Adult nurses' understanding and use of courage in their professional practice

(Realising Courage in nursing)

Submitted for the Degree of

Doctor of Professional Practice

At the University of Northampton

Year 2019

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Abstract

Title: Adult nurses understanding and use of courage in their professional practice

Background: Courage is outlined as one of the 6Cs in the nursing vision 'Developing the culture of compassionate care' (Cummings and Bennett, 2012) and 'Compassion in Practice' (CBCN and DHCHA, 2012). The framework 'Leading Change, Adding Value' (NHS England, 2016) also reaffirmed the requirement for courage. The rationale for this study is the dearth of research and sparse discussion exploring courage and its realization in nursing.

Aim: To develop a grounded theory of nurses understanding and use of courage in their professional nursing practice.

Methods: A social constructionist grounded theory approach was used. This comprised purposive sampling, data collection, coding, theoretical sampling, constant comparative analysis and clarification of categories. Following ethical approval in 2015 - 2016, 12 initial unstructured interviews were undertaken with qualified nurses focused on their understanding and use of courage. Early themes were clarified using theoretical sampling with a further four semi-structured interviews.

Findings and discussion: The iterative analytical process resulted in emergence of a co-constructed grounded theory of courage. The core category emerged as Realising courage. Several categories were identified contributing to the emergent theory. These are presented as pre-requisites to courage, the meaning of courage and being courageous and the consequences of being courageous in the context of adult nursing. Identified in these categories and linking them to one another were themes concerning gender, personality, socialisation and organisational culture.

Conclusions: The emergent theory demonstrates that courage as a concept is social constructed. Cultural socialisation, personality, self-esteem, moral values and personal circumstances are influencing factors in realising courage, as is professional socialisation. The organisational culture is also significant and inspires or negates courage dependent on how it is perceived.

Acknowledgements

My first thanks are to my supervisory team, Doctor Sarah Neill, Professor Judith Sixsmith, Doctor Clency Meurier and Doctor Kathleen Mortimer for their invaluable wisdom and support. To Sarah and Judith, our discussions during supervision enlightened, supported and strengthened my resolve when I needed it most. To Kathy, thank you so much for stepping in at a crucial time.

My thanks to the qualified nurses who participated in the study and without whom this research would not have been possible. Thank you for giving me your time and allowing me into your sometimes personal and difficult stories. I was humbled by all your selfless willingness to help me.

Thanks also to all my colleagues who have supported me, taken extra marking or covered other duties to help me achieve this.

Finally, my family. My children have gone from kids to teenagers during my journey. I think they do not know me any other way than on my laptop, but they have supported me in my endeavour and lived it with me. Also, to my husband who has watched dozens of films alone and on occasion must have felt like a single parent!

I could not have achieved this without you all!

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Chapter 1 - Introduction to Thesis

"I do know the nature of courage; but some-how or other she has slipped away from me, and I cannot get hold of her and tell her nature."

(Plato, 1961)*

1. Introduction to the study

This thesis explores adult nurses understanding of the meaning and use of courage in their professional practice and presents a social constructionist grounded theory of courage in adult nursing practice. The thesis is positioned within health studies, specifically adult nursing. However, the topic area demanded interdisciplinary perspectives and health studies research draws from a range of disciplines. Reading for this study included sociology and psychology research as two key disciplinary authorities and the influence of ethics is also present.

The notion and practice of courage is considered a vital attribute in nursing (Commisioning Board Chief Nurse and DH Chief Nursing

*Source: Plato – The collected dialogues including the letters. Chapter 16. Translated by Benjamin Jowett, pg 452

Advisor 2012, (CBCN and DHCHA), Cummings, 2012; Cummings et al, 2015; NHS England, 2016). The co-construction of data between the researcher and participants produced a wealth of knowledge of adult nurses understanding and experiences of being courageous in their clinical practice. The development of a theory of courage is timely and essential, the Francis report (2013) found a lack of courage contributed to compromising patient safety. An understanding of nurses' comprehension and use of courage can potentially enhance patient safety and inform future nursing development and education.

1.1 Background to the study

In 2012 a national nursing vision, "Developing the culture of compassionate care - Creating a new vision for nurses, midwives and care givers" (Cummings and Bennett, 2012) was launched. The six nursing attributes of: Commitment, competence, caring, compassion, communication and courage were denoted as the 6 Cs; characteristics that all nurses need to deliver exemplary nursing care.

The 6 Cs are not explicitly attributed to external sources (Bradshaw, 2016) but appear analogous to Sister Simone Roaches Six Cs of "compassion, competence, confidence, conscience,

commitment and comportment" defined by Roach in 1987 (pg43 2002). Bradshaw (2016) suggests the omission of Roaches theoretical base reduces the current six 6Cs to products that can be viewed as a form of external control and Middleton (2013) opines the 6Cs are words with no meaning behind them. Publication of "Compassion in practice" (CBCN and DHCHA, 2012) and Cummings and Bennett's nursing vision (2012) defined each of the 6Cs but the lack of apparent theoretical underpinning makes it difficult to locate them in a robust framework or link them together with any research studies. Baille (2015) queries how the 6Cs have become established, ostensibly without question or critical review and that the variations in how they are referred to as values and or behaviours leads to a lack of clarity regarding their purpose. Bradshaw (2016) considers that had the theoretical underpinning been acknowledged, the 6Cs could have been more than commodities or words. Despite their lack of credit to Roach (1987) and absent theoretical basis the 6Cs are presented to nurses as essential attributes and central to nursing care by Cummings and Bennett (2012). This provides a rationale for a research study into courage as one of the 6Cs and to potentially establish the value of courage.

Courage is suggested by Peate (2015) as the cornerstone of the 6Cs as without courage the remaining five of the 6Cs will be unachievable. Following the publication of the 2012 nursing vision (Cummings and Bennett, 2012), a further nursing framework was published. "Leading Change, Adding Value" (NHS England, 2016) outlined ten commitments to support nursing and describes compassionate care delivered with courage as being of the highest priority.

The publication of the 6 Cs piqued interest as to the meaning of courage for nurses within the context of their nursing practice. Many studies have unpacked notions of commitment (Gould and Fontenla, 2006; Spence and Smythe, 2007; Hart et al, 2014; Delgado et al, 2017), compassion (Torjuul et al, 2012; Baughan and Smith, 2013), competence, caring (Paganini and Egry, 2011; Rhodes et al, 2011; Thorup et al, 2012; MacLeod Dyess et al, 2013; Hart et al,2014) and communication (Kourkouta and Papathanasiou, 2014; O'Hagan et al, 2014). However, a search of the literature found relatively little empirical work devoted to understanding the concept of courage in nursing practice.

Courage is relevant to nursing as nurses encounter numerous situations that call for courage in their everyday working lives (Lachman, 2008; Lachman, 2010; Lachman et al, 2012). Understanding nursing courage has potential implications for improving nursing retention, as LaSala & Bjarnason (2010) and Gallagher (2010) write, remaining true to convictions to provide quality care is a daily struggle potentially leading to 'burn out' (Schluter et al, 2008; Hamric et al, 2015) and nurses face serious fears, such as losing their job if they speak out. The consequences of 'speaking out' and challenging the organization reported by Francis (2015 pg 86) also include fear of repercussions and bullying as he says,

> *"some staff who have the courage to raise concerns have bad experiences and suffer unjustifiable consequences as a result of doing so."*

Courage is also relevant in the context of recruitment for nurses. Recruitment interviews are currently based on potential nursing students' values (Health Education England, 2016) including being willing to challenge and take risks. The sparse evidence available in the current literature concerning nurses understanding and use

of courage suggests that nurses find courage challenging. A theoretical understanding of courage may inform future nursing recruitment, retention, nurse education and development.

1.2 Courage in nursing strategy

The Compassion in practice strategy (CBCN and DHCHA 2012 pg 13) and Cummings and Bennett's vision (2012) define courage as the attribute that,

'enables us to do the right thing for the people we care for, to speak up when we have concerns and to have the personal strength and vision to innovate and to embrace new ways of working."

This definition suggests courage in nursing is speaking up [to protect the patient if there are concerns about their care] and embracing change. Superseding this strategy, "Leading change, adding value" (NHS England, 2016) continues to support the 6C attributes noting,

"*we know that compassionate care delivered with courage, commitment and skill is our highest priority. It is the rock on which*

our efforts to promote health and well-being, support the vulnerable, care for the sick and look after the dying is built" (NHS England, 2016 pg 6).

Nursing vision and strategy is explicit that courage is required. However, what nurses themselves understand courage to be, how courage is achieved and what nurses need to fulfil the requirement to use courage is not explicated. This thesis seeks to explore how courage is understood and used by nurses.

1.3 Development of research aim

Courage as a concept dates back to the early Greek philosophers (Rate et al, 2007). Jowett (1961 pg 452) translates Plato who said, he could not '*get hold of her, [courage] and tell her nature.*' Courage in nursing is explicit in two significant nursing publications (CBCN and DHCHA, 2012 and NHS England, 2016), but there is a paucity of research into courage in nursing (Spence & Smythe, 2007; Lindh et al, 2010; Murray, 2007). Development of a grounded theory of courage in the context of adult nursing can explicate how courage may be best understood and the use of courage supported and developed.

1.4 The rationale for this research

The Francis report (2013) found a lack of courage contributed to compromised patient care and safety. Exploring nurses understanding and use of courage in their professional practice is timely and relevant to nursing practice.

The vision for nursing (CBCN and DHCHA, 2012 and NHS England, 2016) both recognize courage as an essential attribute for nurses. However, courage in nursing in the United Kingdom (UK) has not been subject to empirical study.

1.5 Research Questions:

Grounded theory studies focus on action and processes, their titles often start with a gerund and the research questions will focus on process asking questions such as how? (Hood, 2010).

RQ1: How do qualified adult nurses understand the meaning and use of courage in their everyday professional practice?

RQ2: How can a theoretical understanding of courage inform the

future professional practice of qualified adult nurses?

1.6 Research Design

Commensurate with a research study seeking participants understanding and perspectives and driven by the research questions (Charmaz, 2014), a qualitative research methodology was chosen. Qualitative research concerns naturalistic enquiry incorporating a range of differing paradigms that drive the study of people in their social setting (Bowling, 2014).

Grounded theory was chosen as an appropriate methodology enabling a rigorous construction of the research study whilst being a flexible model (Heath and Cowley, 2003, Charmaz, 2014). Since its inception by Glaser and Strauss (1967) grounded theory methodology has developed in differing directions dependent on various authors epistemological viewpoints (Hutchinson et al, 2010).

Charmaz (2014) termed her model of grounded theory constructivist grounded theory. Charmaz adopts Glaser and Strauss's (1967) inductive, comparative and emergent approach with Strauss's (1987) iterative logic and emphasis on action and

meaning. This study uses Charmazian grounded theory underpinned by social constructionism in accord with Charmaz's term constructivist (Charmaz 2008, 2014). Social constructionism was chosen for its social as opposed to individual focus. Nurses do not work in isolation (Nursing and Midwfiery Council (NMC), 2015), rather they work within a socially constructed culture where social processes, historical culture and interactions are evident (Young and Collin, 2004; Read, 2013). The researcher is the author of a co-construction of participants experiences enhanced by reflexivity (Mills et al, 2006; Charmaz, 2014).

1.7 The researcher

Due to the nature of social constructionism it is important to understand the positionality of the researcher (Mills et al,2006; Charmaz, 2014). This section is written in the first person. I am a senior lecturer in adult nursing and a registered adult nurse. Throughout this thesis I will reflexively explore these positionalities. This research investigation developed from a position of both personal and professional interest. My perception in the clinical setting was that some nurses appeared more able to make decisions and to challenge the status quo. These observations were not formulated as courage in a conscious way,

but my curiosity grew as to why this was. The subsequent publication of the national nursing vision and strategy (Cummings and Bennett, 2012 and NHS England, 2016) and the Francis report (2013) brought courage to the forefront. These publications crystalized courage as my area of research interest. Undertaking a Professional Doctorate, it was important to research an area that could contribute to my own learning and development as an educator but also influence nursing practice.

1.8 Thesis structure

The thesis is structured into chapters ordered as follows.

Chapter two sets the research in the wider context accompanied by the literature review.

Chapter three describes and provides a justification for the methodology and methods, a participant overview, information on procedures, ethics, data collection methods and analysis.

Chapter four, five and six present the co-constructed findings of the participants understanding of the meaning and use of courage in their practice. The analysis from the interviews is presented underpinned by extant literature and reflexivity.

Chapter seven presents the grounded theory and assesses its

rigour against published criteria for grounded theory. It also considers the strengths and limitations of the research study. Finally, the thesis is concluded with a critical discussion of the emergent theories contribution to knowledge, implications for nursing practice and future research.

Chapter 2: Existing knowledge of courage and Literature review

2. Introduction

This chapter investigates courage in the wider context of both generally held knowledge and nursing knowledge. Definitions, types and characteristics of courage in mainstream literature are explored through professional discussion and opinion papers. This is followed by literature specific to the context of nursing and finally a literature review of empirical research studies, applicable to the context and practice of courage in nursing is presented.

2.1 The history of courage

The origin of courage comes from the Latin word coraticum, 'cor' meaning heart and 'aticum' denoting action. In Old French curage, and in Middle English corage, referred to having spirit or heart (Numminen et al, 2016) suggesting courage is a multi-faceted concept. Courage as a concept has a rich philosophical history (Putman, 1997) and has been noted in literature as far back as ancient Greece. Rate et al (2007) present Aristotle and Plato as key figures with differing views of courage. Aristotle regarded courage as the disposition to act in situations involving fear, whilst

Plato suggested courage was knowledge of what is and is not to be feared.

Theories of courage are either implicit, evolving from an individual's cognitive constructions or explicit, the constructions of psychologists and based on collected data aiming to measure the concept (Rate et al, 2007). One of the difficulties in defining courage explicitly is its implicit nature. However, there is tacit agreement that courage is a complex and multi-dimensional construct (Rate et al, 2007).

Despite the complexity of the concept of courage writers have endeavoured to offer definitions. These are presented below in table 1 followed by a critical discussion of their relative merits.

2.2 Definitions of courage

Source	Definition
Rate et al, (2007 pg 95)	*"a wilful intentional act, executed after mindful deliberation, involving objective substantial risk to the actor, primarily motivated to bring about a noble good or worthy end, despite perhaps, the presence of the emotion of fear"*
Tillich, (2014 pg 32)	*"the self-affirmation 'in spite of' that is in spite of that which tends to prevent the self from affirming itself."*
Gruber, (2011 pg 274)	*"the cognitive, voluntary mental process used to enact change on a stable system for the interaction of a positive outcome."*
Sekerka and Bagozzi, (2007 pg 135)	*"The ability to use inner principles to do what is good for others, regardless of threat to self, as a matter of practice"*
Shelp, (1984 pg354)	*"Courage is the disposition to voluntarily act, perhaps fearfully, in a dangerous circumstance, where the relevant risks are reasonably appraised, in an effort to obtain or preserve some perceived good for one self or others recognizing that the desired perceived good may not be realized"*
Woodard and Pury, (2007 pg 136)	*"Courage is the voluntary willingness to act, with or without varying levels of fear, in response to a threat to achieve an important, perhaps moral, outcome or goal."*

Table 1. Definitions of courage

Shelp (1984) offers a multi-dimensional definition acknowledging the presence of fear cited by most definitions. However, Woodard & Pury (2007) and Gruber (2011) recognise fear may not be present raising an interesting concept; if someone acts courageously but does not feel fear are they still considered courageous?

Rate et al's (2007) study, Gruber (2011) and Sekerka & Bagozzi's (2007) discussion papers and Woodard and Pury (2007) definitions all allude to a good or positive outcome. However, Shelp's (1984) insightful observation is that an act that requires courage may not always be for good rather, a 'perceived' good for example when considering acts in war.

Tillich (2014) was an existentialist philosopher, his definition of courage in his book 'the courage to be' is arguably the least clear but also acknowledges self-affirmation as a positive outcome. Conversely, Rate et al (2007) found rather than viewing courage as an individual character trait or attribute, courage may be better

understood as a response to specific external conditions. Despite similarities across these definitions a definitive meaning of courage remains elusive. Commensurate with grounded theory a definition was neither sought nor chosen prior to commencing the study (Charmaz 2014).

2.3 Dimensions of courage

Psychologists have explored the dimensions of courage (Goud 2005; Pury et al, 2007; Rate et al, 2007; Woodard & Pury 2007; Maddi 2004). Pury et al, (2007) conducted a quantitative study reporting reasons actions were considered courageous; the action itself (40%), the risk level (32%), the need (32%), individual characteristics (21%), outcome (18%) and overcoming negative emotions (14%). Goud's (2005) content analysis highlighted similar findings identifying three facets of courage required for an act to be termed courageous; fear, acting appropriately and purpose or outcome. Tillich (2014) echoes these sentiments suggesting courage is being ready to take on the adverse despite foreseen fear for a positive reason. However, Goud (2005) notes

that through exercising wisdom and judgement no action may be the courageous option.

Fear or risk taking are highlighted as components of courage (Shelp, 1984; Goud, 2005; Pury et al, 2007; Rate et al, 2007; Gruber, 2011), however Pury et al (2007) challenge this notion finding some individuals risk their own life for another yet feel no fear. A positive outcome of courage has been considered an important dimension (Rate et al, 2007, Tillich, 2014 and Goud, 2005). However Pury et al, (2007) again question this view. They posit, though viewed as less courageous, a positive outcome is not a necessity. Consequently, despite being included in most definitions there are divergent views as to whether fear or a positive outcome are necessary dimensions of courage.

Pury and Kowalski's (2007) quantitative study found hope to be a dimension in all types of courage. The highest ranked trait,

potentially facilitated by hope was persistence. They conclude hopeful persistence may be the hallmark of courageousness. Rate et al (2007) concurred that persistence is important.

A final dimension of courage explored in the literature is whether courage is innate or acquired. Gruber (2011) and Miller (2005) believe virtues including courage, are habits or acquired dispositions, thus that courage can be learned and developed with education. Miller (2005) clarifies courage must be learned before we can be courageous, the irony is we must learn to be courageous by doing courageous things.

2.4 Types of courage:

Several types of courage are articulated in the literature these include; physical, moral, psychological, personal, general, monumental and existential.

Physical courage is differentiated from other forms of courage involving overcoming fear of death or physical harm (Putman, 1997, Numminen et al, 2016) and is often cited in the context of fireman, policeman or similar (Ford Walston, 2004, Miller 2005).

Kidder and Bracy, (2001) describe physical courage as the defence of the tangible; there is a definitive risk to the physical self.

The earliest record of moral courage is noted in 1822 (Scarre, 2010, Numminen et al, 2016) and has attracted the most extensive discussion in existing literature. Moral courage is connected to truth, respect and overcoming fear of emotional harm or well-being. Kidder and Bracy (2001) term it; defence of the intangible and thus less easy to define. Moral courage is influenced by personal and situational contexts or social customs, bestowing it a more contextual individualised meaning (Sekerka and Bagozzi, 2007, Kidder and Bracy 2001). The risk in moral courage is related to the potential for social disapproval (Putman, 1997, Woodard and Pury,2007). Hence Putman (1997) suggests this could be termed social courage. Miller (2005) also comments on the social aspect but points out that although a group may act, each person individually faces their own fears.

The implication of the emotional element to moral courage means individuals need to be able to self-regulate and manage emotion

(Sekerka and Bagozzi, 2007). Martin Luther King Jr is offered as an exemplar of moral courage by Miller (2005) and illustrates that moral and physical courage are often inextricably linked (Scarre, 2010).

Psychological courage is not discussed in the literature as widely as moral courage but in some sense all forms of courage include a psychological aspect (Gruber, 2011). However, the fear to be faced in psychological courage is the psyche itself. Individual irrational fears and anxieties are faced (Putman 1997, Numminen et al, 2016).

2.4.1 Other types of courage

Personal, general, monumental and existential courage are also referred to in the literature as alternative types of courage. Similarly to psychological courage, personal courage relates to an individual's potentially irrational limitations (Pury et al, 2007). Pury et al, also use the term general courage; based on impersonal risks applying to anyone. Neither of these types of courage have received wide recognition in the literature. Monumental courage is identified by Pury et al (2007) referring to courage as a behaviour

which is above and beyond what would be expected in normal everyday life. Finally Maddi (2004) offers existential courage whereby every choice involves choosing either a new unfamiliar path or repetition of the past. Choosing the new path brings ontological disquiet as it is uncertain and may lead to failure. This definition could apply to all types of courage as at some juncture, a choice is made on whether to act or not.

The widely accepted definitions of courage are; physical courage, moral courage and psychological courage. For nursing the question is what do nurses themselves understand courage to be and how do they use courage?

2.5 Context of courage in Nursing

Cummings and Bennett (2012) nursing vision identifies a positive outcome (‘*the right thing*’) and confronting fear or risk (‘*strength*’) resonating with the above definitions. Two months after its release the Francis report (2013) was published chronicling the public inquiry into failings at a Mid Staffordshire Trust. The report notes that enabling staff to courageously speak out requires changes in attitudes, culture, values and behaviour. Furthermore, courage is

complex, choices are often not between right and wrong, but between lesser evils, highlighting Goud's (2005) view that courage requires wisdom.

A year later the 6Cs were reiterated (NHS England, 2014a) and aligned with the triple aims of the Five Year Forward View (NHS England, 2014c). Francis's (2015) independent review. "Freedom to Speak up" followed setting out 20 principles and actions to create the right culture to enable staff to speak up. As Francis's earlier report (2013) observed, staff continued to be deterred by fear of unjustifiable consequences and low expectations of change (Francis 2015). In 2016 "Leading change, adding value, A framework for nursing, midwifery and care staff" (NHS England 2016) continued the theme of the 6 Cs.

Despite courage being confirmed as an important attribute for nursing (NHS England, 2014a) and the assertion that all the 6 Cs carry equal weight (Baillie, 2015 and Bradshaw, 2016), compassion has received more attention than courage. Compassion is cited four times in the Code for nursing (NMC,

2015) while courage is not mentioned. The NHS Constitution (DoH, 2010) expects all NHS staff to raise concerns and although the Code for nursing does not name courage, the professional requirement is for nurses to 'speak up' (NMC, 2015) potentially requiring courage to do so (Francis, 2013). The above policies, strategies and visions say little of how courage may be actualized, nor do they acknowledge the challenges of being courageous.

The literature revealed a wide range of discussion papers on courage (Ford Walston, 2004; Lachman, 2010; Crigger, 2011; Hamric et al, 2015; Cummings et al, 2015; Oakley, 2015; NHS England, 2016). These papers demonstrate professional awareness of the concept and its importance for nurses and nursing. The analysis of these papers identified four themes; courage in nursing, moral courage in nursing, courage and caring in nursing and courage in the organisation.

2.5.1 Courage in Nursing

Ford Walston (2004) observes most people identify nursing with caring but not necessarily with courage suggesting that courage is not a commonly recognised nursing trait. However, Jane

Cummings (Chief Nursing Officer for England), identifies courage is an essential trait as she quotes Maya Angelou, a poet, author and civil rights activist (1928-2014) who said,

"Courage is the most important of all the virtues because without courage you can't practise any other virtue consistently,"

(Cummings et al, 2015 pg 295).

The literature describes courage in nursing as manifest in several forms. Courage may be required to deliver bad news (Hamric et al, 2015) to argue for and provide the best care, challenge colleagues, help patients face their distress and vulnerability (Thorup et al, 2012) and to help patients face death, refuse gifts or take risks (Crigger, 2011). The multitude of definitions together with the several reasons and contexts in which courage can be applied signals courage as both complex and challenging.

Crigger (2011), Hamric et al, (2015) and Francis (2013) observe that several challenges remain around nurses expression and exhibition of courage such as nurses exhibiting courage may be

shunned, alienated or risk their jobs. Such negative outcomes to being courageous are unacceptable and unnecessary. The Francis (2013) report records one nurses' experience of exhibiting courage with the following,

> *"when she did summon up the courage to raise the serious concerns…….she had to endure harassment from colleagues and eventually left for other employment" (Francis, 2013 pg 1504)*

Hamric et al (2015) write that being expected to routinely exhibit courage to survive is cause for concern as for example, courage should not be necessary to ask a question or raise a concern.

Despite Cummings et al (2015) assertion that courage is the most important of all virtues, NHS England (2014a) only ranks courage as 14th when listing the 21 important characteristics of a compassionate leader and yet NHS England (2014a) concurs with Hamric et al (2015) findings that those challenging the system may be disparaged, condemned or lose their livelihood. It appears that to be prepared to challenge the current system is problematic.

2.5.2 Moral courage in nursing

Lachman(2010) observes that dealing with dilemmas between the virtues (identified as temperance, justice, wisdom and courage) as well as enduring distress and overcoming fear denotes moral courage, viewed as the bridge between knowing one's professional obligations and personal values and acting on them (Lachman, 2007). Moral courage is not a new phenomenon as Lachman (2010) writes, Nightingale repeatedly spoke out to protect patients. In recent times nurses are increasingly reminded of their moral duty to exhibit courage (Numminen et al, 2016 and Hamric et al, 2015) but displaying moral courage risks embarrassment, rejection, derision, loss of employment or social status (Lachman 2007, Crigger 2011). Lachman (2012) writes that there are also barriers to being able to display moral courage including the organizational culture, lack of concern of other colleagues and groupthink, where collectively individuals choose to ignore what is occurring, all inferring courageous behaviour is challenging.

The Code for nursing (NMC, 2015) offers guidance to nurses on their obligations but neither the Code or the nursing vision give advice on how to actualize morally courageous care. Numminen et al (2016) found ethical understanding, conscience, conquering fear and experience are important to enact courage and nurses need to believe maintaining integrity is more important than avoiding undesirable consequences (Lachman, 2010). Nurses appear to require an inner quality to uncompromisingly stand up for the right thing despite the barriers or potential negative consequences (Numminen et al, 2016).

2.5.3 Courage and caring in nursing

Ford Walston (2004) suggests caring is the central discourse in nursing while courage remains hidden. Crigger (2011) proposes this may be because courage is only perceived as relevant during acutely hazardous times and being present with someone who is suffering or dying, questioning a doctor, or taking the initiative are not recognized as courageous moments.

Courageous care also lies at the heart of quality improvement noted by Cummings and Bennet (2012) who confirm the role of courage connected to care includes; challenging established procedures, discovering new knowledge, engaging colleagues, confronting the status quo and initiating improvements.

2.5.4 Courage and the organisation

The final theme to emerge from the analysis of the background to courage in nursing is courage and the organisation. Comer and Vega (2015) found more than half of employees in private, non-profit or government work areas had witnessed misconduct in the last year, confronting these issues requires courage. Nurses also require courage to challenge the hierarchy and change the organisational structure (Day, 2007). Organisations do not always foster courage with a clear organizational mission, vision, values and nursing philosophy (Lachman, 2010). LaSala and Bjarnason, (2010) and Murray (2013) observe, shared governance, empowering nurses to act and using the hierarchy to share and discuss issues can foster courage but only if the organisation embraces courageous behaviour.

Gallagher (2010) observes nurses who know what the right thing to do is and yet do not do it may be affected by individual, organisational or cultural factors. Being courageous is not the sole responsibility of nurses at the bedside, organisations as well as nurses need to embrace moral courage, wisdom and integrity (Gallagher, 2011) and nurses should not be exhorted to be courageous whilst organisations continue to make the application of courage difficult (Hamric et al, 2015).

2.6 Key points to understanding courage and courage in nursing

The foregoing analysis of definitions and types of courage has explored a variety of literature outlining the generally held knowledge on courage and courage in the context of nursing. The derivation of courage is rooted in history and although visible in the literature as long ago as 300 years BC, courage has proved difficult to define and there is a lack of consensus regarding whether courage must include a positive outcome or requires fear (Rate et al, 2007; Tillich 2014; Gruber 2011; Sekerka & Bagozzi 2007; Lopez et al, 2003; Shelp, 1984; Woodard & Pury 2007).

The literature cites physical courage (Numminen et al, 2016), moral courage (Kidder and Bracy 2001, Sekerka and Bagozzi 2007) and psychological courage (Gruber 2011) as the most widely recognised types of courage. In nursing courage has been defined by Cummings and Bennett (2012) and moral courage in nursing (Lachman, 2010 Numminen et al, 2016 Hamric et al, 2015 and Crigger, 2011) courage in the context of caring (Crigger 2011) and courage within the organisation (Comer and Vega 2015, Lachman 2009, Murray 2013 and Gallagher 2010) have been explored. Courage is demonstrably a contemporary subject at the forefront of writers' minds and several conclude that courage in nursing needs empirical study (Lachman et al, 2012; Thorup et al 2012; Numminen et al, 2016).

2.7 Literature review of empirical studies of courage in nursing

The methodology for this study is grounded theory and the timing of literature reviews in grounded theory is disputed (Hallberg, 2010). Glaser & Strauss (1967) advocated delaying until after completion of the analysis to avoid seeing data through the reviews lens. Glaser (2012) has maintained this position. However

Strauss & Corbin (1994) acknowledge that the researcher will bring knowledge of the literature to the inquiry and Chamaz (2014 pg 307) suggests this material then can "lie fallow" until categories and relationships are established. Reflexivity lessens the fear of pre-empting analysis and supports the researcher in recognising and challenging personal bias. The literature was searched prior to starting the study to ascertain the gap in research. The following review question was designed.

What is already known about adult nurses and courage in everyday practice?

The review question was used in a scoping literature review for empirical literature to support justification for presentation of the proposal to the research Degrees board in July 2013 and repeated in 2017. Grant & Booth (2009) state this type of review is to identify the nature and extent of available evidence with some narrative commentary and was conducted as follows.

Relevant published literature was identified via electronic databases using a wide range of sources (for a detailed summary of the review strategy, please see appendices 1). Grey literature

was accessed through NHS evidence. Thesis and dissertations were searched using the database EThOS and through University repositories.

Keywords: Courag* AND Nurs*, Daring AND Nurs*, Nurs* AND Guts*, Nurs* AND Fearless*, Nurs* AND valour, Nurs* AND Brav* were searched for in either the title, abstract or keywords.

Inclusion criteria	**Exclusion criteria**
English language	Not published in English
Primary research papers	Non-research papers
Related to Nursing and courage	No relation to nursing and courage

The 2013 review produced 25 articles which were reduced to 9 based on removal of duplicates and non-relevant identifications (see appendix 1 for a full overview of the process). A further 6 papers were identified in 2017 totalling 15 articles retained for critical and thematic analysis. Four themes were identified.

- Courage in the context of care
- The characteristics of courage in nursing
- The consequences of courage
- Courage and education

The 15 papers identified are presented in table 2 below. The studies were from a variety of countries including the United States of America (two), Australia (one), New Zealand (one), England (three) and most of the literature was from Europe (eight papers). All but one of the studies were qualitative papers and the majority used unstructured or semi-structured interviews. Sample sizes ranged from four to 62 with an average of approximately 15 interviews. Four of the papers had courage within their aim. The scoping review aimed to gather a comprehensive overview of available studies on nursing courage and to collate and summarise their findings (Arksey and O'Malley, 2005). This was achieved by reading, re-reading, charting and summarizing the studies main findings (Aveyard et al, 2016) which were then grouped into the above themes.

Reference	Aim	Methodology	Sample and size / Data collection and analysis	Origin of study	Themes related to
Arman.M. (2007) "Bearing Witness: An existential position in caring" Contemporary nurse (2007) 27: pg 84-93	To explore clinical validity for the concept "witnessing" in palliative care	Qualitative study using an Interpretative hermeneutic approach	4 palliative care nurses Clinical data from a Socratic dialogue Interpretative joint reflection analysis	Sweden	Courage in the context of care
Bickhoff.L. Levett-Jones.T. Sinclair.P.M. (2016) "Rocking the boat-nursing students' stories of moral courage: A qualitative descriptive study." Nurse Education today. 42, pgs 35-40	To examine how undergraduate students, demonstrate moral courage when confronted with clinical situations that negatively impact on patient care and what encouraged or inhibited them speaking up	Qualitative descriptive study	9 Nursing students and 1 Nursing graduate Semi structured Interviews Thematic analysis	Australia	Characteristics of courage in nursing The consequences of courage
Black.S. (2011) "Being a mentor who fails a pre-registration nursing student in their final placement: understanding failure" Thesis. London South Bank University.	Explore, interpret and develop an understanding of mentor's experiences of failing pre-registration nursing students' in their final placement	Qualitative interpretative hermeneutic phenomenological study	19 qualified Nurse Mentors Unstructured Interviews Hermeneutic textual interpretation analyses	England	Consequences of courage

Reference	Aim	Methodology	Sample and size / Data collection and analysis	Origin of study	Themes related to
Dahl.B. Clancu.A. Andrews.T. (2013) " The meaning of ethically charged encounters and their possible influence on professional identify in Norwegian public health nursing: a phenomenological hermeneutic study" Nordic college of caring science. Pg 600- 608	To illuminate public health nurses' experiences of being in ethically charged encounters and to reflect upon how these experiences can influence their professional identity.	Qualitative inductive approach - phenomenological hermeneutical	23 Public health nurses Narrative Interviews Phenomenological hermeneutic analysis	Sweden /Norway	Characteristics of courage in nursing The consequences of courage
Dewar. B.J (2011) "Caring about caring: An appreciative inquiry about compassionate relationship centred care." Thesis. Edinburgh Napier University	To examine and evaluate processes that enhance compassionate relationship-centred care within an older people setting in an acute hospital	Qualitative Appreciative inquiry and Action research	40 staff, 10 patients, 12 family members. Appreciative inquiry using Participant observation, stories, photo elicitation, group discussion. Iterative and inductive immersion crystallization analysis	England	Characteristics of courage in nursing Consequences of courage
Dinndorf-Hogenson. G.A (2013) "Perioperative nurses' perceptions of moral courage." Thesis. South Dakota State University	To examine moral courage in response to threat to patient safety	Quantitative descriptive correlational study	154 perioperative Nurses Questionnaire Multiple regression analysis	America	Courage in the context of care Characteristics of courage in nursing The consequences of courage Courage and education

Reference	Aim	Methodology	Sample and size / Data collection and analysis	Origin of study	Themes related to
Ekstrom.L. Idvall.E. (2015) "Being a team leader: newly registered nurses relate their experiences." Journal of nursing management. 23, PG 75-86	To explore how newly qualified registered nurses, experience their leadership role in the ward-based nursing care team.	Qualitative content analysis	12 nurses Semi structured Interviews Qualitative content analysis	Sweden	Characteristics of courage in nursing
Hawkins.S. Morse.J. (2014) "The praxis of courage as a foundation for care" Journal of nursing scholarship. 46,4, pgs 263-270	To analyse the concept of courage and determine its relevance for the present-day context of meaning	Qualitative systematic literature review	Included as: The Concept analysis used pragmatic utility. 18 articles and books utilised. Analytical questions developed to guide synthesis	America	Courage in the context of care Characteristics of courage in nursing The consequences of courage Courage and education
Jensen.A. Lidell.E. (2009) "The influence of conscience in nursing" Nursing ethics 16:31,	To describe nurses' conceptions of the influence of conscience on the provision of patient care	Qualitative phenomenographic approach	15 nurses Semi Structured Interviews Phenomenographic analysis	Sweden	Courage in the context of care Characteristics of courage in nursing The consequences of courage

Reference	Aim	Methodology	Sample and size / Data collection and analysis	Origin of study	Themes related to
Lindh.I.B. Severinsson. E. Berg. A. (2008) Exploring student nurses' reflections on moral responsibility in practice. Reflective practice. 9, 4, 437-448	To explore student nurses' reflections on moral responsibility in clinical practice	Qualitative study	14 final year student nurses Focus group interviews Interpretive content analysis	Sweden /Norway	Characteristics of courage in nursing The consequences of courage
Lindh.I.B. Severinsson. E. Berg. A. (2009) Nurses' moral strength: A hermeneutic inquiry in nursing practice. Journal of Advanced nursing. 65(9), 1882-1890	To interpret nurses' experiences of moral strength in practice	Qualitative study	8 Registered nurses. Individual interviews Hermeneutic analysis	Sweden /Norway	Courage and education
Metcalfe.J. (2014) "A lonely endeavour: Clinical Nurse leadership and the older unpopular patient in community settings." Thesis. University of Portsmouth	To explore the lived experiences of clinical nurse leaders leading a team caring for the older patient perceived as unpopular in community nursing settings	Qualitative Heideggerian hermeneutic phenomenology approach.	11 clinical nurse leaders Semi structured interviews Heideggerian Hermeneutic interpretative analysis	England	Characteristics of courage in nursing The consequences of courage

Reference	Aim	Methodology	Sample and size / Data collection and analysis	Origin of study	Themes related to
Spence.D. Smythe.L. (2007) "Courage as integral to advancing nursing practice" Nursing Praxis in New Zealand. 23,2, pg 43-55	To illuminate courage in nursing	Qualitative study - philosophical hermeneutics	20 participants data on advanced nursing practice examined. A further 6 interviews with advanced nurses. Hermeneutic analysis	New Zealand	Courage in the context of care Characteristics of courage in nursing Consequences of courage Courage and education
Stenbock-Hult Sarvimaki.A. (2011) "The meaning of vulnerability to nurses caring for older people" Nursing Ethics 18,1, pg 31-41	To illuminate the meaning of vulnerability to care providers caring for older people	Qualitative interpretative study	16 Registered Nurses Qualitative interviews Qualitative content analysis approach	Finland	Courage in the context of care Characteristics of courage in nursing The consequences of courage

Reference	Aim	Methodology	Sample and size / Data collection and analysis	Origin of study	Themes related to
Thorup.C.B. Rundqvist.E. Roberts.C. Delmar.C. (2011) " Care as a matter of courage: vulnerability, suffering and ethical formation in nursing care." Scandinavian Journal of caring sciences. 26: 427-435	To explore nurses experience of how their own vulnerability and suffering influence their ethics formation and capacity to provide care	Qualitative study	23 Nurses (8 Denmark, 7 Finland, 8 Sweden). Qualitative semi structured interviews. Coherent interpretation	Denmark, Sweden and Finland	Courage in the context of care Characteristics of courage in nursing The consequences of courage

Table 2. Scoping literature review papers and related themes

2.7.1 Courage in the context of nursing care

Seven papers were identified exploring courage in the context of nursing care. In summary nursing care was described in terms of dealing with vulnerability and patient suffering (Arman, 2007; Spence and Smythe, 2007; Stenbock-Hult and Sarvimaki, 2011; Thorup et al, 2012) ensuring patients' received safe care (Dinndorf-Hogenson, 2013; Hawkins and Morse, 2014) and the role of conscience in providing care (Jensen and Lidell, 2009).

Caring is often considered to be an act of compassion as nurses' advocate for their patients' safety and care. However Hawkins & Morse (2014) state compassion is felt but to act requires courage and so courage is stronger than and differs from caring or compassion. Dinndorf-Hogenson (2013) found patient care is connected to courage regarding patient safety. Her perioperative nurse participants reported almost 90% were prepared to exhibit moral courage when the threat to the patients' safety or care was identifiable.

Maintaining the professional standards required to ensure care is of the highest degree takes considerable courage. Using courage in the context of care requires nurses to remain with a patient in their suffering, exposure to their own vulnerability and reconciling themselves with confronting their own death (Arman, 2007; Stenbock-Hult and Sarvimaki, 2011; Thorup et al, 2012). Jensen and Lidell's (2009) participants described the driving forces behind courageous care as conscience and a close relationship with patients and their families enabling discussion of existential topics such as dying and death in palliation. Thorup et al's (2012) study similarly identified this inner force [conscience], necessitating nurses diverting attention from themselves. This suppression of their own needs in favour of the patients can as Spence and Smythe (2007) found be exhausting; it can take courage to come back in to work and continue caring.

These studies highlight the potential cost to nurses in providing care to their patients and their use of courage to do so. Several writers have observed the effects of moral distress on nurses that can accompany facing a patients suffering and vulnerability

(Arman, 2007; Austin, 2012; McCarthy and Gastmans, 2015; Savel and Munro, 2015).

2.7.2 The characteristics of courage in nursing

Thirteen papers contained findings relating to the characteristics of courage. In summary these were: Confidence and experience, a strong sense of commitment and conscience, being able to speak up and overcoming fear.

2.7.2.1 Confidence and experience

Confidence, experience and knowledge both professional and personal when working in uncertainty were all found to be characteristics of the courageous nurse (Lindh et al, 2008; Dewar, 2011; Stenbock-Hult and Sarvimaki, 2011; Thorup et al, 2012; Ekström and Idvall, 2015). Though both the personal and professional context are mentioned, the studies focused on the professional context and the impact of personal circumstances were not well addressed.

2.7.2.2 Commitment and conscience

Commitment, conscience, inner strength, willingness to stand firm and self-belief were found to be significant as traits in courageous behaviours (Spence and Smythe, 2007; Jensen and Lidell, 2009; Thorup et al, 2012; Bickhoff et al, 2014; Hawkins and Morse, 2014). These findings concur with earlier presented findings in the background to the context of care. However possibly because the studies were not specifically focused on courage, commitment and conscience were not explored in depth.

2.7.2.3 Being able to speak up and rising above fear

Another characteristic identified by several of the papers was the ability to speak up including the curiosity to question (Dewar, 2011; Stenbock-Hult and Sarvimaki, 2011; Dinndorf-Hogenson, 2013; Bickhoff et al, 2016). Speaking up links to the final characteristic of being able to rise above fear. All of the above writers attributed this in some form to courageousness (Dewar, 2011; Bickhoff, Sinclair and Levett-Jones, 2014), alongside the ability to be tenacious or resolute (Metcalfe, 2014), be copers and able to endure stress and manage conflict (Dinndorf-Hogenson,

2013; Dahl, Clancy and Andrews, 2014; Hawkins and Morse, 2014). These all resonate with resilience which is recognised as a required trait for nurses (Traynor, 2017).

2.7.2.4 The consequences of courage

The consequences of courage were identified by 13 Papers. Two papers identified potentially positive consequences to being courageous. Dahl et al (2014) found courage strengthened professional identity and Black et al (2014) that courage enhanced the quality of care.

The negative consequences of courage included: Ostracism, humiliation, exposure to vulnerability, horizontal violence, being labelled as a nuisance, animosity from colleagues and potential loss of employment (Bickhoff et al, 2016 and Dahl et al, 2014). These consequences can cause nurses anxiety (Black et al, 2014). Dinndorf-Hogenson, (2013) found similarly to Bickhoff et al, (2016) also identifying fear of retribution, likely reprisal and retaliation as having the strongest negative effect on moral courage. Dinndorf-Hogenson (2013) like Hawkins and Morse (2014) discuss moral distress as a consequence.

Lindh et al, (2008) and Metcalfe (2014) found nurses need to be prepared to expose themselves to conflict and endure the significant emotional and personal consequences that can accompany being courageous. Dewar (2011) notes another consequence may be a sense of failure if efforts are either unsuccessful or nurses are unable to meet the identified need.

Thorup et al, (2012) summarised the consequences of courage as feeling trapped and powerless between nursing responsibility and lack of authority; thoughts of incompetence led to a sense of inadequacy requiring the nurse to distance themselves from their personal needs, all whilst under threat of expulsion and or abandonment by their colleagues and profession.

2.7.2.5 Courage and education

Education was also considered in relation to courage in nursing. Four papers contribute to this theme. Dinndorf-Hogenson's, (2013) research suggests educational level and peers influence moral distress and courage, improve coping strategies and have a direct influence on the frequency and intensity of moral courage. Other

researchers agreed. Spence and Smythe (2007) and Hawkins and Morse (2014) found clear ongoing education can equip and inspire courage and postgraduate education can also support the development of courage although the exact link remains unclear. Lindh, Severinsson and Berg, (2009) opine, student nurses and qualified nurses should be supported in developing courage.

2.8 Conclusions from the review of the literature

The review of the literature has revealed insights into courage in nursing. Four themes have been presented and explored; courage in the context of care, the characteristics of courage in nursing, the consequences of courage and courage and education. Given the importance of courage as one of the key virtues and values in nursing (Cummings 2012; Cummings et al, 2015; NHS England, 2016) there is a surprisingly small number of substantive writings particularly in scientific literature on courage in nursing. Spence and Smythe (2007) Hawkins and Morse (2014) Numminen et al, (2016) all suggest further empirical research should be undertaken on nurses' courageous thinking and acting, the impact of personality, environmental factors and education.

2.9 Limitations of the literature

The origins of the articles being from various countries is a limitation as healthcare values and practices vary and findings may not be generalizable to nursing practice in the UK. The sample size of the studies was wide ranging with one study only having four participants. The methodologies were also wide ranging, and one study (Hawkins and Morse 2014), though included for some interesting and relevant content was not a research study, rather a concept analysis and systematic literature review.

None of the above studies focused specifically on general adult nurses understanding and use of courage in their practice. The focus of the studies were the context of alleviating suffering (Arman, 2007), vulnerability (Stenbock-Hult and Sarvimaki, 2011; Thorup et al, 2012), student nurses (Lindh, Severinsson and Berg, 2008; Bickhoff, Sinclair and Levett-Jones, 2014), newly registered nurses and leadership (Ekström and Idvall, 2015), advanced nurses (Spence and Smythe, 2007), professional identity (Dahl, Clancy and Andrews, 2014), conscience (Jensen and Lidell, 2009),

patient safety (Dinndorf-Hogenson, 2013) and moral strength (Lindh, Severinsson and Berg, 2009).

Three English studies are referenced above, Black (2011) Dewar (2011) and Metcalfe (2014). All detail interesting findings related to courage but none of the studies had courage as their original focus. Black (2011) studied mentorship, Dewar (2011) compassion and caring and Metcalfe (2014) leadership. Consequently, all the papers fail to study general nurses understanding and use of courage in their everyday practice. As Crigger (2011) notes, courage remains a hidden part of nursing practice.

2.10 Conclusion

Whist the above studies have some thought-provoking findings related to courage and its development, Hamric et al (2015) note courage in nursing, what it is and is not, how it may best be evoked, identified, encouraged and its toll still require further study. This study addresses an identified gap in the research surrounding adult nurses understanding and use of courage in their everyday practice. The following methodology chapter outlines the methods and methodology utilised.

Chapter 3 – Grounded theory methodology and research process.

3. Introduction

This chapter outlines grounded theory methodology and the rationale for the choice of social constructionist grounded theory. The data collection methods, analytical processes and ethical considerations employed in this research are also summarised.

3.1 Grounded theory

Grounded theory is an appropriate approach to explore an area about which little is known (Jones and Alony, 2011) and presents a methodology for collecting data and analysis simultaneously and sequentially enabling emergence of a conceptual theory (Glaser and Holton, 2004). Grounded theory articulates systematic methodological strategies developing theory from research grounded in data, rather than hypotheses (Glaser and Strauss 1967). Grounded theory has been interpreted in several diverse ways dependent on differing epistemological viewpoints (Girvin, Jackson and Hutchinson, 2016). Classic grounded theory entered the research scene resulting from Glaser and Strauss's (1967)

collaboration whilst studying the contexts of awareness in dying patients in America (Hallberg, 2006).

Currently grounded theory methodology alternates between a critical realist traditional perspective and a relativist ontological (evolved) perspective (McCreaddie and Payne, 2010). The choice of which to use depends on the research question and ontological beliefs of the researcher. The stance in this study is relativist, whereby the world has multiple individual realities influenced by context (Lincoln and Guba 2000; Mills et al, 2006). The researcher is integral to the research endeavour and together with the participant co-constructs meaning that is epistemologically subjective (Charmaz, 2014).

3.1.1 Charmaz's constructivist grounded theory

Charmaz (2000) acknowledges the inherent subjectivity of the researchers' involvement in the construction and interpretation of the data and chose the term constructivist, repositioning the researcher as the author of a reconstruction of experience influenced by historical and cultural contexts (Mills et al, 2006). Charmaz (2014) contends, though foundational assumptions

shaping a study may differ, all major versions of grounded theory begin with inductive logic and data is subjected to rigorous comparative analysis.

Charmazian grounded theory similarly to other iterations (Glaser & Strauss, 1967; Strauss, 1987; Strauss & Corbin 1994; Corbin & Strauss, 2008; Clarke, 2003) has several phases. Using a constant comparative analysis approach data is gathered and compared with data throughout the research. Initial coding develops into focused coding enhanced with theoretical sensitivity, bringing an analytic meticulousness to the data analysis. Memo writing aids in development of conceptual categories, these are strengthened and refined with strategic, systematic and abductive theoretical sampling aiming to lead to saturation and emergence of a theory grounded in the data (Charmaz, 2014).

3.1.2 Social constructionism within grounded theory

Charles Cooley was one of the earliest sociologists to theorize that our self-concept is influenced by society and others around us, ideas or concepts are constructed and may not exist without the existence of people or language validating these. Cooley termed this the looking glass self-theory (Cooley 1922). Mead (1913) is

credited with founding symbolic interactionism which has links with social constructionism. Mead viewed language and symbols as crucial in the construction of self, situation and society (Charmaz, 2014). However, Andrews (2012) believes while there are common roots in their philosophical foundations, interpretivism is distinct from social constructionism as it seeks to apply empiricist logic to study and describe human inquiry.

Berger and Luckmann (1991) are cited as key in social constructionism's development (Burr, 2003; Andrews, 2012). Social constructionism actively positions the researcher as a co-constructor of phenomena offering a way to interpret the nature of reality (Berger and Luckmann, 1991, Burr, 2003 and Andrews, 2012). However, rather than the individual perspective seen in constructivism, the focus is social (Young and Collin, 2004). Charmaz (2014) concurs that social constructionism is consistent with her constructivist view of grounded theory. Table 3 illustrates the differences between constructivist and constructionist approaches.

Constructivist	**Constructionist**
Individual focus	Social focus
Cognitive processes	Less interested in cognitive processes – explores interaction, social processes and action
Mental construction	Characterized by relativism
Shares positivisms commitment to dualist epistemology and ontology	Historically and culturally constructed
Internal to individual	Knowledge – product of social practices, institutions, interactions or negotiations between groups
Integrates knowledge (meaning) into pre-existing schemes or changing schemes to fit	Asks a new set of questions regarding choices made and why

Table 3. Constructivist versus Constructionist approaches (Adapted from Young and Collin 2004).

Berger and Luckman (1991) observe that the knowledge central to social constructionism is not discovered but created by the interactions of individuals within society. The assumption is that meanings about objects and symbols are pre - constructed in cultures, thus our understanding of meaning is shaped by

sociocultural influences (Licqurish and Seibold, 2011). This reality is communicated through interactions (Schwandt 2000).

3.1.3 Rationale for choice of methodology

Interactions with the social world are entrenched in society as routine and habit, this knowledge is absorbed by future generations and reaffirmed through the medium of language and by the individual's interactions with others. Our identity and place in society originates as much from social culture and interaction with significant others (Cooley 1922; Andrews, 2012), as it does from personal experience. Social constructionism is an appropriate paradigm for exploring shared meaning in nursing where social capital, culture and a sense of community are integral components in working life (Mills et al, 2006, Royal 2012, Read 2013). Historically knowledge in the health service is based on medicine with a realist stance (Churchman and Doherty, 2010) however, nurses construct their knowledge through interactions not only with medicine, but with their patients and each other. Commensurate with grounded theory and social constructionism understanding will be co – constructed by the participants and researcher enhanced by reflexivity (Charmaz, 2014).

3.2 Research study data collection methods

Co-constructing nurses understanding and use of courage required a data collection method allowing participants to freely elaborate on their experience and understanding of courage. Courage is a nebulous concept and nurses may not have reflected on the concept of courage in their working lives.

Unstructured interviews garner rich data (Duffy et al, 2004), their strength is they do not restrict what can be asked and are useful when little is known about a subject (Doody and Noonan, 2013). Chenitz & Swanson (1986) and Duffy et al, (2004) consider unstructured interviews are appropriate for grounded theory studies. This style of interview allows the participant to talk, the interviewer to encourage, listen and learn (Charmaz, 2014). The first twelve interviews were unstructured. As the developing theory emerges the approach to interview may change (Wimpenny and Gass, 2000) as theoretical sampling is used to narrow the focus on emerging categories, checking, qualifying and elaborating them and their relationships (Charmaz, 2014).

Consequently, the interviews were adapted as simultaneous data collection and analysis continued and tentative categories emerged (Fielding 1994; Charmaz, 2014). The final four interviews were conducted using a semi structured interview approach (Stuckey, 2013), enabling focus on the salient categories forming and guided by analytical questions regarding categories and their relationships (Strauss 1987, Duffy et al, 2004, Charmaz, 2014), strengthening the categories as they formed (Charmaz, 2014).

3.2.1 Sampling criteria

Sampling was purposive as participants were sought who met the inclusion criteria (Morse, 2010). Participants were required to be qualified adult nurses working in practice in one of three district general hospitals or community trusts. Additionally, qualified adult nurses undertaking post nursing registration education at the researchers' university were targeted as potential participants. The sample was sought as adult nurses had not been studied before in relation to their understanding and use of courage.

3.2.2 Ethics

The proposal was approved by the University's ethics committee and research degree board in December 2014. Additional approval was granted at a local trusts research and development ethics committee and the researcher followed the Royal College of Nursing (RCN, 2011b) research code of ethics. An amendment to the proposal was granted in June 2015 enabling inclusion of participants who approached the researcher from the wider clinical environment. Approval was also sought and obtained from the head of research and development for the county to access qualified nurses studying at the University (appendices 3 and 4). The following sections discuss the relevant ethical issues for this thesis.

3.2.3 Informed consent

Obtaining informed consent from the participants was a fundamental part of this research. The RCN (2011a) guidance on informed consent comprehensively defines the parameters of informed consent and guided development of the participant information sheet, including voluntary consent. Creswell (2008) and Turner (2010) note voluntary participation is vital to ensure

participants are willing to openly and honestly share their stories. The information sheet also outlined participants right to change their minds and withdraw at any point prior to the data analysis after which data would have been anonymized (appendices 2). Participants who indicated they wished to participate in the study were provided with consent forms to read, sign and date. Participants were reminded at the start of the interview of their right to withdraw consent at any time. Consent is a difficult concept as neither the interviewer nor the participant can predict what may emerge during an interview (Nunkoosing, 2005), that may change a participants mind about continuing in the study.

3.2.4 Rights, safety and wellbeing of participants

Interviews can profoundly affect participants (Holloway and Wheeler, 2010) unexpected, upsetting or potentially damaging revelations can be revealed (Bickman and Rog, 2009) with risk and vulnerability sensed on both sides (Lincoln and Guba, 2000). Consequently support and debrief should be addressed (Larsen et al, 2008). A protocol detailing appropriate action and sources of support or debrief was available (appendices 5) however, this was not required.

3.2.5 Anonymity, confidentiality and privacy

Anonymity is related to confidentiality and privacy (Novak, 2014). Confidentiality means to keep secret or private and is necessary to maintain trust between the researcher and participant. Anonymity is employed to ensure the participants data is presented as source unknown and unspecified (Novak, 2014) meaning it should not be possible to identify the individuals in the thesis or associated data notes. In this research participants were assured the interview was confidential, however there was a protocol to follow if a patient or staff safety issue was raised necessitating further action and to adhere to the researcher and participants' Code for nursing (NMC, 2015).

The information sheet explained that views and data generated would be anonymized and not attributable to individuals. Respect for the participants' privacy was paramount as the interviews may reveal personal or difficult stories (DiCicco-Bloom and Crabtree, 2006; Doody and Noonan, 2013). Participants were anonymized in both the recording and analysis and assigned pseudonyms in the

findings chapters. Personal details removed if a participant inadvertently identified themselves during recording.

3.2.6 Data management

Personal contact information was stored separately and securely from data collected as part of the research. All data collected was stored in locked cabinets and transferred securely. Electronic data was stored on a password protected Thesis specific secure server. Storage of data followed the guidelines set by the Data Protection Act (1998) and the Freedom of Information Act (2000).

3.2.7 Access to sample

Participants were recruited through direct contact with nurses studying at the University, fliers distributed in the University buildings and advertising on the University module sites. Participants in the acute and community trusts were also recruited through widely distributed fliers at a mentors' conference and via word of mouth. Table 4 details the participants gained from over three hundred fliers and face to face contact. The majority of the initial twelve participants were identified within the first two months. Of these seven were either previously known to the researcher or responded to face to face contact during recruitment. Five had never met the researcher. Of the final four

interviews, one was a previous participant, two were university staff with less than six months out of practice and one was a previous student.

Recruitment fliers and face to face contact	**Participants indicating an interest**	**Consenting participants**
20 students face to face on prescribing module	2	2
2 fliers distributed on Dissertation module student information site	0	0
30 Fliers throughout University buildings	2	2
8 fliers Mentorship module student information sites	1	1
Advertised on 9 modules student information sites	1 (midwife)	0 (not adult nurse)
150 fliers at conference (potential 40 participants from participating local Trust)	3 + 2 (referred on by 1 of the initial 3)	5
30 fliers distributed face to face at mentor update	2	2
4 fliers tissue viability module student information site	0	0
Total	**13**	**12**
Theoretical sampling interviews		
30 new fliers in University buildings	0	0
New advert fliers on 9 NILE sites	0	0
30 fliers distributed face to face in mentor module	0	0
Snowballed through past participants (Heckathorn 2011)	2 (1 new, 1 re-interviewed)	2
Approached 5 new university staff with less than 6 months out of clinical practice	2 (3 others not adult nurses)	2
Total	**17**	**16 interviews (15 participants)**

Table 4. Access to sample

3.2.8 Sample characteristic

A cross section of adult nurses in varying clinical practice settings were recruited. This enabled a diverse representation of adult nursing, range of settings and levels of experience and grades. There is little clear guidance regarding sample size within grounded theory (Bowling, 2014). However when the same stories, issues or themes re-emerge, a sufficient sample size for saturation is said to have been reached (Glaser and Strauss, 1967). Guest et al (2006) suggest six to twelve interviews may be sufficient finding data saturation had for the most part occurred by the time twelve interviews were analysed. The demographic of the participants is outlined in table 5. The acute practice setting denotes nurses working in a hospital trust, the community practice setting denotes nurses working in a clinical setting anywhere outside of an acute hospital trust.

Participant	Pseudonym	Age range	Range of years' experience	Gender	Practice setting
P1	Jo	53-59	30-35	F	Acute
P2	Gracie	32-38	5-10	F	Acute
P3	Natalie	53-59	15-20	F	Acute
P4	Alex	46-52	15-20	F	Community [Acute]
P5	Alexia	53-59	35-40	F	Acute
P6	Jill	46-52	25-30	F	Community [Acute]
P7	Sue	25-31	25-30	F	Acute
P8	Louise	46-52	25-30	F	Community [Acute]
P9	Penny	46-52	30-35	F	Community [Acute]
P10	Sam	46-52	30-35	F	Community
P11	Rosie	25-31	0-5	F	Acute
P12	Molly	46-52	25-30	F	Community
P13	Rosie	25-31	0-5	F	Acute
P14	Maz	46-52	5-10	F	Community
P15	Ruby	39-45	10-15	F	Community [Acute]
P16	Gina	46-52	25-30	F	Community

Table 5. Sample characteristics. [ ] denotes previous experience in that area

All participants were female. As only 10.2 % of nurses in the United Kingdom (UK) are male (Stanley et al, 2016), this could be anticipated. Consequently, the study and theory portray female nurses' conceptualization of courage. The average age between

the first twelve participants was approximately forty-six years with twenty-four years' experience in practice. This revealed a gap in less experienced nurses' views. The theoretical sampling interviews sought to address this gap by targeting participants with less than ten years' experience and was partially successful. Two of the final four had less than ten years' practice experience. The average age of the final four was forty-two with an average of thirteen years of experience. The full range of years of experience was eleven months to thirty-seven years and the interviews took place between 19th March 2015 – 23rd May 2017.

3.2.9 Interviews

In grounded theory studies the theory development depends on the co-construction of meaning between the researcher and the participant (Charmaz, 2014). Consequently, the interviews were pivotal. Interviews have been criticized for not viewing individuals acting in the world at the expense of social context (Kvale, 1996) however, Tang (2002) argues the interview is a social encounter and as Parker (2005) and Charmaz (2014) state, reflexivity mitigates as the researcher examines their own social context in relation to the participants.

The interviews were between forty-five minutes to one hour and forty minutes long. An hour is recommended (Laforest, 2009) and the majority were an hour. Hancock et al (2006) endorses interviewing at a mutually agreed location to ensure participants feel as comfortable as possible (Hancock et al, 2009). The location was chosen by the participant and were the participants workplace (eight), the University (six), their home (one) and face time (one). To begin the interview a generic non-threatening opening topic was used,

"tell me about your nursing career to date"

Holloway and Wheeler (2010); Turner (2010) and Doody and Noonan (2013) suggest this approach helps participants relax into the interview and reminds them of the overall context before potentially more difficult or sensitive topics are raised. A question to bring the focus of the study into view followed,

"tell me what you understand by the meaning of courage in your nursing practice?"

Aiming to explore participants views leading questions were avoided and commonly understood language was used as Bryman

and Cassell (2006) and (Turner, 2010) respectively advocate. Clarifying discussion was used to gain richer data and ensure meaning was understood (McNamara 2009; Nunkoosing 2005) and the participant was central and did most of the talking. Holloway and Wheeler (2010) encourage prompts or probes to inspire elaboration or explanation and as Creswell (2008) notes, flexibility is essential to ensure participants can answer freely. To close the interview the participant was asked if they had anything to add regarding courage which Turner (2010) observes, brings the interview to a natural close.

Minimizing distraction during the interview is important (Holloway and Wheeler, 2010) so interviews were recorded, general field notes were taken prior to and after the interview (appendices 11) and notes were used as required during the interview.

3.2.9.1 Transcription

The interview data was recorded using two digital voice recorders limiting the chance of a missed recording. Interviews were personally transcribed as soon as possible after the interview with careful attention to anonymity (Bannister et al, 2011). Duffy et al (2004) and Banister et al (2011) recommend personally

transcribing to enhance emersion in the data and encourage reflexivity on the researcher role, this approach preserves rich details that may otherwise be missed (Charmaz, 2014). Full transcription also raises awareness in reflexivity, revealing data that requires more exploration in subsequent data collection (Jootun, McGhee and Marland, 2009) allowing data to be returned to in its entirety and potentially saving time in the analysis stage (Banister et al, 2011).

3.3 Analysis of data

Grounded theory is an iterative analytical process (Bowling, 2014, Charmaz, 2014), data collection and analysis occurs concurrently with the resultant analysis informing subsequent data collection (Lingard and Levinson, 2008; Licqurish and Seibold, 2011). Astuteness to how personal and academic life contribute to what is seen and heard, both during the interviews and interpretation of the transcripts should be maintained (Mauthner and Doucet, 2003) and reflexivity embedded in the analysis explicates this.

The decision to use QSR NVivo version 10.2.2 was made based on the volume of data and as Welsh (2002) says can support the

analysis. NVivo is designed to assist management of data and ideas, to probe the data, produce models of it and ultimately report from the data (Bazeley and Jackson, 2013) ensuring a more complete set of data than may occur manually. NVivo compliments and enhances manual methods but does not supplant them (Bazeley and Jackson, 2013). NVivo design is congruent with grounded theory, encouraging data analysis during collection (Bringer et al, 2007; Hutchinson et al, 2010). Welsh (2002) Bringer et al, (2007) and Leech and Onwuegbuzie (2011) state NVivo aids in maximizing potential efficiency and rigor as questions are asked of the data and decisions made. Bazeley and Jackson (2013) caution that software packages may constrain free thought and insights required for deep analytical coding but responsibility lies with the researcher, no software package is capable of the inductive-deductive cycle and co-construction integral to grounded theory (Gasson, 2003).

3.3.1 Coding

Coding was conducted in two phases. Initially line-by-line coding was used followed by focused coding (Charmaz 2014). Table 6 below illustrates the initial, immature and descriptive coding.

Name	Sources	Referen...	Created On	Created By	Modified On
Are there different types of courage	1	3	5 Nov 2015 at 14:37	FAB	5 Nov 2015 at 21:56
Does personal life affect courage	3	6	5 Nov 2015 at 14:22	FAB	5 Nov 2015 at 22:12
Doing the wrong thing	1	2	5 Nov 2015 at 20:45	FAB	5 Nov 2015 at 22:12
How they got into nursing	6	72	15 Sep 2015 at 1...	FAB	5 Nov 2015 at 22:15
Registration and courage	1	1	29 Oct 2015 at 2...	FAB	5 Nov 2015 at 22:11
The importance of the patient in nursing	5	27	18 Sep 2015 at 1...	FAB	5 Nov 2015 at 22:01
Their ideas about courage	4	20	15 Sep 2015 at 1...	FAB	5 Nov 2015 at 22:09
why may courage not occur	5	13	18 Sep 2015 at 1...	FAB	5 Nov 2015 at 22:17
Working with the MDT	6	75	15 Sep 2015 at 2...	FAB	5 Nov 2015 at 22:24

Table 6. Example of initial immature codes

Grounded theory is an inductive process building theory directly from the data. Charmaz (2014) also points to abduction, incorporating inductive and deductive reasoning. Birks & Mills 2015) propose this is cerebral and intellectual bringing together things not previously associated. Charmaz (2006, 2014) advocates coding begins with general sensitizing concepts, reflexively considering self, identity, power, equity, privilege and or oppression. Data is repeatedly re-examined being receptive to the unexpected (Charmaz, 2014). This entails constant comparative analysis. Participants statements are searched for patterns, inconsistencies, contradictions, consequences and observing

implicit meanings (Charmaz, 2014). The data is questioned, for example; what appears obvious or assumed and from whose viewpoint (Charmaz, 2006). The aim is to analyse the data rather than describe as Corbin and Strauss (2008) and Charmaz (2014) advocate.

Line by line coding continued identifying codes for further exploration and subsequent interviews concentrated on learning more about these codes (Charmaz, 2014). Gerunds, nouns made from verbs by adding "ing" were also used to build action into codes as Charmaz (2014) proposes, this offers a different way of exploring the data and further emersion in it.

accepting challenges	8	19	15 Sep 2015 at 1...	FAB
Being tested	4	4	19 Feb 2016 at 1...	FAB
challenging when its difficult	6	12	18 Sep 2015 at 1...	FAB
Not being afraid of being wrong	3	6	16 Mar 2016 at 2...	FAB
not being afriad to be judged	1	1	16 Mar 2016 at 2...	FAB
Making decisions	4	7	5 Mar 2016 at 00:37	FAB
seeing things through	3	5	5 Nov 2015 at 16:36	FAB
Its perseverance	2	6	8 Mar 2016 at 14:13	FAB
Stepping up	1	3	17 Mar 2016 at 2...	FAB
Taking responsibility	6	10	19 Feb 2016 at 1...	FAB
using your knowledge	10	22	15 Sep 2015 at 1...	FAB
Asking questions	7	12	8 Dec 2015 at 15:51	FAB

Table 7. Example of actions in coding using Gerunds

Focused coding followed as the more frequent or significant codes were sifted and sorted, building and clarifying categories. Data was compared with data, data with codes and finally data and codes were compared with the tentative categories. Charmaz (2014) says as codes develop, are defined, described and their causes and conditions explicated they became conceptual categories. Integral to grounded theory, the robustness of tentative categories was tested with subsequent data using theoretical sampling (Charmaz, 2014). Table 8 illustrates the development of tentative categories.

Name	Sources	Referen...	Created On	Created By
Being a change agent	7	18	24 Feb 2016 at 1...	FAB
Evolving socialisation	27	133	23 Nov 2016 at 1...	FAB
Finding your voice	16	26	8 Dec 2015 at 15:51	FAB
its doing the morally right...	17	56	29 Oct 2015 at 1...	FAB
The concept of courage	13	25	5 Nov 2015 at 15:56	FAB
the impact of Gender	28	235	18 Nov 2016 at 1...	FAB
the role of support in cou...	32	153	18 Sep 2015 at 1...	FAB
Traditional role of the nurse	30	270	18 Nov 2016 at 1...	FAB
You have to have strengt...	9	15	5 Nov 2015 at 14:37	FAB
you need Self belief	11	37	24 Feb 2016 at 1...	FAB

Table 8. Tentative categories

Some categories did not have sufficient data to support them while others merged and were drawn together. Finally, as Braun & Clarke (2006) observe, categories become defined, named and a coherent report can be produced. Emerging as themes underpinning the categories were: Gender, socialisation, personality and organisational culture, all noted as potentially influential to the emergent theory of courage.

3.3.2 Memo writing

An intermediate step between coding, category forming, and the first analytical draft is memo writing while coding. Memos systematically help build categories and enhance identification and interaction with the data (Charmaz, 1983, 2006, 2014). During coding written explanations of ideas, (memoing) were noted about the data, coded categories, connected coding, the derived framework and final ideas (appendices 9). Charmaz (2012) recommends asking analytical questions whilst memo writing enabling movement from description to conceptualization of data, moving from how and what questions to why questions.

Participant quote	Memo
P9. "although we do laugh about making sure we use the right words when we're emailing them, occasionally someone was saying the other day, "Oh I don't want to look as if I'm being a bit dim" and I said, "well put it in an email" because I do quite often, "I maybe sounding a little bit dim, however……"	Is this about nurses (women) getting what they want by being submissive and by subterfuge!! Why is this necessary?
P5. "having the courage to maybe question someone who is of a higher authority to you whether it be a Doctor, matron, ward manager".	Is this about the tradition and identity of nurses or gender? The Doctors may be more likely men but not necessarily the matron etc, why does it take courage to do this?

Table 9. Example of memo writing

Memo-ing illuminated conditions under which a category operated, varied and its relation to other categories or codes as potential patterns emerged helping make comparisons explicit (Charmaz, 2014). Theoretical sampling and refining of categories followed with integration into a theoretical framework (Charmaz, 2000, 2014; Charmaz, 2017).

3.3.3 Theoretical sampling

The final stage of the data collection and analysis is an important stage. Individual experiences and understanding derived from the

interviews were drawn together and applied to the social context in which nursing operates (Royal, 2012 and Read, 2013).

As the data was analysed, elaboration of categories aiming to lead to saturation was achieved using theoretical sampling. Through semi-structured interviews specific information was sought in the last four interviews. Charmaz (1983) and Streubert, Carpenter (2011) propose theoretical sampling illuminates and defines categories or their properties and assists development towards the emerging theory. Questions that are asked or ignored are influenced by assumptions and reflexivity and theoretical sampling assists in overcoming this (Primeau, 2003).

3.3.4 Saturation

In grounded theory saturation means theoretical saturation; compelling and robust data supports theoretical categories and the work moves beyond conjecture (Charmaz, 2012). This distinguishing feature of grounded theory involves inductive and deductive reasoning and abduction. Abduction is imaginative reasoning making inferred leaps to consider all plausible theoretical explanations for observations, categories are tested to

confirm or disconfirm their properties and to reach the most plausible theoretical account (Charmaz, 2014).

After interview ten no new codes were added though the process of constant comparison, re-ordering codes and developing categories continued, including during writing up. Hennink et al, (2017) observe code saturation may indicate the researcher has heard it all but meaning saturation is required to understand it all. Subsequent interviews after the tenth interview sought to specifically address perceived gaps in the data with theoretical sampling ensuring data was as saturated as possible. It is recognized that saturation is reached when no new concepts or properties of categories emerge and patterns in data are accounted for (McCreaddie and Payne, 2010; Charmaz, 2014; Saldana, 2016;).

The addition of no new codes does not necessarily imply saturation was achieved. Saturation is subject to discussion and maybe considered an act of judgment (Hennink et al, 2017; Charmaz 2012; Charmaz 2014). Charmaz (2014) cautions that proclaiming

saturation is challenging. Time scales and word limits within a Professional Doctorate may prohibit reaching saturation. Dey (2004) concurs with Charmaz (2014) viewing saturation as "imprecise" and contends grounded theorists may have categories suggested by data rather than saturated by it. Dey (2004) terms this "theoretical sufficiency" and is the term adopted for this research study.

3.4 Theory development

Theoretical development requires the emergence and identification of a theoretical concept which is a co-construction of the derived understanding between the participant and researcher. Charmaz (2014) proposes this is achieved as higher-level categories are subsumed into concepts bearing the most substantial analytical weight. Further comparison of data with data continued during writing up and confirmed the core category, sub categories and 123 subcategory codes.

Core Category: Realizing courage in adult nursing	**Codes**
Pre- requisites of courage	46
The meaning of courage and being courageous in the context of nursing	50
The consequences of using courage	27
Total	123

Table 10. Re - organization of categories and codes during writing up

The final categories and codes in table 10 were achieved by ongoing further analytical refinement and exploration of their relationships to other categories or concepts which Charmaz (2014) considers important. A full list of categories can be found in appendices 7.

3.4.1 Core categories

Hallberg (2006) views the core category of grounded theory as illustrative of the constant comparative method noting it as a fundamental aspect of grounded theory. Conversely, Charmaz (2014) suggests searching for a core category may risk foreclosing

on other significant, often implicit lines of inquiry especially if the core category emerges in earlier interviews. The data was carefully explored for a core category, however perhaps as courage is a complex phenomenon (Rate et al, 2007; Woodard and Pury, 2007) locating a core proved elusive. During writing up, returning to the data 'realizing courage' as a core category revealed itself with three main categories within the core; pre-requisites of courage (where does courage come from and what needs to be in place to use courage), the meaning of courage and being courageous and the consequences of using courage.

The emergent themes within the data are gender, personality, socialisation and organisational culture. At this juncture the literature was reviewed around the developing theory evaluating and defending the researchers position and exploring extant literatures fit with the emergent theory. This process clarifies ideas, enables comparisons to be made and theory development to evolve (Dunne, 2011; Charmaz, 2014).

The resulting theory offers abstract understanding of the relationships between the categories and concepts providing a good fit to the situation that is representative of the data (Dick, 2005). As such, the theoretical interpretation makes sense of the studied phenomenon (Charmaz, 2014). In socially constructed theory development it is acknowledged there are multiple possible realities and the derived interpretative framework is a representation of one of these (Lincoln and Guba, 2000; Mills et al, 2006; Charmaz, 2014).

3.5 Role of the researcher

Using a social constructionist perspective, the multiple realities constituting the participants understanding and use of courage were co-constructed highlighting the importance of the dyad between myself and the participants (Charmaz, 2006). The strength of this relationship is arguably the most important aspect of a qualitative research project (Kvale, 1996) and social constructionism emphasizes the subjective interrelationship and social context between us and the co construction of meaning (Mills et al, 2006). Kvale (1996) Knox and Burkard (2009) state

rather than attempting to negate this interrelationship, I should embrace it as it strengthens the data.

My position as the researcher is integral to the research endeavour. I am a part of the potentially multiple realities influenced by social context (Mills et al, 2006). Together the participants and I co-constructed an epistemologically subjective meaning based on the participants understanding and experiences and my own reflexivity. Holloway and Wheeler (2010), Doody and Slevin (2013) and Charmaz (2014) observe that as the participants and I are co-producers of the theory, a position of mutual respect and equality is central to the relationship.

Hidden and latent themes are explored in social constructionism and grounded theory (Puddephatt, 2007) thus the interpretation was influenced by both my own and the participants locale, historical, situational and contextual factors and my writing style aims to evoke the experiences of the participants (Hildenbrand, 2010). Power dynamics are present in any interaction including interviews (Nunkoosing, 2005) and equality is rarely achieved but

acknowledging these influences is important (Knox Burkard, 2009, Holloway and Wheeler, 2010). Ultimately it is I, as the researcher, who reconstructs the data.

Participants were asked to review the interview transcriptions for authenticity, but status, race, culture and gender all also influenced what and how things were said and consequently what I could write about. Additionally, both the participants and I hold and acknowledge other identities (Nunkoosing, 2005), for example; nurse, teacher, parent, researcher and these factors, explored through reflexivity (Tang 2002) were acknowledged for their influence on the conclusions drawn (appendices 10).

3.5.1 Reflexivity

Reflexivity is central to the co-construction of understanding in grounded theory as it enables the development of resonance with the reader and demonstrates rigour (Streubert and Carpenter, 2011; Engward and Davis, 2015) and addresses subjectivity (Gasson, 2003). Streubert and Carpenter (2011) suggest reality is viewed from a dynamic perspective shaped by personal intrinsic values and beliefs. Reflexively reviewing and acknowledging my

behaviour or social constructs that may have impacted on the subsequent interpretation and co-construction is essential to examine how my interests, position and assumptions influenced the co-construction (Charmaz, 2014) and as Berger, (2015) writes, is a strategy for quality control.

In this research study who I chose or not to study, the questions I did or did not ask, how the research question was formulated, access to participants gained, data analysed, collected and written up, is all dependent on what I heard and understood (Primeau, (2003) and my location of self within hierarchies of power, gender, race, class and sociocultural and historical standpoints (Pini, 2004; Berger, 2015). Additionally, my subconscious exposure to epistemological or theoretical constructs will have silently informed my interpretation (Engward and Davis, 2015). Reflexivity enhances the quality of my research extending understanding of how each stage of the process is affected by my position and interest (Primeau, 2003) and is congruent with social constructionism.

Memos were used to identify potential patterns (Mauthner and Doucet, 2003; Engward and Davis, 2015) and enhance my reflexivity (appendices 9). Gasson (2004) observes that memos explicate to those outside the field what was done and why decisions were made. Supervision also enhanced my reflexivity. Triangulation with the supervision team assisted in considering the accuracy of analysis (Berger, 2015). During supervision I was sometimes in the uncomfortable position of being the subject for sociological enquiry, but a strength of social constructionism is its attention to such social processes, so as opposed to abstract theorizing, reflexive social constructionism enabled me to take a different turn (Macmillan, 2003).

Throughout this research study my personal beliefs, values and subjectivity have been made transparent as advocated by Knox Burkard (2009). I adopted a reflexive, self-aware stance throughout the study, critically analysing how my beliefs, values, knowledge and understanding impacted on the interviews and their subsequent analysis (Gasson, 2004). The findings chapters

contain evidence of my reflexivity connected to the reflexive background presented in appendices 10.

3.5.2 Rigour

It could be argued that the interpretive grounded theory researcher needs to defend their work more robustly than the positivist researcher. Interpretative research does not have formalized procedures to address rigour or a wide ranging historical knowledge and tradition comparative to quantitative research (Gasson, 2004). Lincoln and Guba (2000) argue, rather than judging qualitative research on the concept of validity, it should be judged on its trustworthiness.

In grounded theory objectivity is substituted for reflexive self-awareness as a way of ensuring subjectivity, transparency and authenticity. Critics such as Bury (1986) suggest that a social constructionist approach cannot bring change, there being nothing against which to judge it. However, social constructionism can generate true debate and change, participants views are plausible evidence of their experiences that others can identify with and deliberate (Burningham and Cooper, 1999; Andrews, 2012).

Chiovitti and Piran (2003) suggest three standards of rigour; credibility, auditability and fittingness. Glaser and Strauss (1967) also emphasized the grounded theory will be measured by its fit and credibility. This thesis presents a clear audit trail of the detailed analysis endeavouring to ensure all processes to the reader are explicit (Gasson, 2004). Ultimately this grounded theory aims to resonate or fit with the participants and readers who have had the same, or similar experiences and can recognize these from the co-construction (Chiovitti and Piran, 2003). This research study adheres to Charmaz's (2014) evaluative criteria of credibility, originality, resonance and usefulness and these are explored in chapter 7.

3.6 Conclusion

Grounded theory has been presented as an appropriate methodology for a subject about which little is known. This study uses grounded theory underpinned by social constructionism which is reflective of the social context in which nursing operates. Unstructured interviews were chosen to enable nurses to tell their stories freely and were followed by semi-structured interviews. The constant comparative approach, coding, memoing, theoretical sampling and development of categories led to emergence of a

proposed theory of courage that was co-constructed with the researcher and participants. The following chapters 4, 5 and 6 present the co-construction of the participants data and emergent theory fit with the extant literature concerning gender, personality, socialisation and organisational culture.

Chapter 4 Prerequisites to being courageous in the context of nursing

4. Introduction

This is the first of three chapters presenting co-constructed findings from the data collected. The overall core category that emerged through the data collection and analysis is 'Realizing Courage' and this conceptualizes participants experiences of courage. Realising courage is the overarching term encompassing three main categories. This chapter presents the first of those categories, the prerequisites for courage. Chapter Five depicts findings related to the meaning of courage and acts of being courageous and Chapter Six concerns the consequences of realising courage. The data in the findings chapters contribute to an emergent grounded theory of courage in adult nursing that is underpinned by extant literature concerning gender, personality, socialisation and organisational culture as emergent themes related to courage. Each of the findings chapters conclude with my reflexive analysis which is an essential component of co-construction (Engward and Davis, 2015) cross referenced to the reflexive background presented in Appendices 10.

Throughout the chapters quotations from participants are presented to clarify each component of the analysis and subsequent emergent theory. Each quotation is followed in brackets by the participants number, current practice area, number of years' experience in nursing and assigned pseudonyms are used in the text.

4.1 The context to the prerequisites of courage

Participants were asked to describe the meaning of courage in the context of adult nursing. Although many found this difficult, much data was collected illuminating their concept of courage regarding the influencing factors that enabled them to be courageous, these were organised in patterns in the data part of which concerned an understanding of what were felt to be the prerequisites for courage. These prerequisites for courage were abstracted from the data and categorised into personal prerequisites, professional prerequisites and the origins and development of courage. The first section of this chapter explores the personal prerequisites which are required for a person to feel able to express courage in nursing.

4.2 Personal prerequisites for courage

Table 11 shows the categories and associated sub-categories which were generated during the analysis regarding the personal prerequisites for courage.

Category	**Related subcategories**
Personal prerequisites to realising courage	• Being a woman and being courageous • Age and life experience makes a difference to courage • Self-esteem as prerequisite to courage • Personality characteristics and personal circumstances as prerequisite to courage • Moral values as prerequisite to developing courage

Table 11. Categories and subcategories: Personal prerequisites to realising courage in the context of adult nursing

The prerequisites of gender, age, life experience, self-esteem and personality were described by participants as almost immutable. 'Requiring a moral value system' was described by participants as mutable in the sense that participants thought a moral value

system may change or be adapted dependent on social or cultural influences.

The personal prerequisites are not mutually exclusive and suggest adult nurses hold beliefs about several of these prerequisites simultaneously, such that each intersects with the other providing the context for subsequently feeling or being courageous. Using courage in their clinical setting appeared to require participants to be able to overcome the constraints of their gender as female, have either age or significant life experiences behind them, the personality characteristics to be able to act for example speak up, a positive self-esteem and a strong moral values system.

4.2.1 Being a woman and being courageous

Participants spoke about themselves as women influencing their ability to feel or be courageous and drawing gender into the emerging grounded theory. Courage was viewed as one of the more difficult aspects of nursing and not possible when personal life was challenging. However, the softer skills in nursing perceived as nurturing or caring (Rhodes et al, 2011; Aranda et al, 2015)

were still achievable. The participants in this study were all female and Gina attributes this to gender.

> *"I think when you're on a bit of a life wobble….Hmm, as a woman, dare I say, you become a bit neurotic or a bit shouty…..you haven't got that courage, you think it's all falling apart, if it's all falling apart at home…..the courage is quite hard, whereas doing some of the other soft stuff that's alright isn't it?" [P16 Community specialist nurse 30 years].*

This suggests that nurses need to transgress the female gender norms for example being kind, empathetic and caring (Miers, 2000) and build new norms of being a woman to be successful as a professional nurse. Gina also relates courage to being in a positive place personally which is explored further in the sub category for self-esteem (4.2.3).

4.2.2 Age and life experience makes a difference to courage

Some participants felt age, connected to life experience was a prerequisite to developing their courage and that being confident to speak up in connection to courage grew with age and or life experience. Alexia implies courage is connected to growing older

and to associated lived experience as she says she *'obviously'* could not speak up when she started her nursing, also inferring professional socialisation as a student nurse had not prepared her to be able to speak and or as a female participant, her gender as a woman inhibited her.

> *"I think that [courage] probably grows as you get older, and with the experiences you've had, because obviously when I first started nursing I would not, I could hardly speak would you believe," [P5 Acute nurse 37 years].*

Alexia infers the older female nurse with the benefit of experience may find courageous behaviour easier, whether this is due to maturity and experience or potentially as they feel they have less to lose is unclear. Thorup et al's (2012) study found ethical formation which underpins virtues like courage was influenced by both professional and personal life experience and develops over time, linking to the prerequisite of moral values explored later in this chapter (4.2.5). Alexia does not specify whether she is referring to life experience or professional experience, but other participants specifically related to personal life experiences, for example difficult relationships, divorce and having children. Some

of these critical life experiences were perceived as negative however, having weathered a storm they found they may emerge stronger. The quote below illustrates how some *'terrible'* personal experiences; being undermined at home and undergoing a difficult divorce, ultimately resulted in significant personal benefit by changing Natalie's perspective and her confidence in herself as a strong woman. Life experience in addition to maturity appears instrumental in framing courage.

> *"But then that's life experience, I couldn't have done it at 25, …I hadn't been through anything really, so it's all, you know, swings and roundabouts, and what can be on paper, a terrible experience, you know it's been 3 years of hell, but, actually the benefit personally is huge…..going back to the courage thing, I do think its intrinsically linked with so many different aspects of what's going on, and how you feel about yourself as a person" [P3 Acute nurse 16 years].*

4.2.3 Self-esteem as prerequisite to courage

Many participants identified another prerequisite to courage as self-esteem. Participants articulated how they thought that a sense of positive self-esteem enabled them to enhance the care they gave including realising their courage. Although gender is not explicit in the excerpt below self-esteem is recognized in the literature to be a particular challenge for women (Bleidorn et al, 2016; Dar-Nimrod et al, 2018) relating the prerequisites of gender and self-esteem. Below Alex recounts how she felt when her self-esteem was strong compared to when she felt low,

> *"if I feel well and happy in myself then the care and the courage that I'm going to have is a lot better than if I'm feeling low" [P4 Community nurse 15 years].*

These views were echoed by several participants connecting their self -esteem to positive home circumstances as prerequisites to realising courage. In the excerpt below Natalie had a difficult home life resulting in the undermining of her self-esteem. Once able to remove herself from her challenging home circumstances she developed a strong sense of self-esteem, translating into an

increased ability to show courage at home and subsequently at work. This suggests courage at work is at least partially dependent on an individual's personal circumstances and external influences outside of working life. Natalie said,

> *"you know to be constantly undermined at home, makes a huge difference I think professionally, and then say, like the courage aspect, I wouldn't have had the same courage because I was constantly chipped away here…..but now, I've got my wings out, there's no way them bad boys are going away again [laughs]" [P3 Acute nurse 16 years].*

Natalie's illustrative reference to her *'bad boys'* wings, though light-hearted denotes her wings as having a male gender suggesting that to her, strength and courage are interpreted as male attributes. Ford Walston (2004) and Miller (2005) maintain males are usually associated with physical courage and Natalie's allocation of a gender to her wings resonates with this.

Several participants who had not expressed such challenging home circumstances also identified positive self-esteem as a prerequisite

to realising courage. Alex talked about how positive self-esteem meant she was more likely to be able to provide excellent patient care including courageous behaviours,

> *"if I feel well and happy in myself then the care and the courage that I'm going to have is a lot better….to be able to give 100% to that patient, I know I do on days when I'm feeling really good about myself, and I've looked after myself……and feeling really healthy… actually if we invest in ourselves, then we give out a lot more" [P4 Community nurse 15 years].*

These excerpts reveal that positive home circumstances and self-esteem are prerequisites to realising courage. Both appear connected to the female gender, age and positive or negative life experiences. Karagözoğlu (2008) and Ilhan et al (2016) studies support these findings, relating positive self-esteem to assertiveness which could be said to be an expression of courage.

4.2.4 Personality characteristics and personal circumstances as prerequisite to courage

The participants used personality as a word to describe personal traits they felt acted as prerequisite to courage. Natalie connects her personality to her personal circumstances, previously linked to self-esteem and suggesting these influences are all implicit in courageous behaviours.

> *"I think your personality and your personal circumstances are so conducive to, actually your ability to step forward" [P3 Acute nurse 16 years].*

This concept has been briefly considered in extant theory, Numminen et al (2016) considered how social influences such as personal circumstances relate to an individual's ability to work through life's anxieties and disappointments concluding, personality and its relation to courage requires further study. Natalie asserts that personality characteristics such as confidence (also linked to self -esteem), extroversion and her strong moral values linked to her personal socialisation and background shape her use of courage.

"I find it [courage] difficult and easy at the same time, cos given my personality, I'm quite vocal and I'm quite confident ……..knowing my own personality, I'm very moral, I'm very ethical and I do have a huge sense of right and wrong" [P3 Acute nurse 16 years].

Participants also spoke about the personality characteristic of being able to '*bounce back'*. Eley et al (2012) and Montes-Hidalgo and Tomas-Sabado (2016) posit that self-esteem is connected to resilience suggesting those with low self-esteem find difficulty in adjusting to adversity. Below Louise refers to resilience and how though difficult at first, personal resilience develops and becomes easier,

"maybe as time goes on you get a bit more resilient…….you get a little bit more resilient and you bounce, hopefully, you bounce back a little bit quicker."[P8 Community specialist nurse 28 years].

4.2.5 Moral values system as prerequisite to developing courage

Moral values were viewed by participants as their ability to see things in moral terms as Natalie noted above in relation to her

characteristics, *"I'm very moral, I'm very ethical"* [P3 Acute nurse 16 years]. Gina said moral values developed from socialisation and childhood nurturing pre-nursing,

> *'some of courage to me is a bit like you know, thinking about whether you view something as right or wrong, almost slightly black and white erm and so I think some of that you get from your background, how you're nurtured in thinking this isn't right' [P16 Community specialist nurse 30 years].*

Iacobucci et al (2013) study connects values with experiences which were then potentially further advanced through socialisation as a nurse, as Rosie said, "*now we're, we're encouraged to speak out when things are wrong*" [P13 Acute nurse 3 years]. This view is evidenced by Francis (2015) review "Freedom to speak up" which states 72% of NHS staff were more confident it was safe to raise a concern. Personal prerequisites are connected to professional prerequisites discussed in the following section of the chapter (4.3) as they are enhanced (or suppressed) through personal cultural and professional socialisation.

4.2.6 Extant literature fit with personal prerequisites to courage

The findings presented above suggest there are personal prerequisites to being able to realise courage as an adult nurse that are related to gender, personality and personal and professional socialisation which are all influential and entwined in realising courage.

In relation to gender, women are socialised to accept certain roles and behave in the way expected (Hoschild, 1979; Miers, 2000) and cultural socialisation is influential from birth (Lai and Lim, 2012) shaping how women perceive themselves. In nursing, despite progressions in gender stereotypes (Jinks, 1993 and Jinks and Bradley, 2004) gender as a social construction in a patriarchal NHS where men are more likely to be vested with power and status (McCarthy et al, 2008), continues to hinder nursing as a female dominated profession.

When considering the impact of gender on participants understanding and experience of courage, exploring intersectionality is essential. Gender in isolation as a social

category does not offer the depth of understanding that can be gained from exploring how gender intersects with other social categories. Crenshaw (1989) is credited with first recognising intersectionality in her study of race and gender discrimination. Intersectionality posits that practices, processes, actions and meanings are causal to and sustain social categories such as gender, class and race inequalities (Healey et al, 2011). Gender, for example will be modulated by these mutually inclusive social divisions and so is connected to forms of oppression including subordination (Anthias, 2012) as experienced by participants in this study. Healey (2011) states that even in organisations with highly developed equality and diversity policies, inequalities in all strands of diversity (disability, religion, beliefs and sexuality) continue to exist as these divisions are not acknowledged or understood (Ozbilgin et al, 2011).

Intersectionality acknowledges the influences of knowledge and power which inform gender, diversity and organisational theory and postulates that an individual's social identities are shifting planes derived from overlapping and or conflicting sources of knowledge and power and so are multiple and diverse (Styhre and Eriksson-Zetterquist, 2008 Booysen, 2018). Understanding the

micro, relational and collective identities situated within the meso structure of domination and the macro level societal group dynamic in the workplace enables a deeper understanding of how participants identities, including their gender were constructed (Booysen, 2018), maintained and operate within the organisational culture. In this research gender is co-existent within an organisational system of knowledge and power that compounds the multiple perspectives of intersectionality and influences the participants experience and comprehension of courage within the context of their gender.

Research has found that there are several factors which contribute to the development of personality including childhood interaction (Krizan and Suls, 2009). Personality can be defined in many ways, including characteristic patterns of interaction with the environment and is related to physiological processes (Olver and Mooradian, 2003). Genetic factors have also been posed as impacting on personality traits (Olver and Mooradian, 2003; Caspi et al, 2005; Rushton et al, 2008). Personality is linked with self-esteem and learned experiences (Krizan and Suls, 2009; Valizadeh et al, 2016) and self-esteem is also an important contributor to the

development of values (Iacobucci et al, 2013). Empirical evidence links personality traits and self -esteem, with self-esteem correlating positively with extraversion and negatively with neuroticism and although not so strongly, is correlated to the other three factors of the big five in the five factor model of personality (FFMP) (conscientiousness, neuroticism, extraversion, agreeableness and openness, Barrick and Mount, 1991; Goldberg, 1993; Krizan and Suls, 2009; Parks and Guay, 2009; Van der Linden, 2010; Kawamoto et al, 2017; Van der Linden; 2017). This is of relevance in nursing as those with high self-esteem tend to be able to persist longer after initial failure or in a futile endeavour (Eley et al, 2012), are more flexible, less dependent and more accepting of their strengths and weaknesses. There is an important relationship between self-esteem rising and falling proportionally to assertiveness (Ilhan et al, 2016) linking self-esteem to courage. Alessandri et al *(*2012) and Dar-Nimrod et al (2018) both found those positively rating their social attributes are more likely to evaluate themselves positively regarding self-esteem and that although self-esteem is influenced by genes, positive orientation could change through appropriate interventions, for example constructive socialisation. However, research indicates that women are more likely to suffer from

poorer self-esteem (Bleidorn et al, 2016) making this challenging for female nurses who require a positive self-esteem to display courage.

Research on human moral values presents the moral foundations theory describing the association of moral behaviour with five general moral domains: Harm / care, fairness / reciprocity, in group / loyalty, authority / respect, and purity / sanctity as the domains of intuitive or emotional moral judgements (Parks and Guay, 2009; Graham et al, 2011; Kawamoto, Van der Linden et al, 2017). Moral values are linked to socialisation through learned experiences and social interaction (Eley et al, 2012; Iacobucci et al, 2013) and although socialised behaviour is not necessarily directly linked to personality traits, values can temper their expression (Parks and Guay, 2009) confirming that a person's moral values system is mutable. Eley et al's (2012) study concluded that although not well understood, values are related to decision-making, have an impact on behaviour and are unavoidably entangled with personality. Values relate to our beliefs about we think we are expected to do, while personality relates to what we naturally tend to do. Eley et al *(*2012) state in their study

values do change particularly in adolescence and young adulthood, as new social environments facilitate changes in ones' values. Conversely Iacobucci et al (2013) state once established factors such as age and experience do not change nurses' values. The data in this study suggests women's age, maturity and experience can enable them to challenge their perceived subordinate status, change their perceptions, values system and realise their courage.

Of the above studies only Jinks and Bradley (2004); Hegney et al (2006); Iacobucci et al (2013) and Valizadeh et al (2016) had nursing as their focus, exploring stereotypes, values, self-esteem and personality respectively. Thorup et al's *(*2012) qualitative study did explore courage in nursing in the context of vulnerability and suffering. Commensurate with this study's findings, they found that both life and professional experiences were needed to realise courage described as a prerequisite inner quality. Numminen et al (2016) concept analysis of moral courage suggests that nurses who feel empowered over their own life may manifest courage, tenacity and self-esteem, inferring personal life is relevant and concurring with this study's findings providing a positive underpinning to the data. Thorup et al's (2012) study was in

Denmark and specific to the context of palliation and Numminen et al's (2016) study was in Finland and is a concept analysis of specifcally moral courage.

4.3 Professional prerequisites to courage

This section of the prerequisites of courage findings chapter outlines the professional prerequisites of courage. Table 12 shows the category and associated sub-categories.

Category	**Related subcategories**
Professional prerequisites to being courageous	• The nurse persona and courage • The Code; friend or foe in courage • Game playing and courage • Courage needs professional resilience • Professional trust as a prerequisite of courage • Professional support and encouragement as prerequisites to courage

Table 12. Categories and subcategories: Professional prerequisites to realising courage in the context of adult nursing

Similarly, to the personal prerequisites, professional prerequisites are not mutually exclusive and suggest adult nurses may hold or benefit from several of the professional prerequisites concurrently,

each interconnecting and providing the context for feeling or being courageous.

Using courage in their clinical setting appeared to depend on participants professional socialisation and identification with their persona as a nurse and the Code for nursing (NMC, 2015). Gender, personality and organisational culture were also implicit as professional prerequisites entwined with their professional socialisation influenced how the participants managed the people they collaborated with in the nursing context. Additionally, nurses' strength of character derived from their personality, moral values and professional team trust, support and encouragement within the organisation were important to participants, if these were lacking several participants reported feeling isolated and unable to display courageous behaviour.

4.3.1 The nurse persona and courage

Participants expressed how the nurse persona was an instrumental precursor of courage. Their courage stemmed from pride in their nurse identity and determination to uphold their nursing values. Wearing the nurse uniform helped them to don a frame of mind

engendering courage. In this sense the uniform set the scene for nurses, as Gina remarked *'I do think the uniform does something' [P16]* resonating with Adam and Galinsky's (2012) findings that wearing a uniform confers a deep psychological and behavioural effect. Sue infers that she had to act because she had her uniform on and so she rose to the occasion.

> *"I can remember a lorry, I had my uniform on…..and a lorry 3 cars in front tipped over and knocked a car over and I thought "bloody hell, I've got to get out of the car" so I got out the car……" [P7 Acute specialist nurse 27 years].*

The uniform appears to offer a form of transformation and identification with nursing or alternatively it could be symbolic of what Sue felt nurses stood for as advocates and protectors of the patient (NMC, 2015). Shaw, Timmons (2010) and Timmons and East (2011) respectively found uniforms enhanced confidence and subsequently patient care as the uniform helped to construct professional identity. Sam had a similar view as she said,

> *"I would sooner attend an road traffic accident in my uniform, because I'm more zoned into, I'm more, you know….if you haven't, you're not in the nursey*

mind…….it is slightly different having your uniform on," [P10 Community Nurse 33 years].

Several participants identified a differentiation between themselves at home and their professional nurse persona indicating that they could be courageous at work when in *'nursey mind'* in a way they would not at home. Responding to whether she was courageous at home Rosie replied, *'not out of work no, no I think I'm a bit of a wimp,' [P11 acute nurse 3 yrs].*

These quotes suggest a potential conflict for nurses. At work they are required to behave and act courageously (NMC, 2015) which is not always a natural stance for them in their personal lives. The uniform enables nurses to adopt an 'at work' nurse persona. As Sam said, '*I have a persona that I drive into and drive out of,' [P9 Community specialist nurse 33 yrs].*

Participants also spoke about the social change in the professional and public expectations of nursing. Nursing has become more autonomous as their role has changed over the years. Tosh (2007) observes it is now the nurses' duty to be knowledgeable and

assertive enough to exercise their judgement and the Code for nursing (NMC, 2015) is clear, nurses are accountable and responsible for their actions, intensifying the necessity for courage. Sam captures several participants train of thought regarding the changing requirement for courage as the nursing profession had evolved.

> *"Oh definitely……..you did what you were told when I qualified…… if somebody said "go and do it" you went and did it……. [now] we work more autonomously, our roles evolved considerably," [P10 Community nurse 33 years].*

The quote confirms the changing role of the nurse but as Skår (2010) writes, nurse autonomy depends on nurses ability to make choices, freedom to act and knowledge. Participants expressed freedom to act and making decisions were not always options available to them. This is explored further in the following chapter.

4.3.2 The Code, friend or foe and courage

Participants viewed the Code for nursing (NMC, 2015) as both a tool to direct action, advise and support them but also as a dictate

telling them what they must do to fulfil their nursing role. Penny implies there is a lack of choice underlying courage in nursing.

> *'I think you have to [have courage] because you've got your Code of professional conduct haven't you and that sort of gives you the, the tools, it tells you you've got to do things' [P9 Community specialist nurse 33 yrs].*

In the excerpt below, Rosie describes how she needs to be courageous fearing that if she breeches the Code she may lose her career. This suggests professional socialisation is robust regarding the Code, nurses are aware of its power and importance over their current behaviour as well as their future career.

> *"I don't know really, erm, I have this massive fear I suppose, of doing something wrong and then having everything I've worked so hard for being taken away," [P11 Acute nurse 3 yrs].*

This fear is not entirely unfounded. In 2016/17 5476 concerns regarding nurses practice were referred to the NMC (2016). Approximately two thirds of these were closed as there was no evidence "fitness to practice" was impaired and a very small

number (0.6%) resulted in removal from the register suggesting nurses may have an exaggerated fear of this. This is explored further in Chapter six (6.5.1).

4.3.3 Game playing and courage

The stories below were all given in the context of courage as defined in the nursing vision i.e. as speaking up and obtaining the right care for patients (CBCN and DHCHA, 2012). Natalie summarised her strategy to achieve the right outcome when she said, *'I say you catch more flies with honey than you do with vinegar' [P3]* referring to how she collaborated with colleagues by using a positive and helpful approach. This infers nurses use skills to manage people which Stein (1967, 1990) referred to as the Doctor Nurse game. Holyoake (2011) describes the doctor nurse game as a metaphor to illustrate the dynamics of the interactions of doctors and nurses. In the excerpt below, Maz had anticipated she would meet with resistance. None the less she was able to speak up and strategically ensured that she achieved the outcome she needed for her patient.

> *"I was waiting outside a doctors room to sign an insulin chart……and he [the doctor] looked me up and down and he said "I don't see patients like this" and I*

said, "could you sign this chart," ……..so he said "I can't do it now," so I said "that's absolutely fine, I'll leave it here, you go out and visit him, give him his insulin, when you sign the chart we'll take back over" [he said] "give it here" [P14 Community nurse 7 years].

The quote above details an interaction between a male doctor and female nurse inferring gender or the doctor nurse dynamic often viewed as male and female respectively is influential. However, in the instance below a female doctor is playing a similar game. These examples intimate the game is not exclusively a female-male game driven by gender and neither is it specifically a doctor nurse game. Game playing appears to be complex including elements of gender, overcoming the hierarchy and the confines of previous socialisation to expedite courageous care. In the exert below the doctor flatters Maz who intimates she is aware of the dynamics behind the behaviour,

"one of the doctors [female doctor] said "I know I'm just a doctor," …… but you're the nurse and this wound," and I said, "that's not really our remit," "yeah I know but you're so knowledgeable" [laughs]

and I thought "you're so cheeky…"[P14 Community nurse 7 years].

The courage in the above situation regards the nurse being able to challenge the doctor who, though using a disarming approach still maintains overall authority (British Medical Association, 2017). Nurses may also maintain a façade of their subordinate status to achieve their desired outcome. In the quote below Penny laughingly plays the doctor nurse game,

"we laugh about making sure we use the right words when we're emailing them [doctors], ……"I maybe sounding a little bit dim, however…." [P9 Community specialist nurse 33 years].

Stein in his second article on the doctor nurse game (Stein et al, 1990) believed the game had changed as nurses had become more autonomous and the doctor nurse relationships more collaborative. Holyoake (2011) challenges this and the participants in this study would appear to concur. Goffman (1956) an influential sociologist theorized regarding the presentation of self, positing we are all presenting a performance which may appear spontaneous, but as Penny's quote above suggests, we can convey to others our performance is only a show.

4.3.4 Courage requires professional resilience

To be able to nurse with its oft challenging situations and arduous circumstances, participants expressed they needed to be resilient. Polk (1997) and Herrman et al (2011) suggest resilience is the ability to positively adapt to difficulties, transforming adversity into a constructive experience and is related to personal characteristics and life circumstances. Alexia suggests courage is associated to the personal characteristics of strength and ability to *'never quit'* alluding to the internal nature of courage.

> *"I never quit, I have got this in me, erm, so, I don't know if that's courage or a bit of, like strength I suppose" [P5 Acute nurse 37 years].*

Resilience was spoken about by participants in relation to their personal prerequisites, but also was expressed as a professional prerequisite. Participants recounted occasions where work could be *'a real battle to go in'* [P15] and they needed the courage to *'come back'* [P5], relating to both junior and senior colleagues' behaviour towards them. In the former quote, Ruby's managerial role was consistently undermined by a junior team member. Dinndorf-

Hogenson (2013) found nurses fear reprisal from their peers more than from other professionals. Maz shed light on this as she spoke about how challenging it was to report a nurse colleague with whom she worked together with daily.

> *"I don't think I would report it unless it would be affecting the patients, losing the relationship has got to be a factor I think, because you have got to work together" [P14 Community Nurse, 7 years].*

4.3.5 Professional trust in the team as a prerequisite of courage

Participants said when the professional team worked cohesively as a unit and trusted each other courage was enabled more effectively. Firth- Cozens (2004) and Roth and Markova (2012) state that trust is fundamental to establish and maintain an effective team. Rosie said when she worked in effective teams she witnessed more courageous behaviours.

> *"Wards with good team work…….. I see courage being used more" [P13 Acute stroke nurse 3 years].*

Babiker et al (2014) state that the team members earn each other's trust and respect by their behaviours and actions. Alexia

expresses how courage is required when making requests of team members who do not know and trust you.

> *"So there's that trust thing as well in what you're saying……it's not courageous if people know you is it…….if someone doesn't know you and you have to explain your corner, that takes a bit of courage" [P5 Acute nurse 37 years].*

Courage was not always perceived as a solitary endeavour. Participants reported using the team strategically when they needed courage, for example in a meeting. In the excerpt below, Gina illustrates how potential dissension by the organisational team is mitigated against by enlisting other team members as allies. This approach could be associated with game playing,

> *"before a meeting, because that's often where I find I need to be courageous, if I can run it [her idea] by someone who I think will be an ally, that's sometimes really helpful….then you've got two of you in agreement, think courage comes with that,"[P16 Community specialist nurse 30 years].*

4.3.6 Professional support and encouragement as prerequisites to courage

Closely linked to an effective team dynamic, most participants talked about professional support and encouragement and that lack of their presence impeded courage. Alex outlines how despite the ward being full the nurses were instructed to accept another patient. In this situation the authority of the doctors is seen to override and deride the nurse, reinforcing the established hierarchy,

> *"the doctor had said to one of the nurses, "it's far cheaper to lose a nurse than it is to lose a doctor and I thought if we've not got support from doctors what have we got…..you can have the courage to stick up to them and document the argument, put an incident form in but you are cheaper to get rid of." [P4 Community nurse 15 years].*

Professional encouragement was also a professional prerequisite enabling courage. Hee Noh and Lim (2015) link encouragement to enhancing internal locus of control, resilience and significantly self

- esteem. Participants explained how their nurse colleagues could profoundly affect their confidence and subsequent ability to be courageous by encouraging and believing in them. Alex talks about her colleague showing her things as she was newly qualified and highlighting the importance of socialisation through role modelling.

> *"I had a particular nurse that would encourage me, and showed me how to deal with things as a newly qualified nurse, and people believe in you, when people invest in you, and they give you that courage, they inspire courage in you, to grow,"[P4 Community nurse 15 years].*

4.3.7 Extant literature fit with professional prerequisites to courage

The findings presented above suggest there are professional prerequisites to being able to realise courage as an adult nurse and these are influenced by professional socialisation, gender, cultural socialisation and the organisational culture and are emmeshed with the personal prerequisites towards realising courage.

Professional socialisation is crucial because the nurse persona and sense of belonging is formed through early professional socialisation (Shaw and Timmons, 2010 Timmons and East, 2011 and Zarshenas et al, 2014) and the Code for nursing (NMC, 2015) is instrumental in this process. Role models are important (Dinmohammadi, Peyravi and Mehrdad, 2013; Zarshenas et al, 2014) and individuals learn their responsibilities through positive role modelling and education (Dinmohammadi et al, 2013) which can increase self-esteem influential in professional growth (Iacobucci et al, 2013; Valizadeh et al, 2016). Education and competent role models can facilitate socialisation (Lai and Lim, 2012) and without education or positive role models the negative consequences of inadequate socialisation maybe frequent staff turnover, ritualized practices, role ambiguity, lack of critical thinking and desensitization towards holistic patient care (Dinmohammadi et al, 2013). Cultural socialisation is also influential, Lai and Lim's (2012) paper states initially individual perspectives are internally adopted through birth inheritance and cultural socialisation and are subsequently reinforced by the organisations people work in.

Gender is implicated in the way nurses manage their collaborations with people, as Stein (1967) said the most important rule of the doctor nurse game was to avoid disagreement, to be bold yet appear passive as subordinate females. Holyoake (2011) suggests this has not changed despite Stein (1990) believing it had. Closs (2001), Tosh (2007) and Holyoake (2011) conclude the game remains in play and Churchman and Doherty (2010) also confirm the link to gender as they observe nurses use female charm to influence doctors.

Collaboration is key to an effective service but is impeded through the entrenched power and gender inequalities (Closs, 2001 and Reeves et al, 2008). Game playing enables collaboration, albeit by indirect methods such as pretending to be dim, using charm or subterfuge to obtain the required outcome.

Collaboration and game playing could be viewed in terms of emotional intelligence, a skill recognised as required in nursing and traditionally attributed to women (Ben-Noam, 2018; Kaya et al,

2018). Emotional intelligence is defined as the interrelated emotional and social skills that determine how we understand, express ourselves and relate to others (Cleary et al, 2018) and is linked to personality as people who score highly on the general factor of personality (GFP) (a underlying combination of the big five), are observed to have increased social effectiveness, for example popularity and likeability and are more likely to achieve leadership positions (Van der Linden et al, 2010). Additionally GFP is of particular relevance to nursing as it has been observed to strongly overlap with emotional intelligence (Van der Linden et al, 2017; Di Fabio and Saklofske, 2018).

Goffman (1956) believed that individuals act in a calculating way deliberately expressing themselves to evoke the required response. Participants in this study demonstrated this by for example, pretending to be dim. Goffman also observes people learn to behave this way due to the tradition of the group or their social status that requires it. As Parmelli et al *(*2011) note, the basic assumptions created by the group and taught to all dominate as the right way to perceive, think or feel in relation to any

problems, linking this professional prerequisite to the organisational culture.

Professional socialisation and the organisational culture are influential to professional resilience which is viewed as a required skill of nurses (Hee Noh, Lim, 2015; Traynor, 2017). A hallmark of courage is said to be persistence or resilience (Pury and Kowalski, 2007; Rate et al, 2007) and Herrman et al (2011), Eley et al (2012), Hee Noh, Lim (2015) and Montes-Hidalgo and Tomas-Sabado (2016) all connect enhanced resilience to positive self-esteem, the individual's moral values, personal characteristics and life circumstances, demonstrating an association between the personal and professional prerequisites. Thus, if the personal prerequisite of self-esteem is unhealthy a nurse will be unlikely to possess the professional prerequisite of resilience.

The organisational culture is also implicit regarding professional trust, encouragement and support. The participants thoughts around these factors resonate with Babiker et al (2014) and Kieft et al *(*2014) who found effective team work, trust and respect

positively effect patient safety and outcome. Francis (2013) found patient safety was adversely affected if courage were not present inferring professional trust is instrumental to enabling courage. Supporting this, Manning (2008) writes that Goffman believed trust underlies any interaction within organizations. Macdonald et al's *(*2018) thematic review links encouragement and support to heroism which could be considered synonymous with courage. MacDonald et al suggest heroism can be cultivated in environments that offer support and encouragement, however, being expected to behave heroically in a toxic environment that does not acknowledge the intersectionality between factors such as sexuality, race, gender, power and knowledge is challenging and potentially unachievable without educational support (Iona et al, 2018). The Kings Fund report (2012) into leadership and engagement to improve the NHS, states staff support, recognition and encouragement is critical, connecting these with working in an effective team.

None of the extant literature was focused on courage in nursing and not all of it was concerned with nursing deriving from psychology and sociological work. However, the extant literature

demonstrates a fit with the findings of this study and supports this study's conclusions when applied to courage.

4.4 The origins and development of prerequisites to courage

Table 13 outlines the category and associated sub-categories related to the origins and development of courage.

Origins and development of courage in nursing	• Courage is innate or develops • Courage develops with knowledge, experience, and confidence • The role of education in courage

Table 13. Origins and development of courage as prerequisites to courage

Similarly, to the personal and professional prerequisites the subcategories are not mutually exclusive and each potentially links with the others. Justifying these subcategories as prerequisites, if courage is believed to be innate it is derived prior to nursing. Additionally, knowledge, experience, confidence and education preceding entry to nursing may contribute to later courageous behaviours.

The origins of courage were perceived to be either innate, developed by early cultural socialisation and or enhanced by professional socialisation. Gender was also implicit in how participants perceived their courage developed.

4.4.1 Courage is innate or develops

Opinion was mixed regarding the origins of courage. Courage has been identified as an inner motivation or quality and as inherent (Ford Walston, 2004 Arman, 2007 LaSala and Bjarnason, 2010 and Crigger 2011). The excerpt below illustrates Ruby's belief in the innateness of courage and its internal quality.

> *"I think it's in you, I really think it's in you, because how can you, it sounds really deep I guess, but how can you, teach someone to feel, to feel something, if it's not there…..I'll argue with anybody that I think it's in you"[P15 Community nurse 13 years].*

However, other participants viewed courage as situational connected to a precursor precipitating the act of courage and that courage could be cultivated. In the quote below Gina refers to courage for a patient but also refers to other occasions that may

be outside of her clinical practice. This reveals two diverse viewpoints. One that courage is innate and internal, the other that courage is *'for'* a purpose, has a referent and can also be developed. Gina said,

> *"courage goes with something, it's not just an abstract thought, its courage for something whether it's your patient or an issue, so I think some of it comes from there, but I think it's something you develop as well" [P16 Community specialist nurse, 30 yrs].*

The idea that courage may be developed was considered by participants in terms of their growing knowledge, experience and subsequent confidence in their practice setting, influenced by both personal and professional experiences.

4.4.2 Courage develops with knowledge, experience and confidence

Knowledge was observed to be a powerful prerequisite to courage (Clancy, 2003; Lachman, 2010). Participants suggested they could draw on their experiential knowledge giving them the confidence to be courageous. Knowledge has been included as prerequisite as although knowledge may develop with experience in the clinical

setting, knowledge also needs to be present prior to applying it in courageous behaviours and may derive from personal experience prior to nursing. Sue observed,

> *"knowledge is another powerful thing, isn't it? …..that gives you courage"[P7 Acute specialist nurse 29 years].*

Participants acknowledged that influenced by gender and underpinned by divergent priorities there were power imbalances between doctors and nurses when using knowledge (Porter, 1991 Turnbull, 2016). Sue reveals her belief that female nurses may not have the superior knowledge of the doctor and challenging their knowledge for the patients' best interest takes confidence and courage.

> *"I think women, as well as nurses you know, you don't know everything, and, doctors do train you know, their training is far more, and some of them are very intelligent, but sometimes it's [their decisions] not always in the patients' best interest, and it's hard to challenge that" [P7 Acute specialist nurse 29 years].*

Sue offers an insight into how gender and socialisation influences nurses perceptions. Churchman and Doherty (2010) and Holyoake (2011) recognise doctors' knowledge is perceived as superior because doctors possess exclusive scientific knowledge leaving nursing continuing to search for its own identity among other professional groups (Hallett, 2007). Several participants acknowledged they would not act if they felt their knowledge was incomplete inferring nurses lack confidence unless sure of their knowledge. Thorup et al *(*2012) and Ekström and Idvall (2015) found nurses needed to be confident in and trust their knowledge. Jill observes as knowledge increases, confidence and courage increase exponentially.

> *"I think knowledge definitely, because you can't just be like a bull in a china shop, because sometimes you haven't got the knowledge to back it up. I think the more knowledge you've got the more you can be courageous,"[P6 Community nurse 30 years].*

Participants reflected on the challenge of making decisions which Smith et al (2008) observe involves a multiplicity of factors and requires the knowledge demanded of the situation including '*knowledge of the team and the organisation' [Gina P16],* to be

courageous. Participants also related back to professional prerequisites of trusting their colleagues and relying on them for support to enable their courage (4.3.5 and 4.3.6), suggesting there are multiple factors that apply to using courage. Nurses feeling that they cannot be courageous without peer support implies they lack sufficient confidence in their own knowledge to make decisions and act upon them. The authority to make decisions is ascribed to Doctors as their medical licence bestows legal authority to them (British Medical Association, 2017) giving them a power base (Nugus et al, 2010) and this subordination and inequality can remain a barrier to courage for nursing (Churchman and Doherty, 2010). Rosie thought nurses feel they need to verify their decisions before acting,

> *"definitely more to courage than just having the knowledge, I think it's definitely having peers to discuss that with before you make a decision," [P11 Acute nurse 3 years].*

Experience, closely connected to knowledge was viewed as important in the origination of courage. However, this was not accredited to life experience as considered earlier in personal

prerequisites (4.2.2), but to experience in nursing practice defined here by Rosie as '*learnt experience,'*

> *"I think courage is a lot, is to do with knowledge isn't it, its learnt experiences give you courage…I get courage a lot from my colleagues" [P13 Acute nurse 3 years].*

The terminology used in the above quote is interesting as experience cannot be learnt, rather you learn from experience which Rosie connects to knowledge and subsequently her courage. In the above excerpt and in the quote below, Rosie also draws confidence and support into the theory reiterating as above that as well as trusting and gaining support from their colleagues, nurses need to trust in their own knowledge (Ekström and Idvall, 2015).

> *"I think you need to have confidence to believe in what you've learnt, to use that knowledge" [P11 Acute nurse 3 years].*

The participants view on their learning through experience, knowledge and confidence is indicative that courage is a skill that can be taught.

4.4.3 The role of education in courage

Participants talked about courage in relation to their nurse education. Gina below recalls being taught early in her nurse training not to "*rock the boat"* but nowadays [as women and nurses], expectations have changed and nurses are now required to challenge and can pursue more autonomous careers (NMC, 2015). Providing context to the quote below, the researcher asked Gina to clarify an earlier reference she made to "rocking the boat." Gina's response implies that more senior nurses, not taught to challenge may find courage difficult. She also implies that as women and often part time, nurses may struggle to be taken seriously as an influential and essential part of the work force.

> *"I think that's to do with what we are as nurses [laughs], we're women aren't we, we're mostly part time….so I think, we didn't start by rocking the boat [being courageous] did we, that wasn't what we were taught to be,"[P16 Community specialist nurse 30 years].*

Churchman and Doherty (2010) state one of the characteristics of the gendered division of labour is the fact many women work part time and Miers (2002) and Royal (2012) found that nurse education is perceived as less intellectual due to its practical elements, a view potentially reinforced by socialised family values and beliefs. Rosie, a more junior participant supports Gina's view, proposing that as nursing education has changed to include more focus on nursing autonomy and has become a degree course (Ford, 2009) junior nurses may find courage comes more naturally. Rosie suggests during her more recent education, courage was a clear expectation and became synonymous with her subsequent nurse identity. The use of the word "empowering" is significant suggesting a different turn in nursing to the oft perceived hierarchical subordination and inferiority (Churchman and Doherty, 2010).

> *"I think it's easier for people like myself, who've only been qualified you know, a few years, because you've almost trained in that way, you're given, you're empowered with that courage during your training," [P11 Acute nurse 3 years].*

An analysis of the data suggests that education and learning are prerequisites for the ongoing development of courage. The quote below partially attributes this to education but also to the work environment and feeling empowered, inferring that the organisation and working environment also engender courage. Gallagher (2010) states that organisations have a responsibility to encourage courageous behaviours. However, Rosie suggests this is not everyone's experience as she said,

> *I'm very lucky you know, the University and where I work have given me, you know, give me the ability to empower us….. give you the knowledge and the ability and courage to do it, [P13 acute nurse, 3 yrs].*

The final quote considers whether courage is natural or learnt. If both as Alexia suggests this supports the notion that though potentially innate, courage can also be taught. Miller's (2005) definition and development of moral courage paper states that Aristotle believed courage to be a moral virtue and was not innate. Purtilo (2000) and Clancy (2003) both propose courage can be taught, Alexia concurs.

"I do question, is courage a natural part of you or is it learnt behaviour…..I think a lot of it is learnt" [P5 Acute nurse 37 years].

4.4.4 Extant theory fit with origins and development of courage

The findings presented above suggest the origins and development of courage are linked to gender, cultural and professional socialisation and the organisational culture. Personal and professional prerequisites are also influential factors in the development of courage.

Ford Walston (2004), Arman (2007) and LaSala and Bjarnason (2010) all talk about courage as an inner quality or motivation and thereby see courage as inherent. However, this does not necessarily mean that courage is exclusively innate. The Greek philosopher Aristotle believed courage to be a moral virtue that can be received from another developing from cultural socialisation and moral values (Miller, 2005), supporting its inclusion as a prerequisite. Several writers have posited theories that fit with courage as a developing skill. Thorup et al (2012) and Ekström and Idvall (2015) discuss nurses' confidence and trusting in their

knowledge as instrumental in enhancing their courage. One of the difficulties with nursing knowledge is because nurses are dispossessed of specialist scientific knowledge, which is considered to be superior knowledge, nurses feel their knowledge is denigrated or excluded and erodes their trust in their own knowledge (Stein et al, 1967, Churchman and Doherty, 2010 and Holyoake, 2011).

Concerning education in courage, Purtilo (2000) and Clancy (2003) believe courage can be taught because techniques can be learnt, for example to deal with conflict and make decisions which can then enhance the ability to be courageous. However, Nugus et al *(*2010) and Churchman and Doherty (2010) observe that due to the power base and hierarchical nature of health environments, nurses may still find being courageous challenging. Schein (1996) recognises organisational culture and the basic assumptions invented, discovered or learned by the group are important to the organisation's effectiveness and organisations need to take responsibility for enabling environments in which courage flourishes (Gallagher 2011), Parmelli et al, (2011) opine this is difficult to achieve.

Reinforcing the potential for education in courage, Macdonald et al *(*2018) suggests learning the skills for heroic behaviour is effective in increasing courage and can be achieved through socialisation and education, strengthening the importance of professional socialisation which can be facilitated by education (Lai and Lim 2012).

Krizan and Suls (2009) and Valizadeh et al *(*2016) found courage to be rooted in personality implying that while personality characteristics may have some genetic roots (Caspi et al, 2005) and develop early, courage remains a quality that can develop and grow. This research infers courage could have an innateness for some people but can also be developed and learnt through personal experiences, personality, cultural socialisation of moral values and professional socialisation and education. As a partially heritable trait this relates to the personal prerequisites as cultural moral values, personality traits connected to genetics, self-esteem and cultural socialisation all bear influence early in development (Olver and Mooradian, 2003; Caspi et al, 2005; Rushton et al,

2008; Krizan and Suls, 2009; Eley et al, 2012; Iacobucci et al, 2013).

None of the above studies related specifically to courage in nursing but explored socialisation, education, caring, leadership, self-esteem and personality, both in nursing and in the world. However, many of the studies offer similar findings to the context of this study and resonate with participants thoughts on the positions they find themselves in related to courage in nursing.

4.5 Reflexivity on my construct as a woman

Reflexively considering my interaction with the participants regarding their understanding and use of courage is important in the co-construction of the grounded theory (Charmaz, 2014). Reflexivity enables recognition of the intrinsic and extrinsic constructs influencing the research process (Engward and Davis, 2015).

At the end of each findings chapter a different influential construct regarding the co-construction will be reflexively considered. Gough (2003) writes we all have different selves and performances that

we give, insight into these selves and our performances inform our interpretation ultimately influencing the co-construction (Goffman, 1956; Parker, 2005). Firstly, I will explore how my position as a woman influenced my interpretation and co-construction of the data and analysis and contributed to the emergent theory of courage.

All the participants are women and this will have influenced how I responded to them and co-constructed their stories. Berger (2015) notes that my worldview and background as a woman (appendices 10a) will have affected the way I used language and the lenses I selected for filtering information. I changed how I presented myself depending on the participant and how I judged them to be as a woman. Pini (2004) writes in her research this may range from playing dumb, to being sisterly, well informed or brusque. I felt motherly towards Alex due to the difficulty of her circumstances, this was conversely to Sam whose closed body language made me feel less connected to her and more self-conscious. I realised my sense of personal identification as a women and admiration for participants like Alex who had survived challenging situations (appendices 10b) caused me to feel a

deeper connection with Alex than with Sam. These dynamics may have subconsciously influenced me to select Alex's stories over Sam's and affecting how I subsequently co-constructed the material. Identifying how my own experiences as a woman (appendices 10a) were part of the co-construction in understanding the participants stories is a reflexive strategy, however identifying too closely with a participant can affect interpretation (Berger 2015) as I will have tended to make more meaning of their stories.

Penny talked about playing games with senior colleagues to obtain the outcome she wanted. This resonated with me as I could recall where I had used similar strategies in my personal and professional life (appendices 10a). Reflexivity enabled me to consider the implications of gender within the co-construction. Had I not had similar experiences to Penny I may not have picked up on gender as a potential theme. Additionally, my own constructs may have led me to develop this theme more explicitly. Prior to this study I had not considered the effect of my gender in either my personal or professional life however, gender is strongly internalised and assignations of value and worth are cultural and

symbolic (Bryant and Pini, 2009; Berger, 2015) so despite my lack of awareness, the influence of gender was implicit.

Intersectionality describes the multiple entangled categories of identity that make up an individual and how power is attributed as a result. I have experienced life as not only gendered but classed and racialized. As a white person, which as a race is constructed as socially privileged, I have access to power and privilege that I did not earn, implying that even though I would not intentionally act in a discriminatory manner, my historical location as a privileged group may render me unaware of my located power (Van Herk et al, 2011). This is congruent with social constructionism which views power and knowledge as indivisibly linked and gender itself as socially constructed. My own beliefs and experiences of gender will have influenced my research co-construction and I must question my own assumptions regarding intersectionality, social categories and identities which in turn will have been defined or imposed by the powerful (Else-Quest and Shibley Hyde, 2016).

Reflexivity has helped me to see where I may have interpreted meanings in certain ways due to my position as a woman and due to my own cultural socialisations and consequent assumptions of others. Pini (2004) observes, depending on variables such as gender or age, researchers adjust their performance as they interact with different participants and both are engaged in an exercise of presenting themselves to each other and to the wider community who receive the research (Finlay 2003).

4.6 Conclusion

The co-construction of the prerequisites to courage creates a complex picture. The emerging theory suggests enabling courage in nursing depends on personal and professional prerequisites linked to gender, personality, cultural and professional socialisation and the organisational culture. These are not mutually exclusive, and all interact. The personal and professional prerequisites relate to each other; the nurse persona and Code for nursing are influenced by cultural moral values, game playing by gender and life experiences, resilience depends on personality characteristics, cultural moral values and a healthy self – esteem and trust, support and encouragement are also related to a positive self - esteem. The origins and development of courage are also related

to the personal and professional prerequisites as has been demonstrated by the findings suggesting that cultural and professional socialisation are implicit in the origins of courage.

The emerging theory suggests some prerequisites are present prior to commencing nursing and some develop further during nursing. Additionally, the organisational culture sets the tone to enable nurses to achieve courage, by embracing and rewarding courageous behaviours the organisation can positively impact on the nurses' ability to realize their courage when required.

Nurses continue to be directed to use courage enforced by the Code for nursing and nursing vision (Cummings, 2012; NMC, 2015) yet ultimately find they may be treated as subordinate, overridden or ignored within the organisational culture. Nurses need more than a directive to be courageous. Oakley (2015) notes even in the best health care organisations things do go wrong and therefore there will always be a need for courage. Further themes related to nurses understanding and use of courage are continued in the following two chapters.

Chapter 5 The meaning of being courageous in the context of adult nursing

5. Introduction

This is the second chapter of three presenting co-constructed findings from the collected data. This chapter explores the participants thoughts on the meaning of being courageous and acts of being courageous. These resonate with the prerequisites of courage chapter findings. The interpreted data contributes to the emergent grounded theory of participants understanding and use of courage in adult nursing. A section on reflexivity cross referenced to appendices 10 concludes the chapter.

5.1 The context of the meaning of being courageous

Participants found courage difficult to define and most suggested they did not see themselves in this way setting the early context and tone of the analysis. As discussed in the preceding chapter, perceptions of ourselves, our beliefs and values are deeply rooted through societal norms beginning from an early age (Parsons, 1954; Hoschild, 1979; Miers, 2000; Dinmohammadi et al, 2013), relating to the prerequisites of courage presented in Chapter five.

Maz's response was typical as to whether participants saw themselves as courageous as a nurse.

> *"No, no I wouldn't describe myself as courageous" [P14 Community nurse 7 years].*

Courage was a nebulous concept and without exception participants had not thought about courage, implying that they had not considered courage's place within the 6Cs nor engaged with this aspect of the nursing vision. An explanation for this could be as Hallam (2000) Meerabeau (2001) and Mason et al (2017) observe, nursing gendered as female is invisible to policy makers, moreover policies often arise from conflict rather than consensus (Merrabeau 2001). Resonating with Merrabeau's (2001) view the Francis report (2013) into unnecessary deaths in an NHS hospital was published within months of Cummings and Bennett's (2012) nursing vision addressing some of Francis's recommendations. Additionally, courage appears to have not garnered the same interest as for example, compassion in nursing which has been extensively studied (Cummings and Bennet 2012; Parr 2012; Baughan and Smith 2013; Curtis 2014; NHS England 2014b, 2014a; Bradshaw 2016). Below the use of the word *'strange,'* infers Molly did not see courage as relevant to her, that it was an

alien concept or perhaps that it was taken for granted. However, participants almost unanimous denial in seeing themselves as courageous suggests the latter is unlikely. Molly said,

> *"it's a strange concept, I hadn't really thought about it [courage] much until you sent a flier out." [P12 Specialist community nurse 28 yrs].*

In the following excerpt Gracie was uncertain whether courage was needed by all nurses. As she considered this she concluded courage was a necessity and reiterating nurses lack of recognition of courage.

> *"I think if you don't [pause] you can, not that you couldn't be a nurse without courage….maybe if you don't have courage, you maybe need something else, so if something does come up, and you just don't, not that you just do it, and you think "oh that's wrong," so I suppose then, that is courage really, so I suppose yeah maybe you do" [P2 Acute nurse 7 years].*

Participants also suggested they struggled to perceive courage as a nursing and or female quality hinting at deeper held views of

themselves as women. Gracie verbalized this as '*the polite little nurse*' [P2]. Participants said they often viewed courage as physical and associated with generically male dominated professions (Ford Walston, 2004; Miller, 2005) and Crigger (2011) posits nurses do not associate themselves with courage believing it only applies to danger or threat. This reinforces the dichotomy nurses face, between arguably the taken for granted view of nurses as caring and nurturing (Rhodes et al, 2011; Aranda et al, 2015) versus being required to be courageous. Gracie says nurses' need to *'dig deep'* to see themselves as courageous suggesting that it is challenging to overcome gender and socialised perceptions, or that nurses do not easily recognise courage within themselves,

> *"you wouldn't necessarily put courageous with nurse, you might put courageous with like, policeman or fireman, whereas nurse you think, oh caring, just that polite little nurse, you wouldn't put that with courageous, but I think once you dig deep you think, 'oh no definitely you are.' [P2 Acute nurse 7 yrs].*

Louise echoed Gracie's thoughts that nurses were perceived through their feminine qualities and not with the strong or manly qualities that she felt courage necessitated,

> *"you often associate courage with being physically strong or dominant... rushing into buildings and saving people and as nurses….we perceive ourselves and others perceive us, much more as caring, gentle souls, so how can you be courageous if your being gentle and caring? ……. I guess it feels quite a erm [pause] not aggressive, but quite a positive, you know, courageous is a very positive manly thing" [P8 Community specialist nurse 28 yrs].*

Ellemers (2018) review of gender stereotyping notes that conventional expectations not only define us but also affect how we believe men and women differ. Maz summarises how most participants felt about being courageous,

> *"oh no I don't think I'm really courageous, I'm you know, just me, I'm just doing my job" [P14 Community nurse, 7 years].*

The centrality of the patient, caring and compassion are the foci of nurses professional socialisation (Hemsley-Brown and Foskett 1999; Eley et al, 2012 and CBCN and DHCHA, 2012) and several participants influenced by their cultural socialisation said they expected to be compassionate and caring, but did not expect to need to be courageous. The following section of this chapter explores the meaning of being courageous.

5.2 The meaning of being courageous

Table 14 shows the category and associated subcategories generated during the analysis regarding the meaning of being courageous.

Category	Related subcategories
The meaning of being courageous	• Being protective and yet fierce like a lion • Taking psychological risks • Facing difficult or disliked situations • Sometimes putting myself first

Table 14. Categories and subcategories: The meaning of being courageous

The meaning of courage for participants emerges as connected to the prerequisites of courage. Cultural socialisation and gender appear to have influenced the participants' beliefs about

themselves and their subsequent professional socialisation established their beliefs regarding the nurse persona and the expectations of them as nurses.

5.2.1 Being protective yet fierce like a lion

The meaning of being courageous incorporated a cognitive level as participants talked about what courage meant to them personally. Two participants [Jo P1 and Sam P10] spontaneously used animal imagery to illustrate what being courageous meant to them and this seemed to help them overcome their difficulty in describing courage's meaning. This line of thought was pursued with later participants who were asked; if they had to describe themselves as an animal in relation to courage and nursing what animal they would choose and why? In the exemplar quotes below Rosie and Sue chose two apparently diverse animals, a lion and a swan, however in nature both these animals display similar protective caring qualities, yet both are capable of being fierce highlighting two apparently disparate nursing traits. Rosie and Sue said.

> *"I think I'd probably be a lion, because I think that, I'm quite fierce and protective" [P13 Acute nurse 3 yrs].*

"I think I would have to say a swan, with big protective wings to protect and care for our patients" [P7 Specialist acute nurse 29 yrs].

Rosie connects protection with fierceness proposing an additional dimension to the perceived traditional nurses' caring and compassionate role (Rhodes et al, 2011; Parr, 2012 and Aranda et al, 2015) and resonating with being courageous.

Asking the participants to identify with an animal led to three more lions, a giraffe (*'I may feel small and insignificant inside but will appear to be tall' P15*), a Rottweiler, terrier and sheep dog *('they've got a little job and they're on it' P16*) and a duck *('serene on top paddling furiously underneath' P12*). Being courageous appeared to mean standing tall, doing their job and yet appearing calm. Nurses' view of themselves as '*small and insignificant'* with a '*little*' job to do potentially explains why participants found difficulty relating to courage and implicates the influences of socialisation and gender. Maz chose a cat from the opposite end of the cat family spectrum to the lion. However, the overall

symbolism was similar, again linking the *'softer'* side of nursing but using the same phrase as Rosie adding, *'I could be fierce,'*

> *"Probably a cat, a nice little pussy cat…..they're nice and I hope I'm nice to my patients….I don't know, I could, I could be fierce if I'm needed to be for my patients" [P14 Community nurse 7 yrs].*

The use of animal imagery encouraged further clarification and articulation of participants thoughts. Many of the participants agreed the caring nurturing role of the nurse was expected prior to starting their nursing career; "*everyone always says [you need] caring"* [Gracie P2] influenced by participants' prior cultural socialisation regarding the nurse persona. However, the 'fierce' role of the nurse and courage had not been previously considered, as Gracie added *"You wouldn't necessarily put courageous with nurse"* [P2].

Advocacy encompasses protecting and fierceness. Advocacy is defined as arguing for and defending an individual's rights (Cole et al, 2014). Participants regarded advocacy as their most important

concern. In the excerpt below Jill was asked what courage meant to her as a nurse,

> *"be the patients advocate is the most important one, erm, whether its children, adults, elderly you name it, they are your primary concern and I think it brings out something in your inner self to er, know that you are in that position," [P6 Community nurse, 30 years].*

Sam also talked about advocacy as she spoke about the 6Cs. Sam felt she had been working to the values of compassion, caring, competence, communication and commitment for years but she had not identified with courage. Sam's view was advocacy did not begin with a C, so the term courage was used,

> *"but I did sort of feel courage, I did think, don't they mean advocacy?" [P10 Community nurse, 33 years].*

As discussed earlier (5.1) this provides further evidence of a lack of ownership or engagement with the nursing vision.

5.2.2 Taking psychological risks in being courageous

Alexia expresses her view regarding the inherent risks when she said, *"courage is having the ability to meet a difficult challenge despite the physical, psychological and moral risks in doing so," [P5 Acute nurse, 37 yrs].* Surprisingly despite the well documented context of violence and aggression that nurses face (Merrifield, 2014) no other participants mentioned the physical risk associated with nursing. The moral risks were also not elaborated on further by participants although Alexia said she felt nursing was more to do with *"moral courage"* [P5]. The psychological risks mentioned by several participants and were defined by Alexia as *"understanding [patients' experiences] and the courage of being able to deal that."* Gracie said there were different aspects of nursing and one of these was the *"psychological side"* adding *"you are courageous in different ways"* [P2].

5.2.3 Facing difficult or disliked situations

Another perceived situation that required courage, also found by Spence and Smythe (2007) was going into work and the psychological courage required to do so. The context to the quote

below describes how going into work sometimes felt. Rosie recalled how on occasion she sat in her car for twenty minutes summoning up the courage to go in for her shift. She adds that she did not anticipate needing courage as much as she does implying she had not considered this aspect of nursing.

> *"I did not expect to have to give myself a bit of a pep talk in the car some mornings….. I definitely didn't think that I would need courage, as much courage, as I do some days in nursing," [P11 Acute nurse, 3 years].*

It seems an ignominy that nurses said they needed to be courageous to go into work and implies the emotional labour of nursing is underestimated (Allan, 2016).

5.2.4 Courage means sometimes putting myself first

Being courageous was also talked about by participants as doing something for themselves which was often viewed as a selfish act as opposed to being altruistic. The Code for nursing (NMC, 2015) states nurses must altruistically put the interests of others first.

Natalie's perception is that she is not being altruistic and conversely is selfish,

> *"for myself, courage is a selfish act, I do it for my own benefit, you know, I don't do it just to be this altruistic wonderful human, I do it because it makes my life easier as well," [P3 Acute nurse 16 years].*

Other participants also spoke about how they used courage to achieve something for themselves. The context to the quote below was Alex's courage had been eroded by her professional and personal experiences. She suffered from poor self-esteem and Alex felt professionally her manager "*just made me feel rubbish for a long time"* [P4]. This had escalated to the point where Alex needed to be courageous to leave her current situation and apply for another job. This infers the organisational culture was not conducive to Alex's personal development, she felt trapped in her situation and had to be courageous to escape. Gallagher (2011) writes that leaders need to lead by example but as Francis (2013) reports, staff are deterred from action due to fear and bullying. The Francis report was written in the context of speaking up to protect patients, however appears to also apply to nurses who report suffering at the hands of their seniors.

"I had to be courageous to get out, having the courage to go for that job," [P4 community nurse 15 yrs].

Alex also felt her time off to have a baby limited her opportunities and required her to use courage to gain a better life for herself. This suggests that the social expectations of being a woman, part time worker and mother can limit nurses' development opportunities (Churchman and Doherty, 2010) and means that they must be courageous to change their circumstances.

"I thought I don't want to be left behind this time, I've had a baby but it's not going to limit my opportunities, so I had the [laughs] I had the courage" [to apply for a course] [P4 Community nurse 15 yrs].

In this sense nurses need to stand against the might of societal and organisational expectations and culture if they want to progress. The participants experiences suggest that despite women being a majority of over 85% of the NHS workforce (McLaughlin et al, 2010) they need to be strong psychologically to protect and gain their rights as women in a patriarchal organisation (Miers, 2002; Jinks and Bradley, 2004).

5.2.5 Extant literature fit with the meaning of courage

The findings presented above suggest the meaning of courage to participants was influenced by the prerequisites to courage derived from their gender, personality, cultural and professional socialisation. These factors all contributed to the participants overall understanding of the meaning of courage in their practice.

Considering the fit of the emerging theory with extant literature, the complexity of courage and the difficulties participants had in expressing it, requiring projective techniques to articulate their thoughts (Bond et al, 2011) reflect the findings of Rate et al (2007) and Woodard and Pury (2007) whose studies in the context of psychology found courage too complex to define. The nursing vision provides a nursing definition of courage (Cummings and Bennett, 2012) but this does not appear to have been embraced by participants in this study who unanimously had not thought about courage prior to this study. The emerging theory adds depth and clarification to the ways in which nurses themselves interpret courage.

Gordon (2006) suggests nurses are socialised to talk about themselves in the most highly gendered way, emphasising their skills of caring and compassion, trivialising their complex skills and knowledge and reproducing and reinforcing the traditional view of the nurses both internally and externally. This may be an explanation why nurses could not define courage and perceived they were only doing their job (Crigger, 2011). Nurses find themselves caught between two cultures and mindsets, one where courage and to be 'fierce' is required to fulfil their nursing duties and the other balanced with the nurturing character of nursing (Ford Walston, 2004). The publication of Compassion in Practice (CBCN and DHCHA, 2012) compounds and consigns the continued discourse of nursing as highly gendered by its focus on compassion, highlighted in the documents title, despite stating all the 6Cs including courage have equal significance (Bradshaw, 2016).

The emerging theory implies nurses lack of consideration and association with courage may be connected to preconceived ingrained attitudes developed through cultural socialisation and

the influence of gender on how women should behave (Miers, 2000; Hoschild, 2012). Murray (2018) posits nursing may be complicit in their marginalised position by not challenging it. This study suggests nurses' acquiescence of their position may be because challenging it requires courage.

The meaning of courage is co-constructed as advocacy which is well documented as a nursing trait (Paquin, 2011; Cole et al, 2014; Estes, 2017) and the Code for Nursing (NMC, 2015) cites advocacy twice and 'Protect' or its derivations eleven times. Courage is not cited. Cole et al's (2014) article opines that advocacy encompasses protection and requires autonomy which is challenging for nursing in a paternalistic organisation. Participants use of other analogies relating to insignificance and having a little job to do reveal the inverse context nurses find themselves in. Nurses acknowledge they need to be fierce protect their patients' rights and best interests and yet feel their place in the organisation is disregarded (Churchman and Doherty, 2010; Mason et al, 2017; Murray, 2018). Nurses appear to struggle between adhering to the expectations of women as meek and deferential (Stein, 1967, Miers, 2002, Churchman and Doherty,

2010) versus the fierceness required as a nurse advocating for and protecting their patient (NMC, 2015). This study suggests that professional socialisation needs to address not only the caring compassionate nurse persona but equally if not more so, the meaning of courage connected to being fierce as this does not appear to be a natural stance for women.

Participants also talked about how courage denoted them going into work which was also observed as a challenge by Spence and Smythe (2007). In 2009 occupational health expert Doctor Steven Boorman led a review into the health of the NHS staff finding that despite reporting relatively good levels of health, 25% of staff self-reported time off work due to depression, anxiety, bullying and harassment (Boorman, 2009). Since then the NHS Staff survey reports these figures have increased to 37% (Picker Institute, 2016). The national context is that 1:4 will suffer a mental health disorder but stress is more prevalent in the public service industries (Health and Safety Executive, (HEA) 2017) and the implication that bullying, harassment or poor people management are contributory to work related illness is unacceptable (Boorman,

2009; Jones-Berry, 2017) but offers an explanation why nurses identified going into work as a meaning of courage to them.

Finally, participants said that contrary to the Code for nursing, courage meant sometimes putting themselves first. The Code states,

> *"you put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern" (NMC 2015 pg 4).*

Johnson et al (2007) define altruism as benevolence at cost to self and the concern for others welfare rather than your own. Eley et al (2012) and Lai and Lim's (2012) study found student nurses reasons for entering nursing were primarily altruistic. Nurses maybe conflicted between the principle that they must put others first and their own needs, causing potential emotional distress as the two collide.

The meaning of courage to nurses is complex, varied and individual and is related to nurses' gender, cultural and professional socialisation which influence the meaning of courage prior to and during nursing practice.

5.3 The context to acts of being courageous

Participants perceived their moral values underpinned and informed their acts of courage. In the quote below Natalie spoke of what courage meant to her and how she was able to be courageous. She clearly equates morality and ethical behaviour with knowing what is right and wrong.

> *"I'm very moral, I'm very ethical and I do have a huge sense of right and wrong" [P3 Acute nurse 16 yrs].*

Three quarters of participants used the exact phrase '*right thing'* in the context of being courageous. Ensuring the right thing for the patient was vital to them and ensured their adherence to the Code for nursing (NMC, 2015). The quote below alludes to two different aspects within this. Natalie firstly recognises that it was not always comfortable to be in a position requiring her to enact courage but in terms of doing the right thing she felt she had to act. This suggests that despite personal discomfort and the risk of social disapproval (Woodard and Pury, 2007) nurses are driven to act by

an internal motivation. As observed in the previous chapter, it appears that courage is at least partially an internal quality shaped by socialisation prior to and during their nursing careers and influenced being courageous. Natalie said,

> *"you don't necessarily always feel comfortable in what you're doing, erm ……. I tend to not be able to help myself doing the right thing." [P3 Acute nurse 16 yrs].*

A strong sense of moral values and right and wrong motivates nurses and was also expressed as having a conscience. Jensen and Lidell (2009) define conscience as the moral sense of right and wrong that guides individuals' behaviours.

Table 14 shows the category and associated subcategories generated during the analysis regarding the acts that participants believed denoted courage to them.

Category	**Related subcategories**
Acts of being courageous	• Speaking up within the hierarchy • Refusing to do something wrong • Having courageous conversations

Table 15. Categories and subcategories: Acts of being courageous

The acts of courage described by participants relate to the pre-requisites of courage as they perceived being courageous within the hierarchy could be challenging due to issues around gender, cultural and professional socialization and their perceived place within the organizational culture. Nurses need the ability to be able to overcome the constraints of gender, the confines of their cultural and professional socialisation and to challenge their place within the organisation to be able to undertake acts of courage. For the emerging theory this adds another layer of complexity to being courageous further implicating the influence of socialisation and professional resilience, encouragement and support prior to and during a nurses' career and the influence of the organisational culture in enhancing or negating nurses' courage.

5.3.1 Speaking up and being courageous within the hierarchy

Finding their voices was verbalised by participants as an act of courage. In the excerpt below Maz related her experience of being courageous to speak up to safeguard a patient requiring her to challenge poor practice and relating back to advocacy. The *"scary"* part Maz mentions was associated with the potential for police

involvement. Maz's quote infers socialisation is influential, the nurses' role has evolved in recent years and nurses are expected to speak up if they have concerns (Francis, 2013; NMC, 2014; Cummings et al, 2015; NMC, 2015), yet Maz still found this challenging,

> *"also, courage for me as a nurse to be able to stand up to say, you know, what's going wrong and its quite scary" [P14 Community nurse 7 yrs].*

Several of the participants expressed difficulty speaking up to question decision making if it was someone of a higher authority. Churchman and Doherty's (2010) study explored nurses' relationships with doctors finding nurses would only challenge doctors in particular situations, not for example if they perceived their challenge would cause conflict. This behaviour was noted by Stein some years earlier who said nurses were required to be passive and make decisions appear to have come from the doctor (Stein 1967, 1990). The difficulty in speaking up to question or challenge decisions was found amongst most participants regardless of maturity, years of experience or seniority. The use of the term '*nursey world*' [P8] by Louise illuminates how she perceives nurses are viewed relative to other team members.

Being a woman in an patriarchal and hierarchical dominated structure resulted in Louise feeling she needed to be courageous to be able to question or challenge. Ellemers (2018) observes that women who speak up are unpopular, even amongst their own sex as they are seen to be acting inappropriately to their gender. Louise said,

> *"it does take courage to stand up to people, to question decisions, to challenge decisions, to, challenge, you know, in our nursey world, Doctors, consultant's erm, anyone really" [P8 Community specialist nurse 28 yrs].*

Speaking up to make decisions was also talked about in terms of being able to justify them. Due to the influence of gender and socialisation nurses may feel insecure and insubordinate in their role and are reluctant to make decisions as they expect that their decisions will be challenged. Louise infers nurses' decisions are not valued or accepted. McCarthy et al (2008) suggest this is because nurses are not the key decision makers and so Louise must be ready to justify her decisions,

"it takes courage to take a challenge back again because if you're going out there, people need to be able to come to you and say, "why have you done that?" and that takes quite a lot of courage to justify what you've done as well," [P8 Community specialist nurse 28 years].

Gina like Louise is a specialist nurse with many years of experience and she also verbalised the difficulties she experienced questioning those senior to her. It would appear due to socialisation, gender and the organisational culture, nurses' ability to question courageously can be stifled. There is conflict between the doctors' cultural and established authority to make decisions about patients management and care (Nugus et al, 2010, BMA 2017) and the nurses duty act according to the Code for nursing which cites nurses must challenge poor practice, maintain effective communication, deal with differences of professional opinion and raise concerns immediately (NMC, 2014, 2015). Gina expressed this conflict saying,

"also, groups of men and how formidable they can be, perhaps think of groups of surgeons, and what

they're like, and their whole team, practically god like, I mean, who's going to query what they say and do?" [P16 Community specialist nurse 30 yrs].

5.3.2 Refusing to do something wrong

Refusing to do something that the nurse perceived as wrong was also seen as an act of being courageous. An example of this is a quotation from Gracie who spoke movingly about how to meet set organisational targets for patient transfer through her department, she was expected to move a patient who was imminently dying. Gracie courageously refused knowing the patient's death was fast approaching and she felt that it was not in the patients' best interest to move them,

I: "so can you remember how you felt then?" P: 'quite intimidated….hmm, scared erm, [pause] but then quite confident in that you think, no I've done the right thing" ……you've got to do what you think's right, rather than not what you might get blamed for, I think you've got to forget about that, and just do what you think's right" [P2 Acute nurse 7 yrs].

This excerpt demonstrates how as Fahlberg (2015) notes, nurses are required to overcome their fears and emotions to stand up for what is right. Initially intimidated and scared, then some solace in her confidence of the appropriateness of her actions, followed by fearing she would be blamed or criticised all passed through Gracie's mind. The concept of nurse blame is explored further in section 6.5.2.

Above Gracie was referring to the difficulties of speaking up against the hierarchy and organisation if she felt something was wrong. Whistleblowing, defined as raising a concern with an authority (RCN, 2017) was directly cited by very few participants however there were several stories that alluded to the concept of whistleblowing and the challenges presented by it. Several participants suggested having to speak up against a peer or nurse colleague could be even harder. Dinndorf -Hogenson (2015) found nurses were more likely to have a pre-established relationship and had to continue to work closely together. Ruby talks about standing by your convictions, a phrase used by many of the participants. In the quote below Ruby refers to witnessing a colleague do something wrong requiring her to act and how

difficult this was as she was a nurse colleague, inferring support, development and socialisation of nursing within the organisation are key. Ruby said,

> *'and that's courage, standing by your conviction and the courage to stand by what you have seen and said and documented" [P15 Community nurse, 13 yrs].*

Participants also talked about being courageous by saying no. This was often discussed in relation to doctors. In the excerpt below Jill was a proficient community nurse with many years of experience yet still said she found saying no challenging. Having experienced both the acute and community setting both Jill [P6] and Rosie [P13] suggest as Nugus et al's (2010) study found, the hospital setting may be more challenging than the community as doctors have more status and power in the hospital and nurses are more autonomous in the community. The different power base in respective settings resonates with the emerging theory that organisational culture differs at macro (political), meso (organisational) and micro level (bedside) (Gallagher 2010) and bears influence on being courageous and nurses' experience of this. Jill and Rosie said.

"I think having the courage to stand up to other professionals as well, doctors and things, on wards especially, and having the courage to say "no" to them," [P6 Community nurse 30 yrs].

"*I think probably I would say more autonomous workers would need more courage, so maybe community nurses' …probably need a bit more of courage because you make more of a decision there and then don't you?" [P13 Acute nurse 3 years].*

5.3.3 Having courageous conversations

The final area connected to acts of being courageous was speaking to patients and families and telling them the truth. Louise conjures up a clear picture of the scenario she faced, explaining how challenging this was for her *'shaking'* as she endured and overcame her emotional response. Similarly, to the findings in the preceding chapter in relation to the nursing Code and Natalie and Gracie who talked about they had to do things (4.3.2), Louise feels she has '*got to'* do it despite her palpable fear. This scenario differs to overcoming fear of breaching the Code for nursing. In this situation it was fear of breaking bad news, potentially adding to patients or families distress if not delivered well (Thorup et al,

2012). Both scenarios imply the organisational culture needs to be supportive of nurses' emotional needs and is responsible for creating an environment where courage can flourish (Gallagher 2010). Louise recounted,

> *"the families usually know where you're headed ….the doors were open…..I remember literally, shaking and my head was shaking, and taking a deep breath and thinking "I've got to say those words, I've just got to, got to say them" and you kind of just do, and courage to have those difficult conversations." [P8 Community specialist nurse 28 yrs].*

Another aspect of speaking to patients and families was around truth telling. Although many years ago the story below brought Jill to tears remembering a patient to whom no-one would tell the truth. Nowadays the expectation is honest disclosure with patients (Hodkinson, 2008) and the duty of candour is in the Code for nursing (NMC, 2015). In the excerpt below the patient asks Jill if she is dying, Jill responds honestly but cited how she was troubled by guilt for years as she felt she had spoken above her expected station. Kaya et al (2012) note guilt can be a problem for nurses.

The following day the patient discharged herself as she wanted to die at home.

> *"I just want to know if I'm dying, because if I am, I want to go home and see the plants and the kids for the last time, I don't want to die here" and I just went "yeah, you are" …..that took a lot of courage that did…I don't think I was even allowed to discuss her diagnosis with her" [P6 Community nurse, 30 yrs].*

Respecting that patients with mental capacity knew their own best interests was also considered to be courageous. This could present a complex challenge. In their professional role participants wanted the best for the patient however, some patients would not agree or did not want treatment. This led to the nurse accepting the patients' wishes but potentially creating distress and emotional labour for the nurse if the patients' decision conflicted with their own moral values and reinforcing the necessity of the organisation to support the undervalued emotional aspect of nursing. Jill illustrated this dilemma,

> *"have that courage to stand up and say, 'this really is the best thing for you" you know and if they still say*

"no" you've got to have the courage to walk away and say "OK" [P6 Community nurse 30 yrs].

5.3.4 Extant literature fit with acts of being courageous

The findings presented signify that acts of courage as an adult nurse are related to the prerequisites of a moral values system, gender, personality and personal and professional socialisation.

The participants spoke about moral values as their conscience which Jensen and Lidell (2009) Thorup et al *(*2012) and Numminen et al (2016) explored, describing conscience as an inner motivation and finding that when nurses can act in accordance with their conscience [their values are in synchrony with the organisation], they are at less risk of conflict with their values and avoid feelings of guilt. However, Nugus et al (2010) discern the power of the hierarchy, largely retained by medicine can limit nursing influence [and ability to work to their conscience] and when there is a fundamental mismatch between both sides, as seen above with organisational targets being in conflict with the nurses moral choices, collaborative relationships can be difficult to achieve (Reeves et al, 2008). Participants referral to their fear of

being '*intimidated*' and '*blamed*' suggests they are concerned about being criticised and is indicative of a non-collaborative hierarchical organisational culture that fails to support nurses when they do speak up. Francis (2013, pg89) commented on this in his report when he said,

> *"speaking up can require courage, particularly in work places which do not enjoy an open, patient centred culture".*

It appears there is a conflict between nurses being able to act in accordance with their conscience or moral values and their fearing being intimidated or blamed by the organisation (Nugus et al, 2010). This connects morality to socialisation and the impact of organisational culture. Nugus et al *(*2010) qualitative study findings support the beliefs of participants in this study that although doctors have retained their power base there is a difference between their power in the acute setting to the community. In the latter, subjugation was a potential on both sides, but in the acute settings the doctors never reported being dominated by other professions. Nugus et al (2010) found the organisational culture of the NHS sanctioned the dominance of doctors who are socialised as the key decision makers (Stein,

1967; Stein et al, 1990; Reeves et al, 2008; Nugus et al, 2010) and legally they also hold this responsibility (BMA, 2017). This offers an explanation to why nurses find speaking up challenging as they are not socialised as, nor perceived to be decision makers despite this being a nursing requirement (NMC, 2015).

Johnstone and Hutchinson (2015) observe nurses should not acquiesce to their position but overcoming this requires courage. Responding to their moral values requires nurses to overcome their fears (Fahlberg, 2015) and to altruistically (Johnson et al, 2007) do the right thing by advocating for the patient (Cole et al, 2014) including truth telling (Hodkinson, 2008) even though challenging and at personal cost.

Extant literature offers insight why participants spoke about the difficulty in speaking up, questioning or challenging their colleagues. This was often attributed to doctors or senior team members but could include anyone. McCarthy et al's (2008) article reviewed the report into a scandal in Ireland from a gender, power and privilege perspective concluding, doctors were presumed to be

in authority and the concerns of the midwives involved were silenced and marginalized relating their findings to gender, professional socialisation and organisational culture. The Francis report (Francis, 2013) into a scandal in the UK concluded similarly. McCarthy et al (2008) observe all types of knowledge are credible and should be listened to but the reality is doctors' knowledge is more highly prized (Holyoake, 2011) making this a challenging area for nursing.

To overcome the difficulties associated with challenging the hierarchy or making decisions, Manias and Street (2001) and Closs (2001) both found nurses use the doctor nurse game (Stein, 1967; Stein et al, 1990) as a strategy to create the impression a decision was owned by the doctor and another game called staging whereby nurses would release a little knowledge to inform the doctors decision (Manias and Street, 2001), the outcome being the decision the nurse wanted but apparently made by the doctor. This extant literature resonates with the prerequisites findings chapter.

In patriarchal societies men are more likely to have power, position and status within the organisational culture and thus female voices are constrained by gendered perceptions and the power structures they work in (McCarthy et al, 2008) leaving nurses dispirited, arguably the opposite of courage (Ford Walston, 2004). This lack of a common language or understanding within the organisational culture is noted by Schein (1986) to be one of the most troublesome situations and is attributed here to the organisational values being converse or in conflict with nurses' values (Gallagher 2010) and so becomes prohibitive of acts of courage.

The emerging theory suggests nurses need a system of strong moral values and sense of right and wrong to inform their decisions and enable them to advocate for their patients, ensure their best interests are met and overcome the perceived organisational constraints. Although the above studies imply a fit with the emergent theory, none were focused on courage, consequently the emerging theory adds a new dimension to current research in professional nursing behaviour and courage.

5.4 Reflexivity on my construct as a nurse

The second construct to explore reflexively is how my identity with the participants as a nurse influenced the co-construction of the data and subsequent grounded theory. As a nurse myself it was important to me that the participants felt I was a good nurse (appendices 10e) and consequently may be more prepared to share their stories with me.

Nicolson (2003) writes that the research interview can cause anxiety in the researcher with reference to their own place in the world. As a novice interviewer I feared the judgement of the participants as nurses themselves and this impacted on my behaviour and interpretation of the social situations I found myself in. Reflexively I can see it is how I judged my own performance was being perceived rather than how I was being judged (Burkitt, 2012). Cooley (1922) says insecurity is determined by what we believe others may be thinking of us, theorising that we develop a personal image based on how we imagine others see us. Cooley called this the concept of the looking glass self. Goffman (1956) also posited we perform and present ourselves using information about individuals to determine a given situation and what is

expected on both sides of the performance. Goffman (1956) and Parker (2005) observe that this performance develops in a socially constructed way. As the participants were nurses' I presumed I should identify with them as a nurse rather than a researcher but there were occasions where this may have been misguided.

As an Intensive care nurse, I have my personal view and assumptions of ICU nurses as strong, intellectual and different to ward nurses (appendices 10c). Alex and Louise were also from an Intensive care background and my view of this as a connection between us will have influenced my interpretation of their data potentially leading me to overlook anything they said that did not correspond with my view of them. Jootun et al (2009) warns that undertaking research in a familiar area can lead to significant inherent bias and assumptions leading to premature conclusions or misinterpretations. Reflexive awareness of these potential challenges enabled me to consider participants stories more openly.

During the interviews I came to realise identifying as an ICU nurse may alienate some of the participants. ICU nurses are sometimes considered to view themselves as elite. Becoming aware of this I resolved to stop mentioning I was an ICU nurse (appendices 10c). However, in Ruby's interview (who was not an ICU nurse) I mentioned where I worked, and my grade and I recall being pleased when she seemed impressed however, after the interview I felt embarrassed of myself for seeking this approval. Considering this reflexively I feel it is my own insecurity as a researcher and my own pride in being a nurse that led me to behave this way (appendices 10e). By potentially alienating Ruby I could have influenced our interview dynamic and what she felt comfortable to divulge to me impacting on the subsequent co-construction.

As an experienced nurse but novice interviewer in the first interview I lacked confidence and was nervous. Jo mentioned an analogy to a lion and my response was to ask, "did she mean like the lion in the wizard of Oz?" This was a closed question. Stuckey (2013) and Engward and Davies (2015) recommend open questions as being more likely to develop rapport. I also failed to pursue the line of inquiry further missing the opportunity to

explore what Jo meant in terms of being courageous and the lion. However, as Finlay and Gough (2003) note, reflexivity helps to uncover more interpretation and insight and I can see that my response referring to the wizard of Oz was due to my assumption that Jo must believe nurses are cowardly (appendices 10c). I also feel my lack of experience as an interviewer is evident (field notes appendices 11a) meaning although Jo's data underpins many of the themes in the co-construction her data is not explicitly cited. As my experience of interviewing grew I possibly became a more competent interviewer and subsequent participant stories more clearly illustrated emergent themes, consequently I was more likely to choose them to explain the co-constructed points regarding being courageous.

Sam was also not an ICU nurse and my field notes detail I found this interview difficult (appendices 11b). I thought Sam appeared defensive, arms crossed throughout and I 'judged' she was uncomfortable and felt her body language was not congruent with what she was saying. Burkitt (2012) notes that our thinking comes from emotion and is therefore integral to the relations we have with people. I may have caused the reaction in Sam as despite

positioning myself as 'nurse' as opposed to researcher, I was still present as 'researcher' and Sam may have viewed me as this. Jootun and McGhee (2003) say some nurses are inclined to practical rather than scholarly activity and I recall feeling Sam may be wondering why I did not remain loyal to nursing. Reflexively thinking about our dynamic in the interview made me realise this is how I felt and why I was so deliberate in my positioning of myself as a nurse. I felt embarrassed to say I was a researcher (appendices 10e) and as Pini (2004) suggests can occur, I subconsciously minimised aspects of myself to Sam. Sam like Jo, spontaneously mentioned a lion and directly related this to the wizard of Oz. I was then able to pursue what this meant to her. She clarified it was not the cowardly aspect I assumed was envisaged. In fact, the wizard of Oz lion was brave and determined to find his courage. Finlay (2003) states that the focus for social constructionist researchers is deconstructing the language used and its rhetoric so it was important to uncover this meaning.

The participants and I's personal, professional socialisation and culture will have influenced all the interviews as will our ethnicity. All the participants shared my ethnicity as white Caucasian except

for Molly who was the only participant of a black and minority ethnicity (BME). Molly appeared very proud that her training was a degree; unusual 25 years ago. My field notes record that Molly spoke very quickly, did not always seem to hear my questions and at times we both talked over each other (appendices 11c). I felt she appeared to want to prove herself by talking about the experiences and benefits she got from her degree level training. Considering the interview reflexively, I gave no conscious thought to Molly being from a different culture and ethnicity to mine and did not knowingly behave in a different way to any of the other participants. However, this may have been the wrong approach. A report by the NMC into BME nurses in the NHS found there were specific challenges for this group of nurses (West and Nayar, 2016). I could have sensitively asked Molly if she felt her experiences as a nurse were different due to her culture as a person from a BME background. This was a missed opportunity.

In social constructionism it is important to consider how both the participants and I engaged in presenting ourselves to each other, and how this influenced my subsequent analysis and co-construction. As Goffman (1956) and Pini (2004) observe,

performances are subconsciously adjusted as people interact and Burkitt (2012) reminds us that emotions, psyche and interiority are likely to be inaccessible to even to the researcher themselves. Consequently, reflexivity is a vital tool in the interpretation and co-construction of data (Engward and Davis, 2015) to attempt to uncover and consider nuances in the participants data and stories that may have been overlooked or exaggerated.

Reflexively examining my own motivations, assumptions and positions enabled me to consider my influence in the co construction. Sharing an identity with the participants as a nurse generally appeared to be positive. My professional experience augmented my insight into potential connections between codes and categories, but conversely could have inadvertently blocked my perceptions (Engward and Davis, 2015) due to difficulty separating personal experiences. To moderate this reflexivity enables exploration of personal assumptions (Jootun, McGhee and Marland, 2009) and positions including culture, socialisation and ethnicity.

5.5 Conclusion

The co-construction of the data on the meaning of courage and acts of being courageous contributes to the emergent theory of nurses understanding and use of courage in their clinical practice. Courage is a difficult concept to define and is perceived individually. A dichotomy was noted between the participants identifying courage as strong and '*manly*' and their image of nursing; traditionally centred around perceived female qualities of caring, nurturing and gentleness.

Acts of courage were perceived by participants as utilising their moral values, sense of right and wrong or conscience to be courageous. Doing the right thing, refusing to do the wrong thing and having courageous conversations were informed and underpinned by their moral values.

The developing theory suggests nursing cannot easily separate itself from its history as a socially constructed, gendered female, caring occupation in a male dominated organisational culture. The organisational culture is complex and if that culture gives

precedence to other priorities for example, as illustrated by participants who said organisational targets were put over patient well-being, this creates a conflict between the organisational and nurses' priorities and it becomes challenging for nurses to be courageous. This discussion, its implications and the emerging theory are furthered in the final findings chapter presenting the findings on the consequences of being courageous.

Chapter 6 The consequences of being courageous in the context of nursing.

6. Introduction

This is the final findings chapter and presents co-constructions of the data collected on the consequences of being courageous in professional nursing practice. The chapter reflects the data related to the categories of the personal, psychological, social, and organizational consequences of being courageous and their subcategories. Consequences of being courageous expressed by participants were both positive and negative and relate to the prerequisites of being courageous and being courageous chapters and there is cross referencing between them. While chapter five focused on the meaning of courage and the act of being courageous, this chapter focuses on the experience and aftermath for the individual taking the courageous action. The data contributes to the emergent grounded theory of courage in adult nursing. The chapter concludes with my reflexive analysis.

6.1 The context of the consequences of being courageous

The consequences of being courageous were revealed by participants as they spoke about being courageous and these became an important aspect of the findings, providing additional context to nurses' experiences of being courageous. Ruby observed the consequences vary depending on the cause or situation and Molly that there will always be consequences to making decisions and whilst these may need thought, ultimately you must be courageous,

> *"yeah it can [being courageous] be negative or positive for the person, depending on what you're talking about, and what you are having courage about,"[P15 Community nurse 13 years].*

> *"Every decision, every action that we take has a consequence and sometimes those consequences, you know, I think we spend a lot of time saying what if, so you have to be courageous" [P12].*

These quotes provide the context for the following categories that were selected from the data for the consequences of being courageous.

6.2 Personal positive consequences of being courageous

Table 18 shows the category and associated sub-categories generated during the analysis regarding the personal positive consequences of being courageous.

Category	**Related subcategories**
Personal positive consequences of being courageous	• Pride in knowing they had done their best • Gaining new opportunities • Feeling effective • Gaining the positive regard of others

Table 16. Categories and subcategories: Personal consequences of being courageous in the context of adult nursing

The positive consequences of using courage in their clinical setting relate to nurses' professional socialisation, identification with the nurse persona and their self-esteem as explored in chapter five. However, as women they could find stepping outside the confines of their expected role challenging, relating to chapter four and the prerequisites of gender and cultural and professional socialisation.

6.2.1 Pride in knowing they had done their best

Participants did not verbalise many positive benefits to being courageous. However, they did suggest they gained a personal benefit by knowing they had done their best on behalf of their patient and taking a pride in that. This suggests participants viewed the patient's care as central to their job satisfaction which Baughan and Smith (2013) and Zarshenas et al *(*2014) observe is important. Participants also implied their socialisation into the nursing profession and identification with the Code for nursing (NMC, 2015) had been effective in terms of patient advocacy. Maz expresses these feelings in the quote below,

> *"but it's [courage's] advantage is, you feel like you're doing the best for your patient, and you know that you couldn't do any more for them, if you've got a conscience [laughs] like some people don't have a conscience" [P14 Community nurse 7 yrs].*

The quote implies not all nurses act in the same way and that those without, as Maz perceived it, '*a conscience*' (whether under developed through socialisation prior to or during their nursing)

may fail to do the best for the patient. Glasberg et al (2008) study found the continued stress of being unable to act within an individual's moral beliefs can lead to burnout inferring this lack of conscience may be attributed to nurses becoming emotionally exhausted and links to the negative consequences explored later in the chapter (6.3.1).

6.2.2 Gaining new opportunities and experiences

In the quote below Sue says there are rewards that come from being courageous although does not clarify what the good rewards are, later in the interview she specified the good things as opportunities and experiences she would not have had if she had not pushed herself to be courageous,

> *"but, you know, with pushing yourself comes good rewards, doesn't it, you know, I think that's the thing, you can be mediocre all the time can't you, but if you push yourself and have courage then there comes, you get good things come out of it" [P7 Acute Specialist Nurse 29 years].*

6.2.3 Feeling effective

Another positive consequence to courageous behaviour was related by Ruby who related to several linked elements regarding feeling effective,

> *"…recognition that you are (in) a real profession, you're not fuzzy……..with that comes reputation and you can also get that career elevation……..that's a really positive consequence [of courage] because the higher you can get the more potential you have to effect positive change so that's a brilliant consequence" [P15 Community nurse 13 years].*

Ruby alludes here to nursing's struggle to be recognised as a profession discussed by ten Hoeve et al (2014) and Mishra (2015) and also nurses difficulty in effecting any change unless they have gained a worthy reputation and are in senior positions (Nugus et al, 2010; Whitehead et al, 2015). Nurses should be autonomous within the teams they work in but the reality is they are not (Cassidy and McIntosh, 2014) and remain constrained by the physician nurse relationship and organisational culture. The

nursing visions' definition of courage applies to all levels of nurses citing *"be bold when we have good ideas and to speak up when things are wrong"*(Cummings and Bennett 2012 pg 9) implying that not only more senior nurses, but all nurses should be able to effect change.

6.2.4 Gaining the positive regard of others

The final positive consequence to being courageous related by the participants was in terms of how others view them. The positive regard of others could boost their self-esteem which Hagbaghery et al (2004) and Baughan and Smith (2013) also found. Self-esteem is a pre-requisite for being courageous and this suggests the emergent theory turns full circle and self-esteem is implicated throughout the inception of courage. In the excerpt below Natalie said being courageous enabled her to feel valued and increased her self-esteem as a beneficial consequence. Natalie was one of the few participants who said she felt she had a strong self-esteem which stemmed from her personality. Dar-Nimrod et al (2018) found those positively evaluating themselves regarding the big five personality traits were more likely to have a positive self-esteem. The context to the quote below was Natalie was talking about how

other colleagues ask her to do things as they perceive her as being capable and courageous.

> *"I suppose I like feeling worthwhile, I like feeling useful I suppose…….I do get self-esteem from it……..I think her perception of me would be that I'm courageous,"[P3 Acute nurse 16 years].*

Natalie's thoughts resonated with several participants who found the positive regard of nursing was a benefit to them and connects to the prerequisites chapter which found self-esteem was a necessary element to being courageous (4.2.3).

6.2.5 Extant literature fit with the personal positive consequences of being courageous

The findings presented above suggest there are positive consequences to realising courage as an adult nurse that are related to gender in terms of boosting self-esteem and professional socialisation which had cemented nurses' identity with the nurse persona, a pride in their work and feeling effective.

Courage is normally associated with a positive outcome and when defining courage in the background chapter, Rate et al (2007),

Sekerka and Bagozzi (2007), Woodard and Pury (2007) and Gruber, (2011) all suggest a good or positive outcome is expected as the result of a courageous act. However, although overcoming personal fears is addressed by several writers (Shelp, 1984; Rate et al, 2007; Sekerka and Bagozzi, 2007; Woodard and Pury, 2007; Tillich, 2014) the experience of the individual taking the courageous action is not widely explored, the foci of research being the physical outcome.

There is a dearth of research into positive consequences of nurses being courageous. However, Dahl et al's (2014) study found dealing with ethically charged encounters including courage could strengthen professional identify and Thorup et al, (2012) study similarly found that courage enhanced the nurses' sense of commitment as participants in this study alluded to.

Participants talked about how they could access the positive opportunities and experiences available but had to push themselves resonating with nursing identified as a gendered profession where women are expected to adhere to their

subordinate status (Miers, 2002; Churchman and Doherty, 2010b; Hoschild, 2012) and the challenges nurses said they faced in getting their voices heard (McCarthy and Fitzpatrick, 2008; Francis, 2015).

Being regarded as a professional and that this benefit to courageous behaviour could enable nurses to further their career suggests nurses are proud to be seen as professionals. Zarshenas et al's (2014) study explored professional socialisation, internalization and development and found a sense of professional identity helps nurses to have an appreciation of their usefulness, increases their self-esteem and their feeling of belonging to the profession. However, the literature also discusses the reality of working in practice for nurses where they can be overwhelmed by their apparent powerlessness and ineffectiveness (Lai and Lim, 2012) and as inferred by participants, nursing still struggles to be distinguished as a profession.

Self-esteem has been explored in the preceding two chapters. Cassidy and McIntosh (2014) and Numminen et al (2016) found

nurses who feel empowered with mastery over their own life may manifest courage, tenacity and self-esteem, however Bleidorn et al *(*2016) found women may be more likely to suffer from poor self-esteem, a challenge for nurses as a predominantly female profession. However, in this study Natalie found a positive consequence of being courageous was an increase in her self-esteem. Ilhan et al (2016) and Megahed and Mohammed (2014) found University education in nursing could boost self-esteem finding that students' self-esteem rose during their course, this is important because as Iacobucci et al (2013) found self-esteem motivates nurses to advocate for patients particularly when conflicts in values are encountered. Self-esteem appears an important element of the emergent theory associated with both the prerequisites for courage and the positive consequences of being courageous.

The findings of the above studies suggest a fit with the emergent theory. The study offers new theory on the personal benefits to using courage including strengthening professional identity and increasing self-esteem which is a prerequisite to courage and

consequently the positive consequences to using courage could augment nurses' ability to be courageous.

6.3 Negative psychological consequences of being courageous

Table 17 shows the category and associated sub-categories generated during the analysis regarding the psychological consequences of being courageous.

Negative psychological consequences of being courageous	• The emotional toll of being courageous
	  ○ Exhaustion
	  ○ Lack of nursing support
	• Bearing personal discomfort

Table 17. The category and subcategories of negative psychological consequences of being courageous in the context of adult nursing

The meaning of courage had a psychological context for participants as discussed in chapter five, but they also talked about psychological consequences and how these exacted an ongoing psychological effect surrounding and after the act of being courageous.

The participants stories suggest the organisational culture is not always supportive of nurses who are potentially psychologically

distressed by circumstances surrounding acts of courage and that their professional socialisation had not prepared them for these consequences.

6.3.1 The emotional toll of being courageous

In chapter five Maz talked about how safeguarding denoted the meaning of courage to her (5.3.1) and below she acknowledges the consequence was she found it exhausting. Maz explained that her role in the community had recently required a substantial amount of safeguarding for patients who were vulnerable and needed protection from potentially abusive situations.

> *"Recently it's (safeguarding) been happening quite a lot, and it's very draining," [P14 Community nurse 7 years].*

Gracie related her experience of a particularly difficult situation where she required courage and expresses the lack of nursing support she received following the incident. Farrell (2001) and Wright et al (2014) both found nurses do not always support each other when needed. Gracie related the following scenario.

> *"I gave someone a medication and I put them into cardiac arrest, not knowing that they were allergic to*

it……"I don't think anyone really picked up on that, like in the department, where I was like, 'Oh god, I need to go and have a break," everyone else sort of just got back to it," [P2 Acute Nurse 7 years].

Gracie subsequently left her role suggesting that her new role was not the direction she intended to take and intimating continuous exposure to similar distressing experiences had exhausted her. The literature defines continual exposure to stressful or emotional experiences that may be as the result of being courageous can lead to moral distress or burnout (Schluter et al, 2008; Hamric et al, 2015) and implies that the emotional toll of nursing is not valued or recognised (Miers, 2000, McLaughlin et al, 2010 and Allan, 2016). Professional socialisation does not appear to adequately prepare nurses to support each other in this area, nor is the organisational culture explicitly supportive of the emotional aspect of nursing.

6.3.2 Bearing discomfort

Personal discomfort was associated with decision making and being courageous, these were explored in chapter five as meanings of courage, finding the impact of gender and continued awareness of their inferior position in the organisation meant

nurses struggled with decision making as found by McCarthy et al (2008) and Whitehead et al's *(*2015) studies. Worrying about the consequences of the decisions made whilst being courageous and afterwards was expressed by participants. The excerpt below details Sam's feelings as an experienced nurse, doubting herself after making decisions.

> *"I do really feel very personally responsible for what I do every day, I make decisions about things and prioritize and so on, and I hate it if I feel like I haven't done something quite right, I angst, not angst about it, but mither over it for days until I can feel that I've resolved it in some way or another. [P10 community nurse 33 yrs].*

Molly also verbalises the consequences of being courageous in decision making and the subsequent psychological impact. Molly had just been talking about being courageous, needing support from colleagues to make decisions and the effect being courageous can have, again alluding to emotional burnout and the difficulty nurses may find in decision making (Whitehead et al, 2015). Molly remarked,

"maybe it's a decision that somebody else may not have made…..because nursing is a bit like a roller coaster isn't it, when it's good it's really good, and when its bad its really horrid, and you don't want to do it,"[P12 Community specialist nurse 28 years].

6.3.3 Extant literature fit with the psychological consequences to being courageous

The findings presented above suggest there are negative psychological consequences to realising courage as an adult nurse that are related to professional socialisation, nurses support of each other and the resultant emotional distress implies the organisational culture does not adequately support nurses' emotional well-being. Though not specifically related to courage, Baillie et al (2008) found emotional distress a significant finding in their survey on defending dignity for the Royal College of Nursing (RCN) stating 70% of nurses had sometimes gone home from work distressed and 11% were always distressed. The distress was linked to their inability to do the right thing and give the care they wanted although they knew what that was. This connects to the findings of chapter five and reflects the emotional toll on nurses

which as Spence and Smythe's (2007) study found, using courage can be exhausting.

Several researchers have explored the concept of moral distress, alternatively referred to as burnout in nursing (Schluter et al, 2008; Gallagher, 2010, Barlem et al, 2013; Dahl et al, 2014; Savel and Munro, 2015; Whitehead et al, 2015). Moral distress is defined as occurring when there is inconsistency between an individual's actions and their personal and professional convictions (Barlem et al, 2013) and Schluter et al *(*2008) state that if this happens recurrently a moral residue is left increasing each time and therefore moral distress is not benign (Savel and Munro, 2015) and can lead to burnout and an intention to leave nursing (Whitehead et al, 2015).

Boorman's (2009) occupational health report and the NHS staff survey (Picker Institute, 2016) both found stress affects nurses health. Gallagher (2010) and Hart (2014) further this suggesting that moral distress affects nurses' health and is negatively associated with psychological distress. Gallagher also observes the

relationship between moral courage and moral distress is complex and increasing courageous behaviour does not imply less distress if the organisation is unsupportive. The King's Fund (2012) concur, support and encouragement are essential. However, it is not only the organisation that may be perceived to be unsupportive, Farrell (2001) and Wright et al (2014) also found conflict amongst nurses who do not always support each other.

Higher levels of resilience have been posited as a way of combating moral distress and burnout (Hart et al, 2014 and Turner 2014) relating to chapter four and five's findings. Jackson et al (2007) observes that developing resilience is an essential trait for nurses. Relating the psychological consequences to the findings in the prerequisites chapter, resilience is also correlated to increasing self-esteem (Koen et al, 2011; Montes-Hidalgo and Tomas-Sabado, 2016) and resilience increases with encouragement (Hee Noh and Lim, 2015). McAllister and McKinnon (2009) associate resilience with professional socialization and to mitigate against stress and burnout suggest nurses need preparing for the emotional and cognitive work of caring.

Miers's (2000) book on gender and nursing states emotional labour and emotion work are unrecognised and unrewarded because they are a women's' natural skills lowering their value. Thorup et al (2012) found nurses needed to be able to distance themselves from their own personal needs but as Miers (2000) and Read (2013) suggest, the suppression of countenance can be costly to the self so emotional labour comes at a personal price, resonating with the need for nurses to be resilient.

6.4 The negative social consequences of being courageous

Table 18 shows the category and associated sub-categories generated during the analysis regarding the social consequences of being courageous.

Negative social consequences of being courageous	• Being ostracized
	  ○ Losing friends
	  ○ Lack of social support
	  ○ Social isolation
	• Negative labelling

Table 18. The category and subcategories for the negative social consequences of being courageous in the context of adult nursing

The social consequences of using courage in their clinical setting are connected to professional socialisation and its influence on

participants view of their status and power within the organisational culture which appears to be weighted in favour of the doctors. Gender is also implicated as women may struggle to be heard connecting to the prerequisites chapter findings on gender and cultural socialisation and chapter fives findings concerning the influence of socialisation and making decisions.

6.4.1 Being ostracized for being courageous

Gina was asked what the advantages and disadvantages to being courageous were and she responded, *"it's not a way to necessarily win friends and influence people"* [P16] expressing many of the participants views that there were negative social consequences to being courageous. Some of the participants talked about ostracism after witnessing other colleagues being courageous. One example was a whistleblowing incident which required the nurse to speak up, denoted as an act of courage in chapter five (5.3.2). Rosie recalls what she saw happen to a colleague who whistle blew,

> *"she found lots of things that weren't right, and whistle blowed, they gave her a really hard time…so she left and went into the community because no one would listen to her concerns, and she took it higher*

and higher, and was almost like alienated from the core group of people" [P13 Acute nurse 3 years].

Subsequently Rosie's perception was the organisational culture was not supportive of nurses being courageous by speaking up and discouraged moving out of socialised expectations, a challenge observed by Parker (2005) and Ellemers, (2018). Despite nurses being exhorted to use courage (Cummings et al, 2015; Francis, 2015; Lintern, 2015) the message relayed by this experience was that being courageous resulted in deleterious effects.

Other participants expressed experiences of more subtle ostracism and the solitary nature of being courageous. Several participants talked about how they had been the only one to "speak up" often on behalf of their colleagues, yet found they were not supported by them (Farrell, 2001; Wright et al, 2014). This is perhaps due to nurses being socialised to only act within expected parameters so will not stand up and be courageous (Francis, 2013, 2015). Penny recalls how isolating speaking up in a meeting could be if your peers and colleagues do not support you,

> *"if everyone thinks it's a wonderful idea and you are the one sticking your hand up going "oh I don't think that's such a good idea" that can be really isolating, a very lonely, lonely place to be…….that's where you benefit from peer support"[P9 Community specialist nurse 33 years].*

This relates to chapter fives findings concerning the ability to speak up and find your voice and to chapter four which explored the prerequisite of support and encouragement.

6.4.2 Negative labelling for being courageous

Participants referred to the negative perceptions attached to nurses being courageous. Natalie observed her being courageous meant she would describe herself as *"a bit of a troublemaker"* [P3]. Nurses have been urged to be courageous and to voice their concerns (Cummings et al, 2015; Francis, 2015) yet view themselves, or perceive others view them as troublemakers when they do. In the quote below Ruby questions if she is being courageous or could be perceived as being *'picky'* earning her a negative reputation, observed as a problem by Stein (1967) and Matoušová and Tollarová (2014). This implies nurses are not supposed to stray from their expected role too often, occasional

acts of being courageous may be accepted but if consistent may be perceived negatively. Ruby said.

> *"I think if you're consistently doing it, like there's that point at which, am I being courageous, or am I just being super picky, so I think you could also get a negative reputation if you're consistently doing it" [P15 Community nurse 13 years].*

Raising issues or speaking up were also regarded as having potentially negative consequences. It seems that though nurses' role in being courageous has been made clear through the nursing vision and the 6 Cs (Cummings and Bennett, 2012) the reality for nurses is that there can be unwanted and unwarranted consequences. Nurses are now working outside of the social constructions of gender and they are expected to, for example speak up and make decisions (Cummings et al, 2015, NMC 2015), be autonomous as nurse consultants (Manley and Titchen, 2012) and undertake prescribing (NMC , 2006) all of which require speaking up and the ability to raise concerns, but it appears that the organisational culture does not encourage nurses acts of courage (Gallagher 2011). In the quote below Ruby describes how

she perceives she is viewed for speaking up against a colleague who had been demonstrating negative behaviour towards her,

> *"with regard to that whole courage thing and you know, how you're viewed yeah, I felt like a moaning Minnie, and that it wasn't warranted,"[P15 Community nurse 13 years].*

6.4.3 Extant literature fit with the social consequences of being courageous

The findings presented above suggest there are negative social consequences to realising courage as an adult nurse that are related to gender, professional socialisation and the organisational culture.

These findings implicate the relevance of gender as women may struggle to be heard (Meerabeau, 2001; Mason et al, 2017) and socialisation as nurses are socialised to be inferior to the doctors within the hierarchy (Churchman and Doherty, 2010). The organisational culture is also complicit as Gina infers *"they"* gave her a difficult time and would not listen. Ham and Berwick (2017) observe listening to staff is essential to achieve improved

organisation of care. Nurses appear constantly reminded they are expected to adhere to where their gender and socialisation denotes they should.

Several writers (Stein, 1967; Johnson, 2009; Dahl et al, 2014; Matoušová and Tollarová, 2014) have researched the consequences nurses have suffered in the course of their work, including being courageous. Although dated Stein (1967) was the first to observe that the outspoken nurse may be labelled for example as a 'bitch' by the doctor, more recently Olin (2011) and Matoušová and Tollarová's (2014) research findings suggests little has changed, nurses were labelled as bad nurses, accused of taking things out of proportion and subjected to humiliation for raising concerns. This has been attributed to the doctor nurse relationship. Johnson (2009) examined the results of a survey of 13,000 doctors and nurses behaviour finding that verbal abuse was commonplace alongside a number of other poor behaviours including; throwing instruments, holding grudges and accusations of incompetence and negligence. Goffman (1956, 1963) sociological theory posits we all are engaged in performing in expected ways and teams contain secrets, open or otherwise that

determine how these performances continue to play out and further theorises that if evidence arises of an individual having different or unexpected attributes, for example a nurse speaking up, then they may be stigmatised.

Schein (1996) considered an authority on organisational culture states employees need to work in organisations where they feel in control and that creativity and role innovation will be rewarded but Dahl et al's (2014) research found that nurses were exposed to feeling inadequate and or unimportant. Francis (2015) Hamric et al, (2015) and Picker Institute, (2016) have all written about the challenges of creating the conditions Schein advocates within the organisation. Francis freedom to speak up report (Francis, 2015) cites bullying 167 times and notes the NHS culture is one where bullying and harassment prevail and staff are deterred from speaking up for fear of these. Hamric et al's (2015) view is bullying is tolerated as perceived as unalterable due to oppression and unresponsive systems and the 2016 NHS staff survey (Picker institute 2016) reports 24% of staff report being bullied, harassed or abused by other staff within the last year. Ham and Berwick's (2017) Kings fund report on the organisation of care suggest the

hierarchical gaps that surround staff can be bridged by valuing and respecting staff, crucially by listening and acting on their insights.

The emergent theory is reflective of the extant literature concerning the social consequences of being courageous although none explored courage in nursing or the social consequences for nurses in their practice setting. The organisational culture needs to embrace and support courageous behaviour. Professional socialisation can help prepare nurses for the challenges of being courageous and overcoming the potential consequences they may encounter.

6.5 Negative organisational consequences of being courageous

Table 21 shows the category and associated sub-categories generated during the analysis regarding the organisational consequences of being courageous.

Negative organisational consequences of being courageous	• Fear of the loss of role, job, or registration as a consequence of being courageous • Nurses will take the blame ○ Power dynamics and hierarchies • Whistleblowing

Table 19. The category and subcategories of negative organisational consequences of being courageous in the context of adult nursing

The organisational consequences are linked to the participants perceptions of the organisational culture, their apparent status as nurses within it and suggest nurses sense they are constrained by the hierarchical and patriarchal culture of the Health service.

6.5.1 Fear of the loss of role, job or registration

Several of the participants spoke about their fear of losing their role, job or registration and explained how they felt the

organisational culture negated their use of courage. If the organisation was not perceived to be conducive, for example supporting nurses by encouraging them to speak up and listening to them, this dissuaded them from using courage. Gallagher's (2010, 2011) papers observe the importance of the organisation being conducive to courageous behaviour. In the quote below Maz referred to a colleague in a leadership position who dealt with a situation but failing to follow procedure was subsequently demoted. This scenario impacted on Maz's view of being courageous in the future. Her perception was her colleague was punished by the unsupportive organisation for using initiative and making her own decision, potentially stifling Maz's future responses,

> *"one of my friends, something happened in the team, but she felt she had dealt with it herself….but, somebody complained to higher up….. she got in trouble, and she lost her role actually and she had to go back being a band 6, She's has since retired because of it all……it was awful to see her go through it…….I'd find it very hard to do," [P14 Community nurse 7 years].*

Rosie voiced her personal discomfort as fear of potentially losing her livelihood. Rosie was talking about how contrary to most of the participants she felt she had always been able to be courageous. She felt this was due to her more recent nursing education where courage was taught as an expectation. However, she explained that the reason she was courageous was driven by fear of losing her registration and livelihood, alluding to fear of repercussion which Castel et al *(*2015) found is a complex construct,

> *"people don't always have the courage to do as they should I suppose…….I have this massive fear of losing what I've worked so hard and sacrificed so much for….I think it's, yeah, fear definitely drives me to make sure that what I'm doing is right, yeah definitely" [P11 acute nurse 3 years].*

6.5.2 Nurses will take the blame if something goes wrong

Participants perceived they would take the blame if something goes wrong, as Rosie said, *"it's not the doctors that they blame it's the nurses" [p13]* below she explains why she has courage but also offers and explanation as to why she feels it is the nurse who is blamed.

"I think the knowledge of knowing what is right gives me the courage to voice it…….people see nurses as disposable…..you know, punch bag in a way…the next shift its going to be somebody else, but actually the next morning it's still going to be the same Consultant, so you annoy that Consultant and, you know "oh my god,"[P13 Acute nurse 3 years].

Her perception is that nurses understand that they are less important partly due to the continual changeover of nurses on shift, the doctor however will always be on the ward and the patients doctor, so nurses are more reluctant to challenge or annoy them.

Natalie worked in a specialist environment which she felt engendered courageous behaviour as she felt confident she would be supported, relating back to the importance of support and encouragement. However, her perception of nurses' experiences working within the same organisational culture but not in a specialist area was different. Natalie commented,

> *"as a system I do think that nurses on the wards are massively let down……and you know if that patient, if anything happens, and the patient dies say, you know they're going to rip that nurse to bits,"[P3 Acute nurse 16 years].*

Natalie does not specify within the quote who "they" are but refers to the system. Similarly, Ruby's analogy perceives the organisational culture is unsupportive and unconducive to nurses being courageous. Ruby recalled transitioning from student nurse to staff nurse, being courageous and how that felt as she said,

> *"yes [courage] definitely develops……when you're actually out there on your own, although you obviously have accountability when you're a student, literally you are that nurse now, and it's like being dipped into a pool of sharks,"[P15 Community nurse 15 years].*

Participants also believed nurses were more likely to be penalised than a doctor. Alex observed in chapter four nurses were *"cheaper to get rid of"* (4.3.6) and Rosie earlier in this section that nurses are *"disposable punch bags."* Participants perceived nurses were

more vulnerable than doctors to sanctions on them. This view was expressed by Maz echoing the voices of many.

> *"You don't see many doctors struck off like you do nurses do you, or going through it, it is, it's very sad," [P14 Community nurse 7 years].*

Although much of participants comments were based on fears, perceptions and hearsay rather than evidence, the NMC (2016) and General Medical Council (GMC 2016) reported figures and a recent study (Searle et al, 2017) do suggest some foundation in these fears, it does appear nurses are subject to harsher sanctions and do not receive the same level of support as doctors.

6.5.3 Whistleblowing

The organisational culture purports to be a no blame culture but as Francis (2015) reported this was not always the case. Ruby expressed her experience of the whistleblowing policy and how difficult she found this alluding to the organisational culture being ineffective in supporting nurses to whistle blow,

> *"it's a policy [whistleblowing] because it has to be there, it's politically correct, but how effective is that in actually supporting your nurses to whistle blow?*

…….it was awful, it took me ages, it took me until I left to do it" [P15 Community nurse 13 years].

Ruby's perception was that the whistleblowing policy did not bear relation to nurses operationalising it. Maz also talked about whistleblowing and how difficult it could be to execute. The suggestion by the researcher that the organisational culture was a no blame culture was met with the following response from Maz.

"Oh, but you do…… it's not true, that's what they say," [P14 Community nurse 13 years].

6.5.4 Extant literature fit with organisational consequences of being courageous

Several writers (Day, 2007; Murray, 2007; LaSala and Bjarnason, 2010; Gallagher, 2010, Gallagher 2011) have authored articles that intimate loss of status, employment and retaliation are fears faced by nurses being courageous. Though none are research studies their findings are coo berated by Francis's (2013) respected report into failings at Mid Staffordshire which found the organisational culture dissuaded staff from speaking up. Churchman and Doherty's (2010) research also corroborates these findings concluding male status and privilege continues as Jinks and Bradley (2004) observe, over 80% of the top managerial

positions in the NHS are held by men, and women [nurses], continue to be subordinate in the hierarchy and their work devalued. These authors strengthen the emergent theory that gender, organisational culture and socialisation all play a part in a complex picture of courage adding new theory to extant literature.

The fear held by participants that nurses were more likely to take the blame was not entirely unfounded. Johnson (2007) observed leniency was more likely to be demonstrated towards doctors and resonates with figures from the NMC (2016) GMC (2016) and Searle et al's (2017) recent research study demonstrating truth in the participants fears. Searle et al (2017) analysed more than 6,700 cases of misconduct finding similarities in the types and frequencies of misconduct amongst doctors and nurses. However, nurses appeared to face harsher sanctions.

Organizational factors challenge enacting the values of the profession. Faced with incongruence between values and perceived effectiveness, overall self-esteem, sense of group belonging and professional identity have been shown to decrease (Valizadeh et

al, 2016) linking the organisational consequences to the personal and professional prerequisites.

The participants are located within an organisation and society that is gendered, inferring a level of control that allows inequalities to appear natural and points to the socially constructed organisational culture where conformity to the organizations beliefs and priorities is expected. Thus, participants roles are situational and performed as determined by the organisation or context. Social reality is not one dimensional but multi-dimensional (Styhre and Eriksson-Zetterquist, 2008). In the context of this research, organisational culture confers a level of socially constructed knowledge and power exerting influence on systems such as class, sexuality, ethnicity and race and shaping the participants experience and comprehension of courage.

The emergent theory echoes the findings of the extant literature concerning the organisational consequences of being courageous. The organisation needs to ensure the culture is one where nurses and all staff can speak up and whistle blow, and that the

consequences of courageous behaviours are celebration and reward as opposed to the feared negative outcomes.

6.6 Reflexivity on my construct as a lecturer and researcher

The third construct to explore reflexively is how my identity with the participants as a lecturer and researcher influenced the co-construction of the data and subsequent grounded theory.

Gina was a junior lecturer who had been at the University for less than 6 months and I was more experienced than her. Gina may have felt obliged to consent to the interview as she was still on probation. This potential power dynamic may have influenced how she responded to me and I to her. Ballinger (2003) writes that the way you represent yourself is important and your profession is implicated in this, reinforcing assumptions regarding professional knowledge (appendices 10d). This was also my final interview. I was aware I was hoping to confirm my categories with theoretical sampling and felt apprehensive that something fresh or unexpected would emerge potentially preventing me from seeing anything new. Primeau (2003) notes the questions that are asked or ignored are influenced by assumptions, reflexivity can help the

researcher explore their own assumptions and revisit the data and their interpretation and co-construction.

When interviewing Gracie a research nurse, I was aware as Bryman and Cassell (2006) comment, the dynamic was again altered. For this interview I was conscious I did not position myself so explicitly as a nurse (appendices 10e and field notes 11d) as Gough (2003) observes, there are different selves and performances depending on the situation. I recall feeling nervous that the participant may be more experienced in conducting research than I and critique my inexperienced interview technique. My anxiety may have been palpable to Gracie. Conversely Gracie may have felt more guarded and apprehensive that I was judging her as a researcher. I recall I tried to build rapport confirming we had both worked in the same department, but Gracie appeared nonplussed by this and my attempt at rapport appeared misjudged potentially influencing how the interview proceeded. My preoccupation with how I was presenting myself (Goffman 1956) may have meant I missed important data subsequently then affecting the co-construction.

Applying a reflexive analysis to these interviews and the participants enabled me to see how important the dynamic between the participants and I was. Being too close or too distant, inexperience and attempting to identify with them as either woman, nurse, lecturer or researcher influenced the interviews, data gathered and subsequent co-construction. Harper (2003) says the researcher makes choices that will have consequences, for example using some transcripts more than others as they contain better examples of the themes to follow. The dynamic between the participants and I will have inclined me to which material I chose to co-construct and predisposed which stories and quotes I subconsciously felt drawn to and used in the co-construction.

Another avenue of reflexivity was found in supervision. Triangulation with the supervisory team helped me to consider and hone the accuracy of my analysis (Berger, 2015) and rather than producing abstract theory, reflexive social constructionism enabled new turns in the theory to be identified and followed (MacMillan, 2003).

6.7 Conclusion

Nurse participants appeared to speak honestly and with candour citing their stories of being courageous in practice and the subsequent positive and negative consequences. They perceived that there were beneficial consequences to using courage at a personal level and they drew self-esteem and positive regard from being a nurse, being courageous and knowing they had done the best for their patient. However, the perceived drawbacks were the psychological toll of emotional labour and personal discomfort. Socially they perceived the negative consequences to being courageous including being ostracised and or labelled. Finally, the organisational aspects were seen to include fear of potential loss of role, employment or their nurse registration.

The requirement for nurses to be courageous is confirmed. There is little research regarding the positive aspects of being courageous, but this study suggests the positive consequences of courage could be utilised to enhance nurses' experiences of using courage to benefit their self-esteem, professional identity and further enhance courageous behaviours. The participants observations and the subsequent co-construction of the emergent

theory highlights the influence of socialisation, gender, personality and organisational culture as implicit in the consequences of being courageous. These themes are integral to the developing emergent theory. The final chapter presents the emergent grounded theory of courage drawing the findings of this thesis together.

Chapter 7 Discussion and conclusion

7. Introduction

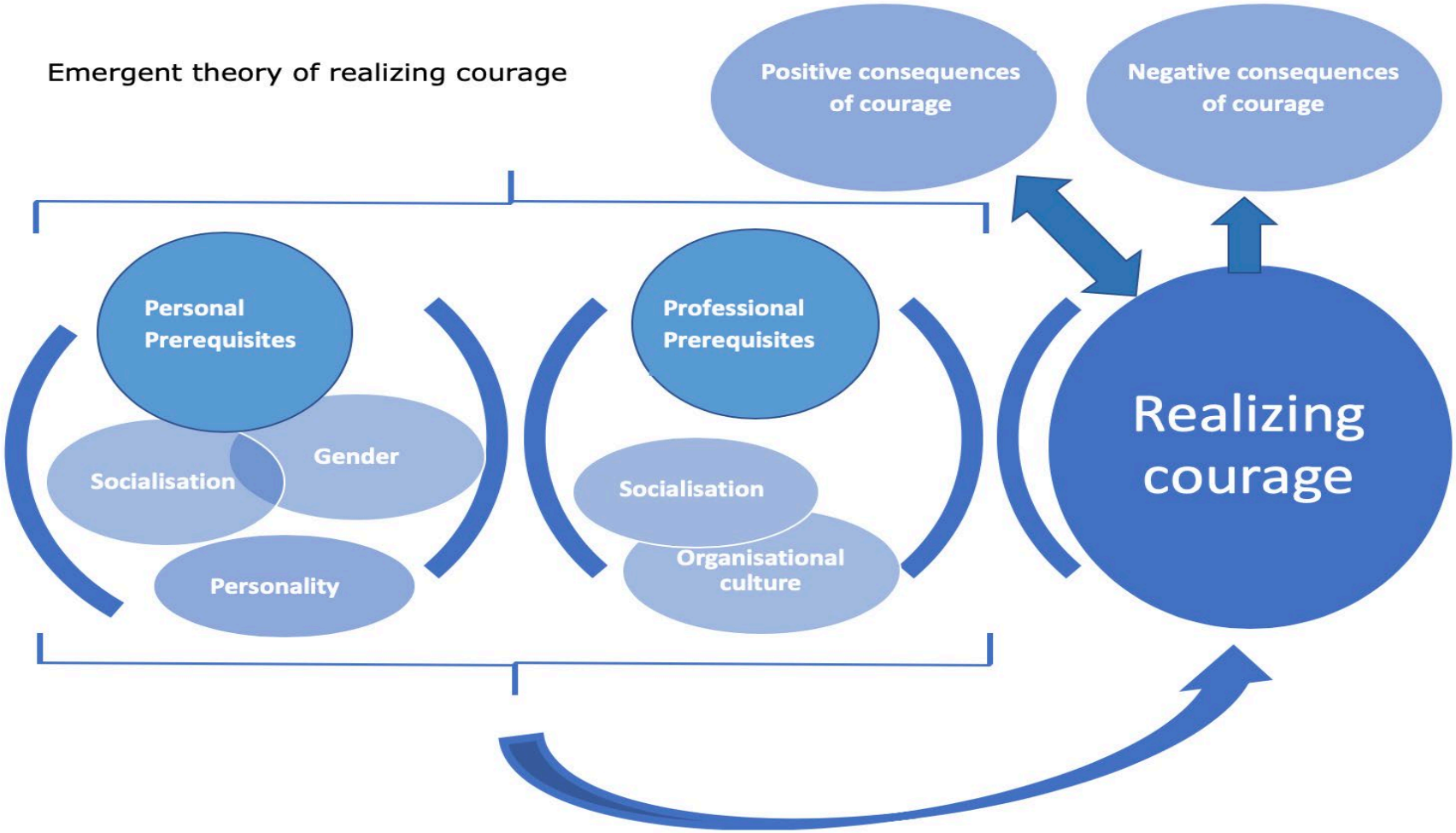
This final chapter discusses the findings of the research locating them in extant literature, drawing the findings of the study together and addressing the research questions: How do qualified adult nurses understand the meaning and use of courage in their everyday professional practice and how can a theoretical understanding of courage inform the future professional practice of qualified adult nurses? The chapter also brings together the evidence from the background and literature review chapter, considers the implications for nursing and nursing practice, offers an evaluation of the grounded theory, its contribution to existing knowledge, the implications for nursing practice, the limitations of the study and future research implications.

7.1 The grounded theory: Realizing courage

The co-construction of the emergent grounded theory is presented under the core category of realizing courage which encompasses the required prerequisites of courage, what courage means to

nurses, acts of courageousness and the consequences for nurses of being courageous. The grounded theory is presented pictorially below.

Emergent theory of realizing courage



7.1.1 Introduction to the discussion of the emergent grounded theory

The emergent theory delineates the concept of courage as socially constructed through the experience, background and the current context the person is in and the realisation of courage is shaped by interacting influences that are not mutually exclusive. Each of the main categories are discussed below in relation to the emergent theory.

7.1.2 Prerequisites of courage

Personal prerequisites are influential prior to starting nursing and cultural socialisation is a crucial influencing factor as a pre-requisite in the social construction of courage. Cultural socialisation impacts on the development of self-esteem, resilience and moral values whilst also influencing the development of perceptions of self-according to culturally gendered expectations. Personality is presumed to be potentially partially heritable but is also influenced by personal cultural socialisation and in terms of courage, life experiences, circumstances and increasing age may all enhance or negate courageous ability. Courage as a social construct developing through experience, background and current context resonates with Rate et al's (2007) view that courage may be better understood as a response to specific external conditions than as an individual character trait or attribute.

Parsons (1954) Hoschild (1979) Miers (2000) and Dinmohammadi et al (2013) found our perceptions are ingrained through cultural and societal norms beginning from an early age and extant literature informs us that women are socialised to accept certain roles and behave in certain ways (Hoschild, 1979; Miers, 2000). Additionally, cultural socialisation influences personality characteristics, self-esteem and age and life experiences which are all significant in the development of a moral value system which is an important factor in realizing courage. Self-esteem is particularly key to courageous behaviours and is connected to personality characteristics, learned experiences and gender as important contributors to the development of values (Krizan and Suls's 2009, Iacobucci et al, 2013 and Valizadeh et al, 2016). Numminen et al's (2016) concept analysis also denotes the importance of self-esteem connecting self-esteem with personal circumstances and resilience and provides a positive underpinning to this research findings. Personality, experiences, gender and self-esteem were all found to be implicit in this study's findings to enable courage and enhance its development.

Moral values were important prerequisites initially developed by cultural socialisation. Conscience and a strong sense of right and wrong underpin nurses' moral values and enable courageous behaviours. Conscience has been explored in the literature by Jensen and Lidell (2009), Thorup et al *(*2012) and Numminen et al (2016) who describe conscience as an inner motivation. Iacobucci et al's (2013) study found once established values were immutable, this study challenges Iacobucci et al's study, finding that women's age, maturity and experience can enable them to challenge their perceived subordinate status in their lives, to change their perceptions, values system and realise their courage.

Professional socialisation was also an important influencing factor in the development of prerequisites for courage continuing the advancement of the perceived nurse persona enhanced by the Code for nursing (NMC, 2015). Professional socialisation also engendered or reduced nurses' resilience and emotional intelligence and if encouragement, trust and support were valued within the team and by the organisational culture, could enhance courageous behaviours.

Professional socialisation sealed nurses' identification with the nurse persona and the Code for nursing enhanced their ability to be courageous. These findings resonate with Lai and Lim's (2012) study into professional socialisation that individual perspectives are initially internally adopted through birth inheritance and cultural socialisation, subsequently being reinforced by the organisations people work in. Shaw and Timmons (2010), Timmons and East (2011) and Zarshenas et al (2014) all opine that nurse identity forms early confirming timely effective professional socialisation is essential.

"Game playing" was revealed by this study as relevant in nursing in the context of courage and is constructed in the emergent theory as collaborative emotional intelligence that is developed through cultural and professional socialisation. Game playing was first observed by Stein (1967) and Holyoake (2011) suggests nurses continue to engage in game playing which is corroborated by Churchman and Doherty (2010) who observe nurses use female charm to influence doctors. Ben-Noam (2018) and Kaya et al (2018) link emotional intelligence to women, confirming the proposed link to gender.

Nurses enacting courageous behaviours need to be resilient. Resilience derives from personality and cultural socialisation and is enhanced or negated by both professional socialisation and the organisational culture. Professional resilience has been widely explored in nursing research (Hee Noh, Lim, 2015; Traynor, 2017) and Herrman et al (2011), Eley et al (2012), Hee Noh, Lim (2015) and Montes-Hidalgo and Tomas-Sabado (2016) all connect enhanced resilience to positive self-esteem, the individual's moral values, personal characteristics and life circumstances, connecting the professional and personal prerequisites to courage. Zarshenas et al (2014) also found professional socialisation could increase nurses' self-esteem and their feeling of belonging to the profession increasing nurses desire to succeed. This study also resonates with Pury and Kowalski (2007) and Rate et al's (2007) findings in the context of psychology that a hallmark of courage is said to be persistence or resilience. Finally professional trust, encouragement and support were found to be prerequisites to courageous behaviours which Babiker et al (2014) and Kieft et al *(*2014) found positively effect patient safety and outcome.

7.1.2.1 Origins and development of courage

The origins and development of courage have not been studied in nursing. The findings of this research are that courage could be believed to be an innate quality but also develops through education as a learnt skill, highlighting the links to both cultural and professional socialisation and education. Courage has been referred to as an inner quality or motivation (Ford Walston 2004, Arman, 2007 and LaSala and Bjarnason, 2010) but Thorup et al (2012) and Ekström and Idvall's (2015) research finds nursing courage is a developing skill. Confidence and positive self-esteem are associated with courage and nurse education could enhance both.

Though not written in the context of nursing Purtilo (2000) and Clancy (2003) papers both state courage can be taught because techniques can be learnt, for example to deal with conflict or make decisions which could then enhance the ability to be courageous. This research concurs with their opinion finding that when courage was integral to nurse education nurses were empowered and there was potential for their courage to be enhanced. Macdonald et al *(*2018) thematic review similarly suggests learning the skills for heroic behaviour is effective in increasing courage and can be

achieved through socialisation, encouragement and education, reinforcing professional socialisations importance.

7.1.3 Realizing courage: The meaning of courage to nurses

This study found nurses do not see themselves as courageous and that nurses' difficulty in identifying with courage is related to their female gender linked to intersectionality. Female nurses struggle to perceive themselves as courageous due to their early cultural socialisation that has shaped their perceptions and beliefs about themselves as women. This study did not seek to provide a specific definition of courage, but participants expressed what they understood courage in nursing meant to them; to protect the patient and be fierce, tolerate emotional discomfort, overcome altruism to put themselves first, be able to speak up, do the right thing, refuse to do the wrong thing, say no and have courageous conversations. Although courage's meaning has not been studied in the context of adult nursing these findings resonate and add to extant literature originating in psychology (Shelp 1984; Rate et al, 2007; Sekerka and Bagozzi, 2007; Tillich, 2014). The nursing definition of courage (Cummings and Bennet 2012) also resonates with the findings of this study in doing the right thing and speaking up. This research offers a view of courage delineated by nurses themselves adding a new understanding of courage in nursing.

7.1.4 The consequences of being courageous

The positive consequences of being courageous were found to be the reward of knowing the best had been achieved for the patient which increased job satisfaction and provided access to more opportunities and experiences which could further nurses' careers. Additionally, the positive regard of others led to an increase in self-esteem linking the positive consequences to the influence of gender, cultural and professional socialisation. The link to increasing self-esteem is important as this study found a positive self-esteem was a prerequisite to being courageous. Dahl et al (2014) and Black et al (2014) found positive consequences of courage were that courage could strengthen professional identity and the quality of care respectively.

The negative consequences of courage have been considered by several writers but none are research studies (Day, 2007; Murray, 2007; LaSala and Bjarnason, 2010; Gallagher, 2010, Gallagher 2011). This research study found as they opined that loss of status, employment and retaliation are fears faced by nurses being courageous and are corroborated by Francis's (2013) respected report into failings at Mid Staffordshire which found the organisational culture dissuaded staff from speaking up. This

research conclusions strengthen the views of the above authors and Francis's report, that nurses' fear of repercussions for being courageous do dissuade or discourage them from courageous behaviours and support the emergent theory that gender, organisational culture and socialisation all play a part in a complex picture of courage. The organisational culture and its impact on courageous behaviours has been written about in opinion papers (Gallagher, 2011; Gallagher, 2011) and this study found evidence to confirm Gallagher's views. Fear that may accompany courage is inclusive in most definitions of courage (Shelp 1984; Rate et al, 2007; Woodard and Pury, 2007; Tillich, 2014) but has not been subject to research in nursing, this study confirms that fear is a presence nurses have to overcome.

The emotional toll and discomfort associated with courage were also revealed by the participants in this study. Several researchers have explored the concept of moral distress, alternatively referred to as burnout in nursing (Schluter et al, 2008; Gallagher, 2010, Barlem et al, 2013; Dahl et al, 2014; Savel and Munro, 2015; Whitehead et al, 2015) but only Dahl et al's study, though not focused on courage but professional identity, makes reference to courage. This study found the emotional toll and discomfort associated with courage

could lead to emotional distress potentially leading to burnout and an intention to leave nursing (Whitehead et al, 2015).

Nurses in this study also confirmed the negative consequences of being courageous considered in opinion papers regarding being socially ostracised and labelled as difficult (Stein, 1967; Kidder and Bracy, 2001; Dahl et al, 2014; Matoušová and Tollarová, 2014). This study confirms nurses fear the consequences of being courageous and implicates the organisational culture as being unconducive or unsupportive to nurses enacting courage.

Schein (1996) suggests the significance of organisational culture has been overlooked and Gallagher (2011) observes the organisational culture is culpable, impacting on freedom to use courage. It is apparent that the expectation of nursing in the organisation is towards nursing as a profession highly suited to females (McLaughlin et al, 2010) however, within the organisation policies, practices and procedures are governed towards a masculine majority (Jinks and Bradley, 2004). This research confirms the view that the organisational culture and hierarchy needs to encourage and be conducive to using courage. The current

cultural landscape of the organisation makes realization of courage in nursing a continued challenge.

7.1.5 The theory's contribution to new knowledge

The emergent grounded theory compliments and contributes to existing extant literature as discussed above and presents new research findings regarding nurses understanding and use of courage. Courage features in four research studies focused on nursing (Spence and Smythe, 2007; Thorup et al, 2012; Dinndorf-Hogenson, 2013; Bickhoff et al, 2014) conducted in Australia, America, New Zealand and Denmark respectively. Thorup was the only researcher whose participants were general adult nurses, but their study focused on care, vulnerability and suffering and courage was not the foci.

This study has identified several new findings in relation to courage in nursing that have not been previously identified. Courage as a concept in nursing is found to be a social construct influenced by cultural and professional socialisation. To realize courage requires personal and professional prerequisites which have not been previously recognised, and self-esteem is implicated as crucial in enabling courageous behaviours and its cyclical effect in enhancing self-esteem and subsequently further courageous behaviours is

important. In nursing as predominantly, female it is also thought-provoking to find that gender is such an important factor in nurses' ability to be courageous and confirms the importance of early effective professional socialisation. Personal life and situational context are also relevant in nurses' ability to be courageous at work and gender and personality are both implicated as contributory to courageous behaviours. This study confirms the opinion and discussion papers suggestions that negative consequences to courage are several folds and that the organisational culture inspires or negates courage setting the tone to enable nurses to achieve courage. However, the organisational culture is not perceived as supportive, rewarding or embracing of courage and has responsibility for stifling nurses' courage. The findings also illustrate there are positive consequences to courage that could be championed, especially its benefit on self-esteem as this can further courageous behaviours.

This study is the first to ask nurses what they believed courage meant. Speaking up and doing the right thing resonates with the nursing vision (Cummings and Bennett 2012) but also revealed new knowledge that nurses perceived courage as being fierce and protective, saying no and having courageous conversations.

Finally, at the start of this thesis the most common types of courage were defined as physical, psychological and moral courage. The researcher did not define these with participants and asked about their experience of courage in generic terms. Moral courage has been referred widely to in nursing literature (Lachman, 2010; Metcalfe, 2014; Raso, 2014; Oakley, 2015; Schmidt, 2015) but has not been studied yet there seems to be an assumption when courage is discussed in nursing it is moral courage. Although participants in this study did consider morality a factor in courage, many of their stories pointed to psychological courage defined by Putman (1997) and Numminen et al (2016) as facing one's own psyche, fears and anxieties as being more significant. This is a new finding.

7.2 Evaluating constructionist grounded theory

Grounded theory is validated by the constant comparison of data with data and the rigour employed to analyse the data and form the theory (Andersen et al, 2013). However, the interpretation and co-construction offered is one story among an infinite number of possible stories (Mauthner et al, 2003). Grounded theory may be criticised for not fitting traditional research criteria making it difficult to evaluate (Luckerhoff and Guillemette, 2011), however,

evaluation of the emerged grounded theory is essential as Charmaz (2014) writes, the theory will make sense to its author but may not to others who will judge it. Additionally undertaking a professional doctorate requires an authoritative account defending the contribution to knowledge (Mauthner etal 2003).

Gasson (2003) observes the theory should be judged on an alternative criterion of trustworthiness which only emerges from sufficient data analysis and the researcher needs assurance it is not a single situation being described. This can be achieved by considering criteria of confirmability, auditability, authenticity and transferability, described by Charmaz (2014) as credibility, originality, resonance and usefulness which are the criterion used in this research.

7.2.1 Credibility

Emersion in the data through personally transcribing and constant data comparison (Charmaz, 2014) results in intimate familiarity with the topic. The co constructed data supports the claims made with a range and number of participant observations that demonstrate depth. Verbatim use of the participants own words and explicit reflexivity related to the findings also adds trustworthiness to the work (Chiovitti and Piran, 2003). Confirmability, authenticity

and credibility have been termed internal consistency (Gasson 2003, Charmaz, 2014). The systematic comparisons between the observations offered and the presented categories have been made explicit and the links between the data, analysis and argument have been made clear. Chapters four, five and six, provide evidence to support the developed theory. Charmaz (2014) proposes the reader can form their own independent assessment from the evidence presented.

7.2.2 Originality

The second of Charmaz's (2014) suggested evaluative criteria is originality. Courage has been studied previously, notably in psychology. However, there are limited studies in nursing specific to courage and none in the UK with general adult nurses. This study has revealed fresh categories and new insights, for example the impact of nurses' personal life on courage, the influence of personality and self-esteem and confirms the opinion papers views on the impact of the organizational culture regarding the negative consequences of courage. Additionally, although previous studies have explored gender, personality, socialisation and organisational culture in nursing, they have not been studied with a specific focus on courage. The emergent theory provides new concepts of courage in nursing that have potential social and theoretical significance and

new and original thinking into understanding the meaning of courage in adult nursing, including the factors that influence nurses' ability to realise their courage.

7.2.3 Resonance

The theory needs to be identifiable to the participants and reader (Charmaz, 2014) or to fit and offer work relevance (Andersen et al, 2013). The categories in this study portray the depth and range of the participants' experience revealing both new meanings and meanings that resonate with the previous studies mentioned above. Parallels are drawn between both participants individual lives but also their interactions with each other and the organisations they work within. These connections offer relevance regarding what is important to the participants (Andersen et al, 2013). The analysis underpinning the grounded theory was shared with nurse colleagues outside the study who confirmed it resonated with their lives and worlds. The early findings from the study were also presented at three conferences and the positive feedback received resulted in an invitation to write a publication for Nursing Management Journal (Barchard et al, 2016 appendice 13). This suggests the study and its findings resonated with colleagues attending the presentation.

7.2.4 Usefulness

Transferability has several meanings and one is usefulness (Gasson, 2003). The grounded theory offers interpretations that are useful in the everyday world of nursing both contributing to knowledge and making a better world for nurses adding to its transferability. These are explored further below in the implications for practice but in brief the grounded theory has the potential to inform nurse education, recruitment, retention, support and development offered in nursing. The analysis suggests areas for further research into substantive areas, for example the influence of personality which is a marker of a study's usefulness (Charmaz, 2014). The methodology outlined in chapter three also adds to the usefulness of this research project. Gasson (2003) writes that ensuring the methodology is clear, reproducible with auditable processes and reflexivity minimizing the impact of subjectivity all add to the researches transferability.

Interpretive research favours discerning socially-constructed norms and relationships located in culture as this research offers. A robust combination between the originality and credibility of the theory increases its resonance, usefulness and the subsequent value of its contribution (Charmaz, 2014). To claim scholarly contribution

relevant cross disciplinary boundaries in the literature are carefully studied clearly positioning the grounded theory. This grounded theory is clearly positioned in adult nursing and the study's credibility, originality, resonance and usefulness judge the merit of the empirical study and theory development.

7.3 Implications for practice

The emergent theory offers new knowledge that has the potential to ultimately inform practice. The findings of the study that have implications for practice are as follows.

- Courage is complex and multi-layered; the educational curriculum and practice need to recognize this to support nurses' development and use of courage.
- There are personal prerequisites to courage:
    - Courage may have an innate quality, but education can develop a more explicit understanding of courage.
    - Gender influences courageous ability in women.
    - Personal circumstances impact on the use of courage at work.
    - Personality characteristics impact on courage.
    - A positive self-esteem is key to courageous behaviours.
- Effective professional socialization, including positive role models will develop and enhance courage.

- Organizational cultures must actively support, embrace, and reward courage negating the negative consequences.
- Doctors, nurses, and the inter-professional team need to work together more effectively within the organizational culture supporting each other to negate the negative consequences.
- Self -esteem and personal value increase by realizing courage.

Each of these are discussed below.

7.3.1 Discussion of implications for practice

Nursing visions have identified courage as a necessity (Cummings 2012, NHS England (2014b, 2016) and courage will always be required to be able to deliver care to patients, for example to deliver bad news (Hamric et al, 2015), to argue for and provide the best care, challenge colleagues, help patients face their distress and vulnerability (Thorup et al, 2012) to help patients face death, refuse gifts or take risks (Crigger, 2011) and as identified by the participants in this study, to protect and be fierce for patients, to tolerate the emotional labour and have courageous conversations. However, ongoing nurses' development and education in the complex and multi-faceted nature of courage has not been evident. This study has found there are prerequisites to courage which have potential implications for recruitment of nurses and the continuance

of values-based interviewing (Health Education England, 2016), but perhaps more pertinently at a time of national shortage, the retention of nurses which could be improved through professional socialisation, education and support.

Nurses professional socialisation, defined as the process through which values and norms of the profession are internalised into the self-concept can be facilitated by education (Lai and Lim 2012). Purtilo (2000) Clancy (2003) and Miller (2005) all suggest courage can be learned and other writers support the notion that education of student nurses should include courage, though the link between education and increase of courage as yet is unclear (Spence and Smythe, 2007; Lindh et al, 2008; Hawkins and Morse, 2014).

Purtilo (2000) observes that anchoring students' moral values and ethics can be achieved within the curriculum through teaching the skills of critical analysis, decision making, problem solving and alliance building using case studies, simulation and role modelling by the nurse educators. These techniques can encourage the development of courage within a safe environment of affirmation.

Ethical issues in nursing apply not only to patients but to inter-staff relationships between themselves and the organisation and are defined by mutually constitutive intersectionality factors including age, culture, class, gender, sexuality and race (Iona et al, 2018). A lack of awareness and understanding of the power dynamics can result in nurse educators and nurses imposing the dominant discourse on already marginalised groups and unintentionally further ostracising them (Van Herl et al, 2011).

Clancy (2003) suggests that courage can be developed through role playing and learning to control fear. Miller (2005) supports the development of virtues through education that cultivates the virtues through habit and supports the views of Lai and Lim (2012) who propose creating the required educational experiences to facilitate professional socialisation and engender courage. Courage within the educative curriculum can be further advanced through initiatives such as Cope and Whittaker's (2012) work on being brilliant. This engenders an ethos of being the best version of yourself that you can be coupled with developing resilience to enable students to develop the skills required to be courageous.

The educational curriculum must acknowledge and develop nurses understanding of how positions are occupied, influence and affect one another and where power does or does not lie. Students and nurses should be encouraged to cultivate their awareness of the multifaceted nature of power and disadvantage (Iona et al, 2018) through exploring their own identities within their education. This can be achieved through innovative educational strategies including role play, simulation and exercises that encourage discussions around diversity, difference and inclusion. Nurse educators need to address the dynamics of education for students from multiple backgrounds and their own intersectionality before they provide care for people who are also from multiple backgrounds (Van Herl et al, 2011). This awareness could help facilitate the courage and resilience required to manage ethical problems between themselves, the organisation and with their patients (Iona et al, 2018).

Harper Simpson's (2009) study suggested socialisation in practice had more influence than socialisation in the nursing faculty and there was incongruence between them, suggesting the practical nature of nursing is more highly regarded and referring to gender and what are perceived to be women’s natural abilities. Benner

(2012) has commented on this phenomenon often referred to the practice -theory gap and states a radical change to nurse education is required. Professional socialisation and education of nurses in practice should include exploration of the impact of gender, personality, self-esteem and personal circumstances on courage.

This study has demonstrated personal circumstances and self-esteem impact on realising courage in practice implying that nurses need support both professionally and personally both from the organisation and each other. Farrell (2001) Wright et al (2014) and Brunworth (2015) all found nurses fail to support each other and Francis (2013) found a lack of organisational support led to failings in the Mid Staffordshire enquiry, emphasising the importance of support for nurses and ultimately in enhancing patient's safety. Supportive networks have been noted by Jackson et al (2007) and Hart et al (2014) to be useful in nurturing resilience and Spence and Smythe (2007), LaSala and Bjarnason (2010) and Dinndorf-Hogenson (2015) all reported peer support helped the collective be stronger and that nursing needs to create supportive environments.

The findings in this study suggest self-esteem is of special relevance in courage. Positive self-esteem enables courage and subsequently

increases positive regard and self-esteem, the converse being true when self-esteem is negative. Developing professional and personal support networks in nursing that enhance nurses positive regard of themselves and each other and increases their feeling of value appears a crucial element to the realization of nurses' courage.

The emergent theory also found that the organisation and its hierarchical nature was perceived to be unconducive to nurses being courageous and that nurses suffered undue consequences or were blamed if things went wrong. Nugus et al (2010) observes health care needs to be collaborative rather than authoritative and Dean and McAllister (2017) note, not only do nurses learn through socialisation and role modelling, so do doctors. In practice doctors and nurses need to collaboratively work together more effectively and more work is needed to ascertain the best design for the work environment, enable facilitation of relationships and realisation of courage. This is not only the responsibility of nursing. Just as nurses need to embrace courage, the organisations also need do more than offer lip service to courage's realisation (Gallagher, 2010, 2011).

7.4 Limitations of the study

The limitations and strengths of the research and the emergent grounded theory are presented in table 22 below.

Strengths
Grounded theory is ideal for subjects about which little is known
The focus on one field provides specific context
Constant comparative approach
Revealed new knowledge and understanding about a topic not previously studied
Use of reflexivity enhances co-construction
Offers direction for future research
Limitations
All participants were adult nurses
All participants were female
Largely homogenous group lacking cultural diversity
The presence of the protocol in case of a safety related issue may have stifled participants stories
Data represents a specific point in participants lives
Declaring Saturation

Table 20. Limitations and strengths of the grounded theory

The choice of constructionist Charmazian grounded theory is a strength. Charmaz (2014) uses the term constructivist and departs from the traditional Glaserian (1967) grounded theory, however she concurs social constructionism is congruent with her beliefs and as Heath and Cowley (2003) and Fendt and Sachs (2008) observe, overly orthodox application of specifics risks undermining the strengths of grounded theory. Amsteus (2014) also concludes divergent grounded theory is valid. The grounded theory was constantly compared to participants data and cross referenced with experts external to the participants exploring if the theory "fit" with them which Cooney (2011) advises. The strengths of the emerged theory are the embedded reflexivity and constant comparative approach (Charmaz 2014).

Potential limitations can be overcome by ensuring the participants guide the inquiry and the theoretical construction is compared to participant data including participants' actual words. The researcher articulates their views, enhanced by reflexivity and each category emergent in the theory is compared to the related literature (Chiovitti and Piran, 2003).

All participants being adult nurses could be viewed as a limitation, other fields of nursing may have different experiences and interpretations meaning the theory can only be said to apply to this one group. However, the focus on one field is potentially a strength as the theory has resonance and impact for that group and opens possibilities for future research regarding different fields. The participants all being female and a relatively homogenous group in terms of diversity also limits the theory, but provides opportunity for further exploration in future research. Presently culture, diversity and differences in gender cannot be commented on but future research could consider this.

The necessity of the protocol to follow should an issue of concern be raised had the potential to stifle participants thoughts and what they were prepared to divulge. The protocol was not required during the interviews, but it must be considered this may be due to participants awareness of it.

Grounded theory represents a specific time in the lives of the participants. However, this was across 15 nurses' lives and the co-constructed categories explicate their experiences. Achieving saturation is considered contentious and may be considered an act

of judgement (Charmaz, 2014; Hennink et al, 2017). However, Guest et al (2006) proposes saturation may be reached within 12 interviews and for the purposes of this study the term saturation sufficiency is used (Dey, 2004).

7.5 Research implications

Future research can elaborate on this study's findings. Research should explore whether similar findings regarding courage apply to other fields in nursing to ascertain if there are different experiences of courage. A second research study exploring all nursing fields with a diverse heterogeneous sample should be undertaken exploring whether courage is different in mental health, learning disability, child nursing and midwifery fields of nursing. Male nurses should also be researched to determine if they perceive courage differently as this has implications for professional socialisation and education surrounding courage.

Another direction for future research could explore how inter professional groups can enhance their understanding of each other, work more effectively together and how they experience courage, this should include a diversity of inter professional roles, including doctors.

The emergent themes of a potential link with personality and courage also warrants further exploration as does the link to self-esteem. Both areas have been implicated in this research, self-esteem strongly so and further research could study the impact and specifics of both these influencing factors on courage.

The requirement for courage has been posited to be different in the community to acute practice and specialist practice and are also worthy of further exploration. A confirmed difference in courage in these clinical settings would have implications for the development and support of health care professionals' dependent on their clinical area.

Support and encouragement has been found to be important in realizing courage but not the specifics of what this may entail and how best it may be offered, research could assist in ascertaining what kind of support is most effective for nurses to realise their courage.

Further research could also explore if there is a correlation between effective professional socialisation and education and an increase in courage. Francis (2013, pg 1579) states,

> *"Courage and judgement are not qualities that can easily be taught".*

The research could explore education and development in courage and which format best supports the realization of courage and if and how it is effective in increasing courage.

Finally, research could explore the influence of organisational culture which was noted by Francis (2013) and this study to be inconducive to realising courage. A research study could seek to find how the organisational culture could be improved to embrace, encourage and reward courage.

7.6 Conclusion

The fifteen participants in this study have contributed to a new understanding of the meaning and use of courage in everyday nursing practice. A trajectory or journey to realising courage has been articulated. This proposes that gender, intersectionality, personality, self-esteem and socialisation are all influential as pre-requisites to courage which is a socially constructed concept. Nurses struggle with overcoming the influencing elements that prohibit

courage due to their gender, cultural and professional socialisation. Effective professional socialisation including educational development of nursing courage may help nurses to overcome these challenges. The organisational culture needs to take responsibility to encourage and reward courageous behaviours and can also mitigate against the negative consequences of courage. The positive consequences of courage should be promoted in professional socialisation as they can enhance a positive self-esteem which is crucial in courage.

The proposed emergent theory illustrates the complexity of the relationships between these dynamics. As Jackie Smith, NMC Chief Executive and Registrar observed, at a time when figures show more nurses and midwives are leaving the register than joining it (Smith, 2017) this new knowledge could assist in recruiting the right people to join nursing, developing, educating and retaining those already in nursing and in enabling nurses to realize their courage to its full potential.

References:

Adam, H. and Galinsky, A. D. (2012) 'Enclothed cognition', *Journal of Experimental Social Psychology*. 48(4), pp. 918–925.

Alessandri, G, Vecchione,M and Tisak,J. (2012) 'The Utility of Positive Orientation in Predicting Job Performance and Organisational Citizenship Behaviors', *Applied Psychology: An International Review. 61(4) pp.669-698*

Allan, H. T. (2016) 'Editorial: The anxiety of caring and the devaluing of nursing', *Journal of Clinical Nursing*, 26, pp. 299–301.

Amsteus, M. N. (2014) 'The Validity of Divergent Grounded Theory Method', *International Journal of Qualitative Methods*, 13(1), pp. 71–87.

Andersen, P., Inoue, K. and Walsh, K. (2012) 'An animated model for facilitating understanding of Grounded Theory and the processes used to generate substantive theory', *Journal of Research in Nursing*, 18(8), pp. 734–743.

Andrews, T. (2012) 'What is Social Constructionism?', *The Grounded Theory Review*, *An International journal*. 1(11), pp. 39–47.

Anthias. F. (2012) "Intersectional what? Social divisions, intersectionality and levels of analysis" *Ethnicities* 13(1) 3–19

Aranda, M., Castillo, M. and Montes, B. (2015) 'Has the traditional social perception on nurses changed? Attribution of stereotypes and gender', *Acción psicoloógica*, 12(1), pp. 103–112.

Arksey, H. O' Malley, L. (2005) 'Scoping studies: towards a methodological framework'. I*nternational Journal of Social Research Methodology.* 8:1, pp19-32

Arman, M. (2007) 'Bearing witness: An existential position in caring', *Contemporary Nurse*, 27(1), pp. 84–93.

Austin, W. (2012) 'Moral distress and the contemporary plight of health professionals', *HEC Forum*, 24, pp. 27–38.

Aveyard, H. Payne, S. Preston, N. (2016) *A Post-graduate's Guide to Doing a Literature Review in Health and Social care*. England. Open University Press. McGraw-Hill

Babiker, A. Husseini, M. Al Nemri, A. Al Frayh, A. Al Juryyan, N. Faki, M. Assiri, A. AlSaadi, M. Shaikh, F. Al Zamif, F. (2014) 'Health care professional development: Working as a team to improve patient care.', *Sudanese journal of paediatrics*, 14(2), pp. 9–16.

Baillie, L. (2015) 'Perspectives: We need to talk about the 6Cs: perspectives on a recent debate', *Journal of Research in Nursing*, 20(4), pp. 331–336.

Baillie, L., Gallagher, A. and Wainwright, P. (2008) *Defending Dignity – Challenges and opportunities for nursing*, London Royal College of Nursing.

Ballinger, C. (2003) Navigating multiple research identities: reflexivity in discourse analytic research. Finlay,L. Gough. B.(eds) 'Reflexivity A Practical Guide for Researchers in Health and Social Sciences', Oxford: Blackwell science.

Banister, P, Bunn, G, Burman, E, Daniels, J, Duckett, P, Goodley, D, Lawthorn, R, Parker, I, Runswick-Cole, K, Sixsmith, J, Smailes, S, Tindall, C, Whelan, P. (2011) *Qualitative methods in psychology. A research guide*. 2nd edn. England Open University Press.

Barchard, F. Sixsmith, J. Neill, S. Meurier, C. (2017) '6Cs and ten commitments: Nurses' understanding and use of courage', *Nursing Management*, 23(10).

Barlem, E, L, D, Lunardi, V, Lunardi, G, Brlem, J, G, Silva da Silveira, R. (2013) 'Moral distress in everyday nursing : hidden traces of power and resistance', *SciELO Analytics*.

Barrick, M. R. and Mount, M. K. (1991) 'The Big Five Personality Dimensions and Job Performance: a Meta-Analysis', *Personnel Psychology*, 44(1), pp. 1–26.

Baughan, J. and Smith, A. (2013) *Compassion, Caring and Communication: Skills for Nursing Practice, Second Edition*. London Routledge.

Bazeley, P. Jackson, K. (2013) *Qualitative Data analysis with NVIVO*. 2nd ed. London. SAGE.

Ben-Noam, S. (2018) 'Cracking the Intrapsychic "Glass Ceiling" for Women in Leadership: Therapeutic Interventions', *Psychoanalytic Inquiry*. 38(4), pp. 299–311.

Benner, P. (2012) '*Educating Nurses: A Call for Radical Transformation* —How Far Have We Come?', *Journal of Nursing Education*, 51(4), pp. 183–184.

Berger, P. L. and Luckmann, T. (1991) 'The social construction of reality: A treatise in the sociology of knowledge. London. *Penguin social sciences Group*

Berger, R. (2015) 'Now I see it, now I don't: researchers position and reflexivity in qualitative research', *Qualitative Research*, 15(2), pp. 219–234.

Bickhoff, L., Levett-Jones, T. and Sinclair, P. M. (2016) 'Rocking the boat - nursing students' stories of moral courage: A qualitative descriptive study', *Nurse Education Today*. 42, pp. 35–40.

Bickhoff, L., Sinclair, P. M. and Levett-Jones, T. (2014) 'Moral courage in undergraduate nursing students: A literature review', *Collegian*. 24(1), pp. 71–83.

Bickman, L, Rog, D, J. (2009) *The SAGE Handbook of Applied Social Research Methods*. 2nd edition. Thousand Oaks California. SAGE

Birks, M, Mills, J. (2015) *Grounded theory A practical guide*. 2ND Edition. London: Sage.

Black, S. (2011) '*Being a mentor who fails a pre- registration nursing student in their final placement : understanding failure*' Doctor of Philosophy. South Bank University. London

Black, S., Curzio, J. and Terry, L. (2014) 'Failing a student nurse: a new horizon of moral courage.', *Nursing ethics*, 21(2), pp. 224–38.

Bleidorn, W. Arslan,R. Denissen, J. Rentfrow, P. Gebauer, J. Potter, J. Gosling, S. (2016) 'Age and gender differences in self-esteem—A cross-cultural window.', *Journal of Personality and Social Psychology*, 111(3), pp. 396–410.

Bond, D. Ramsey, E. Boddy, C.R. (2011) 'Projective techniques: Are they a victim of clashing paradigms?' *Munich Personal RePEc Archive.* Nottingham Business school. University of Ulster

Boorman, S. (2009) *NHS Health and Well-being review*, Department of Health. London. Crown copyright.

Bowling, A. (2014) *Research methods in Health: Invesitagting health and health services*. 4th edition. England: Open University press. McGraw Hill Education.

Booysen. L. A. E. (2018) "Workplace Identity Construction: An Intersectional-Identity-Cultural Lens" [Online] Available at: http://oxfordindex.oup.com/view/10.1093/acrefore/9780190224851.013.47 [Accessed 20/2/19]

Bradshaw, A. (2016) 'An analysis of England's nursing policy on compassion and the 6Cs: The hidden presence of M. Simone Roach's model of caring', *Nursing Inquiry*, 23(1), pp. 78–85.

Braun, V. and Clarke, V. (2006) 'Using thematic analysis in psychology', *Qualitative Research in Psychology,* 3 (2) pp. 77–101.

Bringer, J. D., Johnston, L. H. and Brackenridge, C. H. (2007) 'Using computer assisted qualitative data analysis software to develop a grounded theory project', *Field methods* 18(3), pp. 245–266.

British Medical Association (2017) 'Doctors ' titles : explained', *BMA House.* London.

Brunworth, J. (2015) Eating our young - are we full yet? [Online] Available at: https://www.elsevier.com/connect/eating-our-young-in-nursing-are-we-full-yet [Accessed 1/8/18]

Bryant, L. and Pini, B. (2009) 'Gender, class and rurality: Australian case studies *Journal of Rural Studies*. 25(1), pp. 48–57.

Bryman, A, Cassell, C. (2006) 'The research interview: a reflexive perspective', *Qualitative Research in Organizations and Management:*, 1(1), pp. 41–55.

Burkitt, I. (2012) 'Emotional Reflexivity: Feeling, Emotion and Imagination in Reflexive Dialogues', *Sociology*, 46, pp. 458–472.

Burningham, K. Cooper, G. (1999) 'Being constructive: social constructionism and the environment', *Sociology*, 33(2), pp. 297–316.

Burr, V. (2003) *Social constructionism*. 2nd edn. Routledge. Hove, East sussex.

Bury, M. (1986) 'Social Constructionism and the development of medical sociology', *Sociology of health & illness*, 8, pp. 137–69.

Caspi, A., Roberts, B. W. and Shiner, R. L. (2005) 'Personality Development: Stability and Change', *Annual Review of Psychology*, 56(1), pp. 453–484.

Cassidy, A. and McIntosh, B. (2014) 'The return of autonomy in nursing: a way forward.', *British journal of nursing.* 23(11), pp. 562–3.

Castel, E. S. Ginsburg, L. Zaheeer, S. Tamim, H. (2015) 'Understanding nurses' and physicians' fear of repercussions for reporting errors: clinician characteristics, organization demographics, or leadership factors?', *BMC Health Services Research*. 15(1), pp. 1–10.

Charmaz. K. (1983) 'The Grounded Theory Method: An Explication and Interpretation', Emerson. R. *Contemporary field research*, Boston. Little Brown. pp. 109–126.

Charmaz, K. (2000) 'Grounded theory: Objectivist and constructivist methods. In N. K. Denzin & Y. S. Lincoln (Eds.), (2000) The SAGE Handbook of qualitative research', in *Handbook of qualitative research*. 2nd editio. Thousand Oaks, Calif. : Sage Pub, pp. 509–535.

Charmaz, K. (2006) *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis*. California: Thousand Oaks: SAGE.

Charmaz, K. (2008) Constructionism and the Grounded theory. Holstein . J. Gubrium. F (eds) Handbook of constructionist research pp 397-412 New York. The Guilford press

Charmaz, K. (2012) 'The Power and Potential of Grounded Theory', *Medical Sociology online. A Journal of the BSA MedSoc Group.* 6(3), pp. 2–15.

Charmaz, K. (2014) *Conducting grounded theory*. 2nd edition. London: Sage.

Charmaz, K. (2017) 'The Power of Constructivist Grounded Theory for Critical Inquiry', *Qualitative Inquiry*, 23(1), pp. 34–45.

Chenitz, C, W Swanson, J, M. (1986) *From practice to Grounded theory: Qualitative research in nursing*. California: Addison-Welsey.

Chiovitti, R. F. and Piran, N. (2003) 'Rigour and grounded theory research', *Journal of Advanced Nursing*, 44(4), pp. 427–435.

Churchman, J. J. and Doherty, C. (2010a) 'Nurses' views on challenging doctors' practice in an acute hospital.', *Nursing standard .* 24 (40) pp. 42–47.

Clancy, T. R. (2003) 'Courage and today's nurse leader', *Nursing Administration Quarterly*, 27(2) pp. 128–132.

Clarke, A. E. (2003) 'Situational Analyses: Grounded theory mapping after the postmodern turn' *Symbolic Interaction*, 26(4) pp. 553–576.

Cleary, M. Visentin, D. West, S. Lopez, V. Kornhaber, R. (2018) 'Promoting emotional intelligence and resilience in undergraduate nursing students: An integrative review', *Nurse Education Today*. 68(April), pp. 112–120.

Closs, S. J. (2001) 'Interdisciplinary research and the doctor—nurse game', *Clinical Effectiveness in Nursing*, 5(3), pp. 101–103.

Cole, C., Wellard, S. and Mummery, J. (2014) 'Problematising autonomy and advocacy in nursing', *Nursing Ethics*, 21(5), pp. 576–582.

Comer, D, R Vega, G. (eds) (2015) Introduction: Why Moral courage matters in organisations. Comer, D. Vega, G *Moral courage in organizations. Doing the right thing at work*. 2nd edn. E Abingdon: Routledge.

Commisioning board Chief Nurse Advisor and DH Chief Nursing Advisor (2012) *Compassion in practice*. Nursing, Midwifery and Care staff Our vision and strategy *Department of Health*. NHS Commissioning Board

Cooley,C, H. (1922) *Human nature and the social order*. Revised. New York: Charles Scribner's sons.

Cooney, A. (2011) 'Rigour and grounded theory.', *Nurse researcher*, 18(4), pp. 17–22.

Corbin, J, M, Strauss, A, S. (2008) *Basics of qualitative research: Techniques and procedures for developing grounded theory*. 3rd edition. London: Sage.

Crenshaw, Kimberle () "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics," *University of Chicago Legal Forum*: Vol. 1989: Iss. 1, Article 8.

Creswell, J. W. (2008) 'Research design: Qualitative, Quantitive, and mixed methods approaches'.3rd Edition. Thousand Oaks. California. SAGE

Crigger, N. (2011) 'Of courage and safe harbours', *Advances in Nursing Science*, 34(4), pp. 13–22.

Cummings, J, Bennet, V. (2012) *Developing the culture of compassionate care. Creating a new vision for nurses, midwives and care-givers*. Department of Health and NHS Commissioning Board. London. Crown copyright.

Cummings, J. Clarke, J. Evans, J. (2015) 'The importance of showing courage in delivering effective health care', *British Journal of Healthcare Assistants*, 9(6), pp. 295–296.

Curtis, K. (2014) 'Learning the requirements for compassionate practice: student vulnerability and courage.', *Nursing ethics*, 21(2), pp. 210–23.

Dahl, B. M., Clancy, A. and Andrews, T. (2014) 'The meaning of ethically charged encounters and their possible influence on professional identity in Norwegian public health nursing: A phenomenological hermeneutic study', *Scandinavian Journal of Caring Sciences*, 28(3), pp. 600–608.

Dar-Nimrod, I. Ganesan, A. and MacCann, C. (2018) 'Coolness as a trait and its relations to the Big Five, self-esteem, social desirability, and action orientation', *Personality and Individual Differences*. 121. PP 1-6

Data Protection act (1998) [online] Available from: http:/www.legislation.gov.uk/ukpga/1998/29/contents [accessed 30th November 2016] (1988).

Day, L. (2007) 'Courage as a Virtue Necessary to Good Nursing Practice', *American Journal of Critical Care*, 16(6), pp. 613–616.

Dean, S. and McAllister, M. (2017) 'How education must reawaken empathy', *Journal of advanced nursing*.74(2) pp 233-234

Delgado, C. Upton, D. Ranse, K. Furness, T. Foster, K. (2017) 'Nurses' resilience and the emotional labour of nursing work: An integrative review of empirical literature'. *International Journal of Nursing studies.* 70 pp 71-88

Dewar, B. (2011) *Caring about caring: an appreciative inquiry about compasssionate relationship centred care.* [online] Available at: http://researchrepository.napier.ac.uk/id/eprint/4845.[Accessed 3/3/2018]

Dey, I. (2004) Grounded theory. In Seale.C. Gobo.G. Gubrium.J.F. Silverman.D. (eds) Qualitative research practice. London SAGE

DiCicco-Bloom, B. and Crabtree, B. F. (2006) 'The qualitative research interview', *Medical Education*, 40, pp. 314–321.

Dick, B. (2005) 'Grounded theory: a thumbnail sketch', *Action Research Resources*, paper 59, pp. 1–19.

Di Fabio, A. and Saklofske, D. H. (2018) 'The contributions of personality and emotional intelligence to resiliency', *Personality and Individual Differences*. (121), pp. 140–144.

Dinmohammadi, M., Peyravi, H. and Mehrdad, N. (2013) Concept analysis of Professional Socialization in Nursing, *Wiley Periodicals Nursing forum,* 48(1), pp. 26–34.

Dinndorf-Hogenson, G, A. (2013) *Perioperative nurses perceptions of moral courage.* Doctor of Philosophy Major in Nursing South Dakota State University. South Dakota

Dinndorf-Hogenson.G.A. (2015) 'Moral Courage in practice: Implications for patient safety', *Journal of Nursing regulation*, 6(2), pp. 10–16.

Doody, O. and Noonan, M. (2013) 'Preparing and conducting interviews to collect data', *Nurse Researcher*, 20, pp. 28–32.

Duffy, K., Ferguson, C. and Watson, H. (2004) 'Data collecting in grounded theory-some practical issues.', *Nurse researcher*, 11, pp. 67–78.

Dunne, C. (2011) 'The place of the literature review in grounded theory research', *International Journal of Social Research Methodology*, 14(2), pp. 111–124.

Ekström, L. and Idvall, E. (2015) 'Being a team leader: Newly registered nurses relate their experiences', *Journal of Nursing Management*, 23(1), pp. 75–86.

Eley, D. Eley, R. Bertello, M. Rogers-Clark, C. (2012) 'Why did I become a nurse? Personality traits and reasons for entering nursing', *Journal of Advanced Nursing*, 68(7), pp. 1546–1555.

Ellemers, N. (2018) 'Gender stereotypes', *Annual Review of Psychology*, 69, pp. 275–98.

Else-Quest. N. M. Shibley Hyde. J. (2016) "Intersectionality in Quantitative Psychological Research: I. Theoretical and Epistemological Issues" *Psychology of Women Quarterly* Vol. 40(2) 155-170

Engward, H. and Davis, G. (2015) 'Being reflexive in qualitative grounded theory: Discussion and application of a model of reflexivity', *Journal of Advanced Nursing*, 71(7), pp. 1530–1538.

Estes, K. (2017) 'The Role & Responsibility of Advocacy in Nursing', *Colorado Nurse*, (January), p. 8.

Fahlberg, B. (2015) 'Moral courage: A step beyond advocacy', *Nursing*, pp. 13–14.

Farrell, G. A. (2001) 'From tall poppies to squashed weeds : Why don't nurses pull together more?', *Journal of Advanced Nursing*, 35(1), pp. 26–33.

Fendt, J. and Sachs, W. (2008) 'Grounded Theory Method in Management Research. Users perspectives. *Organisational Research Methods*, 11(3), pp. 430–455.

Fielding, N. (1994) 'Varieties of research interviews', *Nurse Researcher*, 1(3), pp. 4–11.

Finlay, L. (2003) The reflexive journey: mapping multiple routes . Finlay,L. Gough. B. (eds) (2003) 'Reflexivity A Practical Guide for Researchers in Health and Social Sciences', Oxford: Blackwell science.

Finlay, L, Gough, B. (2003) Introducing reflexivity. Finlay,L. Gough. B.(eds) 'Reflexivity A Practical Guide for Researchers in Health and Social Sciences', Oxford: Blackwell science.

Firth-Cozens, J. (2004) 'Organisational trust: The keystone to patient safety', *Quality and Safety in Health Care*, 13(1), pp. 56–61.

Ford, S. (2009) *All new nurses must have degrees*, *Nursing times*. [online] Available at: https://www.nursingtimes.net/news/policies-and-guidance/all-new-nurses-must-have-degrees/5008452.article [Accessed: 22 August 2018].

Ford Walston, S. (2004) *Courage and Caring* [online] Available at: http://www.compassionfatigue.org/pages/NursingCourage.pdf [Last accessed 1/8/17]

Francis, R. (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Volume 3 : Present and future Annexes. The staionary Office. London.*

Francis, S. R. (2015) *Freedom to speak up - A review of whistleblowing in the NHS*. An Independent review for the Secretary of State.

'Freedom of Information act' (2000) [online] Available from: http://legislation.gov.uk/ukpga/2000.html freedom%20of%20information [accessed 30th November 2016].

Gallagher, A. (2010) 'Moral Distress and Moral Courage in Everyday Nursing Practice.', *Online Journal of Issues in Nursing*, 16 (2).

Gallagher, A. (2011) 'If the culture is unethical, acts of heroic staff may be futile'' *Nursing times*.107(36) pp7

Gasson, S. (2003) 'Rigor In Grounded Theory Research : An Interpretive Perspective on Generating Theory From Qualitative Field Studies' Whitman, M. Woszezynski, A. *The Handbook of Information Systems Research*. London. Idea group publishing. pp. 79–102.

General Medical Council (2016) [online] Availbale from: https://www.gmc-uk.org/concerns/hearings-and-decisions/gmc-decisions [accessed 29th November 2016]

Girvin, J. Jackson, D. and Hutchinson, M. (2016) 'Contemporary public perceptions of nursing: a systematic review and narrative synthesis of the international research evidence', *Journal of Nursing Management*, 24(8), pp. 994–1006.

Glasberg, A. L., Eriksson, S. and Norberg, A. (2008) 'Factors associated with "stress of conscience" in healthcare', *Scandinavian Journal of Caring Sciences*, 22(7), pp. 249–258.

Glaser, B, G, Strauss, A, L. (1967) The discovery of Grounded theory: strategies for qualitative research. New Brunswick. Aldine Transaction.

Glaser, B. and Holton, J. (2004) 'Remodeling Grounded Theory' *Qualitative Social Research*. 5(4)

Glaser, B. (2012) 'No Preconception: The Dictum', *The Grounded Theory Review*, 11(2), pp. 3–8.

Goffman, E. (1956) *Presentation of Self in everyday life*, *University of Edinburgh Social sciences centre*. Edinburgh: University of Edinburgh.

Goffman, E. (1963) *Stigma. Notes on the management of spoiled identity*, *Penguin*. London.

Goldberg, L. R. (1993) ''The structure of phenotypic personality traits" *American Psychologist*, 48(12), pp. 1303–1304.

Gordon, S. (2006) 'Beyond the bedside: What do nurses really do?', *Ohio Nurses review*, 81(4), pp. 8–9.

Goud, N. H. (2005) 'Courage: Its Nature and Development', *Journal Of Humanistic Counseling, Education And Development*, 44(1), pp. 102–116.

Gough, B. (2003) *Shifting researcher positions during a group interview study: a reflexive analysis and re-view*. Finlay,L. Gough. B.(eds) 'Reflexivity A Practical Guide for Researchers in Health and Social Sciences', Oxford: Blackwell science.

Gould, D. and Fontenla, M. (2006) 'Commitment to nursing: results of a qualitative interview study', *Journal of Nursing Management*, 14(3), pp. 213–221.

Graham, J. Iyer, R. Nosek, B. Haidt, J. Koleva, S. Ditto, P. (2011) 'Mapping the Moral Domain', *Journal of Personality and Social Psychology*, 101(2), pp. 366–385.

Grant, M. J. and Booth, A. (2009) 'A typology of reviews: An analysis of 14 review types and associated methodologies', *Health Information and Libraries Journal*, 26(2), pp. 91–108.

Gruber, C. (2011) 'The Psychology of Courage: Modern Research on an Ancient Virtue', *Integrative Psychological and Behavioral Science*, 45, pp. 272–279.

Guest, G. Bunce, A. Johnson, L (2006) 'How Many Interviews Are Enough?: An Experiment with Data Saturation and Variability', *Field Methods*, 18 (59) pp. 59–82.

Hagbaghery, M. A., Salsali, M. and Ahmadi, F. (2004) 'The factors facilitating and inhibiting effective clinical decision-making in nursing: a qualitative study', *BioMedCentral nursing*, 3 (2).

Hallam, J. (2000) '*Nursing the Image: Media, culture and professional identity',* London: Routlege.

Hallberg, L. R. (2010) 'Some thoughts about the literature review in grounded theory studies', *International Journal of Qualitative Studies on Health and Well-being*, 5(3), p. 5387.

Hallberg, L. R. M. (2006) 'The "core category" of grounded theory: Making constant comparisons', *International Journal of Qualitative Studies on Health and Well-being*, 1(3), pp. 141–148.

Hallett, C. (2007) A 'gallop' through history: nursing in social context. *Journal of clinical nursing.* pp 429-430

Ham, C. and Berwick, D. M. (2017) *'Organising care at the NHS front line - Who is responsible?'* London. The Kings Fund.

Hamric, A. B., Arras, J. D. and Mohrmann, M. E. (2015) 'Must we be courageous?', *Hastings Center Report*, 45(3), pp. 33–40.

Hancock, B, Ockleford,E, Windridge, K. (2007) 'An Introduction to Qualitative Research', The NIHR RDS EM/YH

Harper, D. (2003) *Developing a critically reflexive position using discourse analysis.* Finlay,L. Gough. B.(eds) 'Reflexivity A Practical Guide for Researchers in Health and Social Sciences', Oxford: Blackwell science.

Harper Simpson, I. (2009) Student to nurse. *A longitudional study of socialization*. Cambridge: Cambridge University press:

Hart, P. L., Brannan, J. D. and de Chesnay, M. (2014) 'Resilience in nurses: An integrative review', *Journal of Nursing Management*, 22(6), pp. 720–734.

Hawkins, S. F. and Morse, J. (2014) 'The praxis of courage as a foundation for care', *Journal of Nursing Scholarship*, 46(4), pp. 263–270.

Health and Safety Executive (2017) 'Work-related Stress, Depression or Anxiety Statistics in Great Britain 2017', *National Statistics*. Health and Safety executive. Crown copyright

Health Education England (2016) *Values Based Recruitment Framework*. [online] Available at: https://www.hee.nhs.uk/sites/default/files/documents/VBR_Framework%20March%202016.pdf [accessed 16/5/17]

Healy. G. Bradley. H. Forson. C. (2011) "Intersectional Sensibilities in Analysing Inequality Regimes in Public Sector Organizations" *Gender, Work and Organization.* Vol. 18 No. 5

Heath, H. and Cowley, S. (2004) 'Developing a grounded theory approach: a comparison of Glaser and Strauss', *International journal of nursing studies*, 41(2), pp. 141–150.

Heckathorn, D. (2011) 'Snowball versus respondent driven sampling', *Sociological Methodology*, 4(1), pp. 355–366.

Hee Noh,J, Lim, E. (2015) 'Factors Influencing Ego- Resilience in Nursing Students', *International Journal of Bio-science and Bio-Technology*, 7(3), pp. 233–242.

Hegney, D. Eley, R. Plank, A. Buikstra, E. Parker, V.(2006) 'Workforce issues in nursing in Queensland, Australia':, *Journal of clincial nursing*, 15(12) pp. 1521–1530.

Hemsley-Brown, J. Foskett, N.H. (1999) Career desirability: young people's perceptions of nursing as a career. *Journal of Advanced nursing.* 29(6) pp 1342-1350

Hennink, M. M., Kaiser, B. N. and Marconi, V. C. (2017) 'Code Saturation Versus Meaning Saturation: How Many Interviews Are Enough?', *Qualitative Health Research*, 27(4), pp. 591–608.

Herrman, H, Stewart, D, Diaz-Grandos, N, Berger, E, L, Jackson, B, Yuen, T. (2011) 'What is resilience?', *Canadian Journal of Psychiatry*, 56(5), pp 258.

Hildenbrand, J. (2010) Mediating structure and interaction in Grounded theory. in Bryant, A Charmaz, K. (Eds) (2010) *The SAGE handbook of grounded theory*. London: Sage.

Hodkinson, K. (2008) 'How should a nurse approach truth-telling? A virtue ethics perspective. *Nursing Philosophy*, 9(4), pp. 248–256.

Holloway, I, Wheeler, S. (2010) *Qualitative Research in Nursing and Healthcare*. 3rd edition. Oxford UK: Wiley-Blackwell publishing.

Holyoake, D. (2011) 'Is the doctor-nurse game still being played?', *Nursing Times*, 107(43), pp. 12–14.

Hood, J.C. (2010) Orthodoxy vs Power:The defining traits of Grounded Theory. in Bryant, A Charmaz, K. (Eds) (2010) *The SAGE handbook of grounded theory*. London: Sage

Hoschild, A. (1979) 'Emotion Work, Feeling Rules and Social Structure', *The American Journal of Sociology*, 85(3), pp. 551–575.

Hoschild, A. (2012) *The manged heart: commericalisation of human feeling*. London: University of California press.

Hutchinson, A. J., Johnston, L. H. and Breckon, J. D. (2010) 'Using QSR-NVivo to facilitate the development of a grounded theory project: an account of a worked example', *International Journal of Social research methodology*. 13(4) , pp 283-302.

Iacobucci, T. Daly, B. Lindell, D. Quinn Griffin, M. (2013) 'Professional values, self-esteem, and ethical confidence of baccalaureate nursing students', *Nursing Ethics*, 20(4), pp. 479–490.

Ilhan, N. Sukut, O. Akhan, L. Batmaz, M. (2016) 'The effect of nurse education on the self-esteem and assertiveness of nursing students: A four-year longitudinal study', *Nurse Education Today*, 39, pp. 72–78.

Iona. R. DeSouzab. R. Kerina. T. (2018) "Teaching ethics: Intersectionality, care failure and moral courage" *Nurse Education Today* 62 (2018) 98–100.

Jackson, D., Firtko, A. and Edenborough, M. (2007) 'Personal resilience as a strategy for surviving and thriving in the face of workplace adversity: A literature review', *Journal of Advanced Nursing*, 60(1), pp. 1–9.

Jensen, A. and Lidell, E. (2009) 'The influence of conscience in nursing.', *Nursing ethics*, 16 (1) pp. 31–42.

Jinks, A, M. (1993) 'A study of attitudes to gender and nurinsg stereotypes in newly recruited student nurses', *Nurse Education Today*, 13 (4), pp. 287–294.

Jinks, A. M. and Bradley, E. (2004) 'Angel, handmaiden, battleaxe or whore? A study which examines changes in newly recruited student nurses' attitudes to gender and nursing stereotypes', *Nurse Education Today*, 24(2), pp. 121–127.

Johnson, M. Haigh, C. Yates-Bolton, N. (2007) 'Valuing of altruism and honesty in nursing students: a two-decade replication study. *Journal of Advanced Nursing*, 57(4), pp. 1–9.

Johnson, C. (2009) 'Bad blood: doctor-nurse behavior problems impact patient care.', *Physician executive*, 35(6), pp. 6–11.

Johnstone, M. and Hutchinson, A. (2015) '"Moral distress" – time to abandon a flawed nursing construct?', *Nursing ethics*, 22(1), pp. 5–14.

Jones-Berry, S. (2017) 'One in ten nurse sick days down to stress or depression', *Nursing standard* [online] Available at: https://rcni.com/nursing-standard/newsroom/analysis/exclusive-one-ten-nurse-sick-days-down-to-stress-or-depression-118881[accessed 20/8/18]

Jones, M. and Alony, I. (2011) 'Guiding the Use of Grounded Theory in Doctoral Studies – An Example from the Australian Film Industry' *International Journal of Doctoral studies*, 6 pp 95-114

Jootun, D. and McGhee, G. (2003) 'Creating a research culture in a nursing school.', *Nursing standard* 18(3), pp. 33–36.

Jootun, D., McGhee, G. and Marland, G. R. (2009) 'Reflexivity: promoting rigour in qualitative research.', *Nursing standard :* 23(23), pp. 42–46.

Jowett. B. (1961) "Laches" in Hamilton. E. Cairns. H. (eds) *Plato the collected dialogues including the letters.* New Jersey. Princeton Univeristy Press.

Karagözoğlu, Ş. Kahve, E. Koc, O. Adamisoglu, D. (2008) 'Self esteem and assertiveness of final year Turkish university students', *Nurse Education Today*, 28(5), pp. 641–649.

Kawamoto, T., Van der Linden, D. and Dunkel, C. S. (2017) 'The General Factor of Personality (GFP) and moral foundations', *Personality and Individual Differences*. 119, pp. 78–82.

Kaya, H., Şenyuva, E. and Bodur, G. (2018) 'The relationship between critical thinking and emotional intelligence in nursing students: A longitudinal study', *Nurse Education Today*, 68(4), pp. 26–32.

Kaya, N. Asti. T. Turan. N. Burcu. K. Emrullah. E. (2012) 'The feelings of guilt and shame experienced by Nursing and Midwifery students', *Nurse Education Today*, 32(6), pp. 630–635.

Kidder, R. M. and Bracy, M. (2001) 'Moral Courage for a University ethics Capston class?', *Institute for Global Ethics*, 28(4), pp. 1–13.

Kieft, R. de Brouwer, B. Francke, A. Delnoij, D. (2014) 'How nurses and their work environment affect patient experiences of the quality of care: A qualitative study', *BMC Health Services Research*, 14(1), pp. 1–10.

Knox, S. and Burkard, A. W. (2009) 'Qualitative research interviews.', *Psychotherapy research : Journal of the Society for Psychotherapy Research*, 19(4), pp. 566–575.

Koen, M. P., Van Eeden, C. and Wissing, M. P. (2011) 'The prevalence of resilience in a group of professional nurses', *Journal of Interdisciplinary Health*, 16(1), pp. 1–11.

Kourkouta, L. and Papathanasiou, I. V (2014) 'Communication in nursing practice.', *Materia socio-medica*, 26(1), pp. 65–7.

Krizan, Z. and Suls, J. (2009) 'Implicit self-esteem in the context of trait models of personality', *Personality and Individual Differences*. 46(5–6), pp. 659–663.

Kvale, S. (1996) 'An introduction to qualitative research interviewing' Thousand Oaks California. SAGE

Lachman, V. D. (2007) 'Moral courage: a virtue in need of development?', *Medsurg nursing :* 16(2), pp. 131–133.

Lachman, V. D. (2010) 'Strategies Necessary for Moral Courage', *Online Journal of Issues in Nursing*. 15(3)

Lachman, V. D. Murray, J. Iseminger, K. Ganske, K. (2012) 'Doing the right thing: pathways to moral courage.', *American Nurse Today*, 7(5), p. 24–29 6p.

Lachman, V. D. (2012) 'Ethical challenges in the era of health care reform.', *Medsurg nursing.* 21(4), pp. 248–50, 245.

Lachman Vicki D (2007) 'Moral courage in action; Case studies', *Med surg nursing*, 16(4), pp. 275–277.

Laforest, J. (2009) 'Guide to Organizing Semi-Structured Interviews With Key Informant. vol 11. [Online] Available at: https://www.sswm.info/sites/default/files/reference_attachments/LAFOREST%202009%20Guide%20to%20Organizing%20Semi%20Structured%20Interviews.pdf [accessed 30/6/17]

Lai, P. K. and Lim, P. H. (2012) 'Concept of professional socialization in nursing', *IeJSME*, 6(1), pp. 31–35.

Larsen, D. Flesaker, K. Stege, R. (2008) 'Qualitative Interviewing Using Interpersonal Process Recall : Investigating Internal Experiences during Professional-Client Conversations', *International Journal of qualitative methods*, 7(1), pp. 18–37.

LaSala, C. and Bjarnason, D. (2010) 'Creating Workplace Environments that Support Moral Courage', *OJIN: The Online Journal of Issues in Nurisng 15 (3)*

Leech, N. L. and Onwuegbuzie, A. J. (2011) 'Beyond constant comparison qualitative data analysis: Using NVivo.', *School Psychology Quarterly*, 26(1), pp. 70–84.

Licqurish, S. and Seibold, C. (2011) 'Applying a contemporary grounded theory methodology.', *Nurse researcher*, 18(4), pp. 11–16.

Lincoln, Y. Guba, G. (2000) 'Paradigmatic controversies, contradictions, and emerging confluences In Denzin, N. Lincoln, Y (Eds.), (2000) Handbook of qualitative research' 2nd edition. California: Thousand Oaks, Sage Pub, pp. 163–188.

Lindh, I-B. da Silva, A. Berg, A. Severinsson, E (2010) 'Courage and nursing practice: a theoretical analysis.', *Nursing ethics*, 17(5), pp. 551–565.

Lindh, I.-B., Severinsson, E. and Berg, A. (2008) 'Exploring student nurses' reflections on moral responsibility in practice', *Reflective Practice*, 9(4), pp. 437–448.

Lindh, I. B., Severinsson, E. and Berg, A. (2009) 'Nurses' moral strength: A hermeneutic inquiry in nursing practice', *Journal of Advanced Nursing*, 65(9), pp. 1882–1890.

Lingard, L, Albert, M, Levinson, W. (2008) 'Grounded theory, mixed methods, and action research', *British Medical Journal*, 337, pp. 459–461.

Lintern, S. (2015) 'Exclusive interview : Francis insists whistleblowing measures have ' teeth '' *Health service Journal*.[Online] Available at: https://www.hsj.co.uk/5082079.article [accessed 2/2/18]

Lopez, S.J, Koetting. K, O'Bryne, K, K, Peterson, S. (2003) 'Profiling courage', in Lopez, S. J, Snyder, C. R. (ed.) *Positive psychological assessment: A handbook of models and measures*. Washington, DC: American psychological association.

Luckerhoff, J. and Guillemette, F. (2011) 'The Conflicts between Grounded Theory Requirements and Institutional Requirements for Scientific Research', *The Qualitative Report*, 16(2), pp. 396–414.

Macdonald, K. De Zylva, J. McAllister, M, Brien, D. (2018) 'Heroism and nursing : A thematic review of the literature', *Nurse education today*, 68(1), pp. 134–140.

MacLeod Dyess, S. Boykin, A. Bulfin, M.J. (2013) 'Hearing the voice of Nurses in Caring theory-Based Practice'. Nursing Science quarterly 26(2) pp167-173

MacMillan, K. (2003) The next turn: reflexively analysing reflexive research. Finlay, L. Gough. B. (eds) (2003) 'Reflexivity A Practical Guide for Researchers in Health and Social Sciences', Oxford: Blackwell science.

Maddi, S. R. (2004) 'Hardiness: An Operationalization of Existential Courage', *Journal of Humanistic Psychology*, 44(3), pp. 279–298.

Manias, E. and Street, A. (2001) 'The interplay of knowledge and decision making between nurses and doctors in critical care', *International journal of nursing studies*. 38(2), p. 129.

Manley, K. and Titchen, A. (2012) 'Becoming and being a nurse consultant : towards greater effectiveness through a programme of support', London. *Royal college of Nursing*.

Manning, P. K. (2008) 'Goffman on organizations', *Organization Studies*, 29(5), pp. 677–699.

Mason, D. J. Glickstein, B. Nixon, L. Westphaln, K. Han, S. Acquaviva, K. (2017) 'The Woodhull Study Revisited : Nurses ' Representation in Health News Media', Center for Health policy and media management. 313(1998), pp. 2015–2018.

Matoušová, O. Š. and Tollarová, B. (2014) '" You Can't Take It Personally: Emotion Management as Part of the Professional Nurse's Role, *Sociologický ústav*, pp. 839–874.

Mauthner, N. Doucet, A. (2003) 'Reflexive accounts and accounts of reflexivity in qualitative data analysis', *Sociology*, 37(3), pp. 413–431.

McAllister, M. and McKinnon, J. (2009) 'The importance of teaching and learning resilience in the health disciplines: A critical review of the literature', *Nurse Education Today*. 29(4), pp. 371–379.

McCarthy, G. and Fitzpatrick, J. J. (2008) 'Research development in a university nursing school in Southern Ireland', *International Nursing Review*, 55, pp. 379–386.

McCarthy, J. and Gastmans, C. (2015) 'Moral distress: A review of the argument-based nursing ethics literature', *Nursing Ethics*, 22(1), pp. 131–152.

McCarthy, J., Murphy, S. and Loughrey, M. (2008) 'Gender and power: the Irish hysterectomy scandal.', *Nursing ethics*, 15, pp. 643–655.

McCreaddie, M. and Payne, S. (2010) 'Evolving Grounded Theory Methodology: Towards a discursive approach', *International Journal of Nursing Studies*. 47(6), pp. 781–793.

McLaughlin, K. Muldoon, O.T. Moutray, M. (2010) Gender, gender roles and compeltion of nursing education: A longitudinal study. *Nurse education today* 30 (4) pp 303-307

McNamara, C. (2009) 'General Guidelines for Conducting Research Interviews' [online] Avaialble at: https://managementhelp.org/businessresearch/interviews.htm[accessed 14/10/17]

Mead, G, H. (1913) 'The social self', *Journal philosophy, psychology and scientific methods*, 10, pp. 374–380.

Meerabeau, E. (2001) 'Back to the bedpans: The debates over preregistration nursing education in England', *Journal of Advanced Nursing*, 34(4), pp. 427–435.

Megahed, M. M. and Mohammad, F. A. (2014) 'Effect of cooperative learning on undergraduate nursing students' self-esteem: A quasi-experimental study', *Journal of Nursing Education and Practice*, 4(11), pp. 1–7.

Merrifield, N. (2014) 'Figures reveal 9% hike in violent assaults on NHS staff in a year', *Nursing Times*. [online] Available at: http://www.nursingtimes.net/figures-reveal-9-hike-in-violent-assaults-on-nhs-staff-in-a-year/5077018.fullarticle.[Accessed 31/6/18]

Metcalfe, J. (2014) *A lonely endeavour: clinical nurse leadership and the older unpopular patient in community settings*. Professional Doctorate in Nursing. Univeristy of Portsmouth. Portsmouth. [online] Available at: http://eprints.port.ac.uk/17607/.[accessed 15/1/18]

Middleton. J. (2013) '6Cs must end the years of make do and mend' *Nursing Times* [online] Available at: https://www.nursingtimes.net/opinion/editors-comment/6cs-must-end-the-years-of-make-do-and-mend/5056249.article [Accessed 10/2/18]

Miers, M. (2000) 'Gender issues and nursing practice', in. London: Macmillan press Ltd.

Miers, M. (2002) 'Nurse education in higher education: understanding cultural barriers to progress.', *Nurse education today*, 22(3), pp. 212–9.

Miller, R. (2005) 'Moral Courage: Definition and Development', *Development*, Ethics resource centre. [online] Available at: http://www.emotionalcompetency.com/papers/Moral_Courage_Definition_and_Development.pdf [accessed 7/7/17]

Mills, J, Bonner, A, Francis, K. (2006) 'The development of constructivist grounded theory', *International Journal of Qualitiative methods*, 5(1), pp. 1–10.

Mishra, S. (2015) 'Respect for nursing professional: Silence must be heard', *Indian Heart Journal*, 67(5), pp. 413–415.

Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). *Preferred Reporting Items for Systematic Reviews and Meta-Analyses:* The PRISMA Statement.

Montes-Hidalgo,J, Tomas-Sabado, J. (2016) 'Self-esteem, resilience, locus of control and suicide risk in nursing students', *Enferm Clin*, 26(3) pp188-193

Morse, J. (2010) Sampling in grounded theory. Bryant, A Charmaz, K. (Eds) (2010) *The SAGE handbook of grounded theory*. London: sage.

Munro, C, L, Savel, R, H. (2015) 'Our view of courageous care', *American Journal of Critical Care*, 24(5), pp. 372–375.

Murray, E. (2018) *How nurses are made invisible and our complicity in this*, *Australian college of nursing*. [online] Available at: https://www.acn.edu.au/publications/nurseclick/nurses-made-invisible-complicity [Accessed: 29 July 2018].

Murray, J. (2007) 'Before Blowing the Whistle Learn to Protect Yourself. *American Journal today*, pp. 40–42.

Murray, J. S. (2013) 'Moral Courage in Healthcare: Acting Ethically Even in the Presence of Risk', The online Journal of Issues in Nursing 15 (3), pp. 1–8.

NHS England (2014a) *Building and Strengthening Leadership: Leading with Compassion*. London. NHS England

NHS England (2014b) *Compassion in practice: 2 years on - experience matters*. Publications Gateway reference:2551. London. NHS England

NHS England (2014c) *Five year forward view*. [Online] Available at: https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf [accessed 15/4/17]

NHS England (2016) *Leading Change, Adding Value: A framework for nursing, midwifery and care staff*.[Online] Available at: https://www.england.nhs.uk/wp-content/uploads/2016/05/nursing-framework.pdf[accessed 10/7/17]

Nicolson, P. (2003) Reflexivity, bias and the in-depth interview: developing shared meanings. Finlay,L. Gough. B.(eds) 'Reflexivity A Practical Guide for Researchers in Health and Social Sciences', Oxford: Blackwell science.

Novak, A. (2014) 'Anonymity, Confidentiality, Privacy and Identity: the ties that bind and break in communication research'. *Review of Communication*. 14:1 pp36-48

Nugus, P. Greenfield, D. Travaglia, J. Westbrook, J. Brathwaite, J. (2010) 'How and where clinicians exercise power: Interprofessional relations in health care', *Social Science and Medicine*, 71(5), pp. 898–909.

Numminen, O. Repo, H. and Leino-kilpi, H. (2016) '[In Press]. Moral courage in nursing : A concept analysis', *Nursing Ethics*, pp. 1–14.

Nunkoosing, K. (2005) ‘The problems with interviews.’, *Qualitative Health Research*, 15(5), pp. 698–706.

Nursing and Midwifery Council (2016) *Nursing and Midwifery Council Annual Fitness to Practise Report*.

Nursing and Midwifery Council (NMC) (2014) *Raising concerns*, Guidance for nurses and midwives. London. The Nursing and Midwifery regulator for England, Wales, Scotland and Northern Ireland.

Nursing and Midwifery Council (2006) *Standards of proficiency for nurse and midwife prescribers*, *Nursing and midwifery council*. Available at: https://www.nmc.org.uk/globalassets/sitedocuments/standards/nmc-standards-proficiency-nurse-and-midwife-prescribers.pdf.

Nursing and Midwifery Council (NMC) (2015) *The Code Professional standards of practice and behaviour for nurses and midwives.* London. The Nursing and Midwifery regulator for England, Wales, Scotland and Northern Ireland.

Oakley, J. (2015) ‘Practitioner courage and ethical health care environments’, *Hastings Center Report*, 45(3), pp. 40–42.

O'Hagan, S. Manias, E. Elder, C. Pill, J. Woodward-Kron, R. McNamara, T. Webb, G. McColl, G. (2014) 'What counts as effective communication in nursing? Evidence from nurse educators and clinicains feedback on nurse interactions with simulated patients'. *Journal of Advanced Nursing* 70(6) pp 1344-1355

Olin, J. (2011) 'Can we all get along? the Doctor- Nurse relationship' *Registered Nurse central*

Olver, J. J. and Mooradian, T. A. (2003) 'Personality traits and personal values: A conceptual and empirical integration', *Personality and Individual Differences*, 35(1), pp. 109–125.

Ozbilgin. M.F. Beauregard. T.A. Tali. A. Bell. M. P. (2011) "Work–Life, Diversity and Intersectionality: A Critical Review and Research Agenda" *International Journal of Management Reviews*, Vol. 13, 177–198 (2011).

Paganini, M.C. Egry, E.Y. (2011) 'The ethical component of professional comptence in nursing: An analysis'.*Nursing Ethics* 18(4) pp 571-582

Paquin, S. O. (2011) 'Social Justice Advocacy in Nursing: What Is It? How Do We Get There?', *Creative Nursing*, 17(2), pp. 63–67.

Parker, I. (2005) 'Qualitative psychology: Introducing radical research', in *Qualitative psychology: Introducing radical research*. England: Open University press.

Parks, L. and Guay, R. P. (2009) 'Personality, values, and motivation', *Personality and Individual Differences*. 47(7), pp. 675–684.

Parmelli, E. Flodgren, G. Beyer, F. Baillie, N. Schaafsma, M. Eccles, M. (2011) 'The effectiveness of strategies to change organisational culture to improve healthcare performance.', *Cochrane database of systematic reviews (Online)*. BioMed Central Ltd, 6(1).

Parr, C. (2012) 'Instilling compassion into care',[Online] Available at: http://www.independentnurse.co.uk/professional-article/instilling-compassion-into-care/64216/ [Accessed 1/8/18]

Parsons, T. (1954) *Essays in sociological theory*. Revised ed. Glencoe, Illinois. The Free Press.

Peate, I. (2015) 'Without courage, the other Cs will crumble.', *British Journal of Healthcare Assistants*, 9(5), p. 218–218 1p.

Picker Institute (2016) *Staff survey 2016*, *National NHS Staff survey*. Available at: http://www.nhsstaffsurveys.com/Page/1019/Past-Results/Staff-Survey-2016-Detailed-Spreadsheets/ (Accessed: 8 August 2018).

Pini, B. (2004) 'On being a nice country girl and an academic feminist: Using reflexivity in rural social research', *Journal of Rural Studies*, 20(2), pp. 169–179.

Polk, L, V. (1997) 'Toward a Middle-Range Theory of Resilience', *Advances in Nursing Science*, 19(3), pp. 1–13.

Porter, S. (1991) 'A participant observation study of power relations between nurses and doctors in a general hospital.', *Journal of advanced nursing*, 16(6), pp. 728–735.

Primeau, L. A. (2003) 'Reflections on self in qualitative research: Stories of family', *American Journal of Occupational Therapy*, 57, pp. 9–16.

Puddephatt, A. J. (2007) 'Special: An Interview with Kathy Charmaz: On constructing Grounded Theory', *Qualitative Sociology Review*, II(3), pp. 7–20.

Purtilo, R. B. (2000) 'Moral courage in times of change: Visions for the future', *Journal of Physical Therapy Education*, 14(3), p. 4.

Pury, C. L. S. and Kowalski, R. M. (2007) 'Human strengths, courageous actions, and general and personal courage', *The Journal of Positive Psychology*, 2(2), pp. 120–128.

Pury, C. L. S., Kowalski, R. M. and Spearman, J. (2007) 'Distinctions between general and personal courage', *The Journal of Positive Psychology*, 2(2), pp. 99–114.

Putman, D. (1997) 'Psychological Courage', *Philosophy, Psychiatry, & Psychology*, 4(1), pp. 1–11.

Raso, R. (2014) 'Find your courage' *Nursing management*. 45(3) pp 6

Rate, C. R. Clarke, J.A. Lindsay, D.R. Sternberg, R. J. (2007) 'Implicit theories of courage', *The Journal of Positive Psychology*, 2(2), pp. 80–98.

Read, E. a. (2013) 'Workplace social capital in nursing: An evolutionary concept analysis', *Journal of Advanced Nursing*, (August), pp. 997–1007.

Reeves, S., Nelson, S. and Zwarenstein, M. (2008) 'the Doctor–Nurse Game in the Age of Interprofessional Care: a View From Canada', *Nursing Inquiry*, 15(1), pp. 1–2.

Rhodes, M. K., Morris, A. H. and Lazenby, R. B. (2011) 'Nursing at its Best: Competent and Caring.', *Online Journal of Issues in Nursing*, 16(2), p. 1.

Roach. M.S. (2002) *"Caring, The human mode of being. A blueprint for the health professionals"* (2nd rev.ed) Ottawa: Canadian Healthcare association press. Copy from Archives of Caring in Nursing, Christine E. Lynn College of Nursing, Florida Atlantic University, ARC-005 Sister M. Simone Roach Papers, 1985-2005, used by permission.

Roth, L. M. and Markova, T. (2012) 'Essentials for Great Teams: Trust, Diversity, Communication ... and Joy', *The Journal of the American Board of Family Medicine*, 25(2), pp. 146–148.

Royal College of Nursing (2011a) *Informed consent in health and social care research. RCN guidance for nurses.* Cavendish square London.

Royal College of Nursing (2017) *Raising concerns*. RCN guidance for nurses. Cavendish square London.

Royal College of Nursing (2011b) Research ethics. RCN Guidance for nurses. Cavendish square. London

Royal, J. (2012) 'Evaluating human, social and cultural capital in nurse education', *Nurse Education Today*. 32(5), pp. e19–e22.

Rushton, J, P. Bons, T, A. and Hur, Y. (2008) 'The genetics and evolution of a general factor of personality', *Journal of Research in Personality*, 42, pp. 1173–1185.

Saldana, J. (2016) *The coding manual for qualitative researchers*. London: Sage.

Savel, R. H. and Munro, C. L. (2015) 'Moral distress, moral courage', *American Journal of Critical Care*, 24(4), pp. 276–278.

Scarre, G. (2010) *ON Courage*. New York: Routledge.

Schein, E. H. (1986) 'What You Need to Know About Organizational Culture', *Training and Development Journal*, pp. 30–33.

Schein, E. H. (1996) 'Culture: The missing concept in organization studies', *Administrative Science Quarterly*, 41, p. 229-240

Schein, E. H. (1999) 'Empowerment, coercive persuasion and organizational learning: do they connect?', *The Learning Organization*, 6, pp. 163–172.

Schmidt, K. (2015) Nurses must summon moral courage to confront unethical behaviour. [online] Available at: https://www.nurse.com/blog/2015/10/19/nurses-must-summon-moral-courage-to-confront-unethical-behavior/ [Last accessed: 12th August 2018]

Schluter, J. Winch, S. Holzhauser, K. Hnderson, A. (2008) 'Nurses' moral sensitivity and hospital ethical climate: a literature review.', *Nursing ethics*, 15, pp. 304–321.

Schwandt, T, A. (2000) 'Three epistemological stances for qualitative inquiry: interpretivism, hermeneutics, and social constructionism.', in Denzin, N. K. Lincoln. Y. (ed.) *Handbook of Qualitative Research*. 2nd editio. Thousand oaks California SAGE, pp. 189–200.

Searle, R. Rice. C. McConnell. A. Dawson. J. (2017) *Bad apples? Bad barrels? Or bad cellars? Antecedents and processes of professional misconduct in UK Health and Social Care: Insights into sexual misconduct and dishonesty.* Coventry Research centre Trust Peace and social relations

Sekerka, L. E. and Bagozzi, R. P. (2007) 'Moral courage in the workplace: moving to and from the desire and decision to act', *Business Ethics: A European Review*, 16(2), pp. 132–149.

Shaw, K Timmons, S. (2010) 'Exploring how nursing uniforms influence self image and professional identity', *Nursing Times*, 106(10).

Shelp, E, E. (1984) 'Courage: A neglected virtue in the patient-physician realtionship.', *Social Science and Medicine*, 18, pp. 351–360.

Skår, R. (2010) 'The meaning of autonomy in nursing practice', *Journal of Clinical Nursing*, 19(15–16), pp. 2226–2234.

Smith, J. (2017) *New figures show an increase in the numbers of nurses and midwives leaving the professions*.[Online] Available at: https://www.nmc.org.uk/news/press-releases/new-figures-show-an-increase-in-numbers-of-nurses-and-midwives-leaving-the-professions/ [accessed 17/11/17]

Smith. M. Higgs. J. Ellis.E. (2008) Factors influencing clinical decision making. Higgs. j. Jones. M. Loftus. S. Christensen. N. (eds) Clinical reasoning in the health professions. 3rd ed. Butterworth, Heinemann, Elsevier. Philadelphia

Spence, D. and Smythe, L. (2007) 'Courage as integral to advancing nursing practice.', *Nursing praxis in New Zealand inc*, 23(2), pp. 43–55.

Stanley, D. Beament, T. Falconer, D. Haigh, M. Saunders, R. Stanley, K. Wall, P. Nielson, S. (2016) 'The male of the species: A profile of men in nursing', *Journal of Advanced Nursing*, 72(5), pp. 1155–1168.

Stein, L. I. (1967) 'The Doctor-Nurse Game', *Archives of General Psychiatry*, 16(6), p. 699.

Stein, L., Watts, D. and Howell, T. (1990) 'The Doctor - nurse game revisited', *New England Journal of medicine*, 322(8), pp. 546–549.

Stenbock-Hult, B. and Sarvimaki, A. (2011) 'The meaning of vulnerability to nurses caring for older people', *Nursing Ethics*, 18(1), pp. 31–41.

Strauss, A, L, Corbin, J, M. (1994) *Basics of qualitative research: grounded theory procedures and techniques*. London: Sage.

Strauss, A, L. (1987) *Qualitative analysis for social scientists*. Cambridge: Cambridge University press.

Strauss, A. and Corbin, J. (1994) 'Grounded theory methodology', *Handbook of qualitative research*, pp. 273–285.

Streubert, H. Carpenter, D. R. (2011) *Qualitative research in nursing : advancing the humanistic imperative*. 5TH Edition. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins.

Stuckey. H. (2013) Three types of interviews. Qualitative research methods in social health. *Journal of social health and diabetes*. 1(2)

Styhre. A. Eriksson-Zetterquist. U. (2008) "Thinking the multiple in gender and diversity studies: examining the concept of intersectionality" *Gender in Management: An International Journal* Vol. 23 No. 8, pp. 567-582

Tang, N. (2002) 'Interviewer and interviewee relationships between women', *Sociology : the Journal of the British Sociological Association*, 36, p. 703.

ten Hoeve, Y, Jansen, G, Roodbol, P. (2014) 'The nursing profession: public image, self-concept and professional identity. A discussion paper', *Journal of advanced nursing*, 70(2), pp. 295–309

The Department of Health (2010) *The NHS Constitution*. *The NHS belongs to us all.* London. Crown copyright.

The King's Fund (2012) 'Leadership and engagement for improvement in the NHS: Together we can', *Leadership Review*, pp. 1–48.

Thorup, C. B. Rundqvist, E. Robers, C. Delmar, C. (2012) 'Care as a matter of courage: Vulnerability, suffering and ethical formation in nursing care', *Scandinavian Journal of Caring Sciences*, 26(3), pp. 427–435.

Tillich, P. (2014) *The courage to be*. 3rd edn. New Haven and London. Yale University press.

Timmons, S. and East, L. (2011) 'Uniforms, status and professional boundaries in hospital', *Sociology of Health and Illness*, 33(7), pp. 1035–1049.

Tosh, K. (2007) 'Nineteenth century handmaids or twenty-first century partners?', *Journal of Health Organization and Management*, 21(1), pp. 68–78.

Torjuul, K. Elstad, I. Sorlie, V. (2012) Compassion and responsibility in surgical care. *Nursing Ethics*. 14(4)

Traynor, M. (2017) *Critical resilience for nurses*. Oxon: Routledge.

Turnbull, A. (2016) 'The NHS gender imbalance: Nurses are still disadvantaged in nursing' [Online] Available at: http://www.independentnurse.co.uk/news/the-nhs-gender-imbalance-women-are-still-disadvantaged-in-nursing/142298 [3/8/18]

Turner, D. W. (2010) 'Qualitative Interview Design : A Practical Guide for Novice Investigators', *The Qualitative Report*, 15(3), pp. 754–760.

Turner, S. B. (2014) 'The resilient nurse: An emerging concept', *Nurse Leader*. 12(6), pp. 71–90.

Valizadeh, L. (2016) 'Pressure and protective factors influencing nursing students' self-esteem: A content analysis study', *Nurse Education Today*. 36, pp. 468–472.

Van der Linden, D. Scholte, R. Cillessen, A. Nijenhuis, J. Segers, E. (2010) 'Classroom ratings of likeability and popularity are related to the Big Five and the general factor of personality', *Journal of Research in Personality*. 44(5), pp. 669–672.

Van der Linden, D. Pekaar, P. Bakker, A.B. Schermer, J.A. Vernon, P.A. Dunkel, C.S. Petrides, K.V. (2017) 'Overlap Between the General Factor of Personality and Trait Emotional Intelligence : A Genetic Correlation Study, *Psychological Bulletin* 143(1) pp 36-52

Van Herk. A. Smith. D. Andre. C. (2011) "Examining our privileges and oppressions: incorporating an intersectionality paradigm into nursing" *Nursing Inquiry* 2011; 18(1): 29–39.

Welsh, E. (2002) 'Dealing with Data : Using NVivo in the Qualitative Data Analysis Process *Forum: Qualitative Social Research*, 3 (2), pp. 1–7.

West, E. and Nayar, S. (2016) *A Review of the Literature on the Experiences of Black , Minority and Internationally Recruited Nurses and Midwives in the UK Healthcare system*.[Online] Available at: https://www.nmc.org.uk/globalassets/sitedocuments/other-publications/literature-review.pdf [Accessed 20/8/18]

Whitehead, P. B. Herbertson, R.K. Hamric, A. Epstein.E.G. Fisher, J. M. (2015) 'Moral Distress Among Healthcare Professionals: Report of an Institution-Wide Survey', *Journal of Nursing Scholarship*, 47(2), pp. 117–125.

Wimpenny, P. and Gass, J. (2000) 'Interviewing in phenomenology and grounded theory: is there a difference?', *Journal of advanced nursing*, 31(6), pp. 1485–1492.

Woodard, C. R. and Pury, C. L. S. (2007) 'The construct of courage: Categorization and measurement.', *Consulting Psychology Journal: Practice and Research*, 59(2), pp. 135–147.

Wright, R. R., Mohr, C. D. Sinclair, R. R. (2014) 'Conflict on the treatment floor: An investigation of interpersonal conflict experienced by nurses', *Journal of Research in Nursing*, 19(1), pp. 26–37.

Young, R. A. Collin, A. (2004) 'Introduction: Constructivism and social constructionism in the career field', *Journal of Vocational Behavior*, 64, pp. 373–388.

Zarshenas, L. Sharif, F. Molazem, Z. Khayyer, M. Zare, N. Ebadi, A. (2014) 'Professional socialization in nursing: A qualitative content analysis.', *Iranian journal of nursing and midwifery research*, 19(4), pp. 432–8.

Adult Nurses' understanding and use of courage

Fiona Barchard

Appendices

Appendices 1. Literature review and search strategy

Inclusion and exclusion criteria

Inclusion criteria	**Exclusion criteria**
English language	Not published in English
Primary research papers	Non-research papers
Related to Nursing and courage	No relation to nursing
Courage cited in either the title, key words or abstract	Courage not cited in either the title, key words or abstract

Relevant published literature was identified via electronic database searching using ASSIA, BMJ, CINAHL, Cochrane library, MEDLINE, Directory of open access journals, Ingenta connect, Internurse, Journals@Ovid and Northampton full text collection@Ovid, Proquest dissertations and thesis, sage journals online, science direct, Taylor and Francis online, Web of science, Wiley and Zetoc.

Grey literature was accessed through NHS evidence. Thesis and dissertations were searched using the database EThOS and through University repositories.

Search terms were selected through discussions with colleagues, and support from Supervisors and Librarians at The University of Northampton.

Keywords: Courag* AND Nurs*, Daring AND Nurs*, Nurs* AND Guts*, Nurs* AND Fearless*, Nurs* AND valour, Nurs* AND Brav* were searched for in either the title, abstract or keywords.

The PRISMA chart below outlines the search process

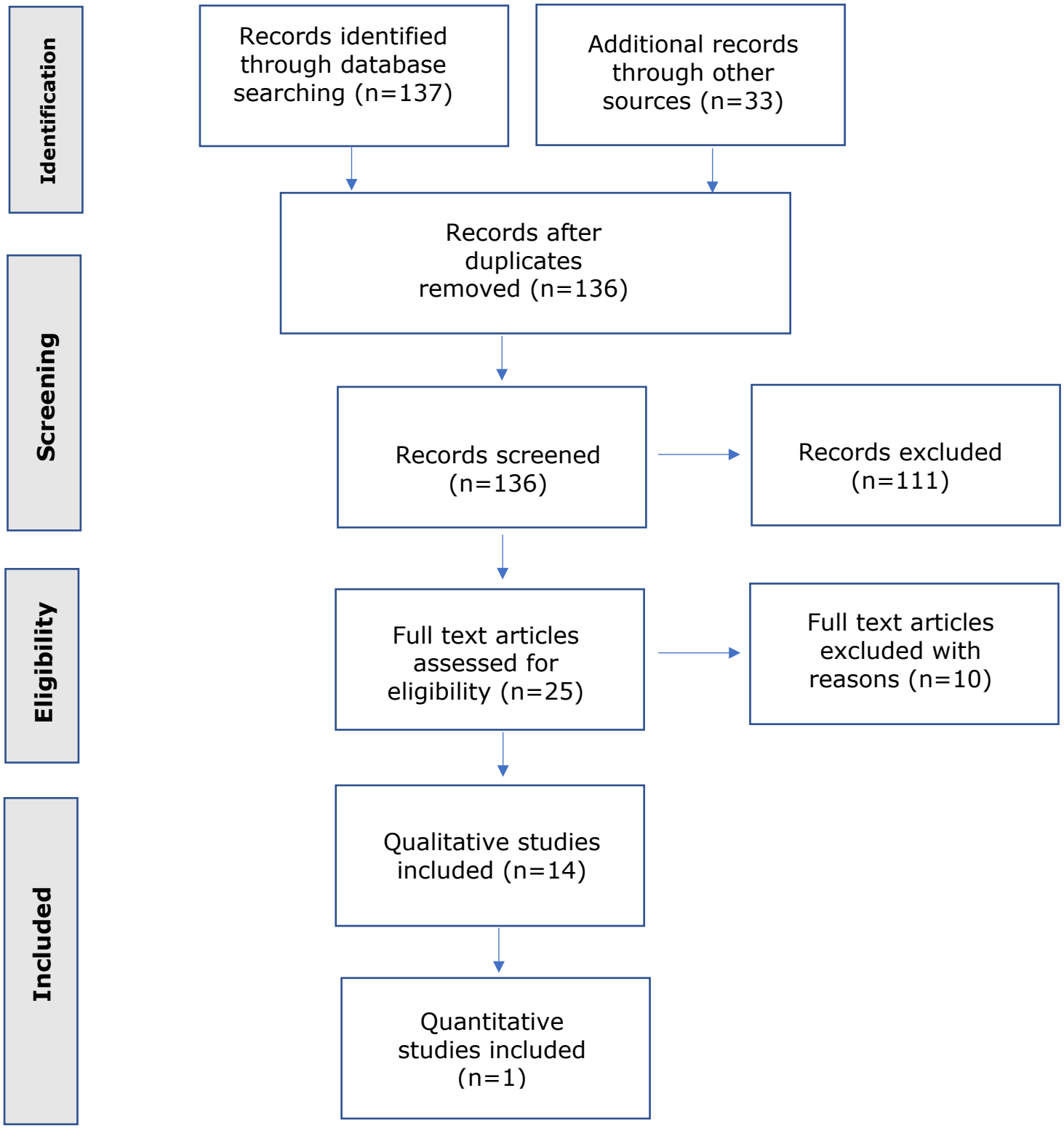


Diagram 1: Preferred reporting items for systematic reviews and meta-analyses: PRISMA diagram (Moher D, Liberati A, Tetzlaff J, Altman DG (2009).

Most of the papers were not research studies and were used for the background review. Specific research papers considered for the literature review were 25. Eight were discounted as irrelevant to nursing, one was discounted as concerned nurse faculty leaders and despite courage being in the key words, had minimal relation to courage and a final paper was discounted as en-courage rather than courage was featured. This left a total of 15 research papers. Books were located using the British Library with keywords and search criteria as above and 5 identified, only one related to nursing. The 15 papers were: Australian, one paper, New Zealand, one paper, England, three papers, America, two papers and Sweden / Norway and Finland, eight papers.

Appendices 2. Participant recruitment and information

Participant Information Sheet

One to one Interview

This information sheet will provide all the information you need to decide whether you would like to particpate.

Study Title: Understanding courage in the context of Nursing

Purpose of the Study:

This research is to enhance the comprehension of adult nurses understanding of courage in the context of adult nursing. This is towards a Doctoral award.

About the Researcher:

My name is Fiona Barchard and I am a Professional Doctorate student from the Division of Adult Nursing, School of Health, at Northampton University. The research study I am inviting you to participate in is leading to my Thesis and award of Doctorate in Professional Practice. This information pack is to give you the details regarding your potential involvement in a one to one Interview.

Before you decide whether to take part it is important that you understand why this research is being undertaken and what is involved. Please take time to read the following information. If you require further information or

are unclear about any aspect related to this research, please feel free to speak directly to me.

What the study involves:

The researcher will conduct 1 to 1 interviews with Adult nurses to explore their understanding of courage in the context of nursing.

What will happen to me if I take part?

Agreeing to take part in this study means you are asked to participate in a interview. This will be 1 to 1 with the researcher and last approximately 1 hour. This will be in a mutually agreed setting. You will be asked about your understanding of courage in your professional nursing context.

For accuracy of reporting the interview will be recorded with a digital tape recorder and the researcher may make some notes. All recordings and notes will be anonymised. After the interview, typed transcripts will be made of the interview. These notes and tape recordings will be kept securely, either in a locked cabinet or password protected on a secure computer. Your interview transcript will be sent to you to validate its accuracy.

What are the risks of taking part?

By taking part in this research you should be aware of possible risks of taking part. There are no physical risks to you as a person; however, should you find as a result of the interview discussions you feel uncomfortable to

continue you are free to withdraw from the study at any point before the analysis phase of the study. You will not be expected to discuss anything you do not feel comfortable with, nor will you be expected to justify your withdrawal from the study. Any questions used will be related to your understanding of courage in your professional practice. Please be assured that you can decline to answer any question at any time.

A protocol has been devised should an issue of concern be raised. A copy of this is available on request

What will happen to the information?

The data collected during the course of the study will be anonymised and each participant identified by a number. Information will be stored in a locked secure place and will be password protected when saved on a computer. The information you disclose will be for my research purposes only. It will not be given to, or accessible by any other party. The information gained will be collated and analysed for themes. It is proposed these themes will form part of a grounded theory into nurses' understanding of courage. With participants' permission I would like to keep the anonymised information for potential secondary analysis at a later date.

What are the benefits of taking part?

By participating in this research, you will contribute to an understanding of courage as 1 of the 6 Cs in adult Nursing. It is envisaged the knowledge

gained will be useful for the future regarding how nurses can be supported and developed in their everyday practice.

Not sure about participating?

If you choose not to participate there are no repercussions. Your consent is voluntary, and should you decide against it, your decision will be respected and not questioned.

If after reading the information you have any questions or would like to see the protocol for dealing with any raised concerns, please contact me and I will explain anything you do not understand.

Only when you feel happy to proceed will you be asked to sign a participant consent form giving your consent to take part in the study.

At any time up until the analysis phase you can terminate your involvement in the study.

Contact the Researcher:

If you have any questions about the research, you can contact my supervisor or me as follows.

F A Barchard (Researcher)

Senior Lecturer

Adult Nursing

Yelvertoft Building (Y210)

Park Campus

Boughton Green Road

Northampton

NN2 7AL

Fiona.barchard@northampton.ac.uk

01604 892863

Dr Sarah Neill (Supervisor)

Associate Professor in Children's Nursing

Children's Nursing

X03

Park Campus

Boughton Green Road

Northampton

NN2 7AL

Sarah.neill@northampton.ac.uk

01604 892871

Who has checked this research?

The University of Northampton, School of Health Ethics Committee has approved this study. Your acute Trust has also given their permission through the research and development committee. The University of Northampton Combined Liability Insurance Policy provides indemnity for students of the institution carrying out research work as part of their course.

Thank You

Thank you for your interest and support. If you would like to participate in the research and take part in an interview and you have no further questions, then please complete and return the consent form in the stamped addressed envelope provided.

Signature and Date of Researcher.

Research Study

Understanding courage in adult Nursing

Seeking Qualified Adult nurses to participate in a one to one interview for a study on understanding courage in adult nursing.

For more information

Conducted by Fiona Barchard. Lecturer and Registered Adult Nurse. School of Health Adult Nursing. University of Northampton

Please contact:

Fiona Barchard

Senior Lecturer in Adult Nursing

Fiona.barchard@northampton.ac.uk

THE UNIVERSITY OF NORTHAMPTON
School of Health

Appendices 3. Ethical and governance agreement

THE UNIVERSITY OF NORTHAMPTON
Graduate School

Feedback from Research Ethics Committee	
Student: Fiona Barchard	Date: 10.12.2014

Action required	Tick ✓
No further REC consideration required	✓
Submit amendments for Chair's Action	
Submit amendments for consideration by members by email	
Resubmit application to future REC meeting	

Decision relating to the proposal	Tick ✓
Full approval was given	✓
Advisory comments were given	✓
Amendments are required before full approval can be given	
Approval in principle was given	
Amendments are required before approval in principle can be given	
In its current form, approval could not be given	

Feedback on proposal
Please amend the information sheet to refer to approval of the Research Ethics Committee rather than the School of Health Ethics Committee.

Advice and guidance:
Please note that if you have been asked to make amendments then you should include a cover note with your resubmission that notes the way(s) in which you have responded to RDB comments and suggestions. You should also highlight any changes made to the proposal (e.g. by using a different ink colour).
The Chair of the Board/Committee can be contacted via the Graduate School if you have any questions about this feedback.

Appendices 4. Ethical agreement (amendement)

THE UNIVERSITY OF NORTHAMPTON
Graduate School

Feedback from Research Ethics Committee	
Student: Fiona Barchard	Date: 25/06/2015

Action required	Tick ✓
No further REC consideration required	✓
Submit amendments for Chair's Action	
Submit amendments for consideration by members by email	
Resubmit application to future REC meeting	

Decision relating to the proposal	Tick ✓
Full approval was given	✓
Advisory comments were given	✓
Amendments are required before full approval can be given	
Approval in principle was given	
Amendments are required before approval in principle can be given	
In its current form, approval could not be given	

Feedback on proposal
A request to change the approved project was received by the Chair for consideration.

This development appears to be a product of the success of the project with participants coming forward having heard of the research. All the participants are the same i.e. nurses so the original approval holds good for the type of participant. The only change here is that the participants will be from a wider working environment. It would seem beneficial that the sample is as broad as possible within the parameters of the research. The only caveat is that these self-selecting participants must be given the participation sheet and consent form in exactly the same way as the participants from MK Acute Trust i.e. it cannot be assumed that because they are self-selecting they 'know all about' the research.

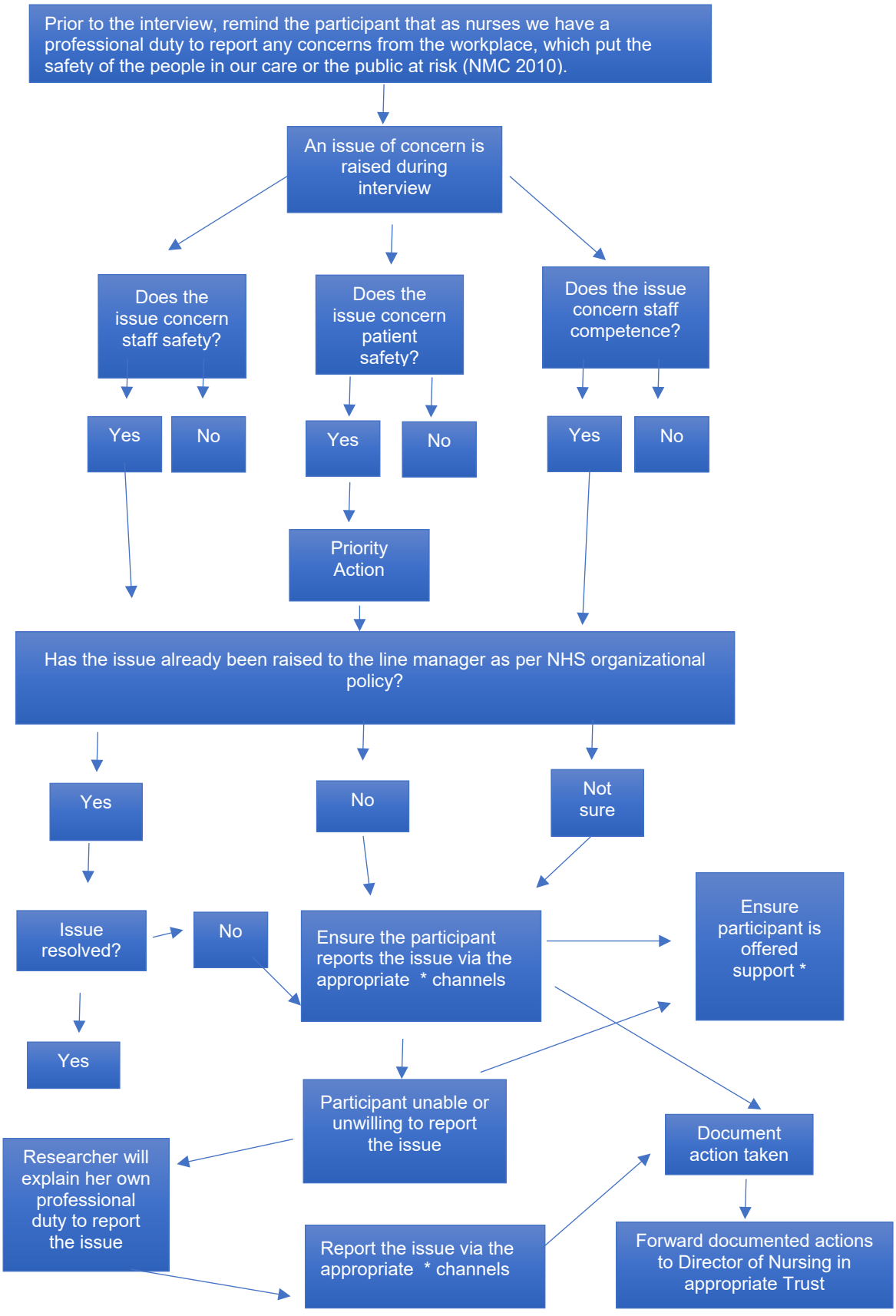
I think that as this is a logical development and is within the boundaries of the original approval it is appropriate to deal with the request by Chair's action and I am pleased to approve it on behalf of the Committee.

Advice and guidance:

Please note that if you have been asked to make amendments then you should include a cover note with your resubmission that notes the way(s) in which you have responded to RDB comments and suggestions. You should also highlight any changes made to the proposal (e.g. by using a different ink colour).

The Chair of the Board/Committee can be contacted via the Graduate School if you have any questions about this feedback.

Appendices 5. Protocol to address raised concerns



*Appropriate channels and escalation in-organization include: Line manager, Department manager / Matron, Chief Executive. Appropriate channels external to organization include: CQC 03000 616161 / Monitor 02037470800 / NHS protect 0800 0284060 / NHS England 03003112233 / Whistleblowing helpline 08000724725 / NMC 02074625800N/ RCN 03457726100.

* Support may include GP, student services and counselling, Union representation.

Process informed by:

Department of Health (2013). "*The NHS constitution, the NHS belongs to us all"* Crown copyright. Department of Health

NMC (2010). *"Raising concerns, guidance for nurses and midwives"* London.

Powell. T. (2013) *"NHS whistleblowing procedures in England"* Social policy SN06490. House of Commons Library

Royal College of Nursing. *Raising concerns. A guide for RCN members.* London

Appendices 6. Consent form

Consent Form – One to one Interview

For participation in the study of:

Understanding courage in the context of Nursing

Further details of research are in attached participant information sheet

Please tick the relevant boxes

	Yes	***No***
I have read the participant information pack and understand what is involved.	☐	☐
I understand that the information I disclose will be anonymised.	☐	☐
I understand that my participation is voluntary, and I can withdraw my participation without explanation or repercussion at any time up until the analysis phase of the study (thereafter data will have been anonymised).	☐	☐
I understand there is a protocol to follow should an issue of concern be raised.	☐	☐
I understand that the research being conducted aims to provide understanding of courage in the context of nursing.	☐	☐
I consent to my data being recorded and transcribed.	☐	☐
I understand anonymised quotes will be used in the Thesis and in teaching, published articles or presentations.	☐	☐
I agree to check a transcription of my interview to confirm its accuracy.	☐	☐
I consent to my anonymised information being securely stored for possible future analysis.	☐	☐

I would like to receive a summary of the research findings on completion.	☐	☐
I am willing to participate in this project.	☐	☐

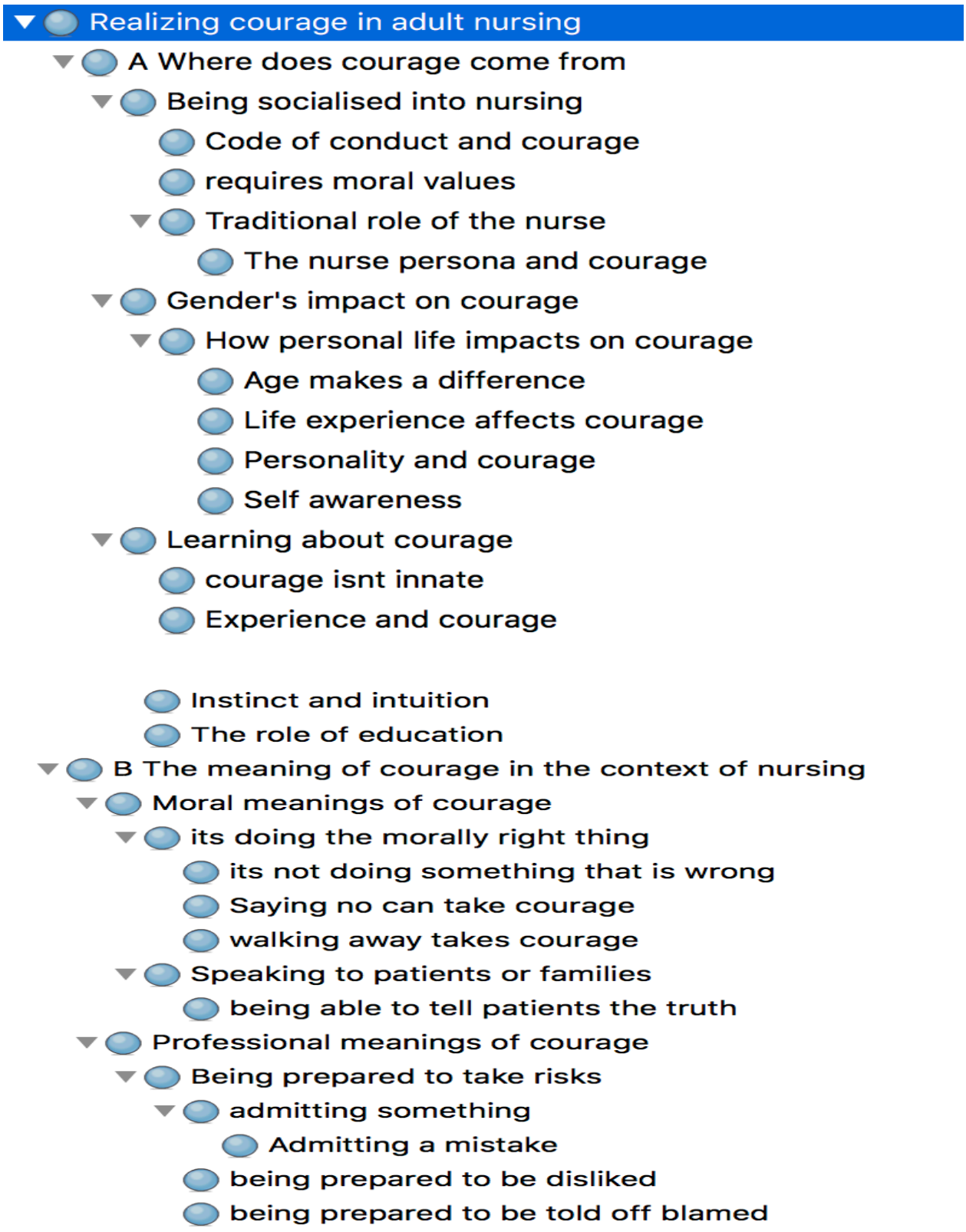
Printed name of the participant ……

Signature of the participant …….. Date: ……

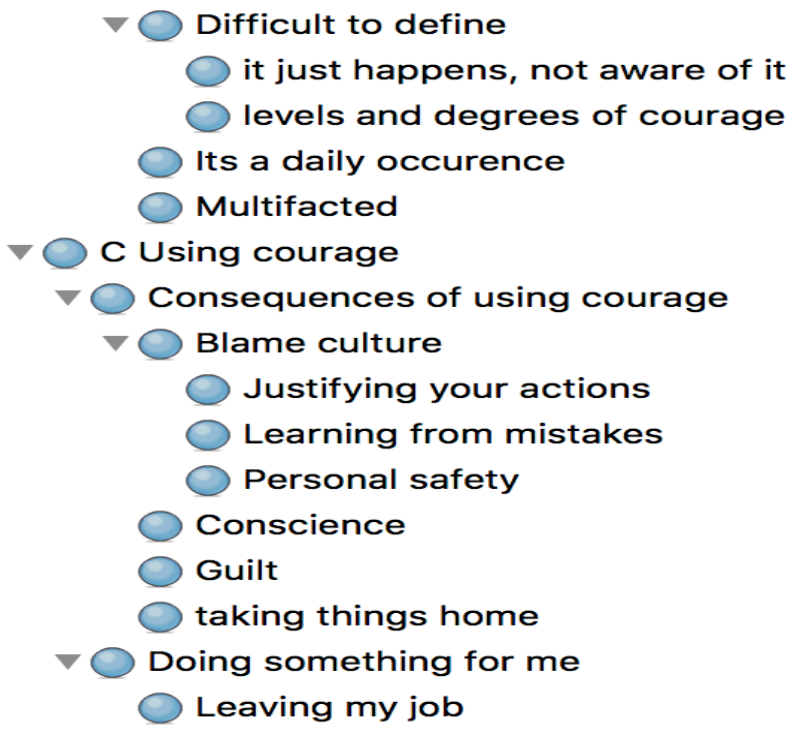
Preferred means of communication (please circle and give details).

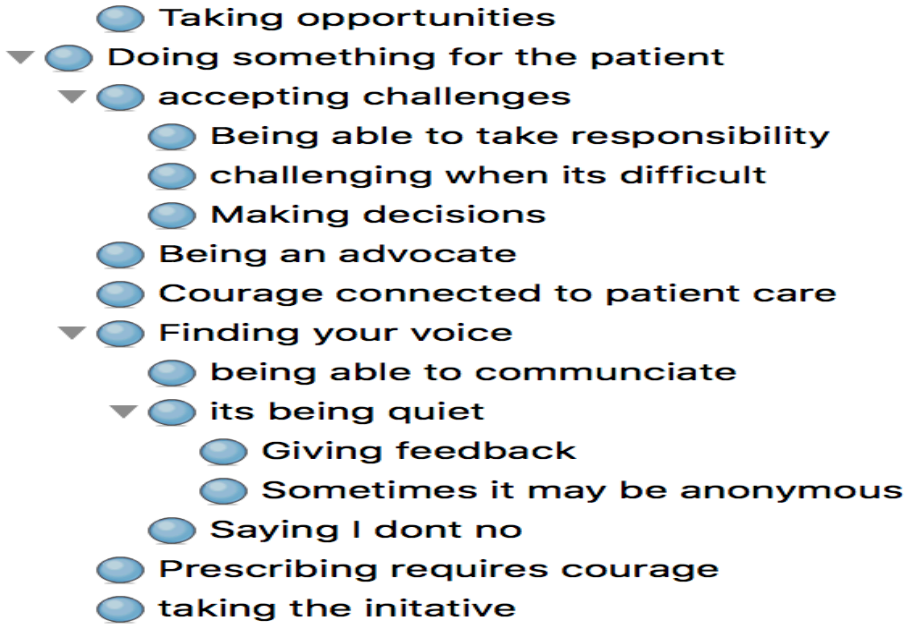
Email:……Telephone:……

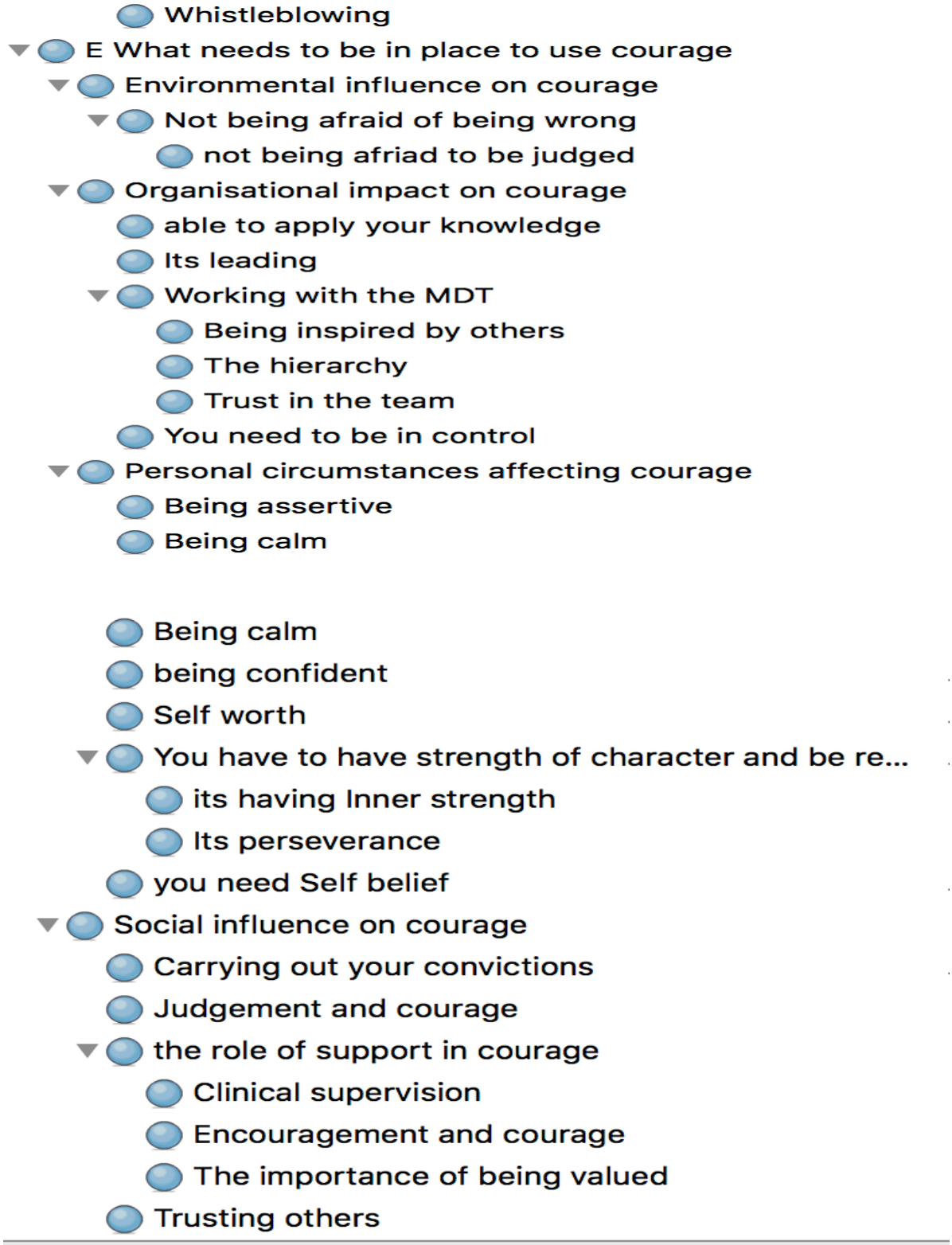
Appendices 7. Categories and subcategories



- Being prepared to fight
- Facing aggression
- its being brave
  - Going back to work
  - Standing your ground
- its just doing my job
- Persuading patients
- Practical action and Being a change agent
  - Getting things done
    - Moving things forward
    - Trying new things
      - looking outside the box
- Psychological meanings of courage
  - Being in a situation you dont want to be in
    - Facing your fears
    - Going into the unknown
    - Knowing when to remove from a situation
    - stepping out of your comfort zone
  - Being like a lion
  - Its letting yourself feel
  - Pushing yourself
  - seeing things through
  - Stepping up when things are difficult
- Social meanings of courage
  - Gender's impact on the meaning of courage
  - Seeing the whole picture
  - Speaking up
    - having an opinion
    - Its knowing when to speak
    - Speaking to senior staff
    - thinking before you speak
- what courage is to them personally


Difficult to define
it just happens, not aware of it
levels and degrees of courage
Its a daily occurence
Multifacted
C Using courage
Consequences of using courage
Blame culture
Justifying your actions
Learning from mistakes
Personal safety
Conscience
Guilt
taking things home
Doing something for me
Leaving my job


Taking opportunities
Doing something for the patient
accepting challenges
Being able to take responsibility
challenging when its difficult
Making decisions
Being an advocate
Courage connected to patient care
Finding your voice
being able to communciate
its being quiet
Giving feedback
Sometimes it may be anonymous
Saying I dont no
Prescribing requires courage
taking the initative


Whistleblowing
E What needs to be in place to use courage
Environmental influence on courage
Not being afraid of being wrong
not being afriad to be judged
Organisational impact on courage
able to apply your knowledge
Its leading
Working with the MDT
Being inspired by others
The hierarchy
Trust in the team
You need to be in control
Personal circumstances affecting courage
Being assertive
Being calm
Being calm
being confident
Self worth
You have to have strength of character and be re...
its having Inner strength
Its perseverance
you need Self belief
Social influence on courage
Carrying out your convictions
Judgement and courage
the role of support in courage
Clinical supervision
Encouragement and courage
The importance of being valued
Trusting others

Appendices 8. Examples of theory evolving

Version 1: 1st Draft: 7/7/16 16.30

Courage is ……..Rising to the challenge, being strong

Courage is……being unafraid (of being wrong or judged, lose registration, being blamed)

Courage is……..Self belief

Courage is…….doing the right thing, suffering personal discomfort, fear, out of comfort zone

Courage is……..pushing yourself, confrontation, moving forward, embracing change

Courage is……. using your knowledge

Courage is…….questioning, speaking up, being quiet

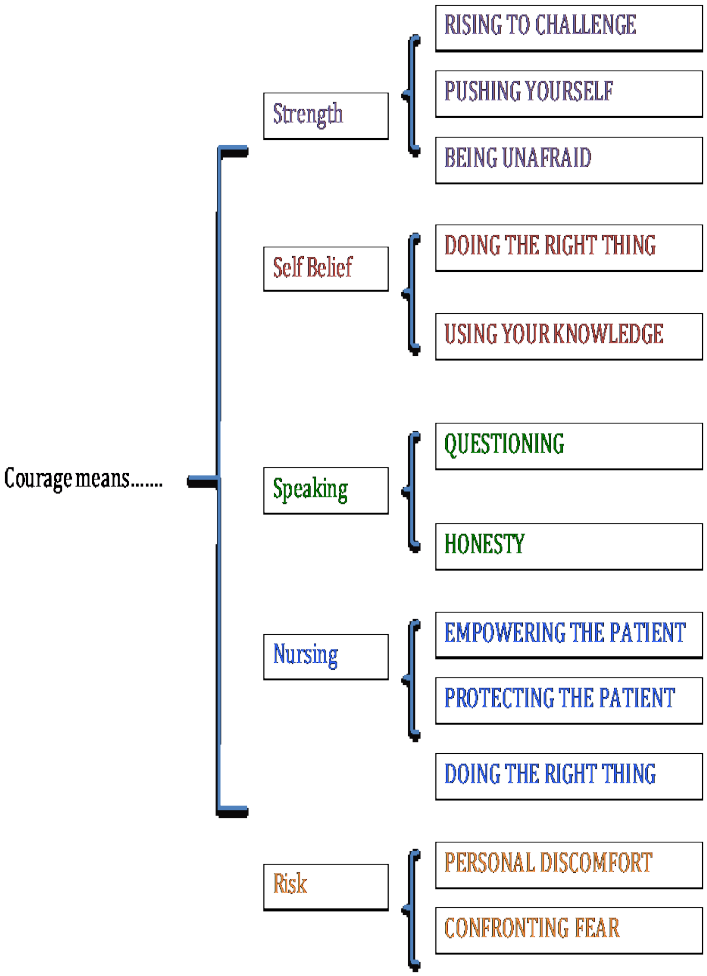
Courage is……..honesty difficult conversations

Courage is……my job, going to work

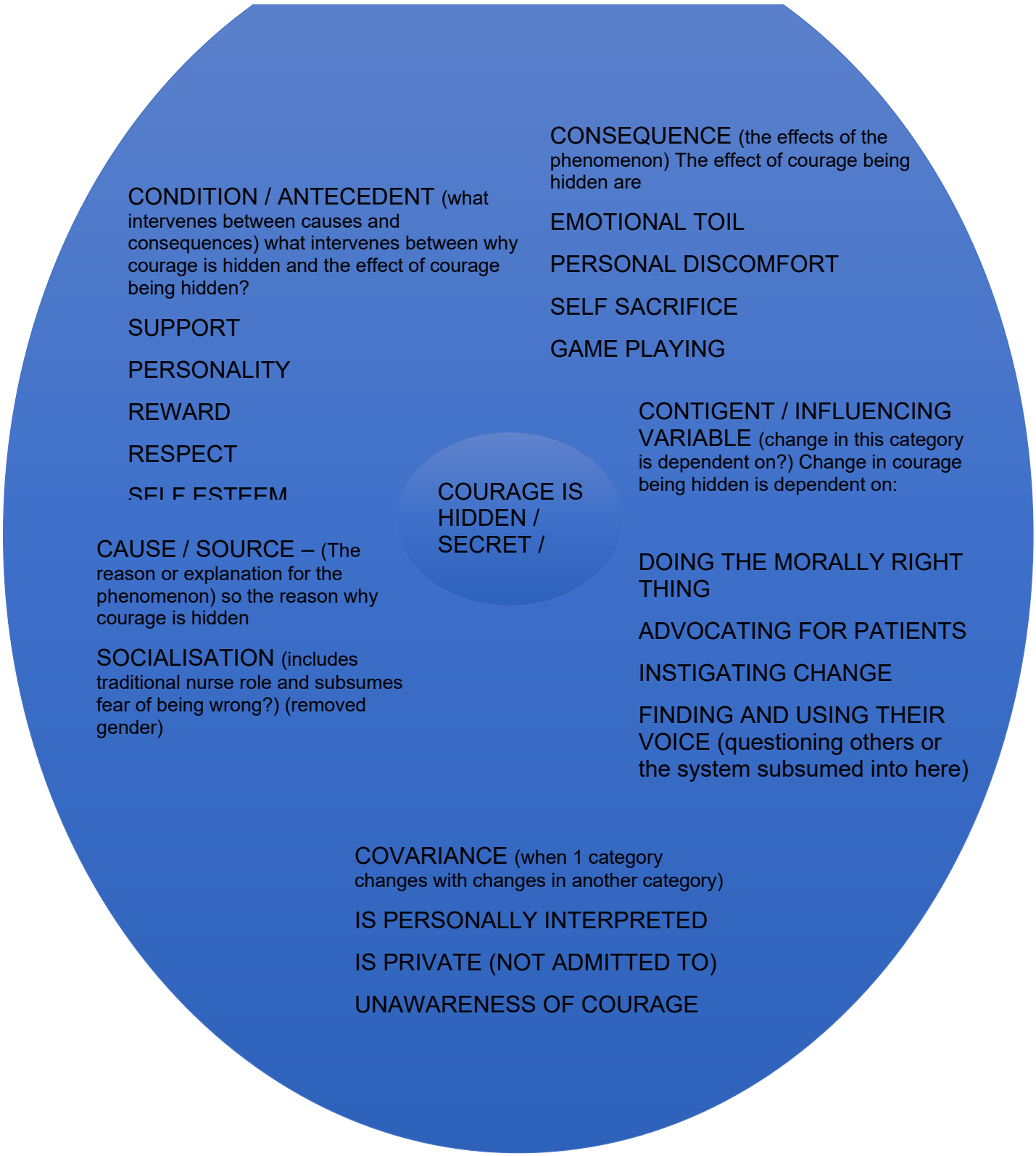
Courage is……..protecting the patient, empowering the patient

Courage is……for me

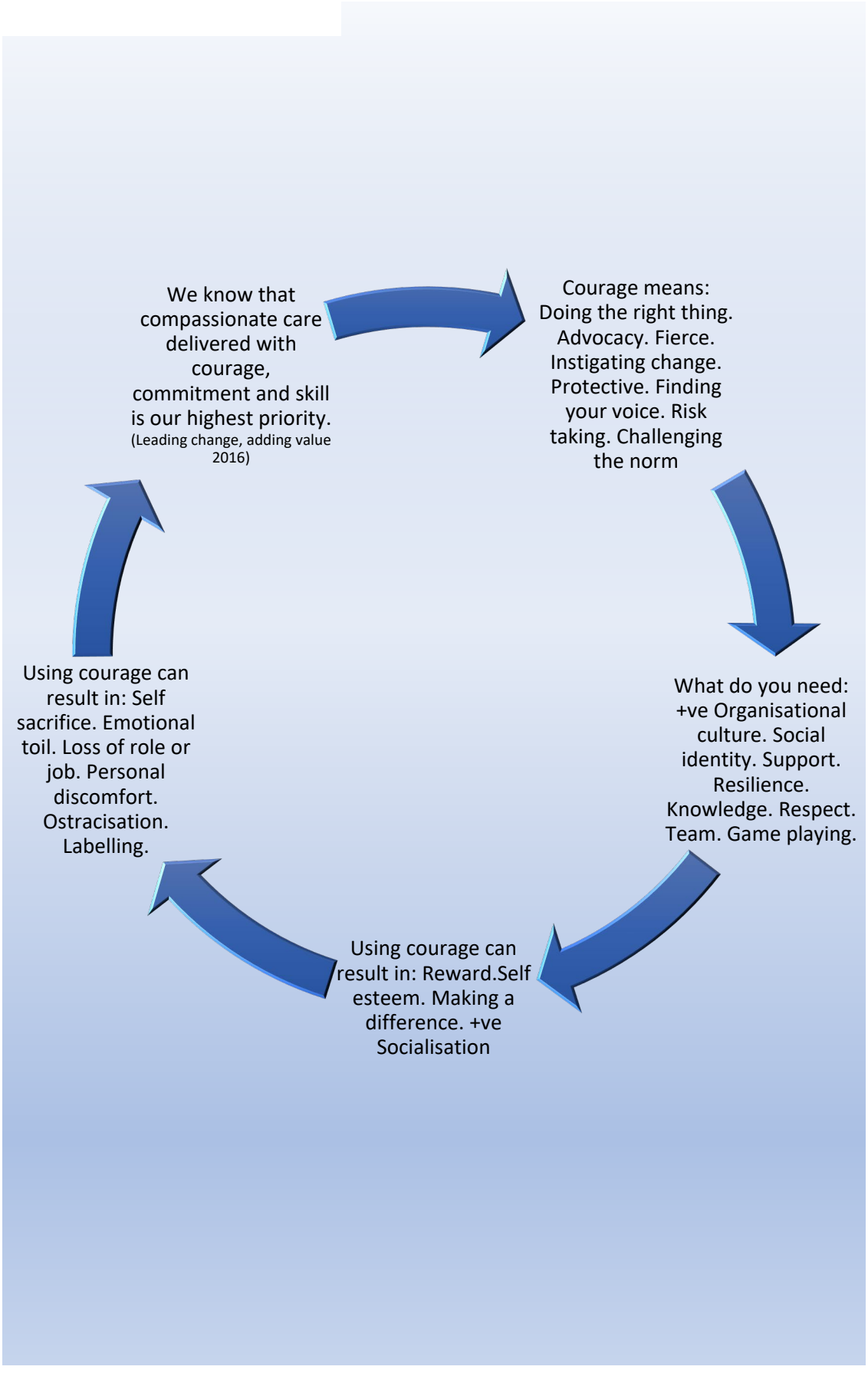
Courage is……..taking risks


Courage means.....
Strength
RISING TO CHALLENGE
PUSHING YOURSELF
BEING UNAFRAID
Self Belief
DOING THE RIGHT THING
USING YOUR KNOWLEDGE
Speaking
QUESTIONING
HONESTY
Nursing
EMPOWERING THE PATIENT
PROTECTING THE PATIENT
DOING THE RIGHT THING
Risk
PERSONAL DISCOMFORT
CONFRONTING FEAR

Version 9: Draft 18/2/17 Based on Glazer's Cs



Version 20 20/8/17



Appendices 9. Examples of memos

Participant quote	Associated Memo
[P6] My mother always says, "oh you never stick up for yourself" and I say "yeah but see me at work where I'm like a Rottweiler.	Several participants have talked about this, in their personal life they are trodden on but not at work, why is that, is it nursing, the way they see themselves or the hierarchy?
[P8] I've been a brain injury nurse for years, but I don't feel in any way shape or form I'm, I'm an expert or that I know a lot.	I could have explored why she doesn't think she's an expert when I would think it appears she is? Is this about nurses not wanting to big themselves up or imposter syndrome?
[P8] One of the Consultants I work with and I sit in with him on clinics sometimes and you know, he's erm, incredibly experienced and he, I've heard him to say to patients "I don't know"	This seems like once she had permission as such from him then it was OK for her, how different would it have been if he hadn't been like that?
[P3] I always try and be respectful, so even though I'm criticizing what he's doing, I make a lot of effort not to be rude, you know, I wouldn't be disrespectful erm, he's still, erm, a sort of well-regarded practitioner in his own right, and just because he's doing that particular bit badly doesn't mean that I get the right to disrespect him, sort of thing, so again it's that balance	Is this a comment on the hierarchical nature of nursing and the submissive nurse or simply good communication, manners and interpersonal skills?

Appendices 10. Background to reflexivity

10a - My worldview and background as a woman

To me the world was always a small place. I grew up in a village, moved to the local town to start my nursing and stayed in the same acute hospital Trust for 19 years. I enjoyed my job, it seemed each time I contemplated leaving I got promoted so I was content with my small world, my friends, job and home life. I would say this narrow view of the world stayed with me until I left the NHS at 40 and started my Professional Doctorate at the University. Moving jobs was a big decision for me, I had always been loyal to where I worked and felt an affinity for the Trust I worked for and safe in my nursing career. Just before I was 40 the Trust where I worked had a re-structure, this meant my post's job description was changed and other people who were losing their jobs could apply for it. I would have to re-apply for my role along with them. This forced the wider world into my view and I realised, though I was loyal to the Trust they were not to me. Turning 40, feeling devalued and realising I had potentially another 25 years in the same job motivated me to apply to the University. I realised as a nurse I had reached the top of my career and unless I moved sideways into management, away from patient care, I faced 25 years in the same role. That was the first time I realised that I was constrained as a nurse in terms of

how much further I could achieve, though I do not remember consciously thinking about this in terms of me being a woman.

My worldview has changed doing this study, it is only as I have interviewed the participants and compared and analysed their data that I have become more aware of the world's influence on women and started to think about my place in the world, as a woman and a nurse. I have become more aware of the news, politics, the world as a bigger place and the power of socialisation that influences everything I do and how I think and feel. It is as though I have suddenly become aware of the constraints women face and I now see news articles regarding equal pay and women's treatment, for example in Hollywood and have a raised awareness of how women are regarded in society. My narrow world view when I started my study will have affected how I perceived participants stories. I was naïve and tended to take what they said at face value. Through reading psychology and sociology theories, talking to my supervisors and as the data unfolded, my worldview of nursing, women and the world around me changed and this will have influenced my co-construction.

As a female, I was the youngest child of 4 with 2 older brothers between myself and my sister. My parents were traditional parents,

dad worked, and mum looked after the children. However, I saw my mum was strong minded and independent. I looked at her as quite tough, though I didn't consciously think of her as a woman, she was mum. Perhaps due to the constraints of old fashioned parents and the teenage will to rebel, I left home at 17 and had my own bedsit in the local town. I prided myself on never asking my parents for money and being self-sufficient, I liked to feel I was independent and strong, on reflection I was perhaps emulating what I saw in my mum and it was important to me that I could survive independently and that she was proud of me.

I don't recall being conscious of myself as a woman in that I did not consider the impact of my gender for example, when choosing to nurse as a career. It seemed more like destiny to me. My mum and sister were both nurses and despite railing against this for a time, it seemed a good option to be a nurse. Now looking back, I can attribute my choosing to nurse to some of my experiences when I was young. I wanted or even needed, to do 'good things'. I did not have a good self-esteem for various reasons and doing good things, including nursing, helped my self-esteem though I didn't consciously realise this at the time. I regarded my nursing choice as partly genes and partly there were not many other options for girls

30 years ago. I never thought I would need courage to be a nurse, just to be caring and do what I was told.

I feel I have always had a caring nature and my friends would often confide in me knowing I would not judge them and they could trust me. I enjoyed being a confidante and someone people came too, on reflection this also helped my self-esteem. I felt I could relate to people who were troubled or overcame adversity. Consequently, when I was interviewing participants I felt a connection with those that had overcome adversity in their lives, for example participant 3 and this may have helped me to let them tell their stories more easily. I admired her strength and ability to overcome her difficulties. Conversely, with participant 10, due to her body language and what I felt was a stoical performance, I did not connect so well, and the interview seemed less natural and more contrived. With participant 7, she also had adversity in her life but did not seem able to overcome it, she seemed to me to be defeatist, this made me feel impatient and again less connected, I wondered why she could not be stronger and overcome her difficulties, this led to the interview tending towards what I felt was more like a counselling session.

Looking back on myself as a nurse and a female through my wider world view glasses, I can see how I was socialised from a young age to become the woman I now am. That socialisation continued throughout my nursing and again as I joined the University. One of the areas pertinent to this study and a result of my own socialisation, is game playing. Reflecting I can think of several occasions in my personal and professional life where, as I realise now, as a woman I used various strategies to get what I needed. Although I prided myself on my independence this did not stop me, for example appearing helpless with the AA man to get help with my car or negotiating a doctor to the conclusion I wanted by making it appear the decision was his. The participants experience of game playing resonated with me due to my own experiences and through researching this behaviour I now understand why women find it necessary to behave in this way.

10b - Surviving challenging situations, admiration of participants and connecting as a mum and nurse

Prior to this study I had not reflected on the meaning of courage in any way including in nursing. For me, courage was something I read about in books rather than applied as a concept to people in my everyday life. I did however, admire people I perceived to overcome great adversity and was fascinated by way they coped

with their situations. One particular moment in my life stands out as the moment that solidified my interest in the notion of courage. That moment occurred when I finished reading "A Boy called it" a book authored by David Pelzer about his experience of childhood neglect and trauma which he turned into personal success. When I think about it, that is perhaps where my interest in courage started, though as I say it was admiration of those people who were able to get a positive out of bad, rather than my thinking, 'oh they are courageous'.

It is my admiration for people who have overcome adversity that created a sense of personal identification with those participants who had survived challenging situations. In these cases, for example participants 3 and 6, as their stories unfolded I felt reluctant to intervene to ensure a strong focus of the interview topic, I just wanted to hear their stories and learn how they overcome their adversity. Furthermore, an inattentive interviewing style, impacted by an attitude of admiration could have resulted in my missing important data, or misinterpreting meanings. For example, when participant 3 reported she thought of her bad boy wings, I responded with a supportive laugh, totally missing the opportunity to deconstruct their meaning with her.

Participant 13 had a palpable pride in being a nurse, she spoke about being inspired by her godmother who seemed to her to be an angel in her nursing cape and described how she almost saw stars when she saw her godmother in her uniform. She also spoke about her struggle to be a nurse, moving from another career and starting nursing, something she had never thought was a possible option for her. Her struggle including missing her daughters first steps and other important milestones. Her self-less devotion to nursing and her apparent pride, dedication and passion resonated with me and excited me. Here was a junior nurse, who did not work in a specialist "protected" area and she could be courageous and was not afraid to say so. Participant 13 was just starting her nursing career and I saw some of myself in her when I first started nursing. I too had missed family Christmas and other important family events due to nursing and felt, though I did not realise it at the time as courage, that I was courageous too. When I reflect, the difference between us was I was in a protected supported environment which enabled my courage where she was not, it was not until I began to analyse the data that I realised why different nurses' experiences are so different dependent on so many factors.

10c - My personal view of ICU nurses and nurses

I went to work in ICU one year after qualifying. I had always wanted to work there after I worked there as a student for a short time, it seemed to me as mysterious, interesting and challenging and the nurses I saw there seemed to be strong and had some control over their work. I soon realised the nurses did have more autonomy and respect in ICU than I had experienced on the wards, nurses were treated as part of the team by the Doctors. I realised we were protected, we were always well staffed, got extra training and were supported by our manager and the doctors. However, I was also aware that meant we were often viewed negatively by some of the wards nurses, they thought we saw ourselves as the elite.

Within a couple of years, I was in charge of the ICU, things were different then and promotion was much quicker. I can recall several occasions where now, I would say I was courageous, challenging consultants and dealing with really difficult situations, but I didn't think it then, I just thought it was my job and I was doing what I was trained to. I now realise we were supported to speak up, the consultant told the junior doctors to ask the nurses advice and what they should do. I observed in ICU nurses seemed able to challenge,

speak up and be more autonomous where ward nurses struggled. I often had ward nurses bring patients to the unit who were critically ill, and the nurse would be frustrated as no-one had listened to them regarding the patient's deteriorating condition. I was also aware the supportive consultants I worked with behaved differently on the wards, demanding the nurses get things for them or behaving in ways they did not on the ICU. However, I did not think about this at the time, either in terms of courage or support. I did appreciate I was in a fortunate position as a nurse and attributed that to the Doctors and the ICU culture I worked in and did not consider why it was different elsewhere, I just accepted it.

My view of nursing within the context of ICU and the wards is I have always been aware that nurses are the largest workforce, predominantly women and yet I would wonder why we could never make a difference or stand up for ourselves. My nurse colleagues and I would complain amongst ourselves, for example at how we perceived nurses were treated compared to doctors, but we would never try to action this unless it was directly concerning a patient. If it was something that affected us as a nursing group, we would grumble but ultimately ignore it. As a group we would feel annoyed how the Doctors were perceived to stick together if things did go

wrong and I did used to wonder why it was. I understood that it was something to do with being women, that somehow, we didn't have the same voice that doctors did because they were in the position of power but felt powerless to actuate anything to negate this. I can now see we were socialised to behave in the expected way by our cultural and professional socialisation and the organisational culture.

Commencing my Professional doctorate, I thought about decision making and why ICU nurses were seemingly able to make decisions when other nurses perhaps could not. I looked at this naively, I understood that ward nurses were not 'allowed' or supported to, but I still felt as a nurse you still should or would, the fact you were not allowed seemed irrelevant to me. I felt you HAD to for your patient. I now see the majority of nurses will be courageous if it is for their patient but will often fail to for themselves, the patient takes precedence over their own needs. Although I did realise in ICU we were protected and fortunate in the support we had if I am honest I had an underlying feeling that ward nurses were perhaps cowardly and that is why when participant 1 mentioned the lion, I responded with the wizard of OZ analogy as I thought of the cowardly lion. I

now understand the ward nurses' situation is more complex than my naive view of it.

10d - Myself as a lecturer and the final interview

The final two interviews were with lecturer colleagues who had left practice less than six months previously. I had been a lecturer for ten years and although we all shared the same job description I was conscious that the two participants may see me as senior to them and we had not met previously so I was aware of making a good impression. I was also concerned they may have felt coerced to participate as they were both on their years' probation and I can remember myself at that time feeling I should join in anything offered. This will have affected the power dynamics between us as participant and researcher.

As was my usual stance I identified to them as a nurse, in some ways even more so, possibly due to my perception they would still identify as nurse rather than lecturer due to their short time at the university and the final participant was also still part-time in practice. However, as a lecturer with 10 years' experience I also felt in a comparatively confident position, for example that I knew more than they did about the role of lecturing, but I was anxious that they would see me in a good light, directing me to think again

about my self-esteem. As I have matured and become more confident in myself I feel my self-esteem is healthy and I believe I am good at my job, however, on reflection in situations like this I can see my self-esteem concerns are not as far behind me as I would like to believe. Additionally, in the previous 4-5 interviews I had not noted anything new or significantly different and I can recall being anxious something unexpected may emerge that would require further interviews or clarification. I consciously tried to not close myself to hearing anything new and remaining open to their direction, but it is still possible I chose to overlook or not hear something they said.

10e - Feeling embarrassed to be a researcher and my pride as a nurse

As the interviews progressed I became self-aware of deliberately situating myself as a nurse (as opposed to a lecturer, researcher or academic) when introducing myself to participants. My belief was this enabled a relationship to form, helping to build rapport as participants were all nurses. For the most part this appeared to be successful; participants seemed able to share their stories, and often referred to how, as I was also a nurse I would know what they meant. However, viewing this choice reflexively, I positioned myself

as a nurse for several reasons, to connect with them but also, I felt proud to identify as a nurse and embarrassed at the idea anyone would call me an academic. I also felt apprehensive of appearing to consider myself superior, or as a nurse who had "sold out' to nursing. I remember myself as a nurse perceiving that nurse lecturers had an easy job and had given up on nursing and were now telling nurses what to do from their "ivory tower".

Reflecting I now see this is the influence of my socialisation about what women can or cannot do, nursing is acceptable but why do I think I can be an academic or researcher? I felt these influences may have inclined participant 10 to not appear relaxed or comfortable being interviewed and I felt uncomfortable and conscious that she may feel I had given up on nursing. I felt apologetic for my role as a lecturer and "academic" and on a personal level I always view myself first as a nurse who is also a lecturer not vice versa. I was concerned participants may not share their stories with me unless they identified with me. However, on most occasions I not only disclosed I was a nurse, but specifically an ICU nurse which given ICU nurses negative elite reputation could have alienated participants or made them feel I was being condescending. I did realise I was doing this and resolved to stop

yet can recall even after becoming aware, repeating the mistake to the point where I felt embarrassed of myself with participant 15.

Thinking back, I am proud of my achievements in ICU and I miss the kudos of telling people I was a Senior Sister in ICU which would result in responses of admiration and praise, something I have not experienced when I tell people I am a lecturer. On reflection I think this connects to my self-esteem, I enjoyed the admiration that being a nurse often seemed to provoke in people but my connection here as an ICU nurse was likely to have been misplaced, except possibly with those participants who had worked in ICU. Additionally, with participant 15 my perception was that she was from a higher class than me from her demeanour, speech and grooming, this perhaps prompted me to want to impress her and I was pleased when she did seem impressed as I recited my ICU history. On reflection this was because of socialised assumptions about our different classes, my feeling momentarily inferior and seeking to impress. This will have influenced the dynamic between us and consequently the data gathered and co-construction.

When I interviewed Participant 2 who was a research nurse this dynamic changed again. I was conscious that it was now acceptable

to be a researcher although I persisted in my identification of myself as a nurse as the participant volunteered she worked in the same area as I before my ICU career. I was anxious to get things right and to enable the participants to identify with me, so they felt they could trust me with their stories. However, I recall I still felt uncomfortable to say I was a researcher, this was only my second interview and I feared the participant may feel I was inept. I did not consider at the time she may also feel I was judging her in the same way. This interview was productive, and I collected good data, however I felt there were things unsaid, for example I had the impression she had left her previous job as she burnout. I did not pursue this with her for fear of upsetting her and derailing the interview, but it may have been a useful source of more data. My identification of myself as researcher and or nurse may have confused the participant who did not feel able to trust me with the unspoken areas I thought I sensed.

Appendices 11. Examples of excerpts from field notes

11a

P1: Overall, I think the interview went well, better than I expected, and I think this was due to a really good interviewee, she was very relaxed (evidenced by her body language) and she was able to correct me if I got what she felt wrong. I did feel a bit nervous at first as I just felt a bit of a novice and a bit flustered, I felt concerned she would realise how inexperienced I was.

11b

P10: Began the interview, not sure why but I found this quite hard work, for much of it she had her arms folded though did relax into it on and off, she seemed quite closed and clipped in her answers and yet she seemed happy to be interviewed and didn't not answer anything or be defensive at all, her words seemed to want to be there and share but her body language and something else indefinable seemed to say different. I found it difficult to lead onto anything else and sometimes really got stuck with where to go next with anything which I have never had before, usually as people say things I make a note and then return to areas they have raised, I did the same here, but I guess there wasn't much to return to and she answered with closed answers – maybe I used more closed questions.

The transcribing was interesting as it didn't come over at all that it was difficult, there was only 1 part where I lost my train of thought a bit and actually she gave some really good answers with plenty of chat, it didn't sound on tape as though she was hesitant or reluctant in any way, she came over audibly as easy to talk to with plenty of ideas and thoughts on it all.

11c

P12: I think almost everyone I have interviewed loves to talk, maybe that's why they volunteer. She spoke easily and freely and as usual we ran over a bit and could have carried on. Listening back to the tape it was like we were on fast forward. I found it difficult to

listen to as she spoke freely and easily but very quickly and there were many times when we talked over each other, finished each other's sentences and it was difficult to transcribe. I am not sure why this was, she interrupted me a number of times or started talking before I had stopped and then I did start doing the same to her, at least I think it was that way round! I think this meant sometimes she didn't answer the question and several times we went off on tangents that weren't relevant or didn't answer the question.

11d

P2: The participant sounded quite nervous throughout, small nervous laughs punctuate the discussion, there were also many occasions where she spoke very quietly and then other times with more conviction, on transcribing I felt like she was holding back. I felt the dynamic was a bit different between us, maybe this was because I knew she was a research nurse, so I tried to identify with that more than her nursing and somehow that felt a bit awkward. I also wondered if her reading the protocol (the only participant so far to ask to see it) if that may have held her back or made her overly aware about revealing anything too much. She came over as a very willing participant but somewhat nervous and anxious to get it right, maybe she felt as a researcher I was judging her as a researcher too.

Appendices 12. Presentations and publications

Barchard, F. (2015) Images of research: Understanding courage. The nursing context. Northampton University. January 2015

Barchard, F. (2016) Nurses understanding of courage. The RCN International Nursing research conference. Edinburgh International Conference Centre. 6-8th April

Barchard, F. (2016) Understanding courage: The nursing context. Northampton University: Research and Integrity conference. June 2016

Barchard, F. Sixsmith, J. Neill, S. Meurier, C. (2016). "Courage, the 6 Cs and 10 commitments: Initial findings of a grounded theory research study into Nurses understanding and use of courage". *Nursing Management.* **23**(10), pp. 26-31. 1354-5760.

Barchard, F. (2017) Getting to grips with grounded theory. A critical reflection. The RCN International Nursing research conference. Edinburgh International Conference Centre. 5-7th April

Barchard, F. (2018) Images of research: Little rays of Light. Northampton University. January 2018.

Barchard, F. (2018) A grounded theory of courage in nursing: A complex and multi layered phenomenon. University of Birmingham. 16th -18th April 2018

6Cs and ten commitments: nurses' understanding and use of courage

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Aim: This article reports the initial findings of a study that explored nurses' understanding of courage, in the context of the 6Cs and the Leading Change, Adding Value framework. The aim was to explore how nurses' understanding of courage can inform future practice, thus enabling preparation and support for nurses' use of courage in practice settings, and to enhance understanding of their use of it in everyday professional practice.

Method: The study used unstructured interviews in a grounded-theory approach, in which a theory is constructed by analysing data, underpinned with epistemology of social constructionism, a theory that examines shared assumptions about reality. Twelve qualified nurses were interviewed in depth about their understanding of courage in professional practice. A literature review was also undertaken.

Results: Nurses discussed their understanding of courage in terms of being in a situation they do not want to be in, speaking up and taking risks.

Conclusion: Understanding nurses' view of courage and its influence on practice can inform future recruitment and retention policies and practice, thus preparing and supporting nurses in the use of courage in practice settings.

Nursing Management. 23, 10,26
31. **doi:** 10.7748/nm.2017.e1550

Peer review

This article has been subject to external double-blind peer review and checked for plagiarism using automated software

Conflict of interest

None declared

Received: 30 June 2016

Accepted: 21 December 2016

Published in print: 27 February 2017

Keywords : courage - grounded theory - nursing management - the 6Cs - understanding - unstructured interviews

Introduction

This article outlines the initial results of a constructionist grounded-theory research study of the understanding of courage in the context of nursing. Cummings and Bennett (2012) define courage as the attribute that 'enables us to do the right thing for the people we care for, be bold when we have good ideas and to speak up when things are wrong'. In the 6Cs, shorthand for the values that underpin healthcare, courage is denoted as an essential nursing attribute (Cummings and Bennett 2012). This is supported in Leading Change, Adding Value (Cummings 2016), the national framework for nursing, midwifery and care staff.

As Cummings (2016) notes, 'we know that compassionate care delivered with courage, commitment and skill is our highest priority', which confirms that courage is important to nursing practice. Yet although there are various studies of the other five Cs, namely commitment (Gould and Fontenla 2006), compassion (Straughair 2012a, 2012b), competence and caring (Rhodes et al,2011) and communication (Kourkouta and Papathanasiou 2014), relatively little work on courage and its role in nursing practice could be found.

Concept of courage

Grounded theory discourages literature reviews before data collection to ensure that understanding derives from participants rather than from researchers' preconceptions. However, literature reviews can be useful for example in writing research proposals (Charmaz 2014), so a preliminary literature review was conducted in 2015 to determine if the subject had been explored.

The library of the University of Northampton, Nelson, CINAHL, Cochrane, EthOS, Medline and Ovid, Google Scholar and the internet were searched for research on courage in nursing. The search terms used were 'courag*' and 'nursing' in any order in the title or abstract in the past ten years. Articles sought were in English and the field of nursing was not specified. No primary research UK studies were found but there were three from outside the UK. Two of them were European (Swedish and Danish), namely Lindh et al, (2010) who conducted a hermeneutical enquiry into moral strength and Thorup et al, (2012) whose interpretative study explored courage specific to vulnerability, suffering and ethics. The third paper, a hermeneutic research study exploring courage in practice, originated in New Zealand (Spence 2004) and suggests that courage in practice is essential.

Four more discussion and opinion papers that met the search criteria were identified. One of them (Gallagher 2010), which originated in the UK, discussed the concept of moral distress and courage, finding it to be an organisational, political and individual responsibility. The other three papers were sourced from the US. A further 12 papers with only courage in the title and specific to nursing were identified in the same search (ten US, one European and one UK), and were a mix of opinion pieces and discussion articles. The review indicates that courage is seldom mentioned in nursing literature which supports the observations of Spence (2004) and Murray (2010).

Lindh et al, (2010) state that despite courage being identified as a fundamental component of nursing (Spence 2004, Cummings and Bennett 2012) there is a lack of knowledge about nurses' courage in practice. Writers such as Gallagher (2010), Lachman (2010), LaSala and Bjarnason (2010), Lindh et al, (2010) and Thorup et al, (2012) identify factors that affect the development of courage. These include constraints within organisational cultures (Gallagher 2010), nurses' characteristics such as resilience (Lindh et al, 2010), experience and intuition in providing courageous care (Thorup et al, 2012), and supportive working environments (LaSala and Bjarnason 2010).

Many other papers used words similar to 'courage', for example 'advocacy', 'moral strength' or 'virtue', but these were not included as the aim was to explore courage as it is named in the 6Cs (Cummings and Bennett 2012).

To truly appreciate what nurses', understand by 'courage', we need to ask them. Given the paucity of research (Spence 2004, Lindh et al, 2010, Murray 2010), this study aimed to explore nurses' understanding of the concept.

Study

Aims

The aims of the study were to explore how nurses' understanding of courage can inform future practice thus enabling preparation and support for nurses to use courage in practice settings, and to enhance understanding of adult nurses' use of courage in everyday professional practice.

Three initial themes from analysis of the findings are presented and discussed below and are applied in the context of Leading Change, Adding Value (Cummings 2016). This nursing framework is designed to enable delivery of the triple aims of the Five Year

Forward View (NHS England 2014): better outcomes, better experiences for patients and staff, and better use of resources.

Methodology

Constructionist grounded theory was used because of constructionism's social, rather than individual, emphasis. Nurses do not work in isolation or with an individual focus (Nursing and Midwifery Council (NMC) 2015a); instead they work in a socially constructed culture where social processes, historical culture and interactions are evident (Young and Collin 2004, Read 2013). Social constructionism is congruent with grounded theory as an appropriate epistemological model for exploring shared social meaning and understanding (Mills et al, 2006). Grounded theory is a structured but flexible methodology and data are collected with simultaneous and sequential analysis. Charmaz's (2014) approach includes emphasis on action and co-construction of meaning with the participants.

Method

Adult nurses were recruited from local acute care providers and the community through fliers and self-nomination. There were 12 female participants and their practice settings and other demographics are shown in Table 1. Most participants had experience of work in community and acute settings.

Table 1

Demographics

Participant	Age range	Range of years' experience	Practice setting
P1	53-59	30-35	Acute
P2	32-38	10-15	Community
P3	53-59	30-35	Community
P4	46-52	25-30	Community
P5	53-59	30-35	Acute
P6	46-52	10-15	Acute
P7	25-31	5-10	Acute
P8	46-52	25-30	Acute
P9	46-52	25-30	Community
P10	46-52	25-30	Community
P11	32-38	0-5	Acute
P12	46-52	30-35	Community

Adult nurses were recruited as the researcher is undertaking a professional doctorate and her area of practice is adult nursing. Additionally, the Francis report on failings in care at the Mid Staffordshire NHS Foundation Trust (Francis 2013) describes failings in 'courage' that while not exclusively related to adult nursing were mostly located in general wards and departments. Unstructured interviews, consistent with constructionist grounded theory (Age 2011) took place in locations chosen by participants and lasted on average one hour. The interviews sought to reveal participants' salient views and what meanings they attached to the word courage (Bowling 2009, Prescott 2009). The opening question was: 'Could you tell me what's your understanding of courage in nursing?'

Data were transcribed and coded to categorise findings to form theoretical themes, using line-by-line coding and repeatedly re-examined so that the researcher remained open and receptive to unexpected directions depending on the information (Charmaz 2014). The aim was to analyse rather than simply describe the data (Corbin and Strauss 2008).

During coding, memos, including written explanations, ideas and linkages about the data helped to strengthen and build categories (Charmaz 1983), enabling movement from description to conceptualisation (Charmaz 2012). NVivo software which

encourages data analysis during collection (Bringer et al, 2006, Bazeley 2007, Hutchinson et al, 2010), was used. The 12 interviews raised 86 codes related to nurses' understanding and use of courage. The codes were refined into a series of themes, three of which are discussed below.

Ethics

Ethical concerns including anonymity, confidentiality, informed consent, withdrawal, briefing and debriefing, and protection from harm were all addressed, ethical approval was granted, and recommendations were followed. Participants received a comprehensive information sheet detailing their involvement in the study, the potential risks of taking part and how the information would be used. They were reassured that consent was voluntary, and that they could withdraw at any point before analysis after which all data would be anonymised. Data held were anonymised, password protected and securely stored. At the request of the university ethics committee, a protocol was devised in case an issue of concern, for example relating to patient or staff safety was raised during interviews.

Findings

The development of a conceptual theory has yet to be completed. Once finalised it will be published in another article. The three initial themes included here are as follows: being in a situation you do not want to be in, speaking up and taking risks.

Being in a situation you do not want to be in

Several participants exhibited courage by staying in a situation they did not like. This involved emotional factors such as facing their fears, going into the unknown or feeling out of their comfort zone and practical knowledge such as when to take themselves out of a situation.

P7 talked about dealing with distressing emotional situations in acute settings: '…it's a situation you don't want to be in, that you wouldn't have chosen to be in, so yeah, I think that's courage definitely', while P10 spoke in general terms about her understanding of courage in the community: 'I guess, perhaps being out of your comfort zone from your every day to day, sort of work.'

P9, also a community nurse, spoke of the personal-safety aspect of courage and how she faced situations and stayed in them, but also knew when to remove herself: 'Yes, so, so it's courage in the, the

true sense of bravery, as in I need to save myself, from, from the situation as it were.'

These participants described various situations they had had to stay in when they would have rather not including dealing with challenging families or patients, managing unexpected deaths, and walking into unknown situations, such as when starting to work with new patients in the community. Most participants had not considered these as courageous acts until they were asked to reflect on them after which they agreed with the sentiment expressed by P7: 'Actually lots of things that we do were courageous, but we don't really think of it like that.'

This theme suggests that nurses are prepared to face discomfort, stay in situations when they are needed, and will face their fears, even though it is difficult and may require them to tolerate personal discomfort.

As P6 noted: 'You don't necessarily always feel comfortable in what you're doing… it is, again, it's facing those fears.'

Nurses might need support to face these situations for the benefit of their patients.

Speaking up and keeping quiet

Despite the NMC's (2015a) expectation that nurses will challenge and question changes in the traditional hierarchy of the NHS and a proposed new style of leadership (King's Fund 2012), participants found that it can be difficult to speak up and to have a voice. P3 and P4, both community nurses with more than 30 years' experience said: 'It's having the courage to have a voice', and '… having the courage to say "No" to them'. Both were relating their experiences of challenging authority or hierarchical processes if they thought something was wrong.

P2 had a similar experience in an acute setting when two departments were being combined: 'Nobody had the courage to speak up; everybody accepted what happened, why it happened; nobody had the courage to challenge it and, if they did challenge it, nobody had the courage to, to back them up and say we can't do this anymore.'

These findings show that even experienced nurses can find speaking up difficult and challenging, so implications for practice include considering how nurses are educated and developed to find their voices.

Taking risks

Participants suggested that being courageous could be considered as taking risks and these risks could include losing their registration, opening themselves up to emotional distress, and being placed in the difficult position of having to 'fight' for something they believed in. Despite the post-Francis climate, there were only infrequent mentions of aggression and whistleblowing.

P10, a community nurse with 25 years' experience said: 'I think it's, it's perhaps, being very brave, taking risks, being out of comfort zone, prepared to take risks', in the context of having difficult conversations with patients or their families. P4 related both nursing and personal aspects to risk taking as follows: '… but, at the end of the day, I couldn't leave him, so I did (treated the patient) but I put my job on the line then; I put my registration on the line', when talking about treating a patient when she was not sure she should do so.

She also said as she recalled a patient who she felt emotionally distressed about 20 years after caring for them: 'I don't know; is compassion connected to courage? I suppose courage in letting yourself feel'. These comments suggest a complex interplay of different facets in relation to risk, including bravery, physical and psychological risk, and fear of losing their registration. Some

interpreted risk differently, for example as being exposed to emotional pain when practising compassion.

Overall this theme has depth and complexity, and implications for practice include supporting nurses to manage the risks they face.

Discussion

The themes described above indicate something of nurses' understanding of courage. Finding the courage to stay in a difficult situation is challenging and this notion of courage is evident in the work of Gallagher (2010) and Edmonson (2010). Gallagher (2010) notes that moral distress affects nurses' health and ability to provide care, which in turn affects job satisfaction, while Edmonson (2010) suggests that distress leads to burnout, desensitisation, and disengagement.

This has implications for the retention of nurses who may need support, for example through guided reflection or clinical supervision (Rolfe 2002) to enable them to continue to face these challenges. Revalidation supports reflective practice, and could enhance retention if nurses use it to unpick some of the difficulties they face (NMC 2015b).

Speaking out revealed that nurses need courage to find their voice on a daily basis. This is also identified by Lindh et al, (2010)'s review of research on courage which found that remaining true to convictions is a struggle for nurses who may face losing their jobs if they speak out, and Lachman (2010), who suggests that nurses usually know what to say but may not do so because they fear embarrassment or punishment. This is supported by Gallagher (2010) while Francis (2013) notes that staff could be discouraged from speaking out by fear and bullying. The final theme was risk. Lindh et al, (2010) also found that courage was related to nurses' willingness to expose themselves to risk, while Gallagher (2010) suggests that organisational, individual or cultural factors can influence this, and proposes that organisations need to embrace moral courage.

The findings should be considered in the context of recruitment using value-based interviewing (Health Education England 2016). They imply that healthcare services need to recruit people who are willing to challenge and take risks and offer relevant development opportunities throughout professionals' careers to enhance retention.

The ten commitments in Leading Change, Adding Value (Cummings 2016) support the desire to deliver care of the highest standard which requires courage, yet the evidence suggests that nurses still find this challenging. This study shows that courage is crucial to realisation of the ten commitments. For example, commitment 3, that 'we will work with individuals, families and communities to equip them to make informed choices and manage their own health', and 5, that 'we will work in partnership with individuals, their families, carers and others important to them', are echoed by P1: 'Everything being a test of courage for the best patient outcome.' Meanwhile, P3 and P4 spoke of their difficulty in finding their voices to achieve these commitments.

Commitment 6, that 'we will actively respond to what matters most to our staff and colleagues', implies that nurses need courage to find their voices, as does commitment 9, that 'we will have the right staff in the right places and at the right time'. Finally, and crucially commitment 8 states that 'we will have the right education, training and development to enhance our skills, knowledge and understanding'. P9 noted: 'Courage is very closely linked to confidence, isn't it, and experience; that if you are confident in your knowledge and you're confident in what you think is right then you have the courage to shout about it.'

Peate's (2015) article entitled Without courage the other Cs will crumble is supported by the notion that courage enables other virtues (Walston 2004). This study suggests that even experienced nurses can find using courage demanding and this should inform recruitment and retention policies. Not only do we require recruitment of nurses who can challenge and take risks, we need to retain them by ensuring there are adequate preparation, training, support and opportunities to enable them to reflect on using courage in practice. As Lachman (2010) notes, courage is far from redundant and is still relevant today as nurses encounter numerous situations that call for it.

Limitations

All the participants were female nurses working with adults, so findings and conclusions could be gender- or field-specific. The nature of the study means it was limited in terms of time and participant numbers, so it might be difficult to realise true theoretical saturation (Charmaz 2014).

Among other limitations the researcher inevitably brought herself into the interviews (Charmaz 2014) while race, culture and gender influence what is said and how it is said and consequently what is found and written about. Additionally, researchers and participants

belong to 'other identities' such as nurse, teacher or researcher, and these factors influence conclusions.

To increase the reliability and authenticity of findings the study procedures are made clear and are repeatable. Reflexivity is central to the analysis and to improve credibility an audit trail of detailed analysis articulates emergent theoretical concepts (Gasson 2004).

It would be interesting to compare results with male nurse participants and nurses from other disciplines and settings to see if their experiences are similar. This study involved a mix of acute and community nurses but findings are presented as one. Future studies could explore these settings separately.

Conclusion

The examples described in this article of how nurses confront and remain in difficult situations, speak out even when they fear the consequences (Francis 2013) and take risks are just some of the challenges they face in using courage.

Only the initial coding for the research themes presented in this article is complete which means that at a conceptual level emergent theory has yet to be explored with further theoretical sampling. However, the implications for practice are becoming clear. Nursing can benefit by considering courage at the point of recruitment and

nurses can benefit from education, support and reflection that begin at recruitment and continue through revalidation and lifelong learning. This could help retain nurses in a profession of which they are immensely proud, but which can be challenging and have a personal cost.