The University of Nottingham

School of Education

The internationalization of UK nurse education: interpreting impact upon nursing identity

Paula Dawson RGN RSCN MSc PGCHE

Thesis submitted to the University of Nottingham in partial fulfilment of the requirements for the

Degree of Professional Doctorate in Education

2019

Student ID no: 4196678

CONTENTS

		Page
	ABSTRACT	
	ACKNOWLEDGEMENTS	
CHAPTER ONE	**INTRODUCTION**	**8**
	Form of thesis	**17**
	Approach to the literature	**20**
CHAPTER TWO	**THE INTERNATIONALIZATION OF NURSE EDUCATION**	**23**
	Defining internationalization	**23**
	Perspectives on existing initiatives	**26**
	The debate about cultural competence	**33**
CHAPTER THREE	**AN IDENTITY FOR NURSING**	**40**
	How nursing may be defined	**42**
	Nursing history and sociology	**44**
	Global mobility and its impact on nursing identity	**46**
	Social and cultural issues	**49**
	The issue of power	**52**
CHAPTER FOUR	**CONCEPTUAL AND THEORETICAL FRAMEWORKS**	**57**
	Critical theory	**57**
	Theories which illuminate and inform nursing identity	**60**
	Theories selected for application to study data	**65**
	Summary and discussion of relevant findings from the literature	**71**
	Study aims and research questions	**74**

CHAPTER FIVE	**METHODOLOGY**	**76**
	Study design	**78**
	Sampling	**80**
	Interview design	**83**
	Ethical considerations	**89**
	Approach to data analysis	**92**
	Study reporting and reflection upon process	**94**
CHAPTER SIX	**CONFLICTING INFLUENCES ON NURSING IDENTITY**	**97**
	Shared and divergent histories	**97**
	Scientists or artists?	**100**
	Influential factors both within and outside the profession	**108**
CHAPTER SEVEN	**THE PARTICULAR INFLUENCE OF INTERNATIONALIZATION ON NURSING IDENTITY**	**114**
	A globally consistent identity?	**114**
	Why do nurses seek international exposure?	**117**
	Changed perceptions both of self and of nursing	**120**
	Limitations and inequalities	**123**
CHAPTER EIGHT	**MISRECOGNIZING DRIVERS FOR IDENTITY CHANGE**	**131**
	What is valued in nursing?	**131**
	How could internationalization make a difference?	**132**
CHAPTER NINE	**INTERNATIONALIZATION AS A VEHICLE FOR IDENTITY EMPOWERMENT**	**139**
	Internationalization as power	**139**
	Individual transformations	**142**
CHAPTER TEN	**A NEW THEORETICAL MODEL**	**147**
	Something is missing	**147**
	Is standardization the answer?	**148**
	The way forward – co-operative development	**152**

CHAPTER ELEVEN		**CONCLUSION AND IMPLICATIONS FOR NEW DEFINITIONS OF NURSING IDENTITY**	**161**
		Implications for how nursing identity may be understood	**161**
		Implications for policy and curriculum development	**163**
		Reflections on limitations of this study	**165**
		Conclusion	**167**
		BIBLIOGRAPHY	**170**
APPENDICES	**I**	Study Information Sheet	**214**
	II	Consent form	**215**
	III	Interview framework	**216**
	IV	Demographic data	**219**
	V	Interview data coding sample	**220**

ABSTRACT

A globally shared professional identity for nursing may be assumed to be universally accepted and understood. However, such an assumption invites challenge. A valuable opportunity to explore nursing identity as it may be defined for global practice is offered by internationalization initiatives in nurse education. Such initiatives emanate from the context of greater workforce mobility and the promotion of nursing competence for increasingly diverse client groups. Internationalization initiatives in nurse education require exploration for their catalytic role in the development of an authentic, contemporary identity for nursing, applicable for twenty-first century practice.

This study presents a qualitative interpretation of the impact upon nursing identity of international educational initiatives in nurse education, through the analysis of data from a purposive sample of UK nursing academics, international post-graduate nursing students and UK undergraduate nursing students from one UK Higher Education Institution. Study data was elicited via one- to-one interviews. Data analysis was undertaken with reference to theoretical concepts developed by Bourdieu and Carper.

Findings demonstrate a continuing manipulation and control of nursing identity by influential forces exterior to the profession, and limited exercise of power and control by nurses themselves. International educational experience, however, demonstrates some achievement of transformational personal knowing within participants. Such knowing has the potential to empower nurses for more confident participation in the future development of professional identity.

Study findings reveal a need for more international research into a globally relevant definition for nursing, the adoption of a new element of co-operative knowing within nursing theory, and the development of additional international elements to nursing curricula.

ACKNOWLEDGEMENTS

My sincere thanks go to my primary supervisor, Professor Simon McGrath, for his invaluable guidance. Thanks also to Professor Monica McLean, from whom I have learned so much.

Special thanks to my sister, Miriam Thain, and my parents, Shirley and Peter Dawson, for their incredible support throughout this journey of discovery.

This work is dedicated to my nursing colleagues, past and present.

‘The future enters into us
in order to transform itself in us
long before it happens.’

(Rilke, 1993, p.65)

CHAPTER ONE

INTRODUCTION

We are frequently reminded that we are living in a global age (Messias, 2001; Giddens, 2002; Beck, 2005; Johnson, 2011); our world is increasingly inter-connected, technological advances provide instant world-wide communication and rapid transportation. The international movement of capital, people and culture are established as accepted norms. The nursing profession is not left untouched by these developments. They present it with both new challenges and new opportunities.

Nursing and midwifery services are estimated to comprise over 80% of the health care services in most countries (World Health Organization (WHO), 2016), and within the nursing profession global mobility of the workforce is well recognized (Rolfe, Bryar, Hjelm, Appelquist et al, 2004). In March 2016 there were 692,550 nurses and midwives on the United Kingdom (UK) Nursing and Midwifery Council (NMC) register (NMC, 2016). Organization for Economic Co-operation and Development (OECD) statistics from 2015 assert that 21.7% of UK nurses were born abroad and the UK exported the highest sampling number of nurses amongst OECD nations, with more than 50,000 British nurses working in other OECD nations, and others working outside the OECD. Across the European Union (EU), only Luxembourg, Ireland and Estonia

are more dependent on nurses from overseas. UK nurse education curricula aim to prepare students to practise nursing within this global workforce; to care for multi-cultural clients; to understand global health trends; and to work effectively with multi-cultural colleagues (DeDee and Stewart, 2003; Leh, Robb and Albin, 2004; Nursing and Midwifery Council, 2015).

National and global efforts to achieve the health targets of the Millennium Development Goals (MDGs) set by the United Nations (UN) in 2000 are thwarted in many countries by shortages of health staff, their inequitable distribution, and gaps in their capacity, motivation and performance (Lee, Walt and Haines, 2004; Haines and Cassels, 2004). Similarly, the ambitious targets set by the UN as part of the Sustainable Development Goals (SDGs) which have now replaced the MDGs (which include for example eliminating preventable maternal and child deaths), will only be achieved if dramatic improvements are made to educate, upskill and expand the global health workforce (WHO, 2016).

The Nursing Now campaign, launched by the International Council of Nurses (ICN) at the end of February 2018, states the following:

> *'The health challenges of the 21st Century cannot be overcome without strengthening nursing. It's time to give nurses more recognition, investment and influence. As the health professionals closest to the public, nurses should be empowered to use their knowledge, skills and expertise to the full. They*

should be valued and respected for their pivotal role at the heart of most health teams'.

If nursing is acknowledged as a globally transferable profession (Ketefian and Redman, 1997; ICN, 2005; Kingma, 2009), one might assume it to be underpinned by an internationally recognizable and transferable identity and associated knowledge-base. It may, however, be argued that nursing identity is unclear and poorly defined in a global context (Beeman, 1991; Holt, Barrett, Clarke et al, 2000; Duffield, Gardner, Chang et al, 2009; Sherwood and Shaffer, 2014). It may be suggested that nurses, though globally numerous, display limited exertion of power and influence upon the profession's development (Perron, Fluet and Holmes, 2005; Bradbury-Jones, Sambrook and Irvine, 2011; Peltomaa, Viinikainen, Rantanen et al, 2013), leading one to ask whether they are merely 'pawns in the game' of healthcare progression, and subject to external manipulation of their identity and thus their role in healthcare provision.

The benefits of internationalizing the nursing curriculum have been extensively rationalized at international, national and local strategic levels (Keighley, 2011; Grootjans and Newman, 2013; Kajander-Unkurei, Salminem, Saarikoski, et al, 2013; Jones and Sherwood, 2014; Kooienga and Carryer, 2015). This is due, in part, to the need for cultural competence with increasingly diverse populations (particularly in northern nations with high levels of migration) (Wells, 2000; Campinha-Bacote, 2002; Soulé, 2014); in part to the need to plug the gaps in a poorly retained workforce through

greater global mobility of available nursing knowledge workers; and in part to a more transformative agenda focused on developing values and skills that will equip students with a sense of agency and identity to be global citizens (Law and Muir, 2006; Aiken, Buchan, Sochalski, J. et al., 2004).

However, in promoting nursing as a globally mobile profession, and emphasizing the need to develop more internationally focused nursing curricula, some preliminary essentials must first be addressed. An exploration of nurses' own terms of reference is warranted, which considers whether nurses are able, and wish, to articulate their own aspirations and expectations for engaging with a global identity. Nurses' perceptions of the effects of internationalization upon the profession's identity need to be elicited and analyzed. The current drive to internationalize nurse education curricula requires critical examination, to interpret whether a shared or divergent professional identity is revealed.

Work which explores nurses' perceptions of the impact of internationalization upon professional identity has proved difficult to find, indicating that study is warranted. Study should analyze shared and differing perceptions of how such initiatives may have an impact upon practitioners' self-perception as nurses, and upon the evolution of the profession's identity. Work in this area

will highlight implications both for subsequent educational developments and, ultimately, the continuing pursuit of nursing identity definition.

My interest in global nursing identity emanates primarily from observations and reflections upon my own nursing experiences. I have been a UK-registered nurse for over thirty-five years. Early in my professional nursing career, I developed an aspiration to experience nursing in an international context. Over twenty-five years ago, I lived and worked for several years as Infirmière-Générale (lead nurse/matron) of a semi-rural hospital in francophone Côte d'Ivoire, West Africa. It was a seminal life experience and included many of the best and worst moments of my existence to date. My own perceptions of nursing were challenged and redefined as I examined and applied my practice alongside individuals with whom I shared no commonality of language or cultural heritage.

An excerpt from a letter home from Côte d'Ivoire, kept from December 1991, highlighted a dilemma which has emerged and re-emerged in the ensuing years, as I have worked as a practitioner, care manager, practice developer and educator:

> *'As well as all the usual work we have also a group of French student nurses who are here for a 2 week visit and require caring for.*
>
> *I am actually finding them quite difficult – they were in no way prepared for what they would see here before their arrival, and have all been pretty shocked to see children with no shoes, people admitted to hospital purely through lack of adequate food, etc. The second day of their visit we took them on a hospital tour. That evening I spent most of my time mopping up tears and trying to help them see that healthcare*

here is not like healthcare in the well-established healthcare programmes of Western Europe.

Yesterday they presented a slide-show showing information about their hospital in France. This time it was my turn to shed some tears, as I was reminded of the incredible possibilities that we have in Europe to care for our patients.

Sometimes I think it would be better not to know what's happening and what's possible across the world……'

On occasions during that experience, I questioned my understanding of myself as a nurse, and what nursing really was for me and my colleagues in that context. Returning to nurse in the UK, I experienced reverse culture shock when caring for a small group of four children in a space that would have held sixty children and their families in the place I had just left. I perceived a need for the nursing profession to seize the opportunities afforded by international experience and collaboration to examine its role and purpose within the field of healthcare, and ultimately to act more confidently in determining its global professional identity.

In the years following my work in Côte d'Ivoire, I have been a children's ward manager, practice development lead nurse, and am currently an assistant professor of nursing in a large UK Higher Education Institution (HEI). I have continued, personally, to deliberate the question of nursing identity through the various changes in nurse education philosophies and models which have been accepted and implemented in the UK in the last 20 years.

My interest in this field of study is thus inextricably linked to my own professional career trajectory. With more than thirty years of professional nursing experience, in the UK and overseas, my own experience and anecdotes attest to the challenges, obstacles and rewards of working across international boundaries. I assert that shared aims and meanings can be extraordinarily difficult to achieve or confirm, and measurable outcomes challenging to gauge across different cultural, economic and social contexts. I recognize some of the difficulties which ensue where theoretical and practice models are imposed or accepted in global contexts other than those in which they were developed. I suggest that nursing, increasingly perceived and practised as globally transferable, must explore and analyze its own identity and core activity as a discipline, to inform international curriculum development. Learning gained may empower the profession to assert an effective influence over its future.

The concept of identity which represents my starting point is that of how the nurse conceptualizes what it means to act as and be a nurse, as defined by Fagermoen (1997). In thinking, interactions and actions, the nurse will be influenced by the beliefs and values which she or he holds; therefore, what is meaningful for the nurse in their work will first be impacted by their perceptions of their own identity as a human being. Additionally, identity will be affected by what has been taught, learned, and assimilated into an individual's way of being a nurse: the embodiment of their knowledge as

knowing (Carper, 1978; Johns, 1995). If knowledge environments may be understood as influential upon nursing identity (du Toit, 1995; Lewis, 1998), educational strategies and approaches cannot but be instrumental in effecting either identity crystallization, fragmentation or transformation. Recent work by Ayala and Nunez (2016) identifies an increasingly diverse nursing community, which is developing apace as international exchange and movement is having an impact. It may thus be increasingly difficult to determine or demonstrate any dominant or primary professional identity for nurses as the diverse nature of their roles increases.

The current drive to internationalize the UK nursing curriculum both excites and concerns me. Motivations for, and influences upon, internationalization may be both beneficial and detrimental to the development of a clear identity for nurses within global healthcare. Drivers to promote a clearer identity must be juxtaposed with economic and social pressures to provide a cost-effective and globally mobile workforce. Underpinning these reflections lies a persistent personal concern that nurses themselves may have limited engagement with, and influence upon, professional identity definition. An increasingly diverse global nursing community risks the potential loss of any communal professional identity. For some, such development may be perceived as no loss, but rather as a positive step in the evolution of diverse nursing identities which will support effective, relevant and contextually-applicable healthcare provision. For others, an increasingly fragmented

definition for a discipline which has struggled to gain recognized professional status could limit its power to influence its future identity and associated development.

I should at this stage differentiate between and define the concepts of nursing identity and nursing knowledge. My interest is particularly in nursing identity; I wish to explore what nursing is perceived to be by those involved in its practice, but I assert that the foundational understandings and activities of nursing must be explored in order to reveal nursing identity. I suggest that how professional knowledge is determined, the constructs which inform it, and how its accepted elements are valued and reviewed, will impact upon its identity. I would argue that whatever comprises the goals, accepted knowledge base, and practical activity of an occupation or profession, will indicate much about its perceived identity, social positioning and influence.

International nurse education initiatives provide a vehicle which brings together those with potentially diverse professional self-definitions. This study presents an exploration of whether, and how, international education initiatives are impacting upon the professional identity of nursing and nurses. My aim is to seek the opinions and developing views of individuals (undergraduate nursing students, post-graduate nursing students and nursing academics) who have engaged with international opportunities; considering

and analysing whether, and how, their nursing identity has been impacted and changed by their international experiences. I am particularly interested in exploring whether nursing identity, as it may be globally understood, takes account (as it evolves) of voices from, and experiences of, nursing experience with a global perspective.

Form of thesis

Chapters 1-4, present background and preparatory work for the empirical study which is explained in chapter 5. Chapters 6-11, present and discuss study findings, consider their implications, and conclude the thesis.

Chapter Two explores internationalization, both as a broad concept and as an element of nurse education. Perspectives on international nurse education initiatives from UK Higher Education nursing programmes, and from around the world, are critically explored. The chapter explores both the driving and restraining forces associated with such initiatives for nursing identity development, and it exposes gaps in current literature which this study seeks to address.

Chapter Three explores literature on the theme of identity in and for nursing. Definitions of identity, as they may be applied to nursing, are examined, along with received histories of the profession's development and

their impact on identity definition and development. Global mobility, and social and cultural issues, which may affect both the understanding and the exercise of nursing identity, are critically reviewed. The influence of power, both over and by nurses, on nursing identity is considered.

Chapter Four explores a range of theoretical constructs. Firstly, it introduces the dimensions of critical theory, and demonstrates that the principles of critical theory represent my own philosophical standpoint, and thus form the overarching lens through which this work has found focus, and through which study findings will be viewed. Secondly, it explores theories which may frame underpinning understandings of nursing and inform perceptions of nursing identity. The exploration of these theories progresses to specific identification of concepts developed by Bourdieu and Carper as appropriate for application to structure the interpretation of data yielded from this study. The chapter culminates in a summary of key findings from the literature review and the elucidation of my study aim and research questions.

Chapter Five presents and analyses strategies for study design and data collection. This chapter describes the rationale for the choice of one-to-one interviewing, sampling decisions, and the plans and interview structure for 18 one-to-one interviews are discussed. Ethical considerations are explored, and associated actions are rationalized. Explanations of the application and use of

selected theoretical concepts are presented, and the approach to data analysis is explained and justified.

Chapters Six to Nine present, analyse and discuss study findings grouped under 4 major themes which either relate to the study questions or have emerged from study data:

Chapter Six explores conflicting influences upon nursing identity;

Chapter Seven explores the particular influence of internationalization upon nursing identity;

Chapter Eight considers whether nurses are failing to recognize some of the drivers which are impacting nursing identity;

Chapter Nine explores how internationalization in nurse education may be a potential vehicle of nurse empowerment for professional self-definition.

Chapter Ten proposes an additional theoretical construct which highlights the need to demonstrate an element of co-operative knowing when seeking understanding of nursing development, and professional identity definition.

Chapter Eleven presents a summative conclusion to the study.

Approach to the literature

A review of existing literature on such broad conceptual themes as those selected for my study requires the identification of an appropriate framework or structure. I rejected any rigid, systematic framework, preferring to explore and present all elements of this study through an iterative, interpretive lens. I thus determined to use a critical approach to the selection and review of literature perceived as relevant to my purposes. A critical review, increasingly recognized as a legitimate and robust approach for research in the domains of health care and social interventions (Rolfe, 1999; Rolfe, 2008; Tanner-Smith and Brown, 2010; Ussher, 2010; Pilnick and Dingwall, 2011; Edgley, Stickley, Timmons et al., 2016), aims to collate a range of types of literature, and draws upon research insights about human behaviour and social context from multiple sources and disciplines. A review conducted from this stance is consistent with both the underpinning philosophy and the methodological approach employed for my empirical work.

The critical review is an organic process, an intellectual and personal journey in which the pathway is created as a direct result of the researcher's critical choices, while the destination similarly cannot be known until it is reached. Philosophically, it emanates from a critical realist perspective (Archer, 2003; 2005; Edgley, Stickley, Timmons et al., 2016), which holds that not all causal mechanisms are empirically visible or measurable. This approach recognises that the social world is vastly complex; that what is influential in one setting

may be less so in another; and that macro social influences may be at play. Unlike a more systematic review, the critical approach makes no claim to have conducted an exhaustive search for all relevant literature, nor to have attempted to explore all potentially relevant themes. The journey taken through the literature will not be replicable by another person; nor will its findings be presented as offering any definitive fact or truth.

There are no strict inclusion or exclusion criteria at the outset, because the review follows an iterative process. My own standpoint will have affected my choice of papers to search and books to read – the resonance of words within titles has drawn me to select some and not others for closer scrutiny. It is likely that I have read with greater interest, and probably selected data for analysis from, sources which either endorse my own views or radically oppose them.

The review focuses on two key elements of focus for my study: identity and internationalization. It also includes a review of theoretical frameworks which resonate with research themes and my own ontological stance as nurse, educator and researcher. The review critically explores existing work in these subject areas. It identifies relevant findings, synthesizes key points, and presents some critical interpretation of their strengths, limitations, omissions and biases. Demonstrating what is missing from existing work, the review ultimately leads to the identification of study research questions and the theoretical framework for my study.

Initially a search was undertaken via a range of databases (CINHAL, EMBASE, ASSIA, PubMed), with the following keywords used in various configurations: identity; internationalization; nursing; nurse education; globalization; history; power; knowledge; theory. Sources ranging from published books to websites and newspaper articles, focusing on nursing as a profession, the development of nursing, the advancement of nursing, nurse education and internationalization were accessed, as were sources from other disciplines which appeared to explore these themes in some way. As appropriate in critical review work, the literature search and subsequent journey through to analysis, was undertaken to allow the gradual revelation and evolution of ideas and concepts. The full extent of the literatures which could have been accessed has clearly not been reached, and I make no claim that another researcher would concur with my decisions and interpretations.

Chapter Two of the thesis will explore literature which focuses on the internationalization of nurse education. It will discuss definitions of internationalization, and it will offer some critical comment on initiatives to internationalize nursing curricula, considering what is revealed of their potential to drive the development of an authentic, global identity for nursing.

CHAPTER TWO

THE INTERNATIONALIZATION OF NURSE EDUCATION

My review of literature on themes relevant to my own research interests commences with an exploration of the concept of internationalization, particularly as it pertains to nursing and nurse education. The internationalization of nursing as a concept is explored, considering drivers, frameworks and some existing educational initiatives. The international nursing curriculum, and its potential impact upon nursing identity is critically discussed. Sources are commented upon and analyzed for their potential value in illuminating concepts and areas for greater exploration in my own study.

Defining internationalization

Nurse education curricula in the UK aim increasingly to prepare students to be effective assets, operating as workers with globally transferable knowledge. Objectives which address this aim are devised within strategies commonly referred to as those of 'internationalization'. Notwithstanding this primary focus, internationalization is a contested term, with diverse meanings (Allen & Ogilvie, 2004; Knight, 2004; Law & Muir, 2006). In the context of Higher Education (HE), it tends to be defined in two particular ways. The first definition emphasizes both the financial benefit of international student

recruitment for the institution, and the benefit to individual graduates of employability within a globalized world with the development of language, inter-cultural communication and greater understanding of discipline-specific global and regional issues. The second definition emanates from a more liberal or transformative agenda and focuses upon building an individual's personal sense of belonging within an interdependent global community (Brooks, 2010; Shamian, 2015). However, neither of these definitions acknowledge the symbiotic and interdependent relationships which may exist between international partners, and by both sending and receiving nations, influenced by historical, political and cultural mores and power struggles. Yang (2002) argues that the term globalization is linked to western colonization and dominance, and is historically burdened. He maintains that the rationale for internationalization lies in an acknowledgement of the universal nature of the advancement of knowledge. It can be suggested that countries around the world have been assisted, encouraged, coerced or colonized into developing their own nursing knowledge and working by following western models. Connell, (2007), argues that there is a history of presenting such theory as universal knowledge – an issue difficult to counter when developing authentically international curricula.

Higher Education Institutions (HEIs) are increasingly adopting a definition of internationalization coined by Knight (2004, p.11), that '*internationalization is the process of integrating an international/inter-cultural and/or global*

dimension into the goals, functions, teaching, learning, research and services and delivery of higher education'. Knight argues for a consensual definition of internationalization. Her definition assumes that certain international elements within curricula are clearly identifiable, and that they can be standardized for inclusion in a shared view. This assumption demands close examination. Notwithstanding any agreed or shared educational processes and structures, the meanings, interpretations and application of learning and knowledge across international boundaries will essentially remain culturally influenced and therefore be difficult to standardize, measure or evaluate.

There is a consensus that there is more to the internationalization of nurse education than recruiting international students and promoting greater professional mobility to address both the 'brain drain' and world shortage of health personnel (Aluttis, Bishaw and Frank, 2014; Ashton and Wagman, 2015). Current initiatives within nursing curricula include international immersion experiences for students, shared study opportunities for students across international boundaries using information technology, and teaching and learning content within taught and self-directed sessions (Svensson and Wihlborg, 2010).

The UK Government supports the development of multi-agency partnerships between NHS organizations, UK universities and overseas institutions to build

healthcare capacity for mutual benefit (Department of Health (DoH), 2010). Likewise, the position of the UK Council of Deans of Health is set out in its International Policy, stating that:

> '*the education and preparation of an educated and skilled health care professional workforce is fundamental to the delivery of effective health care services in all countries; we have a responsibility to exchange education, research and expertise with colleagues worldwide and to promote opportunities for shared learning*' (Council of Deans of Health, 2009 p.1).

While we may enthusiastically endorse the concept of shared learning and its potential capacity to influence nursing identity, there is sparse literature available which explores how this influence might best be exploited.

Perspectives on existing initiatives

To date, the movement of students has been largely from less developed countries to countries of relative affluence. The numbers of students travelling to study nursing in Australia, for example, either as international full fee paying students or as part of an exchange programme, far outweighs the numbers of Australian students who study abroad (Australian Government, 2015). Less than 1% of all Australian undergraduate students complete part of their degree overseas (Daly and Barker, 2005). This bias is further exaggerated by the increasing numbers of courses available to overseas students on-line.

Perceptions of what constitutes good curricula and valuable approaches to teaching and learning may be shared as students and educators cross international boundaries through different educational initiatives. At times efforts are made to apply models and concepts which have been encountered or used in a different context (Altbach & McGill Peterson, 1999). However, the introduction of western nursing curricula in non-western countries is questionable. Holt, Barrett, Clarke et al (2000) suggest that rationalist theories and models of care which have been exported are now being challenged and have further evolved in their countries of origin. Essentially, many have been constructed with reference to models previously evident in western schools of nursing – models now frequently criticized for their adherence to behaviourist, static, inflexible, uncritical and content-driven approaches to learning (Ironside, 2004; Allsop, 2006; Archibald, 2012; Ayandiran, Irinoye, Faronbi et al., 2013). Western influence on nursing curricula raises concerns of cultural imperialism and questions the relevance of education for practice (Holt, Barrett, Clarke et al., 2000; Nonkelela, 2001). It can be suggested that incoming migrant nurses who have learnt their nursing craft through the use of such models persist in being disadvantaged when they discover that their understanding of nursing is at odds with what they see being practised when they arrive as UK incomers.

Commentators warn against the distillation of local meanings and differences into universal explanations and applications (Altbach and McGill Peterson,

1999). Of particular concern is the possible loss of local and traditional knowledge with more value being given to the strong research-based empirical traditions of western ideology. It is a challenge for nurse education to ensure cultural and ethical sensitivity within different learning settings. Western influence on nursing curricula in countries such as South Africa begs the question as to whether education is relevant to the realities of practice (Holt, Barrett, Clark and Monks, 2000; Nonkelela, 2001). Lack of effective connection with local traditional knowledge and practices may leave nurses struggling to meet the needs of the populations they work with (Nonkelela, 2001). It is important to value local cultures, to consider alternative ways of understanding nursing and its practices, and to counter the tradition of western countries to export their knowledge and ideas while rarely importing from others (Holt, Barrett, Clarke et al., 2000). The need for a multicultural perspective is evident, albeit challenging to achieve. Failure to adopt such a perspective risks the creation of anachronistic education programmes, ill-fitted for the changing world of nursing practice (Parker and McMillan, 2007). Practical challenges associated with both academic and practical assessment and management of an international classroom dynamic need addressing through greater understanding and accommodation of cultural differences in thinking and learning styles (Tiwari, Avery and Lai, 2003; Xu & Davidhizar, 2005; Parker and McMillan, 2007). Some studies report a lack of education and relevant expertise within nurse educators in the delivery of international curricula, and also a lack of support for these individuals in their work

(Ciesielka, Conway, Schumacher et al., 2005; Richardson and Carryer, 2005; Parker and McMillan, 2007).

Challenges experienced by international students coming to the UK to study are widely reported in the literature and include problems related to English as a Second Language (ESL), unfamiliar learning styles, differing expectations from teachers, financial difficulty, dealing with isolation, discrimination and other intercultural issues (Sanner, Wilson and Samson, 2002; Moon, 2003; Deumert, Marginson, Nyland et al., 2005; Parker and McMillan, 2007). Despite such challenges, many international students are successful in their studies (Kumar, 2005). Parker and McMillan (2007) suggest that lack of recognition and poor communication often leads to exclusionary and divisive behaviours towards international students, including lack of attention to their histories and their aspirations. All these studies assert that institutions frequently fail to capitalize upon presence and participation of their international students. A greater awareness is warranted of the unique contribution to our understanding of nursing and its identity as an international phenomenon afforded by the presence and contributions of international students.

UK nurse education institutions currently advocate the use of a variety of approaches to expand integration of global nursing perspectives into our

accepted knowledge bases. International courses on campus and internet, videoconferencing (Kirkpatrick and Brown, 1999; Scherubel, 2001); short term international exchange programmes (Inglis, Rolls and Kristy, 2000; Kuczkowski, DeLlisser, Maushammer et al., 2001); long term international exchange programmes (Scholes and Moore, 2000; Duffy 2001); and international placement programmes, involving both developed and developing countries, heighten awareness of the need to engage on a global scale with nursing development.

Empirical studies identified in the search for literature on existing international initiatives in nurse education were exclusively conducted in the qualitative paradigm. A variety of approaches was employed, with questionnaires being used most frequently (Scholes and Moore, 2000; Thompson, Boore and Deeny, 2000; Ryan and Tribell, 2002; Wihlborg, 2002; DeDee and Stewart, 2003; Van Hoof and Verbeten, 2005). Questionnaires completed in the presence of the researcher may be influenced by them (LoBiondo-Wood and Haber, 1998), a point worth noting when most studies were conducted by those teaching the student participants. Questionnaires also afford no opportunity for the researcher to correct misunderstandings or offer explanations (Jack and Clarke, 1998), thereby potentially reducing the value of data they elicit. Interviews were conducted in many studies (Scholes and Moore, 2000; Wihlborg, 2004; Callister and Cox, 2006; Ruddock and Turner, 2007; Edmonds, 2010) with focus groups being used by Evanson and

Zust (2006). Focus groups and group interviews allow researchers to probe answers, opinions and experience (Kitzinger, 1996) and may enable the researcher to increase their knowledge of the insider view (Holloway and Galvin, 2016). However, it must be noted that researcher influence may result in the proffering of views which do not represent participants' true opinion (Morgan, 1997), a point which studies have not always acknowledged. Research literature recommends that participants should be unknown to each other (Bassett, 2004; Tuckett, 2004) in order for more honest contributions to be made in discussion.

Although learning about other cultures may be accomplished through exposure to other ethnic groups within one's own society, Gerrish, Husband and Mackensie (1996), and Garvey (1997), suggest that immersion in another culture for at least three months is the best way to obtain such education. One should, perhaps, question whether short-term exposure does, realistically, result in cross-cultural understandings and development. Programmes aimed at developing nursing research and education may take the form of student and teacher exchanges; collaborative research projects; sabbatical appointments, and consultancies. In reviewing literature on international nursing research and educational exchanges, McAuliffe and Cohen (2005) discovered that most papers were written by faculty (even though most international exchanges were for students), and that most papers were written by persons from only one side of the exchange, this

almost exclusively from the western perspective. Button, Green, Tengnah et al., (2005), also recommend that educational institutions provide opportunities for students to participate in nursing care and education in another country, which enables comparison between cultures, nursing practice and health care delivery (McElmurry, Misner and Buseh, 2003). Beeman (1991, p.63) states that, '*A greater understanding of what constitutes nursing in another culture can often expand one's perception, acceptance and understanding of oneself as a nurse*'.

The immersion experience, a period spent abroad in clinical practice, is the most common international element explored in existing literature. Invariably, following such experiences, students felt that they were subsequently more able to relate congruently and compassionately to diverse clients and colleagues (Callister and Cox, 2006). They argue that international immersion experience makes a valuable contribution to the creation of a culturally sensitive clinical environment due to consequent changed perspectives and practices. One participant stated: '*You can't have a profound life experience like I've had and not have it change you. It changed how I practice [sic] my profession. It changed my life*' (Callister and Cox, 2006 p.98).

Edmonds (2010) asserts that the location of immersion experience is insignificant. Thompson, Boore and Deeny (2000) concur, and add that individuals should be placed where they will encounter a culture which

contrasts significantly to their own, in order to engender greater self-confidence, their use of personal initiative, and illuminate to them the significance of professional values. Van Hoof and Verbeten's large study (2005) in the USA utilised web-based questionnaires to both incoming and outgoing students undertaking international clinical elective experience and theory-based courses. Their findings underline additional attributes which may ensue including maturity, compassion and resilience to live and work in less familiar environments. They suggest that participation in immersion experience is most often rooted in its location and the possibility of seeing the world rather than by any academic or professional motivations. Interestingly though in this, the only study to consider the experience of students travelling as outsiders to western health care environments, these students identify the academic learning they achieve through this encounter as paramount. One may deduce that although students' aims may have been to see the world, much more than that is achieved and seeing the world is not the most significant outcome of their experience.

The debate about cultural competence

When considering the learning outcomes which HEIs are attempting to promote in their students via international elements within their curricula, a wide range of terms are employed which can be grouped together as skills and attributes of cultural competence. Interpretations and understandings of what this is and how it may be developed are widely different as shown in

relevant literature. Schim, Doorenbos, Benkert et al., (2007) review existing work on cultural care and discover a disparate assortment of words such as *cultural diversity*, *competence*, *awareness* and *sensitivity* used by different authors in different ways and interchangeably. They assert that ambiguity has led to confusion and to some resistance towards the development of cross-cultural elements in health care curricula. Their premise is that specific cultural competencies can be defined, learned and identified in practice and that the scope of competence is related to the number and variety of diverse groups and individuals encountered by the health professional. Conversely, Wihlborg (2002 and 2004) takes a non-constructivist view, with an epistemological standpoint which does not separate knowledge and people's life and world, her premise being that knowledge is conceived between humans and their lifeworld. She tempers her assertions with the statement that meaning, knowledge and understanding can vary and will be influenced by the cultural context wherein the learning object exists. She acknowledges that her own analysis as researcher will be affected by her own cultural context and cultural competence. Interestingly, student perceptions in Wihlborg's study were very mixed and varied, contrasting with the almost exclusively positive comments yielded in other papers. Some commented that clearly identified aims, outcomes and how they might be achieved, assessed and evaluated are needed and that, although students may express feelings of personal growth, this is difficult to define and measure and needs more reflection upon and analysis in the classroom. They assert that definitions of international curricula outcomes are needed with valid markers for

achievement. Students wanted more preparation for caring for those with diverse backgrounds and needs to enable them to offer care with more knowledge and understanding.

Campinha-Bacote (2002), presents a model of cultural competence in health care delivery. The model views cultural competence as an ongoing process in which the health care provider continually strives to achieve the ability to work within the cultural context of the client, integrating cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire. If, as she propounds, one attribute of the culturally competent is the desire to become so, we might question whether those who independently seek the opportunity for immersion experience will demonstrate a different learning experience from those who do not. Given the cosmopolitan and multi-cultural nature of many western populations in today's society, we may question whether travel abroad is either necessary or advisable for all students to gain the experience and learning which is sought. Scholes and Moore (2000) suggest that the crucial element of the immersion experience is that of social dislocation, which results in students demonstrating greater empathy for patient experience. If, as they assert, students may ultimately transfer this attribute to any subcultural context (for example age, gender, ethnicity and disease), it could be argued that the professional attributes found to accrue from international experience may be achieved in alternative ways. Findings from one study showed that immersion experiences elicit greater perceived gains in cultural competence than alternative educational

initiatives integrated into curricula (Caffrey, Neander, Markle et al, 2005), although all experiences are deemed as positive in promoting greater confidence in professional identity.

Given the contested definitions and interpretations of internationalization as it pertains to HE and nursing in particular, in order for any logical analysis of the quality and outcomes of any specific initiative to be made, it can be argued that it should be developed against an identified framework or model which illuminates its epistemological standpoint, its reliability and its validity. Indeed, it is ironic that many studies which highlight the importance of attempting to understand that the complexity of international encounter may lead to diverging interpretation and application, do not themselves clarify their standpoint and justify their findings against any rationalized structure.

Some papers discuss what they deem as appropriate theoretical frameworks, both to rationalize their standpoint as researchers in relation to their explored topics, and around which to discuss their findings and ultimate comments. Edmonds (2010) uses Campinha-Bacote's (2002) conceptual model of cultural competence in the delivery of health care. Caffrey, Neander, Markle et al. (2005), use Wells' (2000) model of cultural competence, suggesting that competence results from both cognitive and affective changes. Thompson, Boore and Deeny (2000) consider various models:

Lynam, Browne, Reimer et al.'s (2007), which identifies a need for balance between culture specific and generic issues; McGee's (2001), which questions whether cultural competence is in fact a theme woven through all learning, and whether it can be specifically and separately addressed (for example through immersion); and Leininger's 'Sunrise' Model of cultural care diversity and universality (1997), which highlights concepts of holism and individuality. Evanson and Zust (2006) utilize a reflective approach although they do not explore models of reflection in any depth. Callister and Cox's phenomenological study (2006), undertaken in Denmark, asserts that many studies focus predominantly on the practicalities and logistics of setting up electives and pay little attention to their value in promoting relevant learning. Indeed, there is little literature which explores what learning outcomes ought to be and why. Their own study is based on the International Experience Model (Wilson, 1993), which emphasises the gaining of a global perspective through substantive knowledge and perceptual understanding, and the development of self and relationships through personal growth and interpersonal connections. Viewing the construct of learning differently, Ingulstrud, Kai, Kadowaki et al. (2002), have developed a holistic model of assessing cross-cultural experience, using authentic assessment via student-generated portfolio assessment which measures the degree of cross-cultural awareness by locating evidence of critical thinking and associated learning.

Ryan and Twibell (2002) deduced from a study of 80 nursing students that a

demonstrable transformation to ethnorelativism (an ability to perceive the significance of culture upon identity, behaviours and values) occurred in students who engaged in an international immersion experience, and developed an organizing framework to guide faculty members in designing, facilitating and evaluating culturally focused field experiences. Their framework is based on Leininger's (1997) theory of culture care and universality, and aims to develop culturally caring skills through technological, religious, philosophical, kinship, social and economic themes in education. Their guidelines include recommendations for immersion experiences, such as integrating international experiences into the curriculum, a minimum of two weeks for any visit, and focusing on direct patient care. They studied the application and effect of the model with students via questionnaire, leading to some amendments and further development. The majority of students disclosed that their most helpful learning was not via teaching from faculty, stating that preparation for immersion experience is most useful when it addresses issues such as problem-solving, self-awareness and independent decision making as well as practical issues such as travel, language and situational history. The model is detailed, soundly rationalized and tested and arguably transferable for use in any international curriculum initiative. Although this model has been cited as the basis for several empirical studies relating to student experience and learning in the international context, its validity and reliability has been neither endorsed nor challenged in these works.

Chapter Two has explored the internationalization of nurse education. Definitions of internationalization have been discussed, and driving forces shown in the literature as relevant to the development of nurse education have been analysed. It can be suggested that as internationalization initiatives in nurse education will result in greater exposure to, and sharing of practices from, diverse societies, nursing identity has the potential to be influenced and changed by them. The predominantly western literature-base, as yet, shows little evidence that this outcome of internationalization has been either acknowledged or explored.

Chapter Three will examine broad concepts of identity, and a range of factors which may be perceived as influencing nursing identity.

CHAPTER THREE

AN IDENTITY FOR NURSING

Attention now progresses to explore literature on identity, considering definitions within and outside nursing. Nursing history, and theories of nursing which may continue to influence perceptions of identity, are examined. This leads to some comment upon nursing identity as shown in existing works, and its influence upon (and relationship with) nursing knowledge construction and educational initiatives. Global mobility and migrancy of nurses both for education and practice is reviewed, to consider drivers for professional and educational interchange and the impact of such movements upon identity. Social and cultural issues which may be of relevance, specifically those which may be influencing nursing identity in its diverse international contexts are explored. The theme of power in nursing is explored, with particular focus upon the structures and sources which appear to have exerted (and be exerting) degrees of power and influence over global nursing.

Representations of identity are, through their structure and regulation, guides for conduct and tools with which attempts are made to maintain social order, and to understand both individuals, groups and societies (Foucault, 1977;

Giddens, 2001). The concept of identity has been explained in various ways by theorists. The essentialists' view (Cartwright, 1968; Spelman, 1988; Hall and du Gay, 1996) is that each individual has an element of personal identity which is permanent and unchanging. Cultural essentialism argues that specific groups, for example, races, nationalities, religion adherents and professions, also have a collective, shared, and essentially unchanging identity which can be clearly defined (Grimshaw, 2010). Symbolic interactionists present a different view, in that they argue that while each individual or group has a constant core identity, elements of their identity are malleable, and will change due to the influences of social interaction (Mead, 1934; Cooley, 1964; Hawkins, 2005; Algase, 2010). The postmodernist approach to identity asserts that the increasing complexity of society and its interactions is escalating the rate and enlarging the scale of identity changes for both individuals and groups (Hawkins, 2005; Grimshaw and Sears, 2008). Postmodernists argue that while there is a risk that identities may become damaged, destroyed and potentially may disappear as a result of change, they may also be enriched and become more authentic as representative of the individuals and groups which claim ownership of them, as they have their boundaries challenged, analysed and re-defined (Giddens, 1991; Bauman, 1996; Airey and Tribe, 2005). These differing perspectives have been helpful to explore before examining some of the factors which the literature has shown as having some influence upon nursing identities.

How nursing may be defined

The International Council of Nurses (ICN) describes nursing thus:

> '*Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles*' (ICN 2012).

Orlando's work (1961), considered seminal in structuring the specific actions of the nursing process: the assessment of care needs, the planning and implementation of care plans, and the subsequent evaluation of their success in achieving optimum health outcomes, was further developed over four decades by Henderson. Henderson's 1966 definition of nursing continues to be widely cited in current literature, and quoted in nurse education programmes, as both a foundational and universal description of the work that nurses do (Smith, 1989; Castledine, 1996; Nicely and DeLario, 2011; Clares, de Freitas and Paulino, 2013). Henderson states that the nurse will:

> *'….assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he [or she] would perform unaided if [s]he had the necessary strength, will or knowledge. And to do this in such a way as to help him [or her] gain independence as rapidly as possible…. This aspect of her [or his] work, this part of her function, [s]he initiates and controls; of this [s]he is master.'*

The element of care, accepted as an essential constituent of nursing in received definitions, may thus be considered a universal concept which forms

a linking characteristic for the manifestations of nursing represented in these definitions.

Recent work highlights the advancement of nursing into areas of work more traditionally undertaken by medical professionals, such as caseload management, clinical diagnosis, treatment initiation and medication prescribing, with the interface between nursing and medicine becoming more fluid (Manley, 1997; Hamric, 2000). Manley (1997) identifies new 'subroles' for the nurse: expert practitioner or specialist, educator, researcher and consultant. Many authors welcome these developments as evidence of positive professional progression for nursing (Alpert, Fjone and Candela, 2002; Cummings, Fraser and Tarlier, 2003; MacDonald, Herbert and Thibeault, 2006; Casey, O'Connor, Nicholson et al., 2017). Such views need exploration alongside concerns which are also evident in the literature, that what is perceived as the universal element of nursing – the intimate care of individuals to help them with their essential daily activities – risks becoming undermined as nursing identity expands into advanced roles (Henderson, 2006; Whyte, 2008; Calkin, 2011; Mackintosh-Franklin, 2016).

Advanced practice nursing roles are increasing internationally at a rapid pace (Duffield, Gardner, Chang and Catling-Paul, 2009; Koskinen, Mikkonen, Graham, et al., 2012), with evidence mounting to demonstrate their acceptance (Gardner, Chang and Duffield, 2007; Glasper, 2011; Esperat,

Hanson-Turton, Richardson et al., 2012; Lowe, Plummer, O'Brien, and Boyd (2012). However, notwithstanding the generally positive acceptance of advanced nursing roles, there is also evidence which suggests the presence of some disquiet at the driving forces for their evolution. Coyler (2004), for example, suggests that development decisions have emanated from service gaps and medical staff shortages, rather than from any epistemological debate about nursing ontology. Gioilli (2013) suggests and explores the characteristic of colonization in identity experience: a process in which identities are in a state of constant production and re-invention, influenced by forces largely extraneous to themselves. She suggests that nursing identities are continuously being colonized by the needs of proximal forces, structures and institutions, becoming what these forces need and want them to be, rather than anything that nurses themselves are seeking to either remain or become. It can be suggested that nursing is potentially highly susceptible to the colonizing of its identity by external forces, when its history has been so inter-twined with, and subordinate to, that of medicine. Some would argue that identity formation will be a product of all its earlier forms (Bentley, 2011). Such a perspective suggests that histories of nursing need examination for what they may illuminate.

Nursing history and sociology

Received histories of nursing make little reference to nursing before the UK's Victorian era, when Florence Nightingale acted as both an initiator of, and a

conduit for, the standardization of nursing on a significant, and ultimately, global scale. Writers of nursing history generally divide the development of nursing into three distinct phases (Abel-Smith, 1960; Carpenter, 1980; Davies, 1980; Rafferty, 1996). Firstly, the era from Nightingale to the First World War, with attempts to establish a distinct nursing structure, despite the considerable and sometimes adversarial power of managerial structures and medical hierarchies. Secondly, moves in the early twentieth century for the recognition of nursing as a profession, complimentary rather than subordinate to medicine. Thirdly, developments in the early 1970s which sought to provide clinical nurses with a knowledge base independent of medicine. It can be suggested that many countries around the world have developed their own nursing work by following this pathway.

It is generally held that, while nursing aspires to full professional status, it has not achieved it in the way that medicine has (Freidson, 1970; Rossides, 1998). A professional occupation possesses certain distinguishing features. According to Blane (1982) professions have a specialized body of knowledge and seek to expand on that knowledge through research. They are self-regulating and self-evaluating and are guided by a code of ethics that describes their commitment to the service of others. While UK nurses, for example, may argue that nursing certainly demonstrates most of these features, with regulation by the Nursing and Midwifery Council, an established Code of Conduct (NMC, 2015), and the escalation of nursing-specific research

publications, literature suggests that nursing has yet to effectively demonstrate a unique and specialized body of knowledge, and that essentially nurses remain subordinate to organizational hierarchy, professional agendas, and the culturally-endorsed authority of medicine (Liaschenko and Peter, 2004; Andrew, 2012).

Global mobility, and its impact on nursing identity

Global migrancy of capital, knowledge, communication and human beings is impacting significantly upon nursing and changing the characteristics and development of nursing. Nursing is recognized and accepted as a globally transferable occupation with nurses travelling across international boundaries for employment. Many benefits have been identified as accruing from this mobilization. Aiken, Buchan, Sochalski et al. (2004), and Sparacio (2005) assert that an international nursing workforce has the potential to add value by increasing diversity, capacity and flexibility in the workplace. Papadopoulos, Tilk and Taylor (1998), and Spence (2001), consider that the ethnic and cultural diversity of an international workforce will influence assumptions about the nature of health, illness and health care practices. The impact upon nursing identity of its growing professional diversity requires exposure.

There is a reported shortage of nurses in most member states of the World Health Organization (WHO, 2000). International recruitment can be seen as a solution to this problem. Comprising the majority of healthcare workers worldwide, nursing is extensively integrated into contemporary processes of globalization. The largest group of health care professionals who are working outside their country of origin or training are nurses, due in no small part to the worldwide shortage of nurses, across all health care systems (Yeates, 2009). There is clear evidence that international migration has a negative impact on the health of supplier nation populations (Kingma, 2001). In the longer term there may be a negative impact on the development of culturally relevant nursing knowledge within these countries, who rely on a dwindling supply of educated professionals to both manage and deliver care and build upon the local nursing knowledge base. Kingma (2006) argues that the positive professional development for migrating nurses which may result from international movement must be weighed against a substantial brain and skills drain experienced by supplier countries (Sherwood and Shaffer, 2014). Short-term solutions to resolve the problem of a worldwide shortage of nurses should be a cause for concern, both for global health and for the role and activity of the nurse.

The majority of international nursing conferences and networking opportunities are organized in western nations (defined broadly for the purposes of this paper as encompassing Europe and the United States), and

success in securing funding for presentations and dissemination of papers frequently rests upon the perceived quality of research and innovation emanating from authors and their academic institutions (Johnson, 2011). The literature demonstrates awareness of the need to promote nursing knowledge generation and dissemination from quarters historically excluded from the heard debate (Freda, 1999; Casey, 1999; Sherwood, 2005; Bustreo, Gorna and Nabarro, 2016).

Where there is global application of models initially developed for specific western contexts, critical exploration is required to determine their appropriateness. An examination of literature relating to experience in other fields, such as law and education, reveals some helpful points. Here we see echoes of similar dilemmas, frustrations and successes. Basu (1999) asserts that in the field of education in India, long after independence many features of colonial education and the tendency to look to the west for models still persists. Established scientific and technological institutes and new research programmes are predominantly inspired by western models. He also states that '*while such dependency is probably inevitable given the technological and economic superiority of the West, it makes Indian academics imitative and dampens originality*' (Basu, 1999 p. 167). Although this source is now somewhat dated, it highlights the suggestion that western models may still be considered to hold significant influence. In the legal field, Seider (2004) focuses on the impact of globalization upon the legal system in Guatemala.

She considers the interplay between transnationally promoted institutional reform, state legal formations and practices, and historically shaped expectations of law and justice, and asks what dominant trends mean for human rights and access to justice, especially for the most vulnerable and excluded sectors of society. She argues for a focus on the historical development of the nation state, because transnationally promoted legal reforms have differing effects according to national and local contexts, dependent upon localized state and legal systems, and the legal interactions that historically characterize state-society relations. These papers, each representing scholarship from discrete and long-established disciplines with considerable experience in international collaborations, highlight similar and recurring themes - themes which bear consideration as nursing identity is analyzed and international nurse education is explored.

Social and cultural issues

Postmodernist epistemologies have developed with the rise of globalization – those which regard definitions as bound to time and place as well as to the people who construct them. The postmodernist thus argues that every truth is contingent upon its context and that no understanding transcends its specific social and cultural setting (Anderson and Gehartd, 2007). It is appropriate to consider social and cultural influences which may be influencing perceptions of nursing identity. Ketefian and Redman (1997) argue that social, political and environmental factors are significant when

considering what it is that nurses actually do, and how they perceive their role, purpose and function as nurses, as are national and local beliefs, values and practices.

Exploring nurses' experience can reflect indigenous practice values (Pang, Wong, Wang et al., 2004), which can act as a fertile source of debate, and potentially the identification of a globally inclusive definition and thus a more relevant identity for nursing in the twenty-first century. Pang et al., (2004) reveal a lack of systematic study of how nurses articulate nursing in their everyday practice; however their research shows that although Chinese nurses define nursing in a manner which has similarities to definitions articulated by western nurses, their underpinning epistemic concerns are grounded in the philosophy of traditional Chinese medicine and Eastern ideologies. Their study shows that illness as understood in traditional Chinese medicine is a state of disharmony between the individual and the natural and social environment. They argue that Chinese nurses articulate a version of nursing that is grounded more in their cultural understanding of health than that of translated or transferred versions from the west.

Drawing from traditional health care values in their own cultures, Hisama (2001) and Shin (2001) have considered distinctive features of nursing theory development from an Asian perspective. A survey of the ethical role responsibilities of Chinese, American and Japanese nurses reveals cultural differences. Pang, Sawada, Konishi et al. (2003), assert that Chinese nurses

appear to be more virtue-based, Japanese nurses more care-based, and American nurses more principle-based. Shin (2001) argues that since Korean understanding of health integrates Confucianism, Buddhism and Taoism, direct translation of nursing theory developed in the west may not be applicable. She states the importance of developing a nursing theory that is based on a Korean understanding of reality.

A further example of diversity in perspective is illustrated when considering current western nations' social emphases on the retention of youthful body image, enhanced via media pressure (Ward and Holland, 2011; Coupland, 2007). Such perceptions can be contrasted with views highlighted by Filipino nurses which demonstrate some clear differences in their respect for older adults and a more positive acceptance of the ageing process itself (Daniel, Chamberlain and Gordon, 2001).

The implementation of US supportive nurse education programmes implemented in India (Healey, 2006) elicited responses, upon evaluation, that they were ultimately flawed by their use of American educational models which ignored the socio-cultural context in which they were to be used. The local profession was numerically small, lacking leadership and with poor working conditions. Nurses were also stigmatized in wider society. Rao, Rao, Kumar et al. (2011), further assert that western nursing models, theories and

practices assume nurses' participation in intimate care for patients of the opposite sex. Local culture and practice prohibits such contact and therefore care needs are not fully addressed. They suggest that imposed nursing models have not evolved or developed to take account of such important issues.

The issue of power

Autonomy and authority, definable as '*power and freedom to act on what one knows*' (Kramer and Schmalenberg, 1993, p.62), are propounded as two of the key markers of a profession and its identity (Warren, Weitz and Kulis, 1998; MacDonald, 2002; Lee, Dai, Chang, et al., 2017). Any clear demonstration of nursing autonomy and authority, evidenced through nurses' access to, and effective exercise of, professional power, is limited in existing literature. Writers exploring the machinations of power within professions, emphasize a historical and continuing respect for, and reification of, objective, technical knowledge (Smith, 1990; Scarbrough, 2010). An associated disrespect for subjective, experiential knowledge is particularly evident within healthcare where a biomedical model of practice retains dominance (Canam, 2008), despite the existence of a wider range of more flexible and subjectively interpretive models of healthcare (Roy, 1980; Parker, 1997). Technical discourse does not adequately represent the realities of nursing practice, which is primarily relational rather than technical (Canam, 2008). Nurses are frequently denied authority and autonomy to articulate

their position and unique contribution to healthcare. Their opportunities to exert professional power are therefore limited (Canam, 2008).

There exist arguments that technical discourse is more widely applauded and welcomed within male-dominated environments, of which medicine is a clear example (Smith, 1990; Doering, 1992). Such arguments lead to an exploration of the impact of gender issues upon power within nursing, as nursing continues to be considered a predominantly female occupation (Ohlen and Segensten, 1998; Evans, 2004). Nightingale (1969, first published 1860) endorsed nursing as a job for women, with a view that all women were nurses and that in doing nursing work women were only doing what came naturally to them. A family model of healthcare developed, with the doctor as dominant father, the nurse as caring mother and the patient as docile and obedient child (Ashley, 1976).

Societal perceptions of gender-based divisions of labour within healthcare have remained influential despite the passage of time, with global evidence of an embedded and persistent image of nursing as a profession for women. In 1998 Ohlen and Segesten found that stereotypical images of nurses as passive and female were generally accepted and expected. Although there is evidence from as long ago as the fourth century that men have worked as nurses, (Evans, 2004), as at March 2016, only 10.5% of UK registered nurses, midwives and health visitors practising in the UK were male (NMC, 2016). Men's limited participation in nursing suggests that definitions of masculinity continue to act as a powerful barrier to men crossing the gender divide and

entering the profession. For those men who have entered nursing, a gendered division of labour is evidenced by male nurses' longstanding association with mental health nursing and, more recently, with their disproportionate attainment of masculine-congruent leadership and specialized positions (Huffstutler, Stevenson, Mullins et al, 1998; Takase, Kershaw and Burt, 2002; Evans, 2004; De Araujo Sartorio and Zoboli, 2010). These findings resonate globally. In China, for example, societal mores dictate that people with lower status should act as carers for those of higher status, classifying nursing as a profession of demeaned status as both female and caring work (Pang, Wong and Wang et al., 2004; Liu, 2010). Likewise in Sweden, Dahlborg-Lyckhage and Pilhammar-Anderson (2009) found that nursing is still frequently considered a female profession, with nurses playing a supporting role to medics and exerting limited autonomy or authority through decision-making or power to delegate responsibilities.

Valuing women and confronting gender-based systematic injustices are both key tenets of feminism (Millet, 1971), with radical feminists asserting that the oppression of women is fundamental and exists in all types of socioeconomic structures. Patriarchal societies have not socialized women to exert power (Davies, 1995; Rafael and Adeline, 1996), and nurses as a group have generally conformed to expectations, internalized perceptions of their place within the healthcare hierarchy, and tolerated this position with a *habitus* of submission (Bourdieu, 1981). Their lack of overt, acknowledged power, both as individuals within local healthcare services, and as a professional group on

the broader stage of health service management and development, may in part explain the lack of clarity as to who exactly is controlling the profession's identity and knowledge development in the international arena.

Other writers suggest that nurses actually wield significant power, as professionals with the conferred social mandate of care-givers, health educators and promoters, and that they can act as powerful change agents (Beck, 2005; Peron, Fluet and Holmes, 2005; Howell, Rafferty, Wall et al., 2013). Benner (1984) argues convincingly that nursing power may be grasped, asserted and developed through relationships and caring, which are core elements of nursing practice. This is a seismic shift indeed, for perceptions of the foundational components of power, and implies some scope for nurses to take greater control of their professional identity.

Chapter Three has presented an overview of nursing identity, with a review of nursing definitions, nursing history, global mobility and social and cultural issues which may be impacting nursing identity, and the relevance of influential power factors.

Chapter Four will consider conceptual and theoretical frameworks which resonate with my own philosophical standpoint in undertaking this study, as well as those which may be both informative and influential when examining nursing identity and the influence upon it of internationalization initiatives in

nurse education. It offers some explanation and critique of the theories of Bourdieu and Carper, selected for application to the subsequent analysis of study findings. It will culminate in a summary of, and critical comment upon, relevant findings from the literature review, identifying the rationale for this study, and its purpose to add to the limited work in this area. My research aims will be elucidated.

CHAPTER FOUR

CONCEPTUAL AND THEORETICAL FRAMEWORKS

The third element of the literature review is a critical exploration of theoretical constructs which illuminate perspectives of nursing identity. This section identifies theoretical frameworks selected for use in the empirical study. Their selection is rationalized as being due, partly, to their resonance with my own philosophical perspective and, also partly, due to their limited use in combination with existing educational work in the field of nursing. The review culminates in a summary of relevant findings and the presentation of study aims.

Critical theory

The selection of critical theory as the philosophical lens through which to explore and analyse the work of this thesis is justified through an examination of its central tenets, as represented in some of the available literature. Critical social theory is a multidisciplinary knowledge base with the implicit goal of advancing the emancipatory function of knowledge, and of exposing the tensions between authoritarianism and enlightenment in order to achieve rational change (Horkheimer and Adorno, 1976; Leonardo, 2013). Such theory may be considered 'agitational' (Agger, 1992, p.268) insofar as it is concerned with institutional and conceptual transformations through the challenging of

domination and oppression. It seeks the transcendence of embedded unequal power structures, pursuing alternatives which will achieve positive, egalitarian progress and development (Lemert, 1993; Calhoun, 1995).

The critical tradition illuminates the imbalances of power that mark the economy, the state, the public sphere, law, and global life (Coleman, 1992; Doering, 1992; Beck, 2005; Dale, 2005; Freire, 2005; Burawoy, 2012; Meeusen, de Vroome and Hooghe, 2013; Sideman, 2013). Some examples, discussed in greater depth below, demonstrate that nursing theorists have advocated the application of critical theory for specific purposes or settings (McLain, 1988; Stevens and Hall, 1992; Reutter, 2000); as a framework for nurse education (Thompson, 1987; Harden, 1996; Reutter and Williamson, 2000); and as the overriding framework to guide development of the discipline (Holter, 1988; Lorensen, 1988). It has been argued that critical theory has the potential to provide a broad philosophical foundation for the profession (Mill, Allen and Morrow, 2001).

Data elicited through an exploration of the observed failures of nurses and physicians to collaborate effectively, undertaken by McLain (1998), were analysed using critical theory and revealed both willingness and ability in participants to challenge distortions and assumptions in their professional relationships. Stevens and Hall (1992) advocated the use of critical theory as

the conceptual basis for nursing practice, having presented study data which links oppressive social arrangements with poor health outcomes. Thompson's treatise (1987) suggests that the application of critical theory as a foundational element of nursing scholarship will '*show nurses and others how to reweave the fabric of the social world, how to envision and construct a coherent political base for positive practical action*' (1987, p. 37).

As critical theory considers any fixed structure of either personal thought, institutions, organizations or concepts to be restrictive and lacking in inclusive and progressive development, underlying assumptions relating to existing and developing concepts, practices and theories, are dismantled and questioned. Critical theory insists that problems and possibilities arising from historical and sociological change will result in multiple interpretations influenced by multiple factors. Critical theory challenges any absolutist claims or embedded traditions. It explores the possibilities and potentials of developments to be achieved where human thinking is liberated from structures and boundaries.

The critical method is intent upon contesting *hegemony* (Gramsci, translated by Hoare and Smith, 1971). In a hegemonous culture, the dominant culture engenders habits of subservience in the less powerful. Standard practices and activities are adopted by all, regardless of genuine heterogeneous needs, problems and aspirations. Literature reviewed on nursing history and theories of nursing shows this hierarchy of dominance and subservience

through the embedded cultures and structures within which nursing operates. Critical theory is thus recognized both as an appropriate philosophical foundation for my study, and lens through which to interpret its implications for nurse identity. It offers a framework through which to examine the influences, and the driving and restraining forces, affecting global professional identity definition and development.

Theories which illuminate and inform nursing identity

Much recognized and existing nursing theory has emanated from a rationalist view. Rationalism can be described as '*the preference for reason over sense as a source of knowledge'* (Blackburn, 2005, p.307). Its appropriateness as a foundational ontology for nursing frameworks and theory may be questioned against alternative philosophies. Ecocentrists, for example, argue that humanity exists within a larger life system and is subordinate to nature (Eckersly, 1992). Examples of this exist within aboriginal knowledge, largely ignored in Australian nursing theory, which has developed on the premise that human beings are integrated and subservient to a natural order (Kingsnorth, 2012). Ecofeminists identify rationalism with masculinity and have opposed both forces for their purported violence against nature and women (Warren, 1998). Nursing, accepted as exercising what are perceived as feminine traits of nurture and care, may identify with feminist theory (Davies, 1995). Some writers argue that nursing should more overtly align itself with feminist theory, suggesting that themes of female subordination

and exploitation are representative of both nursing and feminism (Webb, 2002; Wall, 2010).

Attempts have been made to classify elements of nursing for a standardized and potentially universal language. An example of such initiatives is the Nursing Interventions Classification (NIC) (Iowa Intervention Project, 1996), which was developed in the US and is regularly updated, most recently in 2013. The WHO also, has identified five key competences across countries and cultures: patient-centred care; partnering with consumers and other stakeholders; quality improvement; effective use of information and communication technology, and advances in adopting a public health perspective (WHO 2005). Despite such initiatives, many sources argue that nursing theory, research, education and practice all fall short of global relevance (Ketefian and Redman, 1997; Algase, 2010; Andrew, 2012; George and Meadows-Oliver, 2013; Lahtinen, Leino-Kilpi and Salminen, 2013; Bickford, 2014; Hart, 2015).

A paradigmatic identification and organization of foundational nursing theory is suggested by Parse (2000), who proposes the totality and simultaneity paradigms. Each is a world view expressing a particular philosophical perspective of the unique activity of nursing as it relates to its clients and its environment. Barrett (2002) argues that these two world views, and the models constructed using them, provide sufficient scope to encompass all disciplinary activity. The totality paradigm views the whole human being as a bio-psycho-socio-cultural-spiritual being who can be understood by studying

the parts, and yet is more than the sum of its parts. The person, although separate from the changing environment, interacts continuously with it. Health exists on a wellness/illness continuum. Examples of such theorists include Leininger (1995), Orem (1995), and Roy (1997). The simultaneity paradigm views the human being with characteristics that are different from its parts and cannot be understood by a knowledge of the parts. The human cannot be separated from the entirety of the universe as both change continuously in innovative, unpredictable ways and together create health, a value defined by people for themselves. Examples of such theorists include Newman (1990; 1999), who has highlighted the ever-evolving nature of nursing definition and hence its practice, as practitioners recognize familiarities and differences in what they do as they engage with colleagues and patients and are transformed through a process of expanding consciousness.

Predominant and prevalent sociological theories picture the world from the global metropole, i.e. the capital-exporting countries of Europe and North America, identified as either western or northern global regions. Connell (2007) argues that southern theory, denoted as theory developed at distance from the metropole, may have greater meaning and more relevant application for those from a southern centre. However, he posits that attempts to ground globally recognized theory in anything other than northern (western) perceptions of knowledge are 'fragile projects' (Connell, 2007, p. vii). Much literature suggests that many theories which are

presented as universal propositions or tools, actually represent the limited view from the metropole. In the social science context, the models of agency offered by Coleman (1992) and Bourdieu (1977) may be viewed as such examples. In the nursing context, models developed by Orem (1995), Smith (1995), and Roper, Logan and Tierney (2000), view and represent nursing and the nurse's relationship with their clients within the structures and concepts of the metropolitan perspective. These established nursing models identify a continuum, identifying personal independence and dependence as the two polar extremes of individual lifestyle. They propose independence as an ideal, a position in which patients wish to care for themselves and have the right and ability to meet their needs themselves except when their ability is compromised. Furthermore, they assert that independence contributes to self-esteem and a positive self-image. Insight into an alternative ontological view, existing in Nigeria, can be seen in the writings of Morakinyo and Akiwowo (1981) who highlight the importance of community life and sodality: generational and peer group identity and membership. While the different views represented here are not wholly incompatible, they diverge in that they have different emphases on the concepts of individuality and community, differences which will impact on nursing identity and the aims and associated knowledge base of any nursing action.

It is important to mention the emphasis upon evidence-based practice (EBP) in nursing. Nursing practitioners are urged to accept the importance of

research transfer into their practice (Tilford, 2000). Evidence-based practice is an extension of evidence- based medicine, which moves from '*uninformed intuition, unsystematic clinical experience, and pathophysiologic rationale*' as the basis of clinical decision making, emphasizing instead the assessment of clinical research evidence (Olson, 1996, p. 524). Evidence-based practice includes defining the patient or population problem and the information required to solve it, conducting an efficient literature search, selecting high-quality relevant studies, describing the content of the study along with its strengths and weaknesses, and extracting the health message for application to the problem (Olson, 1996). It can be suggested that nursing has allowed the unique interests of nursing as a specific field of healthcare practice to be further overshadowed and engulfed by medicine through the adoption of such a scientifically-based framework (Rutty, 1998; Yeo, 2004; Rolfe and Watson, 2008). Nursing research, however, is showing increasing calls for more humanist and interpretive approaches to be championed for nursing, highlighting nurture and care as nursing-specific elements of professional identity (Clarke, 2004: Newman, Sime and Corcoran-Perry, 2004; Billay, Myrick, Luhamga et al., 2007). Hagell (1989), argues that '*science cannot conceptualize caring nor can caring be measured, only experienced*' (p. 231), comments which resonate with those who advocate a greater reliance on qualitative methods and intuitive knowledge in nursing practice.

Identification and discussion of the theoretical concepts and models cited above provide a glimpse of the complexity and diversity of nursing theory, and its associated knowledge and practice across the globe (Duffield, Gardner, Chang and Catling-Paul, 2009). In seeking to work in partnership towards global development, there is clearly a need for the profession to seek collaborative opportunities to understand and accept this diversity. Findings, if taken forward, could enhance nurses' engagement in a cross-cultural dialogue to promote better understandings of how nursing may be defined, theorized and better understood for global application and practice.

Theories selected for application to study data

The work of Bourdieu (1977; 1984) provides an appropriate framework against which to identify and analyze the underpinning power and influence structures of the nursing profession, and therefore to examine elements of its identity. Pierre Bourdieu has been a dominant figure in social science since the 1950s, influencing many academic disciplines (Robbins, 1991; Giddens, 1996; Webb, Schirato and Danaher, 2002). He has, however, received relatively little attention in nursing research (Williams, 1995; Virtanen, Nakari, Ahonen et al., 2000). Several recent papers, however, have argued that Bourdieu's concepts and assertions are eminently suited for application and use when analyzing elements of nursing (Nairn and Pinnock, 2017; Souza and Silvino, 2018).

Bourdieu uses the term *field* to identify the setting in which individuals within any group exist and conduct their activities. *Habitus* describes the training, structured guidance, personal inclinations, and propensity to think and act in certain ways by an individual or within a specific context, within a *field* such as a profession. He suggests that *habitus* will clearly be influenced by culture, social setting, history, past experience and either affirmation or negation. For Bourdieu *habitus* is created and reproduced '*without any deliberate pursuit of coherence… without any conscious concentration*' (Bourdieu, 1984.p.170), with socialized norms or tendencies that guide behaviour and thinking. Establishment, and embedding, of a profession's *habitus* may lead to the development of associated *doxa,* that is a range of acknowledged beliefs, behaviours and opinions – those which are acceptable and become part of that profession's unquestioned doctrine. *Doxa* may continually act to reinforce existing power structures, strengthening their positions through the institutionalization of accepted rhetoric.

Bourdieu's work has been acknowledged as providing a useful tool to explore social and cultural influences on the nursing profession (Carter, 2014). Sieger, Fritz and Them (2011) argue that effective interactions of care between nurses and patients will rely upon their understandings of themselves and what is influencing what they do, and that this will be impacted by their perceptions of professional and social capital, explorable through the application of Bourdieu's concepts. Furthermore, they suggest that examining nursing with Bourdieu's theory of *habitus* will assist nurses to better

understand their position in relation to influential forces both exterior and interior to the profession, and better equip them to address issues for change and development. Nairn and Pinnock, (2017, p.3) welcome the '*theoretical sophistication*' of Bourdieu's concepts, and suggest their use may give greater credibility to qualitative nursing research which (they suggest) frequently focuses too simplistically on participant narrative alone.

Of interest when exploring nursing identity is Bourdieu's premise that both objective and subjective approaches are needed when attempting to find meaning in the social world (Postone, LiPuma and Calhoun,1995), and that division and separation of these two approaches will be potentially damaging (Bourdieu, 1992). Continuing debate on nursing as either art or science would thus appear to divert attention from achieving understanding of its greater complexity for definition.

Opinions on Bourdieu's theories are varied. While Grenfell (2004, p. 30) feels that they allow us '*to break with the passive acceptance of society as it is given…. and provides foundations to develop an emancipated form of knowledge*', Layder (2006) describes them as presenting individual and group agency as wholly inextricable from powerful social forces, and therefore implies that agents will be impotent to exert any influence over their identity. The selection of Bourdieu's concepts for application to my study data has been made to provide some structure to analysis which gives regard to underlying, and possibly heretofore unrecognized, social forces which will be

exerting influence upon nursing identity, and to augment the limited literature which has, to date, applied his theories to the discipline of nursing.

Before selecting Bourdieu's theoretical concepts against which to discuss and analyze study findings, other theories were explored. Initially, I considered undertaking my study through an autoethnographic lens, recognizing that my own personal experiences of international nursing were both a driving force and an influential factor in my research aims. I noted, however, much literature citing criticisms of this approach as 'hydra-headed' (Anderson 2010); 'self-indulgent, solipsistic and narcissistic' (Etherington, 2004 p.141); showing off, even if 'under-bragging' (Burkeman 2012), and having a 'naïve tendency to believe our own tales' (Learmonth and Humphreys 2012), and therefore determined that my interpretive approach should refer to other recognized frameworks.

I accept that Bourdieu's concepts have been criticized as being deterministic (Archer, 2010), but feel that they provide a helpful framework for my study, as they acknowledge the reality of entrenched, and difficult to change, ideals, expectations and practices.

Bourdieu's theory will be used in conjunction with nursing theory developed by Carper in 1978. She proposed a schematic of patterns of knowing in nursing that recognizes nursing as combining elements of both objective and subjective knowledge. She argues that the body of knowledge which provides

a rationale for nursing definition has 'patterns, forms and structure that serve as horizons of expectations and exemplify characteristic ways of thinking' about the phenomenon of nursing (Carper, 1978, p.13). In seeking to gain an understanding of these patterns, our interpretations of nursing identity will be informed. Carper (1978) suggests four elements within a portfolio of knowledge which informs what and who a nurse is, and the constituents of his or her practice. *Empiric* knowing is that which is informed by objective, abstract, quantifiable 'truth', verifiable by testing, arranged into theories, and (in the context of health care) often underpinned by a biomedical approach to the monitoring of disease and therapeutic response. *Ethical* knowing is grounded in moral positionality, and requires choice, justification and judgement, based on duty, rights and obligations. It has reference to any universal professional values, as well as those of the individual practitioner. *Aesthetic* knowing recognizes an intangibility in attempting any generalizable definition of nursing or nursing knowledge, highlighting the uniqueness and particularity of any nursing encounter, and the intuitive and creative aspects of its nature. *Personal* knowing asserts the significance of self-knowledge and self-awareness in the congruent manifestation of each nurse and their practice.

Nursing literature which comments on Carper's proposals is plentiful, and includes well-rationalized arguments supporting her acknowledgement of the value of practical experience as a valid source of professional knowledge

(Schön, 1983; Heath, 1998). Such recognition, although hardly novel in wider educational literature, evidenced by theorists such as Dewey (1938), was heralded by some in nursing as something of a lifeline for a profession struggling to develop its unique identity, with its proximity to medicine and the dominance of scientific evidence as the source of valued knowledge (Cloutier; Duncan and Bailey, 2007; Bonis, 2008; Fingfeld-Connett, 2008; Bickford, 2014).

Carper's patterns have been much cited and commented on (Johns, 1995; Heath, 1998; Aggleton and Chalmers, 2000; Barrett, 2002; Baumann, 2010; Archibald, 2012; Jacobs, 2013). Expansion of Carper's elements have been proposed by various authors. White (1995), proposed sociopolitical knowing, suggesting that contexts of care require inclusion. Munhall (1993) proposed the element of unknowing, suggesting that before we can know we need to be prepared to relinquish pre-conceptions regarding what might be valued as knowing. Chinn and Kramer (2008) argued for the addition of emancipatory knowing, to address issues of equity and justice. Little work has ensued to explore and evaluate these proposed additions, with several sources arguing that Carper's work, though widely known in nursing, has been poorly realized, developed or applied in healthcare research, and has been largely ignored outside nursing (Silva, Sorrell and Sorrell, 1995; Fawcett, Watson, Neuman et al., 2001; Tarlier, 2005; Grypdonck, 2006; Holtslander, 2008). The selection of Carper's concepts for application to my study data has been made to consider

their relevance for identifying and finding meaning in nurses' knowing as it relates to professional identity. This approach constitutes a new use for Carper's concepts which, to date, have been more particularly applied to the portfolio of knowledge that a nurse develops and uses to practise their discipline.

Summary and discussion of relevant findings from the literature

Current work which explores nurses' own perceptions of the purpose and value of educational internationalization for critical personal development, and its potential impact upon individual, national and global interpretations of nursing identity, is limited and in many contexts non-existent. Data from literature accessed show that nursing identity is currently poorly defined in a global context and that nurses, although globally numerous, display limited exertion of power and influence over identity development. Indeed, there appears little acknowledgement that such development is needed. Existing theoretical frameworks for nursing focus predominantly upon the work that nurses do, without first defining what a nurse is. Most published work which reviews international initiatives is undertaken by western academics, with limited triangulation. There is much literature on how international experience promotes cultural competence (thereby potentially enhancing care quality), but little work on its impact on professional identity. The building of identity through learning from and with each other effectively across international boundaries is poorly evidenced.

The degree to which western nursing interventions are shaping the rapid development of universal taxonomies and languages which reflect nursing throughout the world is notable and should generate questions about whether they merely recreate the rationalistic and behaviourist structures and patterns of history. It seems important to explore ways in which a more globally inclusive understanding and manifestation of nursing may be realized.

In spite of challenge, it can be argued that rationalist knowledge within nursing retains contemporary primacy, although we can suggest that it has become more reflexive, self-conscious, self-searching and self-critical (Smart, 1999; Zander, 2007). As rationalist theory appears to have principally emanated from western worldviews we may be in danger of perpetuating existing power and knowledge structures rather than capitalizing upon opportunities for global partnerships and collaborations to flourish, and encouraging a globally relevant nursing identity to evolve. We must ask how we will overcome the risk of continuing cultural imperialism, and effectively include global, local and traditional knowledge in inquiry and development processes.

Present concerns about the lack of compassion demonstrated by UK nursing professionals (Francis 2013) have highlighted questions as to whether nursing

is constructed on how nursing is to be done, rather than through the facilitation of an understanding of how best to offer personally appropriate, individualized care. Findings from the literature work indicate, from my own analysis, a need to explore whether individualistic, person-centred care is more congruently developed against flexible and varied constructivist models and theories, with the integration of alternative approaches from around the globe (Hisama, 2001; Nonkelala, 2001; Shin, 2001; Pang, Sawada, Konishi, et al., 2003).

Existing work, while plentiful, is limited in both theoretical bases and methodological diversity. It highlights a lack of clarity and consensus in what the international nursing curriculum is aiming to achieve for nursing as perceived by both students and teaching staff. Research is needed which gives voice to nurses themselves. In particular, the voice of incoming international nursing students articulating their own definition of what nursing is, and should be, is heard as but a whisper. An international curriculum designed without sufficient collaboration with diverse international communities is an anachronism, and as such risks insular rather than innovative development of the profession's identity.

Review of these issues leads me to question how robust and enduring received and currently embedded philosophies, theories and nursing

identities will prove to be when increasingly exposed through internationalization initiatives to global alternatives. We must ask whether identity development is occurring with the active and/or passive consent of nurses themselves, and/or whether the profession is being purposefully constructed and led to produce homogenized and globally useful workers. There is a need for us to question whether existing dominant structures are maintaining a powerful position in shaping international debate and influencing our freedom to develop a collaboratively-fashioned, and globally relevant, future identity for nursing as a unique, authentic healthcare discipline.

Selection, analysis and interpretation of relevant findings from the literature review have led to the development of the aims for this empirical study, which are now presented.

Study aims and research questions

This study aims to explore the impact of exposure to, involvement with and learning from, internationalized elements of the UK nursing curriculum upon participants' perceptions of nursing identity.

It aims to identify and analyse values, interests and influences upon some nurses' perceptions of their individual identities as nurses, and to consider

what may require asserting in aspirations for the development of any globally constructed nursing identity.

The study seeks to address the question of whether meanings elicited from individuals' experiences of international education are informing, reinforcing, developing, or transforming perceptions of nursing.

Ultimately, debate upon findings aims to consider the potential for international nurse education to engender or promote an emergent, powerful global identity for the profession.

Through the adoption of a critical theorist's lens, I seek to expose elements which are exerting power over the development of nursing identity and knowledge as illuminated through internationalization initiatives.

Analysis and discussion will use the theoretical frameworks of Bourdieu (1977) and Carper (1978) against which to develop my debate and recommendations. I have selected a sociological theorist and a nursing theorist, as I perceive each of their concepts to interpret identities (and the underpinning knowledges which inform identities) differently, thus affording a range of comment and analysis.

CHAPTER FIVE

METHODOLOGY

This chapter provides detail on the study design, describing steps taken, with associated rationale, to create a framework for addressing my aims which will stand up to scrutiny and demonstrate an accessible transparency, congruent with my declared standpoint.

In disputing the existence of any objective reality, and recognizing knowledge as socially constructed and influenced by gender, race, class, culture, economics, and values (Campbell and Wasco, 2000), I rejected any thought of undertaking quantitative study to address my aims, and determined to utilize qualitative methods to explore participants' constructions of their own versions of nursing reality, and their many potential worlds of meaning (Marks, Murray, Evans et al., 2005). Such an approach emphasizes a need for self-reflection on the part of the researcher, and requires efforts to empower participants to express their views without fear of judgement (Fossey, Harvey, McDermott et al., 2002). I should thus declare my starting point in relation to this exploration. As a nursing professional I spent several years as lead nurse of a semi-rural hospital in French-speaking Côte d'Ivoire, West Africa. This experience, along with continuing work as trustee of a charity supporting

health care in rural Nigeria, as well as educational support work in both Ghana and India in my role as a UK university lecturer in nursing, suggest to me that I have some personal insights into global nursing identity, its development, and applicability in the universal nursing context. I consider myself aware that differing cultural mores, ethical standpoints, gender and social strata issues and assumptions, impact on communication and appropriate strategy development. However, I must acknowledge that the value of these insights has both positive and negative dimensions à propos the ultimate quality of my product. My conversations with study participants will have been affected by the tone, content and progression of my questioning, as well as my body language and responses – all of them affected by my biases, and both conscious and unconscious expectations and aspirations for the study. As a nurse who undertook first level training at the Nightingale School in London, I imbibed the Nightingale legacy as I constructed my own understanding of what nursing is and how to do it. As I began my nursing career I could perhaps only understand nursing as it was presented to me, and at that time felt certain that my accepted nursing identity was universal. In the early stages of any career, building a professional identity is based on initial training and limited experience. Over time, experiences and further training will inevitably modify identity.

Study design

A criticism of qualitative research is the difficulty in proving its validity and reliability (Bassett, 2004). It can be asserted that validity and reliability cannot and should not attempt to be claimed *per se* through qualitative research, although it is essential to be aimed for in its instruments (Marshall and Rossman, 1999; Malterud, 2001). Central to the claim of legitimacy for a qualitative study is that of trustworthiness of approach, implementation and analysis, leading to one form of understanding of a specific situation, somehow enhancing the body of its knowledge. Throughout the process of study design and stages of its implementation I reflected upon the strengths and limitations of available options for action, my decisions and their effectiveness in yielding credible findings.

The first challenge was to determine whose views I was most interested in eliciting and how I would best access them. Participant numbers in qualitative research are usually low; I aimed to undertake in-depth and detailed study (Patton 1990; Miles and Huberman, 1994), seeking rich data to allow the exploration of a particular phenomenon. My sample would be derived purposefully rather than randomly (Mays and Pope, 1995; Reed, Proctor and Murray, 1996; Ezzy, 2002). I decided to access participants from three specific groups of people who had experienced some element of international nurse education: nursing faculty within my own employing

institution with experience of working internationally, either as practitioners or educators, and who were involved in developing and delivering the international elements of the local nursing curriculum; international post-graduate nursing students studying at the same institution who were experiencing the international curriculum as student incomers; and undergraduate nursing students in the institution who had experienced internationalization through overseas elective placements.

Of some concern was my own position as an 'insider' researcher (Patton, 1990; Ritchie, Lewis, NcNaughton Nicholls et al, 2003; Morse, 2015), both as a member of the nursing profession myself, and someone known in varying ways to my potential participants. Nursing faculty participants would know me as a colleague, junior in rank to some of them, a novice researcher and relative newcomer to academia although probably perceived as a credible nursing professional due to my years in practice. Would they patronize me, disclose to me, trust my methods and value the study's outcomes? Both undergraduate and post-graduate students would have been taught by me and would possibly have met me individually for study supervision. Our relationship had, thus far, been very different from the one I now wished to establish with them.

Numerous factors are recognized as influencing the relationship between researchers and participants, including age, appearance, social class, culture, inequalities of knowledge and power, environment, and gender (Baxter & Eyles, 1997; Richards and Emslie, 2000). I was aware that my existing relationship with each participant would not only influence their preparedness honestly to share their views with me, but also my own manner, tone, discussion facilitation and ultimate interpretation of their data. Such anticipatory reflection, it is hoped, made me aware of the potential effects of these issues upon both my conduct and on the data (Holloway and Galvin, 2016). However, I was similarly aware that excessive 'navel gazing' posed the risk that I might display timidity of approach and lack of courage to follow my instincts appropriately in study management and interpretation (Finlay, 2002; Northway, 2000). I aimed to achieve a non-threatening and non-hierarchical relationship between myself and my participants, as advocated in much feminist research (Doering, 1992: Georges, 2013; Pitre, Kushner, Raine et al, 2013; Bickford, 2014), wanting to empower those I questioned.

Sampling

My sampling decisions were guided by reference to the study aims and realistically by practicalities and logistics (Miles and Huberman 1994). I accessed nursing faculty in my own employing institution, and individually invited via email or personal approach those who have engaged in

international curriculum development and international partnership initiatives to participate in one-to-one interviews. I aimed to achieve a minimum sample of six participants from this group. Undergraduate nursing students who have gained experience through an international elective experience during their course of study were individually invited to participate, as were post-graduate nursing students who have experienced nurse education, practice and associated knowledge development and application in different international contexts, again aiming for a minimum sample of six participants in each student group. I was particularly interested in securing the participation of students from parts of the world where local nursing knowledge has limited representation in the global literature, in an effort to elicit comment and opinion which has received a limited hearing, as yet, in an international context. Qualitative research aims to achieve data saturation (Strauss and Corbin, 1998; Qu and Donnay, 2011); that is, continuing collection until emergent themes become repetitive, thus demonstrating that the subject of interest has been explored to capacity. My study engages with sufficient depth of enquiry to adequately address my aims and to obtain a range of material for critical comment and debate.

Some demographic detail of participants is shown below in Table 1.

I hoped that participant sampling would reveal some of the convergences and divergences in perceptions between different groups, nationalities and individuals who participated. It should be noted both that male nurse

representation was minimal, and that a truly global representation of international experience was not achieved.

Each participant was given a numerical code, prefixed by F for nursing faculty; S for UG students and PG for PG students.

Participant code	**Gender**	**Age group**	**Nursing, and associated qualifications**	**Home country**	**Current position**
F1	Female	50-55 years	PhD, MSc, BSc, Registered Nurse, PGCHE	UK	Associate Professor
F2	Female	50-55 years	PhD, MSc, BSc, PGCE	UK	Research Fellow
F3	Female	55-60 years	PhD, MSc, BSc, Registered Nurse, PGCHE	UK	Associate Professor
F4	Female	40-45 years	MSc, BSc, Registered Nurse, PGCHE	UK	Associate Professor
F5	Female	55-60 years	BSc, Registered Nurse	UK	Assistant Professor
F6	Female	35-40 years	PhD, MSc, BSc, Registered Nurse, PGCHE	UK	Associate Professor
S1	Female	20-25 years	None	UK	UG student
S2	Female	20-25 years	None	UK	UG student
S3	Female	20-25 years	None	UK	UG student
S4	Female	20-25 years	None	UK	UG student
S5	Female	20-25 years	None	UK	UG student
S6	Female	20-25 years	None	UK	UG student
PG1	Female	25-30 years	BSc, Registered Nurse	Nigeria	PG student
PG2	Male	25-30 years	BSc, Registered Nurse	Turkey	PG student
PG3	Female	30-35 years	BSc, Registered Nurse	Sierra Leone	PG student
PG4	Female	25-30 years	BSc, Registered Nurse	Pakistan	PG student
PG5	Female	20-25 years	BSc, Registered Nurse	Ghana	PG student
PG6	Female	25-30 years	BSc, Registered Nurse	Saudi Arabia	PG student

Table 1. Demographic participant data

Interview design

I considered several options before determining my data collection approach. Initially I proposed utiltizing questionnaires to elicit demographic and background data from participants, followed by one-to-one interviews with individual participants. I considered achieving an element of triangulation through focus groups, bringing participants together for some group debate. Methods literature (particularly focus group literature) which analyses the use of groups in qualitative research generally suggests that the group be homogeneous (Morgan, 1997), that is that members have homogeneous backgrounds and ought not to know each other, to encourage more authentic contribution from participants (Khan and Manderson, 1992). Although, encouragingly for my purposes, other studies have successfully used groups comprised of members with different power, status, knowledge, and interest in the research outcome and comprising members known to each other (Kitzinger, 1996; MacDougall and Baum, 1997), I was very concerned that data yielded from mixed-participant focus groups might serve only to highlight considerable power and confidence differences, and inhibit free expression by all parties. My reflection upon the potential limitations of focus group work led me to remove this element of data collection from my study. My predominant aim was to seek qualitative comment and opinion through discussion of participants' perceptions of nursing identity, globally shared or divergent nursing knowledge and the value of an internationalized curriculum in promoting clarity for professional definition.

Hammersley and Atkinson (2007) suggest that qualitative research should have a 'funnel' approach, with development of question(s) and approach occurring over time, with reflexivity leading to constant review and clarification until the problem to be explored is finally 'discovered'. In researching the potential strengths and weaknesses of different interview structures, I identified the need to promote trusting and confident responses from participants. Literature on interviewing techniques consistently advocates the use of limited challenge in early questions, allowing the participant to 'settle in' to the process, and facilitate the establishment of an effective communicative relationship between interviewer and interviewee (Spradley, 1979; Patton, 1990; Brenner, 2006), before proceeding to more complex, opinion-based discussion which aims to elicit richer data (Geertz, 1973). Preliminary questioning may present cues to signpost themes, language, and expected levels of response. It appeared that commencing interviews with demographic questions, questions relating to personal histories and foundational education and experience of participants, would provide appropriate themes with which to commence interviews, and thus counter the usefulness of additional questionnaires. One clear advantage of including discussion on participants' personal and professional background in the context of the interviews is that it could lead to greater dialogue and discussion of contexts and perspectives than would be afforded by written responses. With some evidence that questionnaires pose a risk of misinterpretation of questions asked and may fail to yield expected data (Jack and Clarke, 1998; Baxter and Jack, 2008; Green and Thorogood, 2009;

Creswell, 2014), I determined that one- to-one interviews would be the sole approach utilized for data collection. An advantage of utilizing interviews was that it would allow for co-construction of meaning by confirming interpretation during the interview, limiting ethical concerns about power and the imposition of meaning (Wilkinson, 1998). I note that work by Kvale (1996) highlights power asymmetries in interview relationships. He suggests that dialogues may be, of themselves, exercises of power. Kvale suggests that interviews can be a 'seductive form of manipulation' (p481), overlooking the complex power dynamics, and may seriously impair the value of knowledge constructed.

Some argue that the interview is overused in qualitative research and that its uncritical adoption provides little more than anecdotal insights, giving researchers a false sense of authenticity (Hammersley and Atkinson, 2007; Silverman, 2014). Silverman also asserts that selected data extracts may be inadequate sources from which to assert clear lines of argument and, moreover, may provide a suspiciously cohesive summary of responses that do not take account of deviant cases. In an attempt to mitigate this potential limitation, participants were all offered the opportunity to review their interview transcripts and add further clarification or comment on any issue. No participant elected to do this.

All respondents were invited to attend for a one-to-one interview, conducted by myself, lasting about forty-five minutes. Individual interviews aimed to

elicit in-depth exploration of issues, such as participants' previous experiences in healthcare and how they viewed their own profession as an international activity and its associated knowledge base. A pilot interview was carried out with a volunteer colleague, to test both the recording equipment, and the appropriateness of my proposed interview schedule to yield relevant data. Study information was given to all participants (see Appendix I), and their written consent was gained (See Appendix II). Care was taken to conduct interviews in a private, comfortable environment, at a time and place which was convenient for participants. Interviews were recorded and transcribed by myself.

I elected to utilize a semi-structured interview framework (Appendix III), with similar preliminary questions for all participants. In producing a framework from which to launch questioning, I aimed to maintain some control on the direction of each interview (Gillham, 2000). Each interview progressed along similar themes, although I became increasingly confident and ready to allow the conversation and particular views and interests of individual participants to influence the progression and flow of discussion. While steering each interview to address study aims, I attempted to remain mindful of a need to listen, and to clarify meaning with participants as our discussions evolved (Kvale, 1996).

Literature explores a range of question types which may elicit different levels of response in interviewing. Kvale (1996), for example, suggests nine different

approaches which include introductory questions, such as ‘Can you tell me about?’, probing questions, such as ‘You’ve said you think XXX, why do you think that?’, through to interpreting questions, such as ‘What do you think has been the greatest influence on XXX?’ Charmaz (2006a), on the other hand, proposes only three approaches: initial opening questions, intermediate questions and ending questions. I intended that my interview questions should cover a range of styles, with introductory, structured questions on participants’ professional history; direct and probing questions on their beliefs, goals and knowledge bases as they related to their identity as nursing professionals; and interpretive questioning on their perceptions and analyses of themes explored. Adopting an open-ended narrative style as interviews progressed, I was able to ask probing questions based on responses yielded. This provided participants with an opportunity to influence interview progression, and prompted some sharing of control which, I would assert, demonstrated alignment with study aims and my own philosophical standpoint (Spradley, 1979; Wilkinson, 1998).

I aimed to promote an atmosphere in which participants felt able to talk freely and express their opinions openly without fear of redress or identification. Before interviews commenced I reiterated the purposes of the study, and I reaffirmed that all data would be anonymized in the study report. Participants were advised that interview recording could be terminated at their request at any point and that they were free to withdraw as a participant at any time. Students were reminded that I had no further role in

either teaching them or assessing their work, and that thus they need not fear that any comments they made might affect reports or grading. I was concerned to limit any likelihood of student participants tempering their responses to appear '*morally worthy*' (Green and Thorogood, 2009, p.96).

I aimed to utilize effective communication skills through good listening, empathy, and respect for all contributions volunteered by participants, demonstrating Egan's (1975) assertion that one should show both physical and emotional presence in discussion, with positive non-verbal cues and responses. An open posture, regular (yet not excessive) eye contact and a relaxed demeanor is advocated, and I aimed to achieve these, while also consciously reflecting intuitively (Benner, 1984; Stickley, 2011) throughout interviews, attempting to limit any leading or prompting responses or behaviours. I found it very challenging, at times, to desist from offering my own comments and opinions, and experienced some tension between relationship building, my own enthusiasm and interest in the topics for discussion, and the need to avoid showing either agreement or disagreement with participants' offerings.

Each interview was audio-recorded and securely stored prior to and following transcription. Transcription records were stored on a password protected computer. All interviews progressed without requested interruption, and no participants requested the exclusion of any responses from data transcripts.

Regular discussions took place with the study supervisor as data was selected, and emergent themes were identified and analysed.

Ethical considerations

Brinkmann and Kvale (2006) suggest that qualitative research is 'saturated' (p157) with moral and ethical issues, as the human interaction which takes place affects both interviewees and interviewers. They argue that qualitative interviewing has become a danger in itself – reflecting and reinforcing social forms of domination in Western consumer societies, exerting newer, subjectifying forms of power that work by '*governing the soul*' (Rose, 1999 p.7). They argue that ethical rules cannot and should not be universally defined, as Kohlberg (Sullivan, 1977) and Habermas (1984), for example, would propound. This serves to highlight the challenge to the interpretive researcher who claims any universal truths for the ethical conduct of research. Notions that qualitative studies may be perceived and presented as inherently ethical, as though qualitative study of itself embodies ethical goals and ideals as suggested, for example, by Ritchie, Lewis, McNaughton Nicholls et al (2003) are unhelpful. Issues of such import as ethics within a research study should never be assumed to have been considered, whatever the underlying ethos of the study methodology. A comprehensive review of all relevant considerations should satisfy both researched and researcher on this

front. In considering the ethical implications for my study, several elements were identified and addressed.

Ethical approval via the School of Education in the HEI selected for the study was secured. Care was taken to ensure security of, and respect for, participant anonymity and confidentiality regarding both their participation and sensitive response material. Clear details were given in the study information sheet on the anonymizing of data through coding, safe keeping of data in a locked office and/or password protected computer (with its destruction after the required period of storage), and participant anonymity in the final report and its dissemination. As the institution and individuals involved might be identifiable despite anonymization, and the field of enquiry is not large, some details have been omitted to better protect identities while exposing core data. Rights were offered to individuals to review and negotiate amendment of inclusions which they perceived might compromise their identity, although in fact no participants elected to do this.

Information was given to each participant, and reiterated at each stage of the study, highlighting the need for their written consent (which has been recorded and securely kept) to participate, and their freedom to withdraw from the study at any time, with no associated penalty or effect on their own study or work. It should be noted that I was not involved in any other study with participating colleagues, and I had no further teaching or supervision

responsibilities toward students included in my study, either during or subsequent to this work. Information was given on how to raise concerns about research conduct, and contact details provided of an appropriate individual, external to the study, with whom to communicate and discuss any such issues.

There is a potential risk to professional working relationships as an insider researcher (Patton, 1990; Ritchie, Lewis, McNaughton Nicholls et al, 2003; Rowley, 2012; Morse, 2015). This issue was discussed openly with participants, proposing that we worked together on addressing any concerns as and when they arose, seeking external support for debate and resolution if identified as needed by any party involved in the study. It is hoped that through transparency and honesty in approach, clarity of rationale for decision making and interpretations, trustworthiness as a researcher has been demonstrated and relationship risks have been minimal.

Duncombe and Jessop (2002) suggest that there is something inherently unethical about attempts to create rapport between researcher and researched, with a degree of friendship 'faking' resulting from the need to obtain information. They suggest that ethically responsible knowledge may be gained through the open acknowledgment of power differences within debate, and by the avoidance of any leading or supporting strategies. This

was a significant challenge. As instigator of the study I hold a degree of power, compounded by my position in the global metropole of received nursing knowledge. I can but acknowledge this challenge and aim to exercise humility and personal criticality in an attempt to counter its negative impact on authentic findings.

As a UK nurse, registered with the NMC, I am committed to adherence to my professional code of practice (NMC, 2015 p. 15). This requires me to 'act with honesty and integrity at all times', and to 'treat[ing] people fairly and without discrimination, bullying or harassment', being 'aware at all times of how [my] behaviour can affect and influence the behaviour of other people'. Over thirty years of professional experience has afforded me relevant insights and learning regarding effective communications and relationship building with diverse individuals; it is hoped that this experience has served me well in displaying good conduct as a researcher.

Approach to data analysis

Interview transcripts were analysed for some categorization of participants in terms of their educational background, working context and initial interpretation of nursing identity and knowledge. Data elicited from interview transcripts were thematically analysed. A thematic analysis of the interview transcripts was conducted using the steps advocated by Charmaz (2006b):

1. Initial coding, with close, line-by-line reading of transcripts, eliciting researcher questions such as 'What theme and comment is being revealed here?'
2. Selective or focused coding, where the frequency and context of initial code occurrence is considered to sort and commence synthesis of data.
3. Identification of foreground categories or themes, to create a final framework for the presentation and subsequent critical discussion of findings.

The initial coding stage produced a range of codes, generally reflecting the topics in the interview framework but also revealing new, unanticipated, topics of concern and interest to the participants. An example of how initial coding was undertaken can be found in Appendix V. Following selective coding, the number of codes was reduced, focusing particularly on those which informed the development of analyses relating to study aims. Comparisons were drawn between data from the different individuals interviewed, to identify and analyze convergences and divergences of perceptions and relevant practices. In order to construct codes and ensure that relevant data was included, I undertook a line-by-line breakdown whereby each line, having been transcribed verbatim, was reviewed allowing the data to be broken down into smaller component parts, known as open coding (Holton, 2008). This allowed me to see the structure of each participant's narrative and attempt to find meaning in what they said,

assisting me to see repeated points, contradictions, and emerging themes and patterns. I allowed this process to occur organically, although it was clearly likely to relate to the themes of my research interests. I later examined the open codes identified against those I had previously explored in literature work and against the study aims. These codes were compared, merged, and filtered before moving to identify selected themes for analysis.

I considered using a computer package, such as NVivo, to assist in data analysis, but made the decision to undertake all elements of this process personally. I note the assertion of Ely, Anzul, Friedman et al. (1991), that, at its most useful, the process of progressing through data analysis is a very close, intense conversation between a researcher and the data with implications for ongoing method, descriptive reporting and theory building. As propounded by Basit (2003), I came to acknowledge that qualitative data analysis is not a discrete procedure carried out at the final stages of research, but an all-encompassing activity that continues throughout the life of the project. I thus preferred to engage in independent data immersion without resort to computer assistance.

Study reporting and reflection upon process

The thesis now proceeds to present, interpret and analyze, study data, as it reveals participants' perceptions of nursing identity. The application of

concepts developed by Bourdieu is integral to my interpretations, in that they served to prompt the examination of cultural complexities and unacknowledged pressures upon professional structure and understandings. Carper's concepts are likewise utilized to assist analysis and interpretations, predominantly in illuminating the study report findings in relation to their implications for nurse education, theory and practice. Recommendations will be made on points of interest for education research, theory and practice development, with suggestions on issues for future exploration and research.

Participants provided a wealth of data when interviewed, which has revealed much of interest for interpretation as I have considered my research questions. Data is presented and analysed through discursive narrative, with the inclusion of selected verbatim comments from participants. Comments are identifiable against participant source codes as shown in Table 1 (see page 82 and Appendix IV). Numerical codes are prefixed by F for nursing faculty; S for UG students and PG for PG students. Narrative develops under chapter and sub-headings which relate directly to themes which emerged through data analysis, and to some extent demonstrate progression from foundational, taught and received nursing definition articulation and debate, to deeper reflections upon less explicit influences, conflicts, aspirations and possibilities for nursing identity.

Study data has been presented, discussed, and subsequently analysed, with reference to the study supervisor.

Themes revealed via study data are presented in the following sections/chapters, and lead to further discussion on study implications.

Coding analysis revealed the following themes:

- Conflicting influences on nursing identity
- Nurses as either/or/and scientists or artists
- Internal and external influences upon the profession
- The impact of internationalization

The following chapters will present study data as it demonstrates both shared and convergent understandings of nursing identity.

CHAPTER SIX

CONFLICTING INFLUENCES ON NURSING IDENTITY

Nursing identity, as perceived by participants, has been informed and influenced by various foundational elements: their understandings of nursing history, the ways nursing may be defined, nursing's position in relation to medicine, and social and economic forces.

Shared and divergent histories

Participants perceive that nursing across the world has developed in multiple ways, having been influenced by a variety of historical factors, linked to how nursing work has been initiated and supported in local contexts through preceding years. Nursing is considered to have progressed according to what might be called 'families' of development; some building their work via a liberation model, as the US approach might be labelled – supporting the medical profession to 'liberate mankind from the ills of the flesh' (White, 1963, p.52), and others following an approach which aims to organize and manage the optimum environment for the achievement of health, well-being and independent living.

> *'Historical development of nursing across Europe particularly is very different, and if you look more globally it also has huge differences. Whether something has gone through the American liberation model, or whether it's gone through the more UK focused, sort of Florence*

> *Nightingale type model, with more a work-based ethic, will ultimately determine what kind of trainee/nurse you have.' F3*

The historical foundation of nursing's aims, structure and practice in any milieu, appears to retain a degree of power and influence over how nursing is defined and thus may also influence perceptions regarding its current scope and future development. Western nursing ideologies are recognized as historically embedded, and as a dominant influence in all (including non-western) contexts, even though they may conflict with local diversities of culture.

> *'We have some of our cultural ways of doing things, but the British system is actually entrenched in my society and I would say we, I want to say we still feel like the British are still our colonial masters.' PG3*

Of interest is the recognition that no participants referred in any detail to other than western nursing history, in considering their own perceptions of nursing's historical roots. This seems notable in view of evidence that in many parts of the world the practices of traditional healing and western medicine vie for dominance. A preference, in some places, for traditional healers has been attributed to the cultural and economic similarities that are said to exist between patients and their traditional healers (Tembon, 1996). According to the WHO (2014), in Africa there is one traditional healer per 200 people, thereby covering 80–90% of healthcare. It must be questioned, of course, whether international participants were reluctant to share or include what they might have perceived as irrelevant or unacceptable points in a western-centred study, and therefore refrained from acknowledging their possible

influence upon their own nursing identity. This possibility is, of itself, concerning, in that it implies an under-valuing of some elements of international nursing history, which results in them being absent from the narrative. The underpinning beliefs, goals and knowledge endorsed by the driving forces of the dominant western historical foundations of nursing appear to have created an accepted nursing *habitus* (Bourdieu, 1977) among study participants.

In seeking to define nursing, reference is made by participants to formal, known definitions which have been imbued in nursing students over many years. Again, there is a strong emphasis placed upon western influences. Western nursing theorists, such as Henderson (1966), are cited as having provided a framework for individual nurses' conceptualizations of what they are about when they are 'doing' nursing.

> *'A well-known definition we know is that of Virginia Henderson, which I will paraphrase, that it's assisting a patient or a person sick or well, in carrying out activities that pertain to health, or its recovery, or to peaceful death. And those activities are the ones that they would have performed if they had the capabilities and capacities. And you are carrying out these roles in order to make them, to lead to their, independence. So, I love that definition because it encompasses everything that nursing is'. PG1*

> *'Henderson's definition: I heard it in 2001 when I was an introductory nursing student and I was taught history of nursing'. PG3*

The dominance of western referencing in study data echoes points made in work by Ake (1979); Chomsky (2011); Ndulovo-Gatsheni (2013), and Oyedemi

(2018) who argue that there exists a continuing global coloniality of knowledge production which inhibits acknowledgement of alternative truths to those which hold dominance.

Scientists or artists?

In exploring what nurses do, reference is made to nursing as subsidiary and complementary to medicine and, at times, a replacement for medicine.

> *'I think we are taking some part of the physicians as well, the job descriptions. In the past they were doing anaesthesia or the nurse wasn't capable to prescribe, and these kind of things, but now it's happening'. PG2*

> *'Nursing is actually valued, but the medical profession is still up there, on the pyramid, and nursing is somewhere down, you know they actually say nurses and others, but you'd have medicine first, and pharmacy first, second some other thing before you can find the nursing, so nursing is not really that valued.' PG1*

Much is made of the broad range of service users and clinical situations which nurses will encounter, and the apparent indispensability of the nurse as a care provider; someone who will adapt, co-ordinate and adopt different roles in different situations, indicating a degree of role permeability between nursing and other associated professional groups.

> *'You do everything from being with people in their last hours to delivering babies, it's like all human life is there'. F1*

> *''We don't just focus on one thing, and that's the beauty of my profession. Like when I was working on the clinical setting, the doctor*

> *would come and spend like 5 minutes with the patient, focusing on the disease, and all, and then would leave. I will be there to see…. and then I will end up even educating the patient, so I will be a psychologist, I will be a pharmacologist, I will be everything, and it's just beautiful. I think any hospital can survive without a doctor but not without nurses'. PG3*

When defining nursing as a scientific activity, evidence-based practice (EBP) is cited as an important constituent. EBP, a concept which argues that all practice should be grounded in robust research evidence (Holt, Barrett, Clarke et al., 2000; Barrett, 2002; Canam, 2008), aims to ensure that practice actions are those which will most likely achieve positive health outcomes, and to ensure confident, consistent and measurable care planning and delivery. The argument for EBP might be considered an attempt for nursing to distance itself from traditional 'old wives' tales' approaches to care, or any tendency to use 'we've always done it that way, although we're not sure why' approaches.

> *'It's all about evidence-based practice, which involves research and it involves your experience, and then the patient's preferences. So that is the science of nursing'. PG1*

As previously stated, for Bourdieu *habitus* is a social construct, and is a term which represents socialized norms or tendencies that guide behaviour and thinking. The term *habitus* in nursing may be employed to describe the ingrained habits, skills and dispositions which become the accepted and expected modus operandi of the nurse, that is the rules of the game which must be played to be recognized, and 'fit in' as a nurse in the *field* of nursing, resulting in the reward of both social and professional capital through such identification. Establishment, and embedding, of a profession's *habitus* may

lead to the development of associated *doxa*, that is a range of acknowledged beliefs, behaviours and opinions – those which are acceptable and become part of that profession's unquestioned doctrine. *Doxa* will thus continually act to reinforce existing power structures, strengthening their positions through the institutionalization of accepted rhetoric. Nursing *doxa* is embedded through previous and existing power structures, such as colonial influence, global economic forces, gender inequalities, and both the cultural and material valuing of both 'caring' and medical work.

The value of scientific evidence-based practice as a dominant source of knowledge construction for nursing (and ultimately impacting upon nursing identity itself), is currently not only an element of nursing *habitus* but also of *doxa.* It has become an embedded belief and largely unquestioned truth for nurses. Participants from each group appear ready to adhere to the rhetoric that scientific, rationalistic, evidence-based care is, and must be, the cornerstone of their knowledge and practice and is the route by which professional capital will be accrued.

The process of unpacking the progression to such a stance, requires consideration of another *doxic* truth within nursing: the way to advance nursing is to legitimize its professional and social position through academization. A result of the move into Higher Education is that, globally,

nurses are being given increasingly 'extended' roles, such as non-medical prescribing; some forms of surgery; radiology and pathology investigation requesting powers; and diagnostics in first-contact care. Such role expansions demonstrate an important shift, with the traditional, highly regulated and valued role of medics being undertaken by nurses. Study data reveals much reference to medical work, treatments and interventions, and the assumption of more medically-focused work is interpreted as a sign of advancement by some. Such interpretation risks the perpetuation of perceptions (and one *doxic* standpoint) that nursing is best considered and understood as an adjunct to medicine. It is perhaps inevitable, in financially straitened times, that expensive medically-focused tasks will first be delegated, and then be fully designated, to the less expensive and more abundant nursing workforce, especially with its burgeoning academic credentials. Such moves may be interpreted, both from within and without the profession, as innovative, creative, and instrumental in the accretion of professional and educational capital. They will not necessarily, however, assist the profession to more effectively define itself.

Some participants assert quite vociferously that nursing should be whatever it is needed to be in any particular and individual context; that is that nursing should develop and be applied to effectively meet contextual needs. One dominant question, difficult to answer, emerges when considering such a

proposition: if nursing cannot define itself, how can ethical, contextualized decisions be made about priorities for both education and practice?

While there is a general acceptance that current nursing practice espouses an evidence-based approach, participants also acknowledge the place of intuitive, experiential and individually-focused care planning and delivery, concepts which resonate with Carper's element of *aesthetic* knowing (1978). There is some concern that these, more interpretive, approaches to practice are deemed as neither appropriate nor adequately robust when questioned.

> *'So, some of the things we do, I wouldn't deny, a few things, minor things that nurses do is based on gut feeling sometimes. But then, how do you stand in a coroner's court and say that you did something based on gut feeling? So, you might be doomed for life'. PG1*

There is a sense that some terms and concepts commonly used to describe and define nursing work are neither owned nor fully understood by those using them, working with them, and even teaching them.

> *'There's that hideous word that students use, holistic, which I never really like, because you don't quite know what that means.' F1*

Some argue that nursing is flexible, changing and influenced at all times by the context and culture in which it is being practised, as well as by the individuals being nursed, and their own specific healthcare needs, thus defying absolute definition.

> *'…nursing is very wide. We are, I think we are in every area of society'. PG2*

'…what you think nursing is, there is more to it than that'. PG3

Nursing is acknowledged as being influenced in its development both by those who practise it and those who receive it; how it will be both perceived, carried out and experienced constantly impacted by the individuals involved in its activity, and their surrounding social context and culture.

> *'We absolutely should allow nursing to be whatever it is. And we should allow nursing to develop in whatever way suits the local community'. F3*

In practising nursing, individuals are themselves influenced to change and develop their perceptions of what it is they are doing, and who they are:

> *'When I actually started then I discovered there was a whole lot more attached to nursing, that nursing has this way of broadening your horizon, it makes you different, it makes you have a different way of looking at life, and so it changed everything about me'. PG3*

It thus appears that personal and professional identities can become interwoven and somewhat inseparable:

> *'I just think it's part of your identity, it's a bit like being English or something, you know, it's what I am'. F1*

Such revelations illustrate some of the challenges in trying to unpick the concept of nursing identity, as they imply that nursing will be different for every nurse. Carper's (1978) concept of *personal* knowing as an element of nursing is pertinent to consider here. Carper's work suggests that nurses need

to reflect upon their own strengths, limitations, insights, biases and understandings in order to be both congruent in their practice and sensitive in their nursing encounters. Such knowing will, of itself, affect any individual nurse's interpretation of their nursing identity. We may imply from this that the greater the diversity of experience any nurse is subject to, the greater the possibilities will be that their sense of identity as a nurse will be challenged, changed and broadened. While no assumption should be made that such widening of perspective will result in any clarification of a global nursing identity, it seems that individuals' nursing identities will be refined and strengthened as a result of international experiential testing.

A key theme in participants' nursing identity definition is that of 'carer' which, although uncontested as required in nursing, comes with it connotations of gentleness, service, and possibly invisibility and low social status.

'We've always tended to consider nursing as caring'. F1

Recent accusations of a lack of compassion demonstrated by nurses in national healthcare enquiries in the UK (Department of Health, 2012; Francis, 2013) have affected the profession, and brought a major element of nursing's identity and expected *habitus* into question. The implications of nursing care offered without sufficient care and compassion are lamentable. Such revelations lead to important questions about whether care as an expected element of nursing *habitus* is, in fact, poorly understood, articulated and

developed in nurse education. Caring, as explored in nursing literature, is itself a contested term, with some writers citing a struggle between those who identify it as a morally located activity and those who see it as an element of technical expertise (Meerabeau, 2004); in neither case can and should it be assumed as always evident in nursing *habitus*. The development, and global application of nursing competences, such as those created and disseminated by the WHO (2009), risk suggesting that a nursing *habitus* of caring may be taught, learned and universally applied and measured. It risks the reduction of nursing activity to a series of technical tasks, a limited and limiting perspective which finds no resounding echo in study data.

Study data suggests implicit international agreement on the issue of dimensions of nursing knowledge base construction. No dispute is evident in identifying the nature of nursing as 'holistic' (Hayes and Llewellyn, 2008), requiring both elements of *empiric*, evidence-based knowledge of human physiology and disease treatments, as well as knowledge of the importance of *aesthetic*, cultural and psychosocial elements of health and well-being. However, little explicit awareness emerged of the possibly conflicting tenets of these two philosophically contrasting approaches to the practise of nursing. Participants' definitions of nursing offer some clues to their concepts of nursing *habitus*, inculcated through contextual, cultural and educational influences.

Influential factors both within and outside the profession

Interview data reveals evidence of some globally shared elements of nursing *habitus*, and others which appear influenced by different health service infrastructures, different educational models, different models of practice, and both socio-economic, political and cultural influences.

> *'First of all it's a humanitarian profession. It's about us giving care, and care we give is holistic, it's not just focusing on what is affected, the client or the patient, but we also look at a lot of things from that particular condition that are interconnected – holistic care'. PG3*

> *'Nursing is an art because there is never a dull moment with nursing. Nursing is all about creativity. Most of these things you won't see in a book'. PG1*

However, given the personal nature of participants' perceptions of their nursing experience, consensual definitions of what constitutes 'good care' which might inform any universally assumed *habitus*, may be globally challenging to achieve, and indeed may not be appropriate to attempt.

Tensions clearly exist between the various factors which are influencing nursing identity definition. Identity has been impacted by various historical *doxa* (Bourdieu, 1977). Firstly, *doxa* which emanated from respected historical nursing figures who first identified nursing as an art, with a purpose to care for people who are unable to care for themselves. Secondly, the more recently defined *doxa*, the science of nursing, which argues that application of

valid research findings will achieve optimum health outcomes. While there is a recognition that nursing may and will encompass both these *doxa*, the juxtaposition of two such divergent concepts, one essentially positivist, the other interpretivist, and the ongoing tension generated by the continuing acceptance of both *doxa* without critical examination and challenge, may provide some explanation as to why nurses continue to struggle to achieve professional definition.

Bourdieu's argument (1977) that *fields* interact with each other, and are hierarchical, seems pertinent to consider here. Historically, nursing has held, and still holds, a position subordinate, to, and at times, dictated to by the more powerful *field* of medicine. Bourdieu sees power as culturally and symbolically created, and constantly re-legitimized, through an interplay of agency and structure. An active empowerment of, and confident assertion of agency by, the nursing *field* is warranted. Nursing's struggle to be recognized as a field of academe has been a long one. Recent changes in UK nursing which resulted in the termination of diploma-level academic study, and the institution of all-degree programmes as the foundational learning vehicle for students preparing for nurse registration, were welcomed in some quarters as likely to achieve greater recognition of nursing as a respected individual *field* within the larger *fields* of health-associated education and healthcare practice. These changes were not, however, welcomed universally, with some arguing that an emphasis on academic legitimacy would undermine the essential role of the nurse as carer, and exclude many caring individuals from

entering the profession. Reviewing the tenor of UK news reporting produced at the time when the all-degree principle for nurse education was publicly disseminated, for example (see Figure 2), reveals varying degrees of positivity about this development. One might suggest, when considering the widely accepted political biases of individual newspapers, that there are those whose opinions regarding the educational status of nurses are linked to a reactionary aspiration to maintain the social *status quo* and keep nurses in an appropriately lowly, uneducated position in the professional healthcare workers' hierarchy.

Tone of articles about the increased academic level of nurse education				
Newspaper title	Negative	Neutral	Positive	Total number of articles per newspaper
Daily/Sunday Telegraph	10	0	0	10
Times/Sunday Times	41	5	8	54
Guardian/Observer	0	9	8	17
Mail/Mail on Sunday	10	0	2	12
Daily/Sunday Mirror	0	3	0	3
Express	4	0	0	4
Independent	11	5	7	23

Figure 2. (Data taken from Gillett, 2014)

While study findings expose some discussion on the *aesthetic*, social and cultural aspects of nursing, such aspects are not overtly equally valued against *empiric*, scientific, technical and educationally accredited elements of the work. It may be suggested that the nursing *habitus* of accepting a *doxa* which reveres medical knowledge can explain such contributions but will not reveal anything about what participants really think, i.e. they are playing the game by the socially expected rules at this point. However, as previously asserted, the dominant elements of learning and development expressed as accrued by participants from international experience are social and cultural.

> *'What kind of output you have is actually more likely to be determined by sociology and sociological elements'. F5*

The vagueness with which participants engage with the paradoxes of operating both as scientists and artists perhaps serves to endorse another of Bourdieu's premises: that those seeking status through the display of authority through knowledge, afraid of revealing the extent of their ignorance of (or ineffectiveness to challenge) existing *doxa*, minimize the risks by '*throwing a smoke-screen of vagueness over the possibility of truth or error*' (Bourdieu and Passeron, 1990, p. 114). Nurses appear quite uncomfortable about stating personally who they are or what they should be; their status appears to rest on pretty shaky ground, as they are so accustomed to being manipulated by those with more widely accredited social and professional capital.

'We have nurses that are very brilliant but they are being pressured into giving in, sometimes they come up with good ideas, they come up with things that would actually develop the profession, …..other professionals in the medical field sometimes they will just hi-jack some of these projects, these programmes, so that nurses feel stagnated.' PG3

Gender, national identity and perceived professional status appear to influence how nursing is understood and practised, and the particular role(s) assumed by any individual.

'….. it shouldn't be used in a bad way by the government or the other special organizations, private hospitals, to have… we are not slaves, they shouldn't pay less and want more. So there should be a balance I think.' PG2

Service users (who may be identified as all citizens in any one context, as all people will require access to healthcare services) are identified as influencing nursing roles and activity.

'Patients are mobile, and patient expectations of health care in one country are going to be very different from patient expectations in another, because nursing is different'. F6

'If you are expecting your nurse, for example, to come and give you a wash in XXX, forget it. It is not going to happen. So a XXX patient coming to the UK, where they're offered a bed-bath by a nurse will probably wonder whether you've got 3 heads, and why their family are not being expected to come in and do this.' F5

A challenging tension exists between the many needs which are identified as needing nursing action. Study data highlights some of these needs: economic viability; efficient and culturally appropriate healthcare provision; appropriate

workforce education; workforce competency; workforce recruitment and retention; HEI regulation; professional regulation; individual nurses' needs, expectations and aspirations; employer requirements; global mobility; other health professionals' (particularly medics') needs and expectations, and service user preferences and expectations. The moral tension in determining how these multiple needs may be addressed through the effective definition and practice of nursing is compounded by the imbalances of power-holding between relevant stakeholders, as suggested through participant comments.

This chapter has explored a diverse range of factors which are influencing participants' perceptions of their professional identity. The following chapter will focus on the particular influences which international educational experience appear to be exerting upon understandings of nursing identity.

CHAPTER SEVEN

THE PARTICULAR INFLUENCE OF INTERNATIONALIZATION UPON NURSING IDENTITY

A globally consistent identity?

Views vary on whether nursing, as currently developed and practised, has a global genericism which makes it universally transferable to and from any and all international areas and contexts. Those who would argue that nursing is a globally transferable profession and activity may cite collaborative discussion arenas as places where internationally-shared and universally applicable aims and outcomes are debated and agreed.

> *'I've been to a number of International Council of Nurses events, and we're speaking the same language definitely.' F1*

> *'There is actually not much difference in nursing. Nursing is actually the same everywhere'. PG1*

Notwithstanding the obvious benefits for safe patient care of globally applied minimum practice standards, participant experiences suggest that the profession currently has neither the capacity nor the infrastructural support to evidence such development worldwide. UK undergraduate nursing students highlight a lack of policy, structure and organization evident in leadership and management of nursing care in less developed countries, and they find it difficult to identify with nursing colleagues in these contexts, sometimes preferring to work with medical staff.

'I'd often find myself saying oh can I go round with the doctors because obviously they do more things that the nurses would do here'. S2

'I suppose sometimes if I wanted to, not so much challenge their practice because I was a bit wary because that's how they do things, but to try and find out more, I felt like I had to be careful what I said not to like upset them in any way or think I was disrespecting their practice, but also to get information about how they worked.' S6

Students' perceptions of nursing were deeply challenged by their international experiences. They attempted to find nursing as they knew it, and to apply their own expectations and understandings as a nurse to their encounter. The demonstration of their 'dislocation', described by Scholes and Moore (2000), is notable.

'I spent a lot of time Googling, looking at the best NHS procedure and policy. Because they did…… it, it was brutal, absolutely brutal. And I would try and say No, please don't do that…..' S1

'When you walk in you expect the PICU with £6000 beds, and you're like aaaaggggh.' S5

Currently, UG students cite limited contact with international PG students studying nursing locally. Existing encounters are viewed as neither remarkable nor particularly memorable, although the potential for mutual learning and transferable knowledge development is acknowledged, implying that students would welcome additional initiatives planned to expand such links.

'Perhaps intertwining us with our learning, that would be a good idea, so we could speak to them and they speak to us. ….One girl, an international student, came and spoke to me about my poster – she took a photo of it – so, she was interested, and I was interested to speak to her….. It would be helpful to learn about different cultures, because

obviously the UK, especially now with the current political climate, is becoming more and more diverse.' S5

'I would love to show them what a ward is like and how different it is, and get an idea of what's different with their wards, so they could tell me what they do differently and perhaps adopt some of that practice. That would be very interesting.' S6

UG students who accessed international educational experience and exposure via elective placement opportunities would appreciate more international focus in other elements of their study programme, to assist both in preparing them to encounter and understand nursing in a different context, and in reflecting upon the relevance of such experience for their future identity and practice as a nurse. They would have appreciated more opportunity to be advised on preparation by peers who had themselves been exposed to nursing in another country, with a retrospective realization that sight-seeing and tourism attractions are but incidentals in their ultimate experience.

'I think perhaps getting people from the past who've been on their electives to talk to newer students would be great for them. Perhaps there should be more information, I mean you have the elective fair and things but they weren't that helpful, they were just trying to sell it to us, saying it's amazing, you can go and climb Kilimanjaro, you can do all this, but that wasn't helpful to me whatsoever.' S3

Why do nurses seek international exposure?

Nurses may choose to migrate from their native country to access nursing work or educational development, possibly citing financial and lifestyle enhancement incentives.

> *'For a nurse to leave her country and go to another country, what does it mean? It means that the other country, the receiving country has a lot to offer, and that's why the nurses do it.' PG4*

> *'And so when another country presents all these opportunities, so why won't the nurses go?' PG6*

Individuals opt to access immersion into a country and culture other than their native one, for a variety of reasons: for nursing practice experience; to achieve educational outcomes; to offer something which they perceive may be of value to others, or sometimes for very personal reasons.

> *'I always wanted to see what health care would be like abroad. I knew it would be different in first-world countries and second-world countries, but I wanted to see the massive differences in the third world.' S1*

> *'So, I said, why don't you go out and explore other options? See what is happening in the world? Because, you don't know where you might find yourself tomorrow. I've heard a lot about the western world, I haven't been there, so let me just go and see what is going on.' PG1*

Reviewing immersion experience through the eyes of incoming PG students who undertake untrained care work while they study in the UK, and outgoing UG students who access international electives, elicits similar comments on its value in promoting awareness of cultural diversity of both service users and healthcare professionals.

> *'You need to go out, compare practices, you know, I was thinking that, we talk about international cultures and all, yes we do some of that in school, but it's all about, well you have the formal knowledge, but what about the experience, because you can't know the culture of someone if you are not in that culture'. PG1*

Some envisage the potential for indirect nursing development benefits to be gained from international student visits, namely the exposure of areas which need improved resourcing, or innovative development opportunities identified by an outsider with a different perspective to that of the existing team.

> *'Yes, and actually having these nurses sometimes helps, because when they go they discover the problem and sometimes some of them will write projects and then will help provide some equipment, some even provide funds for support for patients and all.' PG3*

Those crossing international boundaries for global experience commented on the welcome, support, attention and respect shown by receiving nations and individual professionals and some interpreted what was expected in their conduct.

> *'I felt welcomed, they were really nice actually'. S2*

> *'They wanted a lot from us, but they didn't want to listen. So they expected us to bring treats and medical equipment and I donated all my scrubs, and my shoes, my pen torch and my badge and everything. They expected that. But they didn't want us there, at the same time. Because we got in the way.' S1*

Such expectations that receiving nurses would listen to UK incomers when they visit and act upon their suggestions for practice developments as they pertain to their own embedded (and often culture-specific) standards are not echoed in comments from international incomers to the UK.

'The only culture shock I got when I reached the UK and when I went to the clinical setting, was the way nurses were just willing to just open up to me and embrace me, and just, they just thought oh she's OK, she can do things and all'. PG3

Some participants, who had themselves acted in some capacity as host for an international visitor, expressed concern for their well-being and the quality of their visitors' immersion experience.

'They were always eager to join us. But we were also worried, you know, we are used to working in this situation, they are not. We would be like oh please be careful and all.' PG3

When UK UG elective experience is commented upon, there appears to be a demonstration by some of a somewhat intransigent belief that best practice standards as they know them, could and should be both aspired to and achievable in all contexts.

'And they said, one nurse said, she was the midwife, and she said we are 25 years behind you, we can't do what you want us to do.' S1

'I realise sometimes I was being disrespectful, when I wasn't able to step back, but now I understand, I do understand, but it was hard, it was difficult to see, yeah, definitely, definitely.' S6

Many opportunities and outcomes appear serendipitously.

'And these things have come along and opened up doors, and I'm a great believer that these things happen and why not, why not go for it. So, that's what I'm doing.' F4

More opportunities could be actively sought, planned for and initiated.

Nursing faculty who had engaged in international work, perceived a lack of

interest from colleagues about the potential value of such experience in enriching and expanding nursing knowledge and practice through sharing and collaboration.

> *'I think we're banging a drum on our own a lot of the time, and there's other opportunities.' F6*
>
> *'There's work there that we could be saying OK we'll share what we've found in the UK, does this have parallels to what's happening in your country or somewhere else, etc.?' F2*

Changed perceptions both of self and of nursing

Personal knowing (Carper, 1978) asserts the significance of self-knowledge and self-awareness in the congruent manifestation of each nurse. All participants verbalized through their comments a belief that *personal* confidence and self-awareness had been enhanced through their international experiences. Of particular note was the realization by some international post-graduate students that they were recognized and valued as professional colleagues by those who received and worked with them in the UK - something they had not been expecting - and perhaps serves to highlight perceptions of unequal status. *Personal* confidence was also developed through difficult and challenging encounters, often resulting in individuals feeling both empowered and verified through a realization that they could further develop who and what they perceived themselves, as nurses, to 'be' in a different context and setting. This verification is recognized as transformative *personal* learning by Mezirow (2000), who asserts that such

learning is a possible, although infrequent, outcome for an individual who is exposed to some kind of disorienting dilemma.

UK UG students, when travelling abroad to learn and practise nursing, are expecting to operate as nursing students within the *field* of familiarity. While superficially acknowledging cultural, language and economic differences, their actual expectations appear drawn from rationalist, evidence-based *doxa*, through which they expect nursing to be a consistently replicable activity across contexts.

Views amongst international PG students are varied. Some see nursing practice as the same everywhere, and argue for a direct global transferability of nursing roles, responsibilities and practices. Others highlight significant divergences. These divergences would inhibit safe practice without additional education specifically focused on sociological, cultural and organizational factors. These diverse arguments are potentially applicable to safe practice across other socially constructed boundaries, such as language, age, ethnicity, disability, health condition and religion.

> *'The only difference is the technology, culture'. PG1*
>
> *'……. the graduate nurse from such countries has had experience, has gone through all those, and knows what nursing is.' PG1*
>
> *'Maybe in some areas it could be the same but generally it differs country to country, because if I come here it also about working environment that you work in.' PG2*

Frequent references are made by PG students to learning and experience they gained from UK exposure, which demonstrated to them the importance of effective communication with service users and consideration of their involvement in, and satisfaction with, healthcare decisions.

> *'We don't really value the opinions of patients actually, and so that is what I have seen here, that patients are number one stakeholders, yes they are the number one stakeholders because you are providing the care for them, and they are the primary care receivers or recipients, and that is one thing I have learnt, and so if I go into education I will try to, you know, emanate this.' PG5*

Some students mention that they thought their own home-based primary, secondary and UG education had been modelled on the British education system, and had been both surprised and challenged by the less-directive learning facilitation approaches they were experiencing via PG studies.

> *'We were actually taught, I would say that our curriculum was mainly based on the British curriculum within school.' PG1*

> *'Education is completely different. More autonomous. Actually I really learned how to learn here. Because in XXX, the information is given to us, always our tutors point out what we need to learn, what we need to know, especially if you had surgery models, they say that you need to know this, this, this and you mostly work on that, but here they ask us what do you want to study, what do you want to learn, they ask us our opinion'. PG2*

Nursing faculty consider that educational experiences may influence ease of nursing transfer across international boundaries, suggesting that type and origin of both nursing and educational models utilized to promote student learning will each have some bearing upon transitions.

> *'Where you get a mismatch is very critical, because you cannot realistically helicopter in a model to aspire to improving nursing education in an environment where sociologically expectation doesn't*

allow the nurse to do it once they're qualified, and that actually creates huge problems. It doesn't help the development of nursing.' F3

'I think there are big differences in education, and I think nurses in the USA and in that tradition are kind of more interventionist perhaps in their mindsets'. F1

Limitations and inequalities

Some participants perceive UK selection and recruitment processes as unduly stringent and lacking in respect for the value of education and practice experience in some other parts of the world. Others value the implication of clear criteria for international nursing recruitment relating to language and clinical competence for patient satisfaction and healthcare outcomes.

'……someone has spent 5 years in school, a graduate BSc holder, nurse, and …. the person has experience too, so I don't know, I don't mean any offence but when you come here you'll be asked first of all what will be presented to you is, you will take the IELTS test, the English test.' PG1

'…..what that English test does is first of all, would I say, no not demoralising, actually gives you a sense of inferiority.' PG1

'…when you're sick you need your own language to communicate because we know, the evidence suggests, that when you're sick listening to other languages is very hard'. F3

Moral and ethical tensions emerge when international migration is discussed: some participants feel strongly that educational benefits accrued from study abroad should ultimately be utilized to improve and develop nursing knowledge and practice in an individual's country of origin. Others argue that all nations have a responsibility to retain, professionally develop (and appropriately reward) their own nursing personnel, and a nurse should not be

expected to stay in, or return to, a professional environment where they are not adequately valued or able to practise to their full potential.

> *'You see them going to Switzerland, going to Germany, going to the UK, oh dear, they just travel, you know, and they just leave the masses that way.' PG1*

> *'Most of them go to those places, you know, to like better themselves, seek greener pasture, some of them because they are not happy with the system, some of them think oh that they wasted years going into nursing, they realise there's no fulfilment for them, these are the main things.' PG3*

Another ethical dilemma emerges when the issue of global recruitment to fill UK nursing vacancies is considered.

> *'…there is a massive ethical dilemma about the UK willfully pillaging employees from European countries who have significantly less funding than we do, who prepare very highly qualified nurses but cannot employ those who have been prepared because of their own issues.' F3*

> *'To go and get them doesn't necessarily benefit the country of origin, and I think that's quite challenging. And it does highlight the differences between countries as well because you can tell immediately where Britain is going to go and look for its nurses – it's going to pick particular countries because they've got a high standard of education.' F5*

Some participants suggest a more acceptable approach is deemed to be one where a migrant nurse receives educational and developmental assets from a hosting nation, equipping them for return to their own practice environment with enhanced learning and skills to more effectively act as a pioneer and leader for nursing development in their own country.

> *'We need to be providing for those nurses, to have their development in our country.' F6*

> *'They could be a lot better if they had better training, but they don't like us coming out to teach them. They don't like it.' S1*

Others reveal a greater flexibility of interpretation, considering situational applicability and relevance of their own practice standards, whilst also exhibiting development of confidence to question and challenge.

> *'I was glad that I mentioned something. Because at least if it was something they decided they could later think about, or maybe reflect on what other students say about practice… But if that's all they've got to give – that's the best way.' S2*

> *'I wanted to know why things were so different.' S2*

Generally, participants endorse and support an internationally sourced nursing workforce, with the provisos that ethically sound recruitment policies are applied, and that language, knowledge and skills of incoming staff are of a measurably high standard.

> *'I think it's difficult, I suppose if there's a definite standardization then it shouldn't be an issue.' S2*

> *'Provided there isn't a language barrier and they still have the skills and knowledge of our ways of working.' S6*

However, potential problems for service users are cited where there are high proportions of international health workers speaking a shared language other than English, with one participant proposing a cap on the number of same-national or same-language foreign nationals in one place.

> *'We know that patients benefit from their own language, their own culture and people who understand them, and whilst they have tolerance of integration, being radical, I suspect that that actually is tolerant to a point. And I am being radical, and that's probably not the thing to say.' F3*

> *'Thinking of nursing care homes where the pay is poor, the work is hard and the people who are likely to be employed are people who are going to get worse pay and harder work in their country of origin. You're more likely to get a pooling of large groups of people who speak one language*

and it might not be the language of the country. I think that's bad actually. I think that's bad for integration, but I particularly think it's bad for patients.' F3

The continuing interaction and interplay of learning and experience may have a gradual, hidden influence upon an integrated identity definition. A novel example of the development of international mobility is that of the international nurse working in the UK, who returns regularly to their own country for part-time study, due to accessibility of cheap travel and preference for first-language study.

'….what they're getting is …. students who have been recruited by the UK coming over to the UK to work and returning once a week to [their home country] to undertake masters because the masters is in their own language. So I think we're seeing unprecendented innovation and ideas.' F3

Faculty express some concerns at the ethical and moral rectitude of exposing international nursing students to learning and development which is then constrained from application by global differences, resource limitations and service infrastructural deficits. Some suggest that models of care and development, which may be advocated for universal use, will prove inappropriate in many contexts, and time spent discovering this will limit more organic and effective local development possibilities, although some perceptions persist that existing and proven models are the best for all.

'You can't create a nurse who then can't do the job that they've been created for. It's not fair, it frustrates and it either does one of two things – the inspired nurses get out (they are very few), the majority will just do whatever sociology tells them to.' F4

'What you are doing is changing a natural course in a way that its natural development won't support. It's not necessarily beneficial, and

you get an uprising of frustrated nurses who want to change the world and who can't. And then what happens is you get a government clamp-down, and you don't go anywhere, and you're not actually doing anybody any favours – it shows a lack of cultural awareness, and a lack of cultural sensitivity.' F3

Some faculty considered the possible impact upon international education initiatives of the UK's vote to leave the European Union (EU), noting that it may impact upon migration both in and out of the UK by nursing personnel, and accessibility to some educational programmes for international migrants.

'We will lose Erasmus funding, we will become a partner country, we will lose it eventually and that will throw our mobility. It could give us opportunities internationally, but I think it will be a real shame to not have that integration with European nursing.' F3

'Erasmus - The networks you get, the opportunities the students have, the ongoing opportunities the students have, the way it changes their perceptions…..' F4

'The saddest, saddest part of Brexit really is the research development, the educational development and the funding arrangements with Europe, but not even the funding, the collaborations. If we lose the collaborations and we lose the networks, we're so much poorer. We're so much poorer.' F5

A clear dilemma in examining the field of nursing is its proximity, both in perception by some, and in practise by many, to the *field* of medicine. Boundaries between medicine and nursing are various and varied across the world, with evidence of role interchangeability, financial priorities and constraints, education and personnel availability in every context of healthcare practice. It would appear reasonable to protest that nursing as a global *field* is frequently required to shift its boundaries to suit the

requirements of the structures operating around it, with an associated curtailment of its (already historically limited) powers of agency. Notwithstanding the potential benefits that internationalization may have in facilitating new and valuable assertions for nursing *field* identity, it may also (or instead) risk the reinforcement of an existing *field* structure which is the result of historically questionable models and power exertion.

It must, however, also be noted that there is a degree of power-play evident from within the *field* itself. A sense of respect for, and higher valuing of nursing theory, knowledge and practice from historically powerful sources, that is from western nations, is demonstrated, and is evident in some participant comments from all contributing groups. Such demonstration will require action planning to counter risks that the *field* will persist in propounding generic theoretical and philosophical ideas which are foundationally inappropriate for global practice.

As summarised earlier, *empiric* knowing is informed by objective, quantifiable 'truth', theorized and, in healthcare work, frequently founded upon a biomedical approach. Nursing models have attempted to structure the aims and activities of nursing in some kind of systematic manner, providing an *empiric* base for identity and practice. The 1970s and 1980s saw the emergence of a range of nursing models, with some literature suggesting that a model was then deemed essential for practitioners in order to promote consistency of care and avoid either confusion or anarchy (Pearson, Vaughan

and Fitzgerald, 2005). Recently, nurse researchers and educators have placed far less emphasis upon such theories, although some persist in asserting the need for an underpinning nursing philosophy (Griffin, 1980; Finfgeld-Connett, 2008; Sawatzky, Enns, Ashcroft et al., 2009; Meehan, 2012). Additionally, there are numerous initiatives which advocate, and provide opportunities for, individual nurses or groups of nurses to build and develop their own nursing philosophy (Denehy, 2001; RCN, 2003; Hemingway, 2013). Internet websites, such as allnurses (2016), offer fast communication routes for nurses to propose and publicize their own personal philosophies of practice. Others, such as Clarke (2006), suggest that theoretical frameworks do no more than offer a minor advancement in nursing's professional credibility, while it is worth noting that McCrae (2012, p.222) asserts that the legitimacy of any profession is 'built on its ability to generate and apply theory'.

Theoretical nursing models, although challenged and questioned widely in the literature, appear to remain a bedrock of reference for study participants, although little acknowledgement or valuing of their relevance and application to the real world of nursing practice is evident. There is a sense in which the *empirics* of nursing have become an element of rhetoric, 'trotted out' when either nursing identity or the mechanics of nursing work are questioned and explored, which practitioners find difficult to relate to themselves and what they are actually doing. These findings resonate with work by Darbyshire and McKenna (2013), who state that nursing has lost its way due to a failure

(particularly by nurse educationalists) to effectively identify the fundamental purpose of nursing.

This chapter has examined the particular influence of international educational experience upon participants' perceptions of nursing identity. The following chapter will discuss the possibility that nurses are not effectively recognizing that nursing identity is being externally manipulated in its development.

CHAPTER EIGHT

MISRECOGNIZING DRIVERS FOR IDENTITY CHANGE

What is valued in nursing?

Nurses value the wide range of activities they engage in while exercising their professional role, and make frequent reference to an increasing assumption of traditionally medical responsibilities. Although there is some recognition that economic and organizational influences are driving these developments, there is also evidence of *misrecognition* (Bourdieu, 1984) by nurses of the insidious impact on the direct caring role of the nurse of their expanding incursion into the realms of medical practice.

> *'Sometimes these community health centres don't have any doctors – it's actually the nurses that will be there working, you know, and then doctors hardly go there so it's actually the nurse…..the nurses will be there diagnosing and all, doing all of that.' PG3*

> *'The hospitals and the governments want to have more nurses to maybe decrease the job of the doctors, physicians. And they also, yeah, also I think another point is that we are specializing a lot, I think we are taking some part of the physicians as well, the job descriptions'. PG5*

Perceptions of the status of nursing, and nurses' financial and career development expectations, are changing. These changes are juxtaposed with the growing world-wide demand for nurses to provide a cheaper form of globally mobile healthcare worker than their medical colleagues. There is a

risk that the profession's focus on its improving educational and social status is concealing its *misrecognition* of the continuing practice of external manipulation of, and imposition upon, its essential identity and purposes.

Notwithstanding the *personal* development merits of international exposure, faculty members cite an apparent lack of cohesive and transparent planning, aim and outcomes setting and evaluation of existing initiatives, as well as limited evidence of sharing and dissemination of learning and development achieved through such initiatives.

> *'There's a lot of international work going on, I think, but we don't necessarily pool it. But, we don't, we don't share it amongst ourselves, we're not very good at sharing it.' F2*
>
> *'What are we doing in terms of integrating an international context, where are we including it, what are we doing?'F2*

How could internationalization make a difference?

There is some concern over an apparent lack of shared communications and strategic planning to make the most of all existing and potential opportunities for further expansion of international elements of the curriculum. Universal knowledge of institutional international strategy is not apparent, and a degree of stigma appears to be attached to staff who seek international opportunities, in some cases perceived by colleagues as driven by participants' personal goals for travel and cultural learning.

> *'The international agenda, I haven't seen anything, have you, recently? Coming out from the school? I've not seen anything. We don't even get*

it off all the emails that we get, the weekly news or whatever else. Nothing on there whatsoever.' F6

'17 researchers from the UK, of which 5 were from the school here, went to XXX. I bet most people on this corridor didn't even know.' F2

'That's when you get that thing, Oh a jolly. Actually it wasn't a jolly – it was very nice, but it wasn't a jolly it was work and a lot of work afterwards trying to keep the momentum going. I think that's fantastic, but where do we share all that?' F5

Some argue that gains achieved from past and present curricular developments, such as the sharing of learning from elective experiences to promote insights and self-awareness, both in those who have accessed such opportunities and their peers who have not, are currently poorly explored, rationalized and structured for further development.

'The poster presentation was interesting but didn't provide much help to me personally…' S1

'I would love to speak to some students who are choosing their elective placements at the moment, and tell them what they might experience and just be aware of it.' S2

Internationally collaborative work has, at times, resulted in the development of long-lasting and evolving partnerships. Outcomes achieved sometimes bear little relation to initially declared aims and objectives. Personal and professional development may be achieved through bringing together diverse individuals for education and development purposes, influencing motivation, engagement and action.

> *'I think these things happen because you make contacts with people and build on them. So we'd made the contact, we'd seen a funding opportunity, we'd gone for it. So in that sense it's a bit random.' F6*
>
> *'And I know it probably goes down seeming like Oh my God you're going off again, a nice week's holiday, fine, if that's what you think it is, that's fine'. F2*

Western nurse education has heralded evidence-based practice as a 'gold standard' with which to give authority to nursing's knowledge base (and thus its credentials for professional identity). This supports a *habitus* which accrues professional capital through adherence to structured policies, protocols and genericized care pathways. The diametrically different care management possibilities afforded by *aesthetic*, individualized, culturally-relevant and person-centred holistic care risk neglect if *empiric,* evidence-based practice fails to acknowledge them. Current emphasis on evidence-based practice leads me to express a fear that nurses 'cannot see the wood for the trees' and would benefit from exposure to, and the opportunity to explore and consider, a wider range of culturally diverse nursing approaches, afforded by greater internationalization, thereby navigating nurses and nursing beyond a dominant *habitus* of *empiric*, evidence-based practice.

However, any premise that the very foundations of nursing may be strengthened and developed to represent a more authentic nursing identity through the growing intellectual confidence of its practitioners and the enrichment of its social and cultural application through internationalization, fails to address another significant element of nursing *doxa.* This *doxa*

constitutes an acceptance that a primary role of resource-rich areas in international initiatives is to assist in the building of competence and capacity in less prosperous areas through the sharing and global application of the knowledge and identity which is operational in western nations. Nurses in each area represented by study participants appear complicit in such acceptance, with little evidence of any confidence or expectation that experiential sharing could result in a valuable revision of nursing concepts in all contexts, or acknowledgement that all those exposed to international differences should themselves be prepared to be challenged and changed by the process and their engagement with it. This further highlights the risk that the internationalization of nurse education may merely serve to further embed the existing low-status position of the nursing profession itself within the hierarchy of healthcare workers, and that it may leave practitioners from non-western nations without symbolic position or legitimization, thus remaining the least heard in any and all debate.

Study data reveals evidence of a sense of pride and achievement resulting from the progression to an all-graduate profession. As educated professionals, nurses' roles are expanding and more frequently being elevated into the realms of valued medical practice. Education is thus conferring both privilege and merit. The preparedness of nurses to move into the medical domain may be perceived as evidence of growing confidence and a long-overdue valuing of their worth. However, are nurses *misrecognizing*

what is, in reality, at least partly occurring through this process of advancement? At what cost to the profession's unique, *aesthetic,* caring role are medical needs being prioritized over the foundational social and practical elements of nursing? Nurses and nursing are being shifted, individually, locally, nationally and globally, albeit no doubt in response to the economics of workforce needs and planning, into more malleable and flexible knowledge workers. Nursing identity may thus be at greater risk than it has ever been.

Study data shows that nurses are engaged in some definitional struggle, which is being influenced from both within and outside the profession. Nursing and nurses are both surrounded by, and contributing to, complex and conflicting discourses. Nurses' experiences appear located between their affiliations to externally declared expectations of quality and changing role, and their understood, historical position and *habitus* as bedside carers. Participants do not, however, recognize that the profession is an object of unwanted manipulation. I would suggest that nurses need to exploit the growing value of their educational advancement, taking any and all opportunities for professional debate, idea exchange and internationally collaborative and co-operative working, in an effort to counter the profession's *misrecognition* of identity manipulation for the advancement of nursing.

Such *misrecognition* may be placed alongside that which relates to the internationalization agenda within nurse education. Participants widely viewed international education access as a vehicle for nursing advancement and travel opportunities. However, internationalization may also be perceived as an additional tool of manipulation, facilitating wider workforce mobility to fill workforce deficits through the enticements of academic, professional and economic capital. It cannot be denied that nursing must, of course, develop and evolve to meet the healthcare needs of health service users, and that regulated standards for nurse education must be set against political and economic definitions, priorities and constraints, and thus aspirations for nursing identity development will be limited by workforce planning needs.

Participants regret a lack of awareness in many colleagues about international learning initiatives, with some citing evidence of resentment or misunderstandings about the motives and ambitions of, and ultimate outcomes for, those able to access them. Little evidence emerged of organized, intentional forums for individuals to share and discuss international experiences, or to use any associated reflection in potentially relevant nursing development debate. Several participants cited a lack of purposeful engagement between international post-graduate and UK undergraduate students: potentially a rich source of personal knowing for all.

This chapter has considered the possibility that nurses are failing to recognize, react and respond to some of the forces which are influencing and impacting nursing identity. The following chapter will explore the potential role of international education as an agent of empowerment for nurses to contribute more effectively to an authentic global identity for the profession.

CHAPTER NINE

INTERNATIONALIZATION AS A VEHICLE FOR IDENTITY DEVELOPMENT

Internationalization as power

The increasing international collaboration and shared learning afforded by technological advances and globalization initiatives within nurse education may ultimately empower nurses to act, possibly more consciously and probably more confidently to challenge existing *habitus*, and thereby affect the accepted norms of any and all future nursing *habitus* constructs.

> *'What it [international networking] is really doing is giving credence to those individuals …….Giving better education to those individuals. We're seeking to develop that, and enable that credibility and authority that nurses can have.' F3*

Access to, and development of global Higher Education, may act as a catalyst to enhance nurses' critical thinking skills, thereby empowering them to critically review their position as members of a discrete and potentially highly influential professional group.

> *'I thought that would be a good thing to, like, develop myself and go initiate something back in my country. So, promote specialisation in nursing for nurses to know that all is not lost, that they have options.' PG3*

Integration of international nurses into the UK workforce has potential benefits for service users, themselves a diverse, multi-cultural group, bearing in mind the less than representative number of black and minority ethnic (BME) nurses in the profession (Pike and Ball, 2007; Martin, 2013).

> *'It can bring new ideas, it can bring new skills, because people are skilled differently, it can offer inter-culturalization in a way that can enable patients to get the very best out of what's there'. F6*

Motivations for PG participants accessing a UK nurse education programme are variously expressed, with evident foci upon personal, local and national gains, professional development and patient care improvements.

> *'In here, it's easier, cheaper, and that was one of the main things that led me to come to UK. The other thing is, the main thing is that the university should be in the first 500, so the quality of the universities in the UK is really good and they are top universities in the world. So, to get a good education, very good opportunity.' PG2*

> *'It created a new window of opportunity for me. It like taught me that I can actually do research and help other nurses benefit from it, I can actually learn to develop curriculum for advancement of nursing in my country.' PG3*

PG students identify a positive impact upon their own perceptions of the value of nursing as a profession, and themselves as individual nurses who can influence standards of care, initiate change and operate as effective leaders and change agents.

> *'I've been able to see things, in different ways, and I've seen the way people value nursing in this country'. PG6*

'But the ones that haven't gone out, they just take in everything and we don't.' PG5

'You actually need to go out and see what is happening, because if you base all your knowledge and everything on the local, it's actually not healthy'. PG5

International students cite the value of global learning and insights into healthcare across the world, sharing their classes, wider learning opportunities and, frequently, their accommodation and free time with a diverse range of other international students. Disappointingly perhaps, they cite little experience of sharing social time and learning opportunities, other than timetabled classroom based sessions, with UK students or other UK citizens.

'I was wowed because we had people from everywhere, almost everywhere, our class was a global class. And, you'd have this opportunity of knowing what is going on in other countries, even though you might not have the opportunity of visiting those countries in the near future.' PG1

'I was able to compare XXX and the UK and XXXX, and I found out that even our next-door neighbours, XXXX, they've gone way ahead of us, when it comes to healthcare.' PG4

PG students are, on one hand, greatly encouraged by the professional progression and enhanced status which they feel an international education will afford them, while they also acknowledge the challenges of acceptance by and integration within home-based nursing teams where longevity of practice experience and managerial seniority are recognized emblems of authority and garner the greatest respect.

'……somebody was saying wow, I think it was a doctor, he said wow he didn't know that there were a lot of personalities in nursing, you know, he stood there, he saw them sitting there and all of them have their PhDs and I was impressed because nursing is actually moving forward.' PG1

'There is this form of friction also in the hospital, when you come in contact with those 'mothers' in nursing who've been there for so long, and then you're coming in as an MSc holder, there is this kind of friction, and everything you do they will be like is it because you have that MSc, and all.' PG5

Individual transformations

For some students, the experience has been personally transformational. Whilst not claiming that such demonstrable confidence and motivation has been solely triggered by international experience, students certainly perceive it as having had a significant personal impact upon their development and future career aims and objectives.

'Before coming to the UK honestly I thought I knew almost everything about nursing. You know, so when I arrived and I started, that's when I discovered there was a whole lot I didn't know and it like opened, I can actually develop projects and have a way of implementing those projects, that nursing wasn't just about me being in the ward and then being in the classroom teaching – there is a whole lot I can do just by being a nurse, that nursing is not just about giving injections any more, nursing involves even engaging in politics, because if we want our profession to develop we have to be politicians somehow. ' PG3

Bringing UG and PG students together to share and exchange experience and learning is rarely, if ever, organized, although some comments suggest that such initiatives would promote useful mutual learning, with the citation of

existing international examples worth consideration and possible adaptation for local application.

> *'I think we don't use it to the best we could. We need to put these PG internationals with a group of UG students from the beginning of year 1 as a mentor group, where they get the chance to meet, share, think about projects, think about PG study, think about internationalization. The benefits would be enormous. We don't do it. And yet there's models around the world that do, and the difference is huge. The concept of UG and PG education being a normality is much increased, the concept of internationalization is much increased, and the students' confidence in believing that they can do some of these things is increased. And I just don't think we make… we have a perfect opportunity, we have a very good resource, and we don't use it.' F3*

> *'Portugal is beginning to adopt this now… having structural projects for their UG students which enable building through the UG programme …. setting up projects which are then fed on into masters and PhD, and they become part of project teams, for innovation and things like that, so I think there are models out there and we should be looking at them and seeing how they can work in the UK.' F5*

Nursing faculty are themselves broadening their own interpretations of the scope and practice of nursing through their own experiences of internationalization. Individuals who engage with international elements of UG and PG curricula development and delivery often have additional and varied international experience and may actively seek to build international initiative involvement into their professional curriculum vitae.

> *'It's enabled me to explore a huge amount about what actually the word nurse means, because it doesn't mean the same thing everywhere. It means very different things.' F3*

> *'Rather than staying in the UK and just doing a UK conference, I went to a European one, and actually it was hugely different. Hugely different than anything I'd ever been to.' F3*

If international working, collaboration and development is to be globally beneficial, existing leaders in nurse education need to be humble and open-minded enough to actively support the development of new initiatives that may work for their international partners, but not necessarily for themselves.

> *'What they were able to do, having worked with lots of different countries and networks, having had a number of conferences where foreign people, consultants, were invited in to present, was actually not write a curriculum that was a foreign curriculum, but accept what they needed to do was write a curriculum that met their own needs.' F4*
>
> *'What was really important in actually that consultancy was not telling them how to do it.' F3*
>
> *'In a way, that's actually about saying, well, you've got a model and we're not seeking to change that, we're seeking to develop that, and enable that credibility and authority…….' F3*

International immersion experience, some would argue, of itself promotes the development of more innovative thinking and preparedness to improvise and consider where the application of existing standards or policies cannot or should not be applied.

> *'So someone might tell you they do this type of things, they do this type of thing, but it's another thing to see it actually, and experience it.' PG6*
>
> *'Or they will ask us about tropical diseases, we will tell them, ask us about our nursing care, how we go about things. Because some of them, they feel it's impossible to work in our setting so they will be like how do you guys cope? Really? Do you have these, no we don't we improvise! Sometimes when they go to the ward they will ask, how do you… so they will just end up saying we improvise, so….. they think it's another way of learning, and knowing.' PG3*

There is some recognition, however, that a more confident exertion of power over nursing identity and professional knowledge development, will have some detractors both from within and without the profession itself.

> *'I'm actually apprehensive. It's a good thing what the university has done for me….. I know I am a fighter. I won't give up. But then I will have to face a lot of obstacles. Going with all of these ideas that I have now, I'll have to contend with …..they will find it very difficult, they will not feel comfortable with me, but then I won't give up because giving up means all of this was just not, you know, it's just useless.' PG3*

Identification and analysis of key learning and gains resulting from internationalization initiatives as discussed by participants illuminate, unsurprisingly, many different individual and wider contextual variances.

> *'What it showed me was how much you can bring a group of very different people into a room with differences in language, huge differences in culture, differences in language, differences on ideas, who were all nurse educators, or mostly, and how you could in a period of days build relationships that would last.' F3*

> *'I went to an international congress in Hungary and Belgium, they teach us how to work as a team, because they divided us like nurse, doctor, and physiotherapists and occupational therapists in every group…. and we learned how to work….. it was really good to see.' PG2*

Work is needed to encourage a sense of need, ownership and involvement in internationalization initiatives.

> *'While-ever people are passionate about doing that, then it will have legs'. F2*

> *'You know, I know now that I can initiate something, that I can innovate something, that I can now be a mover when I go back.' PG6*

> *'I love to work with friends from other countries, because I learn a lot. Sometimes you don't, you're not aware of the things when you don't change your position – maybe somebody else has better ideas than us, for instance maybe they have better interventions for patients' care, so why don't we adapt those to our country to improve the care, the quality of the care? I would love to do it.' PG2*
>
> *'I have seen that the classroom is one big thing you can use to influence society'. PG3*

Learning and experience, gained through international education initiatives in nursing exposed in the course of this study, have demonstrated their potential to strengthen nurses' own confidence to highlight the unique and essential nature of nursing as a discrete and valuable independent field of healthcare practice. They show the value of co-operative and collaborative debate and experience to inform the future development of the field, and a growing desire and confidence in some nurses to be instrumental in the field's global evolution.

> *'We need people who understand who are nurses, who understand nursing, what is needed for professionalization and development of the profession, to move, to impact politics in favour of the profession.' PG3*

This chapter has discussed findings which demonstrate the potential for learning gained through international experiences to empower nurses to participate more effectively in professional identity development. The following chapter will consider the implications of study findings for the future development of global nursing identity, and it will propose a new theoretical element for utilization in construction of its meaning.

CHAPTER TEN

A NEW THEORETICAL MODEL

Something is missing

The persistence of ambiguity and confusion over the aims and objectives of the international nursing curriculum highlights the need for more groundwork and research to be done. Many international initiatives have been created and advanced with limited reference to, or evaluation against, any kind of theoretical framework, leaving students unable to appraise their international learning against any kind of structure. Despite much evidence of personal development and growth, which may be valuable as professional health carers, the impact of learning on understandings of nursing identity requires some formalization through appropriate theory and pedagogy.

Additionally, as study data highlights limited valuing of other than western perspectives of nursing, strategic planning is required to bring other perspectives to our attention and promote a professional culture wherein they are equally valued.

Is standardization the answer?

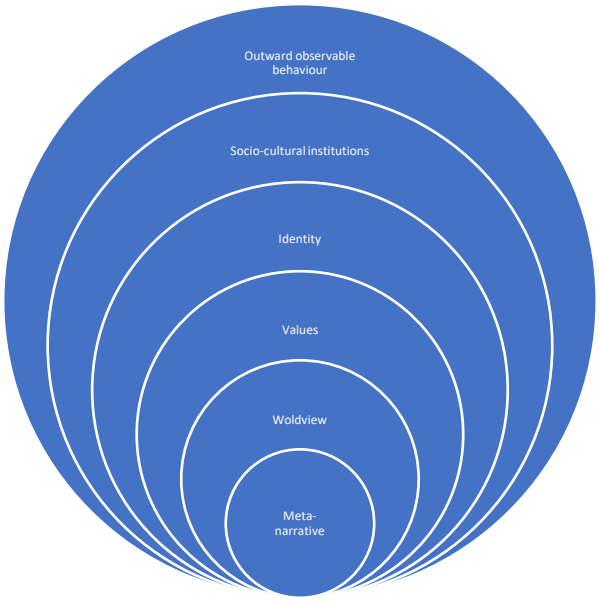
Standardization initiatives which have emanated from the ICN (2010) and the WHO (2009), while commendable in their aims to provide a minimal global benchmark for safe and effective care delivery, fail to acknowledge the constricting effect of generic standards upon the development of culturally appropriate and diverse nursing knowledge. The evidence of varying opinion on what cultural competence is and how it may be achieved, with both epistemological and pedagogical bases being contested, suggests that such a development is inappropriate and would limit the possibility of wider consultation and development along a more evolutionary trajectory.

There is a burgeoning body of work on the internationalization of nursing curricula specifically as well as more widely across HE. Although not investigated for the purposes of this study, the fact that a large number of internationalization measures seem to be evaluated mainly in terms of the increased mobility of students, teachers or researchers is not irrelevant to my debate. It may be suggested that the escalating utilitarian impetus of the global knowledge economy and the drive for financial gain within HE from international student recruitment have adversely impacted upon the potentially more organic development which is needed to create a more cogent and measurable transformative curriculum. The rapidity with which we have responded to the declared need to internationalize, due at least in part to economic pressures, may have taken us down a path from which we

will need to retrace our steps to consult more widely and analyse implications for nursing identity. If we are able to identify, analyse, celebrate and learn from shared and variant expressions of nursing, and at the same time attempt to understand the philosophies which underpin these expressions, encouraging their balanced integration into the profession's future development, we may be starting out on a pathway which will lead us towards a more globally authentic and universal nursing identity.

I suggest that we need to consider how personal, national and international definitions of nursing are impacted by international experience, with a realisation that those who work across cultures have the potential for an improved awareness of difference and positive development opportunities.

Understandings of the tensions and differences between individual and wider/global identities for nursing professionals are important to consider here, in view of the range of factors which may impact individuals' perspectives (see Figure 3). Evidence is clear that we are all influenced In in our perceptions of the world, ourselves and our professional identity, by our practical experience.



Adapted from Strauss, R (2019)

Figure 3.

Early exposure to the challenges of international experience may act as a driver for empowerment. It is evident that nurses' access to, and exercise of, power varies in different international contexts. Gender, national identity and perceived professional status appear to influence how nursing is understood and practised, and the particular role(s) assumed by any individual. Perceptions remain that nurses, despite being globally numerous, exert less influence over their profession's identity and development than they might. In places their ideas and innovations are ignored, stolen by more assertive multi-disciplinary colleagues, and they view themselves as less powerful and valued than other healthcare professionals. One must question, however, whether nurses' historical passivity will persist as the

profession becomes increasingly educated, globally aware and internationally networked.

Increasing and broader access to education is encouraging for future professional development with the sharing of knowledge and opinion afforded by advances in technology and international travel. Greater confidence to speak, act, and deliver as both agents of change and as champions of nursing as a discrete and essential discipline within the healthcare field is being promoted with the increased empowerment of nurses via international education.

An important question to pose is whether the development of an all graduate, internationally educated and mobile profession is, in effect, a symptom of an imposed and poorly acknowledged change in the nursing profession's reason to 'be'. For the nurse who is both encouraged and rewarded by the social and professional capital accrued through higher educational attainment and advanced practice opportunities, the role of bedside carer might appear to be well lost through delegation to the lower echelons of care workers. However, data elicited through this study would appear to show that, while some participants relish nursing's increasing integration into traditional, *empiric* (Carper, 1978), medical territory, others

would rather persist in championing the more *aesthetic* (Carper, 1978) social, cultural and person-centred tenets of nursing artistry.

For Bourdieu (1986), educational credentials will act to reproduce and legitimate social inequalities. If international nurse education and professional development initiatives serve to create a rationale for the progression of university-educated nurses into roles traditionally assumed by medics, a continuous reinforcement of the greater valuing of medicine over nursing is being evidenced. I would argue that initiatives which act to counter such reinforcement, through greater valuing of the diverse social and cultural elements of care, should be promoted. Moreover, I assert that nursing needs to decide whether its niche in academia is most comfortable in either the social or the medical sciences, or possibly neither.

The way forward – co-operative development

I would argue that a process of challenging assumptions, with a conscious reflection upon embedded *doxa*, through the diversification afforded by internationalization, can be used to the profession's advantage. Internationalization can be developed and used as a tool both to confound existing power exertions and to empower those with something to say but no apparent avenue through which to say it. An internationally educated and networked nursing profession, with confidence in its identity, has the capacity

to bring a greater collective recognition of the need to value nurses, and to support them in developing contextually-appropriate nursing practice, rather than relinquish their nursing identity and become either inexpensive medic replacements or globally malleable health workers.

Interpreting study data against Bourdieu's concepts of *field, habitus, doxa* and *misrecognition* (1977), has illuminated some of the challenges for the nursing profession and for individual nurses to define themselves. Study data reveal an enthusiasm and commitment from participants to champion the elements of nursing which value *aesthetic* (Carper, 1978) individualized, flexible, culture and language-specific healthcare provision. Alongside this commitment, many participants also state a belief in the principles of *empiric* (Carper, 1978) evidence-based care which would propound standardization of care to 'best-practice' principles. Little insight is apparent of the paradox of this two-pronged allegiance. Many participants anticipate and expect that education will act as a vehicle for them and others to learn how they, and others, should 'do' nursing, although some demonstrate a recognition that the diverse experiences afforded by international education have rather offered them tools, many of them *aesthetic* in nature, of learning for contextual application.

Exploration of study data against theoretical constructs proposed by Bourdieu (1977) and Carper has revealed considerable boundaries to be breached in

order that the opportunities afforded by international nurse education initiatives for further, and effective, definition of global nursing identity may be realized.

I would suggest that the promotion of a professional self-identity for nursing, which includes an international dimension, requires a further element of knowing to be added to those conceptualized in Carper's (1978) work. It should be noted that these four elements of knowing have already been augmented in the work of Chinn and Kramer (2008), who introduced the concept of emancipatory knowing as an adjunct to the existing quartet of knowing types. They define emancipatory knowing as 'an ability to recognize social and political problems of injustice or inequity, to realize that things could be different, and to piece together complex elements of experience and context to change a situation as it is to a situation that improves peoples' lives' (Chinn and Kramer, 2008, p.64). While I applaud the principles enshrined within such an aspiration for nursing practice, I would question its appropriateness for consideration against the knowing which is associated with nursing identity definition. A search for definitions of the word 'emancipatory' yields vocabulary such as 'freedom from restriction or restraint', and 'liberation from bondage' (Collins, 2014). Firstly, I would argue that such words are unhelpful, in that they imply a sense of initial powerlessness which needs no emphasis for the nursing profession, and also that they suggest a need for some kind of external assistance in order that

power may be exercised. I would rather, with McCrae (2011, p.225), assert that '*in the multi-disciplinary health care of today, nursing must be able to define its role, rather than leaving other disciplines, managers and policy makers to do this by proxy*'. Secondly, any claim, given the multiple factors which have some influence upon nursing and what it is, that freedom from restriction is a realizable aim should be recognized as unwise, and should not therefore be made.

Co-operative enquiry, a term familiar from the literature and methodology of action research, initially propounded by Heron (1971), and further developed by him and others (Heron, 1996; Heron and Reason, 2001), is an appropriate concept to explore as a viable approach to the achievement of the kind of collaborative knowing which could be achieved through international education work, and would impact both perceived and actual nursing identity.

Co-operative enquiry identifies all contributors to any working initiative as equal partners, whose thinking and decision-making contributes to generating ideas and drawing conclusions. Heron and Reason (2001) argue that the quality of any development outcome will be hugely influenced by human interaction, that is that learning and development is, in part, a corporate activity, best achieved through 'getting down and dirty' with each other, and immersing ourselves as far as possible in each other's worlds: a point not

recognised within Carper's (1978) framework, but of great import in developing professional identity for nursing. While I acknowledge nurses as individual agents of development, I would also assert that there has never been a greater need for nurses to work effectively together and confidently assert a clear identity to inform strategic planning for the profession's future. It can be suggested that nursing is hindering its attempts to gain status and legitimacy through constantly trying to reinvent itself within new scientific and professional territories. Social legitimacy and professional identity are being jeopardised by constant role alterations and shifting role boundaries (Nelson and Gordon, 2004). The current emphasis on *empiric* evidence-based practice risks undermining the unique potential for nurses to identify themselves as champions of the individualistic, *ethical*, *aesthetic*, *personal* and additionally the *co-operative* elements of knowing which are needed in the provision of healthcare for the unique individuals that they nurse. Nurses should not, however, lose heart. Freire (2005) argues that every human being, even those 'submerged' in a dominant surrounding culture, is capable of critical reflection through dialogical encounter with others. When provided with appropriate tools, in this case the diverse and challenging experiences of international education, for transformative *personal* (Carper, 1978) learning, nurses may (as demonstrated by some participants) develop new levels of consciousness and feel both empowered and motivated for greater engagement with nursing identity definition.

Freire's (1975) methodology identifies 'conscientization', a 'joint project' (p. 46), dependent on dialogue between people in which they 'achieve a deepening awareness of the socio-cultural reality which shapes their lives and of their capacity to transform that reality' (p. 27). In order to better support the valuing of joint international dialogue to inform global nursing identity development, I propose the addition of *co-operative* knowing, to add to Carper's (1978) concepts of knowing. I argue that foundational nursing curricula should introduce this concept as a core pillar of nursing activity and professional development, encouraging a *habitus* (Bourdieu, 1977) of mutual respect, collegiality and shared learning and development across all appropriate boundaries, but with a prime aim for the purposes of this study, across international boundaries.

Opportunities for *co-operative* knowing as an acknowledged and valued element in the repertoire of learning and development within nurse education can be afforded by all encounters, but may be particularly rich in material when and where that education has an international dimension. Learning constructed through a more *co-operative* process of enquiry could, in its turn, lead to an effective addressing of concerns regarding compassionate care, person-centred focus and cultural competence. The shared learning afforded by international education and collaboration may empower nurses to positively challenge existing *habitus* and deconstruct inhibitive *doxas*. A drive to value all contributions and contributors and

purposefully seek diverse contexts, views and experiences for shared debate and mutually agreed development plans for the profession has the potential to strengthen the profession's ability to define itself and move forward more confidently to articulate its own aims and expectations.

In carrying forward this proposal, much work is needed. Current work which explores nurses' own perceptions of the purpose and value of educational internationalization for critical personal development, and its potential impact upon individual, national and global interpretations of nursing identity, is limited and in many contexts non-existent. Study data show that nursing identity is currently poorly defined in a global context and that nurses, although globally numerous, display limited exertion of power and influence over identity development. Indeed, there appears little acknowledgement that such development is needed. Existing theoretical frameworks for nursing focus predominantly upon the work that nurses do, without first defining what a nurse is. Most published work which reviews international initiatives is undertaken by academics, with limited triangulation. The building of identity through learning from and with each other effectively across international boundaries is poorly evidenced. This area is ripe for international nursing research prioritization. An exploration of nursing *habitus* is helpful when seeking clarity of data interpretation. Bourdieu's theory has been recognized as of some worth through its wide use in education (Reay, 2009; Delamont et al., 1997; Cooper and Dunne, 1998;

McLeod, 2000; Reay et al., 2001). However, the concept of *habitus* has also been condemned as '*ambiguous and overloaded*' (Nash, 1990, p. 446), deterministic (MiMaggio, 1979), and inhibiting of individual agency and consciousness (King, 2000). Through working with the premises of this concept, I recognize that it will be no easy task to attempt any focused influence upon embedded *habitus*; it will take time and the building of *co-operative* engagement of nursing stakeholders in such a process. Giving greater value to the true diversity of existing nursing identities will require initiatives both to dismantle the dominance of western perceptions and to bring international nurses together to learn with each other and co-construct future identities.

I recommend that plans are developed in HEI nursing departments for greater integrated learning initiatives for national and international students, with international group seminars, opportunities for shared reflection, joint project work, and the creation of a shared space for regular professional interaction and social encounter, with an aim to promote the development of more *co-operative* knowing, and ultimately facilitate transformational experience. International students, nursing faculty and service users (and potentially other international stakeholders) should be invited to participate in UK nursing curriculum development, evidencing an authentic valuing of their global diversity and of increasingly egalitarian, co-operative partnership working.

Nurse educators engaged in international initiatives, international post-graduate students studying in the UK, and undergraduate nursing students returning from international elective experience should be encouraged and enabled to share and disseminate their reflections, evaluate their learning, and contribute to future curriculum planning.

These practical propositions will, I assert, be more likely to be accepted and understood for their potential to yield positive outcomes for nursing identity development if they are underpinned by a clear theoretical rationale. The inclusion of *co-operative* knowing as a concept within a wider framework (Carper, 1978) which assists nurses in identifying who they are and what they do will, provide an additional tool for nurses to define themselves and their professional identity.

CHAPTER ELEVEN

CONCLUSION AND IMPLICATIONS FOR NEW DEFINITIONS OF NURSING IDENTITY

Implications for how nursing identity may be understood

This study has explored a range of factors which have impacted nursing identity definition and, in particular, in what ways the internationalization of nurse education experience is influencing nursing identity definition and development. International educational experience, as demonstrated through the findings of this study, highlights the need for nursing to resist pressures to assume any generic or purely *empiric* (Carper, 1978) scientific mantle beneath which to practise. The nurse who opens himself or herself to the transformative knowing potentially afforded by international exposure, and its associated personal 'dislocation' (Scholes and Moore, 2000) may discover that, in order to be what is needed in any given situation across our richly diverse world, a competent, confident practitioner may appear to have, and may need to have, a chameleon-like identity.

However, such a practitioner will need to assert authority and demonstrate a preparedness to challenge existing knowledge and practice, both of self and of those working around them. In the words of one student participant:

> *'….internationalization is very good, globalization is very good because it brings people together and they share ideas. That's very important because this is a global village, we need to learn.' PG2*

It can be asserted that care, as the essence of nursing, is universal across cultures, but like Leininger (1995) I argue that its forms of expression may vary. This is essential to consider when engaging in international work, otherwise we risk making assumptions that our perceptions and understandings of nursing are shared ones, and we may therefore miss valuable opportunities to learn from different global practices. If we are able to identify, analyze, celebrate and learn from shared and variant expressions of nursing, and attempt to understand the philosophies which underpin these expressions, encouraging their balanced integration into the profession's future development, we may be moving towards an authentic identity, a co-operatively formed sense of knowing, and a genuinely international approach to practice and development.

I assert that nursing identity will be better understood and developed through a process of *co-operative* mutual learning across international boundaries, with a purposeful emphasis on promoting transformational knowledge to further empower nurses to be instrumental in their profession's future development.

Implications for policy and curriculum development

The WHO (1994) has stated that academics need to work with central governments, local authorities and communities in order to set priorities for internationally relevant nursing curricula. Collaborative, co-operative dialogue, across global boundaries, has to be advocated - dialogue which acknowledges and attempts to overcome the hindrances and limitations to authentic debate created by issues of power and control. Transcultural research can help answer local questions, considering both emic and etic perspectives, while illuminating aspects of important concepts that are not culture-specific. Continued development on international competencies will help to identify the relationship between universal principles and the particular needs of specific countries and contexts. The achievement of authentic collaboration, with the identification and implementation of development aims which will enhance the learning, nursing practice and care outcomes for all partners, has yet to be evidenced, and therefore there is a clear need for more work in this area. Curricular developments must include increasing initiatives to bring globally diverse learners and professionals together for co-operative engagement, debate and decision making.

There is a danger that nursing identity is currently being manipulated and controlled via internationalization initiatives no less coercively, albeit differently, than it has ever been. Poorly managed and financially motivated global migration of nursing personnel has both potential and proven

disadvantages for health care outcomes, and for the development of authentic, appropriately focused nursing development, particularly in resource-poor contexts.

While concerns are rife that reliance on an international workforce risks undermining standards of care and service user satisfaction with that care, the profession has a responsibility to examine its acceptance of an internationalization agenda which fails to recognize the unique and specific philosophies of nursing and its very essence, that of individualizing, person-centred care giver and advocate. International genericism is not something to accept, for it will not succeed in effectively addressing the health care needs of all populations and, moreover, will undermine the organic evolution of contextualized nursing identity, knowledge and, ultimately, practice.

Notwithstanding these points, with an ever-increasing emphasis being placed globally on HE qualifications for nurses, the days of nurses' acceptance of imposed models, policies and health care strategies must surely be numbered. A well-educated, globally aware and internationally networked profession will ultimately prove to be more implacable than its history might suggest.

Reflections on limitations of this study

This study aims to illuminate the views, values and interests influencing nursing students and academics engaged in international educational experience, and to identify how a globally defined, constructed and practised nursing identity is being developed. There is some sense that the work merely grasps at shadows, showing surmise and interpretation at every step. It is, however, a genuine attempt to express some of the characteristics of nursing as experienced by those immersed in its practice through internationalization, taking from detail and comment some signposts which herald both the opportunities and dangers of creating and re-creating an identity for the future of the profession. While I refute the rightness of developing generically applied theory for a diverse reality, I accept that we live in a world which is governed and managed by systems. The additional theoretical construct I propose for nursing identity development via international initiatives (and, indeed, the subsequent growth of all nursing knowledge), that of co-operative knowing, attempts to swing the balance of power and bestow rights to nurses to further develop their professional identity more confidently both from and with each other.

Sampling was limited, in that the predominant voice was that of female nurses. More work is clearly required to access opinions of male nurses, who have a wider representation in the global profession than that shown in study

data (Fielden and Burke, 2014). Likewise, further work is indicated to elicit data from a wider global perspective.

The work has presented many challenges, most particularly in maintaining confidence that, as an insider researcher (known by all my study participants), I have managed to elicit authentic comment and opinion through interview discussions. I have revisited my data many times, and have attempted to reveal both implicit and explicit meanings as I see them. I take full responsibility for the paths I have (and have not) taken, the interpretations I offer, and the recommendations and conclusions presented. I am fully aware that this study is neither replicable, widely representative, nor generalizable in any way.

Many times during the process I have asked myself why I am undertaking this work at this stage in my career. I conclude that I could not have done it at any other time as I would have had neither the audacity, the sanguinity, nor the preparedness to accept the need to 'burn the midnight oil' in order to complete while working full-time. Engagement in this work has enriched every aspect of my being. I have been intellectually challenged; my organizational skills have been tested; wide reading and associated analysis has, I hope, sharpened my erudition, my academic writing style, and my confidence to construct a cognitively sound argument. My own views on the

value of international education have evolved and made me more convinced of its intrinsic value in promoting greater ownership of nursing identity for nurses themselves. Such progression will, I am sure, influence my approach to teaching and learning. I acknowledge the value of academic study as a vehicle to facilitate individual, professional, societal and global advancement.

Conclusion

In identifying the nursing profession as the *field* of enquiry, it has emerged from this study that the boundaries of the *field* are at once perceived by some as clear, by others as unclear. Fundamental to Bourdieu's premise (1977) is that it is impossible to understand a *field* purely in reference to itself and what lies within it. Rather, it is necessary to situate it in terms of other points of reference in meaning and practice. He suggests by implication therefore, that an understanding of the *field* of nursing and what it represents by way of an identity for nursing itself, can only be achieved by considering its various situational realities – how, where and by whom it is done, and in what specific contexts it operates. The creation of meeting points for the international sharing of nursing knowledge and practice skills cannot but be of value here. The very meaning and identity of the *field*, and those who practise within it, has the potential to be enriched, and become more authentic for practice with the culturally diverse client groups which nurses will encounter in so many international contexts in the twenty-first century. Nurses' perceptions of their professional identity may change as their points of reference shift.

The wider the boundaries, potential experiences and interpretations of the field of nursing are set, the more flexible, moveable and various may be the identities claimed for and by the profession. *Habitus* may be influenced for change through deconstructing and organically rebuilding both the structure and dispositions of those engaged in the activity of the *field*; such change may be influenced by an increased global awareness and diversity of experience. An international dimension to education offers an instrument with which to explore and enrich a nursing *habitus* of care for the profession's global future, which champions the richness and diversity of nursing's practices, including *empiric, ethical*, *aesthetic*, *personal* (Carper, 1978) and *co-operative* approaches.

The drive to internationalize nurse education may yet prove to be an effective catalyst for an authentic empowerment of the largest group of health care players on the global stage. It has the potential to empower nurses and the nursing profession to achieve a globally recognized identity as a discrete (while diverse) and valued profession, able to take its rightful place as a respected contributor to high quality global health care through *co-operative* identity construction, and the development and application of its associated knowledge.

Acceptance of difference is to be valued. Imposing or promoting homogeneity of identity, knowledge and practice fails to acknowledge the diverse nature of what nursing is. Effective co-operation and collaboration through international educational experience reveals touching points where new interpretations of nursing *habitus* and *doxa* may emerge. Nursing identity and knowledge is being enriched and empowered via internationalization.

BIBLIOGRAPHY

Abbott, A. (1988) **The System of Professions**. Chicago: Chicago University Press.

Abbott, A. (1993) The sociology of work and occupations, **Annual Review of Sociology**, 19, 187-209.

Abbott, A. (1995) Boundaries of social work or social work of boundaries?: The Social Service Review Lecture, **Social Service Review**, 69 (4), 547-562.

Abel-Smith, B. (1960) **A history of the nursing profession**. London: Heinemann.

Abraham, E.J. (2007) Pulse on health and nursing in India, **Nursing and Health Sciences**, 9 (2), 79-81.

Ackroyd, S. (1996) Organization contra organizations: professions and organizational change in the United Kingdom, **Organization Studies**, 17 (4), 599-621.

Adams, T.L. (2015) Sociology of professions: international divergences and research directions, **Work, employment and society**, 29 (1), 154-165.

Agger, B. (1992) **The discourse of domination: from the Frankfurt School to postmodernism**. Evanston: Northwestern University Press.

Aggleton, P. and Chalmers, H. (2000) **Nursing Models and Nursing Practice** (2nd Ed.). Basingstoke: Macmillan.

Aiken, L., Buchan, J., Sochalski, J., Nichols, B. and Powell, M. (2004) Trends in international nurse migration, **Health Affairs**, 23 (3), 68-69.

Airey, D. and Tribe, J. (2005) **An International Handbook of Tourism Education**. Oxford: Routledge.

Ake, C. (1981) **A Political Economy of Africa**. Lagos: Longman Nigeria.

Aldridge, M. (1996) Dragged to market: being a profession in the postmodern world, **British Journal of Social Work**, 26 (2), 177-194.

Algase, D.L. (2010) Is there a universal definition of nursing? **Research and Theory for Nursing Practice**, 24 (3), 147-148.

Alikhani, A.A. (2004) **Theoretical principles of identity and identity crisis.** Tehran: Humanities Research Center.

Allen, D. (2002) Night frights, **Nursing Standard**, 17 (7), 20.

Allen, D. (2003) And I can do back flips, **Nursing Standard**, 17 (33), 20.

Allen, M. and Ogilvie, L. (2004) Internationalization of higher education: potentials and pitfalls for nursing education, **International Nursing Review**, 51 (2), 73-80.

allnurses (2016) **What is your personal philosophy of nursing?** Available at: http://allnurses.com/nursing-student-assistance/what-is-your-656245.html [accessed 28 October 2017].

Allsop, J. (2006) Medical dominance in a changing world: the UK case, **Health Sociology Review**, 15 (5), 444-457.

Altbach, P. and McGill Peterson, P. (Eds.) (1999) **Higher Education in the 21st Century: Global Challenge and National Response IHE Research Report Number 29**. Boston: Institute of International Education.

Altbach, P.G. and Knight, J. (2007) The internationalization of higher education: motivations and realities, **Journal of Studies in International Education**, 11 (3/4), 290-305.

Aluttis, C., Bishaw, T. and Frank, M.W. (2014) The workforce for health in a globalized context – global shortages and international migration, **Global Health Action**, 7 (1), 1-7.

Aluwihare-Samaranayake, D.S. (2014) Representations, forbidden representations, and the unrepresentable: creating visibility for mapping emancipatory and transformative nursing praxis, **Advances in Nursing Science**, 37 (3), 258-270.

Anderson, H. and Gehart, D. (2007) **Collaborative Therapy: Relationships and Conversations that Make a Difference**. New York: Routledge.

Anderson, L. (2010) Book Review: Heewon Chang, autoethnography as method, **Qualitative Research**, 10 (4), 493-494.

Andrew, N. (2012) Professional identity in nursing: are we there yet? **Nurse Education Today**, 32 (8), 846-849.

Appleby, J., Hunt, L. and Jacob, M. (2011) **Telling the Truth about History**. New York: W. W. Norton & Company.

Archer, M.S. (2003) **Structure, Agency and the Internal Conversation**. Cambridge: Cambridge University Press.

Archer, M.S. (1995) **Realist Social Theory**. Cambridge: Cambridge University Press.

Archibald, M.M. (2012) The holism of aesthetic knowing in nursing, **Nursing Philosophy**, 13 (3), 179-188.

Arieli, D. and Hirschfeld, M.J. (2013) Supporting minority nursing students: 'opportunity for success' for Ethiopian immigrants in Israel, **International Nursing Review**, 60 (2), 213-220.

Artinian, B.M., Giske, T. and Cone, P.H. (2009) **Glaserian Grounded Theory in Nursing Research**. New York: Springer.

Ashley, J.A. (1976) **Hospitals, Paternalism, and the Role of the Nurse**. New York: Teachers College Press.

Ashton, W. and Wagman, L. (2015) Marketing educational improvements via international partnerships under brain drain constraints, **Education Economics**, 23 (6), 713-734.

Australian Government (2015) **The value of international education to Australia**. [online] Australia: Deloitte Access Economics. Available at: https://internationaleducation.gov.au/research/research-papers/Documents/ValueInternationalEd.pdf [accessed 24 September 2017].

Ayala, R.A. and Nunez, E.R. (2016) Dusting off the looking-glass: a historical analysis of the development of a nursing identity in Chile. **Nursing Inquiry**, 24: e12185. Available at: https://doi.org/10.1111/nin.12185. [accessed 27 December 2017].

Ayandiran, E.O., Irinoye, O.O., Faronbi, J.O. and Mtshali, N.G. (2013) Education reforms in Nigeria: how responsive is the nursing profession? **International Journal of Nursing Education Scholarship**, 10 (1), 1-8.

Bahn, S. and Weatherill, P. (2012) Qualitative social research: a risky business when it comes to collecting 'sensitive' data, **Qualitative Research**, 13 (1), 19-35.

Bapir, M.A. (2003) **Is it possible for qualitative research to be properly valid and reliable?** [online]. University of Warwick. Available at: https://s3.amazonaws.com/academia.edu.documents/6108035/Qualitative_Methods.pdf?AWSAccessKeyId=AKIAIWOWYYGZ2Y53UL3A&Expires=1510145414&Signature=gj4iQly6N2z9AB%2BxmdGeguVVCog%3D&response-content-disposition=inline%3B%20filename%3DValidity_and_Reliability_in_Qualitative.pdf. [accessed 14 May 2016].

Barrett, E.A.M. (2002) What is nursing science? **Nursing Science Quarterly**, 15 (1), 51-60.

Basit, T. (2003) Manual or electronic? The role of coding in qualitative data analysis, **Educational Research**, 45 (2), 143-154.

Bassett, C. (2004) (Ed.) **Qualitative Research in Health Care**. Philadelphia: Whurr Publishers Ltd.

Basu, A . (1999) **Indian Higher Education: Colonialism and Beyond From Dependence to Autonomy**. Dordrecht: Springer.

Bauman, Z. (1996) **Liquid Modernity**. Cambridge: Polity Press.

Baumann, S.L. (2010) The limitations of evidence-based practice, **Nursing Science Quarterly**, 23 (3), 226-230.

Baxter, J. and Eyles, J. (1997) Evaluating qualitative research in social geography: establishing 'rigour' in interview analysis, **Transactions of the Institute of British Geographers**, 22 (4), 505-525.

Baxter, P. and Jack, S. (2008) Qualitative case study methodology: study design and implementation for novice researchers, **The Qualitative Report**, 13 (4), 544-559.

Beck, U. (2005) **Power in the Global Age**. Cambridge: Polity Press.

Beeman, P. (1991) Nursing education, practice, and professional identity: a transcultural course in England, **Journal of Nursing Education**, 30 (2), 63-68.

Bender, A. and Walker, P. (2013) The obligation of debriefing in global health education, **Medical Teacher**, 35 (3), E1027-E1034.

Benner, P. (1984) **From novice to expert: excellence and power in clinical practice**. Menlo Park: Addison-Wesley Publishing.

Benner, P.A., Tanner, C.A. and Chesla, C.A. (1996) **Expertise in Nursing Practice. Caring, Clinical Judgement and Ethics**. New York: Springer Publishing Company.

Benton, D. (2004) What's in a title? **Journal of Advanced Nursing**, 52 (1), 1.

Bergen, A. and White, A. (2000) A case for case studies: exploring the use of case study design in community nursing research, **Journal of Advanced Nursing**, 31 (4), 926-934.

Berger, P.L. and Kellner, H. (1981) **Sociology reinterpreted: an essay on method and vocation**. New York: Anchor Press.

Berland, A., Richards, J. and Lund, K.D. (2010) A Canada-Bangladesh partnership for nurse education: case study, **International Nursing Review**, 57 (3), 352-358.

Bickford, D. (2014) Postcolonial theory, nursing knowledge, and the development of emancipatory knowing, **Advances in Nursing Science**, 37 (3), 213-223.

Bihong, L. and Yangjun, T. (2016) Motivations of faculty engagement in internationalization: a survey in China, **Higher Education**, 71 (1), 81-96.

Billay, D., Myrick, F., Luhanga, F. and Yonge, O. (2007) A pragmatic view of intuitive knowledge in nursing practice, **Nursing Forum**, 42 (3), 147-155.

Blackburn, S. (2005) **The Oxford Dictionary of Philosophy** (2nd Ed.). Oxford: Oxford University Press.

Blane, D. (1982) Health professions, In: Patrick, D. and Scambler, G. (Eds.) **Sociology as Applied to Medicine**. London: Bailliere Tindall (pp. 213-222).

Bolton, R. (2005) **Habermas's Theory of Communicative Action and the Theory of Social Capital**. Denver: Western Regional Science Association.

Bonis, S.A. (2008) Knowing in nursing: a concept analysis. **Journal of Advanced Nursing**, 65 (6), 1328-1341.

Boreham, P. (1983) Indetermination: professional knowledge, organization and control, **Sociological Review**, 31 (4), 693-718.

Botkin, B.A. (Ed.) (1945) **Lay My Burden Down**. Chicago: The University of Chicago Press.

Botma, Y., Van Rensburg, G.H., Coetzee, I.M. and Heyns, T. (2015) A conceptual framework for educational design at modular level to promote transfer of learning, **Innovations in Education and Teaching International**, 52 (5), 499-509.

Bourdieu, P. (1977) **Outline of a Theory of Practice**. Cambridge: Cambridge University Press.

Bourdieu, P. (1981) Men and machines, In: Knorr-Cetina, K. and Cicourel, A.V. (Eds.) **Advances in Social Theory and Methodology: towards an integration of micro and macro-sociologies**. London: Routledge/Kegan Paul.

Bourdieu, P. (1984) **Distinction: A Social Critique of the Judgement of Taste**. London: Routledge.

Bourdieu, P. (1986) **The Forms of Capital: Handbook of Theory and Research for the Sociology of Capital**. New York: Greenwood Press.

Bourdieu, P. and Passeron, J. (1990) **Reproduction in education, society, and culture** (2nd Ed.). London: Sage.

Bradbury-Jones, S., Sambrook, F. and Irvine, F. (2011) Empowerment and being valued: a phenomenological study of nursing students' experiences of clinical practice, **Nurse Education Today**, 31 (4), 368-372.

Bradshaw, A. (2010) An historical perspective on the treatment of vocation in the Briggs Report (1972), **Journal of Clinical Nursing**, 9 (23/24), 3459-3467.

Brenner, M.E. (2006) Interviewing in educational research. In: Green, J.L., Camilli, G. and Elmore, P.B.E. (Eds.) **Handbook of complementary methods in education research**. New York: Routledge (pp.357-370).

Bridges, D. (2015) Working without shame in international educational development? From consequentialism to casuistry, **Ethics and Education**, 10 (3), 271-283.

Brinkmann, S. and Kvale, S. (2006) Confronting the ethics of qualitative research, **Journal of Constructivist Psychology**, 18 (2), 157-181.

Brookfield, S. (2003) The praxis of transformative education: African American feminist conceptualizations, **Journal of Transformative Education**, 1 (3), 212–226.

Brooks, K. (2010) A global profession, **John Hopkins Nursing** [online]. Available at: http://magazine.nursing.jhu.edu/2010/08/a-global-profession/ [accessed 2 February 2017].

Bruni, N. (2002) The crisis of visibility: ethical dilemmas of autoethnographic research, **Qualitative Research Journal**, 2 (1), 24-33.

Bryant, R. (2005) **Regulation, roles and competency development**. Geneva: International Council of Nurses.

Buckner, E.B., Anderson, D.J., Garzon, N., Hafsteinsdóttir, T.B., Lai, C.K.Y. and Roshan, R. (2014) Perspectives on global nursing leadership: international experiences from the field, **International Nursing Review**, 61 (4), 463-471.

Bulechek, G., Butcher, H., Dochterman, J. and C. (Eds.) (2013) **Nursing interventions classification (NIC)** (6th Ed.). St. Louis: Elsevier.

Bunnell, T. (2015) The 'Yew Chung model' of international education: the scope for investigation and research, **Journal of Research in International Education**, 14 (3), 258-270.

Burawoy, M. (2012) The roots of domination: beyond Bourdieu and Gramsci, **Sociology**, 46 (2), 187-206.

Burkeman, O. (2012) The new art of 'under-bragging' **The Guardian** Available at: www.guardian.co.uk/commentisfree/2012/aug/15/new-art-of-underbragging [accessed 3 June 2015]

Bustreo, F., Gorna, R. and Nabarro, D. (2016) Knowledge for effective action to improve the health of women, children and adolescents in the sustainable development era, **Bulletin of the World Health Organization**, 94 (5), 310.

Button, L., Green, B., Tengnah, C., Johansson, I. and Baker, C. (2005) The impact of international placements on nurses' personal and professional lives: literature review, **Journal of Advanced Nursing**, 50 (3), 315-324.

Caffrey, R.A., Neander, M.N., Markle, M.S. and Stewart, B. (2005) Improving the cultural competence of nursing students: results of integrating cultural content in the curriculum and an international immersion experience, **Journal of Nursing Education**, 44 (5), 234-240.

Cahill, C. (2007) Repositioning ethical commitments: participatory action research as a relational praxis of social change, **ACME Editorial Collective**, 6 (3), 360-373.

Calhoun, C. (1995) **Critical social theory**. Cambridge: Blackwell.

Calhoun, C., LiPuma, E. and Postone, M. (1995) (Eds.) **Bourdieu: Critical Perspectives**. Cambridge: Polity Press.

Callister, L.C. and Cox, A.H. (2006) Opening our hearts and minds: the meaning of international clinical nursing electives in the personal and professional lives of nurses, **Nursing and Health Sciences**, 8 (2), 95-102.

Cambridge, J. and Thompson, J. (2004) Internationalism and globalization as contexts for international education, **Compare: A Journal of Comparative and International Education**, 34 (2), 161-175.

Campbell, R. and Wasco, S.M. (2000) Feminist approaches to social science: epistemological and methodological tenets, **American Journal of Community Psychology**, 28 (6), 773-791.

Campinha-Bacote, J. (2002) The process of cultural competence in the delivery of healthcare services: a model of care, **Journal of Transcultural Nursing**, 13 (3), 181-184.

Canam, C.J. (2008) The link between nursing discourses and nurses' science: implications for a knowledge-based discourse for nursing practice, **Advances in Nursing Science**, 31 (4), 296-307.

Capri, C. and Buckle, C. (2015) 'We have to be satisfied with the scraps': South African nurses' experiences of care on adult psychiatric intellectual disability inpatient wards, **Journal of Applied Research in Intellectual Disabilities**, 28 (3), 167-181.

Carpenter, M. (1980) Asylum nursing before 1914: a chapter in the history of labour. In: Davies, C. (Ed.) **Rewriting nursing history**. London: Croom Helm. (pp. 123-146).

Carper, B.A. (1978) Fundamental patterns of knowing in nursing, **Advances in Nursing Science**, 1 (1), 13-24.

Carter, M. (2014) Vocation and altruism in nursing: the habits of practice, **Nursing Ethics**, 21 (6), 695-706.

Cartwright, R. (1968) Some remarks on essentialism, **The Journal of Philosophy**, 65 (20), 615-626.

Casey, D.J. (1999) Professional links: an international program for nursing knowledge exchange, **Journal of Pediatric Nursing**, 14 (3), 143-149.

Casey, M., O'Connor, L., Nicholson, E., Smith, R., O'Brien, D., O'Leary, D., Fealy, G., Mcnamara, M., Stokes, D. and Egan, C. (2017) The perceptions of key stakeholders of the roles of specialist and advanced nursing and midwifery practitioners, **Journal of Advanced Nursing** 73 (12), 3007-3016.

Castledine, G. (1996) Virginia Henderson's legacy, **British Journal of Nursing**, 5 (8), 517.

Castro, P., Lundgren, U. and Woodin, J. (2015) International mindedness through the looking glass: reflections on a concept, **Journal of Research in International Education**, 14 (3), 187-197.

Castro, P., Woodin, J., Lundgren, U. and Byram, M. (2016) Student mobility and internationalization in higher education: perspectives from practitioners, **Language and Intercultural Communication**, 16 (3), 418-436.

Chan, W.Y. (2004) International co-operation in higher education: theory and practice, **Journal of Studies in International Education**, 8 (1), 32-55.

Chang, H. (2008) **Autoethnography as Method**. Walnut Creek: Left Coast Press.

Charmaz, K. (2006a) **Constructing Grounded Theory. A Practical Guide Through Qualitative Analysis**. London: Sage Publications.

Charmaz, K. (2006b) The power of names, **Journal of Contemporary Ethnography,** 35 (4), 396-399.

Chinn, P.L. and Kramer, M.K. (2008) (8th Ed.) **Integrated Theory and Knowledge Development in Nursing**. St. Louis: Elsevier.

Chomsky, N. (2011) **How the World Works**. London: Hamish Hamilton.

Ciesielka, D., Conway, A., Schumacher, G. and Penrose, J. (2005) Implementing and evaluating a culturally focused curriculum in a collaborative graduate nursing programme, **International Journal of Nursing Education Scholarship**, 2 (1), 11.

Clares, J.W.B., de Freitas, M.C. and Paulino, M.H.C. (2013) Systematization of nursing care to institutionalized elderly based on Virginia Henderson, **Northeast Network Nursing Journal**, 14 (3), 649-658.

Clarke, L. (2004) The value of qualitative research, **Nursing Standard**, 18 (52), 41-44.

Clarke, L. (2006) Declaring conceptual independence from obsolete professional affiliations, In: Cutliffe, J.R. and Ward, M.F. (2006) (Eds.) **Key Debates in Psychiatric/Mental Health Nursing.** Edinburgh: Churchill Livingstone Elsevier (pp. 70-83).

Clausen, L. (2007) Corporate communication challenges: a 'negotiated' culture perspective, **International Journal of Crosscultural Management**, 7 (3), 317-332.

Cloutier, J.D., Duncan, C. and Bailey, P.H. (2007) Locating Carper's aesthetic pattern of knowing within contemporary nursing evidence, praxis and theory, **International Journal of Nursing Education Scholarship**, 4 (1), 1-11.

Coburn, D. (2005) Medical dominance then and now, **Health Sociological Review**, 15 (5), 432-443.

Coburn, D., Rappolt, S. and Bourgeault, I. (1997) Decline vs. retention of medical power through restratification: an examination of the Ontario case, **Sociology of Health and Illness**, 19 (1), 1-22.

Coleman, J.S. (1992) The problematics of social theory, **Theory and Society**, 21 (2), 263-283.

Connell, R. (2007) **Southern Theory**. Cambridge: Polity Press.

Cooley, C.H. (1964) **Human Nature and the Social Order**. London: Pantianos Classics.

Council of Deans of Health (2009) **International Policy.** Available at: http://www.universitiesuk.ac.uk [accessed 16 January 2015].

Coupland, J. (2007) Gendered discourses on the 'problem' of ageing: consumerized solutions, **Discourse and Communication**, 1 (1), 37-61.

Cowling, W.R. (2007) A unitary participatory vision of nursing knowledge, **Advances in Nursing Science**, 30 (1), 61-70.

Craig, J.C., Irwig, L.M. and Stockler, M.R. (2001) Evidence-based medicine: useful tools for decision making, **Medical Journal of Australia**, 174 (5), 248-253.

Creswell, J. (2014) **Research design: qualitative, quantitative, and mixed methods approaches** (4th Ed.). Thousand Oaks: Sage Publishing.

Crigger, N.J. (2008) Towards a viable and just global nursing ethics, **Nursing Ethics**, 15 (1), 17-27.

Crossley, M. (2000) Bridging cultures and traditions in the reconceptualisation of comparative and international education, **Comparative Education**, 36 (3), 319-332.

Cuban, S. (2010) 'It is hard to stay in England': itineraries, routes, and dead ends: an (im)mobility study of nurses who became carers, **Compare: A Journal of Comparative and International Education**, 40 (2), 185-198.

Cummings, G.G., Fraser, K. and Tarlier, D.S. (2003) Implementing advanced practitioner roles in acute care: an evaluation of organizational change, **Journal of Nursing Administration**, 33 (3), 139-145.

Dahlborg-Lyckhage, E. and Pilhammar-Anderson, E. (2009) Predominant discourses in Swedish nursing, **Policy, Politics and Nursing Practice**, 10 (2), 163–171.

Dale, R. (2005) Globalisation, knowledge economy and comparative education, **Comparative Education**, 41 (2), 117-149.

Daly, A.S. and Barker, M.C. (2005) Australian and New Zealand university students' participation in international exchange programs, **Journal of Studies in International Education**, 9 (1), 26-41.

Daniel, P., Chamberlain, A. and Gordon, F. (2001) Expectations and experiences of newly recruited Filipino nurses, **British Journal of Nursing**, 10 (4), 254-265.

Daniels, M.R. and Johansen, E. (1985) The role of accreditation in the development of public administration as a profession: a theoretical and empirical assessment, **Public Administration Quarterly**, 8 (4), 419-441.

Darbyshire, P. and McKenna, L. (2013) Nursing crisis of care: what part does nursing education own? **Nurse Education Today**, 33 (4), 305-307.

Davies, C. (1980) (Ed.) **Rewriting nursing history**. London: Croom Helm.

Davies, C. (1995) **Gender and the professional predicament in nursing**. Buckingham: Open University Press.

De Araujo Sartorio, N. and Pavone Zoboli, E.L.C. (2010) Images of a 'good nurse' presented by teaching staff, **Nursing Ethics**, 17 (6), 687-694.

DeDee, L.S. and Stewart, S. (2003) The effect of student participation in international study, **Journal of Professional Nursing**, 19 (4), 237-242.

Delgado-Márquez, B.L., Escudero-Torres, M.A. and Hurtado-Torres, N.E. (2013) Being highly internationalized strengthens your reputation: an empirical investigation of top higher education institutions, **Higher Education**, 66 (5), 619-633.

de Meis, C., de Almeida Souza, C. and da Silva Filho, J.F. (2007) House and street: narratives of professional identity among nurses, **Journal of Professional Nursing**, (6), 325-328.

Dempsey, P.A. and Dempsey, A.D. (2000) **Using Nursing Research: Process, Critical Evaluation and Utilization.** Michigan: Lippincott.

Denehy, J. (2001) Articulating your philosophy of nursing, **Journal of School Nursing**, 17 (1), 1-2.

Deng, Z. (2015) Michael Young, knowledge and curriculum: an international dialogue, **Journal of Curriculum Studies**, 47 (6), 723-732.

Denton, S. (2006) Nation-to-nation challenges to addressing the effects of emerging global nurse migration on health care delivery, **Policy, Politics, & Nursing Practice**, supplement to vol. 7 (3), 76S-80S.

Denzin, N.K. and Lincoln, Y.S. (Eds.) **Handbook of qualitative research**. Thousand Oaks: Sage.

Department of Health (2010) **The Framework for NHS involvement in international development**. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH 117137 [accessed 7 June 2013].

Department of Health (2012) **Transforming Care: A national response to Winterbourne View Hospital: Department of Health Final Report**. London: Department of Health.

Derose, K.P. and Varda, D.M. (2009) Social capital and health care access: a systematic review, **Medical Care Research and Review**, 66 (3), 272-306.

Deumert, A., Marginson, S., Nyland, C., Ramia, G. and Sawir, E. (2005) **The social and economic security of international students in Australia: Study of 202 student cases. Summary report**. Melbourne: Monash University.

Dewey, J. (1938) **Experience and Education**. New York: Macmillan.

Djerasimovic, S. (2014) Examining the discourses of cross-cultural communication in transnational higher education: from imposition to transformation, **Journal of Education for Teaching**, 40 (3), 204-216.

Dluhy, N.M. (1995) Mapping knowledge in chronic illness, **Journal of Advanced Nursing**, 21 (6), 1051-1058.

Doering, L. (1992) Power and knowledge in nursing: a feminist poststructuralist view, **Advanced Nursing Science**, 14 (4), 24-33.

Duff, L., Harvey, G., Handa, U. and Kitson, A. (1995) Quality improvement of nursing care in hospitals in India: the dynamic approach, **International Journal for Quality in Health Care**, 7 (2), 143-151.

Duffield, C., Gardner, G., Chang, A.M. and Catling-Paul, C. (2009) Advanced nursing practice: a global perspective, **Collegian: Journal of the Royal College of Nursing of Australia,** 16 (2), 55-62.

Duffy, M. (2001) A critique of cultural education in nursing, **Journal of Advanced Nursing**, 36 (4), 487-495.

Duke, K. (2002) Getting beyond the 'official line': reflections on dilemmas of access, knowledge and power in researching policy networks, **Journal of Sociology**, 31(1), 39 – 59.

Duncombe, J. and Jessop, J. (2002) 'Doing rapport' and the ethics of 'faking friendship', In: Mauthner, M., Brich, M., Jessop, J. and Miller, T. (Eds.) **Ethics in Qualitative Research**. London: Sage.

du Toit, D. (1995) A sociological analysis of the extent and influence of professional socialization on the development of a nursing identity among nursing students at two universities in Brisbane, Australia, **Journal of Advanced Nursing**, 21 (1), 164-171.

Dyson, S. (2016) Life history and Zimbabwean nursing student: 'global border', **Management in Education,** 19 (1), 8-11.

Dyson, S. (2018) **Critical Pedagogy in Nursing: Transformational Approaches to Nurse Education in a Globalized World**. London: Palgrave Macmillan.

Eckersley, R. (1992) **Environmentalism and Political Theory: Toward an Ecocentric Approach**. London: University College Press.

Edgley, A., Stickley, T., Timmons, S. and Meal, A. (2016) Critical realist review: exploring the real beyond the empirical, **Journal of Further and Higher Education**, 40 (3), 316-330.

Edmonds, M.L. (2010) The lived experience of nursing students who study abroad: a qualitative inquiry, **Journal of Studies in International Education,** 14 (5), 545-568.

Edwards, R. (1998) Flexibility, reflexivity and reflection in the contemporary workplace, **International Journal of Lifelong Education**, 17 (6), 377-388.

Egan, G. (2014) **The skilled helper: A problem-management and opportunity-development approach to helping** (10th Ed.). Pacific Grove: Cengage Learning Inc.,

Ellis, C. and Bochner, A. (2000) Autoethnography, personal narrative, reflexivity: researcher as subject, In: Lincoln, Y.N. (Ed.) **The handbook of qualitative research** (2nd Ed.). Thousand Oaks: Sage Publications (pp. 733-767).

Elston, M.A. (1991) The politics of professional power: medicine in a changing health service, In: Gabe, J., Calnan, M. and Bury, E. (Eds.), **The Sociology of the Health Service**. London: Routledge.

Ely, M., Anzul, M., Friedman, T., Garner, D. and Steinmetz, A. (1991) **Doing Qualitative Research: Circles within Circles**. London: Falmer.

Ernst, J. (2016) Evidence-based nursing in the IED: from caring to curing? **Nordic Journal of Working Life Studies**, 6 (S1), 47-66.

Estacio, E.V. and Karic, T. (2016) The world café: an innovative method to facilitate reflections on internationalization in higher education, **Journal of Further and Higher Education**, 40 (6), 731-745.

Etherington, K. (2004) **Becoming a Reflexive Researcher: Using Ourselves in Research**. London: Jessica Kingsley.

Etzkowitz, H., Webster, A., Gebhardt, C. and Terra, B.R.C. (2000) The future of the university and the university of the future: evolution of ivory tower to entrepreneurial paradigm, **Research Policy**, 29 (2), 313-330.

Eun-Ok, I. (2014) Situation-specific theories from the middle-range transitions theory, **Advances in Nursing Science**, 37 (1), 19-31.

Evans, C. and Stevenson, K. (2010) The learning experiences of international doctoral students with particular reference to nursing students: a literature review, **International Journal of Nursing Studies**, 47 (2), 239-250.

Evans, J. (2004) Men nurses: a historical and feminist perspective, **Journal of Advanced Nursing**, 47 (3), 321–328.

Evanson, A.E. and Zust, B.L. (2006) 'Bittersweet knowledge': long-term effects of an international experience, **Journal of Nursing Education,** 45 (10), 412-419.

Ezzy, D. (2002) **Qualitative Research**. New South Wales: Allen and Unwin.

Fagermoen, M.S. (1997) Professional identity: values embedded in meaningful nursing practice, **Journal of Advanced Nursing**, 25 (3), 434-441.

Falk-Rafael, A. (2006) Globalisation and global health: toward practice in the global community, **Advances in Nursing Science**, 29 (1), 2-14.

Farrell, C. and Morris, J. (2003) The 'neo-bureaucratic' state: professionals, managers and professional managers in schools, general practices and social work, **Organization**, 10 (1), 129-156.

Fernandes, A. and Kale, M. (2009) **As We See It.** Pune: Tathapi Trust.

Fielden, S. and Burke, R.J. (2014) Gendered careers in nursing, **Gender in Management**, 29 (2), 1754-2413.

Finfgeld-Connett, D. (2008) Concept synthesis of the art of nursing, **Journal of Advanced Nursing**, 62 (3), 381-388.

Finlay, L. (2002) Negotiating the swamp: the opportunity and challenge of reflexivity in research practice, **Qualitative Research**, 2 (2), 209-230.

Forestier, K. and Crossley, M. (2015) International education policy transfer – borrowing both ways: the Hong Kong and England experience, **Compare: A Journal of Comparative and International Education**, 45 (5), 664-685.

Forrester, G. (2000) Professional autonomy versus managerial control: the experience of teachers in an English primary school, **International Studies in Sociology of Education**, 10 (2), 133-151.

Fossey, E., Harvey, C., McDermott, F. and Davidson, L. (2002) Understanding and evaluating qualitative research, **Australian and New Zealand Journal of Psychiatry**, 36 (6), 717-732.

Foster, J. (2009) Cultural humility and the importance of long-term relationships in international partnerships, **Journal of GNN**, 38 (1), 100-107.

Foster, K., McAllister, M. and O'Brien, L. (2005) Coming to autoethnography: a mental health nurse's experience, **International Journal of Qualitative Methods**, 4 (4), 1-15.

Fournier, V. (2000) Boundary work and the (un)making of the professions. In: Malin, N. (Ed.), **Professionalism, Boundaries and the Workplace**. London: Routledge.

Francis, R. (2013) **Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry**. London: HMSO.

Freda, M.C. (1999) International nursing and world health: essential knowledge for the 21st century nurse, **The American Journal of Maternal/Child Health Nursing**, 23 (6), 329-332.

Freidson, E. (1970) **The Profession of Medicine: A Study of the Sociology of Applied Knowledge**. New York: Harper and Row.

Freidson, E. (1994) **Professionalism Reborn. Theory, Prophecy and Policy**. Cambridge: Polity Press.

Freidson, E. (2001) **Professionalism: The Third Logic**. Cambridge: Polity Press.

Freire, P. (2005) **Pedagogy of the Oppressed** (30th Anniversary Edition, translated by Ramos, M.B.). New York: Continuum.

Gardner, G., Chang, A. and Duffield, C. (2007) Making nursing work: breaking through the role confusion of advanced practice nursing, **Journal of Advanced Nursing**, 57 (4), 382-391.

Garner, B.L., Metcalfe, S.E. and Hallyburton, A. (2009) International collaboration: a concept model to engage nursing leaders and promote global nursing education partnerships, **Nurse Education in Practice**, 9 (2), 102-108.

Geertz, C. (Ed.)(1973) **The Interpretation of Cultures**. New York: Basic Books.

George, E.K. and Meadows-Oliver, M. (2013) Searching for collaboration in international nursing partnerships: a literature review, **International Nursing Review**, 60 (1), 1-36.

Georges, J. (2003) An emerging discourse toward epistemic diversity in nursing, **Advances in Nursing Science**, 26 (1), 44-52.

Georges, J. (2008) Bio-Power, agamben, and emerging nursing knowledge, **Advances in Nursing Science**, 31 (1), 4-12.

Georges, J. M. (2013) An emancipatory theory of compassion for nursing, **Advances in Nursing Science**, 36 (1), 2-9.

Gerrish, K. (2000) Still fumbling around? A comparative study of the new qualified nurse's perception of the transition from student to qualified nurse, **Journal of Advanced Nursing**, 32 (2), 473-480.

Gerrish, K., Husband, C. and Mackensie, J. (1996) **Nursing for a multi-ethnic society**. Buckingham: Oxford University Press.

Giddens, A. (1991) **Modernity and Self-Identity: Self and Society in the Late Modern Age**. Stanford: Stanford University Press.

Giddens A. (1996) **Defence of Sociology**. Cambridge: Cambridge University Press.

Giddens, A. (2002) **Runaway world: how globalisation is reshaping our lives** (2nd Ed.). London: Profile Books.

Gilbert, T. (1995) Nursing: empowerment and the problem of power, **Journal of Advanced Nursing**, 21 (5), 865-871.

Gillett, K. (2014) Nostalgic constructions of nurse education in British national newspapers, **Journal of Advanced Nursing,** 70 (11), 2495-2505.

Gillham, B. (2000) **The Research Interview**. London: Continuum.

Glaser, B.G. (1998) **Doing grounded theory: issues and discussions.** Mill Valley: Sociology Press.

Glaser, B.G. and Strauss, A.L. (1967) **The Discovery of Grounded Theory: Strategies for Qualitative Research**. London: Weidenfeld and Nicolson.

Global Forum for Health Research (2000) **The 10/90 report on health research 2000**. Geneva: Global Forum for Health Research.

Goodman, N.W. (1999) Who will challenge evidence-based medicine? **Journal of the Royal College of Physicians of London**, 33 (3), 249-251.

Grace, P.J. and Perry, D.J. (2013) Philosophical inquiry and the goals of nursing: a critical approach for disciplinary knowledge development and action, **Advances in Nursing Science**, 36 (2), 64-79.

Grant, A. (2014) Neoliberal higher education and nursing scholarship: power, subjectification, threats and resistance, **Nurse Education Today**, 34 (10), 1280-1282.

Green, J. (2000) Epistemology, evidence and experience: evidence based health care in the work of accident alliances, **Sociology of Health and Illness**, 22 (4), 453-476.

Green, J.L., Camilli, G. & Elmore, P.B. (Eds.) (2006) **Handbook of Complementary Methods in Education Research**. New York: Routledge.

Green, J. and Thorogood, N. (2009) **Qualitative Methods for Health Research**. London: Sage.

Grenfell, M. (2004) **Pierre Bourdieu: Agent Provocateur**. London: Continuum.

Griffin, A.P. (1980) Philosophy and nursing, **Journal of Advanced Nursing**, 5 (3), 261-272.

Grimshaw, T. (2010) Styling the occidental other: interculturality in Chinese university performances, **Language and Intercultural Communication**, 10 (3), 243-258.

Grimshaw, T. and Sears, C. (2008) 'Where am I from?' 'Where do I belong?': The negotiation and maintenance of identity by international school students, **Journal of Research in International Education**, 7 (3), 259-278.

Grootjens, J. and Newman, S. (2013) The relevance of globalization to nursing: a concept analysis, **International Nursing Review**, 60 (1), 78-85.

Gu, Q. and Schweisfurth, M. (2015) Transnational connections, competencies and identities: experiences of Chinese international students after their return 'home', **British Educational Research Journal**, 41 (6), 947-970.

Gubrium, J.F. and Holstein, J.A. (2002) (Eds.) **Handbook of Interview Research: Context and Methods**. Thousand Oaks: Sage Publications.

Habermas, J. (translated by McCarthy, T.) (1984) **The Theory of Communicative Action (Volume 1): Reason and the Rationalization of Society**. Cambridge: Polity Press.

Hadley, M.B., Blum, L.S., Mujaddid, S., Parveen, S., Nuremowla, S., Haque, M.E. and Ullah, M. (2007) Why Bangladeshi nurses avoid 'nursing': social and structural factors on hospital wards in Bangladesh, **Social Science and Medicine**, 64 (6), 1166-1177.

Hadley, M.B. and Roques, A. (2007) Nursing in Bangladesh: rhetoric and reality, **Social Science and Medicine**, 64 (6), 1153-1165.

Hagell, E.I. (1989) Nursing knowledge: women's knowledge. A sociological perspective, **Journal of Advanced Nursin**g, 14 (3), 226-233.

Haigh, M. (2014) From internationalization to education for global citizenship: a multi-layered history, **Higher Education Quarterly**, 68 (1), 6-27.

Haines, A. and Cassels, A. (2004) Can the millennium goals be attained? **British Medical Journal**, 329 (7462), 394-397.

Hall, J.M. and Fields, B. (2012) Race and microaggression in nursing knowledge development, **Advances in Nursing Science**, 35 (1), 25-38.

Hall, S. and du Gay, P. (1996) (Eds.) **Questions of Cultural Identity**. London: Sage.

Hallett, C. (2007) A 'gallop' through history: nursing in social context, **Journal of Clinical Nursing**, 16 (3), 429-430.

Hamilton, P. and Campbell, M. (2011) Knowledge for re-forming nursing's future: standpoint makes a difference, **Advances in Nursing Science**, 34 (4), 280-296.

Hammersley, M. and Atkinson, P. (2007) **Ethnography: Principles in Practice** (3rd Ed.). New York: Routledge.

Harden, J. (1996) Enlightenment, empowerment and emancipation: the case for critical pedagogy in nurse education, **Nurse Education Today**, 16 (1), 32-37.

Harrison, S. and Pollitt, C. (1994) **Controlling the Health Professionals: The Future of Work and Organisation in the NHS**. Buckingham: Open University Press.

Hart, C. (2015) The elephant in the room: nursing and nursing power on an interprofessional team, **Journal of Continuing Education in Nursing**, 46 (8), 349-355.

Hawkins, M.R. (2005) Becoming a student: identity work and academic literacies in early schooling, **TESOL Quarterly**, 39 (1), 59-82.

Hayagreeva Rao, M.V. and Pasmore, W. (1989) Knowledge and interests in organization studies: a conflict of interpretations, **Organization Studies**, 10 (2), 225-239.

Hayes, S. and Llewellyn, A. (2008) **Fundamentals of nursing care: a textbook for students of nursing and health care**. Exeter: Reflect Press.

Healey, M. (2006) 'I'm the gal that can do it if they let me', **International Advisors and Notions of Professionalism in India.** Melbourne: Australia.

Heath, H. (1998) Reflection and patterns of knowing in nursing, **Journal of Advanced Nursing**, 27 (5), 1054-1059.

Heinrich, K.T. (2010) Passionate scholarship 2001-2010: a vision for making academe safer for joyous risk-takers, **Advances in Nursing Science,** 33 (1), E50-E64.

Hemingway, A. (2013) What is nursing care and who owns it? **Nursing Times**, 109 (6), 16-17.

Henderson, V. (1966) **The Nature of Nursing: A Definition and its Implications for Practice and Education**. New York: Macmillan.

Henderson, V. (2006) The concept of nursing, **Journal of Advanced Nursing**, 53 (1), 21-34.

Heron, J. and Reason, P. (2001) The practice of co-operative inquiry: research with rather than on people. In: Reason, P. and Bradbury, H. (Eds.) **Handbook of Action Research: Participatory Inquiry and Practice**. London: Sage [pp. 179-188].

Hill, C., Cheong, K.C., Leong, Y.C. and Fernandez-Chung, R. (2014) TNE – Trans-national education or tensions between national and external? A case study of Malaysia, **Studies in Higher Education**, 39 (6), 952-966.

Hill, E.K., Alpi, M. and Auerbach, M. (2010) Evidence-based practice in health education and promotion: a review and introduction to resources, **Health Promotion Practice**, 11 (3), 358-366.

Hisama, K.K. (2001) The acceptance of nursing theory in Japan: a cultural perspective, **Nursing Science Quarterly**, 14 (3), 255-259.

Hoare, Q. and Nowell Smith, G. (1971) **Selections from the Prison Notebooks of Antonio Gramsci**. London: Lawrence and Wishart.

Holloway, I. and Galvin, K. (2016) **Qualitative Research in Nursing and Healthcare** (4th Ed.). Oxford: Wiley-Blackwell.

Holm, J.D. and Mallet, L. (2010) **The Asymmetries of University Partnerships between Africa and the Developed World: Our Experience in Botswana**. London: The British Council.

Holt, J., Barrett, C., Clarke, D. and Monks, R. (2000) The globalisation of nursing knowledge, **Nurse Education Today**, 20 (6), 426-431.

Holter, I.M. and Kim, H.S. (1995) Methodology for critical theory: critical action research. In: Omery, A., Kasper, C.E. and Page, G.G. (Eds.) **In search of nursing science**. Thousand Oaks: Sage [pp.220-232].

Holton, J. (2008) Grounded theory as a general research methodology, **The Grounded Theory Review**, 7 (2), 67-92.

Holyoake, D. (2001) **The male nurse: addressing the myths of maleness in nursing**. Salisbury: APS Publishing.

Hopkins, P.E. (2007) Positionalities and knowledge: negotiating ethics in practice, **ACME Editorial Collective,** 6 (3), 386-394.

Horkheimer, M. [1937] (2002) **Critical Theory: Selected Essays Max Horkheimer**. New York: Continuum Publishing Company.

Horkheimer, M. and Adorno, T. (1976) **Dialectic of enlightenment**. New York: Continuum.

Hornberger, C.A., Erämaa, S., Helembai, K., McCartan, P.J. and Turtiainen, T. (2014) Responding to the call for globalization in nursing education: the implementation of the transatlantic double-degree program, **Journal of Professional Nursing**, 30 (3), 243-250.

Hotho, S. (2008) Professional identity – product of structure, product of choice, **Journal of Organizational Change Management**, 21 (6), 721-742.

Howell, J., Rafferty, A.M., Wall, R. and Snaith, A. (2013) Nursing the tropics: nurses as agents of imperial hygiene, **Journal of Public Health**, 35 (2), 338-341.

Hu, Y., Shen, J. and Jiang, A. (2010) Nursing shortage in China: state, causes, and strategy, **Nursing Outlook**, 58 (3), 122-128.

Huffstutler, S.Y., Stevenson, S.S., Mullins, I.L., Hackett, D.A. and Lambert, A.W. (1998) The public's image of nursing as described to baccalaureate pre-nursing students, **Journal of Professional Nursing**, 14 (1), 7-13.

Humfrey, C. (2011) The long and winding road: a review of the policy, practice and development of the internationalization of higher education in the UK, **Teachers and Teaching: Theory and Practice**, 17 (6), 649-661.

Hunter, A., Wilson, L., Stanhope, M., Hatcher, B., Hattar, M., Messias, D.K.H. and Powell, D. (2013) Global health diplomacy: an integrative review of the literature and implications for nursing, **Nursing Outlook**, 61 (2), 85-92.

Hunter, J.L. (2008) Applying constructivism to nursing education in cultural competence: a course that bears repeating, **Journal of Transcultural Nursing**, 19 (4), 354-362.

Inglis, A., Rolls, C. and Kristy, S. (2000) The impact on attitudes towards cultural difference of participation in a health focused study abroad program, **Contemporary Nurse**, 9 (3-4), 246-255.

Ingram, D. (2010) **Habermas: introduction and analysis**. London: Cornell University Press.

Ingulsrud, J.E., Kai, K., Kadowaki, S., Kurobane, S. and Shiobara, M. (2002) The assessment of cross-cultural experience: measuring awareness through critical text analysis, **International Journal of Intercultural Relations**, 26 (5), 473-491.

International Council of Nurses (2005) **International Migration of Nurses: Trends and Policy Implications**. Geneva: International Council of Nurses.

International Council of Nurses (2010) **Global Issues and Trends in Nursing Education**. Geneva: International Council of Nurses.

International Council of Nurses (2012) **Definition of Nursing**. Geneva: International Council of Nurses. Available at: http://www.icn.ch/who-we-are/icn-definition-of-nursing/ [accessed 12 September 2015].

Iowa Intervention Project (1996) **Nursing Interventions Classification (NIC)** (2nd Ed.). St. Louis: Mosby Year Book.

Ironside, P. (2004) Covering content and teaching thinking: deconstructing the additive curriculum, **Journal of Nursing Education**, 43 (1), 5-18.

Isaacson, M. (2014) Clarifying concepts: cultural humility or competency, **Journal of Professional Nursing**, 30 (3), 251-258.

Jack, B. and Clarke, A.M. (1998) The purpose and use of questionnaires in research, **Professional Nurse**, 41 (3), 176-179.

Jacobs, B.B. (2013) An innovative professional practice model: adaptation of Carper's patterns of knowing, patterns of research, and Aristotle's intellectual virtues, **Advances in Nursing Science**, 36 (4), 271-288.

Jacobs-Kramer, M.K. and Chinn, P.L. (1988) Perspectives on knowing: a model of nursing knowledge, **Scholarly Inquiry for Nursing Practice**, 2 (2), 129-139.

James, D. (2015) How Bourdieu bites back: recognizing misrecognition in education and educational research, **Cambridge Journal of Education**, 45 (1), 97-112.

Jaworski, A. and Coupland, N. (Eds.) (1999) **The Discourse Reader**. London: Routledge.

Johns, C. (1995) Framing learning through reflection within Carper's fundamental ways of knowing in nursing, **Journal of Advanced Nursing**, 22 (2), 226-234.

Johnson, M. (2011) NETNEP 2010, nursing education in the global community: collaboration and networking for the future, **Nurse Education Today**, 31 (3), 223-225.

Johnson, S.E., Green, J. and Maben, J. (2014) A suitable job?: A qualitative study of becoming a nurse in the context of a globalizing profession in India, **International Journal of Nursing Studies**, 51 (5), 734-743.

Johnson, T. (1995) Governmentality and the institutionalization of expertise, In: Johnson, T., Larkin, G. and Saks, M. (Eds.), **Health Professions and the State in Europe**. London: Routledge [pp. 7-24].

Johnson, T., Larkin, G. and Saks, M. (Eds.) (1995) **Health Professions and the State in Europe**. London: Routledge.

Jones, C.B. and Sherwood, G.D. (2014) The globalization of the nursing workforce: pulling the pieces together, **Nursing Outlook**, 62 (1), 59-63.

Jones, K., Warren, A. and Davies, A. (2015) **Mind the Gap: exploring the needs of early career nurses and midwives in the workplace**. Available at: http://wm.hee.nhs.uk/files/2015/05/Mind-the-Gap-Final.pdf [accessed 22 September 2015].

Kajander-Unkuri, S., Salminem, L., Saarikoski, M., Suhonen, R. and Leino-Kilpi, H. (2013) Competence areas of nursing students in Europe, **Nurse Education Today**, 33 (6), 625-632.

Kanter, R.M. (1990) **When Giants Learn to Dance**. London: Unwyn Hyman.

Kanter, R.M. (1997) **World Class: Thriving Locally in the Global Economy**. New York: Touchstone Books.

Kaplan, I., Miles, S. and Howes, A. (2011) Images and the ethics of inclusion and exclusion: learning through participatory photography in education, **Journal of Research in Special Educational Needs**, 1 (3), 195-202.

Keighley, T. (2011) Globalization, decision making and taboo in nursing, **International Nursing Review**, 59 (2), 181-186.

Kelly, J., Watson, R., Watson, J., Needham, M. and Driscoll, L.O. (2017) Studying the old masters of nursing: a critical student experience for developing nursing identity, **Nurse Education in Practice**, 26, 121-125.

Ketefian, S. and Redman, R.W. (1997) Nursing science in the global community, **Journal of Nursing Scholarship**, 29 (1), 11-15.

Khan, M.E. and Manderson, L. (1992) Focus groups in rapid assessment procedures for tropical disease research, **Health Policy and Planning**, 7 (1), 56-66.

Khawaja, N.G. and Smith, R.A. (2011) A review of the acculturation experiences of international students, **International Journal of Intercultural Relations**, 35 (6), 699-713.

Kingma, M. (2001) Nursing migration: global treasure hunt or disaster—in-the-making, **Nursing Inquiry**, 8 (4), 205-212.

Kingma, M. (2006) Nurses on the move: migration and the global health economy, **Cornell University ILR Review**, 60 (2), 299-301.

Kingma, M. (2008) Nurse migration and the global health care economy, **Policy, Politics, & Nursing Practice**, 9 (4), 328-333.

Kingma, M. (2009) The international workplace: challenges and solutions, **International Journal of Nursing Studies**, 46 (7), 879-883.

Kingsnorth, P. (2012) **Seeing our planet as a factory floor**. Available at: http://www.abc.net.au/environment/articles/2012/10/16/3607124.htm [accessed 22 December 2012].

Kinsella, E.A. (2009) Professional knowledge and the epistemology of reflective practice, **Nursing Philosophy**, 11 (1), 3-14.

Kirkham, S.R., Baumbusch, J.L., Schultz, A.S.H. and Anderson, J.M. (2007) Knowledge development and evidence-based practice insights and opportunities from a postcolonial feminist perspective for transformative nursing practice, **Advances in Nursing Science**, 30 (1), 26-40.

Kirkpatrick, M. and Brown, S. (1999) Efficacy of an international exchange via the internet, **Journal of Nursing Education**, 38 (6), 278-285.

Kitchenham, A. (2008) The evolution of John Mezirow's Transformative Learning Theory, **Journal of Transformative Education**, 6 (2), 104-123.

Kittler, M.G., Rygl, D. and Mackinnon, A. (2011) Beyond culture or beyond control? Reviewing the use of Hall's high-/low-context concept, **International Journal of Cross Cultural Management**, 11 (1), 63-82.

Kitzinger, J. (1996) Introducing focus groups, In: Mays, N. and Pope, C. (Eds.) **Qualitative Research in Health Care**. London: BMJ Publishing Group.

Klees, S.J. (2008) Reflections on theory, method, and practice in comparative and international education, **Comparative Education Review**, 52 (3), 301-328.

Knight, J. (2004) Internationalization re-modelled: definition, approaches and rationales, **Journal of Studies in International Education**, 8 (1), 5-31.

Knight, J. (2013) The changing landscape of higher education internationalization – for better or worse? **Perspectives: Policy and Practice in Higher Education**, 17 (3), 84-90.

Knorr-Cetina, K. and Cicourel, A.V. (Eds.) **Advances in Social Theory and Methodology: towards an integration of micro and macro-sociologies**. London: Routledge/Kegan Paul.

Kooienga, S.A. and Carryer, J.B. (2015) Globalization and advancing primary health care nurse practitioner practice, **The Journal for Nurse Practitioners**, 11 (8), 804-811.

Koskinen, L., Mikkonen, I., Graham, I., Norman, L., Richardson, J., Savage, E. and Schorn, M. (2012) Advanced practice nursing for enduring health needs management: a global perspective, **Nurse Education Today**, 32 (5), 540-544.

Kramer, M. and Schmalenberg, C. (1993) Learning from success: autonomy and empowerment, **Nursing Management**, 24 (5), 58-64.

Kuczowski, B., DeLlisser, R., Maushammer, A., Miller, E. and Walden, M. (2001) Education news: nursing students without borders, **Nursing and Health Care Perspectives**, 22 (3), 114-115.

Kumar, N. (2005) Assessing the learning culture and performance of educational institutions, **Performance Improvement**, 44 (9), 27-32.

Kvale, S. (1996) **Interviews: An introduction to Qualitative Research Interviewing**. London: Sage Publications.

Lahtinen, P., Leino-Kilpi, H. and Salminen, L. (2013) Nursing education in the European higher education area: variations in implementation, **Nurse Education Today**, 34 (6), 1040-1047.

Lane, J.F. (2000) **Pierre Bourdieu**. London: Pluto Press.

Larson, M. (1977) **The Rise of Professionalism: A Sociological Analysis**. Berkeley: University of California Express.

Lasch, C. (1991) **The Culture of Narcissism: American Life in an Age of Diminishing Expectations.** New York: W.W. Norton and Company Inc.

Law, K. and Muir, N. (2006) The internationalisation of the nursing curriculum, **Nurse Education in Practice**, 6 (3), 149-155.

Layder, D. (2006) **Understanding social theory**. London: Sage.

Learmonth, M. and Humphreys, M. (2012) Auto-ethnography and academic identity: Glimpsing business school doppelgangers, **Organization**. 19, 99-117.

Lee, Y-W., Dai, Y-T., Chang, M.Y., Chang, Y., Yao, K.G. and Liu, M. (2017) Quality of work life, nurses' intention to leave the profession, and nurses leaving the profession: a one-year prospective survey, **Journal of Nursing Scholarship**, 49 (4), 438-444.

Lee, K., Walt, G. and Haines, A. (2004) The challenge to improve global health; financing the millennium development goals. **Journal of the American Medical Association**, 291, 2636-2638.

Leh, S.K., Robb, W.J.W., and Albin, B. (2004) Responding to the challenge of developing a global perspective in nursing education, **Nursing Education Perspectives**, 25 (2), 86-90.

Leininger, M. (1995) Culture care theory, research and practice, **Nursing Science Quarterly**, 9 (2), 71-78.

Leininger, M. (1997) Future directions in transcultural nursing in the 21st century, **International Nursing Review**, 44 (1), 19-23.

Lemert, C. (Ed.) (1993) **Social theory: The multicultural and classic readings**. Boulder: Westview Press.

Leonardo, Z. (2013) Critical social theory and transformative knowledge: the functions of criticism in quality education, **Educational Researcher**, 33 (6), 11-18.

Lewis, M.A. (1998) An examination of the role of learning environments in the construction of nursing identity, **Nurse Education Today**, 18 (3), 221-225.

Liaschenko, J. and Peter, E. (2004) Nursing ethics and conceptualizations of nursing: profession, practice and work, **Journal of Advanced Nursing**, 46 (5), 488-495.

Licqurish, S. and Seibold, C. (2011) Applying a contemporary grounded theory methodology, **Nurse Researcher**, 18 (4), 11-16.

Littlejohn, S.W. and Foss, K.A. (2008) **Theories of Human Communication** (9th Ed.). Belmont: Thomson Wadsworth.

Liu, Y. (2010) Nurses' work role in the context of gender and Chinese culture: an online forum study, **Journal of Nursing Research**, 18 (2), 117-125.

LoBiondo-Wood, G. and Haber, J. (1998) **Nursing Research: Methods, Critical Appraisal and Utilisation** (4th Ed.). Philadelphia: Mosby Year Books.

Lorensen, M. (1998) Response to 'Critical theory: a foundation for the development of nursing theories', **Scholarly Inquiry for Nursing Practice: An International Journal**, 2 (3), 233-236.

Lynam, M.J., Browne, A.J., Reimer Kirkham, S. and Anderson, J.M. (2007) Re-thinking the complexities of 'culture': what might we learn from Bourdieu? **Nursing Inquiry**, 14 (1), 23–34.

MacDonald, C. (2002) Relational professional autonomy, **Cambridge Quarterly of Healthcare Ethics**, 11 (3), 282-289.

MacDonald, J., Herbert, R. and Thibeault, C. (2006) Advanced practice nursing: unification through a common identity, **Journal of Professional Nursing**, 22 (3), 172-179.

MacDonald, K.M. (1995) **The Sociology of the Professions**. London: Sage Publications.

MacDonald, K. and Ritzer, G. (1988) The sociology of the professions: dead or alive? **Work and Occupations**, 15 (3), 251-272.

MacDonald, M. (1998) Gender and social security policy: pitfalls and possibilities, **Feminist Economics**, 4 (1), 1-25.

MacDougall, C. and Baum, F. (1997) The devil's advocate: a strategy to avoid groupthink and stimulate discussion in focus groups, **Qualitative Health Research**, 7 (4), 532-541.

Malin, N. (Ed.) (2000) **Professionalism, Boundaries and the Workplace**. London: Routledge.

Malterud, K. (2001) Qualitative research: standards, challenges, and guidelines, **The Lancet**, 358 (9280), 483-488.

Manley, K. (1997) A conceptual framework for advanced practice: an action research project operationalizing an advanced practitioner/consultant nurse role, **Journal of Clinical Nursing**, 6 (3), 179-190.

Marks, D.F., Murray, M., Evans, B. and Estacio, E.V. (2005) **Health Psychology: Theory, Research and Practice** (4th Ed.). London: Sage.

Marks-Maran, D. and Rose, P. (1997) (Eds.) **Reconstructing Nursing: Beyond Art and Science**. London: Bailliere Tindall.

Marshall, C. and Rossman, G.B. (1999) **Designing qualitative research** (3rd Ed.). Thousand Oaks: Sage.

Martin, B. (2013) (Ed.) **How black and minority ethnic applicants are disadvantaged in NHS staff recruitment.** London: Public World. Available at: www.publicworld.co.uk [accessed 20 January 2017].

Martin, F. (2008) Mutual learning: the impact of a study visit course on UK teachers' knowledge and understanding of global partnerships, **Critical Literacy: Theories and Practices**, 2 (1), 60-75.

Martin, F. and Griffiths, H. (2011) Power and representation: a postcolonial reading of global partnerships and teacher development through north-south study visits, **British Educational Research Journal**, 38 (6), 907-927.

Mayo, A. (2014) Improving medical education in Kenya: an international collaboration, **Journal of the Medical Library Association**, 102 (2), 96-100.

Mays, N. and Pope, C. (1995) Rigour and qualitative research, **BMJ**, 8 (311), 109-112.

Mazhindu, D.M., Griffiths, L., Pook, C., Erskine, A., Ellis, R. and Smith, F. (2016) The nurse match instrument: exploring professional nursing identity and professional nursing values for future nurse recruitment, **Nurse Education in Practice**, 18, 36-45.

Mazzarol, T., Soutar, G.N., Sim, M. and Seng, Y. (2003) 'The third wave: future trends in international education', **International Journal of Educational Management**, 17 (3), 90-99.

McAuliffe, M.S. and Cohen, M.Z. (2005) International nursing research and educational exchanges: a review of the literature, **Nursing Outlook**, 53 (1), 21-25.

McCrae, N. (2012) Whither nursing models? The value of nursing theory in the context of evidence-based practice and multidisciplinary health care, **Journal of Advanced Nursing**, 68 (1), 222-229.

McDonald, I.G. and Daly, J.M. (2000) The anatomy and relations of evidence-based medicine, **Australian and New Zealand Journal of Medicine**, 30 (3), 385-392.

McElmurry, B., Misner, S. and Buseh, A. (2003) Minority international research training program: global collaboration in nursing research, **Journal of Professional Nursing**, 19 (1), 22-31.

McGee, C. (2001) When the golden rule does not apply: starting nurses on the journey towards cultural competence, **Journal for Nurses in Staff Development**, 17 (3), 105-114.

McGibbon, E., Mulaudzi, F.M., Didham, P., Barton, S. and Sochan, A. (2014) Toward decolonizing nursing: the colonization of nursing and strategies for increasing the counter-narrative, **Nursing Inquiry**, 21 (3), 179-191.

McGuire, S. (2014) Borders, centres, and margins: critical landscapes for migrant health, **Advances in Nursing Science**, 37 (3), 197-212.

McLain, B.R. (1988) Collaborative practice: a critical theory perspective, **Research in Nursing and Health**, 11 (6), 391-398.

McLaughlin, J. (2001) EBM and risk. Rhetorical resources in the articulation of professional identity, **Journal of Management in Medicine**, 15 (5), 352-363.

Mead, G. (1934) **Mind, Self and Society: From the Standpoint of a Social Behaviourist**. Chicago: The University of Chicago Press.

Meehan, T.C. (2012) The careful nursing philosophy and professional practice model, **Journal of Clinical Nursing**, 21 (19), 2905-2916.

Meerabeau, E. (2004) Be good, sweet maid, and let who can be clever: a counter reformation in English nursing education? **International Journal of Nursing Studies**, 41 (3), 285–292.

Meeusen, C., de Vroome, T. and Hooghe, M. (2013) How does education have an impact on ethnocentrism? A structural equation analysis of cognitive, occupational status and network mechanisms, **International Journal of Intercultural Relations**, 37 (5), 507-522.

Melby, C.S., Dodgson, J.E. and Tarrant, M. (2008) The experiences of western expatriate nursing educators teaching in eastern Asia, **Journal of Nursing Scholarship**, 40 (2), 176-183.

Meleis, A.I. (2012) **Theoretical Nursing: Development and Progress** (5th Ed.). Philadelphia: Lippincott Williams and Wilkins.

Messias, D.K.H. (2001) Globalization, nursing, and health for all, **Journal of Nursing Scholarship**, 33 (1), 9-11.

Mezirow, J. (2000) Learning to think like an adult: core concepts of transformation theory. In: Mezirow, J. (Ed.) **Learning as Transformation: Critical Perspectives on a Theory in Progress**. San Francisco: Jossey Bass [pp.3-34].

Miles, M.B. and Huberman, A.M. (1994) **Qualitative data analysis: an expanded source book** (2nd Ed.). Thousand Oaks: Sage Publishing.

Miles, S. (2011) Exploring understandings of inclusion in schools in Zambia and Tanzania using reflective writing and photography, **International Journal of Inclusive Education**, 15 (10), 1087-1102.

Miles, S. (2015) Creating conversations: an inclusive approach to the international networking of knowledge about education, **Journal of Research in Special Educational Needs**, 15 (4), 266-275.

Miles, S. and Kaplan, I. (2005) Using images to promote reflection: an action research study in Zambia and Tanzania, **Journal of Research in Special Educational Needs**, 5 (2), 77-83.

Mill, J.E., Allen, M.N. and Morrow, R.A. (2001) Critical theory: critical methodology to disciplinary foundations in nursing**, Canadian Journal of Nursing Research**, 33 (2), 109-127.

Mill, J., Astle, B.J., Ogilvie, L. and Gastaldo, D. (2010) Linking global citizenship, undergraduate nursing education, and professional nursing: curricular innovation in the 21st century, **Advances in Nursing Science**, 33 (3), E1-E11.

Miller, R.L. and Brewer, J.D. (2003) **The A - Z of social research**. London: Sage.

Millet, K. (1971) **Sexual politics**. New York: Avon Books.

Moon, S. (2003) Managing international education: Korean students and student support staff perspectives at UNSW. Paper presented at the 17th IDP International Education Conference, Melbourne. In: Airey, D. and Tribe, J. (2005) **An International Handbook of Tourism Education**. Oxford: Routledge.

Morakinyo, O. and Akiwowo, A. (1981) The Yoruba ontology of personality and motivation: a multidisciplinary approach, **Journal of Sociological Biological Structure**, 4 (1), 19-38.

Morgan, D.L. (1997) **Focus groups as Qualitative Research** (2nd Ed.). London: Sage.

Morse, J.M. (2015) Critical analysis of strategies for determining rigor in qualitative inquiry, **Qualitative Health Research**, 25 (9), 1212-1222.

Mortimer, B. and McGann, S. (Eds.) (2005) **New Directions in the History of Nursing: International Perspectives**. Oxford: Routledge.

Moufahim, M. and Lim, M. (2015) The other voices of international higher education: an empirical study of students' perceptions of British university education in China, **Globalisation, Societies and Education**, 13 (4), 437-454.

Murphy, M.M., Begley, T., Timmins, F., Neill, F. and Sheaf, G. (2015) Spirituality and spiritual care – missing concepts from core undergraduate children's nursing textbooks, **International Journal of Children's Spirituality**, 20 (2), 114—128.

Murray, T.A., Crain, C., Meyer, G.A., McDonough, M.E., and Schweiss, D.M. (2010) Building bridges: an innovative academic-service partnership, **Nursing Outlook**, 58 (5), 252-260.

Nair, S. (2012) **Moving with the Times: Gender, Status and Migration of Nurses in India**. New Delhi: Routledge.

Nair, S., Healey, M. (2006) **A Profession on the Margins: Status Issues in Indian Nursing**, Occasional paper. Available at: http:www.cwds.ac.in/OccPaper/profession_on_the_margins.pdf [accessed on 10/11/2013].

Nairn, S. (2009) Social structure and nursing research, **Nursing Philosophy**, 10 (3), 191–202.

Nairn, S. and Pinnock, D. (2017) Pierre Bourdieu: expanding the scope of nursing research and practice, **Nursing Philosophy**, 18 18:e12167. Available at: https://doi.org/10.1111/nup.12167 [accessed 27 December, 2017].

Nancarrow, S.A. and Borthwick, A.M. (2005) Dynamic professional boundaries in the healthcare workforce, **Sociology of Health and Illness**, 27 (7), 897-919.

Navarro, Z. (2006) In search of cultural interpretation of power, **Institute of Development Studies Bulletin**, 37 (6), 11-22.

Ndlovu-Gatsheni, S.J. (2013) The entrapment of Africa within global colonial matrices of power: eurocentrism, coloniality and deimperialization in the twenty-first century, Journal of Developing Societies, 29 (4), 331-353.

Nelson, S. and Gordon, S. (2004) The rhetoric of rupture: nursing as a practice with a history? **Nursing Outlook**, 52 (5), 255-261.

Newman, M.A. (1990) Newman's theory of health as praxis, **Nursing Science Quarterly**, 3 (1), 37-41.

Newman, M.A. (2002) The pattern that connects, **Advanced Nursing Science**, 24 (3), 1-7.

Newman, M.A., Sime, A.M. and Corcoran-Perry, S.A. (2004) The focus of the discipline of nursing, In: Reed, P.G., Shearer, N.C. and Nicoll, L.H. (Eds), **Perspectives on Nursing Theory**. Philadelphia: Lippincott, Williams and Wilkins [pp. 315-320].

Ng'ang'a, N. and Woods Byrne, M. (2015) Professional practice models for nurses in low-income countries: an integrative review, **BMC Nursing**, 14 (44), 1-15.

Nicely, B. and DeLario, G.T. (2011) Virginia Henderson's principles and practice of nursing applied to organ donation after brain death, **Progress in Transplantation**, 21 (1), 72-77.

Nichols, B.L. (2008) Building global alliances IV: global health challenges in a world divided by health iniquities, **Policy, Politics & Nursing Practice**, 9 (4), 305-306.

Nickelsen, N.C. (2009) Rethinking interventionist research: navigating oppositional networks in a Danish hospital, **Journal of Research Practice**, 5 (2), 1-18.

Nightingale, F. [1860] (1969) **Notes on Nursing: what it is and what it is not**. New York: Dover Publications, Inc.

Nonkelela, T. (2001) Rural nursing in South Africa: a tale of two cultures, PhD thesis, University of Newcastle, New South Wales, Australia. In: Parker, V. and McMillan, M. (2007) Challenges facing internationalisation of nursing practice, nurse education and nursing workforce in Australia, **Contemporary Nurse**, 24 (2), 128-136.

Northway, R. (2000) Ending participatory research? **Journal of Intellectual Disabilities**, 4 (1), 27-36.

Nursing and Midwifery Council (2015**) Nurses and midwives trained abroad**. London: NMC. Available at: http://tinyurl.com/gruemw6 [accessed 21 January 2017].

Nursing and Midwifery Council (2015) **The code for nurses and midwives**. Available at: https://www.nmc.org.uk/standards/code/ [accessed 12 August 2017].

Nursing and Midwifery Council (2016) **2015-2016 Annual reports and accounts published**. Available at: https://www.nmc.org.uk/news/news-and-updates/2015-2016-annual-reports-and-accounts-published/ [accessed 4 January 2017].

Nursing Now (2018) **Nursing Now**. Available at: http://www.nursingnow.org/who-we-are/ [accessed 17 February 2018].

OECD (2015) **International Migration Outlook 2015**. Paris: OECD Publishing. Available at: http://dx.doi.org/10.1787/migr_outlook-2015-en [accessed 21 January 2017].

Ohlen, J. and Segesten, K. (1998) The professional identity of the nurse: concept analysis and development, **Journal of Advanced Nursing**, 28 (4), 720-727.

Olson, E.A. (1996) Evidence-based practice: a new approach to teaching the integration of research and practice in gerontology, **Educational Gerontology**, 22 (6), 523-537.

Omery, A., Kasper, C.E. and Page, G.G. (Eds.) **In search of nursing science**. Thousand Oaks: Sage.

Orem, D.E. (1995) **Nursing: Concepts of Practice** (5th Ed). St. Louis: Mosby.

Osburn, J. (2006) An overview of social role valorization theory, **SRV Journal**, 1 (1), 4-13.

Paley, J., Cheyne, H., Dalgleish, L., Duncan, E.A.S. and Niven, C.A. (2007) Nursing's ways of knowing and dual process theories of cognition, **Journal of Advanced Nursing**, 60 (6), 692-701.

Palmer, D. and Kramlich, D. (2011) An introduction to the multisystem model of knowledge integration and translation, **Advances in Nursing Science**, 34 (1), 29-38.

Pang, S.M.C. (2003) Nursing ethics in modern China: conflicting values and competing role requirements. In: Pang, S.M.C., Wong, T., Wang, C.S., Zhang, Z.J., Chan, H.Y.L., Lam, C.W.Y. and Chan, K.L. (2004) Towards a Chinese definition of nursing, **Journal of Advanced Nursing**, 46 (6), 657-670.

Pang, S.M.C., Sawada, A., Konishi, E., Olsen, D.P., Yu, P., Chan, M.F.T. and Mayumi, N. (2003) A comparative study of Chinese, American and Japanese nurses' perception of ethical role responsibilities, **Nursing Ethics**, 10 (3), 295-311.

Pang, S.M.C., Wong, T., Wang, C.S., Zhang, Z.J., Chan, H.Y.L., Lam, C.W.Y. and Chan, K.L. (2004) Towards a Chinese definition of nursing, **Journal of Advanced Nursing**, 46 (6), 657-670.

Papadopoulos, I., Tilki, M. and Taylor, G. (1998) **Transcultural care: A guide for health professionals**. Salisbury: Quay.

Parker, D. *(*1997*)* Nursing art and science: literature and debate. In: Marks-Maran, D. and Rose, P. (Eds.) **Reconstructing Nursing: Beyond Art and Science**. London: Bailliere Tindall [pp. 3–24].

Parker, M. and Jary, D. (1995) The McUniversity: organisations, management and academic subjectivity, **Organization**, 2 (2), 319-338.

Parker, V. and McMillan, M. (2007) Challenges facing internationalisation of nursing practice, nurse education and nursing workforce in Australia, **Contemporary Nurse**, 24 (2), 128-136.

Parse, R.R. (2000) Paradigms: a reprise, **Nursing Science Quarterly**, 13 (4), 275-276.

Pashby, K. and Andreotti, V.D.O. (2016) Ethical internationalization in higher education: interfaces with international development and sustainability, **Environmental Education Research**, 22 (6), 771-787.

Patrick, D. and Scambler, G. (1982) (Eds.) **Sociology as Applied to Medicine**. London: Bailliere Tindall.

Patton, M. (1990) **Qualitative evaluation and research methods** (2nd Ed.). Newbury Park: Sage Publishing.

Pearson, A., Vaughan, B. and Fitzgerald, M. (2005) **Nursing models for practice** (3rd Ed.). Edinburgh: Butterworth-Heinemann.

Peltomaa, K., Viinikainen, S., Rantanen, A., Sieloff, C., Asikainen, P. and Suominen, T. (2013) Nursing power as viewed by nursing professionals, **Scandinavian Journal of Caring Sciences**, 27 (3), 580-588.

Perron, A., Fluet, C. and Holmes, D. (2005) Agents of care and agents of the state: bio-power and nursing practice, **Journal of Advanced Nursing**, 50 (5), 536-544.

Pham, L. and Tran, L. (2015) Understanding the symbolic capital of intercultural interactions: a case study of international students in Australia, **International Studies in Sociology of Education**, 25 (3), 204-224.

Phillips, D. and Schweisfurth, M. (2008) **Comparative and International Education: An Introduction to Theory, Method, and Practice**. London: Continuum International Publishing Group.

Pike, G. and Ball, J. (2007) **Black and minority ethnic nurses and internationally recruited nurses: results from RCN Employment/ Working Well surveys 2005 and 2002**. London: Royal College of Nursing.

Pilnick, A. and Dingwall, R. (2011) On the remarkable persistence of asymmetry in doctor-patient interaction, **Social Science and Medicine**, 72 (8), 1374-1382.

Pitre, N.Y., Kushner, K.E., Raine, K.D. and Hegadoren, K.M. (2013) Critical feminist narrative inquiry: advancing knowledge through double-hermeneutic narrative analysis, **Advances in Nursing Science**, 36 (2), 118-132.

Postone, M., LiPuma, E. and Calhoun, C. (1995) Introduction: Bourdieu and social theory. In: Calhoun, C., LiPuma, E. and Postone, M. (Eds.) **Bourdieu: Critical Perspectives**. Cambridge: Polity Press [pp. 1–13].

Prakasamma, M. (2005) **Status of nursing education in Andhra Pradesh: trends, current status, issues and recommendations**. Hyderabad: The Academy for Nursing Studies.

Premji, S.S., Lalani, N., Ajani, K., Lakhani, A., Moez, S. and Dias, J.M. (2011) Faculty practice in a private teaching institution in a developing country: embracing the possibilities, **Journal of Advanced Nursing**, 67 (4), 876-883.

Prichard, C. and Willmott, H. (1997) Just how managed is the McUniversity? **Organization Studies**, 18 (2), 287-316.

Pridmore, J.A., Murphy, F. and Williams, A. (2010) Nursing models and contemporary nursing 2: can they raise standards of care? **Nursing Times**, 106 (24), 22-25.

Qu, S.Q. and Donnay, J. (2011) The qualitative research interview, **Qualitative Research in Accounting and Management**, 8 (3), 238-264.

Quinney, L., Dwyer, T. and Chapman, Y. (2016) Who, where and how of interviewing peers, **Sage Open**, (July-September), 1-10. Available at: http://journals.sagepub.com/doi/full/10.1177/2158244016659688 [accessed 15 November 2015].

Rafael, F. and Adeline, R. (1996) Power and caring: a dialectic in nursing, **Advances in Nursing Science**, 19 (1), 3-17.

Rafferty, A.M. (1996) **The politics of nursing knowledge**. London: Routledge.

Rao, M., Rao, K.D., Kumar, A.K.S., Chatterjee, M. and Sundoram, T. (2011) India: towards universal health coverage, **The Lancet**, (377), 587-598.

Reason, P. (2002) The practice of co-operative inquiry, **Systemic Practice and Action Research**, 15 (3), 169-175.

Reay, D. (2003) A risky business? Mature working-class women students and access to Higher Education, **Gender and Education**, 15 (4), 301-317.

Reay, D., Crozier, G. and Clayton, J. (2009) 'Strangers in paradise'? Working-class students in elite universities, **Sociology**, 43 (6), 1103-1121.

Reed, J., Proctor, S. and Murray, S. (1996) A sampling strategy for qualitative research, **Nurse Researcher**, 3 (4), 52–68.

Reed, M. (1996) Expert power and control in late modernity: an empirical review and theoretical synthesis, **Organization Studies**, 17 (4), 573-597.

Reed, P.G. (1995) A treatise on nursing knowledge development for the 21st century: beyond postmodernism, **Advances in Nursing Science**, 17 (3), 70-84.

Reed, P.G., Shearer, N.C. and Nicoll, L.H. (Eds.) (2004) **Perspectives on Nursing Theory**. Philadelphia: Lippincott, Williams and Wilkins.

Reutter, L. (2000) Socio-economic determinants of health. In: Denzin, N.K. and Lincoln, Y.S. (Eds.) **Handbook of qualitative research.** Thousand Oaks: Sage [pp. 324-339].

Reutter, L. and Williamson, D.L. (2000) Advocating healthy public policy: implications for baccalaureate nursing education, **Journal of Nursing Education**, 39 (1), 21-26.

Richards, H. and Emslie, C. (2000) The 'doctor' or 'the girl from the university'? Considering the influence of professional roles on qualitative interviewing, **Family Practice**, 17 (1), 71-75.

Richardson, F. and Carryer, J. (2005) Teaching cultural safety in a New Zealand education program, **Journal of Nursing Education**, 44 (5), 201–209.

Rienties, B., Johan, N. and Jindal-Snape, D. (2015) A dynamic analysis of social capital-building of international and UK students, **British Journal of Sociology of Education**, 36 (8), 1212-1235.

Rilke, R.M. (1993) **Letters to a young poet**. London: Norton.

Riner, M.E. (2011) Globally engaged nursing education: an academic program framework, **Nursing Outlook**, 59 (6), 308-317.

Risjord, M. (2010) **Nursing Knowledge: Science, Practice and Philosophy**. Chichester: Wiley-Blackwell.

Ritchie, J., Lewis, J., McNaughton Nicholls, C. and Ormston, R. (2003) **Qualitative Research Practice**. London: Sage.

Ritzer, G. (2004) Rethinking globalization: glocalization/grobalization and something/nothing, **Sociological Theory**, 21 (3), 193-209.

Rix, E.F., Barclay, L. and Wilson, S. (2014) Can a white nurse get it? 'Reflexive practice' and the non-indigenous clinician/researcher working with aboriginal people, **Rural and Remote Health**, 14 (2679), 1-13.

Robbins, D. (1991) **The Work of Pierre Bourdieu**. Milton Keynes: Open University Press.

Rolfe, G. (1999) Insufficient evidence: the problems of evidence-based nursing, **Nurse Education Today**, 19 (6), 433-442.

Rolfe, G. (2008) Nursing and the art of radical critique, **Nurse Education Today**, 28 (1), 2-13.

Rolfe, G. and Gardner, L. (2006) Education, philosophy and academic practice: nursing studies in the post-historical university, **Nurse Education Today**, 26 (8), 634-639.

Rolfe, G. and Watson, R. (2008) Evidence-based practice: a debate, **Journal of Nursing Management**, 16 (4), 486-493.

Rolfe, M.K., Bryar, R.M., Hjelm, K., Apelquist, J., Fletcher, M. and Anderson, B.L. (2004) International collaboration to address common problems in health

care: processes, practicalities and power, **International Nursing Review**, 51 (3), 140-148.

Roper, N., Logan, W. and Tierney, A.J. (2000) **The Roper Logan Tierney Model of Nursing**. London: Churchill Livingstone.

Rose, N. (1999) **Governing the soul: the shaping of the private self** (2nd Ed.). London: Free Association Books.

Rossides, D. (1998) **Professions and Disciplines: Functional and Conflict Perspectives**. Upper Saddle River: Prentice-Hall.

Rowan, J. (2001) The humanistic approach to action research. In: Reason, P. and Bradbury, H. (Eds.) **Handbook of Action Research: Participatory Inquiry and Practice**. London: Sage.

Rowe, N.E. (2010) Nursing identity, **British Journal of Nursing**, 19 (9), 603.

Rowley, J. (2012) Conducting research interviews, **Management Research Review**, 35 (3/4), 260-271.

Roxburgh, M., Taylor, J. and Murebwayire, M. (2009) Rwanda: a thousand hills, a thousand dreams, a thousand challenges for nurses and midwives and the Milliennium Development Goals, **Nurse Education in Practice**, 9 (6), 349-350.

Roy, C. (1997) Future of the Roy model: challenge to redefine adaptation, **Nursing Science Quarterly**, 10 (1), 42-48.

Royal College of Nursing (2003) **Children and Young People's Nursing: A Philosophy of Care**. London: Royal College of Nursing.

Royal College of Nursing (2014) **Defining nursing**. London: Royal College of Nursing.

Ruddock, H.C. and Turner, D.S. (2007) Developing cultural sensitivity: nursing students' experiences of a study abroad programme, **Journal of Advanced Nursing**, 59 (4), 361-369.

Rutty, J.E. (1998) The nature of philosophy of science, theory and knowledge relating to nursing and professionalism, **Journal of Advanced Nursing**, 28 (2), 243-250.

Ryan, M. and Twibell, R.S. (2002) Outcomes of a transcultural nursing immersion experience: confirmation of a dimensional matrix, **Journal of Transcultural Nursing**, 13 (1), 30-39.

Ryan-Krause, P. (2016) Short-term global experiences: reflections, themes, and implications, **Journal of Nursing Education**, 55 (7), 379-384.

Salas, A.S. (2005) Toward a north-south dialogue: revisiting nursing theory (from the south), **Advances in Nursing Science**, 28 (1), 17-24.

Saltman, R.B., Figueras, J. and Sakellarides, C. (1998) (Eds.) **Critical challenges for health care reform in Europe.** Maidenhead: Open University Press.

Sanner, S., Wilson, A. and Samson, L. (2002) The experiences of international students in a baccalaureate nursing programme, **Journal of Professional Nursing**, 18 (4), 206-213.

Savage, M., Barlow, J., Dickens, T. and Fielding, T. (1992) **Property, Bureaucracy and Culture**. London: Routledge.

Sawatzky, J.V., Enns, C.L., Ashcroft, T.H., Davis, P.L. and Harder, B.N. (2009) Teaching excellence in nursing education: a caring framework, **Journal of Professional Nursing**, 25 (5), 260-266.

Sawir, E. (2013) Internationalisation of higher education curriculum: the contribution of international students, **Globalization, Societies and Education**, 11 (3), 359-378.

Sayim, K.Z. (2011) Policy transfer from advanced to less-advanced institutional environments: labour market orientations of US MNEs in Turkey, **Human Relations**, 64 (4), 573-597.

Scarbrough, H. (2010) Knowledge as work: conflicts in the management of knowledge workers, **Technology Analysis & Strategic Management**, 11 (1), 5-16.

Scherubel, J. (2001) A global health analysis project for baccalaureate nursing students, **Journal of Professional Nursing**, 17 (2), 96-100.

Schim, S.M., Doorenbos, A., Benkert, R. and Miller, J. (2007) Culturally congruent care: putting the puzzle together, **Journal of Transcultural Nursing**, 18 (2), 103-110.

Scholes, J. and Moore, D. (2000) Clinical exchange: one model to achieve culturally sensitive care, **Nursing Inquiry**, 7 (1), 61-71.

Schön, D.A. (1983) **The Reflective Practitioner: How Professionals Think in Action**. New York: Basic Books.

School of Nursing (SoN) (2013) **International Strategy**. Nottingham: University of Nottingham.

Schreiber, R.S. and Stern, P.N. (2001) **Using Grounded Theory in Nursing**. New York: Springer Publishing.

Seeber, M., Cattaneo, M., Huisman, J. and Paleari, S. (2016) Why do higher education institutions internationalize? An investigation of the multilevel determinants of internationalization rationales, **Higher Education**, 72 (5), 685-702.

Seider, R. (2004) **Legal Globalization and Human Rights: Constructing the 'Rule of Law' in Post-Conflict Guatemala**. Available at:

http://campus.usal.es/~dpublico/areacp/Doctorado0304/Seminario_Investigacion03/Sie der04.PDF [accessed 7 February 2013].

Seloilwe, E.S. (2005) Globalisation and nursing, **Journal of Advanced Nursing**, 50 (6), 571.

Shamian, J. (2015) Global voice, strategic leadership and policy impact: global citizens, global nursing, **International Nursing Review**, 62 (1), 4.

Sherwood, G. (2005) International collaboration for developing graduate education in China, **Nursing Outlook**, 53 (1), 15-20.

Sherwood, G.D. and Shaffer, F.A. (2014) The role of internationally educated nurses in a quality, safe workforce, **Nursing Outlook**, 62 (1), 46-52.

Shin, K.R. (2001) Developing perspectives on Korean nursing theory: the influences of Taoism, **Nursing Science Quarterly**, 14 (4), 346-353.

Shishani, K., Allen, C., Shubnikov, E., Salman, K., Laporte, R.E. and Linkov, F. (2012) Nurse educators establishing new venues in global nursing education, **Journal of Professional Nursing**, 28 (2), 132-134.

Shultz, L. and Guimaraes-Iosif, R. (2012) Citizenship education and the promise of democracy: a study of UNESCO associated schools in Brazil and Canada, **Education, Citizenship and Social Justice**, 7 (3), 241-254.

Sideman, S. (2013) **Contested Knowledge: Social Theory Today**. Chichester: Wiley Blackwell.

Sieger, M., Fritz, E. and Them, C. (2011) In discourse: Bourdieu's theory of practice and habitus in the context of a communication-oriented nursing interaction model, **Journal of Advanced Nursing**, 68 (2), 480-489.

Silva, M.C., Sorrell, J.M. and Sorrell, C.D. (1995) From Carper's patterns of knowing to ways of being: an ontological philosophical shift in nursing, **Advances in Nursing Science**, 18 (1), 1-13.

Silverman, D. (2014) **Interpreting Qualitative Data** (5th Ed.). London: Sage Publications Inc.

Smart, B. (1999) **Facing Modernity: Ambivalence, Reflexivity and Morality**. London: Sage.

Smith, E.V. (2000) Globalization and nursing, **Journal of Advanced Nursing**, 50 (6), 571.

Smith, F. (1995) **Children's Nursing in Practice: Nottingham Model**. Oxford: Blackwell Science.

Smith, J.P. (1989) **Virginia Henderson: the first ninety years.** Harrow: Scutari Press.

Smith, L. and Coleman, V. (2010) **Child and family centred healthcare: concept, theory and practice** (2nd Ed.). Hampshire: Palgrave Macmillan.

Smith, R.A. and Khawaja, N.G. (2011) A review of the acculturation experiences of international students, **International Journal of Intercultural Relations**, 35 (6), 699-713.

Smith, T. (1990) **The Logic of Marx's Capital: Replies to Hegelian Criticisms**. Albany: State University of New York Press.

Solano, D. and Rafferty, A.M. (2007) Can lessons be learned from history? The origins of the British imperial nurse labour market: a discussion paper, **International Journal of Nursing Studies**, 44 (6), 1055-1063.

Soulé, I. (2014) Cultural competence in health care: an emerging theory, **Advances in Nursing Science**, 37 (1), 48-60.

Sparacio, D.C. (2005) Winged migration: international nurse recruitment – friend or foe to the nursing crisis? **Journal of Nursing Law**, 10 (2), 97-114.

Spelman, E.V. (1988) **Inessential Woman: Problems of Exclusion in Feminist Thought**. Boston: Beacon.

Spence, D. (2001) Hermeneutic notions illuminate cross-cultural nursing experiences, **Journal of Advanced Nursing,** 35 (4), 624-630.

Spence, D. (2003) Nursing people from cultures other than one's own: a perspective from New Zealand, **Contemporary Nurse: Advances in Transcultural Nursing**, 15 (3), 222- 232.

Spigelman, C. (2001) Argument and evidence in the case of the personal, **College English**, 64 (1), 63-87.

Spitzer, A. and Perrenoud, B. (2006) Reforms in nursing education across western Europe: from agenda to practice, **Journal of Professional Nursing**, 22 (3), 150-161.

Spolander, G., Engelbrecht, L., Martin, L., Strydom, M., Pervova, I., Marjanen, P., Tani, P., Sicora, A. and Adaikalam, F. (2014) The implications of neoliberalism for social work: reflections from a six-country international research collaboration, **International Social Work**, 57 (4), 301-312.

Spradley, J.P. (1979) **The ethnographic interview**. New York: Holt, Rinehart & Winston.

Squires, A., Aiken, L.H., van den Heede, K., Sermeus, W., Bruyneel, L., Lindqvist, R., Schoonhoven, L., Stromseng, I., Busse, R., Brzostek, T., Ensio, A., Moreno-Casbas, M., Rafferty, A.M., Schubert, M., Zikos, D. and Matthews, A. (2013) A systematic survey instrument translation process for multi-country, comparative health workforce studies, **International Journal of Nursing Studies**, 50 (2), 264-273.

Stehr, N. (1994) **Knowledge Societies**. London: Sage.

Stevens, P.E. and Hall, J.M. (1992) Applying critical theories to nursing in communities, **Public Health Nursing**, 9 (1), 2-9.

Stevenson, K. and Evans, C. (2010) The learning experiences of international doctoral students with particular reference to nursing students: a literature review, **International Journal of Nursing Studies**, 47 (2), 239-250.

Stickley, T. (2011) From SOLER to SURETY for effective non-verbal communication, **Nurse Education in Practice**, 11 (6), 395-398.

Stiles, K.A. (2011) Advancing nursing knowledge through complex holism, **Advances in Nursing Science**, 34 (1), 39-50.

Stockhausen, L. (2006) Métier artistry: revealing reflection-in-action in everyday practice, **Nurse Education Today**, 26 (1), 54-62.

Strauss, A. and Corbin, J. (1998) **Basics of Qualitative Research**. Thousand Oaks: Sage.

Sue, C.A. (2015) Hegemony and silence: confronting state-sponsored silences in the field, **Journal of Contemporary Ethnography**, 44 (1), 113-140.

Sullivan, E.V. (1977) **Kohlberg's structuralism: a critical appraisal**. Toronto: Ontario Institute for Studies in Education.

Sutton, F. and Smith, C. (1995) Advanced nursing practice: new ideas and new perspectives, **Journal of Advanced Nursing**, 21 (6), 1037-1043.

Svensson, L. and Wihlborg, M. (2010) Internationalizing the content of higher education: the need for a curriculum perspective, **Higher Education**, 60 (6), 595-613.

Takase, M., Kershaw, E. and Burt, L. (2002) Does public image of nurses matter? **Journal of Professional Nursing**, 18 (4), 196-205.

Talley, B. (2006) Nurses and nurse education in Ghana: creating collaborative opportunities, **International Nursing Review**, 53 (1), 47-51.

Tanner-Smith, E. and Brown, T. (2010) Evaluating the health belief model: a critical review, **Social Theory and Health**, 8 (1), 93-125.

Teasdale, D. (2005) Exploring nurse education in South India: implications for success during post-registration neonatal education, **Journal of Neonatal Nursing**, 11 (2), 83-89.

Tembon, A.C. (1996) Health care provider choice: the north-west province of Cameroon, **International Journal of Health Planning and Management**, 11 (1), 53–67.

ten Hoeve, Y., Jansen, G. and Roodbol, P. (2013) The nursing profession: public image, self-concept and professional identity. A discussion paper, **Journal of Advanced Nursing**, 70 (2), 295-309.

The University of Nottingham School of Nursing, Midwifery and Physiotherapy (2013) **International Strategy 2013-2018**. Nottingham: The University of Nottingham.

Thompson, J.L. (1987) Critical scholarship: the critique of domination in nursing, **Advances in Nursing Science**, 10 (1), 27-38.

Thompson, K., Boore, J. and Deeny, P. (2000) A comparison of an international experience for nursing students in developed and developing countries, **International Journal of Nursing Studies**, 37 (6), 481-492.

Thomson, P. (2014) 'Scaling up' educational change: some musings on misrecognition and doxic challenges, **Critical Studies in Education**, 55 (2), 87-103.

Thorne, S. and Sawatzky, R. (2014) Particularising the general: sustaining theoretical integrity in the context of an evidence-based practice agenda, **Advances in Nursing Science**, 37 (1), 5-18.

Tilford, S. (2000) Evidence-based health promotion, **Health Education Research**, 15 (6), 659-663.

Tiwari, A., Avery, A. and Lai, P. (2003) Critical thinking disposition of Hong Kong, Chinese and Australian nursing students, **Journal of Advanced Nursing**, 44 (3), 298–307.

Top Universities (2016) **QS World University Rankings by Subject 2016 – Nursing**. Available at: https://www.topuniversities.com/university-rankings/universitysubjectrankings/2016/nursing#sorting=rank+region=+country=+faculty=+stars=false+search= [accessed 21 January 2017].

Traynor, M. and Rafferty, A.M. (1999) Nurse education in an international context: the contribution of contingency, **International Journal of Nursing Studies**, 36 (1), 85-91.

Trilokekar, R.D. (2010) International education as soft power? The contributions and challenges of Canadian foreign policy to the internationalization of higher education, **Higher Education**, 59 (2), 131-147.

Trnobranski, P.H. (1997) Power and vested interests – tacit influences on the construction of nursing curricula? **Journal of Advanced Nursing**, 25 (5), 1084-1088.

Tschudin, V. (1999) **Nurses Matter: Reclaiming our Professional Identity**. Hampshire: Macmillan Press Ltd.

Tschudin, V. and Davis, A.J. (Eds.) (2008) **The Globalisation of Nursing**. Oxford: Radcliffe Publishing Ltd.

Tuckett, A. (2004) Qualitative research sampling: the very real complexities, **Nurse Researcher**, 12 (1), 47-63.

United Nations (2000) **The Millennium Development Goals**. New York: United Nations. Available at: http://www.undp.ro/libraries/mdgs/MDG_PUBLICATION.pdf [accessed 16 December 2016].

Ussher, J.M. (2010) Are we medicalizing women's misery? A critical review of women's higher rates of reported depression, **Feminism and Psychology**, 20 (9), 9-35.

Uys, L.R. and Middleton, L. (2011) Internationalising university schools of nursing in South Africa through a community of practice, **International Nursing Review**, 58 (1), 115-122.

Vähäsantanen, K. and Billett, S. (2008) Negotiating professional identity: vocational teachers' personal strategies in a reform context, In: Billett, S., Harteis, C. and Eteläpelto, A. (2008) **Emerging persectives of workplace learning**. Rotterdam: Sense Publishers [pp. 35-49].

Van Hoof, H.B., and Verbeeten, M.J. (2005) Wine is for drinking, water is for washing: student opinions about international exchange programs, **Journal of Studies in International Education**, 9 (1), 42-61.

Villeneuve, M.J. (2008) Yes we can! Eliminating health disparities as part of the core business of nursing on a global level, **Policy, Politics, & Nursing Practice**, 9 (4), 334-341.

Virtanen, P., Nakari, R., Ahonen, H., Vahtera, J. and Pentti, J. (2000) Locality and habitus: the origins of sickness absence practices, **Social Science & Medicine**, 50 (1), 27–39.

Visovsky, C., McGhee, S., Jordan, E., Dominic, S. and Morrison-Beedy, D. (2016) Planning and executing a global health experience for undergraduate nursing students: a comprehensive guide to creating global citizens, **Nurse Education Today**, 40, 29-32.

Wainwright, P. (2000) Towards an aesthetics of nursing, **Journal of Advanced Nursing**, 32 (3), 750-756.

Walker, L. (2009) The complex ethics of nurse migration, **Kai Tiaki Nursing New Zealand**, 15 (7), 2.

Walker, D. and Myrick, F. (2006) Grounded theory: an exploration of process and procedure, **Qualitative Health Research**, 16 (4), 547-559.

Walker, S., Dwyer, T., Broadbent, M., Moxham, L., Sander, T. and Edwards, K. (2014) Constructing a nursing identity within the clinical environment: the student nurse experience, **Contemporary Nurse**, 49 (1), 103-112.

Wall, S. (2010) Critical perspectives in the study of nursing work, **Journal of Health Organization and Management**, 24 (2), 145-166.
Ward, R. and Holland, C. (2011) 'If I look old, I will be treated old': hair and later-life image dilemmas, **Ageing and Society**, 31 (2), 288-307.

Warren, K.J. (Ed.) (1998) **Ecological Feminist Philosophies**. Bloomington: Indiana University Press.

Warren, M.G., Weitz, R. and Kulis, S. (1998) Physician satisfaction in a changing health care environment: the impact of challenges to professional autonomy, authority, and dominance, **Journal of Health and Social Behavior***,* 39 (4), 356-367.

Waters, M. (2001) **Black identities: West Indian Immigrant Dreams and American Realities**, Cambridge: Harvard University Press.

Webb, J., Schirato, T. and Danaher, G. (2002) **Understanding Bourdieu**. London: Sage Publications.

Weber, R.P. (1995) Basic content analysis. In: Lewis-Beck, M.S. (Ed.) **Research Practice: International Handbooks for Quantitative Application in the Social Sciences** (Volume 6). London: Sage.

Wellington, J. (2010) More than a matter of cognition: an exploration of affective writing problems of post-graduate students and their possible solutions, **Teaching in Higher Education**, 15 (2), 135-150.

Wells, M.I. (2000) Beyond cultural competence: a model for individual and institutional cultural development, **Journal of Community Health Nursing**, 17 (4), 189-199.

Wengraf, T. (2001) **Qualitative Research Interviewing**. London: Sage Publications Ltd.

Wharrad, H., Clifford, C., Horsburgh, M., Ketefian, S. and Lee, J. (2002) Global network explores diversity and opportunity in nurse education, **Nurse Education Today**, 22 (1), 15-23.

White, J. (1995) Patterns of knowing: review, critique, and update, **Advances in Nursing Science**, 17 (4), 73-86.

White, L. (1963) **Humanism and the Education of Engineers: Studies of courses and sequences in Humanities, Fine Arts and Social Sciences for Engineering Students**. California: University of California: College of Engineering.

White, S. (2003) Autoethnography – an appropriate methodology? **Qualitative Research Journal**, 3 (2), 22-32.

Whitsed, C. and Green, W. (2016) Lessons from Star Trek: engaging academic staff in the internationalization of the curriculum, **International Journal for Academic Development**, 21 (4), 286-298.

Wihlborg, M. (2004) Teachers' understanding of internationalization as an essential part of nursing education in Sweden, **Scandinavian Journal of Educational Research**, 48 (5), 529-546.

Wihlborg, M. (2009) The pedagogical dimension of internationalisation? A challenging quality issue in Higher Education for the twenty-first century, **European Education Research Journal**, 8 (1), 117-132.

Wilkinson, S. (1998) Focus groups in feminist research: power, interaction, and the co-construction of meaning, **Women's Studies International Forum**, 21 (1), 111 – 125.

Williams, S.J. (1995) Theorising class, health and lifestyles: can Bourdieu help us? **Sociology of Health & Illness**, 17 (5), 577–604.

Willis, E. (2006) Introduction: taking stock of medical dominance, **Health Sociological Review**, 15 (5), 421-431.

Willis, I. and Strivens, J. (2015) Academic developers and international collaborations: the importance of personal abilities and aptitudes, **International Journal for Academic Development**, 20 (4), 333-344.

Wilson, A.H. (1993) **The Meaning of International Experience for Schools**. Westport: Prager.

Wilson, D.N. (2003) The future of comparative and international education in a globalised world, **International Review of Education**, 49 (1-2), 15-33.

Wood, M., Ferlieb, E. and Fitzgerald, L. (1998) Achieving clinical behaviour change: a case of becoming indeterminate, **Social Science and Medicine**, 47 (11), 1729-1738.

World Health Organization (1994) **Nursing beyond the year 2000: Report of WHO study group**, **WHO Technical Report Series No .842**. Geneva: WHO.

World Health Organization (2000) **Nursing and midwifery services facing crisis, experts say**. Geneva: WHO.

World Health Organization (2005) **Preparing a health care workforce for the 21st Century**. Available at: http://www.who.int/chp/knowledge/publications/workforce_report/en/ [accessed 21 January 2013].

World Health Organization (2009) **Global standards for the initial education of professional nurses and midwives**. Available at:

http://apps.who.int/iris/bitstream/handle/10665/44100/?sequence=1 [accessed 13 September 2016].

World Health Organization (2011) **Strengthening nursing and midwifery**. Available at: http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_R7-en.pdf?ua=1 [accessed 21 January 2017].

World Health Organization (2014) **Traditional Medicine.** Available at: http://apps.who.int/iris/bitstream/10665/162860/1/A67_R18-en.pdf [accessed 26 October 2017].

World Health Organization (2016) **Health Workforce 2030: a global strategy on human resources for health**. Geneva: WHO.

Wynn, F. (2002) Nursing and the concept of life: towards an ethics of testimony, **Nursing Philosophy**, 3 (2), 120-132.

Xu, Y. and Davidhizar, R. (2005) Intercultural communication in nursing education: when Asian students and American faculty converge, **Journal of Nursing Education**, 44 (5), 209–216.

Yang, R. (2002) Globalisation and Higher Education development: a critical analysis, **International Review of Education**, 49 (3/4), 269-291.

Yang, W., Chao, C.C., Lai, W., Chen, C., Shih, Y.L. and Chiu, G. (2013) Building a bridge for nursing education and clinical care in Taiwan – using action research and Confucian tradition to close the gap, **Nurse Education Today**, 33 (3), 199-204.

Yeates, N. (2009) Production for export: the role of the state in the development and operation of global care chains, **Population, Space and Place**, 15 (2), 175–187.

Yeo, M. (2004) Integration of nursing theory and nursing ethics. In: Reed, P.G., Shearer, N.C. and Nicoll, L.H. (Eds), **Perspectives on Nursing Theory**. Philadelphia: Lippincott, Williams and Wilkins [pp. 355-364].

Yevtushenko, Y. (1991) **The Collected Poems 1952–1990**. New York: Henry Holt.

Yu, X. (2012) International nursing exchange and collaboration with China: a perspective from the south and the east, **Nursing Forum**, 47 (4), 236-244.

Zaman, S. (2004) Poverty and violence, frustration and inventiveness: hospital ward life in Bangladesh, **Social Science and Medicine**, 59 (10), 2025-2036.

Zaman, S. (2009) Ladies without lamps: nurses in Bangladesh, **Qualitative Health Research**, 19 (3), 366-374.

Zander, P.E. (2007) Ways of knowing in nursing: the historical evolution of a concept, **Journal of Theory Construction & Testing**, 11 (1), 7-11.

Zmas, A. (2015) Global impacts of the Bologna Process: international perspectives, local particularities, **Compare: A Journal of Comparative and International Education**, 45 (5), 727-747.

APPENDIX I

Information Sheet for Participants

Nursing knowledge and the development of the international nursing curriculum: digging beneath the rhetoric

You are invited to participate in this qualitative study which aims to explore what we understand as nursing knowledge as it may apply across the world, and to analyse whether international nursing knowledge is actually shared and perceived as appropriately relevant everywhere. It is hoped that findings will impact upon future knowledge development and the development of nurse education programmes.

What will participation involve?

Participation in the research is completely voluntary, and you will be at liberty to withdraw at any time without any prejudice or negative consequences.

If you choose to be involved, you will be asked to participate in a one-to-one interview, lasting about 45 minutes, with the researcher.

How will my contributions be used?

Information gained during the study may be published, but you will not be identified or identifiable, as any and all personal data will be anonymised to maintain its confidentiality.

You will be audiotaped during interviews and/or focus groups. All hard data (copies of audiotapes, transcripts and questionnaires) will be stored securely in a locked cabinet and electronic data will be stored in an encrypted data storage device, accessible only to the researcher and her supervisor until disposed of according to University of Nottingham protocol for data storage.

You may contact the researcher or supervisor if you require further information about the research, and may contact the Research Ethics Coordinator of the School of Education, University of Nottingham, if there is anything you are not happy about and/or you wish to make a complaint relating to your involvement in the research.

Researcher: Paula Dawson (email address available, but removed here to better preserve anonymity of study participants)

Supervisor: Professor Simon McGrath Simon.McGrath@nottingham.ac.uk

School of Education Research Ethics Coordinator:

educationresearchethics@nottingham.ac.uk

APPENDIX II

Consent Form

Project title: Nursing knowledge and the development of the international nursing curriculum: digging beneath the rhetoric

Researcher's name: Paula Dawson

Supervisor's name: Professor Simon McGrath

- I have read the Participant Information Sheet and the nature and purpose of the research project has been explained to me. I understand and agree to take part.
- I understand the purpose of the research project and my involvement in it.
- I understand that I may withdraw from the research project at any stage and that this will not affect my status now or in the future.
- I understand that while information gained during the study may be published, I will not be identified or identifiable, as any and all personal data will be anonymised to maintain its confidentiality.
- I understand that I will be audiotaped during interviews and/or focus groups.
- I understand that I will be sent a full transcript of all interview and focus group content to enable me to check exactly what I have said and make sure that my intended meaning is clear. I will be given a time limit to confirm this, with the opportunity to withdraw any data which I do not wish to be presented in the study findings.
- All hard data (copies of audiotapes, transcripts and questionnaires) will be stored securely in a locked cabinet and electronic data will be stored securely on the School of Education research drive (R), accessible only to the researcher and her supervisor until disposed of according to University of Nottingham protocol for data storage.
- I understand that I may contact the researcher or supervisor if I require further information about the research, and that I may contact the Research Ethics Coordinator of the School of Education, University of Nottingham, if I wish to make a complaint relating to my involvement in the research.

Signed, and Print name: Date:

Contact details (anonymized for purposes of submitted paper)

Researcher: Paula Dawson (contact details available on request)

Supervisor: Professor Simon McGrath (contact details available on request)

School of Education Research Ethics Coordinator: (contact details available on request)

APPENDIX III

Framework for initial questionnaire/interview/focus group work

Age

Sex

First level nurse training/education – format, dates and institution

Nursing/nurse education career history

Have you lived/worked in any other countries than the one you are now based in?

Where? When and for how long? What was your role? What did you actually do?

What are your own motivations and drivers for your work/study in nursing and your/any interest in international nursing?

(For PG students): Why did you choose to undertake PG study in the UK?

What is your definition of the role of the nurse?

How would you define nursing knowledge and identity?

Why do you define nursing knowledge and the role of the nurse in the way you do? Explore received definitions, personal experience, significant teaching, role models, etc.

What is specific/unique about *nursing* in your context (discrete from other health care disciplines)?

Do you feel that your views on the question above are applicable to the following contexts (one, some or all?):

- a particular field or speciality in nursing
- locally
- nationally,
- internationally

Nursing models with which you are familiar and which are used in local nurse education and practice.

Were these models developed locally or adapted/adopted for local use?

Do you have any other structures/frameworks/regulators/regulations for educational curricula and/or practice learning for nursing development? Local/national/international.

Do you feel that elements of nursing which are pertinent to your own definitions and practices (speciality, local and national) are appropriately represented in existing/known nursing models, theories and received 'knowledge'?

Have you been involved in any cross-cultural/international experiences in nurse education or practice? e.g. practice of teaching electives, joint papers, capacity building?

How were these projects initiated?

What were the drivers?

Did one institution lead?

How were decisions made re. aims and objectives, approaches, those to be involved as donors/recipients/developers of 'knowledge'?

How was it funded?

How were participants selected?

What have you learnt personally about nursing identity and knowledge as a result of this work?

Have your perceptions of nursing identity and its knowledge base changed?

Has nursing (speciality, local, national and international) been advanced through these initiatives? How?

What do you perceive as the potential benefits of a recognized universal nursing identity and knowledge base for:

- Nurses themselves
- The identity and development of the profession
- Patients/clients
- Health services at local, national and international levels

What do you perceive as the potential limitations/pitfalls of a recognized universal nursing identity and knowledge base for:

- Nurses themselves
- The identity and development of the profession
- Patients/clients
- Health services at local, national and international levels

Should we be working to develop a universal nursing identity, appropriate for the global profession of the 21st century?

If so, how?

If not, why not?

APPENDIX IV

Demographic data

Participant code	Gender	Age group	Nursing, and associated qualifications	Home country	Current position
F1	Female	50-55 years	PhD, MSc, BSc, Registered Nurse, PGCHE	UK	Associate Professor
F2	Female	50-55 years	PhD, MSc, BSc, PGCE	UK	Research Fellow
F3	Female	55-60 years	PhD, MSc, BSc, Registered Nurse, PGCHE	UK	Associate Professor
F4	Female	40-45 years	MSc, BSc, Registered Nurse, PGCHE	UK	Associate Professor
F5	Female	55-60 years	BSc, Registered Nurse	UK	Assistant Professor
F6	Female	35-40 years	PhD, MSc, BSc, Registered Nurse, PGCHE	UK	Associate Professor
S1	Female	20-25 years	None	UK	UG student
S2	Female	20-25 years	None	UK	UG student
S3	Female	20-25 years	None	UK	UG student
S4	Female	20-25 years	None	UK	UG student
S5	Female	20-25 years	None	UK	UG student
S6	Female	20-25 years	None	UK	UG student
PG1	Female	25-30 years	BSc, Registered Nurse	Nigeria	PG student
PG2	Male	25-30 years	BSc, Registered Nurse	Turkey	PG student
PG3	Female	30-35 years	BSc, Registered Nurse	Sierra Leone	PG student
PG4	Female	25-30 years	BSc, Registered Nurse	Pakistan	PG student
PG5	Female	20-25 years	BSc, Registered Nurse	Ghana	PG student
PG6	Female	25-30 years	BSc, Registered Nurse	Saudi Arabia	PG student

APPENDIX V

Interview data coding sample

P	So it's all about studying your patients and experience plays a lot too in such things. That is the art of nursing, which is otherwise called the aesthetics. And the science, which is also called the empirics, is all about evidence-based practice. So, some of the things we do, I wouldn't deny, a few things, minor things that nurses do is based on gut feeling sometimes, minor. But then, how do you stand in a coroner's court and say that you did something based on gut feeling? So, you might be doomed for life. So, it's all about evidence-based practice, which involves research and it involves your experience, and then the patient's preferences. So that is the science of nursing.
R	Sounds really interesting. I love the way you've defined it. Now you've used the Henderson definition. I'm just wondering where did you hear that definition first?
P	First, it was in my 200 level, 200 or hundred level, when we were studying foundations of nursing. So we did a lot of theory.
R	Who were you taught by?
P	By a graduate assistant then.
R	Nigerian?
P	Yes, a Nigerian.
R	And your discussion on the art and science, which alludes really to some of the Carper ways of knowing, has that come to you since you've been on this course? Has that moved your thinking forward?
P	Yeah. A lot, a lot it has. In fact my course here has actually made me bring things together. You know, they talk about the different types of learners, the deep learners, and all that. Deep learning has to do with you synthesising things, so I've actually, I wouldn't say I'm a deep learner per se, but I've been able to bring thing together from previous knowledge and present knowledge, information that I've acquired. So Carper I first heard about Carper here, so I've been able to bring things together.
R	That brings me to a good point ask you… You've chosen to do post graduate study here in the UK. Why did you decide to leave your native shores and branch out to an international course, rather than to stay at home? Could you have done a Master's at home?
P	Well, I thought of doing a Master's at home at first. But then on a second thought I said why not explore other options? Why not go out, you've been in Nigeria for years, I wasn't born in Nigeria, but I've been in Nigeria right from when I was 5 years old. So, I said, why don't you go out and explore other options? See what is happening in the world? Because, you don't know where you might find yourself tomorrow. So I thought, OK, I will sacrifice whatever it is, because I've had to sacrifice being with my family and all, they are back in Nigeria. So I said, since it's just a year, let me just go out and see what is happening in the UK, what nursing is all about, and I've heard a lot about the Western world, I haven't been there, so let me just go and see what is going on.

R	I know that you've done some nursing work while you've been here, you've been working in a nursing home, do you see nursing being practised and understood, if you like, in the same way here as you would see it in Nigeria?
P	Actually, the other day I was thinking, and I said there is actually not much difference in nursing. Nursing is actually the same everywhere. The only difference is the technology, culture and what else did I even think about? Those are the 2 main things. Yeah, nursing is actually the same everywhere. And come to think of it, we were actually taught, I would say that or curriculum was mainly based on the British curriculum within school. And, why I said this is because I had the opportunity of taking my patient, we don't actually have nursing homes in Nigeria, so there is nothing to compare the nursing home with, but I was privileged to take my resident to a hospital at City, and so, oh, all the practices there, none was new to me.

Themes	**Comments**
Art of nursing	'otherwise called the aesthetics'
Science of nursing	'called empirics'
	'involves research..experience..patients' preference'
Definitions	Henderson (NB. *Referred to on an earlier page*) 'Did a lot of theory' 'let me just go out and see what is happening in the UK, what nursing is all about' 'Nursing is actually the same everywhere' 'there is actually not much difference in nursing. Nursing is actually the same everywhere'
Value of international experience	'my course here has actually made me bring things together from previous knowledge and present knowledge' 'I've been able to bring things together'
International differences/similarities	'there is actually not much difference in nursing. Nursing is actually the same everywhere' 'there is nothing to compare the nursing home with'

P= Participant

R= Researcher