 2002). This level encompassed the issues from the individual level and generated more. Common to much of this literature was the element of 'a research culture' (Cooke & Green, 2000; Thomas & While, 2001; NAPCRG & AFMO, 2002; Thompson 2003; Hazelkorn, 2004) where research is integral and valued and the supporting infrastructure for the development and sustainment of such an environment (Nchinda, 2002; White, 2002; Langsang & Dennis, 2004; Grange et al, 2005). Centres of excellence (Boon & Verhoef, 2002; NAPCRG & AFMO, 2002; Langsang & Dennis, 2004; van Weel & Rosser, 2004) with programmatic research (Thompson, 2003; Pearson, 2004) and perhaps housing a critical mass of researchers (Boon & Verhoef, 2002; Haas, 2004; Hazelkorn, 2004; Pirkis et al, 2005) were viewed as potential key elements to RCB at this level. Collaborative partnerships also featured (Farmer & Weston, 2002; Thompson, 2003; Langsang & Dennis, 2004; Gerrish et al, 2005; Cooke, 2005).

A focus at policy level is evident in the concept analysis. However, many professional groups appeared to focus on the issue with specific events or conferences (Boon & Verhoef, 2002; NAPCRG & AFMO, 2002; Graffy, 2003; Renfrew et al, 2003; van Weel & Rosser, 2004) possibly in the absence of or in an effort to influence policy. Description and analysis of research policy implementation from nursing and midwifery (Bishop & Freshwater[15], 2003, 2004a; Rafferty & Traynor, 2004; Gerrish et al, 2005) was evident. There was an encompassing of individual and organisational level issues at this level but other unique issues arise. Funding and funders were a key element of activity at this level (Sitthi-amorn & Somrongthong, 2000; Boon & Verhoef, 2002; Farmer & Weston, 2002; Hubbard,

[15] And here the wider health service strategy.

2002; Nchinda, 2002; NAPCRG & AFMO, 2002; Rafferty & Traynor, 2003, 2004; Rafferty et al 2002, 2003, 2004; Reading & Nowgesic, 2002; Renfrew et al, 2003; Thompson, 2003; Del Mar & Askew, 2004; Haas, 2004; Langsang & Dennis, 2004; van Weel & Rosser, 2004; Macfarlane et al, 2005), as was visibility, lobbying, representation and leadership at the strategic level (Sitthi-amorn & Somrongthong, 2000; Bradshaw, 2001; Boon & Verhoef, 2002; Thompson, 2003; Langsang & Dennis, 2004; Rafferty & Traynor, 2004; Gerrish et al, 2005).

1.5.2 Underlying themes

One theme from the literature is the notion of capacity building as both an activity and a product, a means and an end (Harrow, 2001). Trostle (1992) firmly places RCB as a process with research capacity as its product. Similarly, Finch (2003) acknowledges it as a process with many strands and Ogilvie et al (2003:113) reiterate that it is best understood as a process of "time, human agency, social structure, change and sustainability", attributes found in the concept analysis. Examples are available from the practice setting (sections 2.2 & 2.5) but evaluation of RCB is problematic (Trostle, 1992; Maconick & Morgan, 1999; Harrow, 2001) or absent (Hyder et al, 2003; Cooke, 2005). This may be linked to the notion of RCB as process or be a feature of the time required to achieve outcomes. The literature revealed that RCB as product was evaluated with metrics such as numbers of researchers (Hyder et al, 2003), publications (NAPCRG & AFMO, 2002; Hyder et al, 2003, Del Mar & Askew, 2004; Haas, 2004), grants awarded (Hyder et al, 2003; Del Mar & Askew, 2004), and funding available (Hyder et al, 2003; Haas, 2004). Cooke (2005) questions the use of such metrics which, whilst easy to quantify, do not capture the 'black box' of research capacity building process. Within an evaluation framework she suggests some cross-level process criteria such as the types of linkages and collaborations established or evidence of confidence building through sharing skills with others. Cooke (2005) acknowledges the impact of policy but her framework does not include evaluation beyond the level of networks. Absent from any debate on evaluation is the notion of markers to assess cultural change. A related issue is that of the attribute of sustainability in research capacity building. However, given the lag-time of capacity building and the debates on retention of individuals, sustainability of process would appear to be an element in some contexts. In conclusion, the process of RCB needs empiric examination.

A second theme from the literature is inter- and multi-disciplinary research. Whilst this is evident in some, but not all of the literature stemming from primary care

(Thomas & While, 2001; Farmer & Weston, 2002; Cooke 2005), it is also a feature of public health and health services research (Stephenson & McCreery, 1994; Hubbard et al, 2001; Nchinda 2002), and organisational critiques (Hazelkorn, 2004). The extent to which this issue is policy driven or a pragmatic outcome of practice or organisation is not addressed in the main. Regardless of rationale, the value of inter- and multidisciplinary RCB is obvious where such research assists skills development for individuals and professional groups and where the boundaries of the research domain are unclear. The extent of this issue for nursing and midwifery was indistinct from this literature where a uni-professional focus tends to predominate in the practice of research (Thompson, 2003; Rafferty & Traynor, 2004), though not in the award of funding (Wilson-Barnett, 2001; Thompson & Watson, 2004). Whilst multi-disciplinarity has its champions in nursing (Rafferty & Traynor, 2002, 2003) and midwifery (Renfrew et al, 2003) it has generated some debate in the literature with issues of visibility and equity driving oppositional argument (Wilson-Barnett, 2001; Thompson & Watson, 2004).

The WHO (2002), acknowledges the role of general capacity building across the spectrum of strategic directions for nursing and midwifery stressing education and research. For the peer-reviewed literature, the emphasis is on the delivery and evaluation of programmes supplied for developing countries with a focus on faculty (Ogilvie et al, 2003) or leadership (Wright et al, 2005) development. In contrast, Sajiwandani (1998) discusses how indigenous nursing research can assist in 'capacity building' in a new state. This leads to the third theme where indigenous versus extraneous capacity reveals the underlying tension between groups or countries of differing power, that some[16] (Trostle, 1992; Wall, 2000: Crossley & Holmes, 2001; Nchinda 2002; Ogilvie et al, 2003; Renfrew et al 2003; Lansang & Dennis, 2004) but not all of the broader literature acknowledges explicitly. For countries, the lack of power may derive from a variety of factors such as the size of nation states (Crossley & Holmes, 2001); recent or frequent political change (Stephenson & McCreery, 1994; Sajiwandani, 1998; Sitthi-amorn & Somrongthong, 2000); or stage of national development (Sitthi-amorn & Somrongthong, 2000; Wall, 2000; Nchinda, 2002). Of note is that the literature revealed professional groups or subgroups that might be termed 'marginal' as discussing the RCB issue. Marginalisation may occur through a number of sources such as subordination to more powerful groups with established research traditions or because of

[16] Trostle (1992:1322) refers to 'scientific colonisation' and Wall (2000:9) to 'research imperialism'

geographical dispersion. The groups included complimentary and alternative health care practitioners (Boon & Verhoef, 2002), public health specialists, nurses and midwives, and occupational therapists (White, 2003). The area of primary health care also produce such literature from multidisciplinary primary health care practitioners in the UK (Bryar, 2002, 2003; Macfarlane et al, 2005) to doctors working in primary care in the US (NAPCRG & AFMO, 2002; Graffy 2003) or Australia (Albert & Mickan, 2002; Dunbar et al 2002; Farmer & Weston, 2002; Shah et al, 2002; Taylor et al, 2005) or internationally (Del Mar & Askew, 2004). Within this literature such groups are often described as 'emergent' disciplines[17] (White, 2003) where defining the disciplinary domain may be problematic[18] due to its generalist nature (Thomas et al, 2001; Del Mar & Askew, 2004), the presence of particular ethical issues (Taylor, 2005) or the absence of a strong alignment with specific methodologies may have restricted research growth in that area. Comparisons are made with established professional groups such as medicine, engineering, social work[19] or education. Medicine is often used (Thompson & Watson, 2004; Meerabeau, 2005) as the comparative benchmark for nursing's performance in research activity and policy. Yet Rafferty & Traynor (1997b :44) caution against treating medicine as "a monolith" and evidence for such is testified by the literature from non-hospital based medical specialities as outlined here. Thus the dominance of medicine as an analytical reference point is questioned (Rafferty and Traynor, 1997b; Scott, 1998) yet even occurs within strategic documents (Department of Health[20], 2000). This debate implies that research capacity not only contributes valuable knowledge and skills on which practice could be based but is perceived as an 'identity marker' of status or enhanced reputation (Hicks, 1998b; NAPCRG & AFMO, 2002) for the professional group.

1.5.3 Theoretical and conceptual perspectives

From the literature it appears that RCB is mainly viewed as a series of practical activities. Hence models (Thomas & While, 2001; Farmer & Weston, 2002; Langsang

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[17] Other terms used in the literature include 'fledging' (Salvage, 1998; Rafferty, 1998), emerging (Oldnall, 1995; Treacy and Hyde, 2003; Ellis and Lee 2005), novitiate (Walker, 2004), neophyte (Mulhall, 1997), young (Tierney, 1998a) and infancy (Allen, 1997a). Elsewhere, nursing research has been described as being in a 'primitive state' (Bradshaw, 2001) or having embryonic research communities (Meerabeau, 2001, 2005).

[18] The concept analysis (Condell & Begley, 2007) showed that some policy documents also acknowledge such a difficulty.

[19] UK literature focusing on social work and its doctoral research however raises similar issues of invisibility (Rafferty et al, 2002) and unclear disciplinary boundaries (Lyons, 2002, 2003; Lyons & Manion, 2003).

[20] The UK Department of Health.

& Dennis, 2004; Potter & Brough, 2004) and evaluation frameworks (Cooke, 2005) of RCB are proposed and reflect activities and levels of capacity building. Three (Thomas & While, 2001; Langsang & Dennis, 2004; Potter & Brough, 2004) integrate a temporal element as a feature. Whilst based on experiences in the field, none of these models were tested empirically and thus the ease of transposition of capacity building ideals into reality is not addressed.

The literature shows that the concept of RCB is separated from any philosophical and epistemological positions and the few exceptions show that a critical notion of RCB is only developing. Whilst power is one of the emergent themes, none of the literature analysed the notion through theoretical perspectives on power apart from Ogilvie et al (2003). Harrow (2001) suggests other potential theoretical perspectives, such as gender, new public management, community development and stewardship theory and elsewhere organisational development (Albert & Mickan, 2002; Macfarlane et al, 2005) has been utilised. Gerrish (1998:9) claims that "problems confronting policy researchers rarely conform to neat disciplinary packages and the answer to a policy question drawn exclusively from a single discipline is likely to be incomplete". In the absence of existing strong theoretical underpinnings the form of this study is one of ethnography using a grounded theory analytical approach to produce a substantive theory of RCB.

1.6 Introduction to the study

This study aims to improve our understanding and develop a substantive theory of how RCB occurs in the context of the emerging academic discipline of nursing and midwifery in Ireland. It will develop narrative accounts of funded individual RCB at a pertinent time. It also seeks perceptions on the cultural contexts of development of nursing and midwifery as professional research disciplines in Ireland and their integration to the health research arena.

The unit of analysis is the individual level but this is contextualised to view capacity building as operationalised at policy level also, in keeping with the literature. The ethnographic case study is undertaken from a nursing and midwifery perspective[21]. It gives voice to individual and professional concerns which may otherwise be dominated by an 'official discourse' (Leonard et al, 2004; p370) that views RCB from a hegemonic health research stance.

[21] Tierney (1998b) claims that *any* examination of the politics of research must be inescapably influenced by the position of the analyst(s).

1.7 Introduction to the thesis

Whilst this initial chapter has introduced the reader to the concept under investigation and situated the study in relation to the policy, professional, educational and temporal contexts, the next chapter introduces the literature on cultures in which the CNMF engage and existing empirical work on elements of research capacity building. Chapter three details study methodology and method. A short overview of the substantive theory prefaces four chapters of findings, with a brief discussion of the main findings in relation to the world literature at the end of each chapter. Chapter nine discusses the emergent theory in the context of five key issues for nursing and midwifery and health research in Ireland.

Chapter 2: Capacity and Cultures.

2.1 Introduction

Previously (section 1.5), we saw that RCB is understood as both a product and a process. This chapter explores relevant existing literature on these notions. The literature reviewed includes that from the nursing and midwifery professions and higher education between 1994 and 2005: with the higher education corpus showing more likelihood of empirical work and the nursing and midwifery corpus offering expert opinion and critique. The search terms used were RCB, doctoral education, research training, research culture, health research, and ethnography. Grey literature was also sourced. Firstly, we examine individual RCB and find a focus on practitioners. To answer why this might be, ethnographies of nursing and midwifery practice are reviewed followed by literature on 'health research'. I then explore literature on organisational RCB finding a stronger focus on the academy in the context of the transition of nursing and midwifery education to the higher education sector. Here, the focus is on the PhD as a metric so the literature is interrogated on the meaning of a PhD, its departmental and disciplinary context including journal publication, and the individual experience including motivation, supervision and assessment. Finally the PhD is placed within an overall career pathway. At all times, the literature is critiqued in relation to the Irish context and, more pertinently, its meaning for nursing and midwifery.

2.2 Individual RCB

Some nursing and midwifery literature was discovered on RCB at the level of the individual in the form of case studies. They consisted of part-evaluations of newly-established on-going schemes aimed at nurses (Happell et al, 2003; Smith & Edwards, 2003) or final evaluations of fixed-time frame schemes aimed at nurses (Meyer at al, 2003) or primary health care professionals including nurses (Bryar, 1999, 2003; Bateman et al, 2004; Lee & Saunders, 2004). All the schemes were specifically aimed at *practitioners* except one that mixed academics and practitioners (Smith & Edwards, 2003). Schemes varied in size, structure and focus (Table 2.1) with differing methods and outcomes (Table 2.2) and differing usage and lack of clarity of the term RCB (section 1.5); overall, it was difficult to draw any firm conclusions from this work. Other RCB schemes described in the literature (Cochrane, 2001) showed no evidence of evaluation.

Author	Programme Length	Participant status	Title and number of participants	Focus of programme	Country
Bryar (1999, 2003)	3 yrs	Full-time or Part-time	Clinical fellows (n=35)	Research generation	U.K
Happell et al (2003)	10 wks	Part-time	Clinical research fellows (n=4)	Practice development through research utilisation	Australia
Meyer et al (2003)	3 yrs	Full-time	Lead R&D Nurses: Care of Older People (n=7)	Practice development through action research (generation and utilisation)	U.K
Smith & Edwards. (2003)	3 mths	Full-time	Research Interns (n=20)	Research generation.	Canada
Bateman et al (2004)	Range 8 mths to 4 yrs	Part-time	Enterprise Award Holders (n=78)	Research generation	UK
Lee & Saunders (2004)	Not specified	Part-time	Bursary Holders (n=22)	Research generation	UK

Table 2.1: Individual RCB schemes: structure and foci.

Author	Data collection methods	Data providers	Main findings/outcomes
Bryar (1999, 2003)	Semi-structured interviews Documentary analysis Questionnaire at 5 year follow-up	Programme participants Key stakeholders including project support.	Individual research skill development occurred including the generation of research. Subsequent low level of skill utilization by employer. Some research-based practice development occurred.
Happell et al (2003)	Semi-structured interviews	Programme participants Key stakeholders from clinical area	Some research-based practice development occurred. Barriers to research utilisation identified
Meyer et al (2003)	In-depth interviews. Focus groups Documentary analysis Reflective field-notes Structured quality measurement tools	Programme participants Key stakeholders from clinical area Other key stakeholders including project management team and policy makers	Individual research skill development occurred including action research Some research-based practice development occurred Barriers to research utilization identified.
Smith et al. (2003)	Questionnaires at midpoint, endpoint and post-5 month follow-up. Group debriefing sessions	Programme participants	Individual research skill development occurred including grant writing and paper submission
Bateman et al (2004)	Questionnaire	Programme participants	Academic awards with planned publication Varied contribution to practice Increased confidence and enthusiasm
Lee & Saunders (2004)	Semi-structured interviews Documentary analysis	Programme participants	Individual research skill development including project management and publication Increased confidence and enthusiasm

Table 2.2: Individual RCB schemes: evaluation methods and findings.

2.3 Nursing and Midwifery Practice Cultures

Why did this literature centre strongly on practitioners? To answer this question the ethnographic literature[1] of health professional practice was examined for potential insights. Additionally, such an examination would provide the cultural context both to the primary professional socialisation of nurses or midwives and the most likely site in which they would conduct their clinical data collection. Available literature included a focus on dentists (Nettleton, 1992), surgeons (Fox, 1992), primary health care clinicians (Gabbay & le May, 2004; Savage & Moore, 2004), midwives (Hunt & Symonds, 1995; Dykes, 2005; Hunter, 2005) and nurses (Street, 1992; Gerrish, 1998, 2000; Latimer, 2000, 2003; Allen, 2001). In addition ethnographies with a focus on interaction within practice were reviewed such as between doctors and nurses (Porter,1995; Allen, 1997a; Allen & Lyne, 1997; Wicks 1998; Allen, 2001; Manias and Street, 2001; Coombs, 2004; Goopy 2005); nurses (Savage, 1995; Allen 1997a, 2001; Johnson, 1997; Goopy, 2005) or midwives (Dykes 2005) and patients and others. Whilst the levels of detail differed, all provided descriptions of the environment in which the ethnography was conducted and the policy and professional context of the study (see Appendix 2 for summaries). These ethnographies fitted the anthropology of work studies category (Schwartzman, 1993) that examine work from a broad perspective and emphasise issues such as conflict and power.

The specific foci of the studies were as follows: Hunt and Symonds (1995) examined the construction of labour ward midwives' occupational identity, Hunter (2005) investigated midwives' emotion work and Dykes (2005) explored midwives' interactions with breast feeding mothers. Street (1992) explored how nurses resist and manipulate the social order in which they practice to produce meaning for their clinical practice. Wicks (1998) and Allen (2001) examined the gendered division of labour with the latter inclusive of an additional economic perspective. Latimer (2000, 2003) explored the bedside as a site where nurses conduct care to produce ward life. Three studies were conducted in the primary care rather than hospital settings: Gerrish (1998, 2000) studied district nurses' approach to the provision of individualised care with ethnic patients, Gabbay & le May (2004) examined the use of research evidence in primary care decision making and Savage & Moore (2004) explored accountability and primary care decision making in a case-study. Porter (1995) examined the gendered power relationships between nurses and doctors on a

[1] The rationale was that ethnographic design best addressed issues of culture

number of levels using critical realism. Whilst Coombs (2004; Coombs & Esser, 2004) focused on clinical decision making to examine the relationship between nurses and doctors in the critical care setting, Johnson (1997) explored the process of social judgement which nurses use with their patients.

One of the themes raised by the ethnographies of practice is the organisation of work. Ethnographies showed the mobility of nurses (Street, 1992; Savage, 1995; Wicks, 1998) and midwives (Hunt and Symonds, 1995) within but restricted to ward settings as opposed to the movement of doctors between settings (Allen, 1997a; Wicks, 1998; Allen, 2001). The exception here was with Dykes (2005) who found midwives in one organisation moving between ward settings in any one shift but under the dictate of management. Other issues from ethnographies show space being shared with others (Street, 1992; Hunt and Symonds, 1995; Savage, 1995; Latimer, 2000) with the resultant lack not just of physical space but also of social and cultural privacy; structuring practice so as to be responsive to emergencies (Street, 1992; Latimer, 2000; Dykes, 2005) or allowing others to be so (Gooby, 2005) and therefore anticipating uncertainty; and prioritising the routine (Latimer, 2000; Allen, 2001; Dykes, 2005) as a method of control. Allen & Lyne (1997: p135) describe this context of practice as 'organisational turbulence'. In contrast to nursing and midwifery in hospital settings, Gerrish (1998) and Savage & Moore (2004) found district and practice nurses working alone or physically isolated although ostensibly part of primary care teams.

A second related theme is the exercise of power. The ethnographies show that nurses practise in professional and institutional hierarchies with medical and managerial dominance, although two of the primary care studies (Gerrish, 1998; Savage & Moore, 2004) showed variation. Such hierarchical power determines the inter-professional division of labour. Nurses negotiated power and influenced medical practice in areas such as clinical decision making or prescribing (Allen, 2001; Manias & Street, 2001; Coombs & Ersser, 2004). Negotiated interactions could differ depending on the hierarchical position of the doctor and the level of experience of the nurse (Hughes, 1988; Porter, 1995; Allen, 1997a; Manias & Street, 2001). Negotiations could also vary with the gender of the participants (Porter, 1995; Savage 1995) or the type of shift work (Brooks & MacDonald, 2000) and were bounded within the hierarchy of knowledge with nursing knowledge as informal 'information' on which the medical knowledge of diagnosis was made (Wicks, 1998). The nursing gaze, and therefore knowledge incorporates the social as well as the

clinical medical gaze (Johnson, 1997; Latimer, 2000). Intra-professional practice changes in response to how nursing knowledge is generated, recorded and used, for example, the introduction of the nursing process (Porter, 1995)[2] or primary nursing (Savage, 1995) can be problematic and threatening to medical personnel.

Exercising power was also found in intra-professional hierarchies such as in the division of nursing labour or occupational ideology. Here, junior nurses practised from ascribed roles and lacked autonomy in undertaking tasks (Latimer, 2000; Allen, 2001) or junior midwives subverted the unwritten rules of their seniors (Hunter, 2005). Indeed the professional ideal of autonomous practitioner is problematic for nurses practising in a bureaucratic organisation (Allen, 2001), although there may be variation such as during different shifts like night duty (Porter, 1995; Brooks & MacDonald, 2000) or with modes of work organisation (Savage, 1995). Savage & Moore's (2004) findings suggest that this may remain problematic even when the setting changes to primary care and they claim that the concept of autonomy itself is ambiguous.

A third theme, also related, is blurred or permeable role boundaries of nurses (Allen, 1997a, 2001; Allen & Lyne, 1997; Gerrish 1998, 2000; Brooks & MacDonald, 2000; Gooby, 2005). Movement across the boundary was shown for nurses with doctors, and support workers. Interestingly, Goopy (2005) in the Italian context also found movement back with doctors undertaking nursing roles at times. Such blurring shows that nurses' role boundaries are arbitrary but the ethnographies reviewed showed degrees of negotiation. For example, both Allen (2001) and Gerrish (2000) found that nurses' rhetoric on the control of the boundary between nurse-doctor and nurse-social care worker emphasised the priority of nursing roles but this was not revealed in the observational data, thus a non-negotiated stance in Allen's study or individual nurse discretion in Gerrish's study where the power relationship differed. The non-negotiated stance is also suggested in the primary care setting with practice nurses using protocols for boundary type work and using occasional referrals to doctors to verify their decisions (Savage & Moore, 2004). In contrast, Wicks (1998) found resistance with nurses as active agents in boundary issues with medics.

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[2] Such changes can also pose intra-professional problems. Porter (1995) notes that nurse academics and leaders may push a professionalizing agenda, such as the introduction of the nursing process, as a means to change nurses' subordination to medicine. However, there is variability in acceptance of such a position by those in practice.

Differing geographical and policy contexts may have influenced these findings[3]; nevertheless they substantiate a cultural ambiguity in practice[4] that can also be found in policy (Davies, 2004). Such ambiguity promotes vulnerability (Bishop & Freshwater, 2004b) and could have implications in developing a discipline within the academic context.

A fourth theme is communication. Street (1992) found a strong oral culture in nursing practice with a devaluing of the written word in the form of the nursing record; the implication being that nurses' skill at articulating themselves on paper is limited in comparison with their oral fluency. Allen (2001) also found the narrative handover, complemented by a ward diary as the communication method of choice. The handover is itself hierarchical with the exception of primary nursing (Savage, 1995) and can be used as the vehicle to convey the social judgements of patients (Johnson, 1997). It is routinised with discursive elements only when issues could not be routinised (Latimer, 2000), suggesting it is not simply a matter of comfortableness with oral over written culture. Although completed, there was resistance to the formal written nursing record as a means of managerial control of practice with little value in the reality of practice (Allen, 2001). The written word is not paramount elsewhere in health care. Gabbay & le May (2004) found primary health care practitioners mixing 'tacit' and explicit knowledge developed from 'communities of practice' and professional networks and this is somewhat substantiated by Savage & Moore (2004) who mixed such opinion knowledge with that of written guidelines.

A fifth theme is the cultural aspects of practice such as uniforms as identification symbols[5] (Street, 1992; Savage, 1995), the extensive use of the colour white as a symbol of purity (Latimer, 2000); rituals for tea-breaks (Street, 1992; Savage, 1995), exemplars of key practice documents such as the 'Labour Book' (Hunt and Symonds, 1995) and the appointment book (Nettleton, 1992).

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[3] van der Geest & Finkler (2004) whilst acknowledging that ethnographies have found a dominant role for hospitals in reflecting and enforcing social and culture processes, are cautious of the view of hospitals as an homogenous entity across different cultures and societies. Such caution is also applied in summarising these ethnographies of practice due to geographical, structural, cultural and societal differences that may be present. What is offered are *suggestive* themes.

[4] Manthorpe et al (2005) suggest similar ambiguity in UK social work practice with a policy driven move to degree status education in 2003 mirroring changes to nurse education.

[5] Fealy (2006) outlines the origins of the use of the nurse's uniform as both an occupational and gendered symbol in 19th century Irish nursing.

In summary the main themes from these ethnographies of practice are the organisation of work, the exercise of power, the permeability of role boundaries, the privileging of oral communication and some symbols and minor cultural practices. Having said that, they offer a wide span geographically and temporally, so culture and historical factors may have influenced these themes, the social practices may have further evolved and they may not accurately reflect *contemporary* Irish practice. Certainly Goopy (2005) cautioned against homogenous generalisation to other national and local cultures as she showed that within one case in Italy, the understanding of nursing varied considerably from the international notion of same as evident in the literature. To balance that, the nurse and midwife participants in this study, being experienced practitioners that could include practice overseas, *may* have been exposed to many of the elements described within the ethnographies. Regardless of their diverse geographical and temporal sources, ethnographies of practice did offer points of reflection *but* did not answer why nursing and midwifery literature focusing on individual RCB was primarily aimed at practitioners.

2.4 Health Research Culture

So as a supplement, available literature on 'health research' was reviewed, revealing possible answers. The importance of a health research culture has been noted with the UKCGE (2003:10) stating "perhaps the fundamental imperative facing the healthcare professions is to develop a properly embedded research culture, the research capabilities to realise this culture and (as part of this) to provide adequate opportunities for research skills training". Whilst Irish policy (section 1.4) is aimed at building this culture for nursing and midwifery, the literature shows that the reality may prove challenging. There is a difficulty in defining a research culture within the context of the health service (Mulhall, 1999) where service hierarchies mitigate against such a culture existing (Marks & Godfrey, 2000) and differing perceptions can occur between practitioners and managers (le May et al, 1998). The UKCGE (2003) highlighted the issue of the high variability in the focus of research within healthcare, requiring a range of methodologies across multiple levels to address the types of research questions raised. So any health research culture is complex. Additionally, there are inherent difficulties that are unique to nursing and midwifery themselves. Mulhall (1995) outlined three constraining factors: the low status of nursing as a profession within health care, the indistinctiveness of the essence of nursing and the low starting base. Hicks' studies have focused on gender stereotyping as a unit of analysis for the nursing (Hicks, 1995c; Hicks, 1996a, b; Hicks and Hennessy, 1997; Hicks, 1999) and midwifery (Hicks, 1993; 1995a, b) position on research and has set

the findings against the female dominance of the workforce and the vocational nature of nursing and midwifery practice. Based on small or convenience samples and conducted in the UK with a longer academic history, the bulk of this work (Hicks, 1993; 1995a,c;1996a,b; 1999; Hicks & Hennessy, 1997) still highlighted potential barriers that Irish nursing and midwifery may face in its bid to build research capacity. Editorial comment on the UK situation also used gender as an analytical unit, as well as social class (Bradshaw, 2001). Being an "extremely heterogeneous occupation" (Allen, 1997b:192) not all of nurse subgroups would support the professionalising agenda that a research culture implies. In addition, Hicks (1998a, b) has also explored how organisationally and not just professionally, a health research culture is problematic for nursing.

The predominantly female Irish nursing and midwifery profession has a particularly strong vocational basis in part due to its historical and long-standing link with religious orders (Condell 1998; Robins, 2000; Treacy & Hyde, 2003). Nurse training leading to registration in Ireland remained outside third level education yet with a high standard of secondary education at entry. This may have led to the situation whereby up to the mid-1990s any third level education for registered nurses appears to have been led from grassroots demand rather than policy initiated (Condell, 1998). Lacking availability, nurses and midwives undertook degree level education in domains of scholarship other than nursing and midwifery. There was also inequality of access to post-registration education, a situation rectified since 2000 with specific governmental funding (Condell, 2004). However, by this time, there was an element of elitism associated with third level education and specifically research, a situation not unique to Ireland (Bishop, 1999; Mead & Mosely, 2000; Mulhall, 1997, 2001; Thompson & Watson, 2001; Holmes, 2002; Bishop & Freshwater, 2004b). Research consisted of small course requirement projects with no coherent policy and a dearth of funding (Condell, 1998) apart from that provided by An Bord Altranais[6] and thus funded by nurses themselves. Committed individuals fostered research awareness through voluntary activities such as the Irish Nurses Research Interest Group (Condell, 1998; Treacy & Hyde, 1999; INRIG, 2004) formed in 1976 or through their own positions within educational institutions[7] and began to inform national agendas. However, the pace of change and the non-sustainable nature of some initiatives[8],

[6] The statutory regulation body.
[7] The Faculty of Nursing, Royal College of Surgeons of Ireland and a Department of Nursing in University College Dublin were established in 1970s.
[8] For example, a Research Officer position in An Bord Altranais was not subsequently filled when the post holder left the position in 1991.

questions the power base from which such individuals were working. So Irish nursing and midwifery lacks a sustained, developed tradition and culture of research and the foundation from which a research culture is to be further fostered has potential inherent difficulties including historical, cultural and gender barriers, especially if, as in the UK "the strength of tradition, though diminishing, outweighs the overall effects of modernisation" (Bradshaw, 2001:125) and professionalisation.

For a health research culture to develop the two cultures of practice and research need to amalgamate and critics point to tensions at this juncture (Mulhall, 1997; Seymour et al, 2003) that have been shown empirically. For example, a study by McInerney & Robinson (2001) in Australia focused on the experiences of nurses (n=6) undertaking a research thesis as part of a one-year, full-time Honours Degree in Nursing programme. These nurses were registered practitioners, some of whom had already practised for a number of years before entering the programme. As such they were breaking traditional boundaries. Course work "highlighted the simmering tension resulting when a research culture intersects with nursing practice" (McInerney & Robinson, 2001:215). Students found themselves in the unfamiliar territory of 'inbetween-ness' with resultant identity struggles. They faced anti-intellectualism in the guise of antipathy, hostility and marginalisation. The main strategy for coping was conformity to the prevailing culture of practice. Similarly, those in service following graduation from a United States (US) taught doctoral programme (n=16) and interviewed yearly for five years after completion, were selective in their use of the title 'doctor' (Heinrich, 2005). They reserved its utilisation for engagement with the likes of physicians and administrators to gain respect or achieve a task and perceived its utilisation with subordinates or peers as promoting elitism. Likewise, a small ethnographic study (Mantzoukas & Jasper, 2004) found a culture in 4 UK medical wards which hindered the use of reflection as a method of critical inquiry.

To summarise, although limited in scope, these findings suggest a health research culture may be problematic and therefore in need of *specific* RCB interventions, hence the focus on practitioners at the level of the individual. Yet what of the nursing and midwifery literature on RCB at organisational level?

2.5 Organisational RCB

Interestingly there was some focus on clinical settings here too (Table 2.3). Three case studies showed partnerships between academia and service with a focus on the

needs analysis (Gething et al, 2001; Jinks & Green, 2004) or baseline data gathering (Tanner & Hale, 2002) for RCB strategies, and another described a multi-disciplinary research facilitator role and its activities within a clinical setting (Grange et al, 2005).

Authors	**Gething et al**	**Tanner & Hale**	**Jinks & Green**	**Grange et al**
Year	2001	2002	2004	2005
Country	Australia	UK	UK	UK
Setting	Health Service	Health Service	HEI/Health Service	Health Service
Strategies	Research training workshops Research mentorship & consultancy Grant scheme Research liaison Nursing research network Colloquia, conferences and newsletter Provision of equipment	Baseline data gathering on nursing research activity	SWOT analysis Joint appointment at professorial level. Development of complimentary research strategies.	Researcher facilitator Identification & facilitation of short courses & training from research generation to research utilisation. Assistance with grant & ethics applications. Identifying potential collaboration Disseminating research results

Table 2.3: Single-case institutional strategies for RCB in health services.

Most of the nursing and midwifery literature referring to RCB at an institutional level centred on the academy and came from the UK and Australia as these countries dealt with transition to higher education sector in the last 20 years. Given its long history in tertiary education, surprisingly the US nursing literature also dealt with the subject (Conn, 2005; Conn et al, 2005) and raises the possibility of the sustainability of research cultures as problematic for nursing. Indeed Crookes & Bradshaw (2002) acknowledge this issue and link it to the lack of a standard solution. Regardless, there was an underlying assumption in this literature of organisational assistance and support being a pre-requisite for research and scholarship development. Strategies of RCB at institutional level appear to focus, however, on engaging individuals with research and scholarship. Literature reviews were published on institutional strategy as a whole (Cooke & Green, 2000; Adderly-Kelly, 2003, Jootun & McGhee, 2003) or on single issues such as mentoring (Byrne & Keefe, 2002) the results of a study tour (Crookes & Bradshaw, 2002) or consultation exercise (Traynor & Rafferty, 1999). Crookes & Bradshaw (2002) generated the following suggestions for strategy, some of which were supported elsewhere[9]: scholarship as obligatory within nurse education (Conn, 2005), developing benchmarks, arranging supportive work patterns (Cooke et al, 2001; UKCGE, 2003), development of expertise in research supervision

[9] For example, the UKCGE report findings from a consultation workshop and subsequent survey with 19 respondents.

as a priority, infrastructure such as the funding of scholarships and commissioning of literature reviews, and developing a topic focus for institutional research activity (Cooke et al, 2001; UKCGE, 2003; Conn, 2005)[10], the purchasing of external research expertise and in Conn et al (2005) with a specific remit to review grant applications pre-submission, or recruitment of staff (Cooke et al, 2001; UKCGE, 2003). However, much of the literature describes structures within a single academic setting to enhance training such as writing groups for publication or grant application (McVeigh et al, 2002; Cumbie et al, 2005), the establishment of a Research Education Unit (REU) (Clare & Hawes, 2001), or multi-faceted institutional strategies (Greenwood & Gray, 1998; Gething and Leelarthaepin, 2000; Cooke et al, 2001; Conn et al, 2005). Whilst comparisons across schemes are problematic as

Authors	**Greenwood & Gray**	**Gething & Leelarthaepin**	**Clare & Hawes**
Year	1998	2000	2001
Country	Australia	Australia	Australia
Setting	HEI	HEI	HEI
Strategies	Formation of designated research groups Publications time release scheme Academic study leave Research and seed grants Productivity-related funding of academic units Research support unit. Conference scholarship scheme. Inter-sectoral funding of 4 Chairs and 2 senior lecturer positions.	Management Plan with performance indicators Research Skills workshops Grant schemes – faculty, university, PhD assistance scheme Mentorship Colloquia and conferences Streamlining teaching loads Resource book	Establishment of a REU with recording responsibility of research activity and staff profile Research forums and bulletins Access to resources on writing and publishing Assistance with grant and ethics applications, career planning, identifying funding and journals, data handling and information retrieval.
Authors	**Cooke et al**	**Conn et al**	
Year	2001	2005	
Country	UK	US	
Setting	HEI	HEI	
Strategies	Explicit research strategy. Recruitment of research expert staff including Chairs. In house workshops and seminars. Research manager support for grant applications. Facilitation to develop practical research skills on funded projects. Workload management. Development of a research centre and research group.	Consultation process with explicit plan. Associate Dean for Research Formation of Research Interest Groups Office of Research support for grant applications Environmental infrastructure Workload model Dissemination of opportunities, celebration of success, external consultancy	

Table 2.4: Single-case institutional strategies for RCB in the nursing and midwifery academy

[10] The latter issue may have stemmed from the fact that departments with research groupings were rated highly in the UK Research Assessment Exercise (Dowding & Fyffe, 2004) – see footnote 39 in this chapter.

terminology differs (Table 2.4) a synthesis of this literature acknowledges the focused effort, time and resources required to build institutional research capacity.

Evaluations or outcomes from such structures, if present, were limited, due in part to short time-frames. Such findings can also be reported in a simplistic manner without analysis as to the real value of the intervention. For example, Clare & Hawes (2001) show an increase in external research funding applications from 20% of staff in 1995 to 55% of staff in 1999 during which time the REU was established. Yet during this time the numbers of nurse academics with PhDs and therefore eligible to apply for such funding increased from 2 in 1995 to 14 in 2000. One study (Gething & Leelarthaepin, 2000) describing pre- and post intervention findings acknowledged that the intervention could not be isolated from other influencing factors. Nevertheless, at three year follow-up there were four fold increases in staff numbers applying for research funds and gaining external grants and dissemination by publication and conference presentation had also increased. One grounded theory study was found; Worrall-Carter & Snell's study (2003) used a purposive sample of 20 nurse academics from 7 Australian universities to explore their experience and perceptions of research and scholarship. The findings of institutional support included changing work patterns and organising work loads to provide extra time for research activity, developmental support such as writing workshops and colloquia, the establishment of resource roles, and the availability of seed-grants. Interestingly, the participants outlined the advantages of collaboration with other disciplines that included experiencing how capacity is built in other academic fields. Such advice has been given elsewhere to nursing (Hallberg, 2004) in addition to broadening dissemination beyond a uni-professional approach (Watson, 1998; Conn et al, 2005).

2.6 The Transition of Nursing and Midwifery to Higher Education.

A transition to the higher education sector is also the context to this Irish study of RCB[11] and this review now examines some of the metrics and their empirical base associated with transition. Given the low educational base of nursing and midwifery, a graduate workforce of educators would be a minimum assumption for transition. In Ireland, these were available from 1987 (Condell, 1998; Treacy & Hyde, 2003). Yet, five years later of the total population of nurse or midwife teachers only 39% (n=86) held or were undertaking a degree with 8.6% (n=19) at masters level (An Bord

[11] McKenna & Coates (2001) deem Ireland to be one of the last nations to undertake such a transfer.

Altranais, 1994). Kirk et al (1996) suggests graduate nurse educators were a U.K. objective from 1995 and records a baseline but no subsequent follow-up to show progress. In Australia like the UK, the transfer of nurse teachers to the academy in the early 1990s did not require *higher* degrees (Clare & Hawes, 2001; Crookes, 1997). Hence the literature continued to show the need to promote research amongst nursing lecturers (Mead & Mosely, 2000; Newell, 2004) with commentators (Lewison et al, 2001:102) describing a decade of "dash for growth" in RCB. Certainly, a database of nurse academics in Australia (Roberts, 1996a; Roberts & Turnbull, 2002) shows increasing numbers of nurse academics with higher degrees over 5 years. Yet Mead & Moseley (2000) claim that the simple catalyst of transition did not fulfil an expectation of flourishing research capacity in the UK. One reason postulated was the time required for RCB. Both Pearson (2002; 2004) and Cleverly (1998) cautioned that the recentness of the transition limited achievement, especially as there was a contemporaneous focus on undergraduate curriculum and pedagogical development (UKCGE, 2003). With no *overall* national data source of nursing and midwifery research capacity in the UK[12] (Bradshaw, 2001; Franck, 2003) or Australia (Crookes & Bradshaw, 2002) impoverishing future planning (Rafferty & Traynor, 1997a, b) attempts were made to capture this data for Scotland (Fyffe & Hanley, 2002; Dowding & Fyffe, 2004) and for UK children's nursing (Franck, 2003). Nursing and midwifery may not be unique in failing to capture such data as Pearson (2004) broadens the issue to the context of health and medical research.

In Ireland, employment in the HEI schools of nursing in 2002 had a minimum entry criterion of Masters level qualifications (Begley, 2001; Condell, 2004)[13]. Therefore, quantifying numbers of nurses and midwives with PhDs is a more relevant indicator to show progress and is also used as an international benchmark (Rafferty & Traynor, 1997a, b; Tierney, 1997). An estimation of 6 nurses and midwives with PhDs in Ireland by 1997 was made by Treacy & Hyde (1999) but considered a conservative number due to its anecdotal nature (Condell 2004). Others (McKenna and Cutliffe, 2001) simultaneously estimate the number to be closer to ten with Treacy & Hyde (2003) retaining caution and gauging less than 10. This situation was somewhat akin to the UK in the 1980s (Bishop, 1999) and other European countries in the 1990s (Tierney, 1997). An Irish mapping exercise showed 18 nurses and

[12] Unlike the UK therapy professions who developed a database for self-registration of Therapy Researchers in 1997 and 1999 (Ilott & Baury, 2002).

[13] Nurse tutors entering HEIs in 2002 were employed on existing academic scales with those entering universities having a specific research remit for which a Masters degree was considered essential assisting with fostering positive attitudes to research (Clifford, 1997).

midwives with PhDs were employed in HEIs in 2003, rising to 33 in 2005 with a similar rise in numbers registered on doctoral programmes (NCNM, 2006). Concurrently, and reflecting the longer establishment in the academy, Scotland showed 10% of nurse lecturers (n=74) with PhDs supervising 146 PhD students (Dowding & Fyffe, 2004), a rise in PhD registrations from 117 in 2002 (Fyffe & Hanley, 2002), whilst a UK mapping exercise recorded 16% of university nursing department staff with PhDs (CPNR/CHEMS, 2001). Similarly, Australian research showed growing numbers of nurses with doctorates: Roberts (1996a) found 7%, Sellers and Deans (1999) found 10% and Roberts and Turnbull (2002) found 19%. Whilst there has been an exponential rise of doctoral nurses (Johnson, 2000; McKenna & Cutliffe, 2001; McVicar & Caan, 2005), with the move of nurse education into academia, the accuracy and currency of such data and access to it (Pearson, 2004), remains somewhat problematic. Even where accurate, sustained data on PhDs is gathered, the question of what is a critical mass of PhDs to allow the furthering of the nursing and midwifery research agenda arises with little attempt within the literature to address it. Proctor (1997) suggests 1% of nurses becoming career researchers[14] but does not justify this figure other than describing it as "modest" (p322) and requiring financial support. Wood (2005) cites a number of three PhDs per annum as providing a good research training environment within academic departments. That being said, Bishop (2005) cautions that numbers of PhDs does not necessarily equate with an increase in research activity; yet limited staff numbers with PhDs indicate restricted supervision capacity.

Previously (section 1.5), we have seen that research leadership is an RCB strategy and examples did occur in the literature examined; an analysis of Scottish data showed a key element was the investment in senior research appointments (Dowding & Fyffe, 2004); the appointment of additional professors was recognised (Gething & Leelarthaepin, 2000) as potentially influencing an increase in research activity in one Australian University and international funding agencies from Canada have valued such a strategy by investment partnerships yielding five 10-year nursing chairs (Edwards et al, 2002). The UK experience of the rapid expansion of academic nursing and midwifery and subsequent need for research leadership has produced "an explosion" in professorial numbers (Maggs, 1996:157) yet Thompson & Watson (2001; 2006) consider this diminishes the status of the professorial role with

[14] Ilott & Bury (2002) give the same 1% for therapy career researchers citing an OECD assessment of <1% total UK workforce in R&D.

subsequent consequences[15]. Elsewhere, the lack of PhD level training for academic leaders has been viewed as historical (Johnson, 2000) and comparable with other emerging professions (LaGro, 1999; Delamont et al, 2000). This resulted in the inappropriate situation (Thompson et al, 2005) whereby the supervisors of nursing or midwifery doctoral students may have themselves received no formal research training. Compared with a considered inadequacy of 22 in Scotland (Dowding & Fyffe, 2004) in Ireland, Treacy (2005) notes that six chairs in nursing and midwifery were established by 2004 rising to 8 in 2005, all of whom had PhDs.

2.7 The Meaning of a PhD.

So we have established a PhD as a requisite for doctoral supervision and a metric of RCB but what is a PhD? Tinkler & Jackson (2004) claim that answering this query is challenging because of a lack of consensus by disciplines and institutions and a variety of interpretations existing (Thompson et al, 2005). Definitions have been attempted but show differing orientations on the issues of product or process (UKCGE, 1996; Tinkler & Jackson, 2004; Park 2005) and empirically remain contested (Pole, 2000). A PhD can also be paradoxical in that a small narrowly focused study confers authorisation to "profess the discipline at large" (Delamont et al, 2000:97). Yet there is international recognition (UKCGE, 2003) of a PhD as "a badge of legitimate membership" (Delamont et al, 2000:34) and "a licence" to become a researcher (Kendall, 2002:138). As such it acts as a cultural symbol. Having acknowledged its contested nature, key elements of a PhD are agreed. For example, it should make a contribution to knowledge and show originality by discovering new facts or integrating previous diverse ideas. Yet Salmon (1992:9) claims that such concepts themselves are "ambiguous and slippery". Originality is itself discipline specific (Delamont et al, 2000) with Lovitts (2005:142) claiming there is an expectation in nascent disciplines that the domain is "ripe for analysis". Pole (2000:106) postulates that there may be an evolution in the nature and role of the PhD from a 'celebration of scholarship' to a research training or apprenticeship as successful doctorates frequently place the emphasis on skills rather than knowledge as the outcome (Pole, 2000). Certainly, in 2001 a National Qualifications Framework from the UK Quality Assurance Agency for Higher Education articulates the expected outcomes of a PhD to include the aforementioned elements in addition

[15] "The glut of professorial titles being awarded, in many instances with little scholarly basis, has been damaging to the already fragile status of academic nursing" (Thompson & Watson, 2001:2).

to attaining a quality that satisfies a peer review process and merits publication (Hoddell et al, 2002).

Unlike elsewhere (Galvin & Carr, 2003; McKenna & Galvin, 2004; Wood, 2005; Yam 2005; Ketefian et al, 2005) doctoral programmes are very recent additions to Irish nurse education (NCNM, 2006). Up to 2005 only the traditional PhD[16] was available and so this became the highest academic award for which RCB funding would be available under the HRB's CNMF scheme. The British model of PhD is followed and consists of a substantive piece of research followed by a viva voce (Hoddell et al, 2002). Whilst this conventional PhD is seen as "the pinnacle" (Ellis & Lee, 2005:222); the gold standard, both of doctoral education (Ellis & Lee, 2005) or research training (UKCGE, 2003); the ultimate in terminal awards (Meleis & Dracup, 2005) and the defining characteristic of an academic (Johnson, 2000), incongruently it is also viewed as a basic research apprenticeship (Johnson, 2000; Thompson & Watson, 2001; Park, 2005) with a requirement for post-doctoral training to research maturation (Yam, 2005). This dichotomy acknowledges the currency of a PhD but reveals dynamism of meaning that can include a PhD as not an end in itself but the start of a career in academia (Ketefian, 2005; Yam, 2005) and the chief research training during the developmental stage of a discipline (Hallberg, 2004).

PhDs emerge from academic cultures and so it is pertinent to examine this field and to do so ethnographies of research cultures were reviewed mostly pertaining to nursing and midwifery in the academy[17] as well as broader literature on the 'generic' academy. The latter showed the contemporary context of change for universities[18], internationally. In addition, geographical and historical difference was noted as varying elements (Becher & Trowler, 2001), thus the literature was interpreted cautiously regarding its application to the Irish context. Also, in this work, nursing and midwifery was used as a case in very limited circumstances, thus highlighting potential non-visibility within the academic field.

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[16] Historically this award emerged from Germany in the early 19th century, and was adopted in the USA before re-emerging in Britain in the early part of the 20th century (Bourner et al, 2001; Wright & Cochrane, 2000; Park, 2005). Johnson (2000) truncates this history by failing to acknowledge the PhD's Germanic origins.

[17] An organisational ethnography of a non-academic research setting in India was reviewed but deemed to have limited applicability for this study.

[18] Changes included an evolving vocational-oriented curriculum (UKCGE, 2003), and substantial disciplinary development invoking 'massification'; enhanced manageralism and market formation; globalisation; and changing relationships (Becher & Trowler, 2001). From that list, the initial two issues have occurred in Ireland, with elements of the latter three also present (White, 2001). There has also been academic drift (White, 2001) so that universities are not the sole providers of academic education and research.

2.8 The Cultural Lens: Disciplines and Departments

Overall the 'academy' was not homogenous (Delamont et al, 2000) and so discussion on an academic culture *per se* is problematic. Instead there are unitary subcultures such as individual disciplines. These are described as "deeply entrenched" (Delamont et al, 2000:3) although intertwined with local, institutional cultural practices. Disciplines are not static. Their formation, development and sometimes demise and their resultant specialisms were described within the 'modernising' and changing university context by Becher & Trowler, (2001) who found great diversity in knowledge production, social structures and processes within academic culture. This expanded previous work by Becher (1989) that had focused on interviews with 220 academics from 12 well-established disciplines[19] to include a wider range of institutional types[20] and literature pertaining to other disciplines. Becher & Trowler's (2001) analysis showed disciplinary and specialist agency in negotiating boundaries and seeking or maintaining status within the discipline and the overall academy. Hence disciplines are a major product of the academy itself. Delamont et al (2000) took a slightly different approach to their exploration of academic cultures. They examined issues common to a number of disciplines such as settings or method e.g. the laboratory and fieldwork, by conducting 286 interviews with doctoral students, supervisors and department heads of 20 academic departments as well as observation in a variety of academic settings. They also included 'newer' disciplines and sub-specialities in the form of those working in multidisciplinary subjects such as development studies and computer programming. Similarities in findings and analysis emerge from these seminal works although neither specifically addressed nursing and midwifery.

Delamont et al (1997a, b; 2000) showed the disciplinary differences in how PhDs are produced and for illustration purposes two dichotomous modes are now described. For the sciences a PhD is usually a prescribed study that builds on previous work. Here, the individual expands the knowledge that a surrounding team or research group has produced, thus knowledge production is cumulative (Delamont et al, 1997a, b; Delamont et al, 2000; Smeby, 2000; Delamont & Atkinson, 2001; Tinkler & Jackson, 2004) and the doctoral student is working to an ascribed role within a hierarchy (Delamont et al, 2000). Hence there is a more collective approach to gaining research funding. This also applies to knowledge production with post-

[19] Biology, chemistry, economics, geography, history, law, mathematics, mechanical engineering, modern languages, pharmacy, physics, sociology.
[20] An ethnography in a newly established university.

doctoral and peer as well as supervisory support (Delamont et al, 1997a, b; Delamont & Atkinson, 2001), thus there is an inherent departmental research culture. Modes of knowledge production can also affect the completion rate of the theses with science-based PhD having greater success rates at shorter time-frames (Wright & Cochrane, 2000) as doctoral students tend to be full-time scholars. Publications are expected within the doctoral timeframe[21].

For the social sciences a PhD is a non-prescribed research study which is self-chosen (Salmon, 1992; Delamont et al, 2000) and can be full or part-time undertakings. These PhDs contain little or no course work but formal guidance is given in the form of supervision. This relationship of supervision is seen as key (Salmon, 1992; Delamont at al, 1997a, b; Johnson et al, 2000) and differentiating (Delamont et al, 1997a, b) as there is no student cohort and a virtual absence of post-doctoral researchers (Delamont et al, 1997b). The relationship is perceived as essentially private[22]. The focus of identity stems from the individual as personal peer (Delamont et al, 2000) and the individual nature of the research topic limits its contribution to institutional or national research agendas or indeed the evidence base for practice (Johnson, 2000). Funding for full-time students is usually student rather than supervisor acquired. Smeby's (2000) analysis also shows that fields such as social sciences show greater scholarly debate with two or more paradigms in competition and a less hierarchical organisation of knowledge. Publications are more likely to feature after the doctoral timeframe (Neumann, 2003).

Disciplines are "frameworks for knowledge construction" (Mulhall, 2001:123), yet for nursing and midwifery the notion of being a discipline *per se* poses challenges as this is contested from within the profession (Thompson & Watson, 2001; 2004). The debate on disciplinary knowledge for nursing and midwifery is long standing and the site of its generation contested. After numerous years of using the theories of other academic disciplines, the importance of disciplinary definition (Donaldson & Crowley, 1978) in order to underpin the uniqueness of nursing become dominant. Hence the focus of nurse scholars was on identifying a paradigm for nursing science and developing grand theories of high level abstraction to guide practice. Whilst such developments had their protagonists[23], Thompson (2003) claims that limited success

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[21] Delamont & Atkinson (2001:88) critique such publications for their omission of the *realities* of scientific practices. Hence for those following there is a 'reality shock' of discovering the level of failure in routine science work.
[22] Delamont et al (2000) note that empirical data is based on interviews and not observation.
[23] Such as Fawcett (1984), Rogers (1992) or Reed (1997).

has emerged from the time and effort invested and Thorne et al (1999) have shown that paradigmatic rigidity and insistence has divided researchers. Additionally, the nursing literature is peppered with debate on a theory-practice gap highlighting the inappropriateness of some such scholarship for practice (Draper, 1990; Im & Meleis, 1999). That being said, the notion of nursing and midwifery as a discipline was shown to be contested out-with the professions too (Sellers, 2002), so acceptance as a discipline in its own right was not automatic within the Australian academy on educational transition (Sellers & Deans, 1998). Similar findings of the perception of unequal status for the individuals concerned was found amongst UK nurse lecturers (Carlisle et al, 1996; Deans et al, 2003), although one study used a convenient sample (Miers, 2002). Some of these concerns have genuine underpinnings in the attitudes of other academics to nursing. For example, Sellers (2002) interviewed 36 academics (n=34 male) at senior lecturer level or higher, who had been purposively sampled across the range of disciplines from pure to social science in Australia. The participants' main source of knowledge of nursing was based on personal experiences. Whilst they held mixed negative and positive views on the place of nursing in the academy, Sellers (2002) noted an absence of any reference of what nursing might contribute to the university culture, even after being present for the preceding fourteen years. There was also confusion as to whether nursing had a discrete body of knowledge and was thus a discipline. Furthermore, there was widespread linking of nursing to medicine in a subordinate capacity. Sellers (2002; p 168) concludes "no participant was able to comfortably describe the research activities or research potential for nursing, none was able to identify a theoretical basis for the discipline. In no measure was nursing considered to be a scholarly pursuit".

However, disciplines are not solely objects of study but have multiple elements such as classification, framing, stance, and mode of knowledge production (Becher & Trowler, 2001)[24]. They also have inherent *cultural* dimensions such as traditions and myths, symbols and artefacts, idols and texts, some of which act as cultural capital. Delamont et al (2000) show that lineages are important but are constructed and

[24] For example, Smeby's (2000) analysis describes two different dimensions of knowledge production which he labels 'hard' and 'soft' but acknowledges this as simplistic with his study showing that some disciplines may contain elements of both. Delamont et al's (2000) descriptive study shows a continuum of doctoral knowledge production between 'hard' and soft' and Becher & Trowler (2001) describe a grid using 'applied' to both the hard and soft fields. Regardless of categorisation as linear or grid the question is raised as to where Irish nursing and midwifery exists within such a process considering its recent entry to the academy.

utilised in varying disciplinary ways. Also, narratives and stories may quickly produce disciplinary myths. For 'emergent' disciplines such as nursing and midwifery these dimensions may be problematic in the absence of a history in the academy. Disciplinary growth is measured by the increasing numbers and types of departments, course provision, research groups and disciplinary associations. For Ireland, nursing and midwifery is part of that growth as a process of 'programme affiliation' and 'subject dignification'[25] (Becher & Trowler, 2001:14) has taken place. Disciplinary growth is also measured in numbers of journals (Becher & Trowler, 2001) and peer-reviewed publication is another RCB metric. Communication is the bedrock for academic practice (Becher & Trowler, 2001) and authoring peer reviewed literature plays a key role in individual academic identity formation (Lee & Boud, 2003). Regardless of their professionalizing role[26], nursing and midwifery journals communicate scholarship including research and therefore act as an indicator of research capacity and performance (Emden, 1998; McVeigh, 2002). There has also been a growth in the development of new nursing journal titles (Cleverly, 1998), showing an increased demand for publication outlets.

Some analyses of research publications were available in the literature. These focused on one journal (Long & Johnson, 2002; Webb, 2004); Australian national outputs across several national and/or international journals for one year (Jackson et al, 1996) or 5 years (Borbasi et al, 2002); a comparison of the yearly output across three UK based international journals with a medical journal (Smith, 1994); a comparison of the two year output of a medical journal with its nursing equivalent (Newell, 2002); the outputs from UK departments in systematic measurement exercises (Lindsay et al, 2001); and an intercontinental comparison of journal publications (Abraham et al, 1995). Whilst Ireland featured in *one* of these papers, differing methodologies, foci and time-spans in these analyses makes cross-national comparisons of RCB difficult to assess from these studies. A common theme was discussion on the professional versus clinical focus of the published research studies (Smith, 1994; Jackson et al, 1996; Borbasi et al, 2002; Newell, 2002); although I would suggest that differences may be an effect of the publications chosen for some of the analysis rather than simply the level of activity in the two areas. In addition,

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[25] Programme affiliation, whereby subjects are integrated into university education, may have been said to occur in Ireland in 1994 with the establishment of pre-registration nurse education at Diploma level. This move could be viewed as a step towards subject dignification, whereby an enhanced status confers acceptability within academe.

[26] Smith (1996a, b) discusses the role of nursing journals as vehicles assisting in professional identification although he did not label them professional 'symbols'.

since such analyses explore publications, there is the issue of journal rejection rates (Long & Johnson, 2002) and their likely impact on the nature of the journal. Similarly there is the question of the breadth of nurse of midwife publication outside of their own professional journals (Lindsay et al, 2001). Smith's (1994) analysis has additional interest, however, as she undertook a critique of research designs. She highlighted that much of the nursing research publications that her study examined were based on small sample sizes using convenience selection in contrast to the comparative medical journal. The value of such a finding is questionable as it reflects differing methods, with the medical journal publishing far more papers using records or laboratory methods. However, a decade later similar sampling concerns (Webb, 2004) and other design issues such as validity and rigour are found (Long & Johnson, 2002). The implication that if less than robust research is passing through peer review to publication what is being rejected and in totality, how does this impact on RCB? In addition, the wide-span of the literature reviewed for this analysis should be considered for its potential implications on conclusions drawn. Empirical range was seen in the work of McVicar & Caan (2005) who undertook a review of information held on 204 nursing theses in a UK electronic database from 1983-2002. With six research settings, eleven frameworks and 28 research techniques, McVicar & Caan (2005) claim a breadth of design supporting White's (2005) contention that nursing and midwifery is a wide field methodologically. Yet McVicar & Caan (2005) also highlighted the dominance of the interpretative paradigm with mixed method design becoming more frequent in latter years. Of note, only four theses acknowledged a funding source.

Bibliometric analysis has been suggested as an appropriate measure to "map the intellectual growth of a discipline" (Traynor & Rafferty, 2001:168). It is a mathematical method of describing and analyzing research publications by a number of measurements which range from topic areas to citations and references. Studies have been conducted in the UK (Traynor & Rafferty, 2001; Traynor et al, 2001; Lewison et al, 2001) and in Spain (Pardo et al, 2001) as an assessment of the development of nursing and nursing research but focusing on different measures. The latter study examined a decade of randomly sampled Spanish publications and used a Spanish medical and a US nursing journal for comparative purposes. The bibliometric focus was on references. Key findings include an insularity of references and the numbers of references increasing with institutional origin of the paper. The conclusion placed Spanish nursing midway on a continuum between science and arts (Pardo et al, 2001). The UK study in contrast examined an eight-year time span

of global publications but with a UK correspondence address. The bibliometric measures also differed with topic area, funding source, multiple authorship and citations being utilised. One arm of the study specifically compared nursing output with the specialist medical field of anaesthesia (Lewison et al, 2001). Key findings include a comparative rapid expansion in the heretofore small field of nursing research with the majority of papers being published in specialist as opposed to general journals (Lewison et al, 2001); a breadth of topic areas and a split between what the authors termed 'exogenous' or practice focused research and 'endogenous' or profession focused research with the latter having more prestige in relation to authorship and site of publication but the former showing greater levels of external funding (Traynor & Rafferty, 2001; Traynor et al, 2001; Lewison et al, 2001). The conclusions drawn are that a preference is shown for the use of 'endogenous' research to assist in defining the profession and establishing a discipline identity (Traynor et al, 2001). At this stage a bibliometric analysis of Irish nursing is problematic; the sustainability of peer reviewed Irish nursing journals has not been demonstrated[27] and databases of Irish nursing and midwifery research outputs have yet to be developed. Additionally, cross-country comparisons of bibliometric studies may be hampered by language differences and the comprehensiveness of databases.

Other measurements have included calculating publication rates, for example, from surveys of particular nurse populations (mainly nurse academics or graduates). Most of this literature stems from North America (Whitely et al, 1998) and Australia. In the latter country, publication rates have been found to be low (<1 publication annually) and similarly comparable across the countries (Roberts, 1997). The rate was deemed to be a direct result of the development stage of the discipline. It should be noted that research publication may be even lower as the term 'scholarship' was utilised in the Roberts (1997) study and has broader connotations[28]. Other study designs have included database searches. Developing and then using a complete national listing of full-time nurse academics to search nursing literature databases using authorial names, revealed that 7% had a publication in a nursing journal in the year studied (Roberts, 1996b). Half (50%) of the 75 articles thus discovered were

[27] The *Irish Nursing Forum and Health Services* was published for six years in the 1980s (1983-1990). The *Nursing Review* commenced publication in the early 1980s, evolving into a cross border publication *All Ireland Journal of Nursing and Midwifery* in 2000 and ceasing publication in 2003.

[28] For example, Whitely et al (1998:183) utilise 'research and scholarship' in their survey which are defined as "empirical research, philosophical inquiry, historical analysis, theoretical formulations, comparative studies, literature reviews and critical analysis".

categorised as research with 66% having multiple authorship. Hicks also conducted a series of surveys on a national random sample of nurses and midwives of all grades in the UK. For nursing, a 46% response rate yielded the finding that 71% had undertaken research at some time, yet only 10% of these had submitted and 9% obtained a publication of the work[29] (Hicks, 1995c). For midwifery, a 72% response from 550 midwives had shown 52% conducting research with a resultant report, yet 18% of these submitting and 13% obtaining a publication from the work (Hicks, 1995a). These results should be read in the light that whilst guidance on random sampling was given to the distributors of the questionnaire[30] of both studies, the assumption that it would be followed was made. Nor was it clear if the sample included those working in academia. Hicks (1995,a, c) suggests, from her findings that whilst nurses and midwives are conducting research, a lack of confidence is the root cause of low submission for publication with the inevitable outcome of a lack of publication. She links this, not just to the stage of development of the discipline but also to the change of ideology required for discipline development. Ten years later Taylor et al (2005), in a changed context of expectation of practitioners to write and publish, also claims a lack of confidence as underpinning the curricular need for a skills development training programme. They describe demand for such programmes as a 'proxy indicator' of the emergent skill of writing for publication (Taylor et al, 2005:96). In conclusion, the question over using publication as a measurement of research activity and thus RCB remains problematic with differing definitions, measures and the unknown impact of editorial control and peer review on what reaches the public domain.

With publication as integral to PhD completion (Emden & Smith, 2004), the skills necessary for publication may be viewed as an intrinsic part of RCB. Additionally, there is a professional onus to communicate findings to allow for wider academic scrutiny *and* to develop the knowledge base for practice. But what effect does the nature of academic emergence in Ireland have on such an onus? Condell (1998) reviewing Irish literature for other purposes found that even with a dearth of *empirical* literature, Irish nurses and midwives were developing writing skills and publishing papers. As such this should augur well as a foundation for the academy. Publishing skills *include* writing, reviewing and editing. Whitely et al (1998:182) describes the literature as 'replete' on developing the writing and publication skills of individuals

[29] This yields 6% and 4% respectively of the total sample that had submitted and obtained publication.
[30] Nurse or midwife managers.

and numerous texts and articles have focused on this area (Cook, 2000; Newell, 2000; Owen & Maslin-Prothero, 2001). Nevertheless, the literature suggests that achieving publication is slow (Emden, 1998; McVeigh et al, 2002), dependant on motivation (Dinham & Scott, 2001) and influenced by gender (Emden, 1998; Dinham & Scott, 2001). Less has been written on reviewing (Emden, 1996; Walker, 2004) and editing, rendering these skills less visible. However, peer review as a 'technology of knowledge production' (Walker, 2004:142) is the standard quality control mechanism (Becher & Trowler, 2001) that assists in the "validation of the knowledge base" (McVeigh, 2002:63) and "goes to the heart of scholarship" (Emden 1996:197). Peer review is one of the key elements of the academic community with its application to publication and funding evaluation, but criticism of the process includes inherent limitations of judgement and an uneven operation across knowledge domains (Becher & Trowler, 2001)[31].

So the discipline has a fundamental role in shaping doctoral education as RCB. Yet viewing academic culture purely through a disciplinary lens Huber (1990) claims is too narrow a perspective as it ignores disciplinary attitudes to wider social and political issues and the social and cultural capital of its members. For example, a key debate within the feminist literature and increasingly acknowledged in 'mainstream' literature (Becher & Trowler, 2001) is the masculine nature of academic practices and discourse that can marginalise women (David & Woodward, 1999; Kent & Palmer, 1999; Leonard, 2001) and as previously noted (section 1.3) this may provide additional obstacles to the 'new entrant' position of Irish nursing and midwifery. An alternative academic subculture is the department (Gerholm, 1990) where a doctoral student learns 'tacit knowledge' and becomes 'encultured' to institutional norms *in addition to* broader disciplinary norms both within and out-with the supervision relationship. Importantly, the department also provides opportunities to mix with peers (Neumann, 2003). Yet departments also have non-disciplinary features, such as recent establishment that can affect the research milieu; for example, the aforementioned availability of supervision capacity (section 2.6). The doctoral student is guided through the PhD process by a supervisor but this relationship can be problematic on a number of grounds such as gender, age, class, or ethnicity (Acker, 2001). Nursing and midwifery's recent entry to the academy can bring additional

[31] Walker (2004) critiques the philosophical basis of blind peer review and urges nursing to explore other means to scholarship production and dissemination; this debate has yet to start and nursing journals and therefore scholars continue using this practice with the consequent requirement for such skills.

issues. McKenna & Galvin (2004) note from the UK experience that supervision on a range of topics commonly occurred but that with maturity a greater focus of research supervision activity is achieved. For this to occur, the numbers available to supervise are also necessary. The UKCGE (2003) survey highlighted supervision capacity as a widespread and chronic obstacle in PhD provision. Its respondents identified strategies used to manage a situation of lack of supervisory capacity: joint supervision, registering students in other departments or schools, recruiting suitable staff, and establishing formal supervision training. For Irish nursing, the 'immature' situation may exist, whereby supervisors cover a broad range and a number of students. Also potentially problematic is colleague supervision, whereby the supervisor and supervisee are both members of the same departmental staff. "The importance of colleague supervision lies in the contribution it makes to raising academic standards and expertise within the higher education community, particularly in disciplines concerned with the professions." (Denicolo, 2004:695). Thus, it may be particularly pertinent given the stage of development of Irish academic nursing or midwifery. It is, however, an under-researched area with just one preliminary study found (Denicolo, 2004) using a convenience sample of 13 participants who completed a questionnaire on the experience by answering open ended questions. Regardless of the limitations of the sample, the findings suggest that particular differences occur in this supervision relationship when compared with the 'norm'. This included a feeling of vulnerability and constant scrutiny on the relationship and a tendency to produce non-threatening scholarship. Other colleagues also played critical negative and positive roles and this has been noted elsewhere anecdotally (Closs, 2000; Pearson, 2000). Another departmental notion critiqued in the UK literature was that of 'critical mass' implying volume and coherence to departmental research activity requiring continuity in knowledge generation and density of researchers and their activity (Delamont et al, 1997a). Delamont et al (1997a, b) demonstrate how this issue is more problematic for some disciplines than others because of their diverse approaches to knowledge production and proposes pedagogic continuity as a more appropriate notion (Delamont et al, 1997b). Regardless of which of the notions are utilised, nursing and midwifery research leadership has also called for cumulative knowledge production with Hallberg (2004) suggesting that doctoral studies be rooted in programmatic research to allow this to happen.

So Irish nursing and midwifery's recent entry and likely volume of research activity given its history (Condell, 1998) indicates that doctoral supervision and departmental

research cultures may be potentially problematic for its doctoral students. Nor might the latter be unique as departmental research cultures are viewed as challenging in more established disciplines. For example, Deem and Brehony (2000) undertook qualitative interviews and focus groups with a purposive sample of 38 part-time and fulltime social science PhD students in two UK universities to examine three cultural foci with permeable boundaries – peer student, research training and disciplinary cultures. Regarding a peer student culture they found some institutional marginalisation, especially of part-time students and competitiveness in higher ranked institutions that contained more full-time students. Regarding research training cultures they found ambivalent or negative attitudes with resultant resistance to attendance and those best positioned to access academic disciplinary cultures such as reading groups and social events were full-time students.

2.9 The Individual Doctoral Experience.

So what has the literature to say on the individual doctoral experience? Whilst Delamont et al (2000) studied the doctoral experience from a disciplinary perspective another large study was that of Neumann (2003). Here interviews (79 with doctoral students, 55 with stakeholders) representing 12 disciplines and documentary analysis at 6 Australian universities explored doctoral students' educational experiences and revealed complexity and diversity formed from disciplinary and institutional elements in addition to type and stage of registration. Thus contextual and cultural elements ultimately shaped the experience. Of note from the findings are older students having several degrees in different disciplines prior to embarking on the doctorate; movement between full and part-time enrolment; an overall positive attitude towards the experience although fairly traumatic for a small number; disciplines with different approaches to recruiting doctoral student and matching doctoral students to topics and supervisors; and inadequate provision of facilities for doctoral students in 'soft' disciplines.

Certainly the PhD is an intellectual challenge so a multitude of texts and journal articles exist to assist individuals undertaking the endeavour. Bryar (1999) reviewed texts aimed at novice researchers. There were the technical, methods types of texts which gave "sanitized accounts" (Bryar, 1999:25) of the research process. This has been somewhat counterbalanced since by what she terms the "getting through the research" type texts (Bryar, 1999:23). Most of these have been published in

response to calls for same from social researchers such as Bell and Newby (1977)[32]. This latter type of text includes advice for individuals undertaking degrees and their assessment at doctoral level. Some of this advice was specific to nurses and midwives (Mason & McKenna, 1995; Bishop, 1999; Jack, 1999; Johnson & Burnard, 2002), whilst more was generalised to other groupings and disciplines (Salmon, 1992; Philips & Pugh, 1994; Holloway & Walker, 2000; Leonard, 2001; Back 2002; Trotter, 2003). Much of this work could be categorised as 'tips for survival' but in contrast to the majority, Leonard (2001) utilises empirical research sources to inform her text from a critical gender perspective. Caution is urged that whilst such advice can be valuable, prospective students should be wary of templates offering 'quick fix' solutions as the process, being creative, is also individualistic and thus not amenable to a "technocratic formula" (Back, 2002:31). Morley et al (2002) also claim that such guidance fails to acknowledge the hidden agendas within assessment of values and beliefs about doctoral studies. In the main, this literature was written from the perspective of those supervising and examining doctoral students with some exceptions by doctoral students (Hobson, 1999; Jack, 1999; Trotter, 2003) and Salmon (1992) whose text was infused with direct quotations from the ten students' experience that was being described. Thus the literature reflected 'voices of experience' information rather than empirical findings and analysis. In addition, much was written for those undertaking studies on a part-time rather than a full-time basis. Usage of this type of literature is variable. For example, Tinkler and Jackson (2002) found only 18% of surveyed candidates utilised this literature with only 11% finding it of value.

In common with social sciences[33] (Salmon, 1992; Delamont at al, 1997b; Delamont et al 2000) the nursing literature describes the PhD process as lonely and isolating (Mason & McKenna, 1995; Galvin & Carr, 2003; Ellis, 2005) or as Johnson et al (2000:146) state "a disembedded and disembodied figure driven by the love of ideas, of scholarship, alone". Whilst autonomy is a characteristic viewed as gendered, Johnson et al (2000) question, based on broad occurrence whether or not isolation is a structural issue related to the pedagogic practice that aims to produce autonomy and independence within the doctoral student. Additionally, there may also be a disciplinary element, but empirics would *suggest* a structural cause. For example, Delamont et al (2000) showed no complaints of isolation from students in laboratory-based disciplines, and nursing literature (Johnson et al, 1992; Gray et al, 1997) from

[32] Park (2005:199) describes the growth rate of such texts as a "cottage industry".
[33] "the most arduous, lonely and challenging work" (Salmon, 1992:15).

the US with its different doctoral pedagogic structure also shows group support and no mention of isolation.

The PhD process itself is transitive from dependence to independence (Delamont et al, 2000) from prescriptive to creative (Lovitts, 2005) and with changing social relationships. Hockey (1994:177) from early empirical work within social sciences emphasises the first year as the most critical period with "intellectual and social processes at their point of maximum novelty, and in turn, possible difficulty". Elsewhere, Wright & Cochrane (2000) cite Becher et al's (1994) findings that in the first year, students are more vulnerable to exit the process and Delamont et al (2000:163) describe isolation as "reported with particular urgency..." in the early stages of doctoral study. Challenges include an interaction of personal and structural considerations such as new status, both intellectual and social isolation, and changes in work patterns. The experience can invoke feelings of anxiety regarding time and intellectual self-worth (Hockey, 1994). Later research shows that disciplinary differences can influence critical transitory periods; for example, anthropologists reporting difficulties during subsequent 'writing up' as much as during initial fieldwork (Delamont at al, 2000). The transitions within the nursing doctorate as PhD have not been researched, although anecdotal literature of the process exists (Bishop, 1999). One US qualitative study with 11 participants reported possible pertinent findings: the themes of confidence (self-confidence and self-doubt), support (presence and absence) and self-discovery in a sacrificial context all developed in a dynamic, non-linear but recurrent fashion for the study participants which was termed a spiral process of becoming (Gray et al, 1997). Although the study participants had not yet reached their dissertation stage and thus the findings are based on part-time engagement in doctoral coursework, the participants fit the general age and gender profile for CNMFs and so similarities may exist.

Informal knowledge contributes greatly to the process (Delamont et al, 2000; Lovitts, 2005) leading to the autonomous doctorate. Such knowledge includes cultural and social knowledge of unconscious rules, discourses, symbols and social boundaries, in other words a set of capacities that are learned and are not inherent. Acker (2001) notes the mystique of this process as she claims that such learning is implicit. On an individual level previous experience of working in the academy can advantage women in pursuing doctoral studies in comparison with other women who have not had that experience (Brina et al, 1999). However, doctoral work can be

characterised by uncertainty and ambiguity (Hockey, 1994; Delamont et al, 2000) further enhancing the difficulty of enculturation in an emerging discipline.

The challenges already noted show that motivation is a key element in the PhD experience. Wright & Cochrane (2000) in examining successful completion rates for PhD theses in the UK raise the issue of the investment for mature entrants in undertaking a PhD. Recognition that such investment is not just in terms of time, money and effort can be seen in the writing of Heinrich (2001) who in a preliminary multi-disciplinary[34] exploration, described the personal investment in 'passionate scholarship'. This meant scholarship that is "exciting and risky, personally meaningful and socially relevant life's work" (Heinrich, 2001:92). It can include researching topics of particular stigma that can be drawn from personal or professional experiences. This may be one motivating factor for undertaking the PhD, with Salmon (1992) and Delamont et al (2000:47) mentioning others such as 'love of subject'. Whilst recognising the personal intellectual and emotional fulfilment gained from the process, there were other outcomes that acted as motivators; the PhD as a first step in an academic career trajectory (Ketefian, 2005; Yam, 2005) or the PhD place as an opportunistic offer that fulfilled other personal needs (Delamont et al, 2000). The UKCGE (1996) list other individual characteristics that bring a successful outcome to the PhD process; they include organisational skills, independence in learning, self confidence and self discipline.

A successful outcome entails bringing the PhD through academic assessment and the literature showed some critique and empirics on this topic. Whilst institutions have regulations and define boundaries these are usually in the form of a measure such as word or time limits. Burnard (2001) bemoans the lack of success criteria. Mullins & Kiley (2002) claim that anecdotes surrounding the assessment of PhDs are common in the absence of a transparent, empirically based, shared understanding, leading to a situation described as mysterious (Johnston, 1997; Morley et al, 2002; Powell & McCauley 2002; Tinkler & Jackson, 2002). For equality and symmetry across professions Burnard (2001) calls for an articulation of a common standard for PhD dissertations. In the absence of such and with existing lack of clarity there are implications for an emerging discipline such as Irish nursing and midwifery as it develops its criteria for success. Nevertheless, research in the area has recently been conducted. Expert discussions have also occurred (Powell & McCauley, 2002).

[34] Participants (n=9) came from the discipline of education, psychology and nursing and were registered in 2 US universities.

Mullins & Kiley's (2002) study explored the assessment process of the written PhD with 30 experienced PhD examiners from a range of disciplines from hard science to the humanities. It is worth noting that this study along with others on the topic[35] employed small sample numbers who effectively act as 'gatekeepers' to their respective disciplines with Powell & McCauley (2002) noting that such 'gatekeeping' can be positive or negative. Examiners reported giving considerable time and effort to the PhD assessment process with an overarching sense of belief and duty in fulfilling the role, even in the context of low failure rates[36] (Mullins & Kiley, 2002). Table 2.5 shows the main characteristics across a continuum as articulated by the examiners (Mullins & Kiley, 2002). It confirms earlier cross-disciplinary studies and from different countries such as that of Johnston (1997) whose qualitative examination of 51 examiners' reports of doctoral theses emphasises the negative influence of inaccurate presentation and the positive influence of sound intellectual endeavours; as well as reluctance on the part of examiners to fail a thesis. Of interest, from Mullins & Kiley (2002) is that apart from the humanities where the assessment is viewed as a summative evaluation of the PhD product, these experienced examiners examine PhD studies as a formative assessment judging the student's *capacity* for independent research[37]; thus emphasising the PhD as a basic unit of RCB. Such a perception can also influence the type of examination of the work whereby the assessment of a product would not include questioning the author in comparison with the assessment of a process that would include this element. It

POOR	PASS	OUTSTANDING
Insufficient coherence Inadequate theoretical understanding Unconfident Incorrect research problem Confused perspectives Unoriginal work Inability to articulate the argument Sloppiness	Scholarship – originality, coherence and student autonomy. Well-structured argument Sufficient quantity and quality Self-critique and reflection.	Creativity Elegance Well designed Artistic

Table 2.5: Assessment characteristics of the doctoral study (adapted from Mullins & Kiley (2002:378-379)).

[35] For example, Delamont et al (2000) interviewed 15 examiners to ascertain their views.
[36] For the respondents in this study, the failure rate was approximately 3% over a 15 year period.
[37] Emden & Smith (2004:37) believe that it is "in the best interest of advancing the nursing discipline for candidates to complete theses fitting their 'apprentice' status, to graduate, and move on to postgraduate research – not languish in their candidature".

should also be noted that individual examiner and disciplinary differences exist on what is expected alongside knowledge of the thesis itself (Tinkler & Jackson, 2002), for example, what constitutes the broader context to the thesis and that may be an area of assessment. Tinkler & Jackson (2000) focused on the institutional policies surrounding the assessment of the doctorate in the UK. From a 100% response rate (n=20) of a stratified sample of universities, they found consistency on what they termed 'key' criteria but considerable variation in policy regulations. Lack of clarity also surrounds cultural issues such as behaviour within the viva situation with an assumed mutual understanding of imprecise terms[38]. Tinkler & Jackson (2000) acknowledge that whilst policy should underpin practice it may not do so in reality. They then report (Tinkler & Jackson 2002) on a survey focused on the viva voce from the perspectives of examiners, supervisors and doctoral candidates from across disciplines (n=230) and extend their work to include interviews with doctoral candidates (n=30) and experts (n=20) and other informal data gathering (Tinkler & Jackson, 2004). The latter sample included participants with a range of roles and the former sample included participants from a range of disciplines. The totality of their findings substantiate those of Powell & McCauley (2002) showing that practices are as divergent as institutional policy might indicate.

The viva voce as a 'gatekeeping' ritual is a "key site of assessment" that can promote a belief of powerlessness within the process itself and effect resultant perceptions of an academic self (Tinkler & Jackson, 2002:87). Thus it is a site of power that Morley et al (2002, 2003) analyse and interrogate. They conclude that an absence of evidence and transparent procedure allows for "too many distortions, disruptions and deviations" (Morley et al, 2002:271). Powell & Claire find a lack of clarity as to the true purpose of the viva as "an examination in the broadest sense of the term or merely a verification of authenticity" (2002:106). Trafford (2003) focused on 25 viva voce from the same university but of ten different disciplines. Some commonalities did exist across these 25 in relation to the opening question. Patterns of questioning emerged both from the different disciplines and the amount of discursiveness and scholarly debate was viewed as an indicator of success.

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[38] "In many cases, institutional authorities seem to rely upon a consensus as to what constitutes appropriate behaviour, perhaps assuming that academics have recourse to an unwritten professional code of conduct. However, such assumptions of homogeneity are unrealistic, as within different cultures, be they those of academic discipline, nationality or others, there are different ideas of what constitutes appropriate behaviour in a viva, and in come cases this could include aggressive questioning." (Tinkler & Jackson, 2000:177)

Of interest to this study, is the notion of a network or community of examiners (Morley et al, 2002, 2003). For emergent disciplines, such an informal group may be very small and thus with even more potential for accusations of bias towards candidates or their respective ideologies. Indeed Johnston (1997) emphasises the conservative nature of the assessment process in this regard. There is also the issue of the practise within the limited expertise in the Irish context. Mullins & Kiley's (2002) study highlighted problems with inexperienced examiners, specifically lacking understanding of the standard required and the constraints on candidatures. Similarly Powell & McCauley's (2002) expert participants also considered that experience, including that of successful supervision, was necessary for judgement purposes as such experience allowed a holistic understanding of the tripartite relationship between student, supervisor and the study.

In summary, variation and diversity in doctoral assessment exists. It can therefore be problematic for emergent disciplines such as nursing and midwifery that are not assisted and indeed may be hampered by this context as they engage with the academic process. However, supervision and assessment capacity are other basic units of RCB; for example the supervision of others by completed CNMFs could be used as a long-term indicator of capacity building as others have done (Hyder et al, 2003).

2.10 The Place of the PhD in a Career Pathway

What are the issues if the PhD is not an end in itself but part of an overall career path? The UKCGE (2003) claimed that individual health professionals utilise the award for career advancement yet critiques of the PhD claim that it prepares individuals for future careers in academia rather than practice (Ellis, 2005) giving descriptions of "professional researchers" (Bourner et al (2001:71) or "professional scholars" (Galvin & Carr, 2003:294; McKenna & Galvin, 2004:106). Yet a greater number of doctorates (Johnson & Burnard, 2002) and pump-primed funding (Proctor, 1997) will be required for nursing and midwifery to become a well established academic discipline and does not *necessarily* limit the work setting to the academy. Additionally, research grant and fellowship awards are recognised as a measure of RCB (Smith, 1994; Emden, 1998; Hyder et al, 2003) and as requisites for developing individual funding track records (Emden, 1998) in research careers[39]. There is some

[39] It should be noted that track records can also be institutional. In the UK, the national Research Assessment Exercise (RAE) is regularly conducted in order to disburse governmental research expenditure based on performance. Using peer review, the

caution from the literature. Jackson (2005) argues for further funding to sustain research careers for award holders as postdoctoral research careers are deemed to be opportunistic and individualistic (Wilson-Barnett, 2001). Franck (2003) acknowledges there is no net-gain from investment schemes like the CNMF if, following completion, nurses and midwives undertake roles that are not research active. Also Thompson & Watson (2001) claim that once attained, there is an exaggerated view of the status conferred from the PhD, with individuals believing that they are "fully fledged researchers"(Thompson et al, 2005:289). This may be because as Johnson (2000) claims, in UK nursing a PhD confers career advantage over and above its true value. As the Irish nursing and midwifery academy grows the same may be true.

We have already noted a policy assumption of PhDs being conducted in an early career phase (section 1.2) but the nursing and midwifery literature also emphasises a difference in the age of its doctoral students (Owen & Maslin-Prothero, 2001) with potential implications on career pathways. McKenna (2005b) and McKenna & Galvin (2004) claim that in the UK 35 years is the average age of those entering doctoral programmes but fail to show how this figure is generated. Interestingly, in this case it is the basic sciences that are used as the benchmark where entry would be approximately 21 years rather than the medical equivalent of a PhD where the age would be late twenties. Indeed, nursing may be far from unique in possessing mature entrants as disciplines such as social work (Lyons, 2002) and education (Leonard et al, 2004) appear to have comparable profiles. Salmon (1992), from the social science perspective claims a similar demographic with the stereotypical image of the

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methodology and scoring system changes between exercises (Watson & Robinson, 2001) and this, along with questioning its pertinence generates much debate (UKCGE, 2003). Nevertheless, within the units of assessment it provides an indicator of development and allows a tentative if crude comparison across disciplines. Additionally, it dictates the rate of research growth for individual departments because of the funding that is attached to success and subsequent academic kudos (Traynor & Rafferty, 1999). Types of metrics used include publications and their impact and international standing, research income, postgraduate numbers and completion rates. McKenna (2005a) outlined that metrics of research esteem, like editorial activities, awards or honours and representation on research bodies were to be included in the 2008 RAE, with the latter already suggested for nursing and midwifery RCB (Mulhall,1995; Crooks and Bradshaw, 2002). In the four RAEs previously conducted (1988, 1992, 1996, 2001) nursing retained bottom place but progress was shown across the rounds with increasingly higher scores (Robinson et al, 2002) and more departments entering the exercise (Kitson, 1997). The performance has led to a number of analyses by nursing (Tierney, 1994; Kitson, 1997) and midwifery (Soltani, 2002) and empirical work (Traynor & Rafferty, 1999; Soltani, 2002; Lindsay et al, 2003; Anthony, 2005) on aspects in order to inform future submission. However, the competitive nature of the exercise has led others (Watson & Robinson, 2001) to claim an unwillingness to act collectively for the discipline by sharing knowledge gained. No such exercise exists in Ireland.

young full-time doctoral student on a funded scholarship as unrepresentative. The basis for the persistence of the image she lays in the structural mechanism for research funding. The research advice texts reflect the problems and issues outside the remit of the stereotypical doctoral student adding weight to the argument that the stereotype is unrepresentative, although it could be argued that there is no market for such texts aimed at well-supported young students. Both Johnson (2000) and McKenna (2005b) question the issue for nursing and midwifery in terms of the impact on individual future research careers of a late start to doctoral study and the effect on the institution of a mismatch of research interests between older students and existing departmental agendas. Thus it is viewed as a factor that slows the pace of RCB. For nursing and midwifery, in common with some of the other health professionals (UKCGE, 2003) another demographic unit of analysis is that of gender. McKenna (2005b) outlines the effect that family responsibility further impacts on age of completion rates of a PhD for the predominantly female nursing profession. Childbearing is certainly an issue for research careers with Kent and Palmer (1999) highlighting a tendency for single and childfree women to be more successful in the academy, but the situation is far from simplistic. For example, other caring responsibilities may be present besides children. A further complicating factor is that entry to research careers via a PhD may be unattractive due to the salary or student stipend available from a funding body who assume that such positions are taken early in a career when financial commitments are limited (Proctor, 1997; UKCGE, 2003). In an analysis of applications to the first six years of the CNMF scheme Condell (2005) found these issues applied within the Irish context of a funding scheme for both Masters and PhD. Of the 92 applications analysed, 81 (87%) were from females and the majority of applicants (n=50) were between 36 and 45 years of age with a range of 27 to 60 years. The area of practice was also examined, and whilst this would not necessarily predict a return to that area post-fellowship, the fact that 58% (n=53) of applicants to the scheme were already education based might imply that these nurse or midwife teachers viewed academia as their natural future career path with the award of a Masters or PhD degree as a stepping stone and their education base may advantage them in issues of enculturation.

2.11 Summary and conclusion

In summary, relevant literature was reviewed with particular appropriateness for Irish nursing and midwifery as it aims to build research capacity through doctoral education. The review points to complexity from a number of stances. There is an absence of a research tradition in the practice setting with nurses and midwives

negotiating role boundaries, power hierarchies and practice cultures that do not fulfil professional ideals such as autonomous practice or individualised care (section 2.3) and that may not support the professionalizing agenda because of its perceived elitism. The review highlights the potential need for specific support in academic RCB, as elsewhere (section 2.5). This is due to the recent departmental establishment in the higher education sector producing a low volume of research activity, limited numbers of post-graduate students to provide a peer culture and restricted availability of supervision capacity. Together with the contested nature of the discipline, its likely mode of knowledge production at this stage of 'emergence' (section 2.7) and the place of the nursing or midwifery PhD in a career pathway (section 2.9) this suggests specific challenges for the individual doctoral student experience within the Irish context at this time. There was no empirical literature on the nursing and midwifery PhD process. On the positive side, it is likely that these nurses and midwives, predominantly coming from nursing and midwifery education (section 2.9) are unlikely to be a 'tabla rasa' to research (section 2.6), may have already developed writing and publishing skills (section 2.7) and are likely motivated to undertake the PhD for personal as well as professional reasons (section 2.8). The next chapter describes how the study was operationalised.

Chapter 3: Operationalising the Study: methodology and method.

3.1 Introduction

This chapter details the specific aim of the study and the objectives and foreshadowed problems that emanate. It then details the methodology, fieldwork and data analysis conducted and the mechanisms undertaken to ensure the study met evaluative criteria. In keeping with good ethnographic practice, the chapter is written reflexively.

3.1.1 Aim and objectives of the study

The aim of the study was to examine the development, and create a substantive theory of research capacity building (RCB) in the emerging academic disciplines of nursing and midwifery in Ireland. The specific objectives were:

Objective 1: Describe the developmental processes involved in funded RCB at the level of the individual.

Objective 2: From the perception of CNMFs and the HRB, explore the cultural context of Irish nursing and midwifery development as professional research disciplines and their integration to health research culture.

3.1.2 Foreshadowed Problems

In ethnography foreshadowed problems are the topics of interest that are present at the outset and from which a set of questions are developed that assist in focusing the investigation *initially* (Hammersley & Atkinson, 1995). In this study the foreshadowed problems emanating were:

- How do CNMFs develop the skills of research capacity? What facilitates or hinders skill development? Do skills change over the Fellowship timeframe?
- How do CNMFs identify themselves as health researchers? What are the activities undertaken to give that meaning? How does that differ from identity as a nurse or midwife? If duality of identity occurs, how is that managed?
- What is the social adaptation that CNMFs require to move to the culture of health research? How does institutional infrastructure assist or hinder this?
- What is the stage of assimilation of nursing and midwifery into the Irish health research culture? What meaning does RCB at the level of the individual have for the assimilation of nursing and midwifery to the health research arena? What meaning does the assimilation of nursing and midwifery into the health research arena have for development of nursing and midwifery as professional research disciplines?

3.2 Methodology

Methodology is a broad philosophical and theoretical framework. This section outlines the rationale for the chosen methodology of the study showing its points of value. It then details the theoretical position of the methodology, including epistemological and ontological premises before describing some current critique. Such philosophical inquiry into the circumstances and possibility of knowledge *prior* to empirical work makes explicit for the reader the assumptions on which the study is based and the stance taken by the researcher thereby allows judgements to occur as to the functionality of presuppositions (Hammersley & Gomm, 1997). Such an exploration is perceived as good practice in social research (Brewer, 1994, 2000) as it enhances 'collegial accountability' (Hammersley & Gomm, 1997). It is a key element in producing a reflexive account.

3.2.1 Rationale

This study aims to examine RCB for nursing and midwifery as they establish themselves in the culture of health research funding and in the culture of the academy. Chapter 1 has already identified the novice status of the professions in both these arenas and culture is a useful frame of reference (Sellers, 2002) for understanding such a dynamic, multidimensional concept as research capacity building (Condell & Begley, 2007). An ethnography is simultaneously a product and a process (Roper & Shapira, 2000). As product "ethnographies are documents that pose questions at the margins between two cultures" (Van Maanen, 1988:4). Ethnography as process, also, is a particularly relevant methodology to use considering this cultural shift for nursing and midwifery, so that ethnography as product can raise pertinent questions for the cultures concerned. Ethnography's focus on context, while still allowing the expression of individuals' experience (Savage, 2006) adds value considering the complexity of the issues involved in RCB in contemporary Irish nursing and midwifery. Importantly also, ethnography is a useful and appropriate tool for studying dynamic situations such as this, as "it does not seek to develop universal generalisations which presuppose society or human behaviour to be static" (Laugharne, 1995:48). Ethnography is characterised by long periods of immersion in naturally occurring settings, allowing rich description of the social behaviours and phenomena which comprise the cultures concerned. The value of immersion gives a longitudinal nature to the data collection. In this study, it allowed for the observation of research capacity building over time thus offering a more penetrating insight and capturing nuances that other methods may have failed to do. In addition, since funding is an attribute of RCB (Condell & Begley, 2007) and

those being funded are a focus for this study, there is a small population involved. Therefore, to capture the longitudinal and dynamic nature of RCB in a small number of individuals and the concern with how research capacity building takes shape as a human behaviour, an iterative methodology such as ethnography is extremely suitable.

3.2.2 The position and critique of ethnography

Ethnography sits as a style of research (Brewer, 2000) in the pantheon that is the social research methodologies. Whilst its origins can be found in the two disciplines of anthropology and sociology (Hammersley, 1998), there is a corpus of applied ethnographic work focusing on specific social science arenas such as education (Gordon et al, 2001), work (Smith, 2001) and health care including medicine and nursing (Bloor, 2001; Allen, 2004; Savage, 2006; Allen, 2007). Methodologies have philosophical and theoretical foundations, as well as political influences and this section outlines those pertaining to this study before outlining criticism of ethnography.

Figure 3.1 attempts to map the position of ethnography for this study from both on ontological and epistemological perspective. Ontology is the nature of being and gives us an understanding of "what is", whilst epistemology is the nature of knowledge and so gives an "understanding of what it means to know" (Crotty, 1998:10). I took the philosophical stance of 'subtle realist constructionism'. By this, I recognise that I set out to understand, by describing, the social and cultural phenomena of a particular group that exists in the contemporary natural world (realism) whilst acknowledging that making meaning of such matters is a constructed process (constructionism). However, there can be a tension between these two stances if taken as dichotomous stands with no intermediary dialogue between the two, or if assuming a crude version of either. Hammersley (1992:52) suggests that a subtle rather than naïve realism is utilised thus rejecting "the notion that knowledge must be defined as beliefs whose validity is known with certainty". I therefore recognise that the descriptions generated from being in the field are provisional and are imbued with the perspectives of all the research participants in the study including the researcher; I manage the latter by using reflexivity to make explicit the researcher's point of view. From a philosophical perspective, Crotty (1998:10) draws a similar conclusion of compatibility of realism and constructionism when stating "the

existence of a world without a mind is conceivable (*but*) meaning (*of that world*)[40] without a mind is not ". Hammersley & Atkinson (1995:9) maintain that naturalism offers a comparable response as by marginality of perspective and position, "it is possible to construct an account of the culture under investigation that both understands it from within and captures it as external to, and independent of, the researcher".

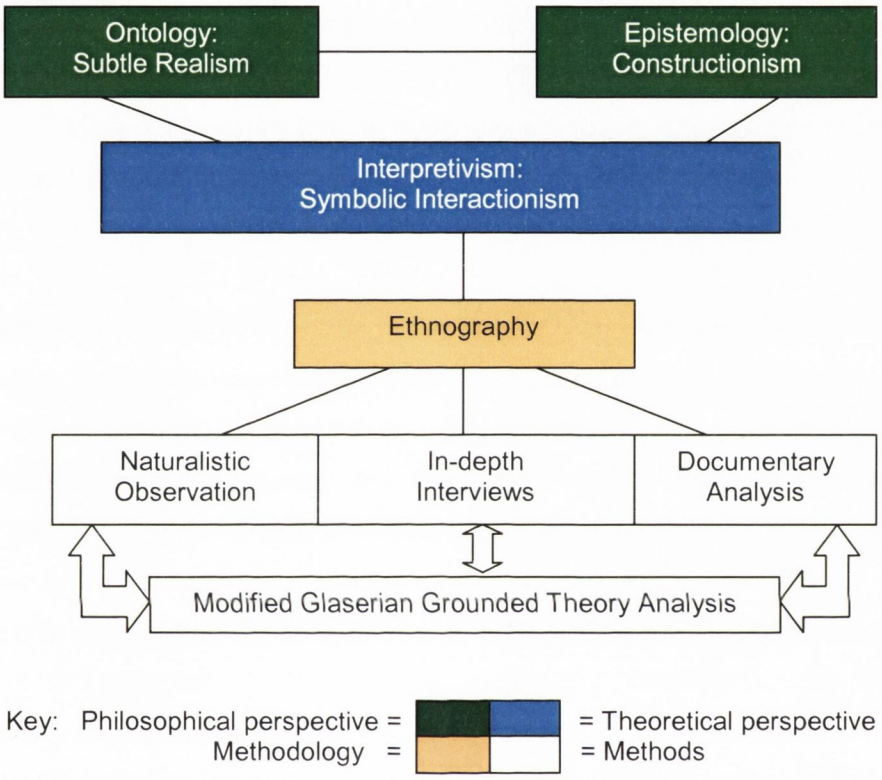

Figure 3.1: The composite of ethnography as utilised in this study.

My philosophical stance of 'subtle realist constructionism' gives a theoretical perspective of interpretivism or seeking "culturally derived and historically situated interpretations of the social life-world" (Crotty, 1998:67). Within this realm, Crotty outlines three potential streams, two of which have central concerns with culture – symbolic interactionism and phenomenology. For symbolic interactionism, culture is a positive force making meanings for people's lives. When symbolic interactionism informs methodology, a pivotal assumption is the unquestioning centrality of participants' meanings. For phenomenology, new meanings are derived when experiences are examined *out with* existing understandings. Here, there is a more critical approach to culture which acknowledges its circumscription and restrictions on meanings as much as its empowerment by them. However, whilst both streams

[40] Since the original statements have been taken out of context, I have added the italicised words so as to aid understanding.

are concerned with the study of human lived experience, for this study I rejected phenomenology, as to appreciate the experience of research capacity building outside of existing understandings devalues the contribution of my own reflections on the phenomenon and limits the scope of data collected by ruling out any incorporation of an introspective element. Instead I selected symbolic interactionism as a theoretical perspective but with an understanding that culture is not always a positive force. In other words, and in contrast to Crotty's (1998) stance of non-criticalness to culture in this perspective, I recognised the constraints that cultural and societal norms place on freedom of choice in the behaviour of people (Benzies & Allen, 2001) and thus I avoided "the reduction ad absurdum of the valid hermeneutical point that the social world cannot be fully understood without taking account of the interpretations of the social actors in it" (Porter, 1993:596).

Mead (1934) and later Blummer (1969) developed the symbolic interactionist approach by bringing together strands of Dilthey's hermeneutics with Cooley's "sympathetic introspection", American pragmatism, and the University of Chicago's ethnographic work (Prus, 1996). The central pillar is that the essence of human life is community. Therefore inter-subjectivity is dominant. There is no self without the other, thus there are multiple perspectives even from one individual. The acquisition and use of language is core and allows reflectivity. Human group life is also activity-based, negotiable, relational and processual (Prus, 1996). There are then three basic tenets to symbolic interactionism: firstly, people act towards things due to the meanings they imbue in them, secondly, these meanings develop through social interaction and thirdly, these meanings result from a process of interpretation (Blummer, 1969). Our worlds consist of action, interaction and interpretation such that we acquire perspectives, achieve identity, undertake activities and build relationships (Prus, 1996). Symbolic interactionism can deal with societal analysis across levels as well as in complex contexts; cross cutting vertical horizontal and temporal dimensions (Prus, 1996) and as such, is a suitable theoretical perspective for this study, considering the initial analysis of the concept of RCB. For symbolic interactionism, it is central that the researcher takes the place of those being studied (Crotty, 1998) and as such this theoretical perspective is highly compatible with ethnography.

So together, the philosophical and theoretical positions adopted in this study are incorporated into the methodological approach of ethnography with its core elements of naturalism, understanding and discovery (Hammersley, 1998). Brewer (2000:10)

defines ethnography as "the study of people in naturally occurring settings or fields by means of methods which capture their social meanings and ordinary activities, involving the researcher participating directly in the setting if not also the activities, in order to collect data in a systematic manner but without meaning being imposed on them externally". The aim is to provide an insider or 'emic' perspective of the phenomenon and to produce "situated knowledge rather than universals and to capture the detail of social life... rather than abstracting from this detail to produce reductive models" (Taylor, 2002:3). That being said, not all ethnography stays at the level of description (Hammersley & Atkinson, 1995) with explanation and theory development often undertaken. For Hammersley & Atkinson (1995), the ethnographer is the vital research tool in fieldwork; thus ethnographies should contain introspective or reflexive elements, acknowledging the researcher in the process.

However, ethnography was, and remains a contested arena with no 'stable orthodoxy' (Atkinson et al, 2001:11). There is no single philosophical or theoretical assertion that underpins it exclusively (Brewer, 2000) and so individual ethnographers adopt and champion differing stances. Skeggs (2001) provides a typology of ethnographic approaches that produce intra-methodological tensions. In addition, positivists have criticised ethnography for being unscientific and critiques from post-modern and post structuralist perspectives have led to what some described as a triple interconnected crisis of 'representation', 'legitimation' and 'praxis' (Denzin, 1997:3; Denzin & Lincoln 2000:17). Contemporary ethnographers must therefore rise to challenges such as what they write does not capture what was studied; what they write can not be evaluated for best quality; and what they write has no potential to generate change as it is simply a textual representation amongst many possible representations. Hammersley (1992), amongst others, has explored these challenges in depth and suggests theoretical arguments and strategies to deal with them. Brewer (1994, 2000) has transformed his own responses into guidelines for good ethnographic practice, as detailed in Table 3.1. Whilst the previous chapters and this section have addressed the first three guidelines, the next section sets out to meet guideline 4 in reflexively addressing the fieldwork that was undertaken for the study including procedures used to collect and analyse data. Key methods of collecting ethnographic data are naturalistic observation, in-depth interviews and documentary analysis (Brewer, 2000). All three were used in this study as congruent with the philosophical stance adopted and are described as applied in the fieldwork.

1	Establish relevance of setting and topic and identify the grounds on which empirical generalisations are made
2	Identify features of the topic being studied and give rationale for and impact of any features omitted.
3	Identify theoretical framework and broader values and commitments of the researcher
4	Establish researcher integrity eg: • Outline grounds on which knowledge claims are justified • Detail experiences of the topic and setting • Delineate experiences during all research stages, especially constraints • Outline strength and weakness in study design
5	Ascertain the authority of the data eg: • Discuss problems as they arise • Outline the categorisation system including participant and researcher generated categories. • Consider alternative explanations • Show sufficient data extracts to allow judgement of the inferences made • Discuss power relationships within the study
6	Display the intricacy of the data eg: • Show any negative cases or contradictory descriptions • Stress and show the influences of the situational nature of accounts

Table 3.1: Guidelines for good ethnographic practice (adapted from Brewer (2000:53).

3.3 Fieldwork:

Van Maanen (1998:117) has described fieldwork as "a long social process of coming to terms with culture". This section describes how I prepared for and obtained access to the fields where I conducted the fieldwork. It then describes the field settings and gives pertinent details of the study participants. Finally, it describes the role I adopted in the field settings with participants. These descriptions give explicit details on the pivotal responsibility and function of the ethnographer in being "part of the social world" (Hammersley & Atkinson, 1995:21) being studied.

3.3.1 One study; two fields

From the literature (section 1.5.1), RCB occurs from micro through to macro-levels. The opportunity to examine the phenomenon from both an individual and a policy perspective gave this study its uniqueness and also meant an examination of two inter-related concurrent fields – that of the Funder (HRB) and the Fellow (CNMF). That is not to say that data from the meso-level (the 'academy') was not collected but only in so far as it related to the perspectives of the participants. The fields themselves were complex, constructed social entities. A context analysis grid (appendix 3.1) was developed to identify the extent of participation and interaction across the fields and to act as a preliminary guide to data collection.

3.3.2 Preparation for fieldwork

Previously, I conducted a feminist study at Master's level that consisted of interviewing nurses and midwives on a personally and professionally sensitive issue. This had taught me technical issues of conducting interviews and reporting research findings both ethically and sensitively. Whilst I had used observation in my clinical practice, I had not utilised this method of data collection before. Earlier, in part fulfilment of an Open University (OU) module on ethnography, I conducted two observation sessions with a CNMF. This CNMF was primarily a friend and ex-work colleague but with whom I had a simultaneous 'power' relationship as co-supervisor for their own doctoral study. Thus this CNMF was not, and ethically could not be, a participant in this study whilst under those conditions. For this exercise I acted solely as an observer, spending a few hours observing the CNMF at study in their own home and at a statistical advice session; the latter being negotiated by myself with the statistician involved after an initial approach by the CNMF. These data were used solely for the OU module work and as participants were informed, they were subsequently destroyed and not included in this study. The exercise was valuable preparation for data collection. It gave me confidence that I could conduct and record in detail unobtrusive observation; it taught me some of the practicalities of setting up observational sessions in an ethical way and it showed me that observing CNMFs was a worthy undertaking if the minutiae of research capacity building were to be understood.

Emerson et al (1995:26) suggest that initial impressions of a field are made to allow the ethnographer "to get started in a setting that may seem overwhelming". So, prior to obtaining formal research access, I wrote of my initial experience in the Field of the Funder based on my first months of working as the NRA in the HRB. Whilst I would not claim this was comprehensive with some initial impressions missing, it did allow a contextualisation for what was to follow, as well as describing my sensitivities to patterns and dissonance that could become blunted over time. For example, issues of difference between the nursing culture and the health research culture were recorded, such as the start time of the working day.

3.3.3 Access to the field

A formal letter of approach to the CEO of the HRB was made with a 12 page copy of the study proposal. This had been preceded by informal soundings with the CEO and a senior manager; thus these individuals acted as 'gatekeepers' for the study. The study was seen as potentially making a contribution to the organisation although

no organisational request was made for a report or copy of the thesis when completed. The study proposal then went to relevant ethics committees as set out in Table 3.2. These mechanisms gave organisational ethical permission to the overarching fieldwork but access to each field required different approaches.

Committee Name	Comments	Date of approval
TCD School of Nursing and Midwifery Studies Research Ethics Advisory Committee	Approval with minor amendment	31/3/2004
TCD Faculty of Health Sciences Ethics Committee	Approval with no amendments	5/5/2004
HRB Research Ethics Committee	Approval with no amendments	24/5/2004 (notified 23/7/2004)

Table 3.2: Summary of Ethical Approval

Field of the Funder

Formally, organisational permission from management and ethical approval by the ethics committees had occurred without reference to the staff concerned. So I undertook to inform them of the study at a staff meeting and seek their verbal consent. My researcher diary records this as follows.

RD18/8 *When the agenda for today's team meeting was circulated yesterday, I asked the manager to include my study under AOB. This was not to denigrate the study but to appropriately locate it in its place with the formal functions of the division. I had not attended any staff meetings since my appointment where staff members discussed their individual work for academic purposes and yet one field of my study was intimately tied to my role and thus linked to the business of the team. AOB, I therefore thought as appropriate. At the meeting, I told my colleagues of the approval gained for the study and gave an outline of the ethnographic design that I was planning to follow and details of data collection in two Fields. I stated that in the Field of the Funder I would be doing an analysis of HRB documentation and keeping a diary of the role of the NRA in the HRB. I stressed that the focus of data collection would be of the NRA role and nursing and midwifery within heath research. I then talked about management of confidentiality throughout the study and the code that would be used for themselves as HRB staff members should they appear in diary recordings. Staff then asked me questions. These focused on design issues such as numbers of potential participants, my opinion on whether participants would agree to be shadowed and whether I'd be using the HRB database to facilitate the study. These questions reflected the academic level of those asking the questions (Masters or PhD qualified themselves). The latter question on use of in-house technology perhaps may have been asked in relation to concerns as to the continued smooth working of the division function. There were no questions on the diary. I verbally sought their willingness to participate and offered to make available further information or answer any points of clarification. This was recorded in the minutes. I found it difficult to assess reaction around the table; whilst some colleagues were smiling and nodding, others had their normal blank expression on their faces. Since some had limited interaction with the NRA, I had to assume a blank expression conveyed a lack of interest due to non-involvement. One team member was absent, so I emailed them after the meeting saying I would fill them in on the details when we were both in the office. At the next break, one staff member came to the office with the opening statement "well, you'll be a busy person then". A conversation ensued, reiterating details. Other HRB staff members asked no further questions but mentioned documentary sources which might be of use and the offer of access to these documents. I took this to be a positive endorsement and support for my work. Later that day I sought out the staff members of the other division and delivered much the same information. As this was in their office and not in the formal setting of a team meeting, their*

more positive reaction of smiles and 'good luck' wishes I deemed to be partly due to the context in which the information was delivered as much as their personalities.

Subsequently as individuals joined the team (n=5) I informed them of the study and sought verbal consent. I gave intermittent updates of my progress at team meetings and my colleagues did make occasional informal enquiries as to my progress during tea breaks. Aware of potential coerciveness, on all occasions I offered the opportunity to discuss the study further, address individual anxieties or give greater clarification but this was never sought. In the main, my colleagues displayed ambivalence. I also discussed study progress with the heads of division at my yearly staff appraisal session. At the close of the data collection period, I sent an email (as I could not attend two scheduled staff meetings) informing my colleagues that data collection had closed. I reiterated confidentiality management and offered to answer any questions when in the office the next day. No questions were asked. Whilst I made the pragmatic decision at the outset to obtain verbal consent only from my work colleagues in this field, I also recorded my interactions as NRA with nurses and midwives. Here, the decision was not to inform these individuals of the study unless there was prolonged or multiple engagements, whereby a verbal consent would be sought. Any data collected from this source were treated with ethical sensitivity and situational judgement (Murphy & Dingwall, 2007).

Field of the Fellow

Letters of approach (appendix 3.2) were sent to all CNMFs (n=17) fulfilling the study criteria and written in a manner to convey non-coercion. Five CNMFs specifically requested further information which I gave either face-to-face or by telephone. At the outset of data collection documentation was made available: a formal consent form detailing aspects of the study such as data collection, confidentiality, voluntary participation, risks and benefits; an information sheet on the role of the NRA; and a briefing note for supervisors (appendix 3.3). A common concern was the amount of time participation might take. I assured them each data collection session was separately negotiated with regard to date, time, and method enabling them to control the amount of time given to my study. So in this field, following the bureaucratic contract of the regulatory regime, consent was relational and sequential (Murphy & Dingwall, 2007).

Issues of access.

My diary recording showed delays in accessing the field. Three formal ethical clearances occurred. From the initial formal approach to the formal granting of

ethical clearance was almost 5 months[41] (appendix 3.4). Further delays transpired. In my opinion, the approach to those in the Field of the Funder was a courteous pre-requisite to approaching those in the Field of the Fellow. For efficiency, I had planned my approach to work colleagues to occur at a team meeting which was a further month on. Within a fortnight letters of approach went to CNMFs and seven weeks later I noted:

RD21/10 *Access to the Field of the Fellow is taking longer than I expected. Having issued the letter of invitation to participate, I am dependant on the Fellows to make contact. Some responded immediately, others were much slower. One left a voice message on my mobile phone which did not feature until another missed caller left a voice message (the blessings of technology!). A second did not receive the letter for a number of weeks as it had been addressed to their university and they had not been in. For those who responded immediately, dates for meeting were set or for further phone contact. My own work schedule is not helping as I try to fit the research into what is an already packed professional and personal life!!*

The five months required for accessing and gaining written consent from this initial cohort had one exception where two negotiated arrangements were postponed. The minimum time from initial approach to consent was six weeks. Such delays in formally accessing the fields were something which I, as a novice researcher, had not anticipated.

The second issue of access was potential coercion in the fields. Within the Field of the Funder, I was extremely sensitive to both the organisational ethical clearance superseding my approach to the team thus having the potential to influence their seeming willingness to participate, and to particular tensions within the team as noted here.

RD18/8 *On reflection, the two approaches to giving information were matched to the two divisions. The first division has more staff and therefore personalities within the team; is longer established and works in a more formal way; and contains more staff that have occupied their current roles for some years and could be considered 'expert'. This compares with the second division which is newer, has a much smaller team and people who have occupied their current roles for a much shorter period. Throughout the approval process I had made first approaches to a particular division as here the NRA role was originally established and the CNMF are sited. But it was also the division I was most anxious about delivering the information as I thought it contained staff that were more likely to challenge the notion of the NRA diary. This perception perhaps stemmed from some of the inflexibility I had witnessed previously... as much as from a strong background of most members in quantitative research. I was glad that one relatively new team member was from a social science background and potentially could champion my research design to positivist colleagues. Immediately following the team meeting, I felt thankful that I was already an established team member, as whilst I could not describe the atmosphere as overtly hostile, neither could I describe it as enthusiastically supportive. However, I recognise that this might reflect an over sensitive analysis on my part due to the preceding anxieties as much as a normal reaction of the personalities on the team! There is also how nursing is viewed within the team: it being only a*

[41] Correspondence from the final committee got lost resulting in a two month delay.

small amount of the overall team activity and thus the study may have seemed to have little relevance to some and thus difficult to generate interest over!

I subsequently learnt of another potential reason for a perceived lack of enthusiasm. This was the meaning of a PhD within the organisation whereby it was a highly contentious eligibility criterion for promotion to management grades. Therefore I was potentially a future competitive threat to colleagues who might seek promotion. This issue impacted on the role I adopted in this Field and will be discussed later. Nevertheless, in my opinion a verbal consenting and ongoing briefing in this Field was justified due to the centrality of the NRA and the peripheral nature of others to the data being collected.

In the Field of the Fellow, despite the fact that the role of the NRA is purely advisory, there was also the *potential* for coercion to participate. Here a more active management process was used. Both the approach letter and the note on the role of the NRA were designed to show explicitly the lack of any formal relationship between the NRA and a CNMF, with the grant being administered by a Grant Manager. The information also clearly stated that Fellows were under no obligation to participate and that their decision either way had no impact on the terms and conditions of their award. Ongoing consent throughout the data collection timeframe meant that the CNMFs controlled access to this field. The fact that one CNMF declined to participate in the study and another CNMF refused a request to observe them at a particular event are some examples of such control.

3.3.4 The field settings

Field of the Funder

The setting for the Field of the Funder was mainly the HRB offices. My space as NRA consisted of a desk, computer, and small filing cabinet on the second floor and was part of the allocation for one of the divisions that I worked in. Immediately outside the office door and at the top of a staircase was the photocopier for both divisions and a water cooler. This was also the turning point for the stairway to the next floor and so served as a space of informal meeting. The floor below acted as the public space of the building. It contained two adjoining rooms where panel, board, and staff meetings were held as well as organisational events. Because of the mix of activities in these formal rooms, each type of event acts as a "symbolic domain" or "bounded interpretive framework" (Jones, 1996:23). These formal rooms were uniquely decorated and contained furniture matching the period of the architecture. The ground floor contained the reception area and offices and in the

basement was a small kitchen and communal eating area. My 'initial impressions' had recorded that this was the third space I had occupied in my 26 months of working with the organisation[42]. There was no staff uniform and staff did not wear any identification. Since the fields in this study were constructed social entities and not simple bounded physical spaces, data collection in this field described my role as a HRB representative outside the physical environment described here.

Field of the Fellow

The setting for the Field of the Fellow was again not a fixed spatial location and data were collected across multiple sites. These included the private space of the CNMFs' own homes and travelling to and from data collection and public spaces such as hospitals, universities, professional meetings and conferences (see 3.4.1).

3.3.5 The participants

Field of the Funder

The participants in this field were those I interacted with in my role as NRA. In the main these were my work colleagues but some were nurses and midwives who contacted the NRA for a variety of reasons. At the time of data collection I worked across two divisions, where all bar one staff member were female. In addition to the NRA, there were seven other types of roles. Those at the management level (n=4) had PhDs, administrative level (n=2) had undergraduate degree and officer level (n=5) ranged from undergraduate degree to PhD. I considered staff turnover as quite high: during the data collection period five new staff arrived, four as replacements for staff taking career breaks or leaving the organisation. This was in addition to what I had recorded in my initial impressions.

***Initial Impressions**: the past 26 months has seen the loss of 2 divisional members of staff and their replacement but with some differing functions. One loss was through the death of a long-serving and valued staff member who was a 'teleworker', and the other person had been with the organisation approximately 2 years. This, combined with the maternity and parental leaves, 'teleworking' and my own sporadic attendance, gave me the perception of a transitory work environment.*

Field of the Fellow

By the data collection period 17 PhD funding awards had been made since the commencement of the scheme and of these, 16 CNMFs were approached to participate in the study. An additional Fellow was invited later on successful completion and award of their PhD (see 3.3.2). One CNMF, following discussion with

[42] I am in my 8th space now but this is not unique in the organisation as colleagues are regularly moved between spatial positions for a variety of reasons.

their supervisor withdrew agreement to participate. In all, 94% of the total population participated. In addition, 2 had been awarded funding for 2 years and 1 for one year because of the stage of their own studies at the time of their success, and three had a prolonged time (> 6 months) between finishing the Fellowship and submission of the thesis for examination. Thus 5[43] had experienced both part- and full-time study. The participants were predominantly female (n=13), eleven were married at the time of their fellowship and 9 had children living at home. The majority were between 35 and 45 years old. Such details show that whilst participants did not fit the policy assumptions of the profile of a doctoral student (Evans, 2002; Barnacle & Usher, 2003; Evans & Kamler, 2005) in common with other vocational-type occupational groups (Lyons, 2002; Leonard et al, 2004), they displayed many similar characteristics to the general doctoral student population (Barnacle & Usher, 2003; Miller & Brimicombe, 2004). The participants were sited all over the *island* of Ireland. Four of the CNMFs were supervised outside of the state and 6 had a second nurse or midwife supervisor because their primary supervisor was not from the discipline. Participants represented all divisions of the An Bord Altranais register and were experienced nurses and midwives as per the eligibility criteria. On entry to the Fellowship, 2 were in clinical practice, one was a research assistant and 13 were in education, either university or hospital based. Within this latter group, one had previously been a research assistant in a non-nursing academic department and another was actively involved in team-based research. In addition, 12 held taught Masters degrees. Hence, the majority had some research ability through conducting a minor thesis (Drennan & Clarke, 2009) or being part of a research team.

3.3.6 Fieldwork Roles

My role as troika.

In ethnography the researcher is an integral part of the study (Hammersley & Atkinson, 1995; Brewer, 2000). The literature stresses the requirement to determine the position of the researcher by determining insider or outsider status. This tends to be written dichotomously (Bonner & Tolhurst, 2002; Borbasi et al, 2005) but the reality is more complex. There can be layers of identity (Leslie & McAllister, 2002) that determine status in a dynamic fashion. In this study, I took the stance of Blumenthal (1999) whereby I acknowledged the identities that inhabit my Self and took a troika[44] role. The sub-roles were NRA, researcher and self with the latter containing elements of self as doctoral student, and self as nurse/midwife/teacher.

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[43] One CNMF had both these issues.
[44] Group of three.

The emphasis of each of these sub-roles varied between and within the two fields where data were collected. Thus the sub-role priority was context specific and 'situational ethics' were utilised to adopt the appropriate insider-outsider stance for individual circumstances. The emphasis was also a factor in the type of observational role adopted in each field. These two issues – the impact of sub-role priority and changing the emphasis, will now be discussed in relation to each field.

Field of the Funder

In the Field of the Funder, I embodied the role of the NRA. This role was a challenge for me two years previously as a health research funding agency was a new culture. The role was a unique joint appointment and my commitment to the HRB was part-time and flexible. The role of the NRA itself, I felt, was perceived as somewhat unknown to my work colleagues. I was the only professional advisor in the organisation and my flexible, part-time joint appointment status was somewhat ambiguous. So whilst I was legitimately an organisational member and so an 'insider', the role of NRA was both formally and informally treated as marginal in the organisation. Whilst I certainly took part in the same activities as staff members, my role differed. It had both strategic and operational elements whereas many colleagues had operational elements only. For example, within one division I spanned the range of activities from initiation to evaluation of one scheme, whereas others held roles that dealt with discrete functions within that spectrum. An organisational map from an internal document showed reporting relationships of the NRA being a dotted line, as opposed to the solid line of others (Figure 3.2).

My role was also unique in spanning the two funding divisions. My part-time attendance could be viewed as similar to the 'teleworking'[45] of two other staff members. However, the fact that my off-site time was embedded in nursing policy and not HRB work meant that I was often quizzed both at staff meetings and informally about "the outside world" as if the NRA was a bridge with elsewhere. Hence, I regarded myself and was regarded by my colleagues as 'at the margins', a border inhabitant rather than a fully embedded indigenous member. My NRA diary entries illustrate this phenomenon and my reaction to the tensions it produced.

NRA Diary – First Impressions. *There is a certain sense of being a visitor to the organisation. Comments such as 'what brings you over to visit us?' were regular in the last two years. After approximately 18 months in the organisation and repeated comments on my*

[45] This allowed the individual to be off site but logged in to the communication systems. Teleworking occurred at least once a week for the individuals concerned.

'visits', I challenged one particular staff member with the statement 'I work here'. What may have been a personal joke for one person however, underlined a perception that others may also have had. For example, on two of the past three partnership days[46] management staff have asked would I be joining the activities and another staff member commented 'oh you're here then' when I joined in a Freedom of Information session. It appears as if no one assumes my engagement with the practices of the organisation.

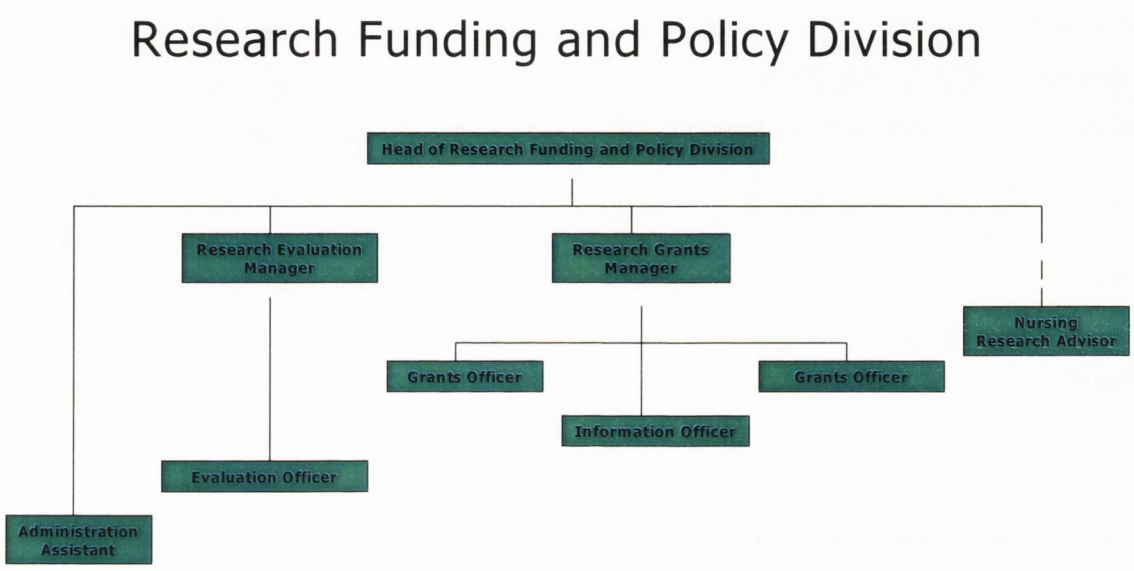

Figure 3.2: HRB Organisational Map

The NRA dominated in the Field of the Funder and Figure 3.3 attempts to portray the emphasis within the troika role. There were a number of reasons for this dominance. Firstly, congruence with the objectives of the study whereby the perceptions of the NRA are utilised in the exploration of the cultural context of Irish nursing and midwifery's development as a professional research discipline and its integration to the health research arena. Secondly, aware that the field was a temporal one whereby I undertake a role of researcher in addition to my role as worker over a set timeframe, and that my relationship with work colleagues had commenced and would continue outside of this temporary frame of data collection, I strove to minimise the disruption of my work relationship with them. I was eager to show that the research did not impact on how I conducted the role of NRA and I did this by ensuring that my NRA tasks took precedent. I was also receptive to the comfortableness of my work colleague peers, who whilst somewhat used to transient research students

[46] Partnership day is an annual event where management and staff spend a half day together discussing issues within the organisation. This is then followed in the evening by a social event.

undertaking summer projects, having a researcher exploring an aspect of unit work in their midst was a new experience. Murphy & Dingwall (2007) report that such actions are in the nature of ethnography and benefit the findings as representative due to non-distortion of the setting. Thirdly, the previously discussed issues of researcher sensitivity on colleagues' seeming willingness to participate and the meaning of a PhD influenced my researcher stance. The self sub-role had least emphasis in this field. My yearly staff appraisal was the only context where self as doctoral student was recognised formally. As previously mentioned, my colleagues did make informal inquiries as to my progress and I answered this from either my researcher or my doctoral student stance or both. However, blurring between these two roles was pragmatic and I felt did not impinge on any ethical stance. Whilst nurse ethnographers in the practice settings (Borbasi, 1994; Gerrish, 1997; Beale & Wilkes, 2001; Colbourne & Sque, 2004; Bailey, 2007) experience blurring of role boundaries, I experienced little such blurring between the NRA and researcher role, possibly because of the privileging that I gave to the NRA position. Between NRA and the self sub-roles of nurse/midwife/teacher blurring had always occurred and continued to do so during data collection.



Figure 3.3: Troika emphasis in the Field of the Funder.

In the Field of the Funder the troika emphasis meant that I adopted a specific role for the naturalistic observation. Brewer (2000:61) determines this as a variation of observant participation whereby an existing role is used to research an unfamiliar setting. The role of the NRA was broad and allowed access to and involvement with activities and events and to colleagues across the funding divisions and yet as previously discussed, its marginality allowed a certain detachment and strangeness. During the two years of recording NRA activities, the process of writing fieldnotes acted as self-consciousness of the researcher stance, and the stance I adopted necessitated discretion regarding when and how I recorded the fieldnotes (see 3.4.1).

Field of the Fellow

In the Field of the Fellow, the troika emphasis differed (figure 3.4); the researcher role was to the fore as much of the interaction with Fellows was during negotiated data collection sessions. However, there were occasions that called for the NRA role and I responded appropriately. For example, when Fellows asked me questions about HRB business and I gave guidance. When such questions were implicit, I commenced my answer with "speaking as the NRA..." so listeners would be clear what role I was based in for that passage. I had a similar background of age, professional career of practice and education and, in most cases, gender with the CNMFs. I was also undertaking a similar process of the PhD, if under the differing conditions of maintaining fulltime work. So whilst I did not experience some of the isolation[47] that the CNMFs mentioned, they did not necessarily experience the exhaustion I had of labouring with a demanding workload and undertaking the PhD. Thus the role of self played a greater part in this field due to the shared, previous occupational socialisation and simultaneous doctoral student processes. Any blurring of boundaries in this field occurred between self as nurse/ midwife/ teacher/ doctoral student and researcher.

In the Field of the Fellow the troika emphasis meant that in the observation sessions the role I adopted varied on a continuum from complete observer to complete participant (Hammersley & Atkinson, 1995) depending on the context. So as complete observer, I observed a meeting between a Fellow and their supervisor; I observed a Fellow presenting at a national, multidisciplinary meeting which focused on a specific, highly specialised area of clinical practice; as complete participant, I

[47] There was a sense that my workload meant I had an academic but not professional isolation. For example, I attended only two research seminars for PhD students as most clashed with work commitments.



Figure 3.4: Troika emphasis in the Field of the Fellow.

participated with some Fellows in delivering a symposium on the CNMF scheme at an international conference; and reciprocally I assisted a Fellow to set up a focus group and participated as a volunteer for a Fellow who was collecting scientific data from healthy human subjects.

3.4 Data

Others (McAlpine & Norton, 2006) have noted difficulty in researching doctoral studies as much of the process is hidden, therefore using a range of collection methods increases the comprehensiveness of the data. Tope et al (2005:479) in a systematic evaluation of 158 workplace ethnographies, showed that incorporating observation, rather than solely interview yielded more data and participant observation produced thicker description than either observation or interview. This section outlines the characteristics of the gathered data for this study incorporating a number of ethnographic methods and appendix 3.5 shows how this occurred across the data collection timeframe.

3.4.1 The Datasets

The Field of the Funder

The main data collected in this field was in the form of field notes and secondly, documentary analysis. My management of the writing of field notes reflected the role I adopted in this field (3.3.6) thus preventing reactivity and any change in practices of those with whom I worked. After 12 months and based on the burden of recording, I moved from recording the mundane "basic routines and daily rhythms" (Emerson et al, 1995:40) or the minutiae of the role of the NRA within the HRB, to recording events of significance only. I found this change remarkable; especially the release from feeling that I had to live my working day twice over as I replayed in my head scenes of social interactions from that working day. After 24 months, I stopped recording fieldnotes in this field.

These data contained 114 fieldnote entries. The corpus consisted of a chronological narrative including issues such as the use of space; general communication patterns, my work and self-presentation as NRA; my interactions with work colleagues and others; and snatches of dialogue related to nursing and midwifery and their relationship within health research. Also there were topics to be followed-up and my reactions and feelings about particular events. Thus the fieldnotes contained process memos, asides and commentary as well as description (Emerson et al, 1995). The style of fieldnote was somewhat 'distant' however, as if I was observing rather than participating. On reflection this was due to the constraint on fieldnote development of participating with a small team. To ensure confidentiality, I wrote the fieldnotes from the outset as gender neutral. I did not use individuals' names and tried where possible to avoid using role titles which would act as identifiers. Writing in this way meant that any of this anonymous data could be presented in the final ethnography.

Secondary data in this field consisted of documents for analysis (Table 3.3). The formal documents examined totalled 28 and covered to the end of 2005. There was one exception: a 2006 review of fellowship schemes of which the CNMF was a part. Thus some of the documents were historical and others concurrent to the data collection timeframe. Other written texts included were smaller items such as email signatures, agendas for meetings and CNMF annual reports.

Document type	Dates	Number
HRB Annual reports	1987-2005	19
Consultation Document – *Making Knowledge work for Health*	2000	1
A Picture of Health	2003-2005	3
Evaluation of the Research Project Grants Scheme	2004	1
Research Funding News	2005	3
Review of RFPD-funded Fellowship Schemes	2006	1

Table 3.3: Documents analysed.

The Field of the Fellow

The data collected in this field consisted of interviews and observation. Small amounts of documentary analysis focusing on identity work also occurred through publication searching, email signatures and reviewing conference programmes. In the main, I travelled to the data collection sites over the data collection period and this meant collecting data across the island of Ireland; there were a small number of exceptions and these are noted below. Data were collected at anytime between 08.00 hrs and 20.00 hrs Monday to Saturday. Whilst the planned data collection period was 24 months, due to researcher illness, collection episodes were cancelled and data saturation of a key moment had not occurred (see 3.4.3). Therefore I made the decision to extend data collection in the Field of the Fellow to 28 months. Forty eight episodes of data collection from the CNMFs occurred within that timeframe[48]. Eight participants participated in 2 or more data collections ranging from 2 to 11 episodes; from that a majority of 5 participated in 2 or 4 episodes. Over 85 hours of data were collected, divided between interviews and participant and non-participant observation.

Thirty-three pre-arranged, formal interviews (representing 31 hours of data) were conducted with the CNMFs across the 3 year time span of a fellowship. All CNMFs gave interviews. At the start of data collection, one interview was conducted with Fellows whose funding had finished (CNMFFs); the exception being that one CNMFF gave a second interview after the viva voce. For those on the Fellowship during data collection, the numbers then ranged from one to five interviews; this variation was due to CNMFs completing or commencing the Fellowship during data collection as much as their accessibility and willingness to participate. The time between sequential interviews varied from 5 to 12 months and in some cases was interspersed by observational data collection. The setting for each interview was negotiated and collaboratively chosen for pragmatic reasons such as accessibility

[48] CNMF1 (n=11), CNMF2 (n=15), CNMF3 (n=11) and CNMFF (n=11).

and timeliness. As such, I had little control on environmental issues such as interruptions. With the exception of 4 occasions when CNMFs chose to come to the HRB building, I travelled to the settings. As well as this, the variety of interview settings included the CNMF's own home (n=10) or workplace office (hospital, university or organisation) (n=9), and seminar rooms in CNMF's workplace or university or my own university (n=8). We also resorted to one interview being conducted in a car and one interview being conducted in an airport room! Interviews ranged from 25 minutes to two hours but the majority were of one hour's duration. Some interviews were especially scheduled to coincide with key moments for the CNMF based on the context analysis grid or when I deemed that the CNMF may be sensitive to a particular timely issue and could provide a vivid account. Other interviews were more a pragmatic 'follow-up' at a time and venue suiting both the participant and myself. Formal interviews at times included solicited and unsolicited observation of the CNMF's work setting, thus providing additional data.

A general interview guide in the form of a list of issues was developed for the formal interviews and used initially (appendix 3.6) to facilitate the interaction. The questions emanated from those delineated to address the study's objectives and focused on cultural issues of activities, identity and self perception, and social relations. To enhance the theoretical sampling based on the context analysis grid, the initial CNMFFs were also asked about key moments in the experience. In subsequent interviews with individual CNMFs the guide was supplemented by emerging issues. These were raised previously by themselves or other participants or were issues from observations. So, this dataset was not foreclosed by the initial questions posed. I attempted to allow participants to narrate without interruption as much as possible giving a free flowing style (Sorrel & Redmond, 1995). This meant digressions occurred at times and the interviews became unstructured. However, Jones (1996:51) notes the centrality of digression to "historical and cultural background, personal and organisational values, point of view and interpretation of events" and adopting such a greater openness "is fundamental in achieving a more viable sense of intersubjectivity" (Prus, 1996:20). As the interviewer, I 'patrolled' the digressions and brought participants back to the interview focus when appropriate using "Can I just bring you back to...?" I also used probes such as "Can you tell me more about... "or "What do you mean by..."? to ascertain greater depth of data. Participants were always asked if there was any additional information they wanted to contribute before interviews were concluded and some used this opportunity to make additional remarks.

In addition, scheduled observation in 15 episodes involving seven of the CNMFs yielded 54 hours of data. Diverse sites of observation across the island of Ireland, at times included informal interviews and with varied roles (see 3.3.6). When observing was the main aspect of the ethnographic role I managed to situate myself to ensure maximum visual range with minimum visibility to the CNMF, striving for unobtrusiveness and a reduction of any reactive effects to my presence. A secondary issue was the comfort of writing whilst observing. The level of writing during observation varied depending on the situation. For example, sometimes fieldnotes could be written as I observed a CNMF undertaking tasks such as research analysis or, when I was a full participant, jotting notes occurred immediately after the event and usually reflected the 'headnotes' I made during the participation. The management of writing fieldnotes in this field has been described in detail elsewhere (Condell, 2008) (Appendix 3.7).

Fieldnote content included issues such as the environment; the presentation of the CNMF with regard to dress, stance, use of title etc; interactions between the CNMF and others; and snatches of dialogue. Fieldnotes cannot record all that happens and the ethnographer selects aspects to be recorded. In these sessions I particularly focused on issues of identity construction, relationships with others, spatiality and temporality as well as noting anything that I thought unusual. Aware that my observational accounts represented what I saw during the session, my initial response to the fieldnote completion was to label and store the account. However, I was frequently asked what I had observed. Finding that a verbal report failed to satisfy, I started to email the observational accounts to the individual CNMFs before storing with the proviso that this was a record of what I had seen and was therefore not for editing beyond changing items for confidentiality purposes. However, additional comments were welcome or suggestions for an aspect that the CNMF would like to see reported in the account. The CNMFs expressed surprise at the level of detail recorded and the lack of their own knowledge in relation to some of this detail. In some cases, additional comments of non-observable issues such as feelings were made by CNMFs. Such comments were kept as italics in the account to differentiate the statements from my own.

Researcher Diary

An additional dataset developed from the outset of the study to address the reflexive element of the study. I used a researcher diary to record issues within the research

process and throughout this account I have selected extracts to illustrate experiences from the field and substantiate and justify the grounds on which claims are made. This dataset also contained diary recordings of self as doctoral student (Appendix 3.8).

3.4.2 Data management

Each piece of datum collected was given an unique file label: for the Field of the Funder this reflected the source (NRA diary, document type) and for the Field of the Fellow it reflected the stage of the CNMF and the method and date of data collection[49]. The interviews were transcribed verbatim by myself as close as possible in time to the event. This enhanced rigour as it removed the opportunity for outsider interpolations or censorship to occur (Lane, 1996). Some sections, which initially were incomprehensible, were repeatedly replayed to activate my own memory of the actual words spoken. When even that failed, the text was marked as incomprehensible. Any potential identifiers were highlighted within the text and at the end of the transcript a table of these potential identifiers and researcher-generated descriptors was formulated. By agreement, I emailed the transcripts to participants within a 2-5 week time frame to allow for verification and agreement of descriptors. At this stage, some participants made minor tidying changes, answered questions of clarification I had inserted in the transcript, or inserted comments to cover incomprehensible sections. Participants also highlighted any text that they did not wish included in the analysis. Any changes made by participants were accepted. Before storage, data cleaning occurred. This consisted of correcting typographical errors, removing the agreed omissions, and inserting the agreed descriptors for the potential identifiers.

3.4.3 Data Analysis

In keeping with the research aim and methodological stance adopted, the complementary Glaserian grounded theory approach was used for data analysis. However, this was grounded theory principles rather than prescription and so featured some pragmatic modifications. Johnson (1997) and Holloway & Todres (2003) argue that modifications and flexibility are defensible if undertaken in a reflexive and explicit manner. Grounded theory, originally conceived by Glasser & Strauss (1967), aims to generate an inductive theory from data and thus its use can move the data forward from ethnographic description. Charmaz & Mitchell

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[49] Section 4.4 details the labelling system.

(2001:161) describe a beneficial synergy between ethnography and grounded theory: for ethnographic studies using grounded theory techniques, there is enhancement of "the analytic edge and theoretical sophistication". Grounded theory analysis is firmly rooted in and emerges from an early critical engagement with data.

In this study, one modification of the grounded theory approach was in relation to reading the literature. The recommended delay of engagement with literature (Glasser, 1998) to allow inductive data analysis is problematic if ethnographers are to 'foreshadow problems' (Delamont, 2007; Hammersley & Atkinson, 1995). In my case much of the specific research capacity building literature related directly to my employment as NRA and therefore I could not approach the study with a *tabula rasa*. Instead, as recommended by Morse (2002), I undertook a formal concept analysis to deconstruct the phenomenon. This, with other reading (section 1.5.3), showed some existing models but no common theoretical framework on which assumptions of research capacity building were based or from which a deductive analysis could be sought. Given my own grounding in the area, it was not possible to have an 'a-theoretical stance' (Cutcliffe, 2005:224). Instead I had theoretical sensitivity and approached the analysis with some 'bare bones' of provisional understanding (Morse, 2002) and literature that suggested tentative lines of inquiry on which to construct an emergent theory. Likewise, many of my participants were potentially informing me from a theoretically sensitive stance.

Grounded theory has three central premises, which aim to guarantee that theoretical concepts are generated from the data themselves and not researcher imposed (Glasser, 1998). These are constant comparison, theoretical sampling and theoretical saturation.

Constant comparison refers to comparing data with data and emerging categories from the outset of the fieldwork. This implies sustained movement of the researcher between data collection and its analysis. Concurrent data collection and analysis is also a feature of ethnographic practice, although perhaps less formalised. In my study, engagement with the data occurred simultaneously with its collection as I transcribed interviews and composed fieldnotes of observations. This allowed a close examination of this data set with the notation of initial ideas that guided further data collection with the same or other participants. Formal coding commenced approximately ten months into the data collection period and proceeded slowly, reflecting the heavy burden of data collection and researcher transcription of

interviews when combined with a full employment load. An initial sectional coding on all interview transcripts, observation fieldnotes and documents was manually conducted, the latter to allow contextualisation. Marginal codes were handwritten onto hard copies of the data. 'In vivo' codes from participants' own discourse were utilised, where appropriate, allowing data to speak for themselves. A second 'blind' coding was then conducted using the software package 'Ethnograph V5'. This was of a more dense nature than the sectional coding (Appendix 3.9) using 'in vitro' codes. Whilst its purpose was mainly data retrieval, the two code sets were cross checked to ensure 'completeness' of coding. These steps, alongside the initial engagement of transcription and writing memos facilitated 'immersion' in the data. Such 'immersion' however, was not the ideal of an intense stretch of time whereby the sole cognitive focus is on the tangible data. Instead the 'immersion' consisted of more than four years whereby I moved between the study data and my 'self' world. Full time employment with stretches of travel meant that sometimes I was away from the data for a number of weeks and transcripts, codes and memos had to be reread repeatedly on return.

Interrogation of the data also occurred by writing analytical memos from the data throughout the process. Following Glaser's ideas (1998:177), these were not written using a prescribed framework but were "free and emergent". They could be categorised into early and later memos (Appendix 3.10). Early memos tended to be short and were recorded in notebooks or 'Ethnograph'. They showed initial ideas of codes and incorporated questions of the data or indicated areas for further probing. Patterns in the data were sought; for example, data from the Field of the Fellow were examined in yearly sets and memos created to reveal similarities or differences across the time phases of the Fellowship. Later memos were recorded in 'Word' files. They displayed the development of my thinking beyond the description of codes and their properties. They attempted to show integration between codes and emergent categories and between categories, culminating in diagramming the theory.

Theoretical sampling is the second key premise in grounded theory. Here the preceding data analysis dictates what and where to gather subsequent data. Thus specific data are sought in order to fill gaps, elaborate analysis or ascertain variation (Charmaz & Mitchell, 2001) from the data already collected and is therefore a purposful rather than random development of the data. A second modification to grounded theory occurred here as theoretical sampling did not dictate the totality of data sampling. In ethnography, sampling within case guides the researcher to

sample across time, people and contexts. So the context analysis grid was formulated prior to the fieldwork to guide initial data gathering. It focused on mainly social interaction as this was an ethnographic foreshadowed problem. Theoretical sampling was then used to enhance this guide, once in the field. For example, at the start of data collection, initial interviews with CNMFFs identified the 'freedom' of time flexibility, an issue that did not arise from the grid. I then explored time 'freedom' with active CNMFs, yielding dissonant and accordant properties. Interview content sensitised my subsequent observations and *vice versa*. For example, unsolicited, one CNMF described incorporating nursing communication skills into their data collection. Consequently, as a volunteer of that study, I noted additional nursing skills.

F2O912 (89-95) ...the CNMF touches my foot whilst asking is it getting cold – I note it as a nursing action, not depending on simple enquiry to answer a clinical question but using touch and nursing expertise to assess my foot's temperature.

Theoretical saturation is the third premise of grounded theory and means that the generated categories are filled with data and that no meaningful ideas surface from engagement with more data (Charmaz & Mitchell, 2001). In practice, this point in the grounded theory process is problematic and noted as unclear (Charmaz & Mitchell, 2001) and imperfect (Brewer, 2000) as it is theoretically possible for further negative cases to occur and thus revise the theory being generated. For Brewer (2000:153), theoretical saturation occurs when the ethnographer "is confident that they have searched strenuously for groups or settings that stretch the code by looking with integrity for as diverse a data set as possible". Within this study, examples of theoretical saturation decisions include the extension of fieldwork to gain CNMF perspectives on the ritual of the viva voce and the more focused fieldnote recording of the NRA diary in year two.

3.5 Operational Issues

Some additional operational issues arose throughout the study. Two of these concern relationship work and relationality, the explicitness of which are important to enhance rigour (Hall & Callery, 2001). This outline offers further detail to that already given in previous sections.

3.5.1 Peer Relationships

Any ethnography requires relationship work and in this study, there were some specific issues because of peer relations. Firstly, relationships required development in both fields and at the outset of the study this varied from initiation to progression.

In the Field of the Funder, I had to progress existing work relationships and initiate relationships with colleagues as they joined the organisation (see 3.3.6). In the Field of the Fellow at outset, 3 participants were acquaintances whom I would recognise from professional arenas and would acknowledge and converse with, 5 participants I had previously worked alongside for varying timeframes and different levels of tenuousness, 2 participants I counted as social friends and 8 participants were unknown to me prior to the study. Initiating relationships is described in section 3.3.3 as the formality of accessing the field. However, informally I had 'sounded out' my two friends as to their willingness to participate and stressing that I did not have any expectation that our friendship would require a positive response to the formal approach. Over the timeframe in the field I also had to maintain relationships and this was done by sensitive communication, reciprocity and managed self disclosure.

Most of my communication with Fellows related to two types. Firstly, it occurred about the practicalities of participating in the study, such as arranging data collection sessions or post-session follow-up. Here, I was sensitive to not wanting to seem over zealous and so tended to give temporal space, as well as giving receptive acceptance of decisions. I mainly used email in preference to telephone communication so that considered rather than immediate responses could be given by Fellows to any requests I was making. In contrast, when communication was initiated by the Fellow, they tended to phone me on my mobile phone.

RD 23/8 *I emailed a CNMF3 and a CNMF2 almost four weeks ago asking if it would be possible to do some data gathering with them. I've not had a reply since and am unsure if this is because both are mothers with children and have taken some time out during school holidays or maybe the CNMF3 is busy writing up and can't afford to give me any precious time from that process. Regardless, it is frustrating, especially since being a part-time PhD student my opportunities for data collection are quite restricted.*

RD 9/10 *I contact a CNMF1 about doing an observational session at an event which she is co-ordinating as part of her research. She replies 4 days later saying she would prefer not to be observed as "I will probably be nervous enough so if its ok could I opt out?" I reply in the affirmative. Ten days after the event I 'drop' her an email to ask how it all went for her. She replies fifteen minutes later to say it went well and she would supply me with some of the documentation that she used.*

Secondly, communication to enhance rapport occurred – an essential if neglected topic in the ethnographic literature (McGarry, 2007). Here, information was sent as reciprocator communication, such as sending conference or funding scheme alerts that may be of interest to their individual focus. In some cases, I linked Fellows up with other researchers with similar interests. Fellows themselves responded in seeking and giving reciprocity.

RD 29/6 *I receive an email from a CNMF3 asking how to access a report I had written for the Commission on Nursing. She wishes to write a short piece on developments in Irish nursing and midwifery but does not want to get "bogged down"... I also send her 2 additional references of published papers which may be of some help.*

RD 27/1 *I am walking out of a university building with the CNMF1 that I've just interviewed in which I've been told that the fellow is transcribing some of the interviews that have been conducted as part of data collection. I ask if she uses a machine to slow the tape and she looks at me quizzically. I describe the memo scriber and the advantage that the foot pedal use means that fingers do not have to leave the keyboard and thus speeds up the transcription process. She says she did not know that such a machine existed although someone who had been doing some transcribing for her did mention a foot pedal. She asked where she might be able to get such a machine and I suggest an office supplies shop. I promise to send her a text with any details of the one I use.*

Managed self disclosure occurred, mainly self-effacing (Allen, 2004) and focused on negatives aspects of my own research process such as issues of research skill development and the rhythms of doctoral work. These were issues that my peers could identify with and confirmed my 'sameness' with them.

RD8/8 *I receive an email from a CNMF3 with a contractual query. I redirect her to the Grants Manager. She tells me she has completed reading the transcript and is happy with the descriptors that I've developed. I thank her for her input and mention my embarrassment at developing interview skills when re-reading a transcript. She replies with the title of a book which she is currently reading and finding very useful.*

RD16/3 *It is 3 months since I've been in contact with this CNMF1 but that has been quite deliberate. I know that she has a transfer hurdle of MSc to PhD and I consciously was giving her the space for this. Her voice is a little quizzical at first until she knows it is me; then she replies warmly "How's it going?" I lament my perceived inability to recommence my own study after my holiday. The CNMF1 acknowledges this experience. Her deadline for transfer is the end of the month "but there is no concrete guidance. I feel when I get this over, I'll know what I'm doing, whether an MSc or PhD or whatever". I try to offer reassurance. "It may be a case of just being a formality, after all you're being funded by a national agency". "Yeah, maybe" she replies. I outline the sort of content that is required in annual reports to show progress – training undertaken, pilot completion, recruitment into study and point out how she has achieved in these areas. We agree a day to meet and she laughingly closes the telephone call with "Now get off those ski slopes and get that brain going again, Sarah".*

In essence, I utilised 'friendship as method' (Tillmann-Healy, 2003) for this relationship work. That is not to say that I developed close, mutual and lasting friendships with all participants, but that I took the stance of working ethically by respecting them as individuals, and honouring and wisely using their contribution to my study (Tillmann-Healy, 2003). As appropriate, strategies akin to feminist ethnography (Skeggs, 2001) were also employed: minimising power differentials, giving opportunity to enhance participant control and reciprocating with information. To an extent such strategies were already intrinsic because of the peer relationship. In both fields, I had greater rapport with some participants than others and relationship work was easy. For others, it required more effort on my part and when combined with the specific role adopted in each field, impacted on the level of

collaboration that ensued (Condell, 2008). As such I worked towards gaining "close familiarity" with the participants' worlds (Blummer, 1969:37).

Others have explored the issues raised by interviewing professional peers. Peer interviews inevitably are framed by past and ongoing relationships (Platt, 1981; McEvoy, 2001). Whilst in this section I have described aspects of previous and study relationships with Fellow participants, I have found that subsequent encounters have prompted mutual responses as researchers at varying career stages. Interviewing peers can impact on the quality of data received with a propensity "to avoid stating the obvious" (McEvoy, 2001:53) sometimes in an effort to reach the point swiftly (Platt, 1981). When this occurred it required active management on my part by asking for clarification or seeking expansion on some points. On reading the resultant transcripts, I judged that I did not always achieve this, resulting in thin explicit data at times. However, theoretical sensitivity implies that I had an awareness of the underlying meanings because of my personal peer experiences.

3.5.2 'All is data'

The "well known Glaser dictum" (Glaser, 2001:145) of "all is data" required careful consideration of legitimacy (Platt, 1981) and demanded ethical sensitivity on my part. For example, some biographical information was not actively sought but previously known or implied within the data collected. Inclusion of how Fellows identified themselves in the public domain, such as on conference posters or in publications was included for comparison even when not explicitly consented for. In addition, my 'personal experience' of self as doctoral student as recorded in the researcher diary (appendix 3.7) added theoretical sampling, category saturation and data verification in addition to acting as a contrasting sounding board to data generated from the CNMFs.

3.5.3 Developing Trust

'Friendship as method' is also dependant on developing trust within the peer relationship. One trust issue is the confidentiality of participation and data. Since participation was confined to a small number of participants, confidentiality preservation was paramount. I applied the usual standards such as non-revelation of participants in conversation. The following precautions were taken in data management: creating agreed identifiers for individuals, institutions, domains of knowledge and practice etc.; using a code to denote the stage of the Fellowship rather than an individual; broad terms to denote roles in the HRB Field; the use of

gender neutral terms wherever possible. One tension that arose on confidentiality was the anonymity of the midwife participants who did not wish to be identified by the generic term 'nurse'. However the small number of midwifery participants meant that using the term 'midwife' meant a greater chance of recognition of individuals. This was managed by returning to the midwife participants with their quotes utilised in the final report and gaining their agreement on the terms to use.

3.6 Assessment of the Study (1)

Criteria for evaluating research show wide variety and debate. Whilst numerous lists, composite or otherwise, of assessment criteria have been generated for ethnography (Hammersley, 1998), qualitative data analysis (Lincoln & Guba ,1985) and grounded theory (Glaser, 2001), this chapter has endeavoured to follow Brewer's good ethnographic practice of establishing researcher integrity and data authority by reflective explicitness of the fieldwork and data. Considering the philosophical stance and methodology adopted and the use of the principles of grounded theory for analysis, the criteria selected for evaluation were those of Charmaz (2006); credibility, originality, resonance and usefulness. I would contend that two criteria, those of originality and usefulness are best discussed once the theory has been detailed and so are explored in Chapter 4. The remaining criteria are explored here, only in so far as details not previously reported (3.3-3.5).

3.6.1 Credibility

Credibility of the data was sought through prolonged engagement gaining familiarity in both fields. In the Field of the Funder my somewhat limited previous exposure to the NRA role meant that a high degree of 'strangeness' to the organisational culture remained at the start of the data collection. Such positioning, in addition to the keeping of a concomitant researcher diary for descriptive and reflexive accounts of the researcher role as opposed to participant fieldnotes, assisted in maintaining analytical distance throughout the data collection period and prevented a 'going native' development. A second data source in this field was the documentary analysis supporting some findings. In the Field of the Fellow there was the aforementioned researcher diary (3.4.1), member checking of all interview transcripts for accuracy (3.4.2), cumulative interviews with the same participants over the timeframe of the data collection and asking for comparisons with others' experiences (3.4.1). In addition, there were observational data allowing triangulation to support and compare findings. Theoretical sampling, as previously described, also enhances credibility. Credibility of the analysis was also sought. In addition to constant

comparative analysis as described, two code sets were developed blindly and then compared (3.4.3) by myself as the researcher and peer debriefing also occurred, whereby the supervisor independently blind coded 3 transcripts from across the range and then agreed the codes. The supervisor also obliged me as the researcher to account for the emerging themes, as did the aforementioned memo writing. The categories once developed were checked against contemporary literature.

3.6.2 Resonance

To check for resonance, once the theory emerged, an outline and its diagrammatic representation were presented to three CNMFs[50] and a participant from the Field of the Funder. This detailed the core and subcategories, their properties and relationships. Responses indicated that participants could relate to the theory easily and that it "makes sense". It encapsulated their experiences of RCB in an holistic and original way and yet gave them new insights - "I never thought of it in that way".

3.7 Limitations of the study

This study was conducted from the perspective of nursing and midwifery. Being a nurse or midwife gave me (and the CNMFs) an identity framework for interpreting experiences (Colbeck, 2008) and the NRA role dominated in the Field of the Funder, both as my explicit choice and by being positioned there by colleagues. Therefore, rather than attempting the unmanageable elimination of such positioning, assumptions are made explicit and critiqued; whereby "keeping an open mind" as opposed to achieving "an empty head" (Mantzoukas, 2005:291) was utilised to produce a reflexive account and an 'emic' substantive theory of RCB.

Given the context, this ethnographic case study necessarily focuses on relatively *new* researchers undertaking PhDs as the unit of analysis but I acknowledge that capacity building is a dynamic process and so can occur throughout the research career trajectory (Gordon, 2005). Likewise, as the PhD is an individual endeavour, I acknowledge that RCB can occur through programmatic team research (Hallberg, 2006; Edwards, 2008)

3.8 Conclusion

After detailing the specific aim of the study, its objectives and the foreshadowed problems that emanate, this chapter reflexively elucidates the methodology, fieldwork

[50] These were selected to show variety in the number and stage of data collection events: CNMFF (n=1), CNMF2-3 (n=11), CNMF1 (n=4)

and data analysis undertaken to operationalise the study in an ethical manner. Some operational issues are outlined before details are given of mechanisms to address two evaluation criteria and the study limitations.

Chapter 4: An Overview of the Theory

4.1 Introduction

This introduction outlines the theory that emerged from this study and acts as a preface to the findings. Following on from the previous chapter, it then details the two remaining criteria for evaluation before finally adding some notes for the reader. Overall it provides an explanatory guide for the reader.

4.2 Theory outline

Figure 4.1 shows a representation of the theory: the core and supporting categories, their relationships to each other, the cross-cutting themes and the context.

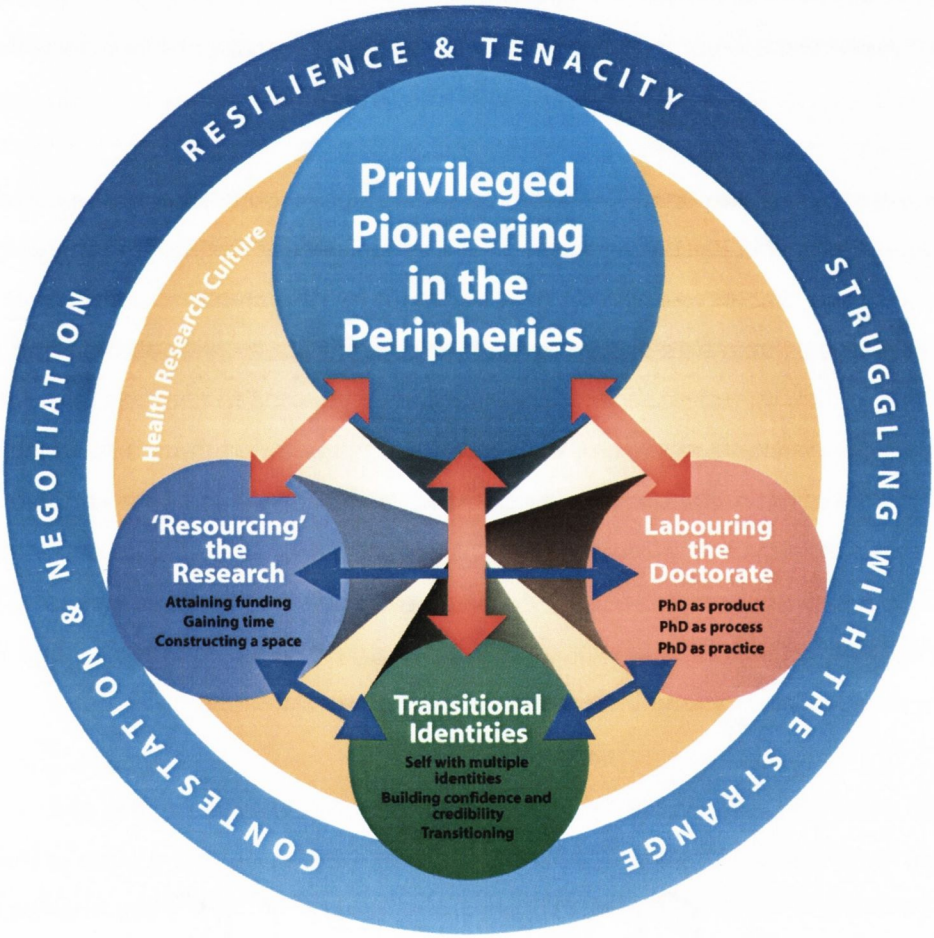

Figure 4.1: The substantive theory of RCB in the emerging disciplines of Irish Nursing and Midwifery.

For Glaser (1998:115) the core variable is "the prime mover of most of the behaviour seen and talked about in the substantive area... what is going on". In this study the core that emerged from the data was that of privileged pioneering in the peripheries. In keeping with the research aim and objectives (3.1) the three peripheries identified were those associated with research and health research but I do acknowledge that other peripheries could exist[51]. One periphery refers to the place of Irish nursing and midwifery research in health research culture, at policy, academic and individual levels. A second periphery refers to the distance between many of the CNMFs and any formal research culture. A third periphery experienced by some CNMFs was the peripheral disciplinary nature of their chosen topics.

Privileged pioneering is the activity and behaviour of 'elite' nurses and midwives (the CNMFs and the NRA) in two fields – Field of the Funder and Field of the Fellow, *within* the specific temporal context. For CNMFs being funded to undertake their doctorates on a full-time basis gives public knowledge of their privilege with resultant tensions on the legitimacy of their labour and imposed obligations; for the NRA, privilege consists of the uniqueness of the role at operational and strategic level. Pioneering behaviours included taking risks, initiating new ventures, identifying opportunities and acting as role models. The nature of pioneering means that tenacity and resilience was shown in the face of contestation, negotiation and the isolation from being marginalised. The pioneers, with varying degrees, struggle to forge a space in health research that is already occupied by others and which, to the new and somewhat naive entrants, is unknown or 'strange'. The core variable of privileged pioneering in the peripheries was supported by three linked subcategories: 'resourcing' the research, labouring the doctorate and transitional identities[52]. The subcategories, whilst discrete entities, were dynamic and interconnected and Figure 4.2 shows examples of how they relate to each other.

In 'resourcing' the research the pioneers attained funding, gained time and constructed a space. Attaining funding meant undergoing or, in the case of the NRA, supporting a competitive process. This required preparation and performance in which the CNMFs displayed resilience and tenacity. It gained for the CNMFs the mythical 'luxury' of a bounded 'flexible' time 'being off' that they had to guard against loss.

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[51] For example, the position of certain branches of nursing to others.
[52] Their properties are delineated in Appendix 4.

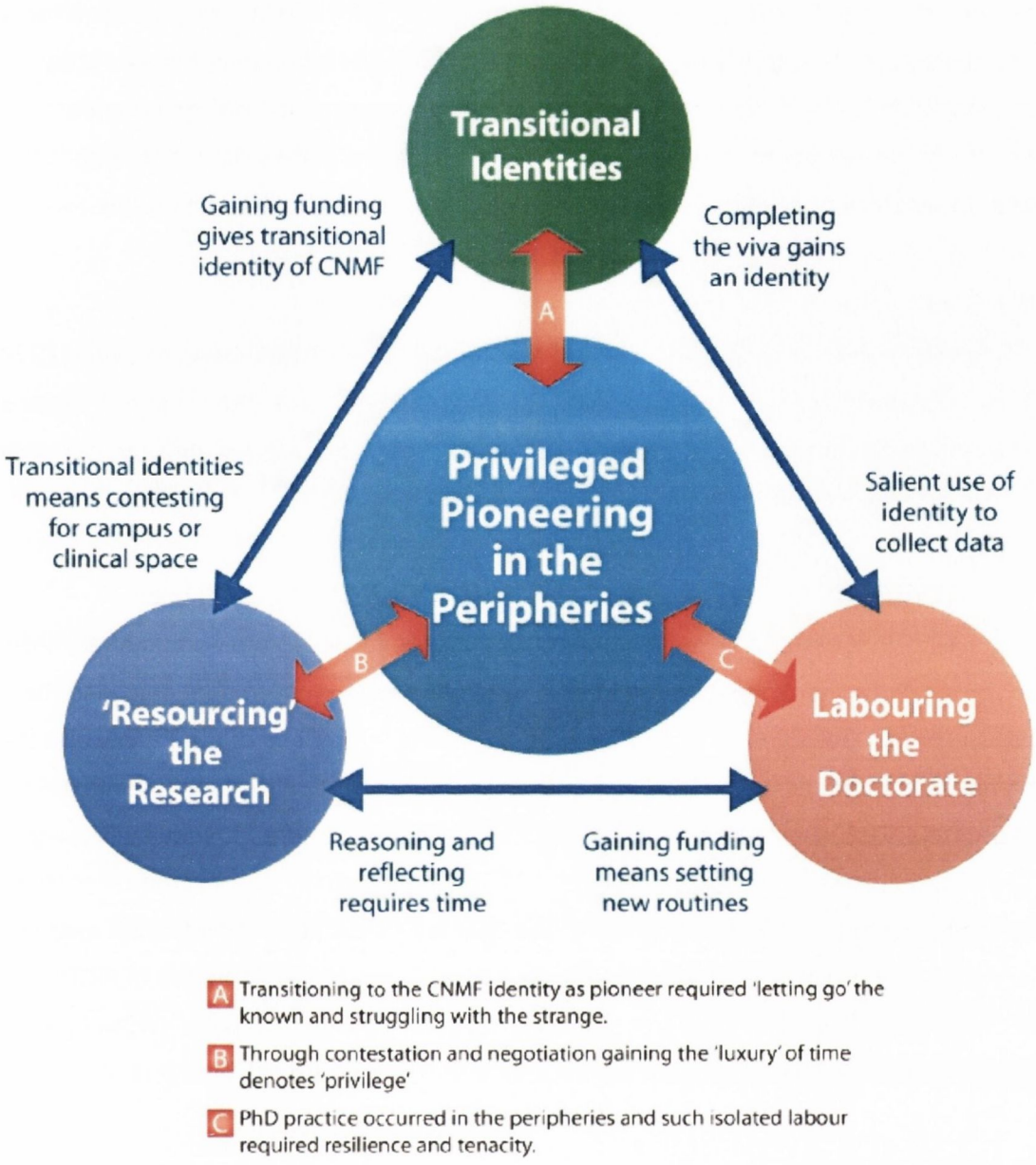

Figure 4.2: Examples of interconnections between categories.

Constructing a space in which to labour meant identifying the optimal environment and equipping this, not just with labour tools, but also with motivational visual prompts and scholarly symbols. In both fields, space was often contested requiring negotiation. In labouring the doctorate the CNMFs work through the processes and practices of the PhD to develop an understanding of, and achieve the PhD as a product, all the while labouring ethically and struggling with the unknown and strange. It entailed developing the skills required and attempting to keep on track, building new routines and managing pace. The CNMFs had to champion the work in and out-with formal rites of passage. In transitional identities the pioneers have multiple identities of self as CNMF, as doctoral student, as nurse or midwife and as

person, and the NRA as nurse, researcher, visitor or HRB agent. They manage these identities saliently with the pertinent identity to the fore in differing contexts. They build confidence and assemble credibility in the identities by 'doing', sometimes overcoming feelings of 'impostorship'. The identities are in transition requiring adjustments such as 'letting go', 'not belonging' and 'contemplating the future'.

4.3 Assessment of the Study (2)

The evaluation criteria of credibility and resonance have already been explored (3.6). The evaluation criteria of originality and usefulness are best judged against knowledge of the findings and so are detailed here for the reader after the overview of the substantive theory.

4.3.1 Originality

The theory that emerged from this ethnographic study adds to the corpus of work on RCB and is the first such study in Ireland. It offers a novel way to conceptualise the RCB process that is informed from two perspectives – the Field of the Fellow and the Field of the Funder. It embeds RCB activity in a socio-cultural-historical context (Cumming, 2010) and portrays its complex and dynamic nature. It shows diversity from the policy assumptions contained within a heretofore hegemonic model of RCB in 'health research', not just in terms of the characteristics of the CNMFs but also in terms of their practices and array of relationships. Many of the attributes of RCB (Condell & Begley, 2007) have been shown to have an empirical base and unique elements such as constructing a labour space have emerged.

4.3.2 Usefulness

The substantive theory has policy and practical relevance, nationally. It will form the core of a summary report to policy makers in the Department of Health and Children in particular to examine its recommendations (Chapter 9) for both health research and nursing and midwifery policy. It will also form the core of a summary report to the HRB that will be presented to staff and Board so that issues of importance will be examined with a view to changing HRB practices. However, the substantive theory also has more extensive scope. The World Health Organisation (WHO, 2009) has recently set the global standard for the professional registration of nurses and midwives at graduate level requiring research capability and faculty with scholarship skills. This implies RCB will remain on the global nursing and midwifery agenda as other nations strive to meet these standards. Recently in the UK, funding has become available to build *clinical* academic capacity in nursing, midwifery and allied

health professionals (UKCRC, 2007). Also, as Neumann (2003) notes nursing and midwifery is not unique in that other disciplinary fields have novice status in doctoral research. Hence the substantive theory of pioneering in the peripheries is likely to have importance in other RCB contexts. In addition, the theory has resonance beyond its empirical base that focused on research and could be applied to 'capacity building' in new areas. For example, the theory could speak to capacity building for advanced nursing or midwifery practice.

4.4 Some reader notes.

The chapters of findings that follow commence with the supporting categories of 'resourcing' the research (Chapter 5), labouring the doctorate (Chapter 6) and transitional identities (Chapter 7) before describing the core category of privileged pioneering in the peripheries (Chapter 8). Throughout the chapters labelled data are used to illustrate the points being made. Quotes from the Fellows are proceeded by the code CNMF followed by the year of funding (1, 2, 3, F(inished)), method of data collection (I = interview, O = observation), and day and month of collection. Quotes from the NRA diary are expressed as fractions (e.g. 13/10) representing the date of collection. In vitro words or terms have double quotation marks and are assigned to the Fellow; those generated from interpretation have single quotation marks. The removal of extraneous words is marked by three dots (...) and italicised words in brackets are researcher generated to improve clarity for the reader.

Chapter 5: 'Resourcing' the Research

F1I309 *(162-165) this Fellowship is like a life line to you... It becomes personal because it's like a lifeline...*

5.1 Introduction

Supporting the core category of the theory is the sub-category of 'resourcing' the research (Figure 5.1). The data supports the findings of Condell & Begley's (2007) review in showing funding as a fundamental attribute of RCB. Two other elements

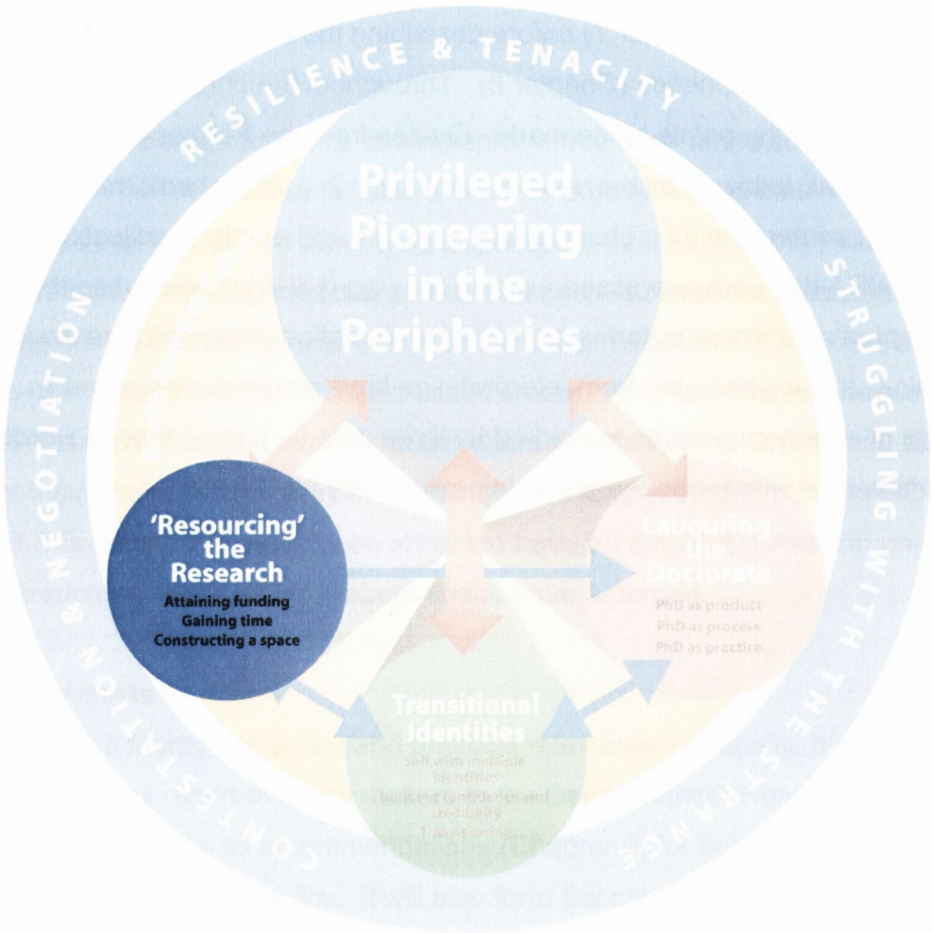

Figure 5.1: The subcategory of 'resourcing' the research in the theory.

emerged to produce a triad of resources; funding, time and space pertaining across both data fields. The elements were interrelated and also impacted on the other supporting categories of transitional identities and labouring the doctorate. The

category of 'resourcing' the research shows research as a contested site, with all three elements of the triad subjected to contention producing tensions. This meant the CNMFs needed to display tenacity and resilience in the face of struggling with the strange.

5.2. 'Resourcing' in the Field of the Fellow: Attaining Funding

The CNMFs showed awareness of funding as competition. They recognised, for themselves as individuals and for nursing and midwifery as nascent research professions, that learning to accept competition and critique was required.

F1I309 (126-134) I put all this work in and then I met loads of people (*at a grant writing workshop*) from different areas... looking at me as if to say "What's your problem? ...I've applied five times... for different grants..." So I thought "well actually it's quite normal" (*to fail*).
F2I2810 (1293-1302) ...we're not used to... applying... we started applying as groups for bursaries and the disappointment in us when we didn't get them. Now... we're starting to see that this is par for the course... (1393-1394) ...we've just got to learn to not be so sensitive about our egos.

As applicants are rivals in the funding contest this establishes winners and losers; chances and odds; strategy and tactics and the CNMFs' description of the process is peppered with the discourse of contest. Not all, but many of the CNMFs have knowledge of their competitors as friends or work colleagues. This sets up individual professional rivalry scenarios that the CNMFs must deal with interpersonally. The potential for professional competitiveness also emerges when CNMFs consider their individual clinical specialities within the heterogeneity of nursing and midwifery. For some CNMFs 'working out the odds' is part of the process.

F1I511 (791-799) Others... who I knew had applied and didn't get short-listed and they were... disappointed obviously for themselves and one kept giving me even digs for quite a while afterwards and I thought "get over it"...
F2I1211 (305-310) ...though I was in a nursing department and had great contacts... it was very difficult to find out how many people were going for interview.
F1I271 (749-754) ...there is a competitive streak... everyone is aware of that. I was blessed because people just knew I was not a lecturer so I wasn't competition to anybody.

From personal knowledge of competitors, the CNMFs sometimes judge their odds of success although not always accurately - a "fifty-fifty chance" (F2I2810); the real success rate is approximately twenty per cent. In addition, the numbers of applications to the scheme vary year on year, yet CNMFs seem to sense that large numbers apply. Regardless of the application numbers, being a competitive process, the CNMFs were inclined to measure themselves against others.

F3I2311 (1483-1492) ...a girl (*previous different grant holder*) told me... that she had gone for it... I thought "she would have been bound to have got it". I couldn't believe it when she didn't... At the time I thought... "oh I got it because (*details omitted*)... I couldn't believe it when she (*the unsuccessful applicant*) didn't so I felt a bit better about it then.

It was perceived by CNMFs that the chances of success might rest on the chosen topic area, especially if "juicy" (F1I23) and on project feasibility and not a "save the world" study (FFI911). In addition, the competitive rhetoric can be seen in the references to 'luck' (n=4) in the process.

F2I2810 (1205-1215) ...resigned to the fact that ok you may not get this... it may not be because the proposal is not good... it may be just that someone else has an angle that they are interested in at that particular moment in time that feeds more into policy... their whole strategy... where they want to bring nursing research...
F1I309 (98-114) the first time was the worst because I had gone with this big study.... I knew I was out of my depth... you're a complete novice and you've taken on too much.
F1I23 (731-733) I felt it was a good proposal and (*my supervisor*) thought it was very tangible. It was something that was doable. (590-595) but everybody who goes for interview... has reached a standard to be considered good enough for interview but then there's a bit of luck there too.

The nature of funding means that the CNMFs are willing to invest great time and effort into the application process, basically 'throwing everything at it' or "pull(*ing*) out all the stops" (FFI911). Being successful at securing funding involves making a good quality application that following peer review is deemed to have reached the necessary standard for short-listing. A shortlist is drawn up of the top scoring 7-8 individuals who are then subsequently invited for interview by a HRB panel. Whilst some CNMFs (n= 5) displayed doggedness in the competition for obtaining funding by repeatedly making applications year on year until successful, others (n=11) were successful with their first application. They conveyed surprise at their achievement as multiple applications were perceived as the norm.

FFI2510 (1009-1020) I thought it would be really good for me to try for funding... it was kind of the first rung of the ladder that I'd try this one (*application*), and see how it went, get experience doing it and then, next time, I would do better... I'd be ready.

Repeated application and applying to other funding agencies or schemes[53] when available were viewed as strategies that increased the odds of success. The feedback from a failed application was used to refine subsequent applications, and to "sharpen up" (FFI2710) the proposal. One CNMF suggested that feedback would be more comprehensive if it included comments on the interview performance.

[53] Four CNMFs reported successfully gaining funding from An Bord Altranais, utilising it prior to being awarded the HRB Fellowship.

F1I309 (87-91) I feel I've an edge above my colleagues because I've learnt a lot more about grant writing than people who would not have gone through the process three times. (186-193) The feedback was well worthwhile... at first it's not very easy to look at it for a while, you've got to wait until you're able to... when you do read it you begin to see and you can pull up on the next proposal.

Additionally, researcher or supervisor assistance with the application was viewed positively. Supervisor input to the applications appeared to vary from minimal input, to editing the application, to developing the project design.

F3I2311 (1506-1520) Somebody who was successful... said "Get... people who are... into research to look at your application" ... So I spent time with... 2 quite senior people spoke to them about it, got them to look at my presentation, changed, took on board everything they said...
F1I1512 (597-609) ...the year before (*when failed at funding*) I had very little support... I had nobody really... a friend helped me and an academic... Whereas this time I felt "well you've got your fees so..."
F1I23 (369-374) I spoke to (*the supervisor*) when I was wanting to put the project together on what my ideas were and he very much helped and supported me... It wasn't just he arrived at the end.

Obtaining funding involves negotiating a rite of passage as short-listed applicants attend an interview. Being short-listed holds meaning, although this was not necessarily recognised by the CNMFs.

F1I511 (783-790) One of the colleagues in the hospital... I was telling him. He was so thrilled because he knew exactly what even being short-listed meant and I don't think I still did.
F2I2810 (1404-1409) ...the other side of it is for people to say "...I applied for it. I even got short-listed"... we'll have to learn how to do that.

For some, the interview was a negative experience. Four CNMFs used terms such as 'daunting', 'traumatic' or 'nerve-wrecking'. The size of the panel appeared to be a particular anxiety for some (n=5), which lessened on subsequent interview appearances. As reported by CNMFFs, there were particular issues around panel membership in the early stages of the scheme. These were firstly, the academic level of panel members; secondly, the perceived behaviour of panel members and thirdly, familiarity with panel members due to the small size of the Irish nursing and midwifery academic community[54]. This latter issue also contributed to 'working out the odds' as CNMFs tried to guess who their fellow competitors might be based on panel membership.

FFI211 (1102-1104) Certainly two (*panel members*) I went to college with. That didn't faze me so much really (1130-1136) ...had I not got it I think I would have reflected... it may have had to do with the panel, so few at PhD level... certainly one person was floundering in asking

[54] One CNMF had been a panel member for the scheme on one occasion just after its inception.

me questions... out of her depth... (1211-1214) the interview may have been a greater challenge... more demanding if more members of the panel were at PhD level (*reportedly the Chair and one panel member*).
F3I185 (1673-1700) It was an awful interview... (laughs) they were just sort of trying to score points off each other. One was a Professor of Nursing and the other had a sociology background... It wasn't a pleasant experience (1732-1745) ...there was no coherence, or... flow... it was about 8 or 9 people and... questions from them all... It was a real grilling, and it was first this one and then that one and they all had their little question... one didn't necessarily follow on from the other.

Some CNMFs complained about what they perceived as panel members' lack of familiarity with their application. However, changes in processes meant that subsequent interviews or other respondents reported less negative experiences concerning the panel.

F2I911 (1340-1347) One of the panellists I felt was unfamiliar with my application. I was being asked the same questions over and over again in relation to ethics... which was all very clear in the form.
F3I185 (1703-1710) ...hers was the last question... it was so obvious she knew nothing about my study... she asked a really inane question like "How do you intend to operationalise (*a term*)...?" (1723-1731) It's (*the term*) quite hard to sort of define... I was thinking "(*expletive*) What a question!" But when I got the feedback it was something one of the externs had said and I just thought "Really!" They just sort of took the questions from the externs.
F1I511 (877-880) I found the interview board themselves actually very good... again that sort of a thing of a 'professional question'. (602- 612) S: what did you mean by 'professional types of questions'? F1I511: I just felt... they weren't trickery... they were intelligent questions, totally relevant to the subject at hand... they weren't something off the wall.

A second anxiety in this rite of passage was that of personal performance at interview, an anxiety common to other rites of passage within labouring the doctorate. A poor representation, such as "felt wrong-footed", "limped though" and "never got to grips" (F1I1512), meant anticipating failure. This could be tempered by accomplishing a performance of 'not letting oneself down' or 'doing justice to oneself'.

F2I2810 (1317-1319) You don't want to go in and... make an 'eejet' of yourself either. (1336-1338) ...it is a bit about the fear and your pride... you don't want to sound a complete idiot in front of...your peers.
F3I2311 (1378-1381) ...the worst interview. I was so unprepared. And they asked me very hard questions and I was very lacking in confidence (1386-1389) (*the second time*) even though I knew I didn't get it, I at least came away feeling... I had passed myself as a person, and as a nurse and as a nurse researcher...
F1I511 (862-874) The only thing I'll say is "I've given it my best shot". I knew I had thrown my all into it.... I thought "I've done a good interview... whether others are better..." but I thought "I won't not get it because I didn't do a good interview".

For some (n=4) the interview was too short and did not allow them a comprehensive performance or, in one case the chance to learn from a panel member's expertise. Preparation is seen as the key to success in the rite of passage and is cited by those who were previously unsuccessful as being the difference between failure and

success. Learning from previous failed attempts was valued and developing a research discourse was necessary.

F1I1512 (516-521) I felt more prepared (*the second time*). I knew my methodology inside out and I had already done a pilot. I felt "Ok I can show them I've made progress... I've had X and X experience and I'll be quite honest and say I had difficulty with recruiting... you know, I've learnt a lot since last year
FFI2710 (1034-1038) ...there was a tremendous learning between being interviewed the first time and not getting it and then coming back for a second interview. (1049-1051) the other part was actually to talk like... a researcher. (1075-1077) the second interview I had done very much with ...a language and a... way of putting things...
F3I185 (1777-1738) She (*a panel member*) was really wanting me to say I was going to keep a reflective diary but sure I was keeping notebooks... just calling them my notebooks... It's almost the terminology.

In common with other rites of passage preparation for the interview included anticipating the questions that might be asked, practising answering skills, and gaining background information on panel membership. Another preparatory approach was seeking assistance from others including those who had previously been successful in the scheme – a practice giving form to the identity of a CNMF (section 7.2.1).

FFI2710 (1103-1110) The second time... I would have thought an awful lot more about the interview... and actually how to manage the interview... to the extent that there were 5 people and so you had to speak to all of them really... (1166-1168) ...you've got to convince these people... that they want to give you this money.

Gaining funding is perceived as an extremely positive development if leading to a somewhat unknown or strange experience that "I don't even know if warning is the right word" (F2I911). For some CNMFs obtaining the funding was critical to the continuation or completion of the PhD research project, "make or break for it" (F2I211) and so you "pin your hopes" (F1I309) on it. Being successful brings relief although 11 reported anticipating failure or being uncertain of the outcome following the interview.

F3I185 (1814-1819) ...if I went back (*to full time work*) that would be the end of the work... I knew that. So that's why it was so important for me to have got that (*time*) off. It really was.
FFI911 (685-700) I got it and it was worth it! (laughs)... one of the best moments that I've ever had... my whole life changed... stopped having to work these terrible protracted long hours all the time. I was able to sort of start thinking "...I could have a life here and I could get a PhD as well".

The knowledge of those that achieve the award is in the public domain and meant being visible. The "golden handcuffs" (F2O1111) brought one of the obligations of being a CNMF; that of finishing in the time frame of the Fellowship. Fear of not

completing[55] acted as motivator for some, with the types of consequences being articulated including penalisation in the career pathway, being ridiculed and combining finishing with full-time work or "dragging on indefinitely" (FFI1012).

F2I194 (734-740) ...the fellowship makes a public declaration of you doing a PhD. So the whole world knows you're doing it because it's advertised who got the fellowships. So the whole world has an expectation that you finish it as well as yourself... (743-748) I had never thought of that before, the pressure that comes... with the funding 'til you in it and you're half way through and you're thinking "am I ever going to get this finished?"
FFI111 (1481-1485) The risk of taking a fellowship is that you have to finish. It is suicide to not finish from a career point of view. (1547-1552) There would be a perceived penalty within the university... the fact that you had a fellowship and even with that couldn't finish it (laughs) would be the implicit...

Whilst the CNMFs labour the doctorate with a spectre of failure, non-completion before the return to full-time work was a reality for five CNMFs, either through choice or effect. This meant dealing with a personal sense of failure and telling others such as colleagues or the HRB.

FFI311 (285-296) You end up having to go over it, like this is what happened and this is why it's not finished... you have to explain yourself... (pause) it is difficult. You feel as if you've not done what they thought you should have done and you're not up at the top, (laughs)... where they expect you to be. (338-347) it was his (*supervisor*) assurance that helped me along that this isn't unique, that... not everyone will finish what they have said or will have completed by such and such a date.
FFI183 (1142-1147) ...in terms of... the HRB... there is a sense of having failed in some way because I haven't completed within the time frame (1162-1168) that is a real pressure. Now maybe that's a pressure I've taken on myself. I certainly haven't received pressure from the HRB. It is self-imposed... (1252-1255)... there was the tension because you hadn't finished and you felt you had failed...

In summary, the representations of funding showed the CNMFs using the discourse of competition. Being successful at securing funding meant negotiating a rite of passage that is the HRB panel interview. The significance of funding meant that many CNMFs put supreme effort into the contest with the knowledge of those that achieve the award then in the public domain. Funding was characterised by obligation, one of which was the responsibility to complete within the bounded funding timeframe. Recognition was therefore given to the perception of failure if this did not occur although some chose to write up when they had returned to employment.

[55] Attrition rates concern policy makers and academic researchers (McAlpine & Norton, 2006) internationally.

5.3 'Resourcing' in the Field of the Fellow: Gaining Time

The data showed that time is an elemental resource of RCB that, too, is contested. Time is bounded and defined by processes, for example the funding period or doctoral registration period. Yet the data show that RCB occurs outside these bounded times. Whilst the funding period to undertake a PhD ought to be a clearly demarcated time, in practice this did not occur for all CNMFs. For example, for half (n=8) the CNMFs, the PhD markedly did not fit the funding time[56]. Registration prior to the funding application averaged 1 to 2 years and for some, tasks such as gaining study access or pilot studies and data collection were already in train. Other CNMFs had taken time out of employment, some with loss of salary, others with sabbaticals. This was taken either side of the funded time; 3 prior to the funding application and 4 prior to employment return.

F2I1211 (164-173) ...I probably did 3 to 4 months to prepare the proposal to send in and that was full-time. I took a year off work and most of that was trying to find a proposal area... then I worked within the lab for about 3 months just to see could I do the techniques before (*the supervisor*) was fully happy... that he would supervise me. (190-193) it was a year without pay so it was a big commitment and I wasn't sure if I was going to get funding.

For five others, the transition onto the Fellowship from employment was challenging either through institutional or self imposed obligations, thus further blurring the boundary of time on Fellowship.

FFI111 (1291-1316) ...for the first 18 months of the PhD I largely kept up all of my commitments to other meetings... We were rewriting (*a curriculum*). I was going to have to come back and teach it so I was going to have to make the changes that I needed made... even if it was going to be within my PhD (*funded time*).
F2I911 (101-111) I had just started (*the Fellowship*) in October and I did a lot of teaching in the university and then I went into the (*research*) site in January and that was the best thing that I could ever have done because I just thought "Well that's it now. I've really started". (495- 506) initially it (*teaching*) was fine, because I suppose I was still... in the swing of it and had some of the prep done... there is no way I could even, possibly conceive of it now. The last teaching I did was (*10 months ago*) and I struggled through it

Even for those without leave either side of the Fellowship, PhD time was longer than the Fellowship period. Time, reported in years rather than months, was spent contemplating commencing a PhD with activities such as gathering information from a number of universities or preparing the knowledge base by undertaking a post-graduate degree in other disciplines. Likewise the endpoint of the PhD was uncertain and blurred with some of the CNMFs reporting difficulty in 'letting go' and closing the

[56] Cases of 'fit' include those who submitted the written thesis at the end of the funding period but who had subsequent viva voca outside the funding period.

work, especially if the CNMF still had to publish from the PhD. Having the thesis bound and clearing study space were activities associated with closure.

FFI111 (647-655) (*post viva)* You knew you had passed it but you still had work to do... I spent most of the next 2 weeks making the changes. (675-683) when I get the phone call to say "the changes are accepted"... you thought "That's it, it's now done... a finished version..." ... I was working on the basis that until I have the bound copy in my hand, it's not done. (1415-1433) ... when do you actually become a doctor? ... I will hand in my bound copies on Friday (*3 days hence*) and that's my commitment to the university done. Now technically I don't get awarded a parchment until June. But there seems to be an understanding that when your bound copies go in that's it... so there's a sort of an in-between somewhere... S: It's limbo land.
FFI211 (3121-3125) In some ways I actually don't feel I've quite closed yet because although it's opened up new avenues, I still think this PhD is very alive for me.

In preparing for the Fellowship, the CNMFs dealt with work issues as well as spatial ones (section 5.4). Those part-way into the research reported changing pace and parking the study in favour of preparing to leave the workplace and dealing with concerns such as their replacement.

F1I1512 (678-685) I was kind of winding down a bit... I knew I was going to have to start again... so I just left it. My co-supervisor said to me just forget about it and have a rest before you start... You'll be living and breathing it for three years.
F1I511 (936- 944) there was a sense of putting things on the long finger because you thought "I'll be off", that awful word... there was a sense too, there was a lot of things at work that I really wanted to get done... to leave on a positive note.
F2I1211 (789-794) When I had heard from the HRB I had to organise with my work to get the leave of absence. And they said I could have it if I could find a nurse (*with the same expertise*) to replace myself. (832-834) I was thinking "here I am now with funding and maybe they won't let me take the time out..."

The resource of time was one of the reasons for seeking funding. However, the data show that time myths exist and as a resource, time can convey problematic realities for the CNMFs. Time was viewed as an ideal and desirable, even a "luxury" (n=4). This features, not just for those who are part way into the PhD when getting the Fellowship, but also feeds into the general perception of undertaking the PhD on a part-time basis. For CNMFs part-time study with fulltime employment is the norm of the scholarship career. Having experienced it previously at lower academic levels, study strategies for such labour are already developed by most CNMFs. An example of such a strategy is "snatched moments" (F1I117) (n=3), whereas being on a full-time Fellowship allowed time to "concentrate on it" (FFI1012) and become "immersed in just academic work" (F3I77).

F3I77 (729-733) I didn't have to be saying "Right I've an hour at it now and then I've to go into class" or "I've an hour from now and then I've to go to a meeting"...
FFI911 (10-18) I had been working on the research for about a year and a half prior to getting the fellowship. So I had a good bit done but I would never have been able to do the kind of

work that I managed to do ultimately with it if I hadn't been able to focus on it fulltime. (333-344) I didn't really realise how hard I had been working... I was actually working all day and... studying... I had 3 children and one of them was a very small baby at the time and once he was gone to bed I would just hit the study and there I would stay until midnight...
F1I309 (169-171) It (*being funded*) doesn't mean that you've to work any less hard but at least you're working on one thing, the PhD and you can focus on it.

However, having time can induce feelings of guilt. It appears particularly pertinent in the early stage of the Fellowship and especially on the issue of having time for scholarly practice such as reading and thinking.

FFI183 (267-274) I remember sitting in the library one day feeling so guilty that I had spent six hours just reading. Whereas you would never do that; if you were reading you were reading to prepare a lecture, you were not reading because you wanted to read.
F1I1512 (660-666) ...there's no comparison. You can get your teeth into something and you can really look at the literature, focus on it, spend the whole day even on one article and not feel that "Oh my God" you know. It is such a luxury really, having the time.

The source of guilt about reading may also stem from the value placed within nursing and midwifery on reading. Certainly, five of the CNMFs described themselves as book lovers or avid readers – "read more stuff" (F2I2810) and so that reading was almost a distracter. Others used reading as a particular strategy: for preparation of an event, getting around a problem or filling time gaps.

F3I2311 (2039-2055) I've loved buying all the books I have, yeah, loads of books... I love books. I'm desperate for them... What I love about it is that you don't have to rely on the library. Well certainly (*the theorist's*) collected works you couldn't get them...

Yet, within the culture of nursing and midwifery practice, there is a focus on 'doing' rather than reading or thinking (Walker, 1997; Miers, 2002; Malfroy, 2005). 'Doing' is embodied in nursing and midwifery culture and the stillness of cognitive work requires adjustment by CNMFs.

F1I27 (835-852) It is a nursing thing because if you work in practice, you do nothing if you work in the university... there is a nursing element there of levels of people doing nothing (laughs). It's as if education, or that side of things, is actually doing nothing. S: Why do you think that is? F1I271: ...Arragh, I think it is a cultural thing. (872-876) there's a cultural element where nursing equals action, it equals movement, practice and if you're not actually moving and doing, then it isn't actually working.
F1I511 (48-58) I have to go for a walk or something around 1 o'clock because I'm frozen solid (laughs). It's just because you're sitting. You're not doing anything, I mean you're studying but you're not moving.

So learning the value of thinking time is a feature of the Fellowship. It is explained by one CNMF as cognitive space and contrasts to the aforementioned 'snatched moments' during the cognitive bombardment of working fulltime. 'Thinking time' is a requisite for knowledge development and therefore RCB.

F3I77 (784-797) ...it is not just about the time, it's about having that cognitive space... when you're in work you have to think about a million other things... once you have that amount of head space even though you mightn't be consciously thinking... there is an unconscious level that stuff is being processed at... later it becomes clearer.
F3I2311 (106-121) I felt I was doing nothing, yet I was doing work... S: Why...? F3I2311: ...because I had more time. And I wasn't used to having this time... one thing that you don't appreciate in having time is how much thinking you do. You've time to think and you take that for granted after a while but you are working without realising it.
FFI211 (1692-1695) I also learnt that... thinking and mulling is as important and perhaps more important than just writing and doing.

The funded period is referred to as 'being off' by the CNMFs themselves (n=6), as well as by others. 'Being off' is a cultural concept from nursing and midwifery and means 'not on duty' or not at work. However, one CNMF restricted the use of the concept of 'being off' simply to time out from the study, whilst fulfilling other scholarly activity such as supervision.

F3I2310 (697-701) Well I think the youngest one (*child*) is still confused. She had this notion that I'd 'be off' for three years and I'm still not 'off' (laughs).

Having the resource of time gives high expectations to what might be achieved. Such expectations are held by others as well as the CNMFs themselves. However, for the CNMFs there is a dawning reality that the initial expectations were an unrealistic ideal. In addition, the learning that the academy's equating of fulltime study as corresponding to twice the time of part-time study is mythical when compared with the reality.

F2I2810 (2151-2160) For me year one is just... getting into it... you think you'll have loads done... Sure I thought I'd have half the PhD done by the end of year one!
FFI211 (1258-1268) At that stage I was 2 years part-time... I was ahead according to (*my supervisor*)... maybe 3 or 4 months ahead of what you would expect. So I thought if I'm going at this rate, I'll finish this in 2 years because already I was equating the 2 years part-time as a year full-time but it never equates in that way, never.

Part of the reality is that time is required for adapting to transitional identities and labouring the doctorate is not at uniform pace or there can be untoward delays.

F1I267 (297-303) ...all those things where people say, "Oh you do have the fellowship and it will be wonderful and you have all the time on your hands" and I thinking "My Jeez, I can't go any faster!" I was at it night and day...
F1I23 (162-168) the time that you might have to develop a questionnaire or to... immerse yourself fully in the literature, you actually don't have that luxury because there is a service need driving something which could very much impact on your entire work.
F2I911 (770-774) Definitely there are weeks where I think "I thought I was on the pig's back here, having a funded PhD and here I am... another 7 day week, another 7 day week...

For the CNMFs there is a concept that they have time ownership. One highly valued feature is that time can be used flexibly. It contrasts with nursing and midwifery culture of 'counting hours', which occurs both in clinical practice and some new academic departments.

F3I2311 (1791-1797) Sunday is a lovely day to work because you've nobody phoning, no distracters... that would mean I mightn't work on a Monday...
F1I23 (90-93) It's the flexibility that's built into it, that there's nobody there watching you. You're not counting hours; it's your own project.
FFI183 (1358-1377) In the school... it is up to them to manage their time[57]... But I know there are some institutions that you almost must clock in and clock out... S: ...among nursing academic departments? FFI183: yeah very much that mentality. That you have to be there and you have to be seen.
FFI121 (1242-1248) I went... to the academic meeting and I didn't have a clue what they were talking about and of course they were talking about counting hours (whispers an expletive).

As here, Bruni (1997:37) in her Australian ethnography found that "the hospital mentality" was used as a metaphor for traditional, circumscribed practices that her participants considered outdated when they moved from hospital based schools to the higher education sector. Using time flexibly can mean that boundaries around PhD labour are porous with the PhD encroaching into other aspects of the CNMFs' lives. One CNMF diverged and described how 'self' life encroached into labour time causing time to 'slip away'.

F2I911 (1798-1800) ...my struggle is trying not to let the PhD eat into every hour...
F3I2311 (1579-1593) It depends on what else is going on in the day because there is other life and I was saying to myself earlier "the other life can sometimes take over a bit"... (*something*) takes you out... and you think "I better buy some vegetables for the lunch and buy some food and get that in" and then 2 or 3 hours have gone and then you come back and prepare lunch and eat it and that's another hour.

Practical issues such as optimal data collection can mean evening or week-end working (Beauchamp et al, 2009). An increase in pace of labour can mean long and "horrendous hours" (FFI1012), especially but not exclusively during the 'writing up' phase. So time flexibility is not always a choice of the individual CNMF.

F2O2711 (5-10) The interview the CNMF is going to conduct is taking place on a Saturday at the suggestion of the interviewee. The participant suggested the day and time as being appropriate as the clinical area will be quiet.
F2I2810 (1935-1939) Like, yesterday evening... I looked at the watch and it was quarter past eight and I said "I better go and put on the dinner"...
F3I248 (367-375) My average day would be 8, 9 in the morning 'til 11 at night. That's a normal day. If... I was due to submit that could be 2... 5 in the morning... literally going straight through, and that's it, it's in.

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[57] Dempsey (2007) identifies time management as problematic in the transition from clinical practice to nurse lecturer.

'Guarding time' is also a concept of time ownership as the funding period is a 'ticking clock' from the outset. The issue of time running out produces anxiety and seems particularly pertinent for those later in the Fellowship.

F1I117 (1159-1161) ...you start off and straight away you think 'my time is running out'... (1082-1091) I find it even more of a conflict nearly now (*than when part-time*) because I think I don't want anything stealing the time. Because you know this time is going to end... your time is running out all the time. So you're trying to guard it and I've a wedding now at the weekend and like to me this is just a nightmare...
F2I296 (954-959) I think everything is manageable now if I just... make the best use of the time I have left. That's the scary bit. The time running out and it's running so fast now.
FFI1510 (463-468) ...the days were ticking away. Initially it was alright (*not getting data*). I said "Ah sure it was another day, another few hours, another day. And that's a week". Suddenly it's a month... gone from the HRB grant, another month gone to the deadline of the PhD...

Time is utilised as a point against which progress in the labour is measured. Therefore time as a limited resource has to be used effectively. The time for tasks is balanced against the time they take to achieve. This can help the CNMF focus on the whole or a part task so the goal of achieving a PhD is reached.

F1O264 (401-405) I'm told that she has recently said to her husband "What am I doing? I've almost a year done of my fellowship and I'll really have to up the ante now".
F2I410 (1078-1083) Initially I thought I was (*well ahead*) but you know, this week now is the start of my second year... it's like you know "Oh my God", the honeymoon is over (laughs).
F1I271 (506-508) It's (*transcribing interviews*) time consuming enough but at least it does get you familiar... (513-514) I'm getting some of them done just to save time.

Timeout is time away from the research and it is self negotiated. Often it is used to award oneself for labour although it can be constrained by child or spousal responsibility. Where this occurs, there can be feelings of time loss or familial and personal demands may be viewed as 'stealing time'. Fitting in holidays was an example here.

FFI2510 (46-55) S: Did you have very clear... down times? FFI2510: ...yes... definitely when it came to 6 o'clock... I always had tennis prepared for evenings and sometimes it was raining and I couldn't get out, I felt like a caged animal.
F1I117 (1265 -1274) You feel... because I'm married that I have to go on a holiday. I know it would be good because it might be nice for my husband to get the odd week with me, but if it was left to me... I would prefer not to have any holidays at all. I'd prefer just to take a few days off at home or whatever.

The study design could impact directly on the ability to take holidays and going away required particular planning because of the 'ownership' of the study. Likewise, taking time out had consequences and required the CNMF to "knuckle down" (F3I2310).

FFI2510 (503-516) ...the first year I didn't take any annual leave for about 13 or 14 months so that was very, very tough and I was just exhausted. S: why...? FFI2510: Because I was data collecting I couldn't be away for more than three days because I would have missed patients. So it was the nature of the data collecting that kept me there.
F2I911 (777-798) Trying to take holidays in the summer was a big issue... once I recruit somebody my data collection is set... I don't have any lee-way... Normally... I'd finish work, "I'm out of here. I'll see you in 2 weeks!" And there were no consequences to going... this time there were... I thought "This is ridiculous. You shouldn't be feeling like this. You shouldn't be concerned about taking a week off"
F1I296 (10-16) ...the run up to the holidays I actually made sure that I had organised myself so that I'd finish all the actual (*data collection*)... then I knew when I came back exactly what I had to do. (86-90) I found the first two days (*back*) quite difficult but I was doing a lot of mundane work like sorting out (*data*).

'Time loss' had negative connotations. It ranged from the minutia of minutes to large segments of weeks or months due to stress or illness with inevitable resultant 'settle back' difficulties, especially for longer 'time loss' periods.

F1I296 (787-797) I had an informal (*supervisory*) meeting... they just don't work...everybody's coming along and interrupting you... the last time was before the HRB interviews and somebody was looking for advice... but that is half an hour gone...
FFI1510 (1327-1334) But every so often I'd find 'this thing' was getting me down and I would close the book for maybe 2 weeks, 3 weeks... if I wasn't able to get back into it, then I would start off my reflecting on why.
FFI183 (1219-1228) Just even engage with the material again, engage with the data again, begin to feel that you're researching again. And it's like starting all over because you've lost... you've distanced yourself from it... then you're taking six months to get into it and then 'Bang' your three years are up.

In summary, the CNMFs claimed time ownership as a result of being funded. However, time was contested and they had to attempt to balance time obligations between their personae. In addition, their cultural heritage from nursing and midwifery imposed guilt as they channelled time away from 'doing' to 'thinking'.

5.4 'Resourcing' in the Field of the Fellow: Constructing a space

Space was the third element of resource for RCB emerging from the data. In all cases, gaining the physical space for studying or data collection over the Fellowship timeframe was contested and required negotiation. Those negotiated with included university administrators, other researchers, clinical staff or family members. Study space was negotiated in the CNMF's own home. For some this was because at the start of their Fellowship, space on campus was not available or deemed not to be suitable for their work; for others it was due to the geographic distance from their university leading to time loss. So preparing a space at home was part of the preparation for the CNMF period. The majority (n=12) had dedicated rooms converted for research use whilst others just had dedicated space within a shared family room.

F3I2311 (984-987): I have my room upstairs... It was the second big bedroom... the summer just before I started... I got the floor sanded and done... shelving begun... and I had my stuff moved into it. (1012-1014) It was like a crèche ready for the baby (laughs)

Space in a home containing children brought particular difficulties. Here there was less opportunity to dedicate a whole room, or if this was done (n=1) it meant a major disruption to family sleeping arrangements and the loss of a child's bedroom. Even for those without children a labour space at home held difficulties in keeping clear identity boundaries.

F1I511 (81-87)...they (*the children*) know not to touch any of my stuff and they are very good but.... I'd have stuff laid out and... they'd be coming in and they'd want it out of the way... Even though, if you like, my half of the room they don't disturb...

Using a dedicated space at home led to isolation in contrast to space on campus, which was always shared with others, mostly those engaged in the research endeavour. For some CNMFs the start of the Fellowship meant negotiating an equipped space that was prepared for their arrival.

F1I23 (46-52) The first week I went in... my office space wasn't set up... there was no P.C., no phones, things like that, and the administrator was off... So I worked from home that week.
FFI183 (363-364) I negotiated an office corner, not an office... and I negotiated access to a computer... It was a redundant computer that was sort of left there. And so I had a space and I had a computer but my telephone privileges were taken away from me.

The positive aspect of shared space was a potential research milieu with debate, dialogue and learning from others, and serendipitous events (section 8.2). However, the CNMFs limited their attendance in shared campus space as the infrastructure lacked basic resources and equipment, reflecting Neumann's (2003) findings on facilities provision for doctoral students in 'soft' disciplines.

F1I1512 (761-764) It took a long time to get a computer here (*at the university*) and... I still haven't got the net.
F3I248 (315-317) I was a year into it before I got a desk... but I had no chair (laughs) (925-929) ...the resources have certainly improved as in the physical accommodation and PCs and that sort of stuff. I know space is an issue...

Additionally, it was not perceived as an optimal place to labour or engagement with other researchers was not valued. Especially for those not registered with nursing and midwifery, campus space was at a premium yet disengagement from this space brought threats of loss.

F3I185 (1446-1463) I could have got a desk down in the department... But I wasn't really interested because I'd seen that they all kind of bunk in together... I talk too much and I have enough people in my life and I don't need to be forming more relationships with people in another discipline
F1I23 (187-191) ...there are eight people, two of the desks have job-sharing people so they hot share... there are actually eight people coming and going in the room.
F3I142 (1107-1118) I was even asked for my desk down here... "As you're here only part-time, would you consider sharing your desk with somebody?" Because you're not in everyday, you're already getting further out the door. And I thought sometimes, will I come from home just to sit at that desk? But it's not worth it. It's not worth making a point or... a long journey.

For one CNMF3, campus space was kept as a 'bolt hole' (F3I185) from family interruptions. There was one exception to shared campus space whereby a lecturer in a long established university school continued to occupy the single office from their previous employment, all others lost their 'lecturer' space. A small number of the CNMFs (n=3) moved their dedicated space once or more over the timeframe of the Fellowship. This was due to learning what worked and what didn't work as far as space was concerned. For example, an inability to access "the practicalities" (F2I410), such as equipment or services quickly, was a negative aspect of having a dedicated space in the home for one CNMF and was used as the rationale for a return to a shared organisation space. Space changes were prompted by changes in the pace or type of labour, or by organisational changes in space use where the space was shared. Having a dedicated room as the research space was highly valued as materials could be left in position overnight. Occasionally even dedicated rooms were used for other purposes.

F3I142 (184-191) ...if I want to sort things out then for the next day I can do that...so that the next morning when you get up it's ready. There's none of this having to lay everything out again... the way you'd have to do if you had to come to work and do it at the desk.
F2I2810 (1808-1813) The only reason that there's things on shelves here at the moment is because we needed that couch recently for a bed. So things had to be put on shelves...

Where there is a whole room dedication, there appeared to be no materials in rooms elsewhere, thus confining PhD labour to this space. However, the location of the space can impact on attitudes to the labour in scenarios where the study space remains visible from areas such as the kitchen. An exception was that one CNMF spread the work throughout the house.

F3I185 (1920-1934) I have (*spread over a few rooms*). (laughs) My daughter thinks I am the worst, there can be nobody like me... a trail of destruction in rooms as you leave them. And it's all books. S: (laughs) ...pieces of paper as well. F3I185: Pieces of paper... downloaded stuff from the computer, email alerts...

Making the space aesthetically pleasing was important to some and the space was maintained even following the Fellowship by others.

FFI211 (3080-3112) I had moved house... it was a house of the 70s with green carpets and pink walls...and I thought "I'm not going to be able to survive here... living in my study"... what I did was... borrow money and part of that was to do up the study. So I have this beautiful study. I've wooden floors... a state of the art desk and office unit... It's just wonderful to be in there... It was a beautiful setting... that was important for me really. I felt that if I was to engage in this in a fulltime basis I had to have the aesthetic surroundings right...
FFI121 (1358-1363) That space is still staying because I'm promising myself that one day a week I'm going to be in that space to read, write and do my research.

Dedicated spaces that were observed were set up like offices. They contained computers and other equipment and research materials. The personal style of the CNMF gave these spaces their degree of order.

F3O248: I ask to see the room that the CNMF has been working in. It is a second bedroom that has been transferred into a study with the only leisure furniture being a red sofa underneath the window. A series of three long open type shelves line the wall. On the shelves are text books which originate from the CNMF's past teaching role as well as textbooks on research methodology and relevant journals. The CNMF points out a series of boxed folders she says are all the interview transcripts from the study. There is also set of hard bound thesis (the CNMF's own Masters and from her supervision of others) and I notice that there is also a thesis of a CNMFF. Additionally there are soft bound theses which she says are British Library loans. Underneath the shelves is pinned a large sheet with a lot of small scribbles, in front of what appears to be a set of small sheets also with small scribbles. They appear to be mind maps of data. I point to them and am told it has been a while since she used these. To the right of the door, she points to what she calls her interview corner. "That's my purple folder which I always bring with me". I assume the rest of the articles there are also connected with the data collection. Along the remaining wall there is the main work activity area. A four drawer filing cabinet contains what the CNMF says are 3 drawers of literature for the study. There is a split level desk. The computer monitor has a number of 'aide memoirs' on sticky note sheets stuck around the edge. A phone, office chair and a combined printer, scanner and photocopier are also in this area... There are signs of work activity with open folders on the floor and books and literature on the top of the desk and filing cabinet.
FFO111 The CNMFF's office was in a modern block of the university. The CNMF name was on the blue door and we entered what seemed to be a long narrow office. I walked to the window alcove at the end to leave my bags. It appeared to be the less active area of the office. It contained a table and two chairs and a fine view of the river through trees. The CNMF commented "Great view for writing a PhD" and I laughingly concurred.

The labour spaces contained visual prompts. Some of these were focused on the transitional identities of CNMF, person-self or doctoral student. The dormant or quiet nature of the labour space could even indicate an identity in transition (7.4) when contrasted with their previous work context.

F1O264 On a ledge is a photograph of the CNMF taken with the HRB CEO at the Fellowship Awards ceremony.
F3O2311 ...a photograph of the countryside, where the CNMF was from, had pride of place on top of one of the bookshelves... Pinned to the facing wall were various notices, including a photograph of the supervisor "to keep me focused".

F1I1511 (16-37) About the 3rd morning coming back (*from leaving children to school*) I thought "God. I'm coming back to the same place again" like... there is nobody but you.... and everything is just the way it was 10 minutes ago. Whereas at work there'd be a phone call or there'd be somebody coming in and out. And it's that kind of a difference that has been very strange... S: So you're coming back into an empty house...? F1I1511: Yes, but also... it was the same as when I left it and this was my third or fourth morning and it was still the same... there was nothing changing in it.

Other visual prompts were analogies to the PhD process or labouring the doctorate and these were used for motivational purposes. Such visuals were about surmounting challenges and the hidden, routine work that goes into such achievements.

FFO111 Following the interview the CNMF points out a large framed photograph on the wall of a human runner on a precipice. It is linked to the CNMF's concept of the PhD as a marathon and reflects a hobby. The CNMFF also points to the notice-board where a poster was pinned during the Fellowship. It showed Everest and the path of the first Irish ascent to the peak, including the position of base camps etc. It was an analogy that, whilst was used during the Fellowship, was not as comfortable as the marathon one as mountain climbing was not any activity that the CNMFF could identify with. I was also shown the screen saver which was used for the final year of the Fellowship. It was a quote from Muhammad Ali "The fight is won or lost far away from witnesses – behind the lines, in the gym, and out there on the road, long before I dance under those lights".

For the CNMFs, data collection occurred across a diversity of settings that required negotiated space. Management of the environmental aspects of the space for optimal data collection and negotiation of the activity within that space also occurred. Some of these spaces were 'public' professional spaces whether that was within a laboratory or a clinical area. In these scenarios the space was shared and the CNMF were under obligation to others for space sharing or assisting with space set up.

F3I2610 (208-226) They gave me a room... in the clinical area... it wasn't their office... it just had a coffee table and a whole load of chairs... they would have maybe general ward meetings there or they'd have meetings with the doctors. But when I was there... it wasn't used.
F3I185 (1049-1052) ...in the early days I said to him (*the consultant*), I was kind of nervous about it, I said "I need a room, I need a room" (laughs)... (1061-1066) He sort of said "yeah, you can use that little room there... I only use it one day a week" and it was very good of him... (1082-1086) I just sort of made myself at home and I used to use that room and put my coat in and my bag... I felt like I had a little space...
F2O912 (27-32) The CNMF tells me that this outer room serves as an office for a doctor who is undertaking an M.D. One of the inner rooms is an office for the professor of the department and the second contains research equipment. (100-113). Although I cannot see into the outer office the doctor has obviously returned to her desk and I can hear people coming and talking to her. One is looking to check a patient's drug prescription, another whom I assume is a student, is admonished about a lack of patient chart access because they were in the student's possession. After explaining the implications, the doctor then reviews a number of charts with the student discussing the suitability of each patient for some sort of a trial.
F1O191 (18-27) We meet in the hospital foyer. After the general greetings, the CNMF tells me she has already been to the room where the event is to occur and it is locked. We got to the reception desk. The CNMF introduces themselves as "the person holding the discussion group" and explains the predicament. The receptionist bleeps a member of household staff

and asks for the room to be opened. (54-64) The room has two distinct areas and both have been set up for events. The large table with 12 seats around has a 'do not disturb' type notice so our conjecture is that the smaller table has been set for the focus group. We discuss the options and the CNMF decides to go with the smaller table but add an additional table to it to make it larger. Together, we move the table and chairs removing a flip chart and slide projector trolley out of the way.
F1I296 (486-501) ...when I arrived the place was all locked up and it was cold and it was the middle of winter... I just thought "God this is awful" and there was no tea or coffee. They had assured me that I'd have all this... but I went to the canteen and they couldn't have been nicer... and the porter opened the place up for me... In most places they were very, very hospitable.

Other data collection spaces were the 'private' spaces of study participant's own homes but even here the space had to be 'set up' to minimise disruptions. Another data collection required a 'neutral' space that was neither private nor professional thus the CNMF specifically hired venues. For the negotiation and management of data collection space, the CNMF adopted the most pertinent identity – nurse or midwife, researcher or customer.

FFI2710 (904-915) The interview was normally in the evening... it was in somebody's home... it was built around ...was there other children? Where were the other children?...there was a lot of planning and setting up... 2 or 3 phone calls to parents to just double check the process.
F3I2311 (261-275) I hired a room that was quite near... because I didn't want it to be in the hospital... at one point a workman was coming into the room just to pick up stuff... and he did it a couple of times and I had to stop the interview and say "Look I'm sorry" and go and speak to the person... actually at one point say "Give us another room".

Thus the CNMFs tried to control the data collection space so as to attain good data but this was often in the context of challenges to that process including the sharing of space. In summary, gaining space, as the third elemental resource, required a negotiation process as sharing space was common on clinical sites and where there were children in the family home. Shared space was seen as not conducive to certain tasks such as writing, so often a degree of isolation was the price of optimal space.

5.4 The triad of resources in the Field of the Funder

The triad of resources also existed in the Field of the Funder with differing emphasis. Being a funding agency, it is not surprising that issues of funding were key elements in this field. The NRA diary showed 21 entries across the calendar year concerning the giving of funding advice to 35 nurses and midwives. This was obviously a routine, mundane task for the NRA and was supplemented by other colleagues also dealing with funding queries from nurses and midwives. The prompts for these queries differed, from media advertisements, supervisor advice, formal NRA

presentations and sometimes just the serendipitous presence of the NRA at events. 'Being known' facilitated some of the queries.

27/10 (*at a HRB event*) We (*a CNMF and I*) are joined by two HRB staff and two awardees, both medics whom I know. I introduce everyone... I am asked by one of the medics about funding opportunities for nurses, as he works with a nurse who is setting up a research project. He requests my business card which he says he will pass on to the nurse concerned. Another connection made. **28/10** Evidence that my card is passed on from yesterday as I spend 30 minutes on the phone with the nurse concerned going through details of the HRB funding schemes and career advice.
6/5 I attend the opening of a School of Nursing by the Minister of Health and Children. During the reception following official proceedings I speak to an ex-student of mine who asks about HRB funding. I give the usual advice that I give to someone at that stage of thinking about an application.

The amount and type of advice varied: this depended on the chosen topic, the stage of development of the study, the eligibility of the topic or the enquirer. Whilst most information given was about HRB schemes, some was about opportunities from other funding agencies. The strategic role of the NRA meant that non-HRB funding sources were also assisted.

14/12 I take a call from a nurse who is interested in seeking funding and who has been directed by another nurse to talk to me. After an outline of her project I advise accordingly. She is well ahead in development of her plan but there is a large educational component. I suggest that she seeks MSc funding for the first and non-educational phase of what she had planned to do. There is obvious delight with "I never thought of that" as a response.
10/8 ...I've spent approximately 2 hours on the phone over the past two days responding to research funding queries from 4 different people... some people are further down the road towards application than others and this obviously affects the type of advice given. For example, one nurse I advised to check out other types of support from the HRB's portfolio... I even spent some time advising an allied health professional although the intended research project is with nurses. That certainly adds dimension to the role and gives nursing some credibility within the broader health research field. As usual, I also try to challenge and broaden the thinking. There was a nurse whose master's education was in a discipline other than nursing. Whilst the intention was to undertake the doctoral study through a nursing department, I raised the issue of where the prospective study lay in academic terms and whether the Irish nursing academy had the capacity to supervise comprehensively the intended study. Rather than give specific direction, I encouraged this nurse to go and ask questions of the intended project itself and of the academy.
3/5 I have received an email seeking advice on research funding. I phone and ask some questions. I learn that the nurse is undertaking a taught Master's programme with a research dissertation. For this she wishes to examine nurses' attitudes to a particular medical treatment. I inform her that there is no funding available from the HRB and she asks where else she should look. This puts me into a think aloud situation and I mention a relevant research charity or a pharmaceutical firm. I also ask whether the consultants she works with would "not have some funding in their back pockets?" "Oh I couldn't ask them" was her reply. It makes me wonder why some nurses and midwives are reluctant to seek such assistance from other members of the clinical team.
26/1 I spend the afternoon with a nurse working in a charitable foundation, helping her to fine tune a research grant scheme for nurses from a particular clinical specialty.

Advice on funding opportunities was supplemented by supports for making applications. Whilst documents were produced by the NRA on how to write good

grant applications and on using the online application system (8.4), support in the form of 'workshops' were also given. In reality these were information sessions. Nurse and midwife researchers did attend alongside others interested in health research.

24/3 There is a Grant Proposal Writing Workshop in the morning and repeated in the afternoon... I have given such workshops myself in the past to nurses and midwives but am interested in the approach that someone else will use. I arrive 20 minutes before the start time... About 10 minutes later the presenter and a colleague arrive. I learn later that a technical problem with the laptop for the presentation delayed them leaving the HRB premises. I start to assist with preparing the equipment and distributing the presentation handout. Meanwhile the audience continue to arrive. There are 10 men and the rest of the audience is women. There were about 60 booked in for each session. I make reference to the presenter's previous comment to me when I requested to attend that most of them were nurses. "I only recognise one". She laughs but says that I can take the spare attendance sheet to check the background of the attendees. I do this during the workshop. There are 13 nurses or midwives booked into the morning session and 20 for the afternoon. In the main their places of work are university departments but there are a few individuals working in clinical trials, as clinical nurse specialists or in practice development. The rest of the audience is made up of occupational therapists, speech and language therapists, physiotherapists, pharmacists, biomedical scientists, psychologists, social work, the research charity and voluntary services sector, and health services management. There are two medics, from general practice and psychiatry. The afternoon attendance shows a similar mix of disciplines... the workshop begins... Everyone is welcomed and their "enthusiasm for getting money from us" acknowledged. The multidisciplinary backgrounds of the audience are also recognised and throughout the presentation different health professional groups and research topic areas are used for illustrative purposes, nurses and midwives included. The presentation commences with some background information on the portfolio of grant support that HRB offers and shows where information can be found on the new HRB website. The Fellowships are described as 'building capacity' although this is not defined... The Partnership awards are described as "building capacity in the system and providing the evidence base" and are the main examples used throughout the presentation. A list of successful applicants is shown. Of the seven awards made, 3 were made to nurses. The last 20 minutes of the workshop is given over to questions and answers. The presenter introduces the other HRB staff including myself as available to take questions. There are no specific questions on nursing and midwifery but I do contribute on two occasions when issues on reviewers and feedback are being discussed.
25/11 The last regional meeting and I am standing up to deliver the short presentation on writing good grant applications. This time I'm acutely aware that in the audience is a failed applicant. I am very tired and can't seem to remember all the nuances and quirks that I gave in this presentation the last 5 times I've delivered it! I cannot look the applicant in the eye and stutter on through the presentation, knowing that it is not as polished a delivery as it once was. In addition there is the sensitivity that any failed applicant might feel or indeed personalise to their own application. This is one of the drawbacks of the joint appointment role that whilst it enables good communication between the HRB and members of the profession, some individuals may be reminded of their failings in arenas where they least expect to. It is of course an issue of maturity and I may well have been transferring my own anxieties onto the failed applicant.

Support also existed post application. Here, all applicants routinely received feedback in the form of the written international peer reviews and for short-listed applicants, any additional comments that the panel make. Preparing feedback is one of the routine elements in the process for the NRA in conjunction with others.

19/5 The place is quiet... My task for the day is to prepare the panel feedback for the interviewed applicants of the CNMF. This takes most of the morning. Another colleague is 'cleaning' the feedback that is already in the online system to ensure individual names or comments about individuals are not made. **2/6** Only the CNMF feedback is to be distributed. I later check with a colleague if I have any more work to do with this. She reassures me that she has the feedback comments that I made from the panel meeting but since this was the last panel to sit, it is also the last set of feedback to go out to applicants. (*it is sent out 4 weeks later*).

Seeking additional verbal feedback on applications was rare but did occur, sometimes at the instigation of the NRA.

19/5 A non-shortlisted applicant phones. She is making an application to another funder and is seeking to strengthen the proposal based on the HRB feedback. I give her it to her verbally. There are little gasps of exclamation like 'gosh' and 'I wonder what they mean by that'. The ability to stand back and see one's proposal through the eyes of others is a skill that has to learnt.
29/8 A Fellowship scheme... from a different funding agency had been advertised. I had sent out notice to the nursing heads of HEIs at the beginning of the month. I had made tentative enquiries from a colleague as to whether their friend who was a previously unsuccessful CNMF applicant would be interested... suggesting that should they wish, they could phone me... (*the later phone call*) I asked if the feedback had been received and was told that it had and had held not great surprises; it just confirmed to the nurse what was a known weakness of the application. I reiterated the main feedback points and then suggested a likely training programme in the UK that could help. The nurse replied they would investigate it. I also questioned as to whether the particular expertise was available in the institution and was told that it was but in other disciplines. I suggested that contact be made seeking help, in order "to beef up" the application. The nurse thanked me for the advice and I wished them luck with subsequent attempts.

Accuracy of feedback is essential. In the following scenario, an inappropriate statement in feedback reveals a lack of knowledge of non-positivist research design on the part of a HRB work colleague.

8/11 There is a feedback query from an unsuccessful applicant regarding a statement in the received feedback. Another staff member has emailed me the exact wording that the applicant received in feedback. There is much more content than I had suggested with the inclusion of a specific design element in any forthcoming application. The applicant deems this inappropriate, I totally agree. I have already trawled through the international peer reviewer's and panel member's comments and my notes from the panel meeting but can find no mention of this design element which suggests that the statement has been added by the colleague who was the last to input information into the feedback... I approach them, outline the issue and say how inappropriate one of the statements is with regard to the particular project as outlined on the application. There is a little conversation as they try to remember why the statement had been made but is unable to recall the rationale for the comment made. The notes have been destroyed. I am sent away to email the applicant acknowledging the error and suggesting a justification on the issue within any future applications. It irks me that I'm charged with the 'mop up' and note that in future I need to check what is written in the feedback before it is sent to recipients. I wonder how many applicants in other schemes get inappropriate feedback due to a lack of knowledge of non-positivist methods...

An additional element in the funding process for the NRA was to identify appropriate researchers to act as international peer reviewers for individual applications or panel

members[58]. In the main, this task was achieved for the former through searching databases for publications in the topic area or methodology of the applications and in the latter for broad expertise in methodologies and clinical specialities.

8/9 Conference attendance gives me an opportunity to make contact with international peer reviewers... for both parties it puts a face to the name associated with a previous email correspondence. Many times, I'm astonished by some aspect of the reviewer – age, height, and accent. Twice this year I am surprised to find that peer reviewers are actually Irish and part of the professional Diaspora. Often these folk are in academic roles at senior lecturer or professorial level. It begs the question of enhanced research capacity in Irish nursing and midwifery, if this Diaspora returned home...

The issue of space for the NRA in the Field of the Funder held similar challenges of contest. As a resource it was periodically in flux and therefore requiring constant negotiation (n=8). There were pressures to share space and the part-time, flexible nature of the NRA role led to the space being occupied by others in temporary roles (n=9). More often than not, I was uninformed of such an invasion prior to their occurrences.

Initial Impressions The office space held by the previous incumbent of the NRA was occupied by someone from another division of the organisation. Initially, I was surprised as I had expected to walk into the NRA 'space' and orientate myself by reading through existing files. When I asked where the files were, the staff seemed vague and appeared not to know. Within a few weeks there was a move to temporary accommodation as there were to be renovations to the building. This move meant everyone was discommoded. I had previously experienced such moves and was prepared for the negotiation involved, however as the building was less spacious and I was the newest recruit and without a full-time commitment to the organisation, I was unwilling to make a fuss about a temporary space allocation. It meant that both I and a 'teleworker' were allocated some desk space in the communal staff room that also served as the facilities for photocopying. It was the site of a lot of activity and noise. I positioned myself with my back to the room in an effort to focus on my work but inevitably the 'traffic' caused distraction. I found myself limiting the time I spent in the organisation. After one year, the building reopened. Here I shared an office with two others, and whilst the desk space was very limited and the personal computer very slow, I had a space... My space changed again approximately six months later... One morning I arrived in and found someone else at my desk and working from my computer. I went off to have a cup of coffee until other staff came in and could give me an explanation. This was a temporary clerical worker who was to be with the organisation for a number of weeks in order to clear a backlog of work. There were a number of tensions surrounding this incident. One was the failure to notify me that this person would be occupying my space and a second was the assumption that this space could be commandeered for others from the division. There was a sense that the backlogged work was more important than the 'hidden' work that I performed and that with priority came the need for space.
13/2 Space remains a contested issue. I have received an email asking if my desk space can be used as 3 'temps' are in to find peer reviewers for the Project Grant Scheme. I agree and so have stayed physically away from the office for a fortnight. However, since there is a team

[58] This element of NRA labour (n=9) applies to other HRB schemes and processes. In addition, I worked to ensure opportunities for Irish academic nurses and midwives contributing as national panel members and nominees to international panels as part of RCB. On occasions, this was noted as helping to solve gender imbalances.

meeting scheduled, I plan to go in for that. I get to the HRB to find that my desk is no longer being used, something I had not been informed about.

Just as the CNMFs labour space gave pointers to their identity, the space used by the HRB for 'public' events could be also value laden.

27/10 It is the launch of HRB'S 'A Picture of Health'. This publication consists of summaries of HRB funded research, written for the lay person and is seen as significant in HRB's attempts to demystify the research it funds. This is also the 2nd time that the launch has been held in the Royal Irish Academy; a building that is part of the 'establishment of science'. The room has 5 rows of chairs, a top table where no one sits, a screen for showing presentation slides, the HRB banner and a lectern. Portraits of men from the 19th century – eminent Irish scientists look down on the afternoon's proceedings from the walls. The atmosphere is one of scholarship in the way the room has been set out and the cases containing books which line some of the walls. As the launch begins, those attending take to the seats. The audience consists mainly of HRB staff and awardees with a few photographers and press reporters. Photographs are taken before and during the launch. It appears as if members of the public are not present and this year there are no politicians... The launch commences with the Chair of the Board welcoming the audience from where he stands behind the lectern. He underlines the importance of the publication in helping to give a greater understanding of science to an increasingly sceptical public. His speech then outlines 3 key issues – the level of funding the HRB receives, the need for 'physician scientists' and the need for research infrastructure in hospitals. He describes the speech as "now, with that rant over..."! With no politicians and a scattering of press, you wonder whether the effort is worth it as technically he is speaking to the converted (*sic*). The floor is then given to 4 presenters to summarise their work in 5 minutes. The choice of presenters, 2 molecular bio-scientists and 2 medics, gives a strong biomedical message considering the range of research funded. One of the medical presentations did have a qualitative arm of the study that was based in primary health care and this was described by the Chair as 'health services research'.

Five half days of time out also occurred in this field. An organisational strategic review meant that time out was given for team reflection and organisational learning. This revealed some of the team tensions around lack of communication and competing interests. The contemporary positioning of the HRB in relation to the health services and other funding agencies are disclosed. Nursing and midwifery are used as exemplars at times.

26/1 The process of organisation review is to include an identification of our customers – I think that it is going to be enlightening! A remark made about the divisional interaction with academics and universities points to the complexity of the relation of the HRB with health practitioners. There is a sense that those based in hospitals rarely apply for funding and so therefore are not particularly relevant to HRB function. There is a lot of learning occurring, as remarked by the colleague who is less than a year in the organisation and who has asked pertinent questions throughout the morning session. Another has shared with us the perspective that the Board itself is only interested in the funding divisions and not in those generating research. A manager points out that this may be because those divisions represent budgets that can be controlled rather than externally generated funds. I try to make the point that this might reflect the positions board members themselves are coming from but am told firmly that the membership is much broader than it was before. I persist with the idea that if research generation is to be valued then maybe some board members should reflect users of research information. **28/1** Today, our task is to identify what it is we do, to whom we deliver a service and what resources are required to carry out our divisional function by scoring ourselves against an adapted questionnaire. This produces tension. Two of the long-

serving members of staff tend to be more positive in their rating. They give examples of improvements that have been made to the processes but documented evidence is not available for the actions they describe. They are also describing knowledge that they have not shared with others. So, whilst there is a flow chart showing various deadlines over the process year, most of the new staff have never seen it and I have only seen it once in my eighteen months in the organisation. One new member of staff is particularly challenging and the two high scorers take this as direct criticism. Raised voices show this - "please let me finish". The tension is dissipated in a number of ways. Humour is used "We can give feedback on the sandwiches" I remark when the lunch is brought into the room... The issue of asking the customer is a strong focus of the analysis. Again the 'positivists' are adamant that this occurs. The challenger points out how in their opinion the only feedback that is solicited is biased as only successful applicants', committee members' and stakeholders views are sought. As the feedback is mainly sought verbally evidence is not available. I point out a valuable group of stakeholders as being the international reviewers. This is in response to the question 'do we make it easy for customers to complain?' I use the example of a reviewer responding positively to a request to review but lamenting about being treated 'curtly' when complaining that the online system is slow. I explain that this reviewer is someone that I've used in the past and I would not like to lose due to poor customer relations! Such reviewers also undertake the task for no recompense. I suggested that an automatic email is sent once they have submitted the review with the opportunity to ask for feedback on our processes... **1/2** The first 2 hours (*organisational review*)... consist of the external facilitator asking questions about our function and processes. Most of the questions are answered by the HoD and there is a good resume of divisional activities with some historical background also described, such as the origins of some schemes. Nursing and midwifery is used as an example amongst others. I report on the scheme's establishment from the Commission on Nursing. It is good for all the team, including myself, to hear some of this background thinking as it gives a sense of where the HRB has come from and some of its key relationships. The main focus in the latter is on academics and the Department of Health and Children; health professionals (those not active in research) are mentioned only on prompting... After the break, we discuss our attempts at scoring the questionnaire... The positivists and challenger immediately adopt the same roles as before. Raised voices at times show increasing tension amidst which the HoD tries to give the conflicting views in a balanced way. The facilitator intervenes but only at the stage where repetition of argument appears... He tells us that our customer focus should be on all applicants and not just those who have been successful; and on our international reviewers as much as our committee members. He asks us to justify our scores and at times remarks that we may be over-critical. **3/2** Our final facilitated organisation review meeting starts 30 minutes earlier than our last sessions. I don't know if it is the uncontentious content of our discussion or whether everyone is tired of being in each other's company and just want the process over but there appears to be less conflict between team members today. Again, in explaining the work of the division and in answering some probing questions from the facilitator, more background information is given. Some of this information I had gleaned in my time in the organisation, and some of it was an insight into the opinion of the HoD. For example, she described the two pillars of health research as outlined in the MKWfH - "you can't put blue water between us and 'R and D'" shows her opinion of a lack of clarity from the strategic framework. Again nursing and midwifery is used as an example to illustrate some issues such as bidding for and attaining of EU funding or whilst exploring the type of feedback loops to the policy makers, I give the example of my reporting relationship to the Department of Health and Children Committee...

In summary, in the Field of the Funder, funding is a labour process involving advice to potential and all applicants, engaging peer reviewers and establishing panels. Funding and space are contested resources. Whilst there is evidence of nursing and midwifery being gradually integrated into funding processes, there remains the sense of difference with assimilation as a dynamic, contested process requiring time. Additionally, the place of the HRB itself within the health system is problematic.

5.6 Conclusion and literature

This category has shown that there is a triad of resources for RCB with funding, time and space being the contested elements requiring negotiation. Recent RCB literature continues to stress the necessity of funding (Frontera et al, 2006; McAlpine & Norton, 2006; Jeans et al, 2008) to provide time (Cooke et al, 2006; Fowler et al, 2009) but the resource of space is not explicit.

Gaining funding conveys status to the individual[59] and is a competitive process. Just as in medicine (Rafferty & Traynor, 1997b; Academy of Medical Sciences (AMS), 2009) this sets up internal competition for non-monolithic nursing and midwifery. Funding applications require labour in both the Field of the Fellow and the Funder. Within both fields, nurses and midwives, as novices, displayed attributes of learning the funding process and necessary skills for themselves that included the advice offered by Owen & Maslin-Prothero (2001) of interrogating those with track records or from other disciplines. Tenacity and resilience were necessary to confront rejection in a highly individualised endeavour. Being funded as a CNMF required a rite of passage in which the salient identity in this social process (Herriot, 2002) was that of self as researcher, including developing a research discourse in order to be successful. Issues of procedural and 'interactional' justice (Erdogan, 2002) were exposed and the CNMFs contemplated their performance in terms of self-justice. Gaining funding takes time but importantly conveys researcher 'authenticity' as found by Archer (2008) in her pilot study interviews (n=8) with 'younger' academics across six disciplines in the UK. It also positions the doctoral student as independent; as Hakala (2009) found in a qualitative study in 2 universities (n=18) and claims is a result of a changing Finnish science funding policy 'fast-tracking' PhD students to research independence.

Yet, funding should not be treated simplistically without examining its associated responsibilities (McAlpine & Norton, 2006) that in this study included a timely completion. Whilst time ownership results from a clearly bounded, funded time for CNMFs, non-completion within the period produced an internalised sense of failure also found in a report (McCormack, 2005) from four case studies of slow or non-completion of Masters by Research degrees. In reality, the literature shows variation

[59] Similarly to the university department (Lucas, 2006).

in completion rates[60] and resultant changes in enrolment status (Neumann, 2003) with a multiplicity of causative factors (McCormack, 2005; Park, 2007; Kearns et al, 2008) including disciplinary mode of PhD production (Wright & Cochrane, 2000), supervisory arrangements, institutional features and personal issues, including self-sabotage (Kearns et al, 2008). Consequently, whilst rhetorically valuing 'not counting the hours', the CNMFs struggle to 'guard time' from encroachment and balance obligations from their different personae. Kearns et al (2008) describe how the identification of 'real' from 'phantom' hours, shows PhD students the time available for quality doctoral work rather than academic procrastination (Ahern & Manathunga, 2004) or responding to multiple demands (McAlpine et al, 2009). Just as Maben et al (2007) found in qualitative interviews with a purposive sample of clinical nurses (n=26) for a longitudinal study, time is a resource viewed as luxurious by the CNMFs and, here, reading is utilised as the exemplar. As in this study, the "snatched moments" for previous part-time doctoral reading are reported elsewhere in a reflective piece (Barnacle & Mewburn, 2010). The funded time is conceptualised culturally as 'being off' suggesting a sense of envious illegitimacy from others. This aligns with clinical practice rosters whereby temporal division is commonly articulated as binary (Brown & Brooks, 2002) and clearly demarcated. Instead, within the funded time, the temporal boundaries of labour are blurred and this presents a site of struggle for CNMFs.

The importance of infrastructure requires attention in RCB (Butterworth, 2009a) and space emerged as an important elemental resource found in only one other study (Neumann, 2003). Labour space was not always clearly differentiated as it can be for disciplines like science (Clegg, 2008). Gaining optimal space for research labour required negotiation with others, whether the space was in the private or professional domain. Personhood factors such as the presence of children, geographic distance, or role factors such as time commitment impacted on negotiation stances. Nurses and midwives in clinical practice have been shown (section 2.3) and reported empirically not only to share space (Halford & Leonard, 2003[61]) but to manipulate it (Andrews & Shaw, 2008[62]). From such professional socialisation, CNMFs and the

[60] Interestingly, the unit of analysis tends to be 4 years fulltime in Europe and Australia rather than the 3 years available in the UK and under CNMF. Park (2007) outlines the UK policy call to extend funding to 3.5 years ahead of the implementation of the Bologna agreement.
[61] From data generated by two periods of non-participant observation and 50 unstructured interviews with nurses and doctors.
[62] From semi-structured interviews conducted with 15 nurses across a range of clinical specialities

NRA adjust to labour space limited to 'as good as it can be'. The CNMFs also assimilate the symbols and spatial embodiment of their transitional identities.

This chapter describes the category of 'resourcing the research' that supports the core category of 'privileged pioneering in the peripheries'. It describes some of the skill development, social adaptation and cultural meanings that nurses and midwives bring to their assimilation into the health research culture and is interlinked to the other subcategories. The next chapter (Chapter 6) deals with the second subcategory 'labouring the doctorate'.

Chapter 6: Labouring the doctorate

FFI111 *(1555-1558) ...not everybody I think appreciates it... the 3 year PhD fulltime is still quite a piece of work.*
F3I77 *(746-749)...one of the reasons that I wanted this fellowship was that to do it well, you need to be immersed in it. You need to stay at it, you need to live it, you need to breathe it...*

6.1 Introduction

As the basic foundation in research capacity building, the CNMFs must labour the doctorate, the second subcategory of the theory (Figure 6.1). Described as "no easy ride" and "a hard slog" (FFI1012), this chapter explores the PhD process as a course of PhD practices or tasks that result in the PhD product and "a stamp to say you've passed that test" (F3I248) that gives "a licence to do research" (FFI111).

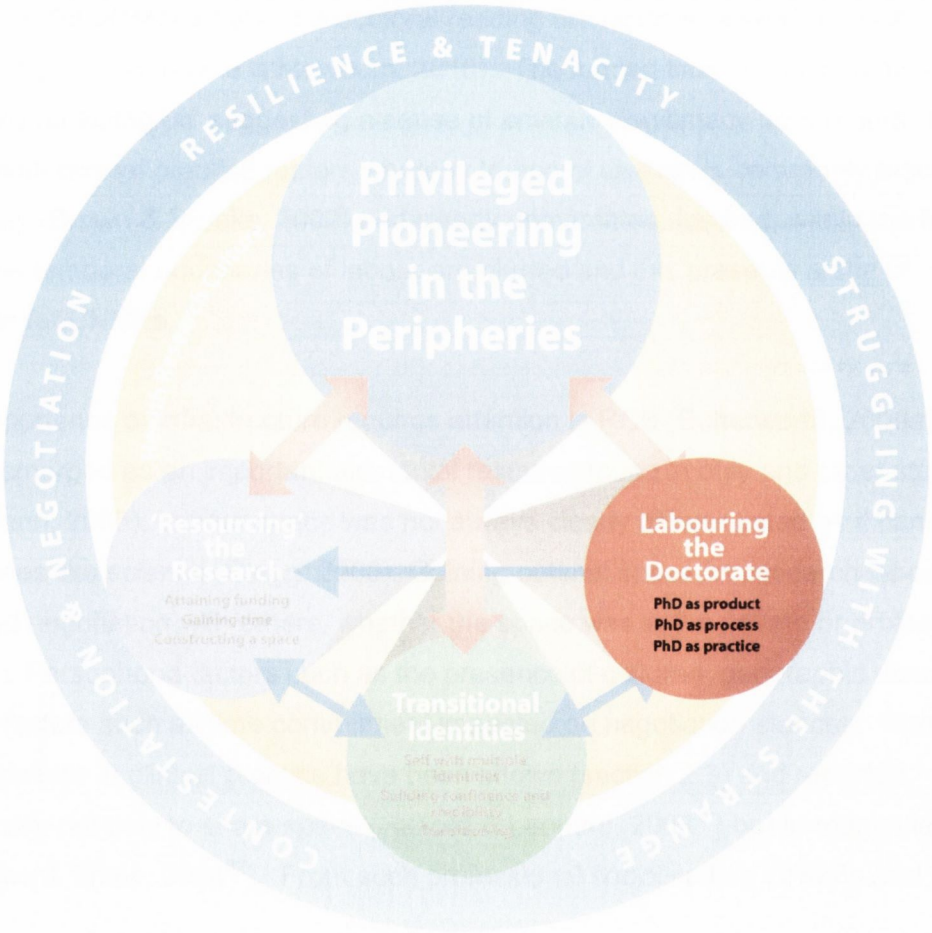

Figure 6.1: The subcategory of labouring the doctorate in the theory.

The chapter firstly shows the PhD as product; initially an obscure ideal, which gradually becomes a known reality. Secondly, PhD as process is described including skill development and rites of passage. Thirdly, the practices of PhD labour are detailed with the main focus on 'building routines' and 'labouring ethically'. Finally, the culmination of the labour in forming the thesis is described and some notes regarding my own labour. The labour required the triad of resources discussed in 'resourcing' the research. Throughout the data on labouring there were cross-cutting themes; structuring of process and product, tenacious struggle or being "an ol' goat hanging on with one leg" (RD18/5) and uncertainty or "feeling at sea" (F2I194). Most were on a continuum of severity and occurred intermittently throughout the Fellowship giving a perception of highs and lows.

6.2 PhD as product: labouring the unknown

For CNMFs, labouring the doctorate included developing a conceptual understanding of the PhD as a product. The leitmotif of one CNMF shows how initially they were labouring the unknown although "PhDness" (FFI121) is finally resolved through undertaking the experience.

F2I2810 (310-317) I keep asking people... "What constitutes a PhD?"... nobody is able to tell me. (323-335) People... that are supervising PhDs and that are marking PhDs... will tell you that – "You'll know it when you see it".
F3I77 (426-430) I have some notion of what the level of the PhD... how a PhD differs from a masters. (536-540) ...in an excellent PhD, even though it has been written by other people, they'll see it in a new way in every chapter in it and not just the discussion and the findings.
FFI121 (219-241) It is a research project that you are doing but in fact the PhD piece is conceptual thinking and development... that's what makes it different to a masters... It is a shift to that higher type of thinking. Debating philosophical issues... the micro-method issues are the master's issues. The philosophical bigger issues are the PhD issues. (1426-1467) ...you've shifted your head and heart and everything else and you show that.

Reflecting Burnard's (2001) earlier plea, two CNMFs complained of a lack of standards and transparency with Delamont et al's (2000:35) "indeterminate qualities", contributing to the unknown. Yet in the midst of this, CNMFs had already presented bounded feasible proposals for funding amidst a tension to explore extensive ground. Difficulty in verbalising a PhD was common and some looked at others' PhD work to assist them in structuring the work or meeting disciplinary demands, so developing the necessary judgement (Delamont et al, 2000). Often there was a practice of 'PhD sharing' which was both observed and reported.

F1I267 (1664-1666) I need to get theses and look at the calibre... judge where I think I am and then work to similar style.

F2I296 (404-420) I've taken some from other libraries from the States... so they gave me a very good idea of... what people are writing about and then how they are presenting results...

Whilst 'depth' was noted as a characteristic, the most common discourse was about the 'level' of conceptual thinking. Time was a requisite to develop such thinking in order to "focus down" (F1I309). Often comparisons with Master's level thinking and writing style were drawn. These distinctions were further emphasised where CNMFs had to fulfil a formal university transfer from Masters to PhD registers (n=3). The level of conceptual thinking was especially executed in questioning during viva voces where the types of questions could differentiate a PhD from other pieces of research.

FFI121. (84-92) ...his questions were borne... out of things on epistemology and ontological positions and your own belief systems and values and so they were different types of questions... (571-578) They were conceptual... Like I got stuff on constructivism, social constructionism, ontology, and epistemologies and relativism...
FFI132 (807-810) ...the questions were very theoretical, very philosophical, a lot of epistemological issues, theoretical perspective issues.

Achieving the 'level' of PhD was a source of anxiety about self ability in the initial stage so as to reach the "PhD standard" (F2I194). This was perceived as a "huge conceptual leap" (FFI211). The PhD as product was an intellectual challenge (n=4) whereby the CNMF had to "stretch... academically" (FFI2510) or alternatively struggle for a recognised interval.

FFI1510 (58-71) ...expectations were totally unreal... It was as if... from day one when the Fellowship kicked in... that I should then be thinking and functioning at PhD level. And I expected this! ...I felt that my thoughts were so basic I will never achieve a PhD standard.
F3I185 (2244-2261) ...it's almost like you have to suffer for certain period, a reasonable period of time before they say "Ah yeah, she's done enough, we'll let her go through it"... There seems to be a lot of that kind of mentality around... it is nothing to do with your intellectual ability. It's just all to do with your psychological health. I would reduce it down to that.

There was also a tension surrounding the CNMFs' perception of what their contribution was to knowledge development or simply just 'finding common sense'. They held a notion that the gold standard of 'originality' in the sense of "rocket science break-through" (FFI211) might not be achievable but that creativity in the sense of a product "going outside of the box" (F1I117) may be so.

F2I194 (462-466) ...the other thing I feel is that I've just found the obvious. (laughs) ...there's a big "So what!" Have I just found what the whole world knows? (482-487) you start out a PhD thinking that you're going to come up with something wonderful. And then you come up with ..."Oh God, this is common sense".
FFI121 (1455-1459) ...it is your piece of work that needs to be done in a creative manner at a higher level... that is the rule that people need to be governed by.

The PhD as product is not just conceptualised as here but operationalised through processes and practices before becoming a tangible product. As the latter it will discussed in 6.5 where forming the thesis will be described from the CNMF's perspective.

6.3 PhD as process

6.3.1 PhD as process: a developmental course

For the PhD as product to be achieved, the CNMFs must complete the PhD as process. Notions of what comprised a PhD also had a process focus, that CNMFs (n=7) metaphorically described as a journey, in common with the literature (Appel & Dahlgren, 2003; Miller & Brimicombe, 2004; Guthrie, 2007; Trafford & Leshem, 2009). Previously reported attitudes to originality (6.2) and the PhD as research training stance (n=2) reflect tensions produced by the relatively recent re-conceptualisation of the PhD (Neumann, 2003; Park, 2007). For PhD as process, labouring was also an unknown in the context of attempting certainty.

FFI2710 (682-690) ...a PhD is training on how to do research.... so this was... a journey of training on how to do research rather than one that uncovered (*new knowledge*). I had to get my head around that at the beginning.
FFI1012 (209-218) ...initially... I overlooked the fact perhaps that the Fellowship was a training Fellowship... I felt I had to know everything... as I embarked onto it... only when I was in it... I began "No, this is what you got the Fellowship for, is to actually learn the process of research".
F3I185 (2199-2204) It's like being in the middle of a big field and you've got the plough and you don't know whether you start here and go down to that corner or if you'll start there and go to that corner.

Some uncertainty sprang from changes in the study design (n=5). These included both additions and subtractions from the original design so as to improve the comprehensiveness of the study. Project management was seen as part of the learning of the Fellowship although one CNMF declared having such skills from previous clinical research experience.

FFI2710 (727-734) There was a big, big thing about the management of your work. You are going to have to decide what needs done, when... how... go speak to the people who need to be spoken to, if there's access that you need to get... do it all well and plain...

The CNMFs developed process plans for a specified time period and with particular goals against which they measured progress. These plans were self devised or negotiated as part of supervision. They assisted the CNMFs to measure progress

and could generate reports for key stakeholders such as the supervisor or adapted for the HRB's annual report.

F1I271 (89-105) ...the supervisor will... set goals that are fairly stringent goals... It focuses your mind and I work well that way... I submitted... a Ghant chart of exactly the timeline for the whole two years... we set goals and every supervision the supervisor compares this to the Ghant chart. So that's the way it's going to progress.
F3I2311 (943-951) ...every time I speak to my supervisor I have to produce something. Now it isn't always chapters... the last time it was an outline... of how I was working on my analysis... and my thinking through of my analysis. (1244- 1254) this is what I needed – a push. Somebody to say "You're to have such done by such a time"... I don't like it but it gets me moving...
F2O1111 The Fellow settles at the computer, then sighs and mutters as she reads the screen. The annual report for the HRB is being written "Thanks be to God I keep a record. I would have put in 2 presentations; whereas I've done 3" she exclaims as she cuts and pastes words from one document into the report.

Such process plans allowed the CNMFs to stay focused on their research practices and completing tasks by time. One CNMF claimed an inability to work to targets, but most others valued the benefit that such structuring gave their labour, avoiding "drift" (F2I410). Having formulated plans the CNMFs then strove to keep on track. However, they experienced that the process did not occur along a straight line of progress or "linear way" (F2I2810 & F1I117) as expected.

F2I296 (934-946)...they're (*supervisors*) saying there's always that point of where you just think you're not getting anywhere and suddenly it clears and you're off running again... you hear people talking about hitting this wall and not going any further... obviously it must have been one of those occasions but I didn't know that's what was happening. (laughs)
FFI211 (36-49) I could see myself in this sort of tangled mesh and I was continuously getting caught and trapped in this web... at the outset of it I had no idea of the difficulties that I would experience, of the struggle it would be for me... to get through this.
FFI1510 (36-43) ...it was like... I'm going along in the dark because I really didn't know where I was going. I had my template and I knew the research process... down to step by step but in fact in reality it was so, so different. The highs of the PhD were often times pulled down by the lows...

The CNMFs described how a PhD could potentially or actually "runaway" (F1I23 & FF183) or "go up and down so many side roads" (F2I2810) if the process was not adhered to. This could occur due to both external contextual and internal personal factors. So keeping on track was vital to "draw closure" (FFI1012) and prevent 'runaway'. Learning what works by making mistakes was one reason for going off track but having funded time was valued for allowing errors to be corrected.

F3I185 (2001-2007) ...a lot of things can go pear shaped... things you don't have control over... you begin to blame yourself. Then you actually begin to feel "what an idiot" and your self-esteem drops.
FFI2510 (1268-1276) I made a couple, a good few mistakes. Like my statistics... I was going to the wrong person and I was getting myself in knots and that took probably four months

longer than it should have. And I still had time to catch up with that... My lit review, wasn't right at the end and again I had time to recover from that and redo it.

'Getting stuck' by encountering a "stumbling block" (F1I117) or being "in the doldrums" (F3I185) brought uncertainty to the ideal 'linear' process. This resulted in anxiety or panic. Some CNMFs developed the technique of moving away (n=3) or doing another task to manage this experience of "stuckness" (F3I185) and move through the process.

F1I271 (609-617) I started working on the publication and pulling it together, I calmed down because I realise then I'm doing something, it's ok... I'm able to do this... at least I felt I wasn't immobilised. I was able to do something and then that got rid of the anxiety.
F3I2311 (1714-1726) ...when I run into a difficulty...I nearly have to edge around it... I'm looking at something and... I'm stone stuck (sighs)... I'll have a cup of tea and I'm away from it.

'Time stealers' also mitigate against staying on track. Some are individual mediated, others are due to external factors. One time stealer is waiting; for example, awaiting the arrival of equipment or materials or the results of supervisory or research processes. "Everything takes a bit longer than you'd expect" (F3I142) and this causes frustration as time 'slips away'.

F2I1211 (677-686) I look at other (*non-nursing*) students and their PhD supervisor is... with them and it's very day by day... Whereas I was finding it was too long (*between supervision visits*) and I had done too much and then maybe two thirds of what I had done was no longer relevant... that's quite depressing...
F2I296 (39-46) ....there was a lot of coming to the university library. Ordering stuff and then I mightn't be able to get there every day and I come back again and they'd have sent it back to (*the store*)...

Thus the data showed PhD as process as a developmental course. This was composed of non-linear and at times overlapping phases so that sometimes in order to progress there was a sense of going back as well as forward. Across the process, there was the generation of differing needs and both negative and positive feelings reported such as panic, stress, disappointment, frustration and delight, satisfaction and pride.

F2I2810 (1589-1597) You have to carve it (*the labour*) up in little pieces but the pieces aren't as discrete as chopping up the pieces of pie equally... they're not discrete pieces and sometimes you don't know where the beginning and the end of the pieces is.
FFI83 (859-870) ...at the end of the PhD you go back into this very vulnerable mode. You're very vulnerable at the beginning. You start to get a little bit of confidence... the data is yours and you begin to understand it. You then go to analysis, you feel a bit of loss of confidence again and then at the very end you're really lacking courage. Does anybody want to hear what I'm going to say?

6.3.2 PhD as process: rites of passage

The PhD as process included a number of rites of passage which the CNMFs viewed as formal 'hurdles' as opposed to the informal 'stumbling blocks'. An early rite of passage is that of gaining ethical approval for the study; a process noted as a "political exercise" (FFI211) with "the pride (*of lions*)" (F3I185). The data showed a diversity of experiences in this process. Three reported the experience in positive tones "asking questions out of genuine professionalism" (F1I511); others held ambivalent or negative attitudes or encountered antagonistic experiences.

F1I1512 (294-306) There was a lot of misunderstanding around my proposal which I felt was due to the fact that they hadn't really read it... one person (*the medical chairperson*) was particularly obnoxious to me... the person was very confrontational. (382-385) before I actually left the room he had moved on to the next business before I actually had gathered myself up.
FFI2510 (421-439) It was an experience! ...there was a huge board table with about 12 or 13 people around it, totally intimidated... they each drilled me... Their main concern was that their institution might be shown to deliver inferior care to people and that there would be a backlash on them... it was just intimidating.

Getting ethical clearance gave rise to time issues: the infrequency of the committee meetings or convincing medics to sponsor the study for ethical clearance. Ahmed & Nicholson (1996) also note the resource issues required for multiple applications. For some CNMFs (n=9) ethical clearance meant approaching two to six ethics committees: some of these approaches tentative for contingency purposes.

F1I309 (463-465) ...it took a long time simply because it's in another city. I had to go up and down. (474-478) ...then I had to wait quite a while because the ethics down there have no admin support...That is what held it up...
F3I185 (429-449)...I started negotiating with the consultant... he introduced me to the other fellow, more senior... I was sweet talking them along for months. Now we're talking about several meetings... looking at the proposal, he'd make a suggestion, I'd say "yes, sir". (laughs) I'd say anything like to get him to say yes... This went on for four months... and he did agree and signed off. And then the ethics committee in that hospital wanted to see the two of us just to clarify some points... What has he done? He's gone and retired and he never told me.

There was a diversity of practices for gaining ethical approval: paper applications, attendance at meetings to defend, presentations.

F1I267 (1033-1038) ...they had questions as well. You give them the twenty one copies (*of the presentation*)... then you just give them the gist of what it is you want to do and then if anybody on the panel has any (*questions*)...
FFI2510 (393-401) Lots of letters to ethics committees, directors of nursing, consultants and form filling... the last one took approximately 10 months to actually get a response from them and I was asked to come in front of the ethics committee...

Attendance tended to be individual endeavours. Exceptions occurred where the CNMF was accompanied by the 'sponsor' from the hospital concerned, such as a research nurse (n=1). In most cases, the imprimatur of a medic was a requirement and the 'sponsoring' medic often represented the study as the investigator, either alone or with the CNMF.

F1I23 (867-877) ...because the Professor was my co-applicant and he worked there (*the hospital*), they wanted him to turn up to the meeting... I had to go back and say "would you mind" but he had two other applications in... there was no problem in turning up for me. So I said I would turn up too just in case there were any problems and it is really unfair asking him. (*this CNMF sat outside the meeting room during the process*).
FFI211 (2044-2048) The consultant went to the meeting but I didn't know that in advance and he came back as the Principal Investigator... They wrote to him.
FFI2510 (441- 470) They questioned both of us but... I gave the answers because... he (*the medical sponsor*) hadn't even read up on the... stuff I had given him... It annoyed me... I felt he shouldn't be there for... a piece of nursing research and he had no idea of the study. He was down as principal investigator and although the questions were directed to him, he had no idea...

The CNMFs displayed varying degrees of acceptance of such 'medicalisation' of the ethical clearance process.

F1I309 (414-417) ...you have to get a consultant to be the first investigator which is just the way it works and that's fine.
F1I1512 (182-191) ...they (*the hospital*) wanted a consultant to oversee... what my supervisor provides... he was very accommodating but there is that kind of attitude...
F3I185 (391-400) ...I just knew by the secretary's face that I was going nowhere with this... I actually learnt a very valuable lesson that if you didn't have medical support to sign off then you hadn't a hope in hell... but I learnt that the hard way.

Engaging with potential 'sponsors' or ethical committee chairs prior to submitting an application, and in one case subsequently, was common and part of a range of 'doing extra' or additional activities that CNMFs undertook in order to gain ethical approval.

F1I1512 (142-152) I was made go around a whole lot of people to sign forms that really they didn't need to sign... the Director of Nursing would have been in a position to sign it but I also had to get the General Manager to look at it and also a consultant which was superfluous really to the requirements.
F3I2311 (759-769) I made sure to meet the nursing representative first, informally and sort of get her on my side and explain it to her so that she had words that she could use because I felt... on these committees and the whole hierarchy, she was a nurse, there was this feeling of having to explain it to a doctor who knows best (laughs).

The membership on ethics committees also varied. In some cases it was unknown, even when the CNMF attended, although this information was supplied later to one CNMF who was conducting a clinical trial. Whilst some committees showed the recommended (Irish Council for Bioethics, 2004) multidisciplinary representation,

including nursing, there was a further sense of 'medicalisation' with many medics holding the key position of 'chair'. Additionally, the meeting was often held at times that facilitated attendance by medical staff.

F1I51 (546-559) ...the one in my own hospital I was familiar with a lot of the people... very diverse... lay people, administration, nursing, legal, clergy, medical - the whole gambit.
F1I267 (1111-1129) ...the chairperson of the panel is a (*medic*)... literally it covered everybody, it was 21 people... health professionals, psychologists, lay people.... they all gave their names and their roles.
F3I185 (384-388) ...the whole committee comprised of all medical people, one legal and one lay representative and the secretary. So this was back six years ago.

For some CNMF's studies, ethical approval processes did not exist because of the research setting or type of respondent. In these cases, a university ethics committee was used or a combination. The data on gaining ethical approval showed a changing context for ethical governance within both the health and university systems leading to a lack of clarity for some CNMFs.

F2I1211 (1029-1038) ...the university had set up its own ethics committee but eventually... after a couple of turns around the committee they said "because you've already got ethical approval from the hospital" and some of our committee are on the parent hospitals... "you shouldn't have to also get it from the university".
F1I1512 (246-249) I had applied already to the regional structure and then the HSE took over so I asked them to have a look at it quickly for me...

For four CNMFs feedback from ethics committees was viewed as "reassuring and affirming" (FFI1012) allowing the study design to be strengthened.

F1I511 (480-514) ...(*the ethics committee was*) the first real appraisal of the whole project... I found them very professional... they weren't trying to trick you... looking back I really wasn't ready for an ethics committee but they were a huge help to me.
F3I2311 (691-699) I had to write a 3 page report...answering all their queries... it was very useful. I brought in things that... I had thought about but I hadn't addressed head on which have pre-empted a problem later...

A second rite of passage in the doctoral process is the viva voce, an oral defence of the thesis conducted by external examiners. This is a hidden process and is the source of myths or 'viva stories', that are mainly negative. The reality is that most CNMFs reported the viva experience positively[63] - "amazing conversation" (FFI132), "fabulous experience" (FFI1510) "actually enjoyed it" (FFI83), or somewhat ambivalently.

[63] Similarly external examiners report the overall experience in positive terms (Carter, 2008)

F2I194 (913-921) a friend of mine... she said it was the most horrific experience and that she had two 'boys' as she called them... vying to look good at her expense. That would be one of my worries.
FFI132 (1397-1405) I didn't hear of anyone having a positive experience with the exception of one colleague... I had asked 3 or 4 others and it was extraordinary negative...'touch and go', 'extremely tough and dodgy'...

The viva as a "critical comment" (FFI132) or appraisal of the work that required the CNMFs to "defend the weaknesses" (FFI111) was not forgotten, even where CNMFs were confident in the quality of the work.

FFI132 (251-257) ...this is the final examination of your three year process and you really are here to sell it and potentially get your reward or not... It's not a chat... it is an examination.
F3O111 The CNMF states that she is concerned about her skill of concise and cogent articulation. The supervisor uses this statement to justify the PhD viva as a method for the examiner to check if the student has written the work. The example of a well written thesis being thrown by a poor viva performance is given and quickly followed by the advice on preparation and rehearsal of answers. He uses the term 'polishing' and emphasises that this process has already commenced.

Therefore, laying groundwork for this part of the doctoral process was required. Preparation centred on reading, and, as in other PhD rites of passage, practising questions and answers. The process of preparation usually occurred in year three. One CNMF was cautioned on over-preparation and warned not to "beat themselves up" (FFI111). Reading had three foci – supporting theoretical work, manuals or "very dedicated time" (FFI1012) to reading the thesis itself.

F3I248 (1464-1474) I've already a list of books that I'm going to read for my viva... On... theory on social worlds... and that sort of stuff, so very philosophical... (1422-1426) I got the questions from the American Psychology Association, the mock viva questions. They're not particularly exciting, they wouldn't challenge you.
FFI121 (259-262) ...I read a 'preparing for your viva' book and I read a couple of articles that people had done on researching vivas.

Practising questions and answers had a number of steps. Firstly, anticipating questions, secondly creating succinct answers to potential questions; and thirdly reciting their articulation sometimes in the form of rehearsing the viva performance in a simulation (n = 7).

FFI111 (86-93) I spoke to other PhD students who had gone through vivas... colleagues who had supervised, there was a consensus of a core set of questions... that tended to come up.
F3O111 ...(*supervisor*) asks for an explanation of the CNMF3's findings as a rehearsal for the viva. The CNMF3 launches into an exposition, gesticulating with her hands and maintaining eye contact with the supervisor except when pausing to find a word or when the supervisor is making notes. She is interrupted by the supervisor at times for points of clarification.

A simulation known as the 'mock viva' was the organisational preparation for the viva voce, although some CNMFs organised additional simulations themselves. Of value were experienced examiners or those that brought a different disciplinary perspective to the simulation.

FFI2710 (53-68) ...my primary supervisor... and the Professor... he is quite experienced with the vivas so... I've been told... by my supervisor... "He does a very realistic one". I'm not sure what that means!

Acting as a rehearsal, CNMFs saw merit in learning necessary behaviours such as how to deal with confrontation but they laid greater emphasis on the cognitive content of simulations and how similar or contrasting that was to the substance of their real viva.

FFI111 (129-145) ...there was one or two issues with the PhD where he... was reasonably derogatory... he said... that he was "deliberately trying to beat me to say it... because you will often get a student who will respond in a viva." It causes an argument. He says "You don't want to do that"...so that was an important lesson because that came up then later on in the viva.
FFI132 (795-800) ...the second examiner actually was the one who asked just about all of the questions. The questions were extremely tough and phenomenally different to what I was asked in my actual viva.

There was a sense that CNMFs had reached a sense of readiness for the viva and then had the anxiety of potential or real delay. Long lead in times to the viva was also problematic in having to resume readiness. Feeling comfortable or relaxed were important identity elements in the process.

FFI2510 (631-638) ...it was due to be on (*date*) and... having got myself ready for it, it was cancelled because the extern couldn't make it... I had to wait a month then...
FFI1012 (1167-1172) I submitted but my viva wasn't until 5 months later, which was quite a span... (1187-1192) then it was the dreaded thing of... how am I going to prepare for my viva because it's so long since I wrote this. Like it's 6 months since I wrote this discussion...

The examiners are key agents in the viva requiring careful identification and due consideration to their role. Most (but not all) CNMFs had some contribution into identifying or choosing examiners for the viva. In its absence, prior knowledge of the examiners is assumed. Concerns in making the choice of examiner included an understanding of the Irish context, and credibility from disciplinary knowledge.

FFI911 (637-652) ...it depends on who examines your PhD. That's what it comes down to in the end and if it happens to be somebody that's sees the world the way you see it then you might be all right, but if it's somebody that doesn't... the best piece of advice I could give anybody... is to, write for the examiners... they're the only 2 people who'll really read it with the amount of interest that you have.

FFI132 (91-118) One was on the basis... that she had been external examiner... and therefore... might have some knowledge of the Irish system and culture and the second examiner is very active in a UK professional organisation... had done the external review previously of when the university school was actually quite new... So there was a sense of understanding... where the school and its research students might be coming from...
FFI1510 (761-777) ...my external examiner, she was a nurse... she was also a sociologist... and she was a research fellow (*in the same area*)... almost a 3 in 1 package... I couldn't have got a better person to be able to come and examine this.

The CNMFs' actual viva voces had a variable time period ranging from 90 minutes to 130 minutes. 'Warm up' questions tended to be the norm, although there was some divergence. As discussed in 'PhD as product' the types of questions held the meaning of PhD level and thus were an indicator of success, as were praise for the work.

FFI121 (530-539) ...the extern started and... asked me a warm up question, you know generally polite... S: What was the warm up question...? FFI121: In terms of how did you come to this topic and I had that kind of rehearsed...
FFI132 (295-307) Each of them started off being very complimentary about a particular chapter... section or... aspect, described how they perceived the information that had been given and how different from their circumstances. And then went into 'could I ask you questions about...?' For example, why did the service develop? And so it was quite different...

The notion of 'defending' the work is part of the viva. Thus the practice was one of facing the challenge and championing the work. Challenges were on a continuum of magnitude. Advice and lessons of non-confrontation were exercised when CNMFs encountered a "picky examiner" (FFI111) and 'judgement calls' were required within the process as to whether continued resistance to challenges were worthwhile.

FFI132 (1012-1018) ...even though there were issues that you had to defend, it wasn't a negative challenge... more really pushing you to persuade them rather than you necessarily being wrong and being told you are wrong.
FFI111 (26-31) It became at times reasonably confrontational. But I suppose there was a bit of me sitting back thinking "Well this is what your job is, so it's my job to defend it". (551-619) one particular issue that arose... in relation to the ethical approval... a decision was taken during the PhD to do it a particular way... (*details omitted*) They felt that that would have warranted (*a different action*)... one in particular got very, very strong about it... you could feel yourself getting drawn in... as it sort of went on, I thought "you're not going to win this"... in the end... as she pursued it I said "Well, I accept your position but there is another way to look at this."... I said "it's something that I would consider on subsequent research" and that was it. It was just left then...
FFI2510 (686-695) ...there was one... examiner that was giving me a bit of a hard time and she wasn't right and I was digging my heels in and she was digging her heels in and at one point I thought..."I can't keep doing this because I'm going to show her up" and I had to make a judgement call there so I backed down and that was hard to do...

Completing the viva meant an identity shift for others to view the CNMF (7.4). Congratulatory behaviours occurred. For 2 CNMFs, contemporaneous celebration was combined with a sense of anti-climax.

FFI111 (661-667) ...people talk about... the anti-climax... when your PhD is finished and yeah, there was quite a big, I'd say a big down... at the end of it you thought "Yea, done it"
FFI121 (1253-1269) ...people were coming up and saying "Congratulations, you must be delighted" but I wasn't. I was so down, I really didn't want to talk to anybody... One of the girls called it... the 'pricked balloon syndrome'. (laughs) And that's it, somebody let the air out of me.

6.3.3 PhD as process: skill development

In this section the data on RCB skills is explored. Three of the CNMFs referred to skill development as "generalisable" (FFI911) or 'transferable' to other fields, thus reiterating policy rhetoric (Gilbert et al, 2004). The skills required to labour the doctorate could be divided into interpersonal, technical and scholarship skills. Some existing skills were refined whilst new skills were learnt; two CNMFs described their learning as absorption, comparing the process to a sponge or vacuum cleaner. Often, and similarly to nursing and midwifery, learning occurred through practice, fostering the perception (n=2) of being self-taught.

F3I185 (2299-2304) I wouldn't be bothered going to listen to her... because I learnt nothing from her (*previously*)... absolutely nothing. Everything I've learnt has been self-taught.
F2I410 (889-893) ...my knowledge of research per se has certainly increased an awful lot and yet I've never gone to any great lectures on research so a lot of it is self-learning.

Interpersonal skills

Whilst there was a sense that the CNMFs already had well developed interpersonal skills by dint of being nurses or midwives, nevertheless some skills such as interviewing were further enhanced in the process – especially by "learning to shut up" (F2I911).

F3I2311 (279-282) ...my interviewing would have been... about silence. My being silent, to allow the person's train of thought (1042-1056) ...transcribing the interviews and seeing where I... intervened in the person's speech just when they were about to say something... this sort of thing was good for my practice and I learnt to be more silent.
F3I185 (2309-2315) I've got better at the interviewing. (laughs) you just get more confident, more at ease I suppose the more you do... As you get into the subject you kind of get to know better questions to ask and when to try and probe...

Becoming "much more of a negotiator now" (F3I248) shows the development of negotiation skills. Beyond the structures of ethical clearance and licensing authority there were numerous gatekeepers with whom the CNMFs negotiated access to research settings – the nursing hierarchy, health service managers, and medics were the main groups. Sometimes a single gatekeeper was required who then cascaded

to others, or more commonly each individual gatekeeper had to be approached by the CNMF. Time delays were common and diplomacy (n=2) required.

F2I410 (127-141) I... went to visit her, she wasn't there and basically she delayed me for nearly 4 months... I rang both the consultant and the ethics person and I said "Look this is all I'm waiting for.... I've left messages, I've sent letters, emails, you name it" and the next thing she just rang the head of the ethics one day and just said "You can go ahead with that"... you do meet people I think who... for reasons known only to them, can be difficult.

Face to face meetings were preferred for such purposes and these, along with information sessions, gave the CNMFs the opportunity to 'sell' the project (n=8) to clinical staff in the research sites; thus developing marketing skills. Whilst the CNMFs gave examples of negative gatekeeping, importantly, gatekeepers could positively influence the project by supporting and promoting the project to others.

FFI2510 (1183-1194) I had sent in letters first of all to the units and spoke to the sisters on the phone... they were asked to... ask their staff if they wanted to get involved in the study... I had (*a number of*) sessions in each of the units telling the staff what it was going to be all about...
F1I267 (738-742) I could only negotiate with one director who then negotiated with the other nine who then communicated to the rest of the nurses. (755-761) Without that person, I wouldn't have got any access at all... she was very supportive and she couldn't understand how her colleagues couldn't do what she was doing...
FFI211 (2138-2142) ...in both settings I met both multidisciplinary teams to actually explain to them what I was doing... (2190-2193) I did send out this energy about this particular problem area being really important. And I think I sold it at those meetings...

Negotiation was also required within research settings. This centred on getting relevant data and optimising the environment for data gathering.

F3I185 (498-508) I asked could I join the consultants on wards rounds... Did that for a couple of weeks and still wasn't getting anywhere near anything. So then I heard all the talk about the case conference so I said "Could I come to the case conferences?" ... they said "Yes".
F1O191 ...we've already met a member of the household staff going up the stairs in the opposite direction. The CNMF says we are part of the group and the woman asks if she'll bring the tea and coffee now. After an initial moment of confusion, the CNMF negotiates that the catering should arrive to the room fifteen minutes before the participants are due to arrive and this suits the women as it is before her shift is due to finish.

Technical skills

The CNMFs develop technical skills during the process of the PhD. As before, there was refinement of existing skills, or new skills were acquired in order to collect or manage the necessary data. Technical training was availed of, mainly in the CNMFs' institutions and centred on various software packages for dealing with references or data. Interestingly, most but not all qualitative researchers reported training on analysis packages but subsequently reject their use.

F1I117 (1000-1009) I went on the training and I started using it and no matter how much you say to yourself 'this does not analyse the data for me'... this mere fact of using it, you start sectioning it and you're not thinking. So I had to just discard it and go back to the drawing board of actually using 'Word' and just the cut and paste.

However, technology gave rise to uncertainty; issues such as lacking familiarity with the software, poor internet access (n=2) and machine failure (n=2) were reported. Hence the loss, not just of time, but also of material.

F1I1512 (735-741) ...initially accessing the university (*online*)... was a real hassle and it was... something that could have been fixed easily. (752-756) In the end I rang up the library and they said "...a lot of people have problems with that. Just download (*another programme*) and you'll be able to access".
F3O248 She tells me that she is on her third external hard drive and second laptop at this stage of the fellowship. She has also had a monitor failure and is resolute about these IT problems with "it could have been worse". She backs up her work every night onto another computer and a memory stick.

Seven of the 9 CNMFs that were on the Fellowship at the time of data collection undertook advanced training in their methodology. It was provided abroad, mainly the UK and the US and four availed of the HRB travel grant to enable them to undertake the training. Such focused training was selected and highly valued for developing understanding of the respective methodological techniques. Examples were given of learning that impacted on their own specific projects. With one exception, all the training was multidisciplinary, thus the CNMFs were exposed to a broad range of professionals from across the globe. In some cases, contacts were made which led to subsequent information exchanges, even to sharing theses (n=2).
Of value, was the access to experts and gurus that advanced training could provide and the subsequent assistance, such as introduction to different literature, that can be gained.

F2I2810 (127-131) ...there's something about meeting the author of a text... getting a feel of where they're coming from that you don't get from just looking at words.
F2I410 (86-92) ...it's given by (*name*) who's the Professor of Medical Statistics there and... another methodological expert... some of it was a little bit challenging for me... They did it very well.

Scholarship skills

The scholarship skills consist of the four 'Rs': reading, reasoning, reflecting and (w)riting that culminate in the product – the thesis. In resourcing the research the CNMFs have already described the guilt associated with having funded time to read. Engaging with the literature could be challenging, however; struggle was implied with understanding the literature of a philosophical nature.

F1I117 (721-726) It's tough because it was original philosophical texts and there was a lot of it to read. I didn't grasp it all but at least the questions made you focus on the specific things.
F2I2810 (2305-2308) ...tease out some of that ...and I could do with wading through Crotty again... he's hard going.

For 3 CNMFs, a worry was about missing potential literature either through a lack of search skills or non-publication. To allay the fear of replicating others' work or non-comprehensiveness of the PhD, good detection work and personal contacts were required. This especially reflected a lack of publishing opportunities in Ireland.

F1I23 (761-771) ...recently I've found someone has spoken to doctors so now I'm actually saying well what's the benefit of me... repeating that? Someone has actually done that for a different small project last year, so I could actually be using that. That wasn't published that's where something is not available at the time you're writing...

There was a recognised need to utilise primary sources because of the uncertainty of the veracity or limited understanding within the secondary sources of nursing and midwifery literature. And there was a process of reading to assist in synthesis of the literature.

F2I410 (777-781) ...some of the original work is actually quite old and quite small... there really isn't any great seminal work...and you really are afraid that you are missing something.
F2I2810 (149-167) I've started to read... other articles on (*the methodology*)... within the nursing literature. I did a literature search...I put them into chronological order and then I started at the oldest one and worked my way through... you can see that a lot of people are writing that really have never read (*all the original works*). They are referencing... to the first text... And they haven't seen how he has developed his thinking in the other texts or his arguments.

The CNMFs described exploratory reading not subsequently utilised and looking at literature from other disciplines to assist in developing new perspectives "with a different eye" (F3I248).

F2I2810 (1488-1493) I don't even know what kind of literature I'm going to be putting in. I mean after all my work on Michel Foucault... he may never turn up in the work.
F3I185 (216-219) I've read so much around (*a discarded method*) ...but I'm sure it hasn't all been wasted.

Whilst there was the utilisation of 'recipe' literature for methods guidance, and PhD process guidebooks were commonly consulted with Phillips and Pugh being popular (n=3) there was also the recognition that reading the literature could not provide all the answers.

F1I296 (861-869) I can't find any literature on... convert(*ing*) the qualitative work into a questionnaire... I've tried all the people who have written about it... but no results really.

F3I185 (2209-2214) My daughter... would say "there must be a recipe for doing a PhD. There must be a framework". (2458-2463) ...sitting down to write up the data is going to be very challenging for me because there is no one big book you can hang on to.

Reasoning and reflecting are cognitive skills that develop during RCB. The data showed that reasoning gave the anticipation and reality of creating difficulties for the CNMFs, referred to by one as "brain pain" (F1I309). As already noted in 'PhD as product', the CNMFs' had notions of a level of PhD that required them to 'think differently', sometimes assisted by other disciplinary perspectives.

FFI211 (2516-2555) The most difficult part for me... was data analysis and pulling the whole thesis together... it's a mammoth piece of work and I had a lot of data... but the synthesis that arises during analysis and at the point of finishing... and writing it up is different again...It's much more complex.
F1I117 (209-223) ...here's my masters' work which is a circle and now I'm here thinking in a square and how can I combine the two... it's ok to say "I was thinking like that but that is not going to help my thinking now"... that took a while too.
F2I911 (434-439) ...a little bit like a prism, you normally only look through your own little window... somebody turns it around... you see something else inside it.

As noted in resourcing the research the activity of reasoning and reflecting or "mulling" (FFI211) was important. Being funded gave the time that allowed CNMFs to maintain their thinking and a 'thread of thought' and was embodied as individual production.

F2O1111 A period of intense typing with some body language (looks out window, 2 hands to mouth) as if seeking to find words to express is followed by a period of reading from the screen with just mouse clicks as the view on the screen is manoeuvred. A dog barks outside but there are no signs that this has been heard as her eyes stay on the screen. She then reads off the sheets containing the interview transcript and handwritten notes and looks back to the screen. Cocooned is the term that springs to mind.

Difficulties centred on theoretical uncertainty or "conceptual fogs" (FFI211), which did not allow clarity of direction for thought. "Ironing out" the thinking (F1I117) could be assisted through dialogue with others. Sometimes this occurred through formal structures like post-graduate seminars or through informal "eureka moments" (FFI911). Six CNMFs showed their cognitive learning by giving examples generated by 'reflection', 'retrospection' or 'hindsight'.

FFI911 (227-239) ...for a period of six months or a year where... you knew there was something there but you didn't know what it was going to be... that was very difficult... soul destroying.
FFI211 (1329-1343) By the time I had arrived at grasping the literature and the various theoretical perspectives...I wanted something different... I got a sense of place... in this process and I thought "I still want to meet peers and I still want that support" but for different reasons now. I want to engage in dialogue... to throw out my thoughts and toss them around and say "have you thought about your study this way or that way?""

F2I911 (335-352) ...whatever way he (*method guru*) ran the workshop... I was sitting... scribbling notes and my process just emerged as I was sitting there and I thought "This is it. This is definitely the way to go"... it was like one of those kind of 'kuch-*ing*' moments... my mind just opened up... I realised that it was right for my data...
F2O194 An environmental change is that one wall now contains 3 large white stiff cardboards which are stuck up with adhesive. They are covered with small writing in green pen and pencil and various arrows going in different directions. There are also pink and yellow 'post-its' stuck at various points on the writing. I ask "what's with the boards" and get told that she is trying to see if there is a pattern. She stands in front and guides me through the thinking that is etched on them. She asks my opinion of what I think is happening in the data she describes. I suggest a key concept as a potential metaphor and we spend an hour exploring this word, its synonyms and meanings. She writes notes in a green notebook as we talk and I can sense her excitement mounting as she applies the concept to all angles of the data. "Do you think this is your Eureka moment?" I ask and get told that it might be.

Reasoning was required to build a defence or argument. As already alluded to, challenge, as an accepted practice especially in the rites of passage required preparation. Some supervisors emphasised this skill by "rattling cages" (FFI211) so that CNMFs learnt to justify their thinking and spend time building "coherent arguments" (F2I2810).

F1I23 (386-390) He (*the supervisor*) was always questioning "Why are you doing that? Why is that?" ... you were always justifying what you were doing.
FFI83 (846-852) ...we had this really long discussion about something that I was challenging in my study and she (*the supervisor*) was very gently probing me and challenging me and I knew she didn't want to destroy... my confidence in what I was trying to say or do.

Writing is a fundamental skill in the PhD and is a labour throughout the PhD process from grant writing to the final thesis. Practising writing was perceived as an element to successful writing and for keeping the project 'on track'; nevertheless, some were apprehensive to the extent of delaying or "knuckling down" (FFI2510) to the final write up stage.

FFI911 (219-223) I wrote all the time... from the very beginning I wrote so it wasn't difficult for to write it up like that in the end.
F3I248 (26-33) I definitely had put the write up off... I didn't want to actually sit down and do it... I think just the academic dread... that feeling of "Oh God, I've got to write all this up now".

Eight CNMFs described writing in terms of 'struggle' and endurance, especially with the final write up stage. In particular, the struggle for some was in creating a composition from their own cognition and conceptualising – "free flowing on your own" (F3I185).

F3I248 (4-7) It might take me three hours to write one sentence and other times I'd write 3,000 words in that time.
FFI2710 (343-356) At times it got very, very difficult in the middle of writing up... it's that sort of 13 to 18 mile stretch in a marathon... all the fun has gone and it's simply grinding out the miles... "You have got to turn out 3,000 words by the end of the week".

FFI211 (766-775) I struggled with my writing... I was intimidated in the process by him (*supervisor*) because he writes so well... he has an excellent command of the English language but I used to struggle.... It wasn't the process of writing. I think it was the process of clarifying my thoughts on paper...

Writing has characteristics that the CNMFs tried to develop – simplicity of language to get "exactly what I want to say" (F3I142) and succinctness to "get it down to the bones" (FFI132).

F2I2810 (1021-1025) ...you have to make each word count. So you go back and you edit it... "Well there's 4 words... surplus to requirements... (laughs)".
F3O111 The topic of writing skill is returned to and the supervisor notes the CNMF style which includes 'redundant' language... He stresses the importance of plain language referring to the "lottery of external examiner" as the potential audience and perhaps a verbose style having a bearing on that outcome. The CNMF3 grimaces and nods...

6.3.4 PhD as process: summary

The CNMFs were labouring in the unknown whilst attempting certainty. Two rites of passage dominated the PhD as process, gaining ethical approval and the viva voce. Whilst interpersonal and technical skills developed during the Fellowship, the main emphasis was on scholarship skills that were often described in terms of personal struggle. The process is a course of practices or tasks.

6.4 PhD as practice.

The practices of PhD labour were detailed by the CNMFs and there were a number of elements to this labour. Previous structures of employment with or without doctoral study were no more, causing difficulties and bringing changed practices.

F3I185 (1489-1498) You can become a little bit unfocused... certainly, I think maybe what happened to me... you just don't have any... there's no sort of structures at all... (2447-2449) but you have that added pressure of being self-motivating all the time...

6.4.1 PhD as practice: building new routines

Becoming a CNMF meant "having one's day changed" (F1I1511). New routines have to be developed in response to lack of external structure. Routines are the outcome of "interaction between personality predispositions and social, physical and cultural contextual factors" (Zisberg et al, 2007: 443). The data showed that CNMFs endeavoured to continue an organised and disciplined day, "just like a job" (F1I267).

F1I1512 (695-702) ...I try and be at my desk at nine and I work until five and sometimes I work a bit longer... I've got a process I go through, I break at ten o'clock for coffee and I have lunch at about two and I go for a walk at five.
F1O264 At 10.20 I ask about her routine – "probably on my third cup of tea by now" is the reply. (178-182) She returns to her space and I hear the modem noise. I assume she is

checking her emails as she has already told me that her routine is to check these in the morning and again at lunch time. (309-314) Her previous workday commenced at 08.30 hrs and she would get up at 07.00 hrs. Her intention was to continue this routine and fit in a walk before the breakfast and school runs but today was the first day that she had done that. (342-345) 13.00hrs. We go to the local pub for lunch. This is one of two lunchtime routines the other being a bread roll at home.

Sometimes the new CNMFs required external structuring or 'fill in' tasks. One CNMF linked this motivation for structuring to both prior educational and practice socialisation whereby nurses' and midwives' experience had been of highly prescribed structuring and routines.

F2I911 (21- 37) I was a little bit lost for direction... I also started another course in the university so that kind of gave me something to help me get started... because... I'm used to structure anyway.
FFI2710 (141-151) "what is it I'm meant to be doing?" (laughs) I said to my supervisor "is that all I'm doing!" and he said "Go and write something". So I wrote up some of my Master's work in a paper.

Clark (2000) outlined the important functions of routines, two of which emerged in this study. Structuring a daily or recreational routine was influenced by self-identity (section 7.2.4) and occasionally, as here, by self awareness of optimal productive time.

F3I185 (1887-1892) I can work well until lunchtime, 2 o'clock... after that, I've had it. Concentration wise. I'd be quite happy to sit down and read in the afternoon...
F3I2311 (1566-1579) I'm good in the mornings. S: Do you mean good 'head wise'? F3I2311: Good 'head wise', yeah and I'm good mood wise... I'm not tired, I'm fresh. My head is clear as well. So I get up... have my breakfast and I try to sit down straight away and do an hour or two's work at that point because I could do good work then.

Having set a structure, the CNMFs then needed to keep that structure. Here, being self disciplined was a trait of value that 2 CNMFs described themselves as having. Others (n=4) had to 'work at it' and be strict with themselves.

F3I248 (1701-1708) I would always have been a good planner... fairly organised... but I now know that that is not reliant on the fact that there is a curriculum or a job - that I can do that regardless... I can create the structure.
F3I2311 (1729-1741) ...yesterday, I went away from it... I was down here and said "No! No, you're not going in here. You're going upstairs again and you're sitting down and you're going to look at it again" and making myself physically sit down and write... I speak like that to myself.

The data revealed that disciplining self became more prevalent in the latter stages of the Fellowship as the funded time diminished. Previously, distractions occurred with a sense that some were even deliberately sought. CNMFs gave examples of social

interaction, sport and television used to counteract feelings of isolation. Even good weather induced feelings of resentment (n=2).

F3I142 (198-204) S: Any distracters... in working from home? F3I142: There was the first and second year... when I got the feeling that time was running out, I stopped.
F1O264 (113- 120) She finds the recent spell of fine weather a distraction as she likes to be "out and about, pottering" when the sun is shinning. Her strategy for dealing with this distracter is to go to the hospital library and to do "a good 3 or 4 hours there".

'Staying focused' was part of the discipline. It was applied to a number of the practices within the doctoral processes as "it's too easy to get diverted" (F2I410). The CNMFs recognised the ability, or its lack, of 'staying focused'.

FFI911 (54-65) I probably got a lot more work done... working in the way that I did, (*at a geographic distance*) because it meant... (*not*) spending a lot of time swanning around the place (laughs)... doing other things, at the various support mechanisms...
F1I271 (666-668) ...I was much more focused as to what I wanted to get out of (*advanced training*). And the main thing I wanted... was to be able to etch out a methodology chapter.

The pace of labour influenced routines. An even labour pace was an ideal and described as "ticking along" (F1I23), "running smoothly" (F2I296) or "chipping away" (F3I2311). Whilst an even pace was achieved in parts it was not sustained throughout the Fellowship. Instead, the pace quickened or slackened in response to both external and individual factors, with the latter being a focus of self-criticism.

F2I296 (472-478) It's amazing... my analysis has speeded up so much from the beginning and my ability to bring out bar charts and graphs and to manipulate them... is so much better.
F1I267 (14-20) ...without it (*the Fellowship*) I actually probably wouldn't have been able to continue on with my project with how change has happened in the HSE. It meant that I had to plan things and move things forward to a greater extent.
FFI2710 (132-139) ...in all that set up time... you're waiting for ethical approval to come through or... you're checking your questionnaires and you're doing your literature but you can't actually do very much.
F1I117 (1152-1155) ...my time management was desperate in the beginning because I was doing too many hours. I burned myself out... (1234-1237) ...forcing myself to do... anything up to fourteen, sixteen hours, it was ridiculous!

Three CNMFs reported "spurts" (F2I1211) of intense work, some of which were self imposed. During spurts of intense labour, the CNMFs needed to "keep track" (F2I2810) of the work.

F2I296 (114-119) I have to work now and I'm glad because I wasn't working at my full throttle in the first year. Definitely not. There were loads of gaps and now I could pray for a gap.
F1I267 (645-654) I was still very structured in my day but... there is only myself and you were sending out a thousand questionnaires... follow-up letters and piloting and different things. So I'd be in our attic until three o'clock. (1254-1264) Lots of things in bullet points... I never had a day where your head was clear... So I just have loads and loads of notes...

When the labour slackened there was 'filling the time gaps', often with mundane labour, which mostly centred on data handling or 'tidying'.

F2I1211 (22-31) S: during the... gaps what did you find yourself doing? F2I1211: I ended up reading round the area... So I started summarising lots of articles... I am completely up to date... article wise and I've learnt computer skills. I've put them into a reference manager so I've everything... and very well filed (laughs)
F1I23 (125-136) There's all the kind of tangible things that you can actually do, waiting... for people to come back to you... where you have to fill in doing different things... you're looking into literature... planning out other things or arranging to meet people... the time is getting filled up...
F1I267 (268-270) ...at the minute all I've done is clean them (*returned questionnaires*) and photocopy them in case they get lost. (1349-1350) there was photocopying... which is boring and tedious.

Nevertheless, tasks that required reasoning, even in small amounts did become tedious or tiring, especially if undertaken for long periods causing the CNMF to become "browned off" (F2I2810). The CNMFs organised the labour so as to deal with these issues, mainly by switching between tasks.

F3I2310 (97-104) ...you get really exhausted with it (*data analysis*) ...because there is no diversion... can't dip in and out of it. So... sometimes I come in (*to the university*) ...just to change the scene... (233-243) what I want to do initially is go through the study just using descriptive statistics... some of the results section I can have dealt with by looking at... the withdrawals and all that. There is an awful lot of donkey work that I need to do...
F1I271 (262-265) I'm going to finish the transcription and try and basically tidy up all those interviews and get them ready for analysis.

Eureka moments also influenced the pace with CNMFs reporting such "golden moments" (FFI1510) occurring in relation to data analysis.

F2I296 (840-844) ...there was big gaps then suddenly it just all slotted into place... it seemed to start running and I couldn't keep up with it.
FFI911 (85-108) Yeah, there was really (*an eureka moment*)... once that came it all came together really quickly... I think it was finding the right question to ask of the data...

Even where they were clearly delineated routines for the labour, the CNMFs reported that the cognitive labour processes continued such as "always thinking" (F1I117) when undertaking other tasks. Such sub-conscious labour perpetuated the perception that the PhD or "the cloud" (FFI1510) was ever present or "never out of your mind" (F1I117).

FFI211 (3201-3215) It was never, ever, ever out of my mind... I would wake during the night and I would be thinking about it. I would get up in the morning, while I'm waiting for the kettle to boil and try to mull.... I wouldn't be thinking about it to the forefront of my mind always but it was always there.
F2O1111 ...before sitting down, the Fellow retrieves a rumpled piece of paper from a soft briefcase. The remark of "in the car going in yesterday" is made to me. I concur with "I do that

too but usually on the bus"... we mutually understand that we are talking about the sudden thought that occurs and must be jotted down as an aide memoir when in the middle of doing something else.

Within the PhD as practice there was struggle from concealed practices and prices. A 'hidden labour' was 'chasing the supervisor' (n=3), the logistics of setting up data collection (n=6) or the "constant battle" (F1I1511) of recruitment. Also less visible was the time required for travel, for example to ethics committees or to attend the university. Here, the CNMFs were pragmatic in decision-making so as to save time.

F1I267 (1021-1026) It (*ethical committee*) was half six in the evening and you have ten minutes presentation... they tell you, you've got it and then the bus back home again (*over 70 miles*).
F1I1512 (809-816) I try not to (*travel to the university*) as much as possible because it is expensive for one thing... like it's €14.50 and €18 on a Friday... that's quite a lot of money...

Data were collected in multiple sites of health care settings or participants' homes by 12 CNMFs and this required journeying either within cities or across regions. Whilst such travel was budgeted into research plans from the monetary perspective, there were also 'hidden costs' of travel such as the time and tiredness of long journeys.

F1I309 (514-521) I was basing it (*decision on second site*) on doing this while I was working fulltime... it was a bit pragmatic because... I'm from nearby originally... I could go (*home*) at the weekend... that's how I actually got the first four or five interviews done.
F1I511 (1109-1113)...you have to be selective. And particularly for me with the travel... going to the other hospital that was nearly 8 hours in the car.
F2O152 I ask has she ever conducted more than one interview on a single day, considering the travel time involved. She tells me she has and "it's exhausting"... she clarifies that it is the driving not the data collection that is her source of weariness when it happens.

Similar to the PhD as product or process, within the practices of research there was disorder or uncertainty within tasks.

F1I267 (66-70) That (*the distribution of research instruments*) in itself had limitations in that there were lag times... and difficulties. People mislaid boxes of questionnaires...
F2O912 During this time, her mobile phone rings and she goes outside to answer... I eventually hear her ask about some minor technical issues that had arisen yesterday.

The CNMFs reported attending to detail and good preparation as a mechanism to reduce disorder or uncertainty not just in their own labour but also checking others' work or planning for the potential loss of work. Stories of work loss were narrated.

F1I267 (661-666) ...(*my spouse*) was there putting the packs together... the freepost envelope, all the other bits and bobs and then you were afraid to hand over in case they missed putting something... (1336-1339) once you have to send out your data to a data entry company there can only be one tick and if you say one tick it has to have one tick.

F2O2611 The technology required is laid out, spares are checked. The name of the nurse is read from the computer screen and written into the consent form. The folder with a 'post-it' saying "don't forget to turn on the microphone" attached to the front contains a door sign saying "do not disturb". The tape is labelled with the appropriate code and after insertion to the recorder a test is done. This is then replaced with "Interview Number 11..." is recorded into the start of the tape.
F1O191 The CNMF shows me that she is prepared for such an eventuality by bringing over and above the number of materials which she will use if just the expected number show... the room set up is complete and the CNMF1 goes to check out where the nearest toilet is and whether it is accessible. When she returns, she tells me the door is locked and that participants will have to use facilities up in the hospital foyer.

6.4.2 PhD as practice: labouring ethically

The CNMFs (n=4) described dealing with the unusual when data collecting. Such individual narratives of situational ethics build into the corpus of myths supporting the notion of the research process as being 'a muddy field' or uncertain. The CNMFs also described their practice of research as one of 'labouring ethically'. Their reports included awareness of confidentiality; showing respect for participants; and ensuring an informed consent through using appropriate discourse. The latter was a specific feature as six CNMFs were collecting data from participants perceived as particularly vulnerable and thus easily coercible. However, fear of exploitation continued to feature throughout data collection, especially as the CNMFs were novice 'insider' researchers (Darra, 2008). Practices described ranged from the macro standard 'best practice' to minutiae. For example, in reducing potential anxiety in study participants, reported practices extended from careful consideration of approaching potential participants without associations, to an individual's vulnerable episode, to being punctual for data collection sessions. The latter practice was noted in observational sessions with 4 CNMFs and may also stem from nurses' socialisation as punctual timekeepers. The CNMFs showed awareness of how laxity could occur across a range of ethical issues; some of which stemmed from being a nurse or midwife or teacher. For one CNMF, failure to display the courage required for 'ethical sensitivity' (Weaver et al, 2008) meant that following ethical research 'rules' inhibited professional concerns and created 'moral burden' (Lützén et al, 2006).

F2I2810 (930-935) I go to interview somebody... and they tell me I interviewed somebody else two weeks ago... (laughs) and I'm sitting there going "now remember the ethics".
F2O2711 Today's interviewee also introduced her to 2 other nurses on the ward whom she reported having a chat with and informing them of her study, with the hope that they would also volunteer to be interviewed... Whilst on other occasions she has joined her interviewees and colleagues for a cup of coffee after the interview was over such behaviour did not occur this time. The CNMF assured me it would not have been appropriate as she wouldn't want to influence their potential participation in her study.
F2I1211 (1130-1133) So this was a group I had never taught which was important that I wasn't in any way pressurising them. (1214-1221) I have to make it clear that, if they're

interested at all they can decline at any time not... not to feel under pressure, it's not going to affect in any way their marks or results (laughs)...
F1I296 (448-454) She (*a participant*) had changed. She had become kind of a quieter... a different person... I'd have liked to have spoken to her about it but I just felt... it wasn't really appropriate.

Issues in labouring ethically included "doing justice" (F1I117) by ensuring quality of, and responsibility of speaking for, the research. Representing study participants was seen as vital to an ethical piece of research. This included the incorporation of raw data into qualitative thesis as well as feeling obliged to share findings through publication and presentation.

FFI211 (2586-2595) I was interested in the whole concept of 'voicing' and giving the people a voice but the problem is you have to act on that commitment (laughs)... even if it's just one quotation...
FFI911 (982-987) ...initially the presentations... I did with nurses from the clinical speciality because I felt I should. That was a kind of a responsibility that I had was to feedback to them the findings...
F3I248 (735-742) I feel a certain responsibility (*to publish*)... I should be saying to the HRB, but my responsibility is actually nearly predominately to the (*participants*) because they have put their heart and soul into this. It's like I've got to get it out there for them

Acknowledging the assistance of others in the process was important – be that gatekeepers or supervisors. However, there were tensions here regarding recognition for those who contributed informally.

FFI211 (570-582) I do think he (*supervisor*) made an intellectual contribution to my work... I do feel that I'm at a different intellectual level... most of what you do, you do on your own... but he certainly just in terms of dialogue and debate and just thinking differently and thinking of problems in different ways.
FFI83 (668-673) I had what I often termed a 'hidden' supervisor which was a colleague from outside Ireland who was very influential... challenging the ideas that I had...
F1I296 (1004-1009) I find her (*an academic friend*) great for kind of bouncing ideas off... But then I'm very conscious that I'm taking up her time and she's not my supervisor and she'll get no credit...

Being rigorous and thorough in practice and thought was reported so as to ensure accuracy and depth of data.

FFI83 (163-169) I listened to the interviews I thought "...I made an assumption there... ". So when I went back to do interviews a second time I would ensure that that was an issue that I would explore.
F3I2610 (145-150) I spent... days then just going through the nursing records... it confirmed for me some of the things that they had already told me...
F2O1111 We discuss the specific issue of how a remark made in passing by the interviewee is a counterview to those given during the taping of the interview. We both acknowledge how this raises doubts when it happens over the veracity of interview content

"Trying all you can to get the data" (F3I185) showed the CNMFs labouring to get good and rich data. For some, this required time and skill improvement as early data are perceived as not reaching the necessary standard or recruitment difficulties mean a subordinate statistical strength.

F2I410 (150-155) I had decided I'd let it (*recruitment*) run to the end of the year... even, if I got another 2 or 3 it would still bring up the numbers. But I'm not going to make my number...
F1I1512 (916-933) I know I'm not quite hitting the nail on the head... maybe I'm not as good as I thought on focusing the subject matter... people are rambling on... instead of... talking about the experience such as I want...

The CNMFs reach a stage of 'good enough' after striving for data or in producing the product. Fatigue (n=2) is mentioned as implicit in coming to this juncture or as an impact affecting the quality of the labour.

F2I410 (178-192) I was really hoping to get (*number*) because that would give me 70%... at the moment... It's only about 66%... that will have implications for the strength of my study... the way I look at it is... I can't make them. I have done everything within my resources and my power to get them... the results will be the results and that will just be it.
F3I185 (942-949) Obviously there are some cases where patients weren't able to be part of it... I had some patients. Not as many as I'd like to but to be honest with you I couldn't afford to hang around and wait any longer...
F3I77 (502-525) I think that an excellent PhD... every chapter in it would have something that is completely different to what has gone before... I think I have it in my findings and I'll have it in my discussion and I may have it in the way I've presented (*the theoretical literature*). My second chapter isn't... it is a presentation of the empirical research and... I'm too tired now to be honest with you to try and find something creative and a new way of presenting that.

'Labouring ethically' also meant not being wasteful with work. Hence the CNMFs described practices whereby material was "recycled" (F2I2810) and reworked: developing a paper for publication from a presentation or from literature subsequently not directly used in the PhD.

6.4.3 PhD as practice: summary

In PhD as practice the CNMFs describe 'building new routines' over which they must exercise self discipline. The routine altered in response to changes in pace. The PhD as practice was subject to uncertainty and disorder which the CNMF tried to control. Throughout, the CNMFs described their practices as 'labouring ethically'. Although they strived for excellence, the CNMFs reach a stage of 'good enough' whereby they accept the existing quality of their labour. The culmination of PhD as practice and PhD as process is the PhD as product.

6.5 PhD as product: 'getting it together' (F2I194)

As already alluded to, forming the thesis was seen as daunting, although the data shows that a vision of the product develops over time. During the third year, CNMFs can envisage their own PhD – "seeing how it's looking" (F3I2311) and can outline their thesis structure. This is because most are at the "significant academic apprenticeship stage" (Delamont et al, 2000:94) of writing up. Also the skill of verbalising the PhD develops. The data on writing showed that most CNMFs were scripting sections or chapters of the thesis throughout the PhD process. There were exceptions: one whereby complete chapters were written in the final year and another whereby the complete thesis is written up on a continuous basis. Eight CNMFs described initial drafting of thesis chapters which are then repeatedly revisited for refinement sometimes including supervisor feedback.

F3I248 (380-404) My supervisor gets the first draft and that's it... I wouldn't construct it and then start moving it and wondering what it looks like. I would have a plan always at the beginning. Where is this chapter going? ...I'll start it and then I'll fill it in and I can't do the middle or the end until I've got my introduction done because if I can't set it up right then I can't write it properly...it gets set up right like an operation! (laughs)
FFI2710 (552-555) I wrote the 94,000 words of the PhD in about 5 months. From start to finish. Just solid writing.

As already stated viewing the theses of others helps in structuring the product but there were also the theses that were held up as worthless or exemplary. For one CNMF, the external examiners placed their theses in the latter category.

FFI121 (1518-1525) I read a few PhDs that I just thought were a bit watery... and I really didn't want that to happen either. Someone to say "Did you read that? It was a heap of crap".
F1I267 (1654-1659) ...everyone says "have you seen hers? It is just so simple to read". But I said 'that's the whole thing'... it's not 'oh, it's so intellectual but nobody knows what you're talking about...'

Producing the thesis as product involves the structuring, sequencing and connecting of material or 'stringing the beads of a necklace' (F3I77). In this phase word counts can become a preoccupation. 'Being selective' produces a tension to ensure completeness of the product within the obligatory academic confines. Thus the CNMFs produce texts which expand and contract – "putting in the kitchen sink" (F3O111) or "wonderful data that I had to leave out" (FFI211).

F3I2311 (905-918) ...I found myself looking at my chapters... I was reading something about writing... up research and saying... put so many words per sections and so I thought "Yeah, that's a good idea." 80,000 words, and... I said "well, it's 8,000 for that and it's....
F3I2310 (63-69) I want it written up by Christmas and that gives me then three months to chop it and format it... if I can get the main body of it actually written and that my supervisor... (*says*) "yes, your content is good enough"... (210-216) my literature review I've most of it

done but it has extended now to about 30,000 words. It just keeps growing and growing. But that will be part of the review... reducing that.
F3I2610 (755-762) ...I took that category and I just put my 27 interviews up here and every time I quoted one of them I gave them a tick. So if I have to start filtering out and I'm making a choice between things that are similar, then I will... drop the ones that are... appearing more...

For the PhD as product, three of the CNMFs admitted to rough guides that in some cases may transcend into unwritten 'PhD rules'.

F3I1410 (1059-1066) ...there was this notional figure presented that about 100 hours of qualitative data would be what was required... So I budgeted for 100 hours... in fact I had... many hundred hours of data (laughs). (1091-1096) Just as a rough guide (*100 hours*) is generally what's in a PhD or what would very much be required from an academic point of view to be considered, I suppose to contribute to new knowledge.
FFI111 (353-364) I made a decision not to... we could have tangentially dropped in a few references in the methods section but they would have known you'd done it and you would have only doing it to get references in and I thought "No we're not doing that" because I wouldn't it at any other time. So they weren't mentioned at all which I think broke one of the rules of PhD!
FFI121 (959-971) ...one of my supervisors (*said to me*) you must remember that the PhD is made up of three thirds, the first third is what everybody else says, the second piece is what the participants say and the third piece is... it may not be a third in numbers of pages but it needs to be a third in substance and weight and this is your piece, what do you want to say... I thought if I was ever supervising people I would shout that home.

The CNMFs disengaged from potential or real distracters so as to give time to writing and located themselves in the optimal environment so as to concentrate on scripting the text. Isolation was only acceptable because it was for a specified time period.

F3O111 (383-388) She plans to start pulling the already written sections together. The supervisor advises her to isolate herself and "write off the top of your head" so as to approach the work with a fresh eye.
FFI2510 (601-603) I kind of went into hibernation mode especially the last six weeks (608-612) I cut right back on... everything really... I just knew it was for a very short period of time so I could cope with it.

6.6 Labouring in the Field of the Funder

Labour occurred in the Field of the Funder too. This consisted of the activities that I performed as NRA and that are described in 'resourcing' the research, transitional identities and privileged pioneering in the peripheries. However, I was also undertaking *this* study as a PhD and so labouring my own doctorate. The researcher diary revealed many similarities with the CNMFs in labour processes and practices. Yet, there were contrasts and tensions many of which centred on 'guarding time' by CNMFs as opposed to my 'fitting it all in'.

RD 20/10 ...I am asked how I'm getting on and I use this as an opening to explain what my study is about and how I hope to collect data. Concerns are raised about the time

commitment especially at this time which is viewed as particularly busy and a list of activities is outlined to me. I explain the different methods that could be used... "I could manage an interview every couple of months, I suppose". I stress the flexibility of negotiating when that might be... We get out our diaries to set an initial interview date. Since I will be in the locality... for an event that the Fellow is attending, we agree to meet on that date. So time is not being taken from the Fellow's own study – important considering the concerns.
RD 24/8 I've just read Trotter's (2003) personal reflection of PhD studies... She describes a series of hoops and even at this stage I can recognise the same issues. She describes the negotiation of time to undertake the work. Similarly, for myself there has been such a negotiation – with myself as much as with others. Having initially agreed one day per week protected time, I agreed to be flexible so as to "keep the show on the road". This meant that often I would go through weeks into months without that protected time. "Claw back" came in a prolonged spell of leave – usually the month of August. However, due to the uniqueness of my role and the lack of clear administrative support, I still found myself in the office on at least one day a week of that 'leave', responding, following up and initiating work for my return. It also meant that for my own work (as opposed to study) there was no 'down time'. Having said that, I also relished and luxuriated in the length of time that I could give my almost full attention span to the PhD in comparison with the other 11 months of the year. Usually on the week leading up to return to full work I most envied my study respondents their award! Trotter (2003) outlines the guilt associated with time organisation. Whilst I did find myself going to the gym in the middle of the some days or taking time out, usually a day when the computer was not switched on, I also found myself working at weekends during this leave time and justifying how I used holidays and weekends throughout the year on the study. Instead *my* guilt was on the *pace* of my work. I *feel* slow... Every piece of writing has to be wrung out of me. This is not helped by faculty pressure for finish dates and the passing of relevance of the study if I do not complete my analysis and write up quickly. Yet I have to balance this with doing justice to the data and not presenting a 'half-cooked' thesis. Whilst Trotter (2003) experienced own-made hoops about her topic area, I too have done so. My issue is that my topic area is so closely associated with my everyday work, that I never feel any break from it! Regardless of knowing the benefits this brings in relation to access to literature, participants etc., there are times when I just long for a week away from the topic without any guilt! Roll on being free of this burden...
RD 16/2 I am transcribing the interview that is my final data collection with the Fellows. There is a sense of fleeting nostalgia that this is the last weekend of listening to voices... but there is also a struggle to make myself do it and not get diverted... This interview is with those who have just undertaken the vivas. In addition, this week I have been emailed by the supervisor of a CNMF3 seeking funding advice on completion of the fellowship. It seems that all around me are Fellows completing and I envy them the stage at which they are at. I can't seem to envisage myself at that stage and feel that the amount of work to transform all the data I've collected into a written ethnography will require an insurmountable effort. The lift of having a paper accepted four days ago for a peer reviewed journal without amendments has dissipated.

6.7 Conclusion and literature

In summary, labouring the doctorate has product, process and practice elements. The product is an initial unknown but contemporary international literature has started to address the issue of PhD as an unknown specifically through the notion of "PhDness" (FFI211) or 'doctorateness' (Park, 2007; Trafford & Leshem, 2009). Transformative 'threshold concepts' have now been delineated. Kiley & Wisker (2009)[64] suggest these are argument, theorising, framework, knowledge creation, analysis and interpretation and research paradigm, all of which the CNMFs described

[64] From 26 survey respondents and 39 interviews with experienced supervisors across disciplines.

in the processes and practices of their labour, as well as some of the difficulties associated with threshold crossing. Trafford & Leshem (2009) argue that it is the synergy from such elements that determines 'doctorateness', thus reintroducing an element of uncertainty into the labour. As a product, the thesis should be "methodologically plausible" and "intellectually coherent" (Trafford & Leshem, 2009:306) integrating the plurality of components. The product reveals itself through the experience of the process and practices.

The CNMFs were labouring in the unknown whilst attempting certainty by formulating process plans, striving to keep on track and dealing with mitigating factors. The data showed that sanitised accounts of a linear process were mythical, confirming others' reflections (Guthrie, 2007). Instead, the CNMFs described progress through the process like a rotating circle that went backwards as well as forwards as it rotated.

Two formal rites of passage dominated. The CNMFs gained ethical approval for their studies in a changing context that lacked clarity, had diverse procedures and took time. The Irish literature has noted the high number and lack of standardisation with regard to research ethics committees' structures, supports and practices (Health Services Executive (HSE), 2008). Membership dominance of research ethics committees is verified as medical[65] from which originates its authority (Edwards et al, 2004). Certainly, medical dominance reflects the hierarchy of ethical decision making (Malloy et al, 2009) in the Irish clinical environment and elsewhere (section 2.3) where nurses (Mooney, 2007) and midwives (Hyde & Roche-Reid, 2004) conform explicitly to existing clinical hierarchies, while implicitly subverting or circumventing the dominant practice[66], thereby exerting moral power (Peter et al, 2004). Such a culture and dynamic between nurses and medics can influence advocacy actions (O'Connor & Kelly, 2005; MacDonald, 2006) that when previously absent led to detrimental patient outcomes in Ireland (Matthews & Scott, 2008). The CNMFs had to learn the ethical requirements through 'doing' and in some cases 'doing extra' to achieve clearance. Nevertheless, this inculcated a perception of learning from the process. The viva voce was a concluding rite of passage during

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[65] Membership shows 76.7% of committees having medics as members with a range of 1-14 and an average of 5 per committee. The second largest group is scientist/researcher with 53.3% of committees and range of 1-12 and average of 4 with such members.

[66] An example was reported in this study of a similar limitation of deference. **F1I1512** (333-342) when I actually got the (*ethical*) approval, the chairperson... said "I would like if you would call your study (*suggested title*)" which is what it's about but you don't write that kind of language, I think, for consumers. So I had to defer to him on that but on the information leaflets I still left it as (*original term*).

labouring the doctorate and was an appraisal of the work for which the CNMFs prepare carefully. None of the CNMF experiences reflected viva myths. The CNMFs did face confrontation within the viva but were rehearsed to deal with it. More disconcerting was the tension some experienced between celebration and anti-climatic feelings.

Generic skills training, underpinned by a managerialist and technicist perspective of research (Phipps, 2005), tends to be framed on a deficit model orientated towards science post-graduates (Craswell, 2007). Given the existing skill set of the CNMFs and the absence of training in some institutions, it was not surprising that attendance at formal skills training was highly selective and self-motivated. McAlpine & Asghar (2010) found in a mixed method action research in a faculty at one university that doctoral students could develop leadership skills by identifying and constructing their own learning opportunities. Certainly, the CNMFs displayed existing leadership through similar actions but without any organisational support in many cases. Like other doctoral students, this fostered perceptions of being 'self taught', which Gardner (2010) also found in her interviews with 60 doctoral students across six disciplines in one US university. Whilst interpersonal and technical skills were learnt or developed during the Fellowship, the main emphasis was on scholarship skills. The four 'R's' of reading, reasoning, reflection and (w)riting were often described in terms of personal struggle requiring resilience and tenacity.

Although a mark of the transition to independence as in this study, a lack of structure has been identified as problematic by doctoral students in a study by Gardner (2008) based on interview data with 40 doctoral students from 2 disciplines at 2 US universities. In PhD as practice the CNMFs describe 'building new routines' in an attempt to 'structure' their labour and optimise their production. This included undertaking 'fill in' tasks so that time is not wasted, whilst similarly they rework materials so that labour is not wasted. In order to keep to their new routine, they must stay focused on their labour tasks by exercising self discipline, a characteristic required for a successful outcome (UKCGE, 1996) to the PhD process. The routine altered in response to changes in pace: 'spurts' of intense work could be externally imposed or a response to 'eureka' moments, slack pace gave an opportunity to fill in with 'mundane tasks'. The PhD as practice included 'hidden' labour and costs and was subject to uncertainty and disorder which the CNMF tried to control. Likewise, in a two month pilot study in which 20 doctoral students produced 78 weekly logs framed by Activity Theory to record their endeavours, Beauchamp et al (2009) noted

an acceptability of inherent tensions in doctoral students labour. Whilst through their practices they strived for excellence, the CNMFs reach a stage of 'good enough' whereby they accepted the existing quality of their labour. Throughout, the CNMFs described 'labouring ethically' from the standard best practice to minutiae. Hence, stemming from their development as nurses and midwives, their research practice was based on 'caring' (Brykcyńska, 1998) and 'moral sensitivity' (Lützén et al, 2006).

This chapter described the category of 'labouring the doctorate' including the skill development and social processes that CNMFs undergo in undertaking funded, full-time doctoral research and some contrasts with my own part-time endeavours. Research processes and practices assist in identity formation (Chapter 7) and require resources (Chapter 5). For CNMFs this was problematic as 'privileged pioneering in the peripheries' meant much of their labour was solitary and isolated (section 8.2). The next chapter describes the transitional identities that occur in RCB.

Chapter 7: Transitional Identities

F2I410 *(709-716) ...you're kind of drifting... I work in the hospital... I'm paid for by the HRB... I'm attached to the university, so where's home? I still find that a little bit... weird...*

7.1 Introduction

This chapter explores the category of transitional identities (Figure 7.1), the third subcategory supporting the core. The CNMFs describe the move from secure identities into a transitional identity that causes discomfort and a sense of 'not belonging'. For some, this transitioning of identity was the largest challenge of the Fellowship – a 'struggle with the strange'. The chapter explores the three main types of professional identity that exist in addition to the 'person-self'. The meanings and practices of these identities are described and the negotiation required due to inherent contestation of multiple identities.

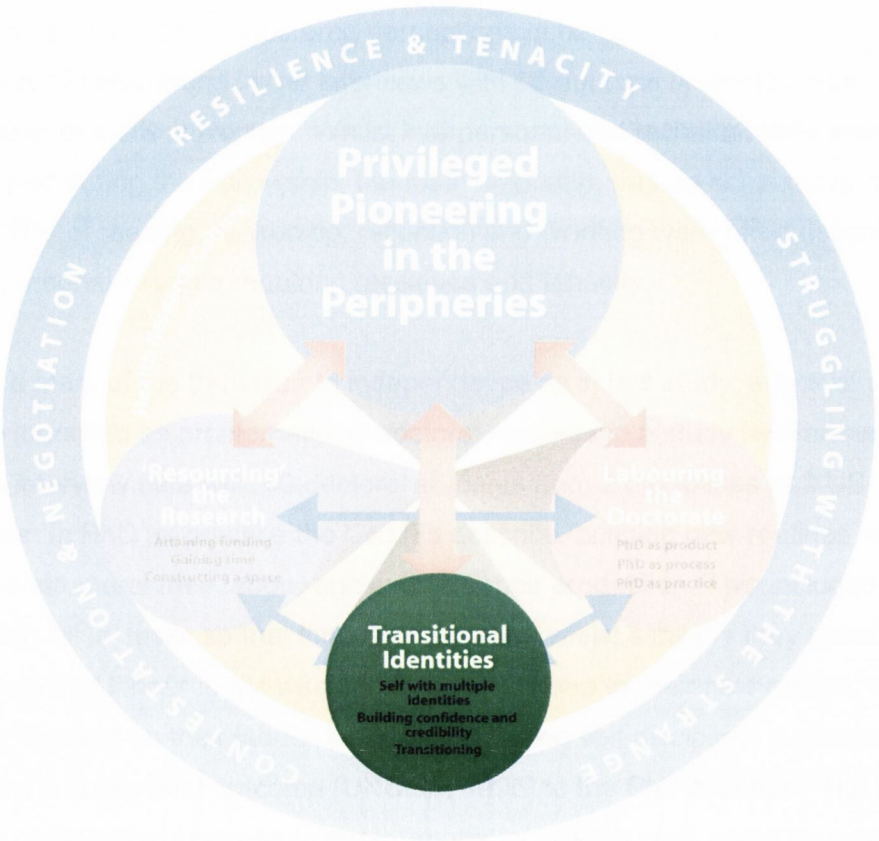

Figure 7.1: The subcategory of transitional identities in the theory.

Some of the issues associated with identity are examined – transitioning and building confidence and credibility. Transitional identity issues also occurred in the Field of the Funder. 'Being a visitor' yet representing the HRB, marginalises the role of the NRA who also has elements of identity as health professional and researcher. The chapter concludes with a discussion of the main findings in relation to recent literature.

7.2 Self with multiple identities in the Field of the Fellow

7.2.1 Funding as identity

Obtaining funding gives an identity of HRB Fellow, being a CNMF means being a funded researcher. It denotes credibility or "kudos" (FFI83) firstly to the individual and secondly to the piece of research because of its competitive origins. It can also represent uniqueness and focuses on the Fellow as different or 'other' to the norm of nurses and midwives involved in research.

FFI2510 (1375-1380) It's the beginning of a track record. It's showing others that someone has invested before in you and it has worked out and maybe you're worthy of reinvestment. **FFI1012** (1438-1440) The Fellowship... assisted in giving credibility to my research. (494-500) I was the only nurse... with a Fellowship undertaking research at that level but there was about 3 or 4 other nurses on the research team as research assistants...

Initially, the CNMF identity is one to be celebrated, although there is a less positive reaction from some colleagues. It is perceived that this identity has greater meaning to some than others: in particular, medics are identified as knowing the value of HRB funding.

F1I271 (759-765) ...people... clap you on the back and are delighted... then there's the people who just run into the office if they see me coming because that's their own issues... **F1I511** (377-397) ...in a sense a lot more medics would have known the significance of it than a lot of nurses... looking back if somebody said to me 2 or 3 years ago that they got a HRB Fellowship, I wouldn't have known quite the significance of it... S: Why do you think that is? F1I1511: Medics are more research aware ...grants and funding... the HRB as a body, they would have been much more aware of it... traditionally.
F2I911 (1091-1114) S: ...reaction from... the clinicians...? F2I911: In relation to the medic, absolute total and utter delight and excitement... the fact that somebody can actually do this full-time... Midwives had no notion. Didn't even know what the HRB was.

The CNMF identity is utilised in the arenas where it has most meaning; for example, in observed conference presentations or when trying to exert influence such as in communication with gatekeepers or study participants, although divergences from this practice were observed.

FFI211 (2423-2450) I took a question and answers approach... "how was it being funded"... "Who is the researcher?" ...Obviously I didn't mention the HRB in (*one set of*) information leaflets but for the professionals and for the (*other set*), yes. "Is the study being supervised? Those types of questions. So I'd have mentioned the Health Research Board...
F2I2810 (720-727) S: How did you describe yourself in that information leaflet? F2I2810: I said I was a clinical speciality nurse, that I was being funded by the Health Research Board.. (*When the CNMF shows me the information sheet sent to participants they have signed themselves as a HRB Fellow and not as a clinical speciality nurse.)*

The transition to a CNMF identity commences with a questioning of place and takes adaptation and the resource of time. Additionally, there was no immediate social group to belong to and thus the identity was one of isolation.

F2I911 (1739-1745) I left my job one day and I started the next day and was still at home, and there was no... going in anywhere. There was no.... starting point and there was no "what are you supposed to do?"
FFI2710 (100-110) It was totally weird because you were thinking "What's happening... where do I fit in? There was a real... I wouldn't say panic... there was a real uncertainty of where did I fit...in the system... you really had no home.
FFI83 (449-455) ...I had to readjust to not going out to work... the issue of being disciplined and that sense of isolation where you don't have anybody and you have no deadlines as such and a week would go by, and then two...

Alternatively time was required to generate a state of readiness for the Fellowship or recover from a hectic lead up to the funded time.

FFI2510 (985-998) When I actually received confirmation that I had got the Fellowship I was absolutely shocked because I hadn't prepared myself... for actually leaving or what was ahead of me re the Fellowship... it took me that length of time (*7 months*) to sort it out in my head that this was what I was going to do.
F3I2311 (46-54) I was exhausted because... handing in my (*MSc*) thesis on (*date*). I gave up my job on the same date which meant as the manager I was... closing everything down... Up to my eyes... I hadn't taken my holidays for a whole year... (59-62) Those first few months.. I must admit I was lying in the bath reading novels (laughs) saying "I deserve this break".

As previously stated being a CNMF denotes obligations. One informal obligation that CNMFs undertake is that of helping those who are subsequently making applications as they themselves sought help from existing CNMFs. A second type of helping behaviour is talking to groups about being successful at the scheme. Whilst this could be interpreted as magnanimous acts of "professional generosity" (Jackson, 2008:2669) existing outside of formal relationships or reciprocity, the CNMFs act as representatives of the HRB in these scenarios.

F2I2810 (1043-1047) I did talk to... a CNMFF... she was very helpful in terms of... "Focus it (*the application form*). Keep it slim..." (1161-1169) I asked another CNMFF and she kindly asked (*a visiting academic*), who has been very involved in funding and giving out large grants and bursaries... I sent him my proposal... and he did 2 interviews with me. He sat me down and he grilled me...

F3I2311 (1547-1554) I did a presentation to lecturers in a university... about applying to the HRB... I told them... not to be put off by not getting it and that in fact the feedback will help you maybe get it the second time which is what happened to me
F3I2310 (387-399) I've done one or two talks to some groups here (*in the hospital*) about research and funding... mainly doctor groups, medical.

Notwithstanding this obligation however, the identity as a CNMF tended to be played out in individual acts. The CNMFs did meet their peers at the Fellowship award ceremony held annually[67] and this generated photographs used for publicity purposes[68]. Although the intention existed organisationally or within cohorts (n=5) – "we all exchanged emails" (F1I296), such encounters did not facilitate a network of CNMFs. So, there was no sense of collegiality between CNMFs. Difference and distances were cited as reasons for lack of contact between Fellows: certainly, their topics showed fragmented research interests and their situations displayed geographic spread.

FFI1012 (1031-1038) There was the 4 of us on Fellowships, around the country, so you didn't have a lot of contact with each other. And we were doing very different things in very different fields. When I reflect back... it would have been really helpful if we had a really good network.

7.2.2 Doctoral student identity

The CNMFs held other identities, such as that of a researcher who buys a research service like data entry or statistical advice or who borrows and lends books to other researchers. For example, identity as a doctoral student was reported and observed to be self-declared in meaningful scenarios and I would contend carried greater weight then that of being a funded Fellow.

F1I117 (558-566) All you have to do is ask a simple question (*at a conference*)... anytime I ask a question I'll always give the speaker "well I'm doing a PhD in this" so that other people can hear.
F2I2810 (754-760) I told them (*research participants*) I was a student doing a PhD... because I think it is important that they know that I am getting something out of this...

Sometimes doctoral identity was activated through collective activities: attending post-graduate research seminars or events for PhD students. The latter in particular were mainly non-Irish nursing or midwifery events, generic university PhD programmes or annual disciplinary functions. This emphasised elements of

[67] The ceremony consisted of the HRB Chair, CEO and guest speaker making speeches and presenting each Fellow with a certificate. All fellowship schemes were included and some Fellows were accompanied by their supervisors. Whilst the NRA diary recorded this event occurring in the HRB building, sometimes it was combined with other HRB events that occurred off-site (section 7.5).
[68] Part of the "public declaration" (section 5.2)

difference such as being funded fulltime as opposed to the 'norm' of part-time nurse or midwife doctoral studentship peers.

F1I117 (574-583) I went to the PhD workshops (*at a UK conference*) I noticed... a lot of the repeated... issues that come up for people when they are working full time and they are studying part-time... the group never allowed the discussion to get beyond that. (588-592) I thought 'there is really no point in me coming here to trawl out all the stuff that I know exists but I need to just leave it now and move on'.
FFI911 (49-53) ...it wasn't really until I started on the European PhD programme that I realised the extent of kind of additional support that you might find in institutions.
F2I1211 (631-639) What we do have is the speciality association... It's UK and Ireland based... you'll find all the supervisors will be at it with their PhD students and it's the PhD student presenting...

For those in the early years of the Fellowship through UK universities or latterly through Irish universities, PhD identity was created through post-graduate seminar attendance[69]. Whilst the CNMFs displayed making choices on attendance, for some, such choices were not available either through absence or non-sustainability of the seminars or geographic distance.

F3I2311 (1962-1968) These days I go to the university a bit more. I'm attending some lectures (*on a theorist*) ...just being able to go and do that... it's aiding my work, it's enriching me and it's something I love...
FFI211 (1521-1526) ...the stimulation I would have got from the entire of my PhD was in (*the UK*) because I went and at least I met students... just a once off sort of snapshot exposure really for monthly seminars.
F2I194 (97-103) Last year at least she (*an academic*) brought us in every so often... to meet and maybe present something we were doing... But since she has gone that kind of has fallen down.

In these scenarios, some of the CNMFs had a sense of marginalisation from their university. Additionally, difficulties in accessing university resources perpetuated this perception (n=3) and some experienced tensions with the university regarding being funded.

F3I2310 (835-841) I don't feel I'm part of the university even though I am and that's nobody's fault. I don't belong to a group there... if I was going to classes maybe that might be different
FFI111 (1509-1518) Your role as a Fellow, particularly as a member of staff who's a fellow is very much tied in to the university - ambassadors for the university and the consequences for the university of it (*the PhD*) not being done and the consequences for you... a flip side to the HRB money.

A PhD identity was also created through having a supervisor. Supervision is pedagogical, dyadic[70] relationship with the supervisor representing both the discipline

[69] Malfroy (2005) contends that such seminar attendance expand RCB and emphasises their role in doctoral pedagogical practice rather than identity formation.
[70] Whilst 12 CNMFs had second supervisors, either funder required or by choice, most described supervision sessions as dyadic not triadic. Similarly, Delamont et al (2000) found episodic reliance on one supervisor.

and university. Occasionally, the supervisor's credibility as a researcher also held meaning for the PhD identity of the CNMF.

FFI111 (1227-1230) ...a number of occasions where I'd be talking to international people I'd just introduce myself as one of my supervisor's PhD students (laughs).
F2I2810 (802-808) ...people would recognise his name... as being very credible... Most people in the clinical speciality field would have read some of his work...

Described as a "delicate relationship" (FFI211), supervision is dependant on clear boundaries around supervisor and supervisee and where there is clarity of purpose that is recognised by both parties.

F1I271 (290-308) ...both of us know what the purpose of supervision is and don't sway from that... my supervisor was very clear in the beginning that there were ground rules... you felt "Wow, this is a bit stringent" but... you have boundaries... It's a friendly relationship but you have to remain focused on the work at the end of the day... obviously there is a supportive role in it but it's when it becomes a completely supportive role or the boundaries get blurred that's difficult.

In practice, such clarity did not always occur and relationships were more complex with "fracas" (F3I185), "tensions" and "conflicts" (FFI211). There were variations in student need and supervisor provision for support, challenge, or direction.

F3I185 (283-291) Maybe I just need a lot of support in some areas... I don't think she sees her role as that. I think she sees it strictly as academic. (1052-1057) I was really having a nervous breakdown because the supervisor was on my back for written work and I couldn't see how I could be down there (*data collecting*) and be writing as well.
FFI83 (824-831) ...she was helping me to form it (*the PhD*). She wasn't checking on me. I never saw her like that... not the critical eye but the supportive eye that would look and encourage. It has become much more critical near the end because I've asked for it.

For six CNMFs, their supervisors held other roles, such as that of colleague, which could potentially alter the supervision relationship positively or negatively as found by Denicolo (2004). For example, trust may already exist from a previous management relationship or the supervisor may continue to behave as a peer.

FFI1012 (346-351) I had worked prior with one (*supervisor*) and... I totally admired his ability as a researcher. I felt he was very knowledgeable and that I really could learn a lot.
FFI83 (628-634) ...my supervisor happened to be my head of department. I had spoken to her about my area of interest... it seemed the natural thing to do to pick her... (775-783) the fact that we had a very, very good working relationship and it wasn't hierarchical... there was never a sense that she had somehow power over me. We would always discuss things openly and challenge each other and that was the same within the supervision.
FFI111 (49-57) I had to keep saying to myself "This (*mock viva*) is not a...discussion with the professor or my supervisor... this is different. There's a role going on here". It was the first time you really felt "I'm a PhD student. I have to defend this" (laughs) as opposed to saying "Look (*supervisor's name*) come on, will you?"

The nature of the supervision relationship is transitory showing change over the timescale from initial dependence to independence (Delamont et al, 2000). This is perceived through the element of trust: what starts as an initial trusting dependence of student in the supervisor ideally transforms into a relationship of trusted independence of supervisor in the student. However, as in all hierarchical relationships, CNMFs showed awareness that supervision has the potential to be abusive or damaging.

F2I1211 (720-728) ...you have to trust that he knows that he's going to get where he wants to be at the end... doing the Gantt chart, for the proposal was useful. I was able to... say "Do you really think we'll be there because look at where we are now", but he was saying "yeah, we will be".
FFI211 (602- 625) ...start out with a naive trust... You're embarking on something that you really are not sure about, once you get into it you begin to realise that you're swimming in some deep water... you rely on him in some cases to take you out of those deep... or muddy waters... a (*professor of nursing*) talks about a guarded alliance... for me there was an element of guarded alliance because... he was at a stage where he was advancing his career... I didn't want to find myself caught in a situation where I couldn't negotiate and say I would like to publish... on my own".

Whilst supervisors were praised for showing patience and understanding, supervision approaches to CNMFs' personal crises during the timeframe varied[71].

F1I267 (1428-1431) ...he is there going "Calm down, don't worry" and he's a very calm person and he's very reassuring and that's great for me.
FFI83 (1263-1272) She recognised that I was genuinely unable to perform and so she backed right off and she gently sent emails or rang me up to see how I was doing... at the same time she was under pressure to try and get me completed within the timeframe which was impossible.
FFI211 (1454-1463) ...he wasn't entirely supportive... his immediate thing was "Is this going to stop you from submitting it early or whatever?" and there was a lack of sensitivity, I felt. He was sensitive on the one hand but on the other hand... it was a good mark on his copy book if I got the PhD in on time.

An additional creation of PhD identity was through 'PhD chat'. PhD chat was primarily a feature of conversation with friends or acquaintances who were also undertaking a PhD with topics such as comparing progress or supervisory relationships. 'PhD chat' were also recorded in six observational data sessions and acted as a conveyer of tacit knowledge.

F3I142 (693-714) She (*a peer PhD student*) was helpful, she's in education, very different but at least the two of us could give out about the same things. S: What sort of things...? F3I142: access to supervisors, (pause). Mostly it would be around that area, what she was trying to do and (*the supervisor*) might be trying to... steer her somewhere slightly different...

[71] The stances adopted may reflect supervisors' attitudes to the policy driver of "getting a PhD" as opposed to the pedagogy of "becoming a doctor" (Petersen, 2007:483) as much as to individual supervision styles.

FFI211 (1559-1572) One of my peers on the PhD... she was a wonderful source of support. And she also had (*the same supervisor*) so it was quite nice to have a little bitch every now and then (laughs). And... reassure ourselves that this guy is good, as a supervisor.
F2O194 We head downstairs to the kitchen for a cup of coffee. We are there 50 minutes but the conversation continues to focus on research. I tell the CNMF that I've read a PhD which I had got on inter-library loan and which affirmed to me my own ability to produce a written work at doctoral level. The CNMF describes the doctorate of another academic that they had read as organised, clear and linear in thinking and negates their own thinking processes. I urge them to remember that they are reading a product and not viewing the process that had taken place.

PhD chat was not always positively conceived but this seemed to be with young doctoral students from other disciplines or because of inappropriate timing.

FFI2710 (197-202) I did make a point of seeking out other PhD students... you'd go for coffee together stuff like that... you talk PhD. (563-567) ...other PhD students who you would meet and would say "Oh I've written 3 chapters" and I'd be sitting thinking "I haven't written any chapters" (laughs).
F3I185 (1456-1466) I actually felt that they'd (*other doctoral students*) unnerve me. What they'd be talking about... my work is so on the margins, that I felt if I started talking to them too much I'd lose all my confidence which I barely have anyway (laughs)... I just felt at some intuitive level, not to go there.
FFI1510 (807-815) ...she started talking all about her study and about the problems she was having... she knew that I was waiting to go in to my (*PhD*) viva... and she just went on and on...

7.2.3 Nurse or midwife identity

An additional identity used by the CNMFs was that of nurse or midwife and was especially prominent when dealing with research participants. However, this identity tended not to be used as just the simple title but to inform participants of the CNMFs' practice background in specific clinical specialities, to enhance their credibility. This action, when gathering data from nurses, underpinned their 'sameness', thus producing legitimisation.

FFI2710 (977-984)...I introduced myself as somebody who had been a community nurse and who worked with (*clients*) and was very interested in... what their experience was like.
FFI211 (2389-2400) I would have said my background was in nursing. I never sort of camouflaged that and in my information leaflet as well I would have said my professional background was a (*branch of nursing*) nurse and where I had worked and how much experience I had.
F1I267 (908-920) ..."what's your background?" "I was the sister"... I could talk to people about the treatment, about the types of clients... there's better treatments now... better success rates but I'm aware of them... the experiences with the clients hasn't changed... so you are very credible when you are speaking to people.

However, tensions did arise for some who were from education, reflecting their awareness of anti-intellectualism in nursing (Luker, 2006; Hendry, 2007).

F3I2311 (402-407) Did I say I had been in a role in the nursing education? At some point I think I did mention that because I felt that that was important that people would take me more seriously...
F2I2810 (740-749) ...the important bit is that I am a clinical speciality nurse and in my heart I can't be anything else... I didn't put down that I was a general nurse. (laughs)... and I didn't tell them I was a teacher either.

In contemporary times, Irish nursing as a domain is heterogeneous and has also been defined previously as including midwifery[72]. The CNMFs researching non-general nursing topics were particularly keen to differentiate their branch of the profession or the clinical speciality, marking themselves or the speciality as different and were critical of 'general nursing'.

F2I410 (613-627) (*at a nursing policy forum*) There was eight posters... one of the first posters was (*from a different branch of nursing*) and they had set up a practice initiative ... I was saying... "I'm thrilled that there's two posters (*on the clinical topic*)"... she wasn't one bit impressed with me (laughs), it was her role that really this was about not about the clinical topic.
F3I248 (1133-1141) ...it will be good for us to have some (*research*) that will be involved in theoretical discourse but not of the proportion that is happening to nursing... it is gone that there is too little clinical and too much theoretical... just bandying the same ball about...

However, using the identity of nurse or midwife to gain entry with research participants could produce subsequent tensions when collecting data as a researcher; for example, by not wanting to disturb the routines of practice. Some CNMFs actively managed these tensions but this was especially difficult when the CNMF used the symbols of being a nurse, such as wearing a uniform, in order to collect the data.

FFI83 (25-34) ...what I didn't want to happen was for the participant to suddenly put me in a nursing role and start querying aspects of their condition... because they were still... surviving an illness... at times it came up... they would say "And do you think that's ok?"
FFI1510 (258-269) I suppose I was afraid that they were going to start asking me (*clinical*) issues... I would have gone to meetings and suddenly I would be asked for my opinion. (1396-1405) I felt that I had more boundaries as a researcher than I had if I was in practice... if I was a nurse caring for this person, at least I could become involved in the intimate care... getting to know them a bit better but... often times I just felt like such a sore thumb sticking out as being the visitor and researcher.
FFI211 (2649-2662) I actually did remove myself from being a nurse... I would say "Look... my background is in nursing... but... I do not understand (*your world*) and I'm very interested in that and if I can as a researcher I would like to make a contribution to your lives through my research...

One CNMF refused supervision advice to wear a white coat when collecting data in the clinical area so as not to "masquerade as a medical student" (F3I185). Such

[72] The publication of the Nurses and Midwives Bill in April 2010 clearly delineates two professions. For a debate on the relationship and some of the inherent tensions between nursing and midwifery see Norman & Griffiths (2007), Thompson et al (2007) and Thompson J (2007).

tensions of identity are noted by Dupont & Sugrue (2007:116) who contend that enhanced clinical relationships with medics may have a "detrimental effect on relationships with nurse colleagues". For other CNMFs, clinical staff regarded them as 'different' and therefore blurring of identities was not reported. Nevertheless, the CNMFs utilised strategies to show their similarity, such as using clinical discourse.

F3I248 (1742-1734) In the clinical site... I'm the only one doing research and the only one doing a PhD... that alone is going to segregate me and make me different. I physically have a different role since it's non-clinical and I don't have the same impositions that they have because of the clinical workload, being employed, wearing a uniform and all that sort of stuff.
F3I185 (1085-1089) I had a little space and I felt I had a bit of an identity... the clinical nurse manager used to say "Oh (*name*) is our resident in-house researcher".

The CNMFs brought their professional role as a registered nurse or midwife to their current research and subsequent education practice or their findings. It was perceived that this imposed obligations on them with regard to their code of professional conduct.

F1I267 (377-388) I said "We are accountable as nurses. We are bound by confidentiality. (821-827) I suppose in dealing with the (*patient*) support groups and highlighting we were nurses and it was very much nursing and you were coming back to your registration and your accountability and your confidentiality.
F1I309 (365-380) ...but you're left with a kind of a duty... as a registered nurse if someone brings up something and I'm not talking about a big ethical thing like child abuse... I'm literally talking about if they are saying "I don't know anything about a potential treatment. Nobody has ever mentioned it to me..." You can't just finish the interview without working it in, trying to get staff involved like "Would there be any chance maybe he could see a consultant?". (386-392) ...an onus...you have a responsibility if people feel they need some care... you have to make it known to somebody.

The CNMFs also brought their knowledge and skills from clinical practice to data collection or even to writing a chapter where one described their preparation as akin to setting up for an operation.

FFI1510 (1423-1426) A lot of the time patients would get upset and the tears would come... but I was very comfortable with that.
F2I1211 (1357- 1382) ...maybe it's the nursing experience. I'm able to speak with them and keep it very professional 'cause... when you're putting on the (*equipment*)... to talk your way through it and... keep them relaxed... that was a gift and I've seen a few other people doing it and they weren't able to... talk while they were doing it...
F2I911 (629-644) S: Do they ever ask you questions about their health care? F2I911: They do... the questions are often very simple... usually what happens is that they are so stressed out and so focused on the technical information... that what they forget to do is ask about things like..."when should I go to hospital?"

As nurse or midwife researchers, they get to know their research participants particularly well. This can extend to holding memories of them beyond the research process. They valued "being back with the patients" (FF2510) reflecting a sense of

loss some feel when they move to education and supporting Dempsey's (2007) findings from an Irish qualitative study with a purposive sample of six clinicians who had become lecturers.

F1I296 (600-607) They couldn't believe that I remembered their names... they'd say "you've a good memory" and I'd say "But I've been listening to you for the last month" ...I knew all their stories very well. (660-664) because I knew the voices so well I could tell exactly who was saying what and even if I looked at a transcript now I can still remember... (*their health service experience*)
F2I911 (878- 893) ...they have been through such life changing events... they're prepared... not just to tell you about it but to almost let you into it and be part of it...
FFI1510 (1773-1782) I remember those poignant moments. You never forget them ... I still hear their voice coming in and supporting maybe what nurses have said... I can almost still see... the colour of the pyjamas or the dressing-gown...

As clinicians, four also reported being negatively surprised by some of the data they collected.

F1I296 (385-389) I was quite upset with a lot of the stories. I thought "You're young... and you ended up having a (*particular intervention*)... (422-433) S: do you think that it (*'shock'*) came from being a clinician or being a researcher? F1I296: It came from being a clinician, yeah. I think if I was a researcher I might of thought "...there's probably a reason for that". But there's no reason for anybody to be treated the way some of them were treated.
FFI2710 (1259-1265) ...quite frustrated that after all these years, some professionals were still getting it so wrong... felt like... saying "Did you not realise that you shouldn't be doing that?"

Generally, they drew on their previous clinical experience to help them explain or understand issues which arose for their participants or themselves within their own study. This included the low priority given to research in the clinical area producing the perception of "being a nuisance" (F3I185).

FFI1510 (1405-1413) I would go on... the formal consultant rounds... And I used to cringe... because having known... how the patient was... I'd say "they don't need another body going with this entourage".
F1I267 (769-772) People were supportive but what they said "We're very busy. We've an awful lot... without yours"
F3I248 (197-201) ..."the clinical work is so busy and research..." everybody loves it but... it is not on the agenda when it comes to time and resources.

For those using clinical sites where they had previously worked, there was an additional benefit of organisational knowledge accelerating initial study processes. Nevertheless, even with a strong association between their practitioner identity and their data collection processes, there was still a sense of 'not belonging', especially if the research site had previously been unknown. Work was then required to "pass yourself" (F3I185) with practices such as attending social events.

F2I410 (515-520) I do feel a little bit of an outsider... I kind of feel I'm in on their space. (534-539) Nobody has ever made me feel that I'm in the way... but it's a bit strange. You're still in a no man's land really, and that's kind of difficult.
F2I1211 (1450-1467) S: Does that feel strange, being in a hospital...? F2I1211: Yet not knowing people? Yeah, I found that very hard. So I always make sure I've a book with me when I go down (*to the canteen*)... all these people... and they're all wondering what am I doing and the security are asking "who are you?" (laughs).
F3I185 (767-770) ...you were trying to be there and get a grasp of the culture and what was happening and remember people's names... (993-995) The minute you go through that front door you're working on it. It's how you present yourself. It might be what you talk about... (1143-1159) I went to the Christmas dinner and the consultant said... I'm glad you're here, nobody ever wants to sit with me"... he said "...Will we share it (*purchasing the wine*) out?" ...he used to probably get stuck with the bill... I said "Yeah, that's no problem. I'll buy a bottle as well"...

7.2.4 Person-self.

In addition to the professional identities described of CNMF, doctoral student and nurse or midwife, there was also the identity of the 'person-self'. The 'person-self' can be a source of enforced 'timeout' from the PhD and events occurred on a spectrum of severity. Bereavements (n=3), accidents and illnesses (n=2), even moving house (n=1) took the focus off PhD tasks. Some of these events can "knock you for six" (F3I185) and cause difficulty resuming the researcher identity.

F3I185 (633-639) ...my (*parent*) just got sicker and sicker... then died six months later on. And I was very shattered after all that to be honest with you and I was just hanging in there really.
FFI2710 (367-387) ...just after I really got into writing, my running partner, who I had run with for years... killed himself... it was very, very complicated (*details omitted*) but apart from... the trauma of the suicide... I didn't have a running partner anymore.
FFI211 (1418-1426) I went through a very difficult time where my personal health was failing... I was getting somewhat hypertensive. I was extremely tired. I was getting a lot of pain... I thought "... something is acting up here".

Family responsibilities can be a distracter and this includes parental care as well as childcare. Whilst a period of family illness causes extra strain on the researcher identity or reduces the 'cognitive space', daily living within a family can also impact. There were divergences when research activity takes from 'person-self'.

F1O264 (367-380) 14.40hrs. I hear her mutter – "here's mummy". The CNMF's mother had been due to arrive at 16.00hrs and so is earlier than planned. She goes to the kitchen door to greet her... This marks an unexpected early end to the CNMF's work...
F3I2311 (123-149) ...my father was in a nursing home... my mother had had an eye operation... my sister's husband developed a cancer. She couldn't visit. He was having chemotherapy... I was the only one who could keep an eye. And being a nurse I could see where he wasn't getting care. He was depressed. And I was in like every day and sometimes up to 3 times a day... that... took a huge amount of time... a huge amount of my thinking and worry...
F3I142 (211-215) The kids have been sick... last week, I've had at least one home each day but... they're downstairs and I don't hear them. (232-234) They were too sick actually to annoy me. You'd hear a little noise... beyond that very little (laughs)

F1I267 (283-297...the week before the course and the whole week of the course... I was going away very early in the morning... I didn't see anybody at home... S: So your personal life and your family life... F1I267: Completely went on hold.

For CNMFs, there was a tension between identities. The research self took precedence at times, yet the obligations within 'person-self' identity are valued for reminding the CNMFs that this should not always be so. 'Achieving balance' between roles was valued.

F1I309 (159-162) ...you do have to compromise. You have to put everything second...if you're serious about it (*being awarded the PhD*).
FFI1012 (1365-1377) ...having interests... hobbies... stuff outside of the Fellowship and outside of the research is absolutely critical because people really do need to re-energise and re-focus... I had a very balanced approach to it... Nothing like children and family to re-focus you (laughs)
FFI2510 (525-528) Most of the time I got the balance (*with personal life*) and other times it just got almost out of control that I almost lost it...

Looking after oneself was deemed important. This could be achieved in a number of ways. 'Going for a walk' (n=6) incorporated beneficial, 'person-self' moments into the daily routine. Sports activity was included by many whilst others resorted to complementary therapies or arts.

F3I185 (1870–1879) I've taken up running as well... just starting my body might start my brain. (2400-2408) when I got the HRB... It has really taken a lot of the pressure off me... It has meant that I've had money to go towards looking after my health. I've been taking a massage once a month and acupuncture which has really helped get me back on stream.

Whilst having children structures the day for the CNMFs that were mothers, having a spouse can also help with constructing a daily or recreational routine.

F3I142 (608-633) I don't work at weekends and when they come home from school... *recently* I've done a little bit maybe until five, just if I wanted to finish off... My daughter can make the pasta... that's only this year that she is able to... but most times I was down (*stairs*) by half three, that's when the first come home from school.
F1I271 (678-683) ...if my spouse came in from work at six or half six, then I'd stop and I'll do the dinner... if not then I'll just keep going.

7.2.5 Managing multiple identities

So the CNMFs had a variety of personae and therefore multiple identities. Some used (n=3) the metaphor of wearing different hats to represent their differing personae.

FFI911 (372-374) I kind of more or less used to take off my nurse's hat to whatever extent I could.... (1233-1236) I bring a nursing view to it, even if I have my research hat on I still see the world through nursing...

Identity 'work' was shown through the discourse used by CNMFs. For example, the researcher identity was conveyed in the mentioning of names of methodological experts (n=7) and admiration for nurse academic 'gurus' (n=10). Professional terminology and the use of clinical terms conveyed the nursing or midwifery identity. Material symbols of identity were described: parking permits, keys and staff swipe cards denoted a hospital identity, passwords denote a doctoral student identity and a conference briefcase denoted a scholarly identity.

F2O42 (*in a presentation to medics*) In some cases the medical acronyms which describe the particular condition of service users are identified in addition to what I presume are pseudonyms.
F2I1211 (1473-1475) I've got a parking permit thing now... but that took a good while (1475-1482) they couldn't understand who I was 'cause I'm not actually under the hospital's staff... what am I doing there...and why have I keys to the place...
F2I911 (719-726) I'd a name tag but that's purely because... the hospital require it... all the doors are secured now so you can't actually get from one end of the hospital to the other, unless you've got your swipe.
F2I410 (725-727) I registered (*with the library*) and I got my passwords and whatever and I haven't been back. (laughs)
F2O2611 ...All materials (*for data collection*) are placed in a small briefcase – the type that is given as part of a conference pack.

The identity to the fore depended on the context. The CNMFs described their willingness to use their identity pragmatically and contextually to achieve their needs; so different audiences meant different approaches.

FFI2710 (755-763) ...we used to joke that... when I didn't want to do something I was a student...I was on a HRB Fellowship... But when I needed from the library in a hurry I become a lecturer (laughs) or if I needed to requisition something. (962-974)... the second phase of the study, all the qualifications came back and it was name, role, School of Nursing, HRB Fellow... and the HRB logo and stuff would have been on... any of the stuff that was sent to the nurses. But that was very much to get them to sort of sit up and pay attention. That was the language they needed to hear. I didn't do that with the (*participants*)... it was much more low key...
FFI83 (64-70)...for the past service users although I didn't say it openly, in my mind I was a researcher who happened to be a nurse. And for the medics I was a researcher, I was not a nurse. (112-116) The reality was that I was there as a researcher at all times because... that's what my role was at the time and that's what my focus was in collecting this data...
FFI2510 (278-290) I was wondering if they actually knew I was a nurse or a doctor... I didn't (*enlighten them*) (laughs) not (*at that conference*).

In addition, observations showed the diversity of approaches that CNMFs used to describe themselves through media such as project publicity or electronic communication. All identity elements could be utilised within single episodes.

F1O191 I pick up a promotional flyer to look at. There is information about this part of the study and a reply slip... On the back are the CNMF's contact details. I note that she calls herself a 'doctoral clinical speciality' and gives the university at which she is registered. There is no mention of the HRB. (*Later I note that this CNMF when publishing in a clinical speciality journal includes the HRB Fellowship but omits the clinical speciality*).
RD14/10 Emails from one of the CNMFs have thrown up an identity issue. There is an automatic signature with contact details at the end of the emails. This CNMF has called herself 'HRB Research Fellow'. There is no mention of nursing. The rest of the contact details show the department in which this CNMF is registered, which is not a nursing one.
F1O1011 Throughout the presentation, the CNMF moves between the identities of researcher and nurse, although the latter appears stronger. Comments such as "I might even get a PhD at some stage" show the researcher identity. For nursing, the CNMF refers to her experience as "a clinical speciality nurse" and the implications of a particular finding.
FFI911 (403-409) I started to match the data from the parents to that of nurses and... directors, like in some ways I was a parent myself, I was also a manager, I was also a nurse, so I could kind of take which-ever focus I wanted to.

Such usage however, belies the enigmatic position of the CNMF and the confusion in identity that some felt in 'not belonging', raising questions of self-identity for the CNMFs.

F3I142 (811-829) *The supervisor* thinks of me as a bit of an anomaly really. Not a true scientist in some ways... when I do do something good, he looks surprised as if 'oh so you do have it in you after all'... he would see me first as a nurse and not first as a scientist.
F2I911(1028-1041) It took a while for the... staff to realise that I was coming and going and that I couldn't be there every day... the midwives desperately wanted to claim me... because I was the one that was out that was getting all this potential knowledge... then the medics almost wanted to claim me because now I had all this information which was really valuable to them. So who was I? ...I neither belonged to one group nor the other?
F3I2310 (808-830) ...that sense of being a little bit lost... like I'm hanging off the end of this dangling arm... I'm paid by one and employed by another and being supervised by another... if somebody asks who are you working with at the moment? I'm not sure... I find that very strange.
FFI1012 (1387-1402) ...you were not part of... the buzz of what was happening in the field. You weren't the buzz of what was happening in maybe a large school of nursing... in the clinical area... You were kind of a bit out of both streams really... I found it somewhat isolating.

In summary, the CNMFs display a number of identities within research capacity building. The identities are used pragmatically depending on the context but the CNMF identity itself suffers from weaker usage than the others. Issues arising from the relevant data will now be discussed: building confidence and credibility and adapting to an identity in transition.

7.3 Building confidence and credibility.

The data showed that stability of identity was dependant on acquiring confidence in that identity – "all you need is hard neck" (F3I185) and confidence was enhanced when perceived as credible. The data showed that this was an outcome of RCB and required the resource of time.

FFI211 (2023-2032) This whole sense of credibility... has been a very striking experience for me in undertaking a PhD. It is a hallmark of doing a PhD, that is, becoming a credible researcher. It is amazing really... how you're perceived by others...

Credibility had to be achieved in all the professional identity arenas. As previously noted, the CNMFs' previous nursing and midwifery roles in association with the hospitals bestowed clinical credibility in the eyes of patient or professional participants so they are not "someone who's jumped on the bandwagon" (F1I267). For doctoral student identity, having previous roles as assistants on research teams (n=3) or helping with other's research (n=2) assisted with research credibility and showed that in the main the CNMFs were not complete novices. Being known (by the department or supervisor) also determined an element of trustworthiness and where unknown, the CNMFs had to 'prove themselves' in some cases.

FFI111 (981-990) To some extent... the experience of doing the PhD gave me a chance to look at research in detail... not to be too sort of big headed about it... I would have been a reasonably established author and researcher in (*the clinical speciality*). But the PhD copper fastens that.
F2I1211 (179-189) ...he thought I was a very different type of student. He had never had someone come in from another discipline... I had got a first... but I think he still was unsure of my... skills and wanted to see how I worked. So it was something he had asked for, would I come in and work with someone... in the (*research site*).
FFI911 (579-582) I sent a paper (*to a potential supervisor*) that I had had published in the JAN as a way of kind of credentialing...

There were two elements in confidence building – that of process and product: the "self-belief" (F2I410) in one's own ability to conduct the research and the confidence in the value and quality of the study. Building self confidence was against a background of much anxiety about self ability. Eight of the CNMFs voiced their feelings of doubt and concern about their individual capability to undertake the doctorate.

F3I248 (1821-1836) I don't lack the confidence in getting out and doing the project. It is a case of how am I going to get this done? ...before it was, 'oh I don't know, I'm not sure and will I or won't I...S: So there's been a build up of confidence? F3I248: absolutely from a research point of view, for sure.
FFI2710 (739-745) I think there was another part of it around confidence as well, where you felt... "Well I've done this and I've done that and I know I can do this". So that became a big part of it.
FFI211 (2499-2504) ...at the beginning, certainly... questioning my own ability and my confidence. "I really won't be able to do this. This is really for very, very intelligent people".

Developing confidence was not a straight upward trajectory. Instead it appeared as a series of peaks and troughs, contrasting strength with vulnerability so that confidence was fragile requiring nurturance and defence.

FFI211 (2526-2530) ...pulling all of that (*data)* together was, I found extremely difficult and I went back into that mode of "I'm not going to be able to do this..."

Adding to some CNMF's perception of vulnerability was the burden of being funded or considered for funding. Whilst being funded boosted confidence by "empowerment" (FFI1012) or "reassurance" (FFI83), a dichotomous position of 'feeling a fraud' (n=3) early in the Fellowship increased anxiety about the capability to undertake the doctorate with a potential resultant loss of personal credibility should the CNMF not achieve.

F1I271 (585-590) I just thought the fraud police were going to come and... say (laughs) "You don't have a clue what you're doing, do you, really?" and "We've got to come and take the money back" (laughs)
FFI2510 (85-93) I was waiting for someone to tap me on the shoulder and say "Look, we've made a mistake. You shouldn't have got the Fellowship. It was meant to go to somebody else". I kind of had faith in my own study but I didn't think anybody else really did until that point (*transfer to PhD*) ...
FFI1510 (69-76) I felt... I will never achieve a PhD standard. What are the implications of this for the funding, for my fees, for the HRB and in particular for myself? My credibility - I felt, was going to go out the window.

Within the doctoral process, confidence was built in the tasks of 'doing' and becoming comfortable with techniques required to gather the data but self-doubt could remain in interpreting the data collected.

F2I296 (873-881) I'm not scared to go in now... "I'm going to try this." "I'm going to try that", doing exactly what I thought my supervisor would have done... working your way through what was the problem.
F3I2610 (472-479) ...I got repeatedly the same information... if I had confidence I should have been able to drop that issue six interviews on and moved on... but again... that sense of reconfirming and reconfirming...
F2I194 (652-661) Maybe that's it... I doubt myself... if you're writing the literature, you're writing an opinion that someone else has expressed ...whereas when you've to write your own... it's that doubting. "Is this right? Is this nonsense? Is this coherent?".

The CNMFs described the key role of oral or written dissemination in confidence building and developing credibility. The early occurrences are particularly noted as CNMF's have varying levels of confidence in their ability to achieve peer-reviewed dissemination.

F3I248 (680-692) I didn't have the confidence to write whereas now... it's almost like publication is not beyond me... So that bit has passed but that was a major stumbling block... It was almost like 'this is an amazing talent that other people have that I don't have'.
FFI1012 (822-830) ...one of my supervisors... with a very strong research background felt "...you need to be presenting your work and getting known in the field and getting established, right from the beginning". So I would have... presented internationally very quickly.

Comfortableness is also a requisite for the task of dissemination. Additionally, developing the necessary discourse builds confidence.

F3O411 The CNMF uses no notes in the delivery and speaks in a confident and polished way around the issues displayed in the powerpoint. Whilst there is an automatic slide change which sometime runs ahead of the delivery the CNMF deals with this quietly and efficiently. They also ignore a loud noise from the road outside... Although increasingly a nervous flush appears on their neck area the overall impression is one of comfortableness with the content and the audience.
F1I117 (512-525) I was presenting on stuff... that I didn't feel that comfortable with because I'm really only trying to get into philosophy...I realise now this could go very wrong if I'm asked the wrong question (laughs) as you always do when you present at these things.
F3I2311 (485-499) I've become very much more confident now... about the PhD and about being able to speak about the psychological aspect... maybe I've learnt... so much more about it myself or found more words for what I understood before. I knew it would be alright but just never really knew how to word it...

Building confidence included becoming assured in the worth or quality of the study and withstanding challenges by 'knowing the stuff'.

F1I511 (1032-1048) "Here's me doing (*the study*) on my own except for my supervisor." I said "What am I at, who am I kidding...?" But by the 3rd day (*of advanced training course*) I thought "...you've covered all what they're doing and yes, things could be improved but fundamentally it was fine"... I sometimes have to remind myself "Wait a minute, the ethics committee, the licensing authority, the HRB, they've all approved it... these people don't approve something unless it's all right"...
FFI2710 (477-496) ...as you start to present the papers... you start to think "Now this makes sense." I think part of it was my anxiety. In the background was I'm not in (*that particular field*)... and to be able to present that to people whose day in day out work was (*that field*) and for it to make sense... I thought to myself "well that's ok"... needing reassurance...
FFI2510 (346-356) ...there was a couple of times (*in presentations*) the consultants really drilled me on statistics and... I felt I really needed to know my stuff, whereas with nurses they wouldn't drill me as much... from the first time that happened I was much more prepared. I'd be ready or I'd be anticipating tougher questions from medics.

Audience affirmation is valued but there is also a social practice of positively supporting peers in conference presentations. One supervisor prepares a CNMF to not become complacent by accepting such affirmation unconditionally.

F2O811 There is also audience reaction in the form of laughter, nodding heads and murmurs to the direct quotes that the CNMF2 presents as findings. There seems to be audience recognition of having heard these sorts of statements before and a rising vexation with the content of some of the quotes.
F3O111 The CNMF3 acknowledges the verification that she has got to date when discussing or presenting the work but the supervisor humorously challenges with "What if someone says it is complete and utter nonsense?"

A key relationship for building confidence was that with the supervisor. The data showed that initial promoting ability and safeguarding exploration develops into increasing independence or beginning "to stand back" (FFI211) with confidence from

the supervisor. In addition, a poor supervisory relationship can shatter any developing confidence.

FFI1510 (485-492) I was unfortunate... I did employ an outside supervisor...who would have been the expert in *the clinical speciality*... and she totally and utterly... shattered me (496-502) everything was negative... "this isn't PhD standard"... "If this was my university, this wouldn't be passed..."

7.4 The issue of transitioning.

Described as an "upheaval to quite a different way of life" (F1I117) the initial transition *onto* the Fellowship takes time and adaptation. Some of the difficulties were about locating the labour space or resetting a structure for the PhD labour.

F1I271 (571-576) I haven't really made the transition into knowing that I'm doing this full time... I keep thinking that I'm only part-time... so it's forcing me (*to work at a quick pace*).
FFI211 (1619-1622) I found it extremely difficult to move from full-time employment to fulltime student and to sit and... stay working on the same project. I was so used to my pattern...
FFI2710 (84-89) I was totally unprepared for... the difficulty in becoming a full-time student... no one had ever said "It's a problem".

Missing the workplace depended on the type of previous role: those in clinical roles missed the excitement and sociability of the practice setting, those in education missed activities such as programme co-ordination, those in managerial type roles were more used to less social, independent working.

FFI2710 (89-100) So I went from having been... co-ordinator of teaching, co-ordinator of placements and very involved in what was going on, very busy... and within a space of... the first 2 or 3 weeks of the Fellowship, the phone stopped ringing... It was totally weird (181-184) I needed to... make a transition that said "well you're not on the phone anymore, you're sitting at your desk".
F1I1512 (839-849) No I don't (*miss workplace sociability*)... I was in a managerial role... I did a lot of admin... a lot of work on my own... a lot of teaching and meetings... so I didn't really.

Some CNMFs experienced specific difficulties in 'letting go' of lecturer or teacher roles and 'ownership' of courses. Destroying only one of two uniforms also showed a reluctance to 'let go' from clinical practice.

FFI83 (241-252) I didn't start the fellowship in my thinking until the January... when I could actually distance myself from work... having physically distanced yourself from work, because you were coming in, you were dragged into work issues all the time. (261-266) I think personally huge difficulties letting go of the only thing that I knew for the last fifteen or tweny years and being this full-time student.
FFI2510 (979-985) ...at the time I was happy in my job and had helped develop a course, and really enjoyed running this course and didn't want to hand it over to anybody else because nobody else could do it as well (laughs)
F1I511 (201-212) I had my two uniforms and I thought "what am I going to do with these?" .. so I binned one of them...I thought in case they'd ever ask me to come in for a day or something, I thought "I'd better have something there".

Being funded meant dealing with changes to salary and another indicator of an identity in transition. For one CNMF sorting a salary was particularly acute as the changing context of nurse education meant getting leave of absence from the workplace 3 months before the start of the Fellowship with the resultant lack of any salary and time spent negotiating unsuccessfully with the university and the HRB to try and secure an advance.

F1I1512 (770-772) I found that the whole process of getting your expenses a little bit tedious. (786-794) you have to pay upfront for your fees which is €2,000 ... for your computer, another €2000 ... I found myself actually very low on cash because then you have a reduced salary as well.

Unsurprisingly the data showed some similarities in transitioning onto and off the Fellowship. One example is that of the social discourse in the workplace that marks the concept of 'belonging' to those who participate.

F1O264 I reiterate how hard it is, especially as you realise that you've moved on personally as well as professionally. The CNMF illustrates this by saying how when she now returns to the hospital there are people she does not recognise and who do not recognise her.
F3I142 (670-678) ...we had a very nice lunch with everyone discussing different things... its adult social contact... listening to people... and hearing what's going on with the courses I was running, that kind of thing...

Becoming "the visitor" (F1I511) to the workplace and dealing with isolation and faltering confidence, brought a questioning of place in the first year. The data showed that the second year was a time of contemplating the future and acceptance that 'there was no going back'.

F2I410 (1020-1024) ...two years time, where am I going to be? What am I going to be doing? So you have to kind of publicise yourself a little bit as well.
F2I911 (1842-1846) ...totally knowing I can not go back to my role pre-fellowship... I cannot go back to my previous clinical role. (1857-1862) you do wonder where you fit from an employment perspective. Not where you'll get a job or will you get a job. But what do you want to do and is there a job that matches what you want to do...

Envisaging a future role showed a variety of idealised possibilities. For some, these included a commitment to clinical practice (n=4) or policy (n=1) as well as continuation of a research career. Yet, the lack of post-doctoral funding available was criticised – "like you've built a house but didn't bother giving money for the roof" (F3I1410).

FFI111 (1133-1139) I hanker after practice but I haven't quite grasped how I'm going to get there yet. (laughs)... I don't see myself purely as an academic in the older sense of

researchers... to some extent detached. (1148-1153) I applied a few years ago for an advanced practice post that would have taken me back into practice... but would have delayed my PhD...
F3I185 (2319-2325) I would in the future like to think I would really stay in touch with (*the clinical area*)... maybe have one or two days on the ground every week as some kind of facilitator or educator...

The third year brought another transition into view – that of returning to the workplace. Two CNMFs described a readiness to return in contrast to others.

F3I2310 (657-665) It is going to be so difficult (*return to the workplace*). It will be great in some ways but.... When you've got used to... working on your own and I'm going to have another year... It will take getting used to.
FFI311 (140-144) I was just ready to come back and meet people... and have less time and make more use of it. (157-161) I was out long enough. I needed adult company and the money of course (laughs). So I felt ready to come back...

However, the return brought negative thoughts to some CNMFs, as they "start all over again" (FFI2710) and "prepare from scratch" (FFI132). These centred on the politics of workplace cultures and potential loss of skills as much as increased workloads and reduced time for their individual scholarly activity.

FFI2510 (896-909) ...(*transition back to the workplace*) was awful. In the beginning I didn't want to leave the workplace... at the end I didn't want to give up the Fellowship because I just loved the freedom of being able to do my own work and be autonomous... I didn't want to actually face the whole rat race of being in a job, all the politics that go with it, all the stresses, working within defined parameters...
FFI83 (1090-1095) ...coming back... was as difficult as leaving, 3 years previously and I remember coming in and sitting in my office and thinking "What am I going to do?" (1104-1109) that sense of being equally as vulnerable coming back... feeling very much deskilled in terms of teaching, in terms of my confidence of standing up in front of big groups...

Almost all CNMFs were transiting from the Fellowship directly into the academy as lecturers or similar teaching roles. There were two exceptions whereby CNMFs got research roles in government agencies.

FFI2510 (953-962) I did some consultancy work, research... It was a breath of fresh air just to stop my study and actually be with people was a nice introduction back into the workplace. I was actually kind of dreading it but I really enjoyed it...

The lecturer role that some CNMFs aspired to on return to the academy was an idealised combination of education and research. Yet, those with actual experience of the role described a differing reality. The pressure of teaching, assessment and academic administration in new university departments (Dempsey, 2007; Holopainen et al, 2009) meant a perception that RCB at post-doctoral level falters.

F3I77 (1652-1663) ...the thought of going back upsets me... I have these notions of what I want to be doing but in fact when I get back in there, you'll find that there are so many courses on... so many hours to be taught and so many assignments to be corrected... (1675-1679) in some ways there is that expectation that if you have your PhD... that you make space for the other people to do it.
F2I1211 (1710-1721) I've spoken to people that have gone back in. They have ended up not having any time... the same number of hours... endless committees and paperwork ...they still can't get at their research... I have to take time out to prepare post-doc proposals... and get funding...
FFI2510 (922-924) I'm in a different job... I don't particularly get a kick out of it. (941-946) I love teaching and it's not teaching... I'm doing very little research... an awful lot of sitting at a desk, at a computer... doing secretarial work...

The use of the title 'Doctor' marks a large identity transition. It is used by others in celebration of the achievement of the PhD commencing immediately after viva completion and then becoming a practice for the CNMFs themselves. Social practices to mark the event included organisational as well as personal celebrations. Whilst symbols such as parchments denote the change in status, some CNMFs retained symbols of the success that were personally derived.

FFI111 (726-731) ...to a large extent within the School, PhDs among the staff tend to be reasonably well celebrated... there's quite a bit of acknowledgement... "You've done it" and "It's good". (1359-1368) the 'Doctor *Name*' was stuck on my door when I came back to work... I'd done my viva on a Friday and when I came in on Monday... next door had stuck that on my door.
FFI211 (3155-3173) ...when I finished... got my viva, I just seemed to be going out... I've kept all the... business cards of the restaurants and the nicest congratulations card... that's going to sit in the middle... a collage of... cards and that is... symbolic of my celebration.

The CNMFs acknowledge that this transition results in an anticipated and actual transformation of 'self' – "grown through it" (F3I2311) to become "totally and utterly changed" (FFI1510). It can also raise presumptions of what can be expected and perhaps move the individual out of previous 'comfort zones'.

F3I185 (1384-1397) I've gone to the nursing conference for the past 5 years. I'm not going this year... in my head I moving towards something else and that can only be good... that is what I set out to do.
FFI2510 (271-277) ...they introduce you as Doctor and that's kind of nice, you do feel more confident, I suppose but you also feel there's more expected of you. You stand up there and have 'DR' beside your name, you think, "Oh God".

In summary, their identity was in transition onto and off the Fellowship and required adjustment to changing circumstances. Confidence was necessary both in the process and product and being funded impacted both negatively and positively on this element. Confidence building was an undulating trajectory.

7.5 Identities in the Field of the Funder

Issues of identity also occurred in the Field of the Funder. The NRA identity itself was ambivalent as that of visitor to the HRB yet representative of the HRB, depending on the context. Additional identities were health professional and researcher. As previously discussed (section 3.6), there was an initial sense of NRA as 'being a visitor' to the HRB. Diary entries showed this continued and I tried to manage it by optimising my visibility in the organisation.

3/3 I'm at my desk by 8.45... My new office mate arrives just after 9.00 and approximately 30 minutes later another colleague steps into the office on her way up the stairs. "We haven't seen you in a while" she remarks when she sees me. "I was here last week" I reply "though it may have been towards the start of the week". "It seems ages ago" is her response.
8/12 A colleague appears in the office with a pile of Christmas cards. Everyone else from the division has signed... This is the first year that my signature has been sought even though I know it is a routine practice. A case of being in the right place at the right time?
22/10 Yet more travelling... so unless I go into the HRB today it will be a month since I was last there. Regardless of the head cold and with no pressing HRB work I still go in for a half day to show my face... A coffee in the kitchen downstairs reveals only one other colleague at this stage of the morning "There'll be no-one around today, a lot of people have taken the day off". So much for trying to increase my visibility in the organisation! I am sitting at my desk when a colleague stops at the water fountain outside. "Hello stranger" reminds me of my absence.

Being a visitor contrasted with being the face of the HRB. The identity of HRB agent tended to occur in nursing and midwifery arenas or at public HRB events.

4/11 (*at a conference*) I meet the CNMFF later... and give my congratulations (*for their presentation*). I am urged to attend a second paper later in the day... I am told that very few can attend and "I thought you would be there representing the HRB?"
29/04 The day was taken up with a regional meeting with Directors of Nursing. Here, I am the face of the HRB and give updates on organisation activities e.g. new website development, on-line application to schemes. The nurses always seem pleased to hear of progress such as increasing numbers of nurse applications. It appears such information acts as a 'clap on the back' for professional development... yet little or no questions are generated on the research piece.

In multidisciplinary arenas, the identity emphasis was on the NRA although at times it could be invisible and marginalised. For example, one diary extract notes how others were publicly acknowledged at a university event for "championing nursing research" and no mention was given of the NRA role.

13/10 I've spent the last two days on regional meetings... this time I get two specific questions with regard to research applications. My past impression of speaking to the wrong audience may be misplaced. I have a 5 hour drive as tomorrow there is the launch of a Health Education and Research Centre at which I'm speaking. **14/10** The HRB CEO addresses the audience of about 120 first, focusing on the HRB's role in R&D. I follow giving the national perspective on nursing and midwifery research with an emphasis on its contribution to health research in general. I am asked one question only in relation to multidisciplinary research. At coffee, I'm congratulated by several members of the audience.

However, this was aimed at my coping of the technological glitches that occurred throughout my presentation, with only two focusing on the content! If nursing is remembered for its calmness in the face of adversity rather than its content, it is still better than being forgotten!
30/11 Today is the Fellowship awards ceremony. The formal proceedings commence with a welcome from the CEO, and congratulations from the HRB Chairperson who notes the broadness of the Fellowship schemes. The guest speaker is the Chief Scientific Advisor (CSA) to the government. The opportunity to promote research and debate its funding and place in the health services is used by all 3 speakers... The CEO introduces me to the CSA who says he is delighted to see nurse and midwife awardees present. I return the compliment by congratulating him on his new job remarking how delighted I was to hear his comment on the broadening of the meaning of science!

A second identity was that of NRA as health professional. This was played out in two ways so that the NRA was 'more than a nurse'. The first was when the NRA was utilised within the HRB for the knowledge of the health service thus expanding the advisory role beyond nursing and midwifery. The second was as health professional with clinical knowledge.

12/11 A colleague steps into the office... The issue is the distribution of the publication of "A Picture of Health (PoH)" to people in the health services. I make a few suggestions. *Two months later* a colleague gives feedback on progress of the PoH survey. Fifty returns have been made from the 181 circulated. Labels are being prepared for over 300 Health Centres with the intention of posting both the document and the survey together to these centres. There is a debate about the likely value of this. I add that as this is a front-line service to patients the returns may be even lower than from other 'desk-type' services such as libraries.
26/1 (*during organisational review*) We analyse the case study... whilst there is reference about our own health service in comparison... only myself and the medical epidemiologist speak with any credibility, as we are the only 2 persons in the room that have actually worked in the hospital setting. So the case study's documentation on professional activity of its staff I remark as being the cultural norm...
14/1 My first phone call is from a divisional colleague with a query, which I assume is personal. The information sought is of my knowledge of the existence of any website which lists the side effects of drugs – in other words identifying me with clinical knowledge. As I don't know any specific website, I tell her that the British National Formulary and MIMS (*medical publications*) are what doctors in practice use...

A third identity was NRA as researcher and this occurred in circumstances where 'different' methodologies were to the fore. The NRA was perceived as representing the non-dominant methodologies.

Initial impressions I was asked to read and make comments on a draft document on writing a good grant application. The document was positivist in nature and some of the guidance to the reader would not specifically apply to those conducting qualitative research. I made suggestions on alterations to broaden the document and discussed these with those responsible. The discussion developed into a negotiation on my suggestions with compromises being made as to inclusion and exclusions of terms/points by both parties. Both the author of the document and the acting head of division had backgrounds in laboratory science, so a defence of my suggestions was required in the negotiation. The draft document had also been sent for comments to expert researchers used by the organisation for peer review. I was subsequently told that one such expert (a health services researcher) raised similar concerns to my own. This appeared to verify the NRA contribution to the document and showed the value of the NRA to the work of the division.

8/12 A colleague is developing a form to evaluate PoH... and asks if I will 'pilot' it. The form is sent as an email attachment an hour later. I fill out the form and identify 3 problematic areas. I go up to her office... I wait behind the desk as my colleague finishes an email. I then go through the form and point out the issues as I see them. She is a little defensive at times "Yeah, I thought that mightn't work but I didn't make these up", at other times there is acceptance "I see what you mean". I make suggestions for improvements in some of the areas and tease out some issues with her. I get a positive reaction to this. At the close of the interaction I say I'm sorry that my queries have raised more work for her. "Oh no, I really appreciate it. Thanks very much" is her reply. **12/1** A colleague gives feedback on progress of the PoH survey... The HoD makes the decision not to include the survey and maybe to seek such 'customer satisfaction' next year. A focus group is mentioned as a potential and "Sarah, you'll be able to help us with that. You know all about methodologies". (Yet a colleague holding the masters in social research methods is sitting opposite!)

In summary, the NRA experienced elements of transitional identity. Within the HRB organisation itself, these included visitor, health professional and non-dominant methodological researcher. The identity of visitor contrasted with that of the 'public' identity as HRB agent giving a perception of 'nominality' to the NRA.

7.6 Conclusion and Literature

This category has shown that identity in individual RCB for nursing and midwifery is not a fixed feature. Instead, it is an identity in a situational transition indicating a passage of change or transformation of identity requiring time (Kralik et al, 2005). Within the process of transition was movement between pre-existing identities of nurse or midwife or person-self and the temporary identities of CNMF or doctoral student aspiring to independent researcher or academic with the latter already a dynamic, contested identity (Henkel, 2005; Clegg, 2008). Whilst there is a recent focus on transition, as an element of doctoral socialisation, such as the aforementioned study by Gardner (2010) and the "fractured subjectivity" that doctoral students can occupy in Barnacle & Mewburn's case study (2010:436), no previous empirical studies exist on the transitions encountered in fulltime PhD studies by nurses and midwives. The CNMFs managed their identities pragmatically, adopting the identity of relevance or "salience" (Colbeck 2008:10) to each context by 'passing oneself'.

Transitions bring uncertainty to self identity (Kralik et al, 2005). Culturally, nurses and midwives have already undergone vigorous professional socialisation processes in the healthcare system as practitioners. Empirical work examining events where nursing identity is threatened such as strike action (Brown et al, 2006) or new work environments (Snelgrove, 2009) find nurses continue to set their identities on traditional nursing frames of reference and integral role components such as caring, patient advocacy, empathy and, implicitly, service delivery. In this study, for

example, getting to know research participants well framed the CNMFs as nurse (Skår, 2009) or midwife (Hunter, 2004; Carolan & Hodnett, 2007) and they displayed proactive patient advocacy (Vaartio & Leino-Kilpi, 2005) by giving clinical information to research participants. References were made to the code of conduct or regulatory guidelines, explicitly placing the CNMF as professional nurse or midwife. Such documents outline norms and moral obligations in relation to patients, colleagues, the professions and practice (Dobrowolska et al, 2007; Numminen et al, 2008). Critiqued for being atemporal, acontextual and reflecting existing power relations (Thompson, 2002), empirical studies show their use as limited with nurses using their own moral and societal values instead (Tadd et al, 2006; Numminen et al, 2008) or in Ireland a combination[73] (O'Connor & Kelly, 2005). Nevertheless, here in this study, the code acted as a representation of professional identity (Tadd et al, 2006:385) and was utilised as a "useful endorsement" in a problematic situation. Leslie & McAllister, (2002) claim that the 'nursedness' brought to research by nurses or midwives enhances the research that is conducted because of their social mandate and positioning within healthcare. Championing the branch or clinical specialty by differentiating themselves and their research from the perceived domination of 'general nursing' is also reflected in the international literature notably amongst midwives (Hillier et al, 2007) and shows nursing and midwifery as a contested site. Youngblood (2007) claims that such intra-disciplinary tensions occur especially in broad 'bridging' disciplines whose defining scope, if not practice, covers many academic domains.

In transitional identities, nurse or midwife selves are combined with the new identity elements of PhD student and CNMF. Others have noted the multiple identities including previous professional occupation (Colbeck, 2008) integrating with that of doctoral student (Barnacle & Mewburn, 2010). Importantly, the level of amalgamation of identities is postulated as moderating the inherent tensions of multiple identities and sometimes producing a beneficial synergy (Colbeck, 2008). Recent empirical work (Jazvac-Martek, 2009) based on mixed method longitudinal data collection with 9 doctoral students found shifting identities but the 'oscillation' was solely between that of doctoral student and academic aspirant producing the synergistic development of 'be(com)ing' an academic. In this study, both CNMFs and the NRA show greater identity shifting than mere oscillations between an identity and its aspirant outcome.

[73] Three focus group interviews with 20 clinical nurses in one hospital.

Issues of PhD student identity as found here are reiterated by recent empirical studies that ground identity in research materials (Barnacle & Mewburn, 2010) and everyday practices (Holley, 2009[74]; McAlpine et al, 2009) as much as the formal processes of doctoral studies (section 6.3.1) (McAlpine et al, 2009) and social interaction or relational work. They and others (Devenish et al, 2009; Pilbeam & Denyer, 2009) uncover the importance of *informal* academic and social activity with peers. In this study such interactions were limited to 'PhD chat', which was most meaningful and cohesive when peers had similar characteristics rather than solely disciplinary orientation or institutional registration. The level of engagement in such activity varied and appeared 'ad hoc' rather than planned deliberations. Nevertheless, potentially 'PhD chat' was a site of vicarious learning (Roberts, 2010).

Literature, focusing on peer support or networks, frames much of the discussion on elements of Lave & Wenger's (1991) notion of "communities of practice" whereby social relations produce meaningful learning. Communities of practice, through the central constituent of participation, can foster a sense of belonging in episodes of identity transition (Andrew et al, 2009)[75] or identity formation in learning to research (Dison, 2004) and positive features such as collegiality and cooperation have dominated this discourse (Cumming, 2008). Pilbeam & Denyer (2009) caution that such a focus ignores the supreme *individualistic* effort of doctoral studies, partially found in this study by the absence of networking or development of a *collective* CNMF identity out-with its previous competitive origins. Also, belongingness to an academic community cannot be assumed (Appel & Dahlgren, 2003) especially as the literature reports on single cases of doctoral students experiencing 'not belonging' even in highly structured PhD programmes (McAlpine et al, 2009). Negative features such as conflict (Cumming, 2008) and from this study, competition, require further critique.

The CNMFs experience 'not belonging' across their various identities, intimating a sense of being marginalised or 'being other'. Notions of this peripheral place are compounded by the sense of privilege (section 8.2) associated with this non-collective role. Lave & Wenger, (1991) account for such *initial* perceptions through

[74] For example, in Holley's (2009) ethnographic study developing skills in animal laboratory practice assisted with the integration of doctoral students to the field of neuroscience research and the development of a congruent disciplinary identity.
[75] In this case from clinical practitioner to educator.

their notion of 'legitimate peripheral participation'. Yet this does not adequately account for CNMFs, as the construct is dependant on the existence of 'masters', presumes a novice state on entry and implies a trajectory of engagement, elements that did not exist for all CNMFs. Nor does it account for the 'visitor' status that CNMFs experience in clinical settings where some question their own legitimacy as researchers 'in situ' and where they are clinical masters rather than novices. Additionally, as visitors they can be positioned by others as similar to medics in their spatial access and mobility (section 2.3) (Allen, 2001; Halford & Leonard, 2003) as much as their relationship with research. The literature highlights tensions in combining identities such as for nurses collecting data in clinical scenarios (Beale & Wilkes, 2001; Colbourne & Sque, 2004; Borbasi et al, 2005; Arber, 2006) or becoming nurse teachers (Holopainen et al, 2009).

With fluctuating engagement in post-graduate seminars due to a variety of reasons, this study shows that identity tensions also occur in academic settings: such as with peers, based on student difference and with supervisors, based on prior or existing relationships, with the latter cautioned against in the literature (Jackson et al, 2009). Although a central site of doctoral pedagogy that denotes PhD identity (Green, 2005), supervision is critiqued for lacking theorisation (Petersen, 2007; Lee & Green, 2009) and empirical understanding through observation (Delamont et al, 2000; Li & Seale, 2007). Lee & Green (2009) explore the conceptualisation of supervision through the arche-metaphors of authorship, discipleship and apprenticeship to describe a complex, ambivalent space. However, as described they are not discrete analogies but share constituent elements. With both players as stakeholders, supervision is a symbiosis requiring skilled negotiation (Li & Seale, 2007) through a transforming relationship (Jackson et al, 2009). In addition, the practice of supervision holds disciplinary meaning (Hasrati, 2005) that can be enhanced by a supervisor's own disciplinary credibility. This study showed a range of supervision practices.

As already stated, 'doctoral becoming' (Barnacle, 2005) is transformative and previous empirical work has shown identity transitions in the first year of such processes (Hockey, 1994; Duncan, 2000). In this study it crossed the total timeframe of doctoral study[76]. Other longitudinal empirical work has noted a phase of 'letting go' or disengagement in episodes of professional (Drury et al, 2008) or cultural (Weiner-Levy, 2008) identity transitioning. MacIntosh (2003) from her grounded

[76] Indeed the lack of 'boundedness' found (section 5.3) suggests that transitional identities extend outside formal timeframes.

theory[77] contends that nurses continually rework their professional identity across the career trajectory in response to recognising discrepancies and experiencing dissonance so as to develop a reputation. Here, anxiety regarding intellectual self-worth (Hockey, 1994; Appel & Dahlgren, 2003) occurred for the CNMFs with a lack of confidence particularly prominent in 'feeling a fraud'. Brookfield (1993) claims such 'impostership' is inherent in nursing as the perpetuation of an initial survival mechanism to convey control in clinical culture. It is subsequently triggered by episodes of performance scrutiny or novel ventures and has been found in academics who were previously clinical practitioners (Gourlay, 2010). Considering the investment the CNMFs have already made in developing reputable nursing or midwifery identities (section 8.2), being threatened by facing new identity challenges including that of 'other' underpins initial 'letting go' difficulties.

This chapter described the subcategory of 'transitional identities' that supports the core category of 'privileged pioneering in the peripheries'. It describes some of the social adaptation and cultural meanings that nurses and midwives bring to doctoral research and assimilation into the health research culture and is interlinked to the other subcategories of 'labouring the doctorate' and ''resourcing' the research. The next chapter (Chapter 8) explores the core category of 'privileged pioneering in the peripheries'.

[77] 21 participants with a range of years in nursing practice across clinical specialities and health care settings

Chapter 8: Privileged Pioneering in the Peripheries.

FFI1012 (1427-1429) The world of academia is strange. The world of research is strange. **FFI211** (1529-1534) We were swamped... doing PhDs at very difficult times...there was so much happening in nursing... so much development (1535-1537) there's great credit to anybody who does a PhD in these particular contexts.

8.1 Introduction

The core concept in RCB in Irish academic nursing and midwifery at this time was that of privileged pioneering in the peripheries (Figure 8.1). Pioneers are initial entrants to a field preparing a way for others to follow. Some are solitary leaders; others are groups involved in construction and demolition in order to lay the groundwork for those following. Thus whilst CNMFs had to resource the research and labour the doctorate whilst dealing with transitional identities, they also found themselves as privileged elite in the "whole new ball game" (F2I2810) of funded research. Not only had they to achieve the goal of an 'individually owned' PhD but were burdened with the task of forging a space in the margins of funded health research; a space viewed by the CNMFs as the 'broad church' of health policy rhetoric (n=6).

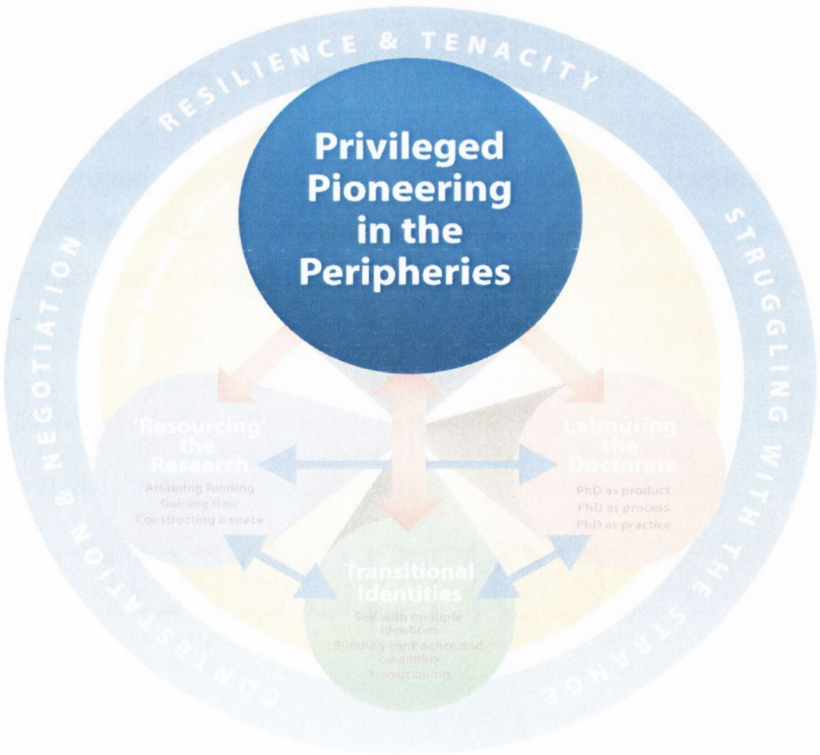

Figure 8.1: The core category of privileged pioneering in the peripheries.

Yet this space is colonised by other disciplines. The CNMFs also had to construct this position from the weak academic base of their own discipline (McNamara, 2009) and a previous professional socialisation with professionals with whom they were now in competition. That being said, the data showed that they were experienced, self-aware persons of "informed knowing" (FFI121): knowledge of their own characteristics, such as self discipline; knowledge of their own behaviour, such as optimal learning patterns and importantly "know(*ing*) my limitations" (F1I23).

This chapter explores the elements of privileged pioneering in both the Field of the Fellow and of the Funder: being an initiator, a role model, a risk taker, and showing resilience in the face of challenges such as isolation or tension. It also examines the position of nursing and midwifery research in the arena of health research.

8.2 Privileged Pioneering in the Field of the Fellow

Being a pioneer CNMF gave notions of status or privilege (n=7). However, being privileged somewhat belies the realities of being a pioneer.

FFI211 (1126-1128) It's a very prestigious award really and it's a wonderful opportunity to get it... (1743-1744) having a HRB is a very privileged position to be in to get this money...

Being early to the field meant that, as the data show, the majority of CNMFs experienced isolation. In common with other discourse on PhD studentship, the data showed the CNMFs using the analogy of 'lonely journey' (n=3) or the "lone soldier" (FFI211) to describe this issue. Experiences of isolation, however, were not universal; four claimed to have experienced it as a positive rather than negative feature.

F3I77 (710-714) It was a pleasure to be here (*at home*) because no one can tell me anything (laughs) and I didn't really have to care (*about colleagues' stress*). (880-883) I would be quite happy to remain isolated (laughs). I have become quite reclusive at another level.

In common with other doctoral students (Delamont et al, 2000) the CNMFs described two types of isolation that occurred during their time on the Fellowship. Almost all described a social isolation such as "only you and the dog" (F1I511). This was contrasted with their previous experiences of being in a workplace. A second isolation was that of intellectual isolation.

F2I911 (1779-1789) (*I was*) possibly unprepared for the... isolation...The physical isolation of not going to a workplace, of not having colleagues... you're now on your own.

FFI211 (1494-1496) It was an intellectual isolation and I suppose there was a social isolation as well (1517-1519) But the intellectual side of it was extremely, extremely isolating.

The isolation has greater impact in the initial phases when the CNMFs are adjusting to the transition onto the Fellowship (section 7.4), subsequently getting "...more used to it" (F3I2310). Some develop personal strategies to deal with the isolation, such as "go round and do a bit of chatting" (F1I271) after supervision sessions.

FFI2510 (732-736) I had left work and I was working on my own I... felt a little bit lost at the beginning where I wanted to actually talk to people... involved in research.
F3I142 (664-669)...whenever she said she couldn't find anyone, I had no hesitation in saying I'd do the seminar... I wanted to come and talk again about it... (laughs) Get somebody to listen to me.

Five of the CNMFs considered themselves privileged for having obtained funding. As noted in resourcing the research being funded was a "daunting responsibility" (FFI1012) like a "noose around the neck" (FFI211) that imposed obligations. An obligation, already alluded to and described as "like a constant toothache" (FFI2510) is 'coming up with the goods' - a self-demand for doing justice to the investment of "taxpayers' money" (FFI211) and making the most of the opportunity to gain a PhD. As noted in transitional identities this fed into the anxiety about their capability to undertake a PhD *but* also their credibility as privileged.

F2I194 (700-715) All my education has been at my own expense... you always had that wee choice... of not finishing or of dropping out... when you have funding it is different... you feel that there is an obligation on you... not just to finish it but to produce a good piece of work.
F1I271 (596-602) ...the reality of you've been given this money hit me... it was never a case of thinking I wouldn't do it, it was just a case of "am I able to do it?"
FFI1510 (99-104) I'm not going to be able to achieve a PhD, therefore I'm going to have to give all of this money back to the HRB. They'll never want to hear again... That was just a nightmare for me.

Some of the CNMFs described being funded as giving choice. Much of this was in the rhetoric of 'freedom' primarily from work responsibilities and of time flexibility. This enhanced the perception of privileged pioneering.

FFI2510 (1280-1283) It just gives freedom to learn, to make mistakes and to recover and to enjoy it.

Except 'freedom' was somewhat illusory and the reality was that choice was fairly limited by inbuilt constraints within doctoral and funder governance processes, as

well as contextual variables and specific study constraints[78]. Two CNMFs did discuss choice in the context of applying and accepting a funding award. They recognised that whilst being funded brought the awards of time and reputation, there was also a cost factor. That meant that accepting the award was an individual decision within a set of personal and professional circumstances.

F3I77 (1688-1715) Recently I said to somebody "...doing it while you were working... you did get released for parts of time... and you kept your wages. Now I choose to apply for a fellowship... but it meant I didn't get my pension, I didn't get my increments and I came out... three increments below you... life is about choices and that was your choice and this is mine..." So there is a piece of me that gets irritated... they wouldn't take the fellowship because they wouldn't forfeit the other things in life either...
FFI211 (912-930) There are huge sacrifices... Financially I was prepared to do it... in fact I borrowed money even with the HRB because I continued to pay my pension and that alone was something like 10,000 punts... I was prepared to be at a financial loss...

These pioneering CNMFs were prepared to take the financial risk of accepting funding, but not all their colleagues were willing to do so. The NRA diary revealed that some sought to negotiate alternatives to suit their personal circumstances.

16/1 I have a query with an application... My work colleague tells me that they had had quite a bit of communication with the applicant who "doesn't seem to know what she's doing!" (*I am unsuccessful at making contact with the nurse concerned but do so the next day*). I explain who I am and then say that in checking the applications for completeness and eligibility I have noted the intention of employing a research assistant and I want to clarify that this is not possible on the CNMF scheme. I'm a little surprised in that she says she has already been told that by somebody in the HRB. I then have to listen to a monologue on how the scheme does not suit nurses in her particular situation – a senior clinical nurse who because of fear of damaging pension entitlements does not wish to take the 'timeout' that the Fellowship facilitates. There is also some talk of loyalty to the hospital and the inability to fill the gap should she vacate her role for 3 years. This is off-set by a stated desire to undertake a PhD even though it would not entitle her to better pay and conditions. I suggest that she thinks a little more about the implications of what the 'timeout' should mean were she successful and to explore the range of possibilities with her employer...

Whilst accepting privilege meant taking public risks, pioneering also encompassed seeking out and taking opportunities, actions that some of the CNMFs appeared comfortable with on a micro and macro personal level.

F2I2810 (1786-1792) My whole life... opportunities have come my way and I've taken them.
F1I23 (971-981) ...one of the health services is running a study day and the person... has done a lot of work on qualitative research so I contacted them, and asked... if they had any free places... really to know and find out if you can tag along...

[78] Appel & Dahlgren (2003) report doctoral students describing the 'freedom' of research as problematic due to blurred boundaries between labour and leisure time. Clegg (2008) related 'ambiguous' academic freedom to universities as gendered spaces.

For example, 5 of the CNMFs had a "lot of irons in the fire" (F2I410) of other collaborative or solo research projects being conducted contemporaneously to the PhD. However, CNMFs were cautioned to be discriminate about opportunities which could distract them from the ultimate achievement of the PhD.

FFI211 (1773-1789) (*My supervisor*) would have pushed the whole notion of ruthlessness. I looked at that sceptically initially... but I think he was right... in the sense that you have given a commitment to doing a PhD... therefore you have to say "No" to other opportunities or challenges... that might encroach on this passage...

Other elements of pioneering showed CNMFs initiating new ventures or acting as a role model in academic or professional domains thus building leadership skills.

F3I77 (892-907) I've taken on that (*research group between service and academy)*... I've been doing all those meetings... getting it up and going... it took us a year to get this kind of collaboration going...
F3I1410 (375-383) I happen to also be the only midwife who's presented at a medical speciality conference and it's now making them suddenly think "We know as much... why aren't we presenting?" So there's that bit of a stir. They seem to be developing a sense of... professional pride...
FFI1012 (900-903) I... would have been influential in setting up a nursing domain within the international speciality organisation.

The specific academic context also formed the pioneering CNMFs. In the main, the CNMFs (n=9) were pioneer PhD students in the recently established schools of Irish nursing and midwifery academia[79]. This gave rise to factors particular to the context of a research milieu being developed from a vacuum. For example, there was no volume of PhD studentship or "norm reference group" (FFI211), resulting in a lack of "intellectual engagement" (F2I194) and peer support to "talk out" (F2I194) the PhD and provide informal support. Thus isolation, especially intellectual isolation, occurred, raising issues for academic integration. Being privileged meant being 'other' as any peers were mainly unfunded part-time doctoral students labouring at a different pace.

FFI132 (1281-1286) When I did the PhD there were very few research students and the structures and that are there now at the end of my PhD in relation to say research seminars... just weren't there at the beginning.
F1I296 (974-979) I have nobody at my level... there are... people just starting out and... people finishing up but... very few people at my stage...

Assumptions are made that the research rhetoric of 'critical mass' exists elsewhere, whether that be PhD volume or theme grouping within the field. Yet, for those

[79] The remainder were registered students in UK academic schools of nursing and midwifery or other disciplinary departments in Ireland

CNMFs supervised outside academic nursing or midwifery, this did not exist because the topic was considered borderline within the discipline. Alternatively, they did not engage due to geographic distance or doctoral student difference, so all the CNMFs were 'other' regardless of their individual arrangements. For those supervised by nursing and midwifery outside Ireland, the distance meant limited engagement. Yet distance was viewed positively by 2 CNMFs with previous knowledge of the "small 'p' political dynamics" (F3I77) of academic departments.

F2I911 (1754-1758) I'm sure it's just a case of... so few in a particular school at that particular time and I'm sure it probably is well established in other... faculties or whatever.
FFI911 (30-36) ...in some ways that (*being at a distance*) was very good because it meant that I wasn't subjected to a lot of the kind of difficulties that there are in academic departments... I could be a bit outside that.

All in the schools were perceived as lacking experience in funded research or ongoing engagement with a research milieu. Unlike the arrangement in other disciplines such as science, post-doctoral contribution to supervision (Delamont et al, 2000) was not developing in some institutions.

F1I511 (759-762) ...yet they (*academic people*) had no great experience of knowing people who had got funding so that they could say that (*give false hope*) ...
F2I194 (60-70) ...it's a new department. The expertise... isn't developed itself in terms of having post-PhD people... I'm not sure they see their role as... as engaging with students doing PhDs.

For five CNMFs, who had previously taken risks in becoming lecturers in new academic schools, there was now the additional burden of role release. This was not simply an exchange of teaching responsibilities but included release from the quasi-leadership roles of pioneers in small schools. Such roles could extend outside the academy as 4 CNMFs describe previous or concurrent guest presentations in professional arenas.

FFI83 (291-297) at the time the School was very small, so the pool of people to pick up the slack was much less... one of the things I'm seeing now when I see people who are awarded fellowships is that people just step into the role.
FFI211 (1720-1724) I've always had difficulties... in terms of the sense of dependency on a very small few and unfortunately I'm one of those people.

Even as privileged pioneers, six CNMFs describe themselves as naïve at the outset of the Fellowship whilst two others described naïve behaviour[80]. Given the lack of research infrastructure and the power relations in the field of health research, it is no

[80] Even in the context of the CNMFs' previous research experience (section 3.5).

surprise that some CNMF based decisions concerning research sites, non-reaction to medical representation or choosing journals for publication on pragmatism or naivety.

FFI211 (2965-2972) ...none of this I would have known. This sort of political awareness... academic awareness... where best to disseminate the findings through publications.

The issue of choosing a supervisor also displayed some CNMF naivety in addition to the limited supervision resource available and a lack of tacit knowledge on the topic in the professions. Seven selected their primary supervisor based on convenience, reputation or ability to "get along with" (FFI911) rather than topic, clinical speciality or method expertise. One CNMF was allocated a supervisor by the institution, and all others (n=8) sought out those with a research interest in the area in which their topic was based. In the former group, co-supervision additions (n=4) were made to fill perceived gaps or advanced methodological training was undertaken.

FFI211 (417-422) I started bouncing it (*ideas about choosing a supervisor*) off people who were doing PhDs... they weren't in nursing, because there was very little... to draw on for that type of advice.
F1I271 (185-192) I was happy with that (*supervisor suggestion*) because I really didn't know anyone in the field... I couldn't have thought of somebody who would have had a particularly strong background in (*methodology*) because I was blinkered into thinking Ireland.

In developing a research milieu, there were cultural behaviours and practices or tacit knowledge (Gerholm, 1990) to be learnt; an example was learning small data management practices of keeping back-up copies. The scholarly skill of debate seemed particularly problematic requiring the development of "a trust with each other" (FFI83).

F1I117 (281-300) We've got to a stage where it (*post-graduate group*) actually works very well. But that didn't happen overnight. There was skin and hair flying because obviously people were being challenged not very pleasantly and that was a fault on both sides... people have developed how to properly question and yes, how to challenge but not in a nasty way. And equally... most people have learned how to take that on board... to develop and grow. (357-362) she (*a visiting academic*) actually introduced the whole idea of... a very open discussion... discussing issues quite frankly which we wouldn't have done here before.

Whilst visiting academics and post-graduate groups were mechanisms reported as used latterly by four of the universities to assist in research knowledge and milieu development, the solitude of labouring a doctorate in the particular context meant that many CNMFs sought a research milieu elsewhere, thus setting up socialisation for self. They then critically contrasted their own situations of isolation against the international arena but showed acceptance of the situation as part of pioneering.

One CNMF was perceived by peers as a pioneer within their own cohort, even though other exemplars of persons with PhDs were present.

F1I511 (988-996) I thought "Wait a minute now, you've gotten this far... pretty much on your own. Yes, other people have helped you but you certainly have never been directed... So cop yourself on. That's the way... it's going to be and just keep going".
FFI1012 (254-260) ...within (*the branch of*) nursing particularly there was very few people... going down the research route... there is more now but at the time a number of years back that wasn't the case.
FFI111 (741-754) "...you're the first (*branch of nursing*) nurse" and I said "I'm not, actually... there's another two" and he said "yeah, but you're the first one of us"... it was down to the fact that I had a lot of contact with practice... I had worked with these people as staff nurses and they were now senior managers...

As with advanced training, international travel was the norm for seeking the research milieu. Conference attendance (n=12) shows CNMFs travelling to the UK, Europe, North America, Australia. This helped build networks, which served the immediate purpose of intellectual engagement and reputation building. Information provision and support was also sourced from formal email listings and informal peer connections. There was also a value of future potential collaboration (n=4), visiting centres of excellence (n=2) or, potentially though unmentioned, impressing subsequent peer reviewers. Such travel revealed to CNMFs how RCB occurred elsewhere and assisted them to become known and "get the break" (FFI1012).

F2I410 (950-967) I had met a researcher in the same field at a conference and he's a research fellow in the unit abroad... he gave me all sorts of contacts and... for a chap that really you don't know, I found he did a lot of work for me. I've got the letters of invitation both from him and from the Head of the Research Unit abroad
F3I185 (574-582) I had used it (*her writing*) with the students and I really liked her work... I happened to meet her at a conference... she is very approachable... she very generously offered to sponsor me (*to visit US centre of excellence*).

Though describing naivety, some familiarity assisted the pioneers in other realms of the RCB process. Such familiarity mainly consisted of knowing some staff in clinical sites by dint of previous practice or less commonly through having taught them previously. This was perceived as helpful as the CNMF and "what I was about" (F3I185) were known. That being said, the level of familiarity varied and all but 2 CNMFs incorporated data collection from additional 'unknown' sites, where their professional identity was beneficial.

FFI2510 (1100-1105) I was made very welcome... And before I went onto the units I had actually got to know the sisters that I had known before, much better.
F2I2810 (902-905) Some people would know me well. Some people would know of me and then some people have never heard of me, obviously.
F1O191 ...Whilst she has not herself worked in this institution she has contacts with some of the senior professional staff whom she names.

As pioneers in a competitive landscape, the CNMFs were prone to being the target of jealousy. This can stem from colleagues in both the academic and clinical environments. Having funded time for PhD labour was a source of "huge envy" (F1I271) from others with which the CNMFs had to deal. There also exists a perception that funded time is inauthentic and leads to a non-bona fide product.

FFI111 (1560-1574) I... rang a reasonably senior colleague... to tell him I'd got the Fellowship... 3 years fulltime... he just laughed and he says "That's not a real PhD". Now he said it as a joke... But to some extent there is a mentality around that says... "He's finished his PhD." "Yeah but he had a Fellowship".

This can extend into the post-doctoral period when the CNMFs use careful management of their doctoral identity, or 'PhD PRN', especially with clinical colleagues who can give "stick" (FFI111) for the change in status. The usage of the doctoral title can be divisive and not embracing. It gives a hierarchical status to those who have attained it. Such sensitivity of identity has been found by others (Heinrich, 2005; Clegg, 2008) (section 2.4) and may in part be reactive to nursing derogation of academia.

F3I248 (1926-1964) I got a comment which I found really upsetting... This was someone (*a past clinical colleague*) who I would have aspired to emulate from a clinical point of view... said "I didn't think you'd come over and talk to me now" and I said "what do you mean?" and she "Well sure you're doing your PhD, you're going to be a doctor... I didn't think you would talk to the likes of us".
FFI111 (1088- 1122) ...I purposely didn't put 'Doctor surname' on my slides... my supervisor in introducing the paper said "Here is one of our newest doctors..." (*Later*) one of the managers from the local service commented... "It'll soon get to the stage where no-one else will be allowed to present... except for the PhDs" ... that was one of the days when I thought "... we have got to be so careful where we start to use this term 'doctor'"...

Whilst such comments stem from the envy of others, they may also be as a result of the invisibility or the legitimacy of research work which is context and time specific – the "moving goalposts" (FFI83) of professional development or from the suggested lack of professional maturity (n=7). Already alluded to as 'risk-takers', some of the CNMFs reported discomfort with existing structures within the health services or the fractious culture of nursing and midwifery, motivating non-conformity and a pre-existing sense of 'otherness' or being "outside the loop" (FFI911).

F1I271 (860-871) I paid up front and enrolled (*for a course*)... that wasn't normal... staff were very begrudged that I got on this course and they didn't. They were waiting for someone to come and take them and put them on it.
FFI911 (1079-1113) ...in Ireland... we've no tradition of that (*discussion and debate*) and we've no capacity for it and if you're seen to step outside that and challenge some of those things... you're seen a) as a trouble maker and b) as somebody who should be fobbed off or

keep the lid on...I've had an almost fervent commitment to the clinical speciality for *many* years and I found not just the people at the top but people at a much lower level who were hugely threatened...
F3I248 (1714-1730) ...the boundaries that are set up for no reason within the health services... I've always had difficulties with them...now that I'm on the outside... I can see all the little webs that they're all caught up in and I just think I was obviously always trying to get out of one of those...and didn't really see it for what it was.

For the CNMFs the uniqueness of their PhD gave a sense of ownership and their solitary labour gave a sense of independent working to the point "you were so saturated with it" (FFI911). These factors were motivational and empowering with a singular rather than collective focus. This differs from their clinical experiences where the professional ideal of autonomous practitioner was found to be problematic in 'team' based clinical hierarchies (section 2.3).

F3I248 (1532-1536) ...you think you're autonomous but it is like being self-employed... it is all sitting there waiting for you. (1693-1697) ...having a complete responsibility for everything. Normally you've responsibility for part... you don't have responsibility for the whole.
F3I2310 (644-648) I'm getting very used to working on my own, being my own boss to an extent, along with having the supervisor... you make your own decisions...
FFI132 (958-970) I was completely responsible as far as I was concerned... for the entire implementation and conduct and everything of the study you are totally responsible, I feel as a doctoral student. I know you've got the supervisor there... (*but*) from day one I thought this is my baby and I want it.

Reflecting the neophyte stage of development the notion of a research grouping held sway as an ideal strategic approach. Examples were given both pre-doctoral as PhD support and post-doctoral as either a multidisciplinary approach to research or assuming a research leadership role on the topic area, with the latter two becoming a reality for CNMFFs.

F3I142 (763-771) ...next to me... there's a group of six under the one supervisor and the amount of help they give each other. Just simple things... they're all working together... that must... speed you along so much
FFI1012 (1756-1762) ...it is getting the team of people around me... realising now, to let go of the research and setting other people up... this is all new learning experiences...

In addition, the changing culture in nursing and midwifery means that the notion that the perceived value of the PhD is to the individual is gradually shifting to a collective ownership; be that organisationally or professionally.

FFI2710 (237-259) The biggest thing was getting comfortable with... the value of what you were doing... the difficulty was that you...weren't seen (*by peers*) as working... because you were doing research...there's maybe cultural thing... I was described as 'being away', 'being off'... (272-274) It took me several months to... satisfy myself with what I was doing, was work....
FFI83 (337-345) I was arguing that as I had brought funds into the college, there wasn't a requirement (*to teach*)... The HRB had given everything to release me... I had no

responsibility at all to provide anything back to the school. (436-445) I was still part of the school and this (*HRB*) funding... gave benefits to the school... So it's seeing the wider picture. At that point it wasn't being seen by the people in the school.
FFI311 (201-207) ...the school is recognising that if we want recognition from the college as a whole it is through research... the push is coming from above.
FFI2510 (859-866) I've always felt it was important for clinical speciality nurses to have some Irish clinical speciality research and... they are proud of that. I think that's good for us as clinical speciality nurses to have that.

Certainly, the CNMFs as individuals privileged by funding, feel a professional obligation to 'give something back' to their respective institutions and, more vaguely, the professions of nursing or midwifery.

FFI1510 (954-960) I would love to be able to bring everybody on that journey but I know everybody can't... that is why as part of my role here I can... enthuse people and give them the flavour, give them the buzz...(*of research*)
F3I2311 (1146-1153) I wanted to help other researchers and I felt that I owed it... I know later... I'll be able to give back what I've got in winning this to nursing.

8.3 The Peripheries in the Field of the Fellow

One way in which a CNMF's PhD might enhance the collective ownership recognition is through the promotion of value to nursing and midwifery. Yet, the data showed this as potentially problematic due to the nature of the topic areas researched. Topics were individually selected rather than allocated and all CNMFs chose topics that stemmed from their clinical speciality. With the two exceptions of research questions emerging from a clinical speciality research programme or group, most research questions had arisen from CNMFs' time in practice and this was lauded as the 'ideal' source. 'Enthusiastic' and 'passionate' were adjectives used to describe their attitudes to their topic. Altruistic reasons were also cited. Choosing the topic was influenced by others' advice and one CNMF changed topic with their future career in mind.

FFI2510 (1123-1128) ...the study was real and it would mean something. And involving patients just... brings it all home that this is what you're doing research for, it's for these patients.
FFI211 (127-139) He (*the supervisor*) said to me, which was really invaluable "How marketable is this? You're entering into a market when you become a researcher and you're going to be selling a product in 5 years time"... I chucked that out at that point because (*the initial topic*) has been studied to death and also health care was changing and there were fewer and fewer (*of these patients*) in the hospitals.

Whilst the CNMFs chose topics that interested themselves, the nature of the topics meant that others did not necessarily view them as central to nursing and midwifery. For example, CNMFs recognised the discomfort of their topic to others because of a

cultural taboo (n=3) or a lack of understanding of the area (n=3) so that their "eyes glaze over" (F3I185).

F3I2311 (429-451) I also felt a bit defensive because... people would have called it, a woolly area. An area that people find most difficult... I've always had this... "This is nothing to do with nursing" "How come you're being given funding for this?" ...It would make you quite... careful about speaking about things...
F2I1211 (492-502) I think it (*a conference presentation*) was a shock to the people that were there... even the chair person said "that was a shock to the system"... (laughs) listening to something very scientific.

Eleven of the sixteen topics were potentially controversial: six CNMFs were researching topics with types of participants traditionally viewed in the research field as vulnerable. In seven cases there were also political sensitivities, six of which centred on the critical practice of medics and other members of the multidisciplinary team. Thus the CNMFs learnt to negotiate others' defensiveness.

FFI2510 (217-224) My very first presentation to the medics... they're extremely defensive regarding it and I had actually put it quite subtly... and I had some kind of funny comments from doctors I knew afterwards...
F2O152 She tells me that the medics seem nervous about her possible findings rather than having an attitude of not wanting to know. To illustrate she gives the example of her presentation being mentioned at the opening of proceedings thus bestowing value to it. This is contrasted by a "balanced view" being urged by another medical colleague when discussing her presentation...

Four CNMFs defined their specific application of other disciplines to examine their topic with two using the term 'interdisciplinary' as a description. Other CNMFs had research questions that bordered or were influenced by different areas of scholarship. This sometimes produced difficulties in obtaining relevant literature from diverse sources.

F2I410 (782-795) The source of the literature is a variety of journals... written by scientists and medics... A lot of the nursing stuff... it's not actually original material... a lot of it is replication.
FFI911 (120- 138) I was looking to that kind of literature but... most of the work... has focused on outcomes... it didn't really work for this type of nursing because you had to have something that could tell you something about the process.

Some, but not all, expressed doubts on the epistemic nature of the research.

F2O2611 ...she was collecting data from nurses but it was not nursing research. I later asked her to clarify "...increasingly I question if nursing research gets that label just because it's the domain in which the data is collected". She cited that her study could be equally conducted by a sociologist and that the findings could apply not just to nursing practice...
FFI211 (844-849) We live in a very pluralistic society and anybody could carry out my study if they had the skills... the commitment, the motivation to the topic area.

F2I911 (648-656) ...being honest, and I've thought about this a lot... it would be incredibly difficult for someone to do the study that I'm doing without the (*clinical speciality*) background... you could do it but I reckon the data you'd get would be very different.
F3O411 She acknowledges that being a (*professional*) has added to the data collection as she has been able to show understanding and reciprocate with information to her study participants. This has allowed openness on their part...

Such doubts were compounded by the chosen methodologies. Broadly speaking the CNMFs used qualitative[81] (n=9), quantitative (n=4) or mixed methods (n=4). However, some perceived that nursing and midwifery research is qualitative in nature, a perception emanating from their experience of the two being closely aligned[82].

F3I142 (293-296) They (*nursing conference audience*) said it was extremely interesting to hear a very quantitative piece of research which would be unusual enough...
F1I23 (955-962) I asked if I could attend some of the master's in nursing, some of the qualitative sessions... a well known nurse academic is coming over to that (*workshop on a particular methodology*) and they said that I could attend that.
F2I1211 (430-435) ...went to a course in qualitative methods, just for interest... I was sitting with all people from my own (*nursing*) department that were doing their PhDs.

Holmes (2002) claims disciplinary defensiveness in novice academic nursing produces a narrow vision. He predicts that attitudes will change to incorporate emergent disciplinary alliances and the data certainly showed the CNMFs holding such an open attitude. They showed awareness of the rhetoric on the development of Irish nursing and midwifery as a distinct discipline within the academy but reported limited exposure, displayed ambivalence or distanced their focus from such activity.

FFI911 (506-516) It (*European PhD Programme*) was all nursing science... in some ways I was outside of that because (*of*) my background...a lot about the science of nursing and what is nursing and how does nursing develop...
FFI211 (832-843) I probably had the sort of mind set that they (*the HRB*) were looking for something very definite about nursing... the discipline of nursing... Five years ago I'd have been waving the banners out there. "Let's get a discipline of nursing. Let's all move together sisters and brothers" (laughs) But I have changed considerably... It's difficult to have boundaries around knowledge. (2638-2645) maybe it was my experience of the ethics committee where... being a nurse doing research was not credited... I also wanted to remove myself from striving for some disciplinary knowledge that was... the nuts and bolts of nursing.

Instead their focus was primarily on developing knowledge for clinical practice or service delivery and not the testing of grand nursing theories. Instead theories were

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[81] Including grounded theory.
[82] There was a sense that this alignment was enhanced by the recent entry into clinical sites of both qualitative methodologies and the nursing and midwifery research domain. **F3I185** (390-391) they (*a clinical research site*) weren't used to qualitative design... (658-661) ...the climate has changed a lot now... they are much more open to qualitative designs...

used for sequential knowledge development for specific interventions or generated for their particular clinical speciality with potential application to other specialities. A position of nursing and midwifery as boundary disciplines within the field of knowledge that can bridge disciplinary divides or absorb other disciplinary knowledge is also implied by the CNMFs' research and its dissemination.

FFI911 (803-811) I bring something... that somebody... from a social science background can't bring. Or... a medical background... it's actually a nursing focus and it... crosses that kind of scientific divide between social sciences and medicine.
F2I1211 (843-837) It's good that nurses are diversifying into different fields and then bringing that knowledge back into nursing.

This lack of insularity may partly be explained by some CNMFs already holding masters in areas such as education, sociology, psychology or public health. Research training, such as grant writing or methodology workshops, was multidisciplinary and so raised the opportunity of diversifying perspectives. In addition, other disciplines dominated within the academy as primary or secondary supervisors, critical readers and thesis examiners[83], due to a lack of such capacity within nursing and midwifery[84]. Such input was highly valued and in some cases revered.

F3I77 (378-397) S: The *critical readers* are both from another discipline? F3I77: Yeah... they are steeped in a wider body of theory... they have a very critical lens. Now part of that is maybe their nature but... part of that is also the nature of the discipline that they have been exposed to...

Additionally, 'discipline envy' was displayed in the context of the tensions surrounding the emergence of nursing and midwifery as a discipline and its associated rhetoric and reality.

F3I248 (1091-1096) ...academically we are disadvantaged by not having a strong theoretical background and I would have loved to have done sociology or psychology and be a bit more steeped in these 'ologies'... (1156-1163) ...for all our criticisms of the medical model and the history of... medicalisation... the one thing that medicine does well is that it has clinical, it has teaching and it has research.

Sometimes, 'discipline' envy can lean towards the criticism of individual endeavours and derogation of nursing's application of academic conventions as they try to demonstrate the claim of an academic position. Similarly, Porter (2008) claims

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[83] Primarily sociology and psychology although physiology also featured in a small number of cases.
[84] Similarly, as elsewhere (Kim, 2009), reviewers for CNMF funding applications show discipline diversity. However, 2003-2008 panel committee membership has comprised solely of suitably qualified nurses and midwives.

defensive practice in the application of phenomenological philosophy to nursing research in order to gain gravitas.

F2I2810 (271-283) We go on so much in nursing...Taping, ethics... reflexivity... all of this stuff... you're there thinking "well these other (*disciplinary*) people just get on with it, they do it". They don't get hung up... There is a sense that...in nursing that we have beat every concept to death...
FFI911 (613-631) I realise... how difficult nurses make it for themselves doing PhDs... "What are we trying to prove?" or "who are we trying to prove it to?" ...there is an issue around a developing profession making it much more difficult than it needs to be...(1191-1194) maybe it's innate in nurses... to want to do much more than they really need to do.
RD2610 Nurses give 100% - "not like other students who seem to get away with 40%, it's a real nursing thing to give over and above what's required".

The findings from CNMF studies had relevance beyond nursing or midwifery. Certainly, the domain of clinical practice is not the remit of a single discipline or profession and some clinical specialities, such as learning disabilities are particularly contested. So, with the exception of one CNMF, a broad audience existed for dissemination purposes.

FFI911 (966-974) I understand how to get published in nursing journals... outside of nursing I'm not very familiar... so it's more difficult for me to kind of say "It's good enough".

Chaplaincy, social workers, educationalists, dieticians, geneticists, as well as medics, nurses and midwives were some of the groups that were disseminated to orally either at research sites, formal conferences or invited presentations. In contrast to an internal HRB report's (Curran, 2006) finding of a comparatively 'disappointing'[85] peer review publication rate by CNMFs, and with varying levels of supervisory support, there was wide written peer-reviewed dissemination either planned or published; this included medical journals of the clinical speciality as well as nursing or midwifery general and clinical speciality journals. In addition, papers were being written, submitted or published in multidisciplinary journals focusing on methodological issues or findings for the broader audience of social science and education[86]. Few published in non peer reviewed publications. Thus the research contribution by CNMFs was broad, diverse and outward looking as well as strategically reputation building.

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[85] The comparison of peer-reviewed publication rates showed one per CNMF in comparison with 2.4 across all the HRB's Fellowship schemes. The report did acknowledge issues such as lag times to publication and the use of non peer-reviewed publications.
[86] A search of PubMed conducted in July 2010 using this study's participants' names showed varying numbers of papers published per CNMF, ranging 0-4, in 11 peer reviewed nursing or midwifery journals, 10 peer reviewed journals from other disciplines and 2 magazine publications.

F3I1410 (144-147) ...I'm more interested in multi-professionals getting to it than it being in a specialised journal to be honest. (176-183) the impact factors in the likes of three different multidisciplinary clinical speciality journals are much higher than JAN. They're double... there's more usefulness to disseminate in medical journals.
FFI1012 (957-964) I made a conscious decision... where I would go to publish... to make sure that my work was available and read and evaluated by interdisciplinary professionals working in the field.

Such dissemination strategies reduce the development of a nursing or midwifery epistemology *sui generis* yet is still explained by the drive for individual or collective recognition. Considering the policy arena's rhetoric of 'health research', an awareness of the neophyte academy and the previous 'positioning' of nurses as (in)visible support workers in the research endeavour[87] such efforts concerned legitimising the place of nursing and midwifery as credible researchers if not "equal partners" (F3I2610) with "strong enough" research (FFI1012).

F1I309 (791-798) I used to help out a bit... during the (*medical clinical*) trials but only in data collection... questionnaires or taking bloods... They could never get cover for it all the time so I used to fill in the gaps...
FFI1012 (67-78) I was lucky to actually be afforded the opportunity to work with (*two medical professors*)... as nurses sometimes we just think "...we're handmaids for the medics"... I would say to any nurse "...get experience working with some of these very experienced researchers... you will learn a lot".
F3I2610 (1216-1230) In earlier years any nurses that were engaging in research, they were... collecting data for medical research... nurses can and will contribute... as we get more people with (*PhDs*)... and we build a reputation for being able to conduct quality research.

Dissemination in multi-disciplinary arenas can reflect the power relations of the clinical domain (section 2.3) and the CNMFs, as nurses and midwives, boasted of their pioneering accomplishments in dissemination.

FFI1012 (836-839) ...the international speciality organisation. I was the first nurse to ever present at that meeting.
FFI211 (2623-2635) I have a paper... in the (*specialist medical journal*)...They very seldom take qualitative research and they very seldom have nurses publishing in that journal. (2700-2701) I'm so proud to be a nurse published in that journal...

However, such dissemination can be problematic. For example, it can reiterate for medics their ownership of the health research arena and thus influence their practices. In the following observation, by addressing the CNMF by her first name only[88] and reducing post-presentation questions, the chairperson limits the position of

[87] The documentary analysis showed that historically nurses as formal or informal research support workers were not acknowledged in the HRB Annual Reports with the exception of the Excessive Menstrual Bleeding Research Unit (Annual Reports 1987-1991) whereby they were named as part of the research team.
[88] Such practice is reported by Dupont & Sugrue (2007:115) in the Irish clinical setting.

the CNMF and reduces the value of the content of her presentation, in contrast to the treatment of the other speakers.

F2O42 I observe a CNMF presenting to a meeting of multidisciplinary professionals from the clinical speciality in which the PhD is set. It is the afternoon of the 2nd day of the meeting... The room is dark except for a lighted lectern and large screen. Once my eyes adjust I can see that there are about 80 people sitting in 5 or 6 rows... The gender mix – predominantly women, could lead me to believe that the majority of attendees are from nursing and midwifery but later as I leave the meeting the check-in tables have certificates of attendance for Continuing Medical Education points. Of the forty or so laid out I count 17 with 'Dr.' written before the name. I'm later told that most of the medics attending are non-consultant hospital doctors and allied professionals to medicine were also registered for the meeting. There is a 'top table' with 4 chairs on the opposite side of the podium and a man is sitting there. I assume he is the chairperson of the session... The first 2 speakers I observe are male doctors from the clinical speciality. Their styles of presentation are very similar and are focused on technical aspects of practice. One describes research on a particular procedure, the other is not research focused. There are plenty of diagrams, pictures and even a video clip. The red dot of a laser point is used frequently to highlight and sometimes emphasise the issue they are talking about. When there is text, it is in the form of figures or presented in bullet form. One of the speakers is local, and so some 'in jokes' are made about another hospital. There is also the odd cartoon in the presentation. Applause occurs at the end of each talk and the chairperson asks some questions of the presenters before opening the session to the audience to ask questions. For these two presenters, 6 questions are asked by men from the audience and 2 from women... It is the turn of the CNMF2 to go to the lectern. As laptops are changed the chairperson introduces the CNMF... "(*first name*) is doing a PhD and is sponsored by the Health Research Board. Many of you would have got a questionnaire from (*first name*) recently. You'd nearly need an afternoon to complete it". The familiarity of first name usage contrasts to the other introduction that he has made whereby the full name and hospital of the medic concerned is given... This presentation has a totally different style. This may be linked to the non-technical content but also might include a disciplinary difference. Certainly the CNMF2 links some of the information with what others have said over the 2 days showing her presence and attentiveness to others. She stands to one side of the lectern rather than behind it as others had done. Her slides contain lots of quotes from the users of the clinical speciality and she apologises for not using a highlighter. However, there are some similarities within the content. Three cartoons are used in the presentation. In some cases the medical acronyms which describe particular conditions are identified in addition to what I presume are pseudonyms. The lights go on at the end of the presentation and the chairperson describes the presentation as "a most informative talk". This time he does not ask a question immediately and makes it clear that he seeks only one from the audience. Whilst this is understandable considering the session is now running approximately 30 minutes late, such restrictions had not been placed on the previous two speakers. There is one question which the CNMF2 answers... As I leave, there is another medic presenting and the style reverts to bullet points, figures and the red dot highlighter.
FFI211 (1938-1945) I talked to the chair (*a medic*) ...he was taken aback that I was doing a PhD. "You're doing a... doctorate is it?" and I said "That's right". "And what consultant are you working with?" And I was really taken aback at this... (1999-2003) "I'm a bit confused", he said "you're a nurse doing a PhD" ... "But... are you not doing this with a consultant?" and I said "No".

'Making a contribution' was one value espoused by the CNMFs (n=8): and the offering was to service improvement or patient care and the research field itself. As such, the data revealed a moral obligation on the CNMFs for their research to bring about change in practice or else they "may as well just give up" (F2I911). One considered such a stance as naïve as "there's no one researcher can make change"

(FFI211). Whilst some could already articulate changes, one experienced frustration at a lack of progress in translating findings to practice.

F2I410 (1116-1127) ...you're already in this process making links with others who are interested in this particular field... you're helping to build a body of work, which is not your own but is international... justifying that in your head, that actually you might want to change the world but you might not get to change the world in this 3 years.
FFI2510 (839-849) It has also helped nursing and medical care of people. I know (*clinical benchmarks*) have improved indirectly... because I presented and they went and tried to improve... or change the site of treatment delivery... it's really important to see that coming from research.
FFI2710 (1440-1462) ...several of the doctors recognised themselves... one of them... described it as a very salutary lesson... "I know I say those things" ...when I went in a few months back... (*presenting further findings*) they actually have quite a progressive view and said "well we have a responsibility... what are we doing about that?"
FFI911 (993-1003) I did take it to other places where I thought they might be in a position to make some changes. Nothing happened.... that has been my experience... it doesn't really matter what you publish or it doesn't really matter what you say, actually it doesn't effect changes... it just stays the same. I found it very disheartening.

Whilst 'making a contribution' is a value of researchers, its practice for the CNMFs can be aligned to 'making a difference' which nursing and midwifery uses to differentiate themselves in the clinical domain. Improving care provision or service quality shows that the CNMFs' research is orientated towards their professional code and standards as much as meeting the funding demand of 'clinical research'. For 3 CNMFs, there was also the perception that the data collection had a positive effect for their study participants. Thus the CNMFs postulated that a social value was produced from their intellectual labour and hence was legitimate.

F2I911 (934-940) I think what they're getting from it is possibly a healing in some ways. I have asked all (*participants*)... how do they feel about their participation in it and they have all sounded extremely positive.
F3I2311 (361-371) All the participants in fact have said that they've gained from it... That speaking about their work has helped them think about things that they'd never have thought about...

Some CNMFs participated in 'making it visible' or promoting their research to the general public. The HRB publication *A Picture of Health* is published annually and contains lay summaries of the research conducted, including CNMFs. However, the NRA diary showed that their level of engagement with the launch of the publication, varied year on year during data collection. Additionally, through mainly national print media, CNMF research was publicised. This occurred after the PhD was complete (n=3); an exception was one CNMF had a local celebration for being funded, including a photograph in nurse's uniform. Moreover, as NRA I nominated a CNMF to present a poster of their research at a nursing policy event to show that nurses and midwives were conducting research for their practice. Most of this publicity

focused on findings and implications of the research with little or limited focus on the CNMF being a nurse or midwife.

F2I410 (587- 594) (*when speaking to the Minister for Health & Children*) I should have pitched it the other way round... this is nursing research... rather than it being my study as such. So I was little bit disappointed with myself...

8.4 The NRA as privileged pioneer in the peripheries.

The NRA role was unique and privileged. I was the only professional advisor in the organisation and my flexible, part-time joint appointment status made the role somewhat ambiguous and anomalous. That being said, similarities could be found in roles elsewhere.

26/1 At the start (*of the organisational review*) we are asked by the facilitator to introduce ourselves... I explain that I straddle the two funding divisions and straddle functions within the RFPD by inputting on grant assessment, management and evaluation. **28/1** One of my first comments is a reflection of what happened previously when everyone was introducing themselves and their role within the division. "For the first time I realised how narrow people's roles were" I remarked, adding that I thought that my role differed from others because of its cross-functionality. The HoD responded by saying that this specialisation was a product of the division's expansion of personnel. As activity increases, sub-roles become roles in themselves...
6/10 I have a conversation with a nurse involved in another Irish statutory agency with research funding. We discover there are so many commonalities! Being different but on the edge of the academic community; the poor quality of some of the applications for funding; nurses' reluctance to seek support and guidance as potential applicants.

Separately, nurses and midwives too were discerned as 'other'. Individuals were perceived by HRB staff as different or difficult with jokes such as "it's always the nurses that give us trouble" (8/12). The data showed some staff members' attitudes to nurses and midwives were partially revealed through comparisons with other types of applicants on issues such as computer competence and heeding advice.

8/4 I gave a quick update to the HoD on where we were at with the CNMF process. (*Drafting the short-list has been slightly problematic due to an issue with a potential attendee.*) As I leave the office I say "Is it just me or the nurses or does this happen on other schemes?" She laughs and says "No the nurses have a (*pause*) reputation... for requiring flexibility. I think it's mainly because they are that bit older".
12/1 In order to assess if people have utilised the eGrant FAQ I ask a colleague if many nurses or midwives have used a helpdesk option... I am told there have been a few calls and emails and that the issues raised are mundane. "Let me think is there anything out of the ordinary?" is added before I am told of a common problem across all schemes. "They are fairly good for nurses. I don't mean - but you know, nurses are not very technology minded?" I reply that I understand where my colleague is coming from (this colleague has previously worked in a nursing organisation) and am given an example of talking through an issue with a nurse who has phoned the helpdesk
14/1 The colleague brings me in a printed application to show me, though I've not asked to see it. "I explained to her that it needed more information in the project summary and then she put in less. I don't think she's on this planet!" she says. As I look at the form, she tells me that this is one of 3 ineligible or incomplete applications that have been received for the

project grants but whom she had given advice to prior to their submission, even speaking up to 3 times with one applicant. I ask "are these all nurses?" She replies "Oh no, just that one. The other two weren't". I feel relieved that this example is not a specific criticism of nurses or midwives per se but of potential applicants of all disciplines not heeding advice.

Pioneering elements of initiating new ventures or nursing and midwifery being a role model also existed in the data from the Field of the Funder. Some of these centred on strategic concerns for the organisation so that issues undertaken by nursing and midwifery, such as setting research priorities or international networking, found a space in subsequent corporate plans.

1/9 I have planned to publicise the eGrant FAQ existence in a professional newsletter. This will supplement a piece I wrote on writing good grant applications... Other divisional members have had an opportunity to make comments and the document has now been finalised incorporating their points. It will also be made available on the HRB website. This is an example of how a 'new kid on the block' can identify opportunities for enhancing services and challenge the notion of familiarity that members of an organisation develop. **9/2** A draft of the Division's newsletter is shown to the team... there is a piece on the eGrant FAQ document and I am pleased that such recognition is being given to something that initially was just considered by some as 'something for the nurses'.
16/1 There is the possibility of monies for a fellowship for the therapies. I am told what the six therapies being considered are. I stress the small numbers in some of these areas of practice and am asked "How many nurses are there, 17,000?" I reply "No, the figure in 2002 was 32,000 in practice with an additional 4,000 estimated in the private sector". **12/5** ... A Therapies Fellowship call was made with the model of the CNMF used with some modifications. **14/6** At a health research conference I'm approached by a project officer... She has been advised to talk to me about how nursing and midwifery has managed to progress the research agenda in the profession. I give her my card... **28/7** I meet with the project officers in the Department, one of whom has been given responsibility for writing a research strategy for the therapies... Whilst they mention that they are coming from a low base, by the end of the hour and twenty minutes, they acknowledge that nursing and midwifery came from an even lower base. It is interesting that nursing and midwifery are now being seen as the example although they still have much to do to secure a foothold in health research as equal players. During the discussion, many similarities such as the femaleness of the professions are outlined but many differences also such as the numbers in the professions. I leave the meeting feeling that I have somewhat deflated the two, firstly by emphasizing that not all practitioners buy into the concept of research and secondly by focusing on the need to ensure that the financial supports are in place before strategy publication.

That being said, a tension continued to exist when initiating new ventures, ostensibly on the quality of research produced by nurses and midwives.

15/9 I discuss the possibility of establishing a clinician scientist type scheme for CNS/ANP with funding from NCNM with a key decision maker. Although stating favourability, I hear some reservations coming through in the conversation. It is implied that the idea of 'protected time' for clinically based researchers is the work of the other funding division. When I don't seem to 'bite', my colleague says "How can I say this – we don't want to get pulled into training issues, we want to focus on good research". This seems ironic to my ears considering the discussion at the team meeting on another call for PhD training sites and the Chairperson of the Board asking for an event and medal for doctoral students on the pilot! I emphasise the research remit for the accreditation of ANP/AMPs and try to impress that such a role aligns them with medics undertaking research, thus trying to enforce research as

integral and ongoing. (*This scheme was subsequently established through the other funding division*).

The data showed that nursing and midwifery research was constructed as 'other' by myself, as NRA, on occasions supported by colleagues. This was done especially to limit the application of potentially inappropriate hegemonic standards and counter an assumed familiarity with the HRB.

5/9 Two colleagues were trying to 'fathom' the logic of a statement I had made previously that some CNMFs supervised in UK departments had encountered a policy of non-publication of papers prior to submission on thesis... I was asked if this was policy in any Irish institutions. I replied by email "I don't know of any department here but that's not to say... The rationale is that writing short papers is a different skill and takes time away from writing the thesis." The next day I'm on a coffee break with the same staff member and ask if the reply made sense. They replied in the positive but exclaimed that it seemed weird to them as defending a PhD from which papers had already been generated and peer reviewed was easier... They recognized that the issue might be supervisor dependant and described their own experiences whereby supervisors actively encouraged papers to be written but they knew of others whose supervisors had not done so... **26/1** I ask a colleague if the fellowship review is complete. I am told that there is some tidying up to be done but it is almost there. A comment is passed that the outputs from the CNMF and HSR are awful in comparison with the other fellowship schemes... I comment on the difference in knowledge production... **22/12** (*over 600 reviewers of project grant applications are required and temporary workers are employed to assist*) I learn that the criteria that they have been told to use for referees is 2 pages of publications by the individual in 'Pubmed'. I reveal that there are 6 nursing applicants and that this might not be possible, as not all nursing or midwifery journals are represented on this database. (*I look for the nursing referees*).
12/1 A colleague is prompted to give her opinion when the HoD declares that in the future advertisements for the HRB schemes are not required in the print media – "everyone knows about them". The person charged with responsibility suggests that there is still a value... many of the phone calls that I have dealt with over the past 6 or so weeks have mentioned the (*nursing and midwifery magazine*) advert. **29/7** ...I read an email which has said that a decision has been made by the HoD in my absence regarding the advertising of the CNMF. The nursing and midwifery magazine wanted €1300 to publish the advertisement which has already been published in a national paper and 3 medical publications. Since the Board Chairperson has queried the budget spend on advertising, the HoD has decided not to run with the specific CNMF advertisement this year. I query the cost of advertising in the medical press and was told that it was €900 for each advertisement. I calculate that the total cost for nursing and midwifery specific advertising is approximately €1150 cheaper than medical but has still been 'pulled'!

Over the timeframe of data collection, there was evidence of the CNMF scheme being gradually drawn into the orthodox application processes. In addition, acknowledgment of the progress of nursing and midwifery research is made and other processes show its diminution 'as a special case'. This produced tension for me as NRA in getting the timing right for advising on changes that strengthened the legitimacy of nursing and midwifery's position.

10/8 This is the first year that the CNMF has been fully advertised alongside other HRB schemes. **12/1** ...I explain that this is the first year of online application for the CNMF because I had argued a special case. The justification was that many nurses and midwives still did not

have access to computers at work and as the online application system was still under development they were not a group for testing such a new development. The colleague agrees the rationale with the adage "they'd have got very frustrated and angry".
1/9 ...there were emails on the latest work on the new HRB website with the opportunity to input before it goes 'live'. This gives me a dilemma. In the past, nursing and midwifery had its own page as it was deemed necessary for visibility in establishing itself operationally within the organisation and at the interface with the website users. However, with the NRA role now established for five years and with greater visibility to the profession since its conjunction with the RDO role in the NCNM, is this still the situation? Is funding success at sufficient level to merit a reduction in 'special case' measures...?
14/6 There is a big multi-disciplinary health research conference hosted by the HRB... at which nursing and midwifery research is commended and held up as a model by key speakers (politicians, government officials and the HRB CEO) due to a launch of a report identifying research priorities for the professions. I meet some CNMFs... A successful CNMF applicant who is yet to commence, whispers how amazing it is to hear – "Who would have imagined this five years ago?"

Gradually, nursing and midwifery were beginning to compete successfully in the contested funding schemes, although were discerning in their applications.

3/11 I ask whether any nurses or midwives have been successful at the Partnership awards, the panel for which was held a week ago. She promises to send me the list. "Will you recognise the names of the nurses?" I answer in the affirmative and when I do receive the recommended awards I'm delighted to see half (3 out of 6) are nursing projects, hugely over representative of the applications...
4/10 In a conversation with a research participant, I learn that a nursing and midwifery research project has been awarded a 3 year project grant. This is the first time that a successful application has been made to this scheme. It shows progress as 2 applications in the previous year have not been funded, although may have been fundable[89]. I email a HRB colleague to ascertain some more information... This time I learn that whilst nursing and midwifery were included in the 5 year programme grant call, there were no applications.

Yet, there was continuous tension on budget allocation, with efforts to try and expand as much as to ensure no erosion[90]. The 'mainstreaming' of nursing and midwifery research required continued championing for funding against the bulk of basic bio-medical science and other types of research.

24/3 The budget is discussed with 6-6.5 million mentioned as available for new starts; this is an increase. We're told verbally that it has been allocated so that approximately 20% success rate is given to fellowships with a slightly higher success rate to project grants, justified because of the change in committee structure! This reveals the tension around the emphasis between biomedical science and health services type research. However, with 60 applicants to the Public Health and Epidemiology Committee (7 from nursing and midwifery) this may improve the chance of a nursing or midwifery applicant being awarded a project grant. There is further detail with the HoD saying "that means 4 for nursing and 3 for health services (*fellowships*)". The person in charge of HSR reacts as there has been 24 applicants to HSR as opposed to 17 to CNMF. The HoD moves on saying "we'll sort it out later". I am pleased to secure even 3 awards, as the ring-fencing of the nursing and midwifery monies means that new starts are dependant on on-going commitments and I had thought that 2

[89] Ranked in the fundable range but below the cut off point of funding available.
[90] At the time, since the organisation received annualised budgets from the Department of Health and Children, yet gave contracts for 3 years, some fluidity occurred. This meant that the CNMF scheme on occasion was supported from other budget lines.

might be the more likely number of awards this year. The allocation of the budget to nursing and midwifery remains problematic and seeking clarity brings me up against seeming brick walls. **8/4** The agenda today included the budget breakdown and I noted that the CNMF remained at 4 awards... I supported this remaining so saying that the HSR application numbers included nurses applying to both schemes.
25/4 Lunch time I join a small group... I come in on a conversation where a colleague is saying that at least these nurses have jobs, those applying to other schemes can be dependant on success of the funding bid for future salary. I'm not sure what has prompted this remark although I have heard it from this colleague before when trying to argue for more money at team meetings... (*later*) The CNMF interviews are finished and the decisions have to be made. Those who clearly meet the standard for funding are decided almost unanimously; those not fundable at this stage are also decided rapidly. This leaves two applications for one award. Debate commences as the panel members are asked their opinions of the individual applications. Peer reviewers comments are alluded to. Ring-fenced money that has been "hard fought for" is remarked by the chairperson in response to my colleague's suggestion that only 3 awards might be made and the left-over money given to another scheme. After about 10 minutes, a decision is made on the final award...
7/07 A quick meeting has been scheduled... on the forthcoming advertising of the Fellowship schemes and possible changes to the call documents... I was not informed that this meeting was due to occur nor that I was included until I showed in the office this morning. The post-doctoral fellowship scheme is to be opened to all health professionals and not just scientists. This is a Board decision... There is quite a strong voice from one colleague at what she views as the unfair advantage nurses and midwives have in the potential to apply to a number of Fellowship schemes. The HoD does point out that scientists can also apply under the project grant scheme as well. I also highlight that the CNMF is restricted to 'clinical nursing and midwifery'. This restricts nurses and midwives that wish to investigate a more service focused problem and that some applicants are hedging their bets because of the potential marginality of their topic area. The discussion moves back and forth across the issues involved. All present use the nurses and midwives as examples. In the end, a decision is made that all applicants are restricted to applying to one scheme only. (*A number of related issues are discussed*). During this the HoD says "We can't be seen as valuing one area of research over another"...

The data showed how the rhetorical discourse and not just the funding of health research continued to be contested.

3/2 (*in organisational review*) An example of 'fudgeness', in the opinion of a colleague is the lack of a response from the Board on what is meant by 'health research' in light of the establishment of Science Foundation Ireland as a competitive funding body for bench science. **23/11** (*ten months later, the feedback from the organizational review by international peers is given to staff*) ... There are some explicit messages such as 'seize the moment' and the general goodwill to the organization. There are also some messages that are couched in less clear terms. For example, "We have heard about the strong support for clinicians" and a rival funding agency's budget is mentioned. It appears as if a recommendation of a shift from 'discovery' to 'development and dissemination' will be made. However, as stated by some leaving the room at the end, the 'devil will be in the detail'.
7/07 There is a press release announcing a major new initiative for the provision of clinical research infrastructure in which the HRB is teaming with the Wellcome Trust. Interestingly, the justification for the initiative refers to the 2001 *Making Knowledge Work for Health* strategic document's identification of clinical research centres as a priority for building health research capacity in Ireland. From then on in, the announcement refers to clinical research. It appears as if the two terms are synonymous: the relationship between the broader term of health research and clinical research is not explicit.

In common with the CNMFs, I as NRA was concerned to show the contribution of nursing and midwifery research to the health research agenda. This entailed seizing opportunities to make it visible.

10/11 A colleague... asks me for a contribution to a new HRB newsletter about research funding that will be sent to interested stakeholders... Whilst my colleague's perception is that many nurses and midwives in academia may read the newsletter, I consider this an opportunity to inform the academy of nursing and midwifery's presence in the research arena. This is especially important in the inaugural publication. I agree to write a paragraph...
27/09 I start preparing the presentation on "Nursing research – the national perspective" which I am due to present... This is an important opportunity to ensure the nursing and midwifery voice at the launch of a multidisciplinary research foundation. It is the sort of presentation that I've done in other arenas, but this time, as well as show our recent professional development, I want to stress the contribution of nursing and midwifery research to health research and evidence for practice. I think I'll do this by highlighting some of the studies that the CNMF are undertaking, especially the ones that cross disciplinary boundaries. Some do this, either by being grounded in disciplines such as sociology or applied science or by producing results with implications for health professionals that include nurses and midwives.

8.5 Conclusion and Literature

To assist in understanding pioneering, the literature examined focused on the socialisation of doctoral students. Here the literature varied depending on the analytical lens utilised with anthropological (Gerholm, 1990) or sociological analyses (Weidman & Stein, 2003) preferencing departmental over disciplinary difference as the unit of analysis or analytical comment in contrast to Delamont et al (2000) or Beacher & Trowler (2001). Regardless of perspective, the underlying assumption of these analyses is that of an organisational culture as a socialisation agent. As an analytical tool Gardner (2008, 2010) has criticised socialisation's monolithic assumptions and Bieber & Worley (2006) show its incompleteness as an interpretative construct, cautioning against its use. Certainly, for the CNMFs, it has problematic utilisation as their experience was one of structural isolation with departmental distance, non-engagement, or, as also found by Golde (2005) in his study of doctoral attrition from four departments in one US university, a small laboratory with few peers. Non-integration to a research culture is common for other Irish post-graduate nursing and midwifery students too[91] (Drennan & Clarke, 2009). For CNMFs, there was also a lack of disciplinary clarity together with a previous potent occupational socialisation. It could be argued that many of the CNMFs were

[91]Contemporaneously a cross sectional survey of 322 taught Master nursing and midwifery students with a 68% response rate showed showed that post-graduate students were not integrated into a research culture or community whilst undertaking masters programmes in the Irish nursing and midwifery academy (Drennan & Clarke, 2009). An assumption was made that this was due to part-time attendance and lack of opportunity, rather than the absence of such a culture.

less than novice and had already acquired some cultural competencies of the academy; therefore this requirement was less critical. Nevertheless, the CNMFs inherently recognised their isolation and need for intellectual engagement with a research culture. In the main they sought this through individually derived agendas sometimes out-with their departments to build on existing knowledge, attitudes and skills.

The funding focus on clinical research is strategically important as empirical work on emerging disciplines show that 'endogenous' research predominates initially (Traynor et al, 2001; Newell, 2002; Forbes, 2009[92]). The diversity of topics could be accounted for because of the range of clinical specialities that the CNMFs represented, yet Happell et al's (2008) examination of sixteen nursing doctoral theses from one clinical speciality in an Australian state also showed corresponding variety. I would argue that diversity is also due to the low empirical base of Irish nursing and midwifery. The perceptive alignment of qualitative methodologies with nursing and midwifery distances this research field from the core of health science where quantitative research is the dominant modality, both rhetorically and in practice (Sandelowski, 2008). Others have shown that whilst nurses and midwives use a diversity of methods (McVicar & Caan, 2005; Hillier et al, 2007[93]; Forbes, 2009), the interpretative paradigm predominates. This can be problematic; such that policy concerns regarding the strength of focus in the interpretative paradigm led the discipline of education to develop RCB initiatives in the UK to diversify methodologically (Rees et al, 2007). Although small numbers, this study suggests a methodological span in Irish nursing and midwifery RCB. How far this is a feature of being funded or the scheme's focus on clinical research is unknown. Certainly, Martín-Arribas et al's (2009) analysis of successful nursing applications to a Spanish research fund found 88% used purely quantitative methods and McVicar & Caan (2005) found that UK doctoral theses addressing clinical issues were strongly associated with experimental methods. Other disciplines concerned with RCB such as education and social work share characteristics with nursing and midwifery such as a strong vocational foundation (Orme & Powell, 2007), concerns about epistemological appropriation (Lorenz, 2003; Bridges, 2006) and broad interests

[92] A snapshot of 517 papers from one year published in three leading European nursing research journals showed 12% as clinical intervention studies as the unit of analysis, 39% descriptive studies of patient problems and 37% studies describing professional issues.
[93] Similar to McVicar & Caan (2005) (section 2.7), Hillier interrogated the same database with a specific focus on midwifery and health visiting researchers and then searched journal databases using the names generated. In total, 31 theses were included in the analysis, 29 of which were PhDs.

requiring an empirical base best addressed with a 'plurality of methodologies' (Rees et al, 2007). Reed & Lawrence (2008) perceive that methodological pluralism constructs the place that sustains the exploration of valued approaches to address knowledge development. Additionally, in their edited book Rafferty & Traynor (2002) demonstrate how methodological pluralism impacted on nursing and midwifery clinical practice and policy.

A positive finding was the commitment to publish from the doctorate, found previously as mainly student motivated, with or without supervision support (Dinham & Scott, 2001). Viewed as problematic in the literature publishing requires intervention such as writing groups (Lee & Boud, 2003; Lee & Kamler, 2008) or writing courses and coaches (McGrail et al, 2006). Similarly to Kamler (2008) in her case study of two different disciplinary approaches and featuring 12 doctoral graduates from 4 different universities, supervision support for writing during the Fellowship varied ranging from advice to desist (n=1) through to co-authorship. Unlike Neumann (2003), conclusions could not be drawn regarding a specific disciplinary pedagogy on simultaneous doctoral publication. In addition, by publishing in high-quality multi-disciplinary journals, the CNMFs showed awareness that local research can have global implications (Ketefian et al, 2010) in addition to bestowing academic prestige. This finding also supports Allen et al's (2006) mapping of general nursing literature who found a broad dispersal of citations underpinning the profession's interdisciplinary nature.

Choosing topics of sensitivity is one element of the 'nursedness' that nurses and midwives bring to research practice (Leslie & McAllister, 2002) and that emphasises nursing's mandate of social responsibility (Tyer-Viola et al, 2009). However, there was also the advocacy dimension of critiquing practice and challenging status quos, such as service provision (Bu & Jezewski, 2006). This produced challenges, tensions and discomfort (Robinson, 2002) for CNMFs. To an extent, this is seen through the CNMFs' 'making a contribution' common to other doctoral students (Neumann, 2003) although paradoxically, some emphasised the professional ideal such as 'making a difference' as their motivation to research (Woodward et al, 2007). The latter may have been professional rhetoric, boosting pre-held nursing and midwifery ideals (Price, 2009). Yet, CNMFs reported that 'PhD envy' from some clinical colleagues subordinated any contribution they were making to practice or knowledge (Bishop & Freshwater, 2004b). Nevertheless, both the CNMFs and NRA strove to make visible the contribution of nursing and midwifery research to health research.

This eighth chapter has described the core category of privileged pioneering in the peripheries that is supported by three interlinked subcategories of 'resourcing' the research (Chapter 5), labouring the doctorate (Chapter 6) and transitional identities (Chapter 7). These categories, together with the cross-cutting themes of contestation and negotiation, tenacity and resilience, and struggling with the strange, provide the substantive theory of "Privileged Pioneering in the Peripheries" that emerged from the data as an explanation for RCB in the emerging academic disciplines of Irish nursing and midwifery. In the next and final chapter five key issues for nursing and midwifery and health research that the theory has exposed are discussed and recommendations for policy, its practice and further research are made.

Chapter 9: Critical consequences of the substantive theory of 'Privileged Pioneering in the Peripheries' for RCB.

F3I2311 (1940-1947) It's actually been fantastic for me... Having time to stand back from it (*nursing*) and see what I like and don't like... and see where I want to go...
F3I77 (1406-1409) I don't know whether the HRB truly realise the extent of how these (*Fellowships*) have helped nursing.

9.1 Introduction

The concept of 'RCB' implies a "funded, dynamic, intervention operationalised through a range of foci and levels to augment ability to carry out research or achieve objectives in the field of research over the long-term with aspects of social change as an ultimate outcome" (Condell & Begley 2007:273). However, a concept analysis de-contextualises the concept. This study aimed to examine the development, and create a substantive theory, of RCB in the emerging disciplines of nursing and midwifery in Ireland. Thus it embeds the concept in naturalistic settings and utilising symbolic interactionism reveals the contextual variables that arise.

The substantive theory of privileged pioneering in the peripheries (Figure 4.1) emerged from the data as an explanation for RCB that by conceptualisation and contextualisation aids our understanding of RCB's 'situated processes' (Segrott et al, 2006; Green et al, 2006, 2007) and social exigencies (Rees et al, 2007). The theory of privileged pioneering in the peripheries supports the attributes of RCB identified in the initial concept analysis but shows that its practice, far from being a simplistic, policy model, is broad and complex. The theory incorporates RCB across levels, uniquely showing some similarities in processes and nuances between the individual and policy level. Green et al (2006) stress the need for a holistic approach to RCB incorporating all the interconnected constituents that in this theory were 'resourcing' the research, labouring the doctorate and transitional identities through experiences of contestation and negotiation, struggling with the strange, and tenacity and resilience.

Considering the broadness (Potter & Brough, 2004) of the concept, not all attributes could be examined *comprehensively* within one study; nor had any single previous theory sought to address all attributes of RCB together. That being said, I have attempted to compare the *emergent* theoretical categories with an eclectic but relevant mix of existing theoretical constructs such as disciplinary pedagogy and cultural identity to throw a light onto obscure issues. I contend that the substantive

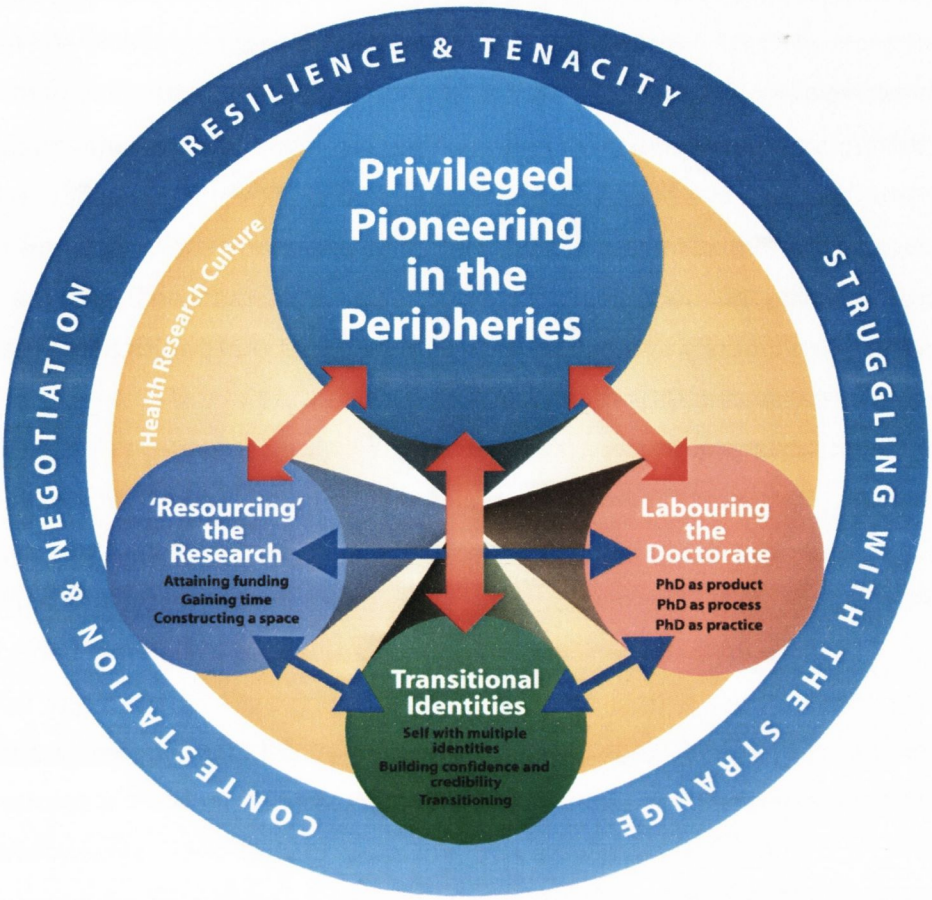

Figure 4.1: The substantive theory of RCB in the emerging disciplines of Irish Nursing and Midwifery.

theory is a useful 'starting point' for developing RCB as it describes the conditions and the broader social relations under which it occurs (Rees et al, 2007). In this chapter, I discuss five key issues for nursing, midwifery and health research that the theory has exposed. The first three issues have epistemological and ontological origins and the final two are policy orientated. From these issues strategic RCB recommendations emerge.

9.2 The lack of culture and tradition.

This study showed that, in the main, the CNMFs built research capacity in the absence of a cultural tradition of nursing and midwifery research in Ireland. The first key issue has epistemological and pedagogical origins in that the CNMFs laboured the doctorate in the absence of national guidelines for PhD programmes (Irish

Universities Quality Board, 2005) and as an *individualistic*, mainly solitary, full-time activity removed from a research infrastructure of critical mass (Delamont, 1997a; Boon & Verhoef, 2002; Haas, 2004; Hazelkorn, 2004; Pirkis et al, 2005; McNamara, 2009) or formal networks (Sitthi-amorn & Somrongthong, 2000; Thomas et al, 2001; Boon & Verhoef, 2002; Farmer & Weston, 2002; Nchinda, 2002; Stillman et al, 2005; Pirkis et al, 2005; Cooke et al, 2006; Ried et al, 2006; Cooke, 2007) espoused by the RCB or policy literature. In previous chapters, I have already shown how this raises difficulties in using the theoretical analysis of socialisation (section 8.5) or the constructs of 'community of practice' or 'legitimate peripheral participation' (Lave & Wenger, 1991) (section 7.6).

In identifying their development needs and constructing their own learning, the CNMFs held perceptions of being self taught and learning by doing. Arguably, this would be to a greater extent than doctoral students from other disciplines as, being an academic novitiate, pedagogical programmes and enculturation mechanisms were not readily available to all CNMFs. Indeed, 'doing extra' showed how some CNMFs, even with the privilege of a HRB Fellowship, had to prove to others their legitimacy as researchers in the absence of a nursing and midwifery research tradition. The data showed that, over time, research cultures were slowly developing in the Irish nursing and midwifery academy with strategies such as post-graduate seminars[94], visiting academics and contributions from other disciplines. Nevertheless, there were factors particular to the context of a research culture being developed from a vacuum. An insufficient research milieu meant that as pioneers, the CNMFs independently carved out their own. They sought out opportunities to learn informally and through programmes of formal transmission of de-contextualised propositional research knowledge that Rees et al (2007) contend are the main focus of RCB. They made connections and links (Green et al, 2006; Cooke et al, 2007), most often international, with experienced, even leading edge, researchers of similar topic or methodological interests. However, a concern would be that because of geographic distance, registration in small nursing departments or other discipline and biographical differences some did not engage optimally in their *own circumstantial* research culture.

[94] Recent literature (McCarthy et al, 2010) show the Irish nursing and midwifery academy developing further strategies: annual PhD Away Days in one institution assist in counteracting isolation and developing novice supervisors.

In addition, the CNMFs, through independently gaining their own funding, negotiating space, and choosing their own topic developed a strong understanding of *study ownership* that enhanced their perception of individualism and solitariness. I would argue that this is not a disciplinary feature but stems from an academic novitiate state of nursing and midwifery where well developed topic streams did not exist that could accommodate topic allocation by a supervisor and there was a "paucity of cumulative research programmes" (McNamara, 2010:772) *or* is a feature of the interdisciplinary nature of some CNMF projects. Whilst study ownership is positive in fostering the independence and specialisation that doctoral studies promulgate it had particular consequences for the CNMFs. As doctoral students of disciplines with self selection of topics (Hasrati, 2005), the responsibility of achievement is fundamentally experienced personally (Delamont et al, 2000). The fear of failure for CNMFs extended beyond the anxiety of rejection in publication or funding application experienced by nurse academics in organisational RCB programmes (Green et al, 2006) to the overall PhD enterprise where they laboured the unknown and struggled with the strangeness of new identities and predicaments. 'Feeling a fraud' and therefore open to challenge stemmed from the anxiety of being funded in the context of uncertain ability and particularly manifested itself in the obligation of timely completions. Yet alterations in enrolment status are not unique through resource changes (Neumann, 2003) and it emerged from this study that PhD time is not as clearly bounded as funded time. I would contend that the tension of timely completion was particularly enhanced for CNMFs by three further factors. Firstly, the public knowledge of privileged funding whereby the HRB celebrated the establishment of the scheme and thereafter the NRA strove to keep it visible contributed to the surveillance that CNMFs, as funded Fellows, underwent. So they not only had to report progress formally to the HRB in addition to their supervisor(s) but also informally to enquirers, some of whom had vested interests, such as professional advancement concerns. Secondly, with previous opponents as contemporaneous peers, the CNMFs had rivals against which they, and others, could measure their progress thus sustaining the initial competition. Thirdly, for some, they had already made considerable investment in establishing disciplinary and professional pedigrees (Delamont et al, 2000) that could be threatened if they did not succeed. These latter two factors were in the context of nursing and midwifery as a heterogeneous, contested site whereby some CNMFs were *already* part or on the margins, of a group of pioneers or elites of their clinical speciality within nursing and midwifery.

Taking cognisance of the stage of academic emergence, one questions if funding Fellowships[95] was the optimal approach to RCB as such a peculiarly solitary activity has implications for future nursing and midwifery research. Firstly, it embeds research in an individualistic and competitive culture and does not necessarily develop collaborative skills or attitudes within the CNMFs, as future nursing and midwifery research leadership. This has the potential to impact on research practices; for example, the slow development of post-doctoral contribution to supervision or the promotion of a cautious approach to networking. Collaboration is a feature of recent RCB literature (Marshall-Lucette et al, 2007; Priest et al, 2007; Lee & Metcalf, 2009) and is not solely applicable to the individual level as further development may require collaboration at the meso-level too. So, in the context of securing diminishing funding, strategic alliances between nursing and midwifery academic schools, as proposed by McNamara (2010), or other appropriate clusters harnesses the necessary expertise to compete successfully. Secondly, it separates nursing and midwifery from its place as part of a multidisciplinary team providing a health service, although the CNMFs and NRA did strive to show the individual contributions and their meaning for multidisciplinary practice. This partition may maintain the nursing and midwifery research endeavour as a peripheral professionalising activity rather than essential to the development of a future multidisciplinary and inter-disciplinary (AMS, 2009) agenda. Such an agenda is required for the future to address emerging issues such as quality service provision or patient safety. As the portfolio of health research Fellowship awards expands to incorporate the health and social care professionals, who too have a low research base in Ireland, the following recommendations have meaning beyond nursing and midwifery. Additionally, nursing and midwifery will need to meet the challenge of gaining funding in a multidisciplinary arena.

It is recommended that:-

1. academic schools of nursing and midwifery should approach funding applications as partnerships between applicants and supervisor(s) and schools should have formal preparation of applicants for interview, if short-listed;

[95] Three years after the CNMF scheme was initiated a 5 year nursing and midwifery programme grant was awarded building a team rather than solitary approach to research.

2. the HRB should request that *full* details of the institutional *and* departmental research culture are disclosed on application and successful applicants be directed to supplement same if the awarding panel deems the culture inadequate;

3. future HRB funding calls should promote the building of collaborative skills by seeking partnerships across all aspects of Fellowships such as training, supervision and mentoring;

4. the HRB should give greater guidance to successful individuals on the experiences and expectations of Fellowship awards.

9.3 The meaning of identity for RCB

The second key issue is ontological in origin and focuses on how identity informs RCB. In adjusting to their solitary labour, CNMFs then frequently perceived themselves as *visitors* to social arenas. In both academic and clinical settings they experienced degrees of 'not belonging' and being positioned as 'other'. So rather than integrating identities, they transitioned *between* salient identities depending on the context. The strongest identity was that of nurse or midwife with both the NRA and CNMFs positioned as such by family members or colleagues lending weight to the adage "once a nurse or midwife, always a nurse or midwife". Combined with choosing research topics of passionate altruism, the study shows the CNMFs relying on the "virtue script" (Gordon & Nelson, 2006:11) from which derives the social legitimacy of nursing and midwifery itself. Whilst the identity of nurse or midwife gave a frame to their labour in data collection, this occurred in arenas that could be culturally antipathetic (Hendry, 2007), discordant (Mulhall, 1997) or ambivalent to research, that valued doing over thinking (Walker, 1997; Woodward et al, 2007; Hannes et al, 2007) and where stereotyping may still generate dissonance between practitioners and researchers (Hicks, 1995 a, c; 1996a, b). The study showed that regardless of these negative elements the professional identity of nurse or midwife remained strong and was privileged to assist the CNMFs in accessing their study populations, negotiating their data collection spaces and dealing with situational ethical dilemmas. In their activity, the CNMFs legitimated the intellectual within the context of the professional. They did this across the categories through references to professional codes, making a difference to patients, getting to know research participants well, labouring ethically and incorporating nursing and midwifery skills and knowledge into their data collection. Thus they maintained attributes of nursing

(and midwifery) care (DalPezzo, 2009) as central to the intellectual labour of undertaking their doctorates as it is to the practice of nursing (Brilowski & Wendler, 2005) and midwifery (Nicholls & Webb, 2006). I postulate that maintaining a professional focus was assisted for some by the contextual differences influencing relationships; so that the nurse or midwife researcher-participant relationship differed to that of nurse or midwife-patient relationship. Hence the time provided by funding the research allowed the CNMFs to fulfil professional ideology of supportive relationships and "narrative proximity" (Malone, 2003:2319) rather than the reality of organisational nursing and midwifery work that focuses on the creation and management of care contexts to meet service needs (Hunter, 2004; Allen, 2007[96]) utilising the "cults" of "busyness" and "superficiality" (Walker, 1997:9). Along with developments such as advanced nursing or midwifery practice[97] (Condell, 2004) this refutes the perception of academic development distancing the nurse or midwife from the patient (Domajnko & Pahor, 2010) and supports the notion that successful RCB investment (Rafferty et al, 2002) does not solely produce a *professional* benefit.

The weakest identity was that of CNMF. The data showed usage confined to contexts where it had particular meaning such as accessing research sites or gaining credibility for the study or its obligations such as assisting potential applicants or acknowledgment at the point of dissemination. Over time its perception of privilege stemmed from gratefulness for the funding and the time it conveyed rather than simply the prestige engendered by such an award as conveyed in the Fellow's Award ceremony. Regardless of its origin – distance, difference or competition, the lack of organic networking of CNMFs also contributed to a weakened state. This raises the question of *why* nurses and midwives might limit this particular identity. I postulate that firstly, although having implications for the future as part of an overall 'track record', the CNMF identity was confined to a particular timeframe for individuals. Therefore, investing in it would produce only short-term gains. Although unknown, it could also be assumed that Fellows on other funding schemes would behave similarly. Secondly and more importantly, the data showed the problematic issue of

[96]A review of fifty four publications representing 27 ethnographies of practice by Allen (2004b; 2007) offers eight bundles of nursing activity which are "managing multiple agendas; 'circulating' patients; bringing the individual into the organisation; managing the work of others; mediating occupational boundaries; obtaining, generating, interpreting and communicating information; maintaining a record; and prioritising care and rationing resources" (Allen 2007:43). These studies reflect the variety of nursing work across settings omitting midwifery.

[97] Although evaluations at the time of writing have yet to show how embedded is the research element of the ANP/AMP role.

envy. The 'luxury' of 'being off' to conduct their studies identified the CNMFs as risk-taking pioneers. Yet it constructed question-marks on the legitimacy of their labour from part-time nurse or midwife doctoral students and ignored the 'hidden' investment made by CNMFs in order to *gain* the award. Within clinical arenas 'being off' signifies a freedom from the highly valued but pressurised 'doing' of practice. Here too as CNMFs, they perceived *themselves* through their professional lens and *assumed* clinical peer presumptions of 'being off'. Hence as researchers, they were free to pursue aforementioned professional ideals in organisationally constrained professional practice contexts (Maben et al, 2007) but moreover as CNMFs, they were luxuriously 'paid' to do so. Additionally, the health service culture traditionally identifying the HRB (and research) with medics, the CNMFs were aligned to this powerful group in clinical settings with the potential for resultant intra-professional tensions (section 7.2.3) and from the strongly hierarchical culture, being negatively distinguished as career aspirants. So I postulate that the CNMFs limited this particular identity in order to protect themselves from unwanted and unwarranted envy of the prestige associated with the award.

It is worth noting from the theory that a relevant emergent issue in 'resourcing' the research was negotiating a labour space. It impacted on transitional identities and was an element of an individual's perception of organisational value (or lack thereof). For example, only one CNMF maintained their own labour space in their original work place but they were from a longer established academic school with a well embedded research mandate. Additionally, the content and nature of labour space held meaning for identity through the symbols and cultural artefacts that it contained. I would suggest that space negotiation took up valuable time, hampered adjustment to the Fellowship and potentially delayed the key identity formation as a doctoral student. This aspect of the theory is worth further exploration.

It is recommended that:-

5. to assist identity formation *and* ensure a research culture for Fellows, the HRB should examine the roll-out of PhD Training Sites beyond the current six that focus on health services research (n=1) and clinical science (n=5) to multi-disciplinary Health Research Training Sites;

6. until PhD Training Sites are established, the HRB should explore mechanisms to strengthen identification with the HRB: suggestions include

formal ambassadorial roles or a Fellows' summer school to initiate networking;

7. the HRB should request that *full* details of the institutional labour space are disclosed on application and that the institution be directed to supplement same if the awarding panel deems the space and equipment is inadequate;

8. further research be conducted on the impact and meaning of labour space for HRB Fellows and their identity.

9.4 Valuing nursing and midwifery research(ers).

The third key issue returns to epistemology as I contend that the strong professional identity of nurse or midwife has meaning for the type and value of research produced and ultimately RCB itself. The origins of the RCB concept imply building indigenous RCB skills and leadership (Schuller, 2007) (section 1.5.2). Unlike other fields such as education, whereby researchers are imported from other disciplines (Rees et al, 2007; Munn, 2008), here we have RCB developing nurses and midwives to research their *own* field of practice, albeit necessarily drawing from a range of disciplinary knowledge (Normand, 2007). As a broad field both topically and theoretically, nursing and midwifery requires methodological diversity and some CNMFs used the funding opportunity to broaden their competence across methodological skills whilst others confined their learning to deepening their understanding of their individual methodological specialisation. Although from small numbers, no methodological paradigm could be asserted as dominating the portfolio, helping to dispel the cultural orthodoxy of aligning nursing and midwifery research with the interpretive paradigm. Such diversity of methodological skill development means that the future aggregate Irish nursing and midwifery research community, has potentially the ability to address the demand of a variety of research questions (Rees et al, 2007) and the agenda for knowledge generation for Irish nursing and midwifery practice can possibly be controlled from within the professions (Forbes, 2009). On the negative side however, considering the time required for RCB (Milèn, 2001; Ogilvie, 2003; Nuyens, 2005) non-identification with a single methodology may well further impede the speed at which nursing and midwifery RCB can occur.

As a feature of funding, the portfolio necessarily focused on 'exogenous' research (Traynor et al, 2001) as opposed to the Irish nursing and midwifery academic "tendency to decentre clinical practice as an object of inquiry" (McNamara,

2009:490). Whilst the diversity of topics reflected the clinical specialities of the CNMFs as already stated it characterises a low empirical base and also points to the heterogeneous, contested site of nursing and midwifery. This, when combined with the aforementioned 'PhD envy' and study ownership, implies a potentially slow development of any real sense of *collective* professional valuing of nursing and midwifery research. Why might this be? Firstly, Schuller (2007:90) claims that RCB confronts professions as the greater the success of the collective capacity development, "the more transparent to the outside world... are the professional practices of particular groups". By empirically examining clinical practice problems, the CNMFs are making such problems visible, although this may be inherently *threatening* to the professions and their multi-disciplinary colleagues. Secondly, the Irish nursing and midwifery professions, like their counterparts elsewhere (Walker, 1997; Mead & Moseley, 2000; Thompson & Watson, 2001; Miers, 2002; Yam, 2005) are imbued with the 'hang-over' of anti-intellectualism from apprenticeship training[98] and the historic elitism associated with third level education (Bishop, 1999; Mead & Mosely, 2000; Mulhall, 1997, 2001; Thompson & Watson, 2001; Holmes, 2002; Bishop & Freshwater, 2004b). Additionally, the promotion of research has not been helped by the long standing focus of nursing scholarship on defining and debating the science of nursing and developing broad meta-theories that lack nursing distinctiveness[99]. This has contributed to the "relevance gap" (Risjord, 2010:18), whereby clinical practitioners ignore research on grounds of it being irrelevant to practice. Thirdly, whilst the professions themselves are heterogenic, they also contain *hierarchies of position and value* so that, as previously discussed (section 9.3) researchers can be negatively positioned as career aspirants and, as just noted, their research, as cognitive work, viewed as extraneous because of the dominance of practice. So, whilst nursing and midwifery research might be appreciated by some for its part as a professionalising mechanism, there are still a number of barriers to its acceptance as a collectively valued core for nursing and midwifery practice. What can those concerned with RCB in Irish nursing and midwifery do to start addressing this?

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[98] Similarly to the UK (Lorentzon, 2003), Fealy (2006:67) shows the historic disdain of the Irish leadership of nursing towards intellectual ability and ambivalence towards education in the 19th century. In the early 20th century, the situation shows a little improvement with more theoretical instruction for nurses. However, practice remained dominant within training programmes. Fealy (2004:652) shows that this attitude to education was sustained into the latter quarter of the 20th century sustaining the myth "that the intelligent nurse was not a good practical nurse" and thus not the ideal.

[99] It should be noted that midwifery does not seem to have undertaken this endeavour to the same extent, although it must be assumed that North American scholarship was encompassing midwifery.

The CNMF portfolio of research itself fits into the broad definition of nursing (*midwifery*) research by Forbes (2009:558) as "...led by nurses (*midwives*) with the purpose of developing knowledge of relevance to the... profession". Risjord (2010) claims that the distinct knowledge of nursing only emerges through research motivated by *moral* and *political* values as the nursing standpoint seeks to integrate the biomedical world with that of the patient. In selecting topics of potential controversy from their specific clinical experience, the CNMFs were using their PhDs to assist them to speak out to improve care (Stevens, 2009) and to advocate for service users. Using the authenticity and status conveyed by doctoral studies to move from the cultural ambiguous nursing stance (Davies, 2004) and the "tyranny of niceness"[100] (Walker, 1997:8), the CNMFs became legitimate and authoritative sources on their topic. Hence in addition to a knowledge contribution, CNMFs were agents of 'making a difference', however modestly. I would contend that it is *this* contribution that needs to be highlighted for valuing by the professions and not simply the gaining of academic 'kudos' for individuals and the professions.

This may take additional funding to show the translation of research findings into practice but that could be beneficial in a number of ways. Individually it would allow Fellows to develop a programmatic approach to their research career and would sustain RCB in the immediate post-doctoral period. Whilst activities by the NRA and individual CNMFs did raise nursing and midwifery's research profile in a bid to demonstrate its contribution, Edwards (2008) evokes nursing leaders to leverage such findings to illustrate the essential contribution of 'opaque' nursing research to effective, quality health care. Hence the audience should be broadened to include policy makers, health service managers and other health care professionals. So funding to show the translation of research findings into practice would benefit the HRB organisationally as it would give greater justification for the funding it awards both to policy makers and the general public. This follows the Canadian position of expanding RCB to include knowledge transfer (Ellis, 2007; D'Amour et al, 2008; Miller et al, 2009) and would assist nursing and midwifery research to increase its impact (Tilden & Potempa, 2003).

Two additional notes of interest in this key issue are that firstly the CNMFs fulfilled RCB's ultimate outcome of *social change* in two ways: by realising nursing and

[100] Walker (1997) contends that the tyranny of niceness suppresses nurses' ability to challenge dominant structures and cultures to produce change.

midwifery's own social mandate and, together with the presence of the NRA, by changing nursing and midwifery's relationship with funded health research. Secondly, none of these CNMFs returned to practice with all now academics, career researchers or educators. However, metrics from information in the public domain, such as further funding and publications, imply differing levels of subsequent research activity (Appendix 5), raising questions of sustainability for a very small number of individuals.

It is recommended that:-

9. the HRB should explore establishing a funding stream that promotes the translation of its Fellows' research into practice;

10. the HRB should consider extending evaluation markers beyond dissemination to translation of findings;

11. the researchers and policy makers of nursing and midwifery should collaboratively develop a strategy to promote the collective contribution of nursing and midwifery research to health research agendas and health policy makers in addition to professional practitioners, in a sustainable manner;

12. the HRB should monitor the career trajectories of Fellows using metrics appropriate to the particular professions.

9.5 Challenging dominant models.

The fourth key issue is that the theory challenges the dominant models of doctoral studentship *and* RCB conceptualisation as simply programme provision of propositional knowledge (Rees et al, 2007). That is not to say that such models are inherently erroneous but rather that they are *inadequate* to explain the totality of either phenomenon.

This study showed that, in the main, CNMFs built research capacity as a response to funding. They achieved this by *doing* research so blurring any subtle distinction that Segrott et al (2006) claims can exist between RCB and the process of research production depending on whether the RCB focus is interventionist or facilitative (Nchinda, 2002). In addition, the theory shows that RCB also occurred at the level of the funder. Of concern, is the threat that RCB will become solely focused on

methodological skill development as Rees et al (2007) implies is occurring in other fields and therefore simply a "euphemism" for research training (Potter & Brough, 2004:336). Why might this happen? The main reason the concept could narrow in such a manner is due to its inherent intricacies[101]. I postulate that how funding agencies conceive the concept, apply it to their competitive processes and how that in turn is interpreted by applicants may force them to adopt a de-contextualised simplified approach. Instead this theory of RCB can assist research funding agencies by demonstrating that they *themselves* are subjected to RCB and not simply those they fund. The theory shows *all* the key areas that need to be addressed in any RCB initiative whose context should determine the emphasis applied to each substantive area.

The literature has shown the questioning of hegemonic policy models of doctoral education on a number of issues (Neumann, 2003; Park, 2007; Cumming, 2010) some of which are strongly supported by findings from this study. What this literature is demonstrating is the greater level of complexity and dynamism of doctoral education than is usually recognised (Cumming, 2010) thus challenges an assumption of 'one model fits alls'. In chapter one it was noted how the CNMF scheme supports the policy element of full-time registration. Yet the data showed that whilst there was a clear, bounded funding time many CNMFs had a mix of full and part-time registration for their PhD, supporting Neumann's (2003) findings. The reason for the choice of 3 years as the maximum full-time funding allowable is not explicit but I would assume its origins lay in the long established 3 year HRB Project Grants that, whilst not their primary objective, traditionally supported PhD students. For this scheme, there is limited data on completion rates but a single year[102] 'snapshot' showed 26 of 37 PhD completions within 3-4 years (O'Donovan & McCafferty, 2004). Together, both sets of findings suggest that 'completion rates' for full-time funded health research PhDs, regardless of the mechanism of HRB funding, are at variance with the orthodox 'norm'. An investigation to interrogate PhD 'completion rates' is required; this should determine what the PhD timeframe actually is and the grounds for slow or non-completion of Fellowship and Project Grant PhDs, whether they be personal, disciplinary, methodological, or contextual in origin. Such

[101] Alternatively the concept could broaden. Munn (2008:423) states that RCB for educational research refers to "the users and commissioners of research"; and much contemporary UK nursing and midwifery literature adds the notion of 'capability' or includes the 'd' in 'research and development' (McCance et al, 2007) to imply user understanding and application of research.

[102] 2001

data would enable funders to set an empirically-based completion rate for Irish health research and allow funders (and HEIs) to address supports to overcome slow completion.

It has also previously been noted that the placing of doctoral studies as an early career presumption is policy orthodoxy reflecting the 'majority' or 'typical'[103] and is certainly a practice norm in the Irish academic world (IUA, 2004). It is argued that this then gives a full career trajectory in research benefiting the initial investment[104]. In my opinion, this has a number of problems. The first is that non-attrition is assumed, either during the doctoral studies or post-doctoral. Secondly, in the early career model it is most likely that individual research skills would need to develop from scratch including grant writing skills (Longo, 2009) to attain funding for post-doctoral work. In this study the CNMFs were mid- rather than early career PhD students and nor were they a 'tabla rasa' coming to the process. As mature professionals, many but not all, had a foundation of existing research skills[105], some had the advantage of having worked in the academy (Brina et al, 1999) and all had specific clinical experience that assisted negotiation in their clinical research sites and with their participants. This stood them in good stead for the specific challenges they faced in the particular context such as the solitary labour and the need to fashion their own research culture, although may have exacerbated the difficult transitions in and out of the Fellowship. Considering that *most* have secured further funding from a variety of sources (Appendix 5) shows their continued commitment to research. I contend therefore that mid-career positioning can expedite a 'fast track' to independence and of interest would be a comparison of career trajectories between early and mid-career PhD students or between mid-career PhD students of different professions to empirically show investment value.

The theory also raises issues for the meaning of the term 'health research' and the cultural challenges whereby health research is a synonym for biomedical research

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[103] Here commentators such as McKenna (2005b) are using the model from science that as Brew (2001) comments dominates funding policy. In Ireland too, whilst given arbitrary acknowledgment to differences to the norm, the model of laboratory science prevails (Irish Universities Association, 2004).

[104] Funding early career PhDs is 'cheaper' than those at mid-career if assessed *simply* on the initial investment.

[105] A lack of definition by Priest et al's (2007) causes difficulty in placing CNMFs on neophyte-midiphyte' continuum and so making any comparisons.

(Pearson, 2004)[106]. Contrary to many nurses' and midwives' beliefs, at that time science rather than medical dominance prevailed in funding and operational terms. For example, a review of Project Grants which are "the single biggest annual investment in the research system by the HRB" (O'Donovan & McCafferty, 2004:13) showed that the €33 million awarded between 1997 and 2003 supported 173 PhD students. In a survey of 261 researchers supported by the scheme with 35.6% response rate, 52% of the projects were conducted in university laboratories and 10.8% in hospital laboratories and 70% of respondents classified the research as basic science (O'Donovan & McCafferty, 2004). For the NRA too, HRB colleagues with PhDs came from science backgrounds and no medic was employed to operationalise the funding streams. That being said, it was medics that the CNMFs had to engage with over their research endeavour in clinical arenas and whilst some CNMFs encountered individual, problematic medics, such as at ethics clearance, others were paternalistic or tangibly supportive. However, the dominant representation of medics and scientists on research ethics committees (HSE 2008) (section 6.6) and within the HRB, together with the 'norm' of scientific challenge or rejection of application, fostered notions of biomedical ownership of health research and maintenance of the funding status quo. This is reflected internationally where hierarchies of power and social status continue to influence societal[107] and medical (Edwards et al, 2009), policy and academic (Meerabeau, 2006) perceptions of nurses' and midwives' engagement in research.

White (2005) suggests that nursing and midwifery research's subordinated position is not due to any medical conspiracy to frustrate professional aspirations yet medicine's research tradition still conveys the perception of "unwarranted power" upon nursing research (Woodward et al, 2007:235) and stimulates envy of their funding success (Butterworth, 2009b). Whilst others have challenged the dominance of medicine as a benchmark for nursing and midwifery (Rafferty and Traynor 1997b; Scott, 1998, 2002) and have sought professional groupings within and out-with the broad health arena (CPNR/CHEMS, 2001) for progress comparison in RCB, I propose that of interest to nursing and midwifery would be an analysis of medicine's relationship with

[106] Geography too has seen a broadening of one of its specialities from medical to health geography and expanding its base from purely quantitative to incorporate qualitative methods (Andrews, 2003). The claims of collegiality and complementarily, (Kearns & Moon, 2002) may well result from this occurrence having a single disciplinary origin rather than the contestation seen when a number of disciplines compete for the term 'health'.

[107] Indeed some (MacNamara, 2005; Fealy & McNamara, 2007) contend that, as in the UK (Meerabeau, 2001, 2004), the Irish *general public* displayed anti-intellectualism in reaction to the development of academic nursing and midwifery.

'health science' to ascertain what lessons could be learnt. Policy changes (Appendix 5) now confronting Irish health research include a shift from basic to applied science and greater emphasis on research for patient services and care. So whilst nursing and midwifery continue their assimilation to the health research culture, health research itself has to modify towards an agenda that shows greater alignment with an understanding of 'health research' as a broad cross disciplinary field concerned with producing knowledge for translation to health care and service provision. These planned policy shifts, the raised profile of new field entrants showing their contribution to patient care and service provision, and increasing recognition of the necessity of interdisciplinary approaches for health research (AMS, 2009) will challenge the situation heretofore. Simplistically it implies that the RCB theory will become less relevant to the Irish nursing and midwifery context as the margins of health research change. Yet, I forecast that such change will be slow and as White (2005) and Luker (2007) contend, nurses and midwives must also produce quality research to become central participants with parity of esteem in the health research arena. Thus the RCB theory may modify under continued application to Irish nursing and midwifery in the future.

It is recommended that:

13. the theory of RCB should be shared with other national and international research funding agencies;

14. the HRB should monitor future career trajectories of the PhD students it funds into the long-term (10-20 years) so as to assess where and how investment should be best targeted;

15. the HRB should evaluate the PhD completion rates across its schemes in order to set an empirically based 'norm' and investigate grounds for slow or non-completion to assist it and others (HEIs) in support provision to overcome these issues.

9.6 Positioning of the NRA

The final key issue is the role of the NRA. Uniquely, this study incorporated the perspective of RCB from the Field of the Funder by including an examination of the cultural brokering work of the NRA. Facilitation roles (Perry et al, 2008) or joint appointees (Duke et al, 2009) are positively evaluated for their effectiveness in RCB.

Yet they can be inherently vulnerable during times of change (Ogilvie et al, 2004) and a number of issues can limit achievements. The pioneering activities of the NRA did raise the profile of nursing and midwifery research in the HRB and of the HRB in the professions of nursing and midwifery. I would contend that more is achievable and necessary if the new agenda for the HRB is to succeed.

This study shows that as a professional advisor, I, as NRA had to learn the funding culture from scratch and importantly show the legitimacy of the position and the credibility of the person in the role. This meant a strong initial focus on operational issues whilst strategically representing the HRB to the nursing and midwifery professions. The ability to influence funding decisions required time and in-house supporters, yet was somewhat limited by role positioning. Additionally, it necessitated existing nurse and midwife researchers to engage with the funding agenda, show the merits of what they could achieve in the context of building research skills from a low base. The joint appointment status assisted with 'cultural brokering' but allowed only partial engagement in daily HRB activities. So the ability to convert *practices* to discriminate positively for nursing and midwifery, such as ensure nursing and midwifery's presence on panels, was at times haphazard due to NRA absence. That being said, such operational work is indispensable in a contested site such as a funding agency where the tendency is to maintain a cultural 'status quo'. The role, I found, bore many tensions and constraints. Some were personal such as organisational time-keeping and modes of communication. Others had strategic origins such as the undervaluing of research domains that were not biomedical and a focus on academic based rather than service based research, although the advent of clinician scientist type schemes has initiated changes to this attitude. Such issues provoked professional discomfort and frustration for me. There was tension in reconciling the rhetoric of support for nursing and midwifery research with the concurrent reality of guarding what had been achieved and pushing for greater resources. I learnt that cultural change was slow. I also learnt that greater resources were more likely to become available when supported by evaluative 'evidence' rather than simply 'advice'. That being said, some organisational champions did exist that supported the role and its associated agenda. In fairness and gratification to them and my position as a HRB worker rather than any Janus-faced insincerity[108], the data from the Field of the Funder does not *fully* reflect my *personal* thoughts and feelings

[108] Perhaps my personal "tyranny of niceness"!

on these tensions. Instead, I strove to record processes and practices in a balanced way so as to allow the reader to interpret from their own standpoint.

Moving the strategic direction to a broader concept of health research has to surmount the contestation for research funding. It also requires a greater understanding of the complex health service on the part of the funders and a sustained unity of operation and strategy. Whilst the former can be assisted by the NRA role it would benefit further should the role be situated in a less peripheral position organisationally. A strategic perspective requires support beyond what the current NRA role delivers and would benefit from input at decision-making levels by health service research *users* and not simply enterprise or academic research *generators*. In addition, I would suggest that politically aware nursing and midwifery leadership could exert greater influence on research policy (Rafferty & Traynor, 2004; McCance et al, 2007), not with solo *professional* priorities but for a patient orientated and health services research agenda to which nursing and midwifery research can subscribe. Nor can (or should) nursing and midwifery attempt to achieve this on its own and so an exploration of the potential to coalesce with other key health professional researchers needs to be undertaken. In the absence of professional or health service research user representation at the decision-making level, nursing and midwifery *research leadership* should also be proactive and *engage* in building relationships with the HRB to exert informal influence.

It is recommended that:

16. the Minister for Health and Children should appoint representatives of health service research users to the Board of the HRB;

17. the NRA role should be sustained and positioned to allow greater input to strategic decision-making within the HRB;

18. nursing and midwifery research leadership and policy should explore potential alliances with like-minded others for the mutually beneficial broadening of the 'health research' agenda to benefit patients and the health service directly.

9.7 Summary and conclusion.

This chapter, the final chapter of the thesis, has explored five key issues for nursing and midwifery or health research from the critical consequences of the substantive theory of RCB. It has outlined recommendations for policy, its practice and further research.

Over a decade ago Morgan (1999:20) stated that capacity building is a "risky, murky, messy business with unpredictable and unquantifiable outcomes, uncertain methodologies, contested objectives, many unintended consequences, little credit to its champions and long lag times". This thesis goes some way to assist clarity in the application of the concept to research. Overall it is the first empirical study of RCB in Ireland. It was conducted at an opportune time when the concept of RCB was emerging and dynamic and it contributes to the corpus of work internationally. Through its methodology it uniquely combines data from two fields and shows similarities in processes and nuances across the levels of RCB. The substantive theory emerging from the data supported the initial concept analysis of RCB but, by empirical examination, expands its attributes. The theory has policy and practical relevance. It also has resonance beyond its empirical base that focused on nursing and midwifery research in Ireland. The theory will assist individuals, organisations and policy-makers to optimise RCB by showing all the substantive areas that should be considered in operationalising the concept beyond a 'product' focus so that what can be expected and how best to respond is explicit. The subsequent betterment in the RCB process will improve the cultural contexts and provide for aspects of social change that the building of a broad health, nursing and midwifery research workforce for Ireland necessitates.

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Appendix 1 Documents supporting Chapter One

1.1 Press Release 1999 announcing the Clinical Nursing and Midwifery Fellowships



PRESS RELEASE

1999 CLINICAL RESEARCH FELLOWSHIPS IN NURSING & MIDWIFERY

The Health Research Board today announced funding for four new research fellowships in nursing and midwifery. The four fellowships are being awarded at a total cost of £330,000 over the next three years. The Fellows were selected on the basis of their abilities and promise following an open competition, international peer review and interview (see Annex for details on the Fellows and their research interests).

Speaking at the awards, Ms Peta Taaffe, Chief Nursing Officer at the Department of Health and Children and guest of honour, said that the fellowships .....(quote). Dr Ruth Barrington, Chief Executive of the Heath Research Board, said that this was the first time that the Board had offered career support for nurses and midwives in research. (Quote from Ruth)

The development of research in the clinical practice of nursing and midwifery was one of the recommendations of the Report of the Commission on Nursing. The purpose of the fellowship scheme is to provide experienced nurses and midwives with an opportunity to carry out research in Ireland in clinical nursing and midwifery, leading to a postgraduate qualification at masters or doctoral level.

1.2 Call documents 2001 & 2008

THE HEALTH RESEARCH BOARD

CLINICAL RESEARCH FELLOWSHIPS IN NURSING & MIDWIFERY

Purpose: The purpose of the Fellowships is to provide experienced nurses and midwives with an opportunity to carry out research in clinical nursing or midwifery, leading to a postgraduate degree at masters or doctoral level. These Fellowships will provide nurses with the research experience necessary to develop their expertise as specialists in their chosen field of nursing or midwifery.

Value of Award: Salary payable is up to £25,000 p.a. This is subject to tax and PRSI and is paid through the host institution. Postgraduate fees will be paid where the fellow is registered for a higher degree. Fellows should normally be registered in a university in Ireland or Northern Ireland; exceptions will be considered on a case by case basis only and must be justified. Up to £5,000 per annum is available for running costs, including small items of equipment and consumables.

Duration: The Fellowships will be tenable for one to three years, depending on the project and the postgraduate qualification sought. The Fellowship will be held on a full-time basis. The payment of the Fellowship in the second or third year will depend on a satisfactory annual review of the work of the Fellow.

Where Tenable: Fellowships are tenable by nurses or midwives employed in a recognised health service or an Irish academic Department of Nursing and registered with an academic department of nursing or other relevant academic department for a postgraduate degree. One of the academic Sponsors must be a nurse or midwife.

Eligibility: To be eligible for a fellowship a candidate must:

- be registered as a nurse or midwife;
- have practised professional nursing or midwifery for at least five years;
- hold a post in nursing or midwifery practice or a post related to nursing or midwifery;
- have been employed in the Irish health services, or an Irish academic Department of Nursing, within two years prior to the closing date for application to the Fellowship;
- have a research proposal involving a field of nursing or midwifery in either Ireland as a whole or the Republic of Ireland;
- have obtained the prior approval of the head of an academic Department of Nursing for the research study being carried out;
- secure ethical approval for the research, if such approval is required.

Selection Procedures: The Fellowships will be awarded following open competition on the basis of :

- the research quality of the proposal;
- the clinical applicability of the proposal;
- evidence that the candidate has adequate research skills to complete the project, or is planning to gain these in a way which is compatible with completing it in the time frame;
- shortlisted candidates will be required to attend for interview.

Note: Definition of 'Research with Clinical Application in Nursing or Midwifery'
Clinical research has as its objective the uncovering and/or identifying of findings which can impact on nursing practice. Practice includes nursing assessment of patients/clients, nursing decision making and planning, nursing interventions and evaluation of this process. Data are generated in close proximity to patients/clients. Findings have the realistic potential to be used and/or be applied in nursing practice. They do not merely have a possible application to practice but are directly applicable. Immediate utilisation of findings may not be possible (for structural, educational, resource or other reasons) but if the research will provide evidence which to practice it is acceptable.

Completed application form should be returned **unstapled, in hard copy** by the closing date of **Friday, 5th January 2001** to: The Manager
Medical & Health Services Research Division
The Health Research Board
73 Lower Baggot Street
Dublin 2

HEALTH RESEARCH BOARD

CLINICAL RESEARCH TRAINING FELLOWSHIPS IN NURSING AND MIDWIFERY 2008

Please note each applicant may only apply to one 2008 Fellowship scheme.

Purpose: The purpose of the Fellowships is to provide experienced nurses and midwives with an opportunity to carry out research in Ireland in clinical nursing or midwifery, leading to a postgraduate degree at masters or doctoral level. These Fellowships will provide nurses with the research experience necessary to develop their expertise in their chosen field of nursing or midwifery.

Explanatory Note:

Research in Clinical Nursing or Midwifery

Research in clinical nursing or midwifery has as its objective the uncovering and/or identifying of findings which can impact on nursing or midwifery practice. Practice includes nursing or midwifery assessment of patients/clients, nursing or midwifery decision making and planning, nursing or midwifery interventions and evaluation of this process. Data are generated in close proximity to patients/clients or their families. Findings have the realistic potential to be used and/or be applied in nursing or midwifery practice and have relevance to health and social gain. They do not merely have a possible application to practice but are directly applicable. Immediate utilisation of findings may not be possible (for structural, educational, resource or other reasons) but if the research will provide evidence for practice it is acceptable.

Eligibility: To be eligible applicants must:

(i) be registered as a nurse or midwife;

(ii) for applications for funding for a masters' degree (by research): have practiced professional nursing or midwifery for at least three years;
for applications for funding for a PhD: have practised professional nursing or midwifery for at least five years;

(iii) hold a post in nursing or midwifery practice or a post related to nursing or midwifery;

(iv) have been employed in the Irish health services, or an Irish academic Department of Nursing and/or Midwifery, within two years prior to the closing date for application to the Fellowship;

(v) have support/approval from the Head of Department in which the research study is being carried out and provide evidence of academic supervision from a suitably qualified nurse or midwife;

(vi) be an EU citizen or be a nurse/midwife from outside the EU with permanent Irish resident status or a valid work permit.

Selection Procedures: The Fellowships will be awarded following open competition on the basis of:

- the research quality of the proposal;
- the clinical applicability of the proposal;
- evidence that the candidate has adequate research skills to complete the project, or is planning to gain these in a way which is compatible with completing it in the time frame;
- the quality of the mentoring environment.

Short-listed candidates may be required to attend for interview.

Duration: The Fellowships will be tenable for one to three years, depending on the project and the postgraduate qualification sought.

Where Tenable: Fellowships are tenable by nurses or midwives employed in a recognised health service or an Irish academic Department of Nursing and/or Midwifery and registered with an academic Department of Nursing and/or Midwifery or other relevant academic department for a postgraduate degree. One of the academic sponsors must be a nurse or midwife.

Conditions: Salary payable is €46,964 - €48,550 - €50,130, this is subject to tax and PRSI and is paid through the host institution. The HRB will reimburse the host institution for employer's PRSI and pension costs (15% of salary for employer's contribution and 5% for employee's contribution). A contribution will be made towards postgraduate fees. Fellows should normally be registered in a university in Ireland or Northern Ireland. Up to €7,500 per annum is available for running costs, including small items of equipment and consumables. Fellows are expected to provide an annual report describing their progress and a final report on completing the fellowship.

A one-off grant of up to €7,000 is available to enable fellows to gain research experience overseas or in Northern Ireland. The duration of the visit should be between four and six months and the visit should be made in the first or second year of the fellowship. Before the grant is awarded, fellows will be expected to provide a programme of work, a breakdown of costs and letters of support from the host institution and from the academic sponsor in Ireland.

Fellows must participate in formal taught sessions relating to the conduct of research at the host institution or elsewhere (such sessions may include: research ethics, data analysis / statistics, etc).

The appointment of a Fellowship Mentoring Committee is a requirement of this Fellowship scheme. The committee should be made up of the academic sponsor, a nurse/midwife mentor and an independent advisor(s) from outside the fellow's academic department. The Committee should hold bi-annual meetings with the fellow to review academic progress, to advise on matters relating to the PhD thesis and provide the fellow with a supportive mentoring environment.

Outputs: Fellows will be expected to provide an annual report describing their progress and an end of grant report on completing the fellowship. Note that the HRB will not consider fellows or their sponsors for funding in the future if this condition is not met.

Closing Date: The closing date for applications is Friday, 14 December 2007 at 5.00pm.

The HRB reserves the right to reject any application that does not meet the terms of this call. Canvassing of panel members will result in the disqualification of the applicant. The decision of the Board in respect of any grant application is final and cannot be appealed or reviewed.

If you have any queries regarding the above information please contact Patricia Cranley e pcranley@hrb.ie; t 353 1 2345120.

1.3 The concept analysis of RCB (Condell & Begley, 2007)

International Journal of Nursing Practice 2007; **13**: 268–275

RESEARCH PAPER

Capacity building: A concept analysis of the term applied to research

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Condell SL, Begley C. *International Journal of Nursing Practice* 2007; **13**: 268–275
Capacity building: A concept analysis of the term applied to research

Recent policy developments in Ireland have led to a focus on research capacity building as a means of consolidating nurse and midwifery education in the Irish academic setting. This follows similar initiatives in the United Kingdom and Australia. However, sparse literature and a lack of clarity of the term 'research capacity building' leads to some confusion. A concept analysis using Rodgers' framework was conducted. The literature examined included 'grey' literature, policy documents and indexed papers across a range of disciplines, derived from CINAHL/PubMed searches. The concept of research capacity building was deemed to imply a funded, dynamic intervention operationalized through a range of foci and levels to augment ability to achieve objectives in the research field over the long-term, with aspects of social change as an ultimate outcome. This is presented as an interim statement because of the evolutionary nature of the concept and the limitations of the exercise.

Key words: capacity building, concept analysis, nursing research, research capacity.

INTRODUCTION

Irish nursing and midwifery education has recently moved to the academic setting as part of a broad professionalizing policy,[1] occurring some years after similar initiatives in the United Kingdom and Australia. There is now a focus on developing research to enhance the position of Irish nursing and midwifery within the academy and to build the knowledge base for practice. However, while policy-makers and academics use the term 'research capacity building', there can be some confusion around its meaning. Additionally, literature on the topic within nursing and midwifery is limited[2] and fragmented[3] leading to further lack of clarity.

AN OVERVIEW OF THE RATIONALE FOR THE CONCEPT ANALYSIS

Research capacity building is described as being in its third decade as a concept[4] and practice,[5] yet literature on the topic within nursing and midwifery is a recent phenomenon. It consists mainly of scholarly opinion and description of policy use. There is a dearth of empirical literature although some exemplars and case studies of practice exist. However, this is mainly in the developmental literature. Further complexities occur because, as Gorard[6] outlines, there are a variety of contexts and ways in which

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the terms 'capacity building' and 'research capacity' are utilized by research policy-makers, funders and researchers themselves.

Viewed as a key factor in development,[7,8] though a fragile goal,[9] the concept of capacity building has been described as broad,[10] elusive[11] or chameleon-like and 'theoretically homeless'.[12] Harrow gives the theoretical strands with a claim on capacity building as: community development, agency, stewardship, new public management and possibly gender studies.[12] Some writers[11–16] have noted ambiguity and a wide range of understandings surrounding the concept that reflect emergence and a lack of conceptual maturity. Elsewhere, when linked with research, it is regarded as an overarching[3] or 'general term' with multiple assumptions and complexities.[9] Such difficulties with conceptualization result in linkage to other intangibles and abstract concepts such as partnership, sustainability and empowerment[12,16] with further lack of clarity in these layers. Segrott *et al.* claim a 'rather disjointed literature with a blurring of terms and a plurality of meaning attached to them'.[5] This mirrors what has occurred in the capacity development discourse with such concepts routinely used as 'buzz words' in debate and dialogue[17] but not always having clear meanings.[18] Thus, the need to conduct a concept analysis of capacity building and its relationship to research was identified.

METHODS

Rodgers explores the philosophical basis of concept analysis and distinguishes between the reductionist view of concepts as entities with exact boundaries that are rigid both temporary and culturally, and concepts as dispositions, which relate to usage, and are thus dynamic and evolving.[19] Rodgers' framework[20] emphasizes an inductive approach to the analysis, which focuses on the emerging usage of the concept. It was thus viewed as particularly relevant to this exercise. The framework uses a number of phases which interrelate and are circular rather than linear in process. It also demands a full explanation of the data used in the analysis.

This particular analysis was conducted in three segments. The initial segment used 'grey' literature such as reports and discussion papers from regional and global development agencies from which the use of the term arose. A previous finding for the Global Forum for Health Research identifies this literature as the main source of material on the topic.[8] The literature was found using the term 'capacity building' on the world wide web based search engine Google and Google Scholar. As such, this search was not fully comprehensive and additional literature was found through cited references. In total, nine documents were identified.

The second segment of the analysis was to examine the use of the concept in 16 nursing, midwifery, health and educational research policy documents and reports. The third segment used CINAHL and PubMed databases to extract multidisciplinary peer-reviewed literature from the domains of medicine, health, nursing and midwifery. An initial keyword search of CINAHL for the years 1998 to January 2006, using the term 'research capacity building' found 64 results. A manual deletion removed those concerned with conservation biology, tropical insect science, plant ecology and hydrobiologia. In addition, news and course and conference listings were removed. The final sample consisted of 58 results. A second keyword search used the term 'building research capacity' with 56 results for the same time frame. In this sample, a manual deletion removed those from pure and applied science, a book review and the news, course and conference listings. This yielded a further 41 titles. The total CINAHL sample was thus 99 titles.

The PubMed search used the term 'research capacity building' for the years 2000–2005, with the decision of starting at 2000 because of the limited numbers that the CINAHL sample revealed for the years 1998 and 1999. A total of 519 results occurred, the same number as when 'building research capacity' was used. A manual deletion of those from pure and applied science and those not written in the English language was undertaken. Also removed from this listing were those titles that did not relate to research. This gave a sample of 78 results with 15 overlaps with the CINAHL sample, reducing the PubMed sample to 63. The total sample was thus 162 titles. A random sample of 20% ($n = 32$) was generated from the 162 titles after one publication by the author (SC) and one publication previously reviewed for segment one were removed. Inter-library loans were ordered if the papers were not available within the researchers' own library. The final total of all literature used in this analysis was 57, and consisted of nine reports, discussion papers and books on capacity building, 16 research policy documents and 32 peer-reviewed journal papers (See Tables 1–3).

RESULTS

An initial phase of Rodgers' framework[20] is the identification of surrogate terms and their uses. For capacity

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Table 1 The sample of 'grey' and published literature on 'capacity building'

No.	Type	Year	Author	Agency/Discipline	Title
1.1	Discussion paper	1995	Paul[24]	WHO	Capacity building for health sector reform
1.2	Literature review	1999	Lusthaus *et al.*[11]	Universalia for UN	Capacity development: Definitions, issues and implications for planning, monitoring and evaluation
1.3	Report	1999	Unknown	UNDP/UNICEF[15]	Planning and monitoring of capacity development: Workshop report
1.4	Book	1999	Maconick & Morgan[13]	UN	Capacity building supported by the UN—Some evaluations and some lessons
1.5	Peer-reviewed paper	2001	Harrow[17]	Management	'Capacity building' as a public management goal
1.6	Paper	2001	Milén[22]	WHO	What do we know about capacity building? An overview of existing knowledge and good practice
1.7	Report	2002	UN Secretary General[14]	UN Economic & Social Council	United Nations system support for capacity building
1.8	Book	2002	Fukuda-Parr *et al.*[25]	UNDP	Capacity for development: New solutions to old problems
1.9	Peer-reviewed paper	2004	Potter & Brough[10]	Health policy	Systemic capacity building: A hierarchy of needs

UN, United Nations; UNDP/UNICEF, United Nations Development Programme/United Nations Childrens Fund; WHO, World Health Organization.

building, the surrogate terms were capacity development, capacity strengthening and capacity enhancement. Malik suggests that the literature on capacity development is immense and it is from here that the term 'capacity building' arises.[21] Milén[22] claims that the three terms have slightly different connotations but along with others[11,15] uses the terms interchangeably. Morgan[23] outlines that the differing connotations deal with improving or utilizing what already exists rather than the 'starting from scratch' which some authors[9] consider the word 'building' to imply.

Segment one

The concept analysis identifies the attributes or primary characteristics of the concept. These attributes must always be present. The literature in segment one was a purposive sample of mixed source literature on 'capacity building' (Table 1). Here the following attributes were present.

A *dynamic* (responsive, creative, expansive) *intervention* (activity, strategy, technique) to *augment* (build, strengthen, improve) *ability* (capacity, capability) to carry out functions or achieve objectives over the *long term* (sustainability, time) with aspects of *social change* (participatory, ownership, partnership) as an ultimate outcome. The concept has a number of levels, differing dimensions and a focus from broad to narrow and can be viewed as both a process and product, with both supply and demand drivers.

A further phase of Rodgers' framework requires the recording of antecedents, consequences and references. Within some of the literature[14,22,24,25] an antecedent was the definition of capacity. Others gave exemplars of capacity building,[12,13] guidance for its operation[15,22] or discussed issues for strategy formation,[24] thus building the context in which the concept was used. The phase of identifying related concepts was assisted by Lusthaus *et al.*[11] listing the conceptual predecessors as institution building, institutional development, human resource development, development management/administration and institution strengthening, although earlier Paul[24] had noted overlap between some of these concepts. The central reference of the concept was situations requiring development. A particular difficulty with this piece of the analysis has been the emphasis within the reviewed

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Table 2 The sample of research capacity building reports and strategies

No.	Year	Author	Discipline	Agency	Title
2.1	2000	See Agency	Nursing	Department of Health (UK)[33]	Towards a strategy for nursing research and development
2.2	2000	See Agency	Nursing	R&D Office, NIHSSCSA[44]	Building R&D capacity within nursing
2.3	2000	Marks & Godfrey[29]	HR/HSR	Nuffield	Developing research capacity within the NHS: A summary of the evidence
2.4	2000	Aleta[45]	HR/HSR	Alliance for Health Policy & Systems Research	A decade of health systems research
2.5	2000	Unknown	HR/HSR	Alliance for Health Policy & Systems Research[77]	HPSR capacity strengthening: Report on consultation, Bangkok
2.6	2000	McIntyre & McIntyre[30]	Education	ESRC TLRP	Capacity for research into teaching and learning
2.7	2001	Furlong & White[37]	Education	Universities Council for the Education of Teachers	Educational research capacity in Wales
2.8	2001	Gorard[46]	Education	ESRC TLRP	A changing climate for educational research? The role of research capacity building
2.9	2002	See Agency	Nursing	Scottish Executive[47]	Choices and challenges: The strategy for research and development in nursing and midwifery in Scotland
2.10	2002	See Agency	HR/HSR	Global Forum for Health Research[7]	The 10/90 report on health research 2001–2002
2.11	2002	Taylor[78]	Education	ESRC TLRP	The RCBN consultation exercise: Stakeholder report
2.12	2003	See Agency	Nursing	Department of Health & Children[78]	Research strategy for nursing and midwifery in Ireland
2.13	2004	See Agency	Nursing	Welsh Assembly Government[34]	Realising the potential, Briefing Paper No. 6 Achieving the potential through research and development
2.14	2004	See Agency	HR/HSR	World Health Organization[31]	Report from the ministerial summit on health research
2.15	2005	Nuyens[3]	HR/HSR	Global Forum for Health Research	No development without research, a challenge for research capacity strengthening
2.16	2005	McCance & Fitzsimons[35]	Nursing	NIPEC	Using and doing research: Guiding the future

ESRC TLRP, Economic and Social Research Council's Teaching and Learning Research Programme; HR/HSR, Health Research/Health Services Research; NIPEC, Northern Ireland Practice and Education Council for Nursing and Midwifery; R&D, Research and Development.

literature on intellectual exploration of the concept. Although this is useful in assisting clarification of thought, it reiterates the need for steps two and three for analytical comprehensiveness of the usage of the concept.

Segment two

Research policy documentation was the focus of segment two of the analysis, with Table 2 showing the literature that was reviewed. The purposive sample was again drawn from 'grey' literature and was for the years 2000–2005. A mix of disciplines was obtained being Health Research/Health Services Research (HR/HSR) ($n = 6$), Education ($n = 4$), Nursing and Midwifery ($n = 6$). A surrogate term was 'capacity strengthening', which was used in the HR/HSR literature.

Within this research capacity building literature the attributes remained as in segment one. One additional attribute was found and that was the element of *funding*

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Table 3 The 20% random sample of peer-reviewed journal papers (Title as per reference)

No.	Year	Author	Discipline
3.1	1998	Newell *et al.*[48]	Nursing
3.2	2000	Sitthi-amorn & Somrongthong[47]	HR/HSR
3.3	2000	Cooke & Green[7]	Nursing
3.4	2000	Editorial, The Lancet[4]	Medicine
3.5	2000	Bligh[43]	Medicine
3.6	2001	Williamson[50]	Nursing
3.7	2001	Riley *et al.*[51]	HR/HSR
3.8	2001	Hubbard *et al.*[52]	Nursing
3.9	2002	Reading & Nowgesic[53]	HR/HSR
3.10	2002	Farmer & Weston[54]	HR/HSR
3.11	2002	Boon & Verhoef[64]	HR
3.12	2002	Thompson[55]	Nursing
3.13	2003	Jackson *et al.*[56]	HR/HSR
3.14	2003	Smith & Edwards[57]	Nursing
3.15	2004	Pearson[58]	Nursing
3.16	2004	Roberts *et al.*[59]	HR/HSR
3.17	2004	Rafferty & Traynor[60]	Nursing
3.18	2004	Joffres *et al.*[37]	HR/HSR
3.19	2004	Brazil *et al.*[42]	Nursing
3.20	2004	Langsang & Dennis[40]	HR/HSR
3.21	2004	Haas[61]	HR/HSR
3.22	2004	Ross *et al.*[62]	Nursing
3.23	2005	Grange *et al.*[38]	Nursing
3.24	2005	Gerrish *et al.*[63]	Nursing
3.25	2005	Darbyshire *et al.*[64]	Nursing
3.26	2005	Macfarlane *et al.*[65]	HR/HSR
3.27	2005	Royall[66]	HR/HSR
3.28	2005	Hofman *et al.*[67]	HR/HSR
3.29	2005	Cooke[39]	HR/HSR
3.30	2005	Stillman *et al.*[68]	HR/HSR
3.31	2005	Pirkis *et al.*[69]	HR/HSR
3.32	2006	Frontera *et al.*[41]	Medicine

HR/HSR, Health Research/Health Services Research.

for capacity building. There were some differing emphases of attributes both within and across the discipline sources. Socio-political impact tended to be focused on the professional grouping rather than to society at large with the exception of Taylor.[26] The attribute of sustainability was more explicit in the HR/HSR literature although implicit in the emphasis on career pathway development across all areas. Education and training remained a key intervention across the disciplines, and together with career issues gave a strong focus at the level of the individual. However, broader levels were represented through issues such as funding, network and partnership development, priority setting and a large emphasis across all the literature on multidisciplinary research. The later literature recognized the role of leadership for strategy implementation and for nursing, specifically, representation at all levels was a key intervention. Although these documents themselves were responses to what was identified as a capacity gap, less tangible within this literature was a sense of dynamism to the interventions. There appeared to be much repetition of the types of interventions, if just couched in differing terminology. The need for evaluation of efforts[7] and a conceptual framework[8] were recognized.

The antecedents in this segment differed to those in segment one. Only three reports gave definitions of capacity building.[8,27,28] However, research capacity was defined[28–31] and some reports noted that the boundary of research for the discipline was viewed as problematic with difficulty in defining educational[32] and nursing research.[33–35] References of the concept within this literature were either countries or disciplines that were deemed to be well developed in research with a sense that marginalization had occurred because of low numbers and the lack of opportunity.

Segment three

Peer-reviewed literature was the focus of segment three (Table 3). Again, a mix of disciplines was contained in the sample and it was stratified for the time frame searched. The sample contained literature reporting on researching capacity building as well as capacity building for research and unsurprisingly, there were no additional attributes found for the concept. Funding remained central to the concept and this literature as a whole showed the concept used on a number of levels and from the narrow focus of individual training and research careers to the broad foci of networking or priority setting. The issue of a long-term perspective and sustainability remained stronger in the HR/HSR literature than in nursing and the need for a multidisciplinary approach was found across all the disciplines in the sample. Of note in this segment was the criticism that the concept lacked an evaluation framework.[36,39]

Antecedents within this segment consisted of four papers giving definitions of research capacity building[2,39–41] with a further three giving definitions of research

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capacity.[38,42,43] References of the concept were similar to segment two and the surrogate terms of capacity strengthening and capacity development were present.

DISCUSSION

The coalescence of primary characteristics identified in each of the three segments lends credence to the final description of the concept 'research capacity building' using the attributes found. The addition of 'funding' as an attribute derived solely from segments two and three is understandable, given that the literature in segment one was in large part from supra-developmental agencies with the attribute implied. The mix of antecedents across the segments showed no disciplinary trend. Instead, it might point to the struggle of writers when dealing with the concept and show attempts to clarify meanings for their readers. Reasons for disciplinary differences in emphasis of attributes, such as sustainability for HSR, were not found in the literature reviewed and as such lie outside the scope of this conceptual analysis exercise. The reference to the usage of the concept was consistent across the segments as filling a developmental need.

Using computerized databases to generate listings is one of the strengths of Rodgers' framework in that it gives the total population of indexed literature. The use of this concept appears to be policy-driven, which can mean that the literature in which it is utilized is not indexed. This exercise attempted to overcome this issue by balancing the sources of the literature reviewed between indexed and non-indexed. Rodgers emphasizes three types of sampling of the literature to enhance the rigour of the analysis: sampling across disciplines, across time and conducted systematically.[20] Although all three sampling types were attempted in this exercise, such sampling was hampered by the dependency of downloadable 'grey' literature and the limited use of the concept in peer-reviewed literature. Additionally in this exercise, the databases used for the indexed literature focused on disciplines under the broad band of 'health'. Although this generated some mix of disciplines, it could have been greater had other databases been searched as well.

It was noted that key published peer-reviewed literature from nursing and midwifery on the topic remained outside the index generated by the search. Although this could have been due to the search terms used, it was more likely due to variance in indexing procedures, as Rodgers[20] notes, or databases not holding a comprehensive listing of all journals published in the field. The time frame chosen for searching (9 years for 'grey' literature, 7 years for CINAHL and 5 years for PubMed) was also a limitation but reflected the growing usage of the term across the literature and its move from policy to peer-review.

No other systematic analysis of the concept was found in the literature. A critical literature review on the topic, with a focus on one level of operation only, that of academic departments, has been conducted by Segrott *et al.*[3] Using a 5-year time frame only, a broader range of search terms and slightly different databases (Social Science Citation Index, Medline and CINAHL), their search generated a similar size but differing sample of 150 papers, only 47 of which were deemed relevant for inclusion in their review. Their review was supplemented by manual 'shelf searches' which together with the differing database search strategy might account for only five of the papers from that review being included in the concept analysis reported here.

CONCLUSION

From this exercise, the current usage of the concept 'research capacity building' implies a funded, dynamic intervention operationalized through a range of foci and levels to augment ability to carry out research or achieve objectives in the field of research over the long-term, with aspects of social change as an ultimate outcome.

However, caution needs to be applied. The result of the concept analysis should not be viewed as a fixed definition given the evolutionary nature of the concept[14] and the multiple sources such as policy, academic and practitioner literature.[17] Additionally, Morgan suggests that definitions might be too abstract to be of assistance outside of the context of specific programmes.[23] Nevertheless, in the context of usage of the term 'research capacity building' that indicates a lack of shared understanding of its meaning, a concept analysis such as this, which provides an interim statement, acts as a useful reference for further debate and critical thinking.

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Appendix 2: Tables of Practice Ethnography Summaries

Author	Nettleton	Fox	Street	Hunt & Symonds	Gerrish
Year	1992	1992	1992	1995	1998, 2000
Country	UK	UK	Australia	UK	UK
Health professional	Dentists	Surgeons	Nurses	Midwives	Nurses
No. of sites	2 clinics	4 hospitals.	1 hospital	2 hospitals.	6 district nursing teams
Researcher	Observer	Observer	'Participant Observer'[1]	Participant Observer	Participant Observer
Length of data collection	'winter'	18 months	9 months	6 months	6 months
Author	**Latimer**	**Allen**	**Savage & Moore**	**Gabbay & le May**	**Hunter**
Year	2000	2001	2004	2004	2004, 2005
Country	UK	UK	UK	UK	UK
Health professional	Nurses	Nurses	Primary Care Team	Primary Care Team	Midwives
No. of sites	1 Hospital	2 hospitals.	1 setting	2 settings.	1 hospital + community in 1 NHS Trust
Researcher	Participant Observer	Participant Observer	Participant Observer	Observer	Observer
Length of data collection	8 months	10 months	6 months	Intermittent over 2 years	12 observations over 8 months

Table A2:1: Summaries of ethnographies of practice

[1] Of note, is the somewhat loose term of 'participant observation' with some authors (Hughes, 1988; Street, 1992) claiming it as a method of data collection, though unlicensed to practise nursing *per se*.

Author	Hughes	Savage	Porter	Allen	Johnson
Year	1988	1995	1995	1997	1997
Country	UK	UK	UK	UK	UK
Focus of Interaction	Nurse-doctor	Nurse-patient	Nurse-doctor	Nurse-doctor & others	Nurse-patient
No. of sites	1	2	1	2	1
Type of site	A&E	General ward	Critical care	General ward	General ward
Role of researcher	'Participant Observer'	Participant Observer	Participant Observer	Participant Observer	Participant Observer
Length of data collection	10 months	12 months	3+ months	10 months	'summer months'
Author	**Wicks**	**Brooks & MacDonald**	**Manias & Street**	**Coombs**	**Dykes**
Year	1998	2000	2001	2004	2005
Country	Australia	UK	Australia	UK	UK
Focus of Interaction	Nurse-doctor	Nurse-nurse	Nurse-doctor	Nurse-doctor	Midwife-client
No. of sites	1	1	1	3	2
Type of site	General ward	General hospital	Critical care	Critical care	Maternity wards
Role of researcher	Participant Observer	Observer	Participant Observer	Participant Observer	Participant Observer
Length of data collection	6 months	4months	3 years	9 months	2 year span

Table A2:2: Summaries of ethnographies of interaction

Appendix 3 – Documents supporting Chapter 3

Appendix 3.1 Context Analysis grid

	CNMF	Supervisor	Research participants	Clinicians	Researchers	NRA	HRB Staff	HRB Board
CNMF	HRB media events	Supervision meeting	Data collection (varies)	Feedback Conference Data collection Ethics clearance	Tutorials Conference Ethics clearance Viva	Conference HRB media events Interview Email & telephone contact	HRB media events Email & telephone contact Reports	HRB media events Interview panel Board documents
Supervisor	Supervision meeting						Website Newsletter Publications	
Research participants *Clinicians*	Data collection (varies)							
	Feedback Conference Data collection Ethics clearance					Promotion of CNMF scheme Individual advice		
Researchers	Tutorials Conference Ethics clearance Viva					Promotion of CNMF scheme Individual advice		
NRA	Conference HRB media events Interview Email and telephone contact			Promotion of CNMF scheme Individual advice	Promotion of CNMF scheme Individual advice		Website Newsletter Publications	
						Promotion of CNMF scheme Individual advice	Team & HRB meetings HRB social events Email & telephone	Interview panel HRB media events
HRB Staff	HRB media events Email and telephone contact Reports	Website Newsletter Publications			Website Newsletter Publications	Team & HRB meetings HRB social events Email & telephone		
HRB Board	HRB media events Interview panel Board documents					Interview panel HRB media events		

Context analysis grid to guide data collection (following Schwartzman 1993)

Figure A3.1: Context Analysis Grid

Appendix 3.2 Letter of Approach to HRB Fellows



Dear colleague,

As a fellow doctoral student, this letter is requesting assistance from you in relation to my own studies and the approach that I am now making to you has been approved by the Health Research Board.

I am conducting an ethnographic study with a working title of *Building individual research capacity in an emerging discipline in Ireland*. As part of this I hope to develop narratives of how nurses and midwives make the transition to researcher. This includes issues of identity, skill development and the activities undertaken to give social meaning to being a researcher. I also wish to gather opinions on the value of such an award to the integration of nursing and midwifery to the health research arena and consequent development as a professional research discipline. My study involves following nurse or midwife HRB Fellows during a period of their award for doctoral studies. Data collection methods will include diary keeping by Fellows at key time points, in-depth interviews and/or focus groups, and observation. I fully recognise that not all methods of data collection may be possible depending on your own research. I would be happy to consider with you the most relevant approach to your own situation that would not impinge on your own research, especially with regard to the time involved. The research design is flexible to allow for variation in data collection methods over the timeframe of the award and the type of activity that you are undertaking. With your permission, I will also inform others involved e.g. your supervisor. The issue of anonymity and confidentiality is extremely important and all steps will be taken to ensure that you or your research is not identifiable in the final thesis or any papers developing from the study. You are under no obligation under the terms and conditions of the Fellowship Award to participate in this study. However, I hope you will give this request due consideration.

I would be happy to discuss the issue further and address any concerns you may have before you make the decision on whether to participate. I would be willing to meet at a time and place convenient to you and may be contacted by telephone (087-2394109) or email (scondell@hrb.ie).

I look forward to hearing from you. Regardless of your decision to participate in this study, as the Nursing Research Advisor in the Health Research Board may I congratulate you on being awarded the Clinical Nursing and Midwifery Fellowship and I wish you every success with this wonderful opportunity.

Yours sincerely,

Sarah Condell
Nursing Research Advisor.

Appendix 3.3 Consent form and supporting documents

TRINITY COLLEGE DUBLIN
Research Involving Human Participants
INFORMED CONSENT FORM

Project: Building individual research capacity in an emerging discipline in Ireland

Principal Investigators: Sarah L. Condell

DECLARATION:

This study and this consent form have been explained to me. The investigator has answered all my questions to my satisfaction. I understand what will happen if I agree to be part of this study. I have read, or had read to me, this consent form and the information sheet outlining the role of the Nursing Research Advisor in the Health Research Board. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights. I have received a copy of this agreement.
I understand I may withdraw from the study at any time.

PARTICIPANT NAME:
.....

CONTACT DETAILS:.....

PARTICIPANT'S SIGNATURE:
.....

Date:.....

Statement of investigator's responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

INVESTIGATOR'S SIGNATURE:.....

Date:.....

(Keep the original of this form in the investigator's file, give one copy to the participant).

HRB Fellows Consent

1. Title of study: Building individual research capacity in an emerging discipline in Ireland

2. Introduction:
This is a unique time for Irish nursing and midwifery and specifically its emergence as a research-based profession. Education for registration as a nurse is at now degree level and this affords nurses an academic career with inherent research capacity. However, the HRB Clinical Nursing and Midwifery Fellowship scheme in particular, is aimed at experienced nurses and midwives whose professional socialisation has been embedded primarily in practice. The social change from practising nurse or midwife to Fellow and the process of individual adaptation to the new culture of health research over time will be examined (the field of the Fellow). This ethnographic study will also examine how policy is enacted in practice through the integration of nursing and midwifery to the health research arena. This will occur by seeking the opinions of key stakeholders, documentary analysis of HRB documentation, and the reflective diary of the Nursing Research Advisor in the HRB (the field of the Researcher).

Data collection will be over a 2 year period (data collection is until September 2007) for both fields. Your own time commitment is dependant on the data collection methods which you choose (see 3). You may opt out of the study at any time.

3. Procedures: Data will be collected at purposive sampled times, and settings. Data collection may extend into the period when you have completed your Fellowship and own study. These will be identified by you, together with the researcher. The types of settings may include libraries, laboratories, tutorial and supervision sessions, conferences etc. The types of times may include searching the literature, seeking ethics approval, collecting data, dissemination your work.
The optional data collection methods are in-depth qualitative interviews, focus groups, observation, diary keeping. If you agree to participate, you may choose which method to use at which time and setting. Please note, **observational data will not occur during your own data collection with patients**.
Your academic supervisor will be supplied with Briefing Note on the study, if appropriate.

4. Benefits: The reflection you may undertake for this study may assist in your own work. This is also an opportunity for you to voice your opinions with regard to the themes being studied.

5. Risks: If during data collection, the researcher becomes aware of unethical practice in your own study, it will be brought to your attention. However, the seriousness of unethical practice means that it will also be reported under academic and/or professional codes of conduct to the necessary bodies.

6. Exclusion from participation: Those awarded HRB CNMF at Masters Level only. In addition, any nurse or midwife holding a Fellowship award, where there is a pre-existing supervisory relationship with the researcher.

7. Confidentiality:
Your identity will remain confidential. Your name will not be published and will not be disclosed to anyone outside the study group. You will be assigned a code, known only to the Researcher. This code will reflect the stage of the Fellowship you are at when the data is collected and so will change over the course of the study. Descriptors will be given to any of the settings in which data is collected e.g. hospital, university library. You will be given a list of the descriptors applying to your data and the opportunity to discuss changes where you think there is identifiable material. Any data for verification (e.g. interview transcripts) will be sent to a postal address which you will supply and the envelope marked private and confidential.

8. Compensation:
This study is covered by standard institutional indemnity insurance. Nothing in this document restricts or curtails your rights.

9. Voluntary Participation: You have volunteered to participate in this study. If you decide not to participate, or if you quit, you will not be penalised. Participation in this study does not affect the terms and conditions of your award from the HRB. You may quit at any time. Your consent will be sought verbally at each data collection point.

10. Stopping the study: You understand that the investigators may stop your participation in the study at any time without your consent.

11. Permission: This study has Research Ethics Committee approval from TCD Faculty of Health Sciences. The HRB has given permission for the study to be conducted.

12. Data not utilised: Ethnographic studies generate copious amounts of data which means that not all data is utilised in the final ethnography. In the case of data not used for the final report and pertaining to you, your permission will be sought for any subsequent usage up to its destruction five years post completion of the study.

13. Further information: You can get more information or answers to your questions about the study, your participation in the study, and your rights from Sarah Condell, who can be contacted by email at scondell@hrb.ie or by telephone at-087-2394109

Consent form supporting document 1.

Briefing Note to Supervisors



Dear colleague,

I am currently conducting an ethnographic doctoral study with a working title of *Building individual research capacity in an emerging discipline in Ireland.* This involves data collection on individual nurse and midwife HRB Fellows experiences, behaviours and the attached social meanings across the timeframe of their Fellowship award. The data will allow the development of narratives of how the Fellows make the transition to researcher and this will be set against the context of the integration of nursing and midwifery to the health research arena and consequent development as a professional research discipline. The data will be collected by a number of methods, with the degree of utilisation varying over the timeframe of participation and negotiated individually with each participant. The methods are in-depth qualitative interviews, focus groups and a diary kept by the Fellow for a two month period at key stages. I also hope to shadow and observe Fellows at purposive sampled times and in purposive sampled settings. Observation may occur at social as well as solitary settings and thus includes Fellows' offices, academic libraries, laboratories, student tutorials, attendance at conferences, supervisory sessions etc. Observation will not occur during the Fellow's own data collection with patients. Verbal consent will be sought as necessary during observation periods. To maintain confidentiality in such a small cohort of participants, Fellows will be anonymous and identified in the final report only by a code which will reflect the stage at which they are at when the data is collected i.e FY2.(Fellow Year Two). Similarly, specific settings will be identified only by a descriptor e.g. university library, hospital etc. All Fellows will be issued with a list of descriptors as they are developed and given an opportunity to refine any which may be thought to contain identifying features.

There are some benefits for the students who participate in that the reflection they undertake may assist in their own work.

I have approached Ms. Nurse, who, after a period of reflection and clarification has agreed to participate. I understand you are the primary supervisor for their Fellowship. May I reassure you that in negotiating the data collection methods with Ms. Nurse, I shall endeavour to ensure that this study does not impinge in any way on Ms. Nurse's own field of study. This includes the time commitment that will be required. I would be happy to discuss the issue further and address any concerns you may have as Ms. Nurse's supervisor. I would be willing to meet at a time and place convenient to you and may be contacted by telephone (087-2394109) or email (scondell@hrb.ie).

This study has the support of the HRB and has been approved for ethical clearance by the TCD Faculty of Health Science Ethics Committee.

Sarah L. Condell
Nursing Research Advisor.

Consent form supporting document 2.

Information Sheet for HRB Fellows.



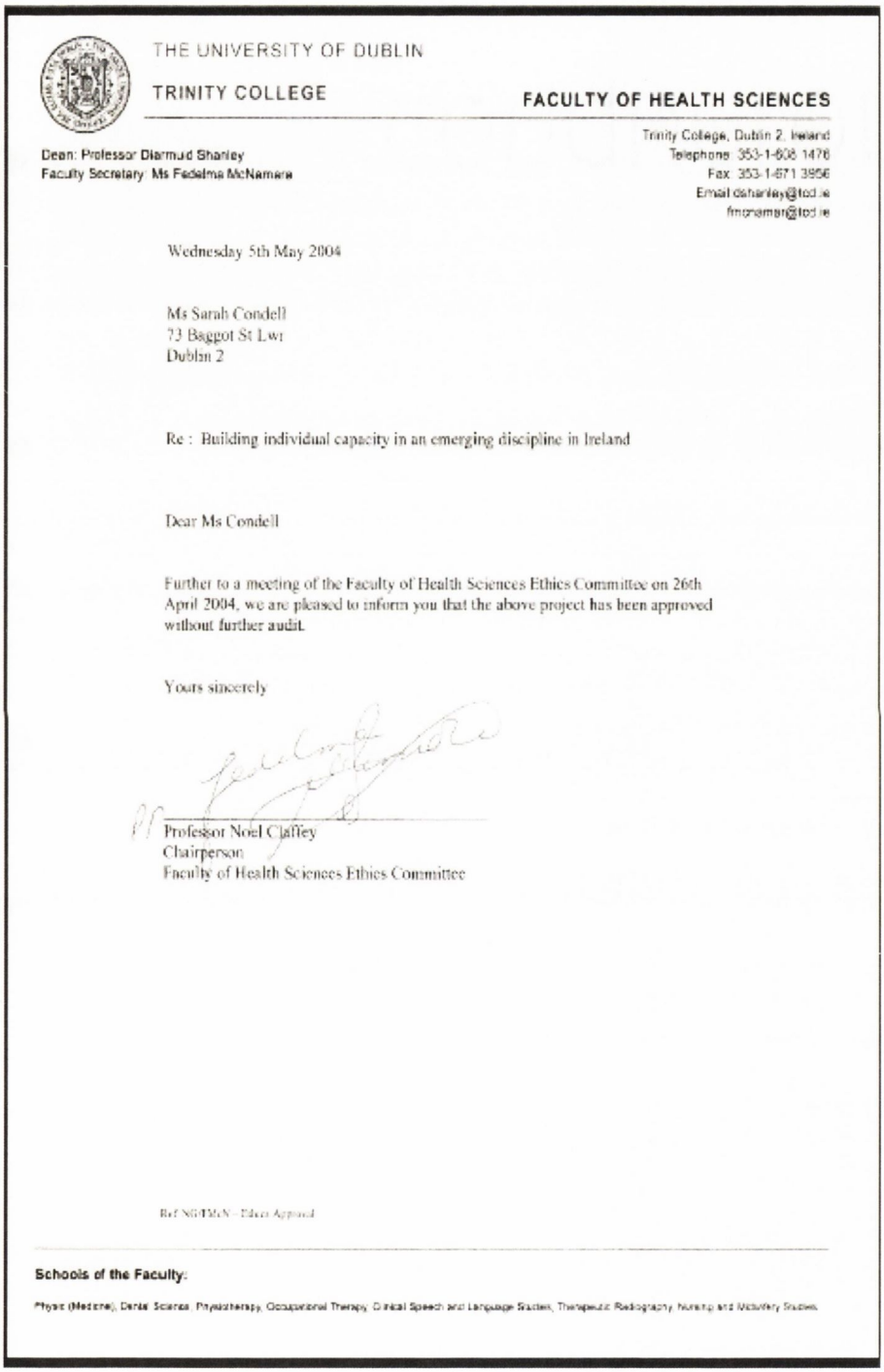
Role of the Nursing Research Advisor.

The Nursing Research Advisor (NRA) was established in 1999, on a part-time basis. The post has since developed into a full-time joint appointment with the National Council for the Professional Development of Nursing and Midwifery's role of Research Development Officer in order to lead the implementation of the *Research Strategy for Nursing and Midwifery in Ireland* (Department of Health and Children, 2003).
Whilst there are elements of overlap in the totality of the joint appointment role, the primacy of the Nursing Research Advisor role remains the same as when first established. The focus is on building research capacity through existing HRB schemes and activities, advising and representing the HRB in relation to the profession and acting as a communication conduit between the HRB and the profession. As such, the NRA may act as the first point of contact between a nurse or midwife and the HRB, especially as potential applicants to schemes . However, there is no formal power relationship with individual Fellows. Instead, the administration of the award is managed by the Research Grants Manager, and the academic supervision is provided by the Institution which holds the award on behalf of the Fellow

As a participant in the study *Building individual research capacity in an emerging discipline in Ireland*, the fact that the researcher also holds the position of NRA in the HRB does not in anyway affect the terms and conditions of the award that you have successfully obtained. Likewise, as a HRB Fellow, there is no obligation on you to participate in the study, just because the researcher also holds the position of NRA in the HRB.

If you have any questions or wish to seek further clarification, I may be contacted by telephone (087-2394109) or email (scondell@hrb.ie).

Appendix 3.4 Letters confirming ethical approval



THE UNIVERSITY OF DUBLIN

TRINITY COLLEGE

FACULTY OF HEALTH SCIENCES

Dean: Professor Diarmuid Shanley
Faculty Secretary: Ms Fedelma McNamara

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Wednesday 5th May 2004

Ms Sarah Condell
73 Baggot St Lwr
Dublin 2

Re : Building individual capacity in an emerging discipline in Ireland

Dear Ms Condell

Further to a meeting of the Faculty of Health Sciences Ethics Committee on 26th April 2004, we are pleased to inform you that the above project has been approved without further audit.

Yours sincerely

Professor Noel Claffey
Chairperson
Faculty of Health Sciences Ethics Committee

Ref NC/EMAN - Ethics Approval

Schools of the Faculty:

Physic (Medicine), Dental Science, Physiotherapy, Occupational Therapy, Clinical Speech and Language Studies, Therapeutic Radiography, Nursing and Midwifery Studies

Sarah
we are puzzled
about when the
letter want to -
we have no record
of receiving it.
At all events, the
message is positive!
Best wishes
RB

24th May, 2004

Dr. Ruth Barrington,
Chief Executive,
Health Research Board,
73 Lower Baggot Street,
Dublin 2

Dear Dr. Barrington,

I acknowledge receipt of your letter of 18th May, together with copy letter dated 5th May from the Chair of the Ethics Committee of the Faculty of Health Sciences in Trinity College.

This seems to be an interesting piece of research and I wish Sarah the best of luck in the project.

Yours sincerely,

Michael Griffith
Chair
Research Ethics Committee
Health Research Board

Appendix 3.5: Table of Data Collection episodes

M 1	M 2	M 3	M 4	M 5	M 6
3 interviews	5 interviews	1 interview	2 interviews		
1 observation	3 observations	1 observation		2 observations	
NRA Diary	NRA Diary	NRA Diary	NRA Diary	NRA Diary	NRA Diary
M 7	**M 8**	**M 9**	**M 10**	**M 11**	**M 12**
1 interview	1 interview	1 interview			1 interview
2 observations			2 observations		
NRA Diary	NRA Diary	NRA Diary	NRA Diary	NRA Diary	NRA Diary
M 13	**M 14**	**M 15**	**M 16**	**M17**	**M18**
4 interviews		1 interview	1 interview	1 interview	2 interviews
	1 observation		2 observations		
NRA Diary	NRA Diary	NRA Diary	NRA Diary	NRA Diary	NRA Diary
M19	**M20**	**M21**	**M22**	**M23**	**M24**
No data collected due to illness	No data collected due to illness	1 interview	3 interviews	1 interview	
				1 observation	
		NRA Diary	NRA Diary	NRA Diary	NRA Diary
M 25	**M 26**	**M 27**	**M 28**		
1 interview	1 interview		2 interviews		
	2 observations				

Key:

Field of the Fellow	Field of the Funder

Scatter of data collection sessions across the timeframe.

Table A3.5: Table of Data Collection Episodes

Appendix 3.6 Interview Schedules

Interview schedule CNMF1,2,3.
Please note that this schedule may change to reflect on-going analysis during the data collection period and further refinement of the research questions. As the interviews will be unstructured the following questions may be used in any order and further prompting questions may be asked as the interview develops.

What are the developmental processes involved in capacity building at the level of the individual?
How does the HRB Fellow develop the skills of research capacity?
What facilitates or hinders the development of these skills?
Do these skills change over the Fellowship timeframe?
How does the HRB Fellow identify him/herself as a health researcher?
What are the activities undertaken to give that meaning to him/herself and others?
How does that differ from his/her identity as a nurse or midwife?
Does duality of identity or movement between identities occur and, if so, how is it managed?
What is the social adaptation that is required of the individual to move to the culture of health research?
How does institutional infrastructure assist or hinder this adaptation?
What is the value of the CNMF to the integration of nursing and midwifery to the health research arena and consequent development as a professional research discipline?

Interview schedule CNMF (F).
How did you find the experience of being a CNMF?
What, for you were the key moments/points of the CNMF? Why? How did you manage these key points? What are the developmental processes involved in capacity building at the level of the individual?
What sort of skills did you acquire over the CNMF? How did you develop them? What facilitated or hindered the development of these skills? Did these skills change over the Fellowship timeframe? Did these differ from skills you held previously, How? Do you use these skills currently? Which ones, how?
How did identify yourself - as a health researcher or nurse researcher? What were the activities undertaken to give that meaning to yourself and others? Presentation/publication – which arena? If health researcher, how does that differ from your identity as a nurse or midwife? Does duality of identity or movement between identities occur and, if so, how is it managed?
What was the social adaptation that was required to move to the culture of health research?
How does institutional infrastructure assist or hinder this adaptation?
What has been the value of the CNMF Scheme to you? – personally, career
What, in your opinion, is the value of the CNMF to the integration of nursing and midwifery to the health research arena and consequent development as a professional research discipline?

Appendix 3.7 Condell (2008)

FOCUS

Writing fieldnotes in an ethnographic study of peers – collaborative experiences from the field

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PhD student
Trinity College, Dublin

Abstract Fieldnotes and their processes tend to be implicit endeavours in the nursing and midwifery literature. The opportunity, therefore, to build an understanding of the social practice of this part of the research process is lost. This paper explores fieldnote generation in an ethnographic doctoral study examining the building of research capacity. Ethnographers claim that data is generated collaboratively. In this study, data was collected from two fields of 'peers'. First data set contained 50 h of observation with doctoral research fellows, and the second data set contained 2 years diary recording of a nurse working in a national research funding agency. The paper shows that the levels of collaboration in constructing the ethnographic data can depend on the field itself, the stance of the researcher and the willingness of peer participants.

Key words collaboration; ethnography; fieldnotes; peers

Introduction

Agar (1996; p. 4) in his seminal work on ethnography states that data is 'actively constructed over time in a collaborative way'. Thus, ethnographic data is studiously generated and not merely passively collected. For Hammersley and Atkinson (1995), the field researcher is the tool of data generation but such a statement oversimplifies a complex, purposive process and fails to acknowledge the input of others. This paper describes just such an aspect from a doctoral study examining the building of research capacity. The data generated for this study was with peers either as fellow doctoral students or work colleagues. This paper is an exploration of how fieldnotes for the study were generated, including a reflective account of constraint on their development and the differences stemming from differing ethnographic roles being adopted in the field.

Allen (2004) has called for systematic reports of fieldwork processes. The writing of fieldnotes is often an invisible part in fieldwork processes (Emerson, et al., 1995;

Montgomery and Bailey, 2007), yet these are the 'raison d'etre' of the observer (Lofland, 2004). This paper aims to help address a gap in the nursing and midwifery literature whereby the 'explicit pragmatics' (Montgomery and Bailey, 2007; p. 66) of fieldnotes are explored. There is broad variation of what ethnographers regard as fieldnotes and their practices (Emerson, et al., 2001) although similar qualities are found in the majority of descriptors used (Montgomery and Bailey, 2007). The term spans the single words written as reminders through the interpretative, analytical accounts. This paper reviews fieldnotes as the processes of 'raw' writings that occur in or immediately following the exit from a data gathering 'session'.

Context of skill development

Borbasi, et al. (2005) have noted the skills of observation and jotting notes that nurses, such as myself, bring to fieldwork develop from the experience of clinical practice. For nursing, a key competency is the skill of observation. This is usually focused on patients and their families and can include aspects such as body language, clinical condition and mood. Although acknowledging that research observation differs from clinical observation in its construction and organisation (Lawlor, 2003; Mulhall, 2003), experienced nurses, nevertheless, have a legacy of using the visual sense to interpret the world. A second legacy of my clinical practice was that of note taking. In practice, short-written notes were based on the lengthier, verbal 'handover' report of patients from the previous nursing shift. Such jottings consisted of both retrospective actions and planned activities personalised and written in shorthand by each nurse. Contents included key nursing tasks, important numerical data such as blood tests and forthcoming events such as ward admissions. These jottings were added to as the shift progressed and referred to when compiling the end-of-shift report. They formed an informal record by each individual nurse as opposed to the shared, formal documentation of patient care. They have been described and investigated as part of ward culture elsewhere (Hardy, et al., 2000). Such a skill base was fundamental for developing further craft skills in the ethnographic field.

The study

The study explored the building of research capacity. A review of the literature had showed that research capacity is built on many different levels with funding being a key element (Condell and Begley, 2007). An opportunity arose to examine the phenomenon from both an individual and a policy perspective in the emerging academic discipline of nursing and midwifery within an Irish context (Treacy and Hyde, 2003). Degree level undergraduate registration education was only introduced nationally in 2002. Doctoral programmes are very recent additions (NCNM, 2006) and up to 2005 consisted of the traditional PhD with a substantive piece of research followed by a viva voce. In Ireland, employment in the higher educational institute (HEI) schools of nursing and midwifery has a minimum entry criterion of Masters level qualification (Begley, 2001; Condell, 2004) but a PhD is increasingly a requirement for tenure and promotion. A mapping exercise in 2003, conducted shortly before data collection for this study, showed 18 nurses and midwives employed in HEIs with PhDs and a further 36 registered on PhD programmes from a total nursing and midwifery staff of 267 (NCNM, 2006)

Ethical clearance was granted by the Faculty of Health Sciences Ethics Committee in the University of Dublin, Trinity College and the Health Research Board. The study

entailed tracking over a 29-month time frame, funded nurses or midwives, known as Clinical Nursing and Midwifery Fellows (CNMFs) who were carrying out individual PhD studies on a full-time basis, whilst simultaneously recording the work of the Nursing Research Advisor (NRA) in the funding agency, the HRB, Ireland. The latter role I held as a joint appointee with another national nursing agency. Hence, this study had two fields and the fieldnotes discussed in this paper were the 'writings produced in or in close proximity' (Emerson, et al., 2001; p 353) to these two researcher-constructed fields (Atkinson, 1992). I called them the Field of the Fellow and the Field of the Funder.

Fieldnote processes in the field of the fellow

In this field, the 16 fellows meeting the inclusion criteria of being awarded funding for PhD studies were invited to participate in the study. An additional fellow was invited but only on successful completion and award of their PhD as the researcher had acted as a co-supervisor to their work. So as to avoid coercion all fellows were initially presented with an information sheet detailing the role of the NRA. This outlined the lack of any formal relationship between the NRA and a fellow, with the grant being administered by a Grant Manager. The information sheet clearly stated that fellows were under no obligation to participate and that their decision either way had no impact on the terms and conditions of their award. In all, 16 of the 17 signed consent forms agreeing to participate. Following this, interviews and observations were individually negotiated during which ongoing informal consent was obtained. Even though it was a mixed gender group of participants, the researcher stance and strategies in this field were akin to feminist ethnography (Skeggs, 2001): minimising power differentials, giving opportunity to enhance participant control and reciprocating with information. Such a stance seemed 'natural' considering the shared, previous occupational socialisation and simultaneous doctoral student processes that the fellows and I were undergoing. Examples are contained in fieldnotes.

> Following a second interview with the CNMFF[4], I was asked "How is your own work going?" I described the amount of data gathering that I had conducted. I also said laughingly "Of course, I've nothing written!" I meant by this the type of formal writing of chapters and sections. I felt safe in saying this as this particular CNMFF had described how writing had only commenced in the second half of the third year of the Fellowship.
>
> Researcher Diary 11/1/05

> It is 3 months since I've been in contact with this CNMF1 but that has been quite deliberate. I know that she has a transfer hurdle of MSc to PhD and I consciously was giving her the space for this. Her voice is a little quizzical at first until she knows it is me; then she replies warmly "How's it going?" I lament my perceived inability to recommence my own study after my holiday. (*A conversation ensues on CNMF1 progress – content omitted here*). We agree a day to meet and she laughingly closes the telephone call with "Now get off those ski slopes and get that brain going again, Sarah".
>
> Researcher Diary 16/3/05

In the observation sessions, the role of the researcher varied on a continuum from complete observer to complete participant (Hammersley and Atkinson, 1995) depending on the observational situation. For example, I observed a fellow presenting at a national, multidisciplinary meeting which focused on a specific, highly

[4] The code shows the stage at which the CNMF is at. F denotes finished, 1 denotes in first year, 2 in second and so on.

specialised area of clinical practice, I observed a meeting between a fellow and their supervisor, I assisted a fellow to set up a focus group and I was a volunteer for a fellow who was collecting scientific data from healthy human subjects. When observing was the main aspect of the ethnographic role, I managed to situate myself to ensure maximum visual range with minimum visibility to the fellow striving for unobtrusiveness and a reduction of any reactive effects to my presence as observer. A secondary issue was the comfort of writing whilst observing. The level of writing during observation varied depending on the situation. Sometimes fieldnotes could be written as I observed a fellow undertaking tasks such as research analysis. My notebook of preliminary fieldnotes show these accounts to be messy with symbols, abbreviated words and partial sentences, which whilst accessible to myself as the writer would not be readily available to other readers. These writings needed subsequent transcription into a full, comprehensive account. At other times such as when I was a full participant, jotting writing occurred immediately after the event and usually reflected the 'headnotes' I made during the participation. Jottings consisted of phrases or snatches of conversation, types of activity or behaviour undertaken, brief descriptions of settings or anything that I thought would act as an 'aide memoire' in writing up the fieldnote and were similar in format to those used in practice contexts. The value of generating jottings and not simply relying on frail headnotes was subsequently shown to me.

> How fragile getting data can become. I spent 4.5 hours yesterday with a Fellow in the Fellow's own home... (*content omitted*) Having sat with my back to the window for most of the afternoon, I had not noticed the forecasted storm had arrived. We both leave the house at the same time as the CNMF is meeting a friend for dinner. I run to my car to write some jottings from the encounter to discover a car with no power! I sit in the dark and cold with the wind and rain raging around me waiting for rescue. By the time this happens with a jump lead start, a drive through long queues of traffic trying to avoid floods and I get home, warmed up and eat something, the intended jottings are gone! I sit and try and recall the 'head notes' of snatched phrases from after the interview that I still remembered on the run to the car but seem to have vanished in the panic of the situation but to no avail... Today as I'm involved in something else, I remember what it is I wanted to record. This time leaving nothing to chance I wrote a note to myself on a post-it.
>
> F2/C/28/10

Fieldnote content included issues such as the environment; the presentation of the fellow with regard to dress, stance, use of title etc.; interactions between the fellow and others and snatches of dialogue. Fieldnotes cannot record all that happens and the ethnographer selects aspects to be recorded. In these sessions, I particularly focused on issues of identity construction, relationships with others, spatiality and temporality and noting anything that I thought unusual. Aware that my observational accounts represented what I saw during the session, my initial response to the fieldnote completion was to label and store the account. However, I found that most of the fellows frequently asked what I had observed. Finding that a verbal report failed to satisfy one fellow, I started to email the observational accounts to the individual fellows before storing with the proviso that this was a record of what I had seen and was, therefore, not for editing beyond changing items for confidentiality purposes. However, I welcomed comments from the fellows. In the main, the fellows expressed surprise at the level of detail recorded and the lack of their own knowledge in relation to some of this detail. For example, one fellow had not noticed that during preliminary state-

ments preceding her presentation at a multidisciplinary conference that she was referred to by the chair by first name only, whereas medical practitioners were afforded their professional titles and surnames throughout. In some cases, additional comments of non-observable issues such as feelings were made by the Fellows. Such comments were kept as italics in the account to differentiate the statements from my own.

There were two ways in which the fellows collaborated in the generation of observational fieldnotes for this field of the study. The first was the identification of sessions to be observed. Although the researcher developed a context analysis grid following Schwartzman's (1993) outline, to identify the potential activities for purposive sampling in the study, in this field, fellows maintained a 'gatekeeping' role to what was observed. Individual fellows differed in their preferred method of data generation with some agreeing to interviews and no observation at all; others were more open to the experience. Requests for observing particular events were refused at times, for example, on the grounds of anticipating nervousness in a particular situation without added pressures. Thus, control of access to data collection was with the fellow and not the researcher, thereby reducing any potential coercion. Nevertheless, more than 50 h of observation in 15 different sessions over 2 years involving seven fellows was achieved in this field. The second way in which fellows assisted in the generation of fieldnotes was in reading them and making additions. This allowed opportunity for different perspectives to be included explicitly and richer detail to be generated. Fellows could also see that issues in the data requiring confidentiality and anonymity were being managed by the researcher. Participation in the study allowed for reciprocal benefits as noted in this extract and added to a sense of collaboration in this field.

> I'm attending a conference and go along to listen to a CNMFF present their work. There has been no negotiation of data collection and I'm present solely because I'm interested in how the study findings will be presented. During the presentation, the CNMFF explains the mechanisms which helped develop their thinking as the study progressed. Within this slide is acknowledgement of the interview and observation transcripts that we generated for my study. I inform the CNMFF afterwards that I will be making a note of this for my own work with their consent, which was given.
>
> Researcher Diary 9/11/06

Fieldnote processes in the field of the funder

Although I had formerly worked in hospitals and academic settings, a health research funding agency was a new culture for me, 2 years previously when I took the role of NRA. This was a unique and privileged joint appointment, and my commitment to the HRB was part-time and flexible. Emerson, et al. (1995) suggest that initial impressions of the setting are made to allow the ethnographer 'to get started in a setting that may seem overwhelming' (p. 26), so first, I wrote of my initial experience in the organisation. Although I would not claim this was comprehensive with some initial impressions missing, it did allow a certain contextualising for what was to follow and describing my sensitivities to patterns and dissonance, which could become blunted over time. Details such as the physical environment were recorded. Issues of difference between the nursing culture and the health research culture were recorded, for example, the start time of the working day. After formal organisation ethical clearance and informal consent of management and my colleagues, I was ready to start

recording fieldnotes in the Field of the Funder. The researcher stance and method of recording fieldnotes reflected an 'insider researcher' aspect of this field. Such positioning has been used elsewhere with nurses conducting inquiries in their own work settings. (Cudmore and Sondermeyer, 2007; Simmons, 2007)

In this field, the researcher stance differed from that of the Field of the Fellow. Aware that the field was a temporal one whereby I undertake a dual role of researcher in addition to my role as worker over a set timeframe, and that my relationship with work colleagues had commenced and would continue outside of this temporary frame of data collection, I strove to minimise the disruption of my work relationship with them. I was eager to show that the research did not impact on how I conducted the role of NRA, and I did this by ensuring that my NRA tasks took precedent. I was also sensitive to the comfortableness of my work colleague peers, who whilst somewhat used to transient summer students undertaking research projects, having a researcher exploring an aspect of unit work in their midst was a new experience. In addition, there were two further issues which influenced the researcher stance. I was aware that my colleagues' consent to participate was initially given collectively at a team meeting and was superseded by organisational ethical clearance, thus, having the potential to influence their seeming willingness. Subsequently, as individuals joined the team I informed them of the study and sought verbal consent. This occurred on five separate occasions. In any subsequent conversations, I emphasised the centrality of the NRA role for generating the data in congruence with the overall study objectives. I gave intermittent updates of my progress at team meetings, and my colleagues did make occasional informal enquires as to my progress during tea breaks. Aware of potential coerciveness, on all occasions I offered the opportunity to further discuss the study, address individual anxieties or give greater clarification but this was never sought. In the main, my colleagues displayed ambivalence, if not disinterest as shown in the extract below.

> I catch the new staff member in an office on her own. This is only the second day that I've been in the HRB since she started in her job. I tell her about the study and how confidentiality is managed and that I'm available for questions. She is wishing me the best of luck when someone walks into the office and the conversation ends. However, although there were no indicators from her facial expression or body language that indicated anxiety, on reflection, I consider that I've not informed her as fully about the study as my other colleagues and I plan to remedy this in the near future. (9/12/04) I follow-up with my colleague by asking if she needs more information or clarification on my study but she has no questions and doesn't seem particularly interested...
>
> Researcher Diary 2/12/04

The second issue was the meaning of a PhD. Within the organisation, a PhD was a highly contentious eligibility criterion for promotion to management grades. This meant that I was potentially a future competitive threat to colleagues who might seek promotion. Being sensitive to these issues in this particular field, meant that the researcher stance I adopted necessitated discretion regarding when and how I recorded the fieldnotes.

The role of the NRA itself, I felt was perceived as somewhat unknown to my work colleagues. I was the only professional advisor in the organisation and my flexible, part-time joint appointment status was somewhat ambiguous. So whilst I was legitimately an organisational member and so an 'insider', the role of NRA was both formally and informally treated as marginal in the organisation. The role had both strategic and operational elements and so differed to that of my 'peer' colleagues many of

whose positions had operational elements only. An organisational map showed reporting relationships of the NRA being a dotted as opposed to the solid line of others. This positioning of the role of NRA did not allow a 'going native' development to occur rather it gave rise to the impression and feeling of being a 'visitor', although perhaps justifiably so at times. This was further enhanced by colleagues asking of 'news from the world outside' as if the NRA was a bridge with elsewhere. The following field notes show this phenomenon and my reaction to the tensions it produced.

> There is a certain sense of being a visitor to the organisation. Comments such as 'what brings you over to visit us?' were regular in the last two years. After approximately 18 months in the organisation and repeated comments on my 'visits', I challenged one particular staff member with the statement 'I work here'. What may have been a personal joke for one person however, underlined a perception that others may also have had. For example, on two of the past three partnership days[b] management staff have asked would I be joining the activities and another staff member commented 'oh you're here then' when I joined in a Freedom of Information session. It appears as if no one assumes my engagement with the practices of the organisation.
>
> NRA Diary – First Impressions

> I'm at my desk by 8.45 and reading emails. I have quite a list of tasks to achieve today. My new office mate arrives just after 9.00 and approximately 30 min later another colleagues steps into the office on her way up the stairs. "We haven't seen you in a while" she remarks when she sees me. "I was here last week" I reply "though it may have been towards the start of the week". "It seems ages ago" is her response.
>
> NRA Diary 3/3/05

Overall, the NRA role gave a feeling of being a border inhabitant rather than a fully embedded indigenous member. My somewhat limited previous exposure to the role meant that a high degree of 'strangeness' to the organisational culture remained at the start of the data collection. The part-time nature of the role in addition to the keeping of a concomitant researcher diary for descriptive and reflexive accounts of the researcher role as opposed to participant fieldnotes assisted in maintaining analytical distance throughout the data collection period.

During the 2 years of recording NRA activities, the process of writing fieldnotes acted as self-consciousness of the researcher stance and, for that timeframe, positioned me in the dual role. However, as previously stated, I privileged the NRA role over the researcher role, and unlike nurse researchers in the practice settings (Borbasi, 1994; Beale and Wilkes, 2001; Colbourne and Sque, 2004; Bailey, 2007) I experienced little blurring of boundaries. My management of the writing of field notes reflected the role I adopted in this field thus preventing reactivity and any change in practices with those I worked with. In this field, writing always commenced with jottings which were recorded on 'post-its' or scrap paper and removed from the setting for writing up into field-notes. These jottings were made covertly and usually in the privacy of my own office. Occasionally, they were made under the guise of writing for another purpose, for example, making notes at a meeting. The implication of optimal participation is that writing may be suspended (Emerson, *et al.*, 1995); therefore, I performed my NRA role and recorded only jottings simultaneously. As before, the jottings were embarrassingly scruffy with untidy writing, idiosyncratic shorthand

[b] Partnership day is an annual event where management and staff spend a half day together discussing issues within the organisation. This is then followed in the evening by a social event.

and personal abbreviations which subsequently acted as 'mnemonic devices' (Fetterman, 1998; p. 114).

Again fieldnotes were developed from the jottings and made fairly contemporaneously with the observations. Fieldnotes were rarely written within the work setting itself, but this did occur on a very small number of occasions when the notes were saved to a floppy disc only and not held in the work setting. Routinely, the fieldnotes were usually written in the researcher's own home on return from the day's work in the setting, this being the most practical option (Fetterman, 1998). The interval between jottings and writing fieldnotes varied from 3 h to 3 days, but they were developed as soon as possible so as to capture the sharpness of the observation and not lose the 'rich, nuanced detail' (Emerson, et al., 1995; p 40). Long-interim periods (more than 8 h) between leaving the field and developing the fieldnotes from jottings were rare but due to a variety of reasons such as long and late work hours or maximising participation at conferences or HRB social events. In this study, I made the conscious decision to write when less tired as advised by Emerson, et al. (1995). After 12 months and based on the burden of recording, I moved from recording the mundane 'basic routines and daily rhythms' (Emerson, et al., 1995: p40) or the minutiae of the role of the NRA within the HRB to recording events of significance only. I found this change remarkable; especially, the release from feeling that I had to live my working day twice over as I replayed in my head scenes of social interactions from that working day. After 24 months, I stopped recording fieldnotes in this field.

These fieldnotes were a chronological narrative with the content including issues such as the use of space; general communication patterns, my work and self-presentation as NRA; my interactions with work colleagues and others and snatches of dialogue related to nursing and its relationship within health research. Also, there were topics to be followed up and my reactions and feelings about particular events. Thus, the fieldnotes contained process memos, asides and commentary as well as description (Emerson, et al., 1995). For example:

> I have planned to publicise the Basic Guide's existence in a professional newsletter that is posted to every nurse and midwife on the Live Register. This will supplement a piece I wrote on writing good grant applications which is due to be published shortly in the same newsletter. Other HRB staff have had an opportunity to make comments and the document has now been finalised incorporating their points. It will be made available on the HRB website as well. *This is an example of how a 'new kid on the block' can identify opportunities for enhancing services and challenge the notion of familiarity that members of an organisation can develop. (example; an aside)*
>
> NRA Diary (1/09/04)

> Advice to a nurse considering application to the HRB. A personal connection is made as the nurse mentioned a previous work colleague of mine with whom she now works and who advised her to talk to me. *'Making connections' is important to the Irish and nurses and midwives are no different. The arena of potential and real researchers in nursing and midwifery is very small which makes the 'making connection' process even easier. It may also act as a potential barrier, however, as ex-colleagues may not feel comfortable in seeking my advice. (example; a commentary)*
>
> NRA Diary 2/9/04

The style of fieldnote was somewhat 'distant', however, as if I was observing rather than participating. On reflection this was because of an issue of constraint on fieldnote development. The team was small, consisting of 9–10 people over the 24 months, one of whom was male. To ensure confidentiality, I wrote the fieldnotes from the outset as gender neutral. I did not use individuals' names and tried where possible to avoid using role titles which would act as identifiers. Writing in this way

meant that any of this anonymous data could be presented in the final ethnography. Within this field, the level of collaboration of data generation was low resulting in mainly author privileged fieldnotes that gave primacy to the researcher's own voice.

Discussion

The generation of data as a collaborative ethnographic venture is dependent on a number of issues. These are the field itself, the stance of the researcher and the willingness of participants. In this study and over time, the data was actively constructed as Agar (1996) propounds. However, the two fields and the relationships within them varied enormously and impacted directly on the level of collaboration. In addition, neither field in which the data was generated had a fixed spatial location. The NRA diary described my role outside the physical HRB building but still as a representative of the organisation and observing fellows occurred in multiple locations; thus, the fields were constructed social entities and not simple bounded physical spaces.

In the Field of the Funder, a number of constraints led to author privileged fieldnotes. Collaboration did not develop following a slight sceptic, dismissive tone of voice being used by one influential colleague on two initial occasions when my diary was mentioned thus leading me to assume an unvoiced unease stemming from nonfamiliarity with my data collection methods. I made a decision that trying to convince my 'positivist' colleagues of the merits and value of collaboration for fieldnote writing on top of their everyday work would have been a battle too far! Although one of my colleagues did show the potential for engagement as outlined in this extract, this occurred some 15 months into data collection, and I deemed it too late into the fieldwork to change processes.

> A new staff member has commenced work almost eight weeks ago. My presence in the office has been infrequent because of regional meetings and anytime that I've been in the office I have not managed to see her on her own to explain about my research. I was in the HRB last Friday and went round all the offices to say hello. Another colleague asked me how my research was going in front of the new staff member. I replied honestly but thought afterwards of the fact that I had not informed the new staff member. The next working day I email her with apologies and a short explanation. I asked to meet her in the near future to give her more detail. She replies promptly with enthusiasm to learn more about the project as it sounds "so interesting and so different" from her own scientific background.
>
> Researcher Diary 7/11/05

Regardless of the lack of active collaboration on fieldnote writing, these peers were part and parcel of some of the transactional exchanges that occur in the social field of the Funder and so were passive partners in fieldnote generation. Fieldnotes from this field, though detailed, were constrained by confidentiality issues and lacked a sharpness of presence, though not the essence of the experience. They were a solo perspective of happenings and thus a filtered version of events (Emerson, et al., 2001).

In contrast, for the field of the fellow there was a level of comfortableness for me as researcher in a milieu of peer researchers of the same discipline. Similar experiences between me and the participants were recorded. For example, the following quote of participant observation by a Fellow mirrored my own feelings recorded in my researcher diary.

> Em… I felt uncomfortable initially because I felt, you know, I felt like a little bit of a spy really and that there might be concerns about you eh… revealing bad practices and so on and so forth…
>
> CNMFF/1/21/1

> A team meeting allows me to scribble jottings in the guise of recording notes of the information we are being told. At times this dual role (of worker and researcher) feels like being a spy in the camp and I feel quite tense about it! I try to hold over in my head certain words that folk say in the discussions and write them down at what seems a 'natural' time or when others are also making notes. I think I am extra sensitive to how others perceive this study of mine and hope that I relax more into the combined role.
>
> Researcher Diary 12/11/04

Similar previous professional socialisation and treading the same path of doctoral studies, albeit at different paces, lent itself to immediate rapport with most participants. Individual negotiation of data collection and varying levels of involvement in fieldnote writing gave rise to a collaborative effort for the generation of rich and detailed fieldnotes, many incorporating dual perspectives.

Conclusion

Fieldnotes are a neglected aspect of the ethnographic nursing literature (Mulhall, 2003) and so warrant more attention such as in this endeavour. This paper has shown that as fields are constructed entities they 'shape and constrain the writing of fieldnotes' (Emerson, et al., 2001; p. 354). This in turn impacts on the level of collaboration achieved between researcher and participant in ethnographic data generation. This paper has shown that fieldnotes are produced from complex, purposive processes with varying levels of collaboration depending on the field itself, the stance of the researcher and the willingness of participants. Ethnographers of nursing or midwifery should consider making such issues explicit so as to aid our understanding of fieldwork processes and aid reflexivity of the social practice of research processes.

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Appendix 3.8 Extracts from the researcher diary.

Researcher feelings:

RD 23/8 I've just read Trotter's (2003) personal reflection of PhD studies and found some bells ringing in my head. Similar experiences included large scale change at the outset of the process – a false start (she with a supervisor change and I with a new research question). She describes a series of hoops and even at this stage I can recognise the same issues. She describes the negotiation of time to undertake the work. Similarly, for myself there has been such a negotiation – with myself as much as with others. Having initially agreed one day per week, I agreed to be flexible so as to "keep the show on the road". This meant that often I would go through weeks into months without that protected time. "Claw back" came in a prolonged spell of leave – usually the month of August. However, due to the uniqueness of my role and the lack of clear administrative support, I still found myself in the office on at least one day a week of that 'leave', responding, following up and initiating work for my return. It also meant that for my own work (as opposed to study) there was no 'down time'. Having said that I also relished and luxuriated in the length of time that I could give my almost full attention span to the project. It was usually on the week leading up to return to full work that I most envied my study respondents their award! Trotter (2003) outlines the guilt associated with time organisation. Whilst I did find myself going to the gym in the middle of the some days or taking time out, usually a day when the computer was not switched, I also found myself working at weekends during this leave time and justifying how I used holidays and weekends throughout the year on the study. Instead my guilt was on the pace of my work. I feel slow... Every piece of writing has to be wrung out of me. This is not helped by faculty pressure for finish dates and the passing of relevance of the study if I do not complete my analysis and write up quickly. Yet I have to balance this with doing justice to the data and not presenting a 'half-cooked' thesis. Whilst Trotter (2003) experienced own-made hoops about her topic area, I too have done so. My issue is that my topic area is so closely associated with my work, that I never feel any break from it. Regardless of knowing the benefits this brings in relation to access to literature, participants etc., there are times when I just long for a week away from the topic without any guilt!

RD 16/2 I am transcribing the interview which is my final data collection with the Fellows. There is a sense of fleeting nostalgia that this is the last weekend of listening to voices whilst wishing I was somewhere else. There is also a struggle to make myself do it and not get diverted to other non-PhD tasks. This interview and its immediate predecessor have been with CNMFFs who have just undertaken their vivas. In addition, this week I have been emailed by the supervisor of a CNMF3 seeking funding advice on completion of the fellowship. It seems that all around me are Fellows completing and I envy them the stage at which they are at. I can't seem to envisage myself at that stage and feel that the amount to work to transform all the data I've collected into a written ethnography will require an insurmountable effort. The lift of having a paper accepted four days ago for a peer reviewed journal without amendments has dissipated.

Researcher skills

RD 12/11 As I gather the data and write my field notes, I constantly wonder am I recording the correct things? Am I focusing on my own behaviour, rather than others? What is this health research culture that I'm supposed to be exploring? I'm currently reading an ethnography of midwifery practice in a labour ward (Hunt) and as I read I note the pointers that this research highlighted. It helps to guide me as to whether there are similarities in the health research culture. From the library I order other ethnographies of professions and practice to keep this issue to the fore in my analysis.

RD 2/2 In crafting the chapters of findings, I find that I have swamped the text with quotations in order to justify my interpretation and not solely to 'give voice' to my participants. I recognise that this is a feature of doubt and that I will become more confident in the findings. I remember the struggle of some of the CNMFs with this same issue. I am now in a process of 'slimming down' the text by cutting surplus quotations and even cutting extraneous words from others. In this activity I notice that often where I have interview quotations and researcher observations illustrating the same point, the observation is removed. Why is this? Why favour participant words over my own observation? Do I continue to doubt my vision and have confidence in the words of others? Sandelowski (2002) explores the dominance of interview data in qualitative research and explores how researchers use this data naively and unproblematically. She calls for greater embodiment and attention to the material world by incorporating other sources of data to understand our experiences and culture. This literature focuses however on championing data collection from a variety of sources and types – which I have done. The paper does not describe my current challenge which is the *practice* of resisting the privileging of some data sources over another in crafting the research report. In my cutting, I have to continuously challenge myself not to cut my observations. I should write a paper on this to add to the corpus of 'de-santitised' accounts of research practice.

Researcher Practice

RD 4/10 I've just made a long journey to meet the CNMF2. In the car I do a last minute check on the equipment for the forthcoming interview. The tape recorder is not functioning properly as the tape is not turning. I change the batteries to the new set that I always bring with me but again the malfunctioning occurs. My heart begins to beat as panic sets in. I had checked the equipment and prepared the tape less than 24 hours before when getting the travel bag ready so what could be wrong now? I start to run through how long getting another tape recorder would take me and other types of contingency. Then I notice that the pause button had been inadvertently switched. Calm is restored.

What is a PhD?

RD 8/11 I am attending a research seminar in the university in which I am registered... The CNMFF commences the session discussing the experience of qualitative data analysis. Some insights strike home. One is the nature of the data which is described with the adjectives 'simplicity' and 'ordinariness'. This is an issue for me, as I read through the interview transcripts and field-notes that I've developed to date in my own study and for another CNMF, who has expressed worries as to the 'common-sense' of data collected. Some myth-busters are explored by the CNMFF such as 'more is richer' data and the number of qualitative interviews, more items on which I have spent some thought... Confidence-building is described which reiterates what the CNMFF told me when interviewed 12 months ago.

Appendix 3.9 Examples of coding

Example of initial coding.

CNMF2: And... some of the original work is actually quite old and quite small and so... there really isn't any great seminal work in the area and you really are afraid that you are missing something. But the source of the literature is a variety of journals. So they would be we'll say *a related clinical speciality* journals, *a health science*, a lot of it would be written by *scientists and medics*. So you are out of the nursing arena. A lot of the nursing stuff that I've read are from people whether they are now professors or whatever in nursing it's not actually original material. It's writing about the issue and while it is... and while well referenced and that a lot of it is replication then. So that's very frustrating because you have all of this but you're thinking but actually have I found anything, and you're just hoping you haven't missed anything.

S: There is a specific journal for your clinical speciality though isn't there?

CNMF2: There are a few and they would generally be around the same level. There might be one or two that would be a little bit ahead.

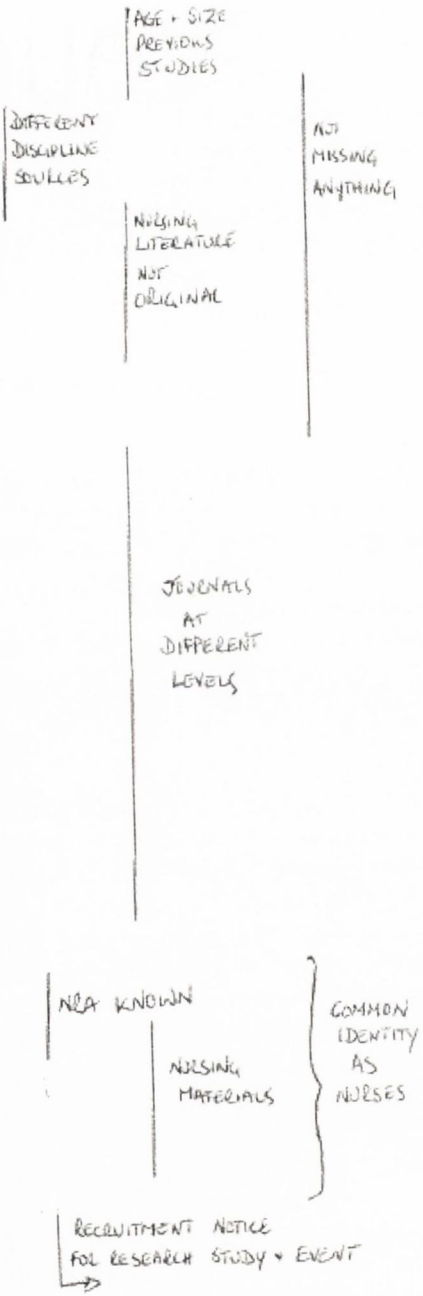
S: Ahead in which way do you mean?

CNMF2: That they would be more scientific as opposed to commercial. Em... but the journals that would give you... the better journals would still be maybe the general nursing journals...

S: The general nursing journals as in the Journal of Advanced Nursing or..?

CNMF2: yes. Yeah. That there isn't that level...

(Another nurse comes into the room and the tape is switched off. This nurse knows me professionally and has worked with the CNMF2 clinically. There is some general conversation in which I am included. Some conversation centres on a patient with a particular complex condition and I am shown materials used in the care of this patient. The nurse removes her 'civvies' from a cupboard and exits to change out of uniform. On her return she makes a phone call about another patient before she goes off-duty. During this time I note that on the wall of the treatment area and again in the small office space there are notices about recruitment



Example of later coding using Ethnograph

```
F2/I/9/11                                          1

S: You're just actually starting into              3
  your 2nd year. So how is your 1st year           4
  been for you?                                    5

#-TRANSDIF
F2I911: First year…em…. I suppose the              7  -#
  one thing I would have said in                   8   |
  relation to the beginning of the year            9   |
$-PHDASID
  was that all of a sudden I had left             10   |-$
  where I was employed……and now I was a           11   | |
  full-time PhD student…in the space of           12   | |
  24 hours and I thought "What am I               13   | |
*-UNCERTANTY
  going to do?"  "What will I actually            14   | |  -*
%-USELIT
  do now?" And I suppose traditionally            15  -#-$-% |
  what you hear about PhDs is that                16       | |
  people spend the 1st year sort of               17       | |
  closeted doing literature reviews and           18       | |
  that and my design was such that it             19       | |
  precluded me completely from doing a            20       | |
$-FILTIMGAPS
  literature review. So then I was a              21    -$-% |
#-TIM2GETETH
  little bit lost for direction. Mm… I            22  -# |  -*
  already had my ethical approval, you            23   | |
  see…from all of the sites.  I did that          24   | |
  while I was previously employed. So it          25  -# |
  was basically then that I was able to…          26      |
  start working on my pilot and start             27      |
  data collection. So I… registered in            28      |
#-(UN)STRCTR
  the October but I also started another          29  -# |
  course in the university so that kind           30   | |
  of gave me something to help me get             31   | |
  started. And…                                   32   |-$
                                                       |
S: Why was that important do you think?           34   |
                                                       |
F2I911: Eh… because… number one I'm used          36   |
  to structure anyway. It's just my, my           37   |
$-TIMRUNOUT
  big thing! Two, I didn't….want to               38  -#-$
  discover that at any point I was going          39     |
  to be way behind because I was lost at          40     |
  the beginning. So I didn't want to              41     |
#-RESWK>925
  suffer at the end.  Em…Three I wanted           42  -#-$
  (indecipherable)…. To keep it to a 40           43   |
  hour week but I failed miserably at             44   |
  that. (laughs)                                  45   |
                                                       |
S: (laughs) yeah.                                 47   |
                                                       |
F2I911: but that was the original plan.           49  -#
#-SENSITIVE
  Em… what else was an initial worry?             50  -#
  Oh yes, because of the sensitive                51   |
  nature of my population… there were             52   |
  many issues that were coming up for me          53   |
$-NORESSITES
  before I even started.  Would I be              54  -#-$
#-UNCERTANTY #-TIME2RECRU
  able to manage with one site?  Would I          55  -# |
  need to negotiate a second site                 56   | |
```

Appendix 3.10 Exemplars of memos.

Early memo – the medical dominance of ethical clearance.

F1I23 (864-891) This segment shows the 'gatekeeping' role of ethics committees and whom they consider as the research stakeholder. They have insisted that the professor as staff member should attend the ethics committee but the nurse as co-applicant is not required to attend. What does that say about the value of co-application where there is a power differential? Here, the nurse sits outside "just in case". What does that say about the supportive role of nursing? Where is the ownership of the study proposal? The CNMF is pragmatic and fulfils others' requests regarding ownership, attendance etc. They also appear ambivalent. What is seen as "unfair" is to ask the Professor to defend the study which is not his own. The "unfairness" of not being valued as the applicant is not mentioned nor implied by the CNMF. Check do all CNMFs adopt a similar stance.

F1I1512 (332-359) In this section the chairperson as a consultant medic has a particular interest in the study as it concerns his particular clinical speciality. He considers that the title of the project has an inaccuracy because of its use of 'lay language' and he recommends a change to a more scientific discourse giving greater accuracy – noted by the CNMF as 'nitpicking'. The CNMF prefers a more 'consumer-friendly' term, thus aligning themselves as advocates with service users (and their potential research participants) and showing their identity as a nurse/midwife. Because of the hat he wears as chair of the ethics committee, the CNMF agrees to the change. However, resistance is reported as the CNMF re-exerts control by making the change in only one document. This extract shows the power and control exercised over contested issues. Issues can become contested at times of 'peer review' for decisions that are critical to progress the study. Here, the traditional power differential between medicine and nursing is exaggerated since gaining ethical approval is mandatory.

Early memos – the nursing value of 'doing'

FFI183 (267-277) This segment is an example of 'reading not doing' and the guilt that scholarly nurses and midwives feel in enjoying reading – as it is a "luxury". In nursing and midwifery practice, doing is valued and reading is not, unless it is for a specific purpose such as lecture preparation. This segment also shows the time required to cognate and the privilege the CNMF feel to have such time.

F3I2311 (106-120) Here, feeling as if 'doing nothing' links to the memo on time taken to read. In this incidence the CNMF is doing work (for supervision meetings) but is also spending time thinking. There is more time available, and thinking may not be viewed as tangible ("working without realising it"). Thinking may also be undertaken whilst doing other activities eg. travelling, domestic chores (links to 'it's always with you'). In nursing and midwifery, thinking is not doing.

F1I511 (48-58) In this section the CNMF describes studying as "not doing anything" – meaning a physical activity and being inactive means becoming "frozen solid". So the CNMF contrasts life in the clinical world (movement, doing) with life in the research world (stillness, thinking).

F1I23 (109-137) This section outlines the tasks of 'doing' that the CNMF undertakes to access the research population. What is interesting here is the idea of 'filling in' times gaps with "tangible tasks". Whist this shows effective use of time, it is also quite a 'nurse/midwife' action where fallow time is spent doing preparatory work for the future. The way the CNMF describes

the process is as a scattering of activity not necessarily concentrating on one task in depth – "fill in doing different things". Partly, this is so as to be available and responsive to others – "waiting for the phone to ring". Such labour emulates practice and is linked to identity. Might it also be attributable to transition whereby time to read or think is not yet valued?

Later memo – transitional identities influenced by contestation

Being a CNMF was a transitional identity – frequently used beyond the timeframe by those in academia but not other arenas such as policy. An assumption is made that this is because gaining a funding track record has greatest importance in the academy than elsewhere. During the funding timeframe, the CNMF was an identity which was utilised intermittently. Its usage was confined to actions or events whereby utilisation brings benefit to the individual – for example gaining access to the research site. It was used in formal (letter heads, publications) and informal (helping others apply) situations. All these activities are *individually* focused. There is a sense then that there is no collective identity of CNMF and no network of CNMFs that could generate such a collective identity. Why is this? The excuses of difference (field or methods) and distance were expressed for not networking with other CNMFs. Yet, CNMFs describe using friends from other disciplines or ex-colleagues from abroad for support. So, difference and distance are not necessarily network confining issues. This begs the question of what confines the organic networking of CNMFs?

One possible reason is that the origin of the CNMF identity is formed from a competitive process (cf. CNMFs trying to elicit their competitors' identities from the panels' expertise) wherein some CNMFs have previously failed. The **spectre of failure** continues through the funding timeframe as CNMFs continually struggle with time and project management issues and cognitive challenges as they labour the doctorate. This sense of failure is intensified by the obligation that being funded means a timely completion. But some CNMFs have knowledge of other CNMFs in their university who have not completed in the timeframe – 'career suicide'. When collecting interview data, I am frequently asked "how are the others doing?" **'PhD chat'** shows that doctoral students do engage with such enquiries. This request I interpret as seeking reassurance for the 'norm' of struggle and from a confidentiality perspective, and I reply with generalisations. However, where public knowledge of 'the golden handcuffs' of funding allows a clear comparative timeframe CNMFs can continually judge their progress (and be judged) against that of the other CNMFs. Given the contextual origin of the CNMF identity, there is therefore the potential sustaining of **competition** that mitigates against networking and the formation of a collective identity.

Within other identities the issue of competition also arises. The heterogeneity of the identity of nurse is rejected by the CNMFs who differentiate themselves into their respective branches eg. children's nurse, public health nurse, learning disability nurse or the category of general nursing into the clinical speciality (part of the non-networking excuse of 'difference'). They describe elements of competition between these identities: for example, pride at being the first from the branch to be funded or publish in a prestigious journal. As such, they emphasise **individual elitism rather than collectivism**. The implication is that the cross-cutting theme of contestation produces the sense of **solitary** pioneering.

Appendix 4: Properties of the subcategories.

'Resourcing' the Research

	Attaining Funding	Gaining Time	Constructing a space
Field of the Fellow	Funding as competition	Blurring temporal boundaries	Negotiating a labour space
	Making an application	Learning the value of scholarly time	Balancing the impacts of space
	Being short-listed	Time myths	Space as a conveyer of meaning
	Meanings of being funded	Guarding against time loss	
Field of the Funder	Advising on attaining funding	'Time out' for learning	Negotiating a labour space
	Support applicants		Space as a conveyer of meaning
	Selecting reviewers		

Table A4.1: Properties of 'Resourcing' the Research

Labouring the Doctorate

	PhD as Product	PhD as Process	PhD as Practice
Field of the Fellow	Achieving the conceptual level	Keeping on track with planned progress	Building new routines
	Forming the thesis	Championing the work and facing the challenges in rites of passage	Managing labour pace
	Meaning of PhD	Developing the required skills	Ethical labour and labouring ethically

Table A4.2: Properties of Labouring the Doctorate

Transitional Identities

	Self with multiple identities	Building confidence and credibility	Transitioning
Field of the Fellow	Self as CNMF	Assembling credibility across identities	Letting go
	Self as doctoral student	Feeling a fraud	Not belonging
	Self as nurse or midwife	Building confidence in ability by 'doing'	Contemplating the future
	Self as person	Getting affirmation of the study's merits	Adjusting to the new title
	Managing multiple identities		
Field of the Funder			
	NRA as HRB visitor or agent	Getting affirmation for the NRA role	
	NRA as more than a nurse		
	NRA as a researcher		

Table A4.3: Properties of Transitional Identities

Appendix 5: The current context

Up to the point when the CNMF scheme was amalgamated in 2009 with other HRB Fellowship schemes 26 PhD and 8 Masters by Research awards had been made (Condell, 2009). The Research Training Fellowship for Healthcare Professionals scheme was established in 2009 for all health care practitioners. In the two years of its existence, 3 nurses and 2 midwives have gained PhD funding. There have been changes to the application process the most noticeable of which is that all members of the selection committee are international and show a range of clinical specialities and methodological expertise. Thus, the opportunity to build national reviewing capacity in nursing and midwifery has been restricted.

By July 2010, the CNMF participants of this study have shown varied progress in their research careers, with all bar one remaining in Ireland. With one exception who is still labouring their doctorate, all have successfully completed their PhDs. The CNMFs were mainly working in HEIs: 7 had attained lecturer or academic co-ordinator positions, 2 had become senior lecturers, 4 were assistant professor, 2 were heads of school and 2 were full-time researchers, one of which worked at policy level. Curran (2006) noted that by 2005, over one third of CNMFs had made 15 applications for further funding with a 27% success rate. By 2010, a website search revealed that 4, either individually or as part of a team, had received further HRB funding and likewise 8 had received funding from other statutory or charitable sources. Thus, as far as it can be ascertained, some, but *not all*, were continuing to build a funding track record. See Chapter 8, Footnotes 8&9 for information in relation to publications.

By July 2010, the NRA remained a joint appointment between the HRB and the National Council for the Professional Development of Nursing and Midwifery (NCNM). However, this position was somewhat precarious as the NCNM was due to be dissolved under forthcoming legislation. The HRB had a new strategy (Health Research Board, 2009) and had undergone further restructuring at the outset of 2010. The NRA role continued to straddle its new divisions even with the changing emphasis for health research from basic biomedical to clinical, health services and population health sciences research. The HRB itself was not free of threat. A report (Department of Finance, 2009) urged the government to merge the HRB into a single stream of research funding even whilst the Action Plan for Health Research 2009-2013 (Department of

Health and Children, 2009) envisaged it leading some of the actions outlined. Given the findings of this study, pertinent actions from this strategy include revision of the ethical committee structures and processes to establish national co-ordination; incentivising the translation of health research into practice and policy; increasing and developing research careers in the health services. Interestingly, building capacity was referred to as plugging skills deficits!