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# The professional development and career advancement of Technical Diploma Nurse graduates in Egypt

Student Registration Number: xxxxxxxx

Submitted in partial fulfilment of the requirements for the degree of Doctorate in Health-Professions Education (DHPE)

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## Abbreviations

| | |
|---|---|
| AGT | Achievement Goal Theory |
| AMS | Academic Motivation Scale |
| BERA | British Educational Research Association |
| CASP | Critical Appraisal Skills Programme |
| CINAHL | Cumulative Index to Nursing and Allied Health Literature |
| CPD | Continuing Professional Development |
| CVP | Central Venous Pressure |
| CV | Curriculum Vitae |
| DOH | Department of Health |
| EULC | Egyptian Universities Libraries Consortium |
| EN | Enrolled Nurse |
| ERIC | Education Resources Information Centre |
| GDPR | General Data Protection Regulation |
| HEI | Higher Education Institution |
| HIO | Health Insurance Organisation |
| HPE | Health Professions Education |
| ICU | Intensive Care Unit |
| IELTS | International English Language Testing System |
| ICN | International Council of Nurses |
| IOM | International Organisation for Migration |
| LMIC | Lower-Middle-income Country |
| LPN | Licenced Practical Nurse |
| MOHE | Ministry of Higher Education |
| MOHP | Ministry of Health and Population |
| MVLS | College of Medical, Veterinary and Life Sciences |
| NAQAAE | National Authority for Quality Assurance and Accreditation in Education |
| NARS | National Academic Reference Standards |

| | |
|---|---|
| NES | National Health Service Education for Scotland |
| NHS | National Health Service |
| NCLEX-RN | National Council Licensure Examination for Registered Nurses |
| RN | Registered Nurse |
| R&D | Research and Development |
| REC | Research Ethics Committee |
| SCT. | Social-Cognitive Theory |
| SDT | Self-determination Theory |
| SERA | Scottish Educational Research Association |
| SSPS | Statistical Package for Social Sciences |
| TDN | Technical Diploma Nurse |
| TIN | Technical Institute of Nursing |
| TA | Thematic Analysis |
| UK | United Kingdom |
| UNDP | United Nations Development Programme |
| UNICEF | United Nations International Children's Emergency Fund |
| USA | United States of America |
| VAD | Ventricular Assist Device |
| WHO | World Health Organisation |

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## Author's Declaration

I declare that this thesis represents my own work except where referenced to others.

I declare that this thesis does not include work forming part of a thesis presented successfully for another degree.

## Abstract

**Background:** Global strategic agendas for strengthening the nursing workforce have emphasised the need for nurses to participate in professional development and career advancement to ensure the high-standing of the profession. However, key challenges within lower-middle-income countries, such as Egypt, have prevented nurses from fully engaging in professional updating activities and progressing successfully in their careers. While attention has been paid to perceptions of professional development and career advancement of nurses within the international literature, an Egyptian perspective, and specifically that of Technical Diploma-level nurses within the country has not been represented.

**Purpose:** The aim of this research was to explore and describe the perceptions of the professional development and career advancement of Technical Diploma Nurse graduates from a private non-profit Technical Institute of Nursing in Egypt. Moreover, the study aimed to gain an understanding of Technical Diploma Nurse graduates' aspirations and motivations for their development, as well as the opportunities and challenges they face, and the factors influencing their decision-making around their professional development and careers.

**Methods:** This study used a qualitative descriptive exploratory design guided by an interpretive stance, and in-depth semi-structured interviews to extend the knowledge on this topic. Data collection involved two phases. Phase 1 involved interviewing 18 Technical Diploma Nurse graduates from the identified Technical Institute of Nursing who were employed at the Institute's key stakeholder hospital. The perceptions of nurse educators (n=2) from the Technical Institute of Nursing, and healthcare managers (n=3) from the stakeholder hospital, were also explored using in-depth semi-structured interviews for Phase 2. Interviews were transcribed verbatim and data were subjected to Braun and Clarke's (2006) thematic analysis using an inductive approach. The interpretation and discussion of findings was facilitated by the study's conceptual framework. This was based on the social and cultural influences on, and its relationship to, the motivations and aspirations of Technical Diploma Nurses' professional development and career advancement to which Ryan and Deci's (2000a) Self-determination Theory of Human Motivation was an integral feature.

**Findings:** Three themes were prominent in perceptions of the participants: 1) mechanisms for learning and development; 2) sources of support, and 3) moving up the career ladder. The theme 'mechanisms for learning and development' consisted of two sub-themes: 'wanting a higher degree' and 'participating in work-related learning'; whilst the theme 'sources of support' had the sub-themes of 'family and marriage' and 'organisational support'.

**Discussion and Conclusion:** The study's conceptual framework, rooted in Ryan and Deci's (2000a) Self-determination Theory of Human Motivation, helped to explain the phenomena described around extrinsic and intrinsic tendencies of Technical Diploma Nurses' motivation towards their professional development and career aspirations in this context. The key findings suggest social and cultural factors were important contextual determinants of professional development and career motivation. Social contexts supportive of the basic psychological needs for autonomy, competence and relatedness were identified which impacted positively on motivation and facilitated behaviours that were more autonomous and self-determined. Organisational factors, as well as social support from senior colleagues and peers were influential in stimulating learning and the careers of Technical Diploma Nurse graduates. Domestic support and influence of family, as well as marriage and children also played a significant role in decision-making regarding Technical Diploma Nurses' development. Nevertheless, Technical Diploma Nurses faced significant challenges which limited opportunities for professional growth and explained why controlled extrinsic motivation and aspirations tended to be prioritised by the graduates interviewed in this study. Outwith the context of the stakeholder hospital, existing educational and healthcare structures in Egypt appeared to thwart satisfaction of innate psychological needs, shifting Technical Diploma Nurses towards extrinsic rewards, focusing on income, promotion and prestige. Economic conditions within the country, as well as the poor societal image of the nurse were also identified as important extrinsic drivers. When presented with limited prospects for development, graduates sought possibilities outside of Egypt to fulfil their professional development and career aspirations. Nevertheless, often these extrinsic drivers represented how Technical Diploma Nurses could ultimately achieve more important intrinsic aspirations.

**Significance:** Technical Diploma Nurses constitute a significant part of the nursing workforce in Egypt and it is therefore important that they can fully actualise their professional development and

career aspirations to effectively contribute to the healthcare system in Egypt. This study, from a private non-profit Technical Institute of Nursing employed at one hospital in Egypt, draws together the perceptions of key stakeholders and provides a more nuanced understanding of the social and cultural factors which influence Technical Diploma Nurse graduates' motivations and aspirations for development. Although perspectives were gathered from only two institutions, the study's key findings and implications could provide a baseline for suggestions on how Technical Diploma-level nurses could be best supported to achieve optimal growth within an Egyptian context. Recommendations for further research are highlighted along with some implications for practice and for policy.

(792 words)

# Chapter One: Introduction

## 1.1 Introduction

This chapter presents a summary of the recent drivers for professional development and career advancement within the nursing profession before moving to a synopsis of the social, economic and demographic profile of Egypt. An overview of nursing and healthcare and the continuing professional development (CPD) and career structures for nurses within the country is also given. The specific professional context of this research is also presented along with a rationale for this research. Lastly, a brief overview of the structure of this thesis is provided.

## 1.2 Professional development and career advancement of nurses

The context of healthcare is continually evolving which has ramifications for nurses and how they work (Scottish Government, 2017). The rapid pace of change within healthcare in the 21st century requires nurses to be able to respond to the needs of the population in which they serve (Hegarty, et al., 2009; Scottish Government, 2017). Challenges for the future of nursing include increasing globalisation, advances in science and technology, complexities in healthcare, as well as changes in patient characteristics (Hegarty, et al., 2009). These challenges highlight the necessity for nurses to continuously develop professionally and create career pathways that meet healthcare priorities of the future (Hegarty, et al., 2009; Scottish Government, 2017). Global strategic agendas for strengthening the nursing workforce have subsequently called on countries to widen opportunities to engage in professional development and career progression within their health systems to allow nurses to work to their full capacity and maximise their contribution to patient care (World Health Organisation (WHO), 2016a; 2016b). The recent publication of the 'State of the World's Nursing 2020' report (WHO, 2020a) has further highlighted these needs.

Policies within countries such as the United Kingdom (UK) have focused on creating increased access to career opportunities and trajectories for nurses and ensuring they are supported by professional development activities appropriate for their role. Among those most notable was the 'Modernising Nursing Careers' policy document in 2006, which outlined a prospective strategy for nursing education, careers and leadership, and image (Department of Health (DOH), 2006). The report stated that '*nurses need to have a career structure that allows them to work in different*

*settings, take on these new challenges and roles and develop skills and undertake further education and training when required'* (DOH, 2006, p.16). More recent strategies from within the UK have focused on enhancing educational healthcare infrastructure for nurses (Scottish Government, 2014), as well initiatives such as the Early Clinical Careers Fellowships which aimed at supporting nurses' development in the early stages of their careers (National Health Service (NHS) Education for Scotland (NES), 2015). Nurse practitioner and advanced practice roles have also emerged within the profession in the UK, as well as internationally (King, Tod and Sanders, 2017). This has allowed nurses the opportunity to acquire an expert knowledge base, practice autonomously (International Council of Nurses (ICN), 2017) and implement new models of care delivery to meet the changing needs of the population (Scottish Government, 2017). Subsequent policies, such as the Post-registration Career Development Framework (NES, 2017) published in Scotland, have created opportunities for vertical and horizontal career paths for nurses and outlined the associated professional development expectations for each stage of the career trajectory.

However, these developments outlined above have happened in the context of the UK where the professionalisation of nursing is more robust and therefore may not be wholly transferable, nor desirable, to a developing country where healthcare provision is different. Various social, cultural and political factors within countries can affect career and development opportunities for nurses (Donner and Wheeler, 2001) and it is known that key challenges within lower-to-middle income (LMIC) countries have prevented nurses from fully engaging in professional updating activities and progressing successfully in their careers (WHO, 2016c). Nursing within Egypt is still moving towards the path of professionalisation (Farag, 2008; Ma, Fouly and D'Antonio, 2011) and such policy agendas within the country have still to be realised.

This thesis describes a research study exploring the professional development and career advancement of nurses within an Egyptian setting. Having briefly outlined recent calls for enhanced CPD and career development for nurses, it is therefore relevant to explore the healthcare and educational context of nursing within Egypt to orient readers unfamiliar with the country. For further background information on the Egyptian context see Appendix I: The Social, Economic and Demographic Context of Egypt.

### 1.3 The profile of nursing and healthcare in Egypt

Egypt has a very complex and fragmented healthcare system with multiple service providers and finance structures (Gericke, 2005). The Ministry of Health and Population (MOHP), Ministry of Higher Education (MOHE), Health Insurance Organisation (HIO), as well as an increasing unregulated private sector and non-governmental organisations, are all involved in managing, providing and financing healthcare (International Organisation for Migration (IOM), 2011). There is minimal collaboration both within and between providers and services are often inefficient and highly centralised with weak quality assurance programmes (WHO, 2018). The focus of delivery remains on tertiary healthcare provision with little attention given to providing primary care or specialist services (Gericke, 2005). Around 50% of the healthcare labour force in Egypt is employed by the MOHP (IOM, 2011).

Nursing in Egypt has seen little change over the past 25 years due to lack of investment in education and healthcare (WHO, 2012; Ali, 2017). As a result, nurses face many challenges and their work is generally undervalued (Hofman, 2005; WHO, 2012). The working conditions in healthcare settings are generally poor (IOM, 2011). Long working hours, coupled with low pay and lack of incentives, contribute to a poor social image of nursing in Egypt (WHO, 2012). Healthcare environments are frequently inadequately resourced, and the organisational culture is often not conducive to the empowerment of nurses, together with little institutional recognition or support (El-Salam, et al., 2008; Kamal Elden, Ibrahim Rizk and Wahby, 2016; Ali, 2017).

There is a chronic shortage of nurses per se, and adequately qualified nurses in Egypt (Baumann and Fisher, 2007; Farag, 2008; Ma, Fouly and D'Antonio, 2011). Recent figures from the WHO (2020b) estimate a projected shortage of nurses in the range of 9000 to 10000 by the year 2030. Egypt's qualified nurse to population ratio is one of the lowest in the WHO's Eastern Mediterranean Region at 14.5 nurses for every 10,000 Egyptians (WHO, 2019). A greater shortage is experienced in rural Upper Egypt which remains particularly underserved (WHO, 2006; Farag, 2008). This contrasts to Tunisia, a neighbouring LMIC, which has 40.9 nurses per 10,000 population, and high-income countries in the region such as the United Arab Emirates, which enjoys a ratio of 56.8 per 10,000 population, and Kuwait, with 65.0 nurses, respectively (WHO, 2019). Shortages and inequities in distribution within the nursing workforce in Egypt have been exacerbated by imbalances in healthcare staffing. High enrolments to medical schools

coupled with chronic under-enrolment within pre-registration nursing education mean that in the 1980s and 90s, Egypt graduated more physicians than nurses (Fullerton and Sukkary-Stolba, 1995). With a ratio of doctors now at 8.5 per 10,000 population (WHO, 2019), this excess, however, has been falling in recent years due to increasing levels of emigration within the medical workforce (IOM, 2011).

The prestige associated with medicine dominates the doctor-nurse relationship in Egypt (Fullerton and Sukkary-Stolba, 1995) and the workforce remains highly gendered, with most physician positions being occupied by men and the majority of nurses being women (IOM, 2011). In recent years however, high levels of youth unemployment and subsequent increased employment prospects instigated by nursing shortages have been pull factors for men to enter nursing (Mohamed and El-Nemer, 2013). Current figures show men now make up 9% of the total labour force (WHO, 2020b). Nevertheless, poor societal perceptions of nursing often cause disproportionate numbers of men to leave the nursing career (Ali, 2017). The social stigma of working outside the home has also traditionally impacted recruitment and retention among women (Ali, 2017). Critically, most nurses who leave the profession in Egypt have less than 10 years of experience (Ali, 2017).

Inadequate standards of preparation of nurses linked with a lack of professional development opportunities have resulted in a poorly educated and under-skilled workforce with poor career prospects (WHO, 2012; 2016c). The MOHP and MOHE are responsible for healthcare education (Hofman, 2005). Coordination between each Ministry is weak, and the education system, which does not consider the needs of the healthcare system, is rigid and inflexible (Ma, Fouly and D'Antonio, 2011). There is also a growing private sector within nurse education with collaborations from foreign nursing schools in a bid to raise standards (Baumann and Fisher, 2007). Like healthcare, regulatory systems, however, are not robust leading to significant variations in educational standards between higher education institutions (HEIs) and governance systems needing to be strengthened (Hofman, 2005; Ma, Fouly and D'Antonio, 2011).

Formal education for nursing commenced in the latter part of the 19th century in Egypt and was initially heavily influenced by British traditions up until reforms in the mid-60s to early 1970s which

saw the formation of a three-level system for nursing education (Ma, Fouly and D'Antonio, 2011). High School Nursing Diploma-level entry education was established in 1972 based at Technical Secondary Schools of Nursing located within MOHP hospitals (ibid.). Nurses at this level completed three years of training, for which students applied after just nine years of schooling, and were educated to the equivalent of nursing assistant level in developed countries (Fullerton and Sukkary-Stolba, 1995; Ma, Fouly and D'Antonio, 2011). Instruction was given in Arabic and students studied basic sciences, as well as the fundamentals of nursing with an emphasis on practical training (Fullerton and Sukkary-Stolba, 1995). Nevertheless, in a bid to improve educational standards, further reforms saw this type of education phased out in 2011. These nurses, however, are still legally able to practice, and they have been offered some, albeit limited, opportunities to upgrade their existing nursing credentials. Before 2011, a total of 98.4% of the nursing workforce was educated to this level (Kandiel and Gharib, 2017).

Currently, Egypt has a two-level entry preparation system for nursing: Technical Diploma and Bachelor degree-level. Nurses can gain a Diploma from a Technical Institute of Nursing (TIN) based in post-secondary HEIs under the remit of the MOHP. In recognition of the need for more qualified nurses, this second level of nursing education was introduced in 1973 (Ma, Fouly and D'Antonio, 2011), which saw the entry requirement for nursing raised to a minimum of 12 years of general education (Brownie, et al., 2018). This level involves a two-year course including a three to six-month internship programme, after which students are awarded a Technical Diploma in Nursing. Technical Diploma Nurse (TDN) graduates can apply for a Bachelor's degree from a university only if they obtain a high score on graduation which will place them in the second year of the Bachelor programme (Ma, Fouly and D'Antonio, 2011). Although students have a basic understanding of English from high school, most of the instruction within TINs is conducted in Arabic. Previously around 0.5% of nurses in Egypt were prepared to Technical Diploma level (Kandiel and Gharib, 2017), although numbers have risen rapidly since the High School Nursing Diploma has become redundant.

Bachelor degree-level programmes have been available to nurses in Egypt since the mid-1950s, with the first Masters and Doctoral programmes being established shortly after (Ma, Fouly and D'Antonio, 2011). Nurses can obtain a university degree in either free public or fee-paying private universities which are under the authority of the MOHE (Baumann and Fisher, 2007). In keeping

with established traditions in medical schools and other university courses, Bachelor degree programmes are usually taught in English (Abdelaziz, et al., 2018). A Bachelor's degree course spans a total of five years, including a one-year internship. Bachelor courses are open only to those with distinguished high school scores or the top TDN graduates (Ma, Fouly and D'Antonio, 2011). As a result, only around 1% of the nursing workforce is educated to this level (ibid.).

Most healthcare professions education curricula in Egypt are delivered through didactic, large-group lectures and apprenticeship approaches to clinical teaching which promotes a task-based model of care (Abdelaziz, et al., 2018). This is especially true of Technical Diploma-level nursing curricula, which has contributed to the conceptualisation of the subservient image of the nurse (Brownie, et al., 2018). Nurses are licensed by the Egyptian Nursing Syndicate and MOHP (Baumann and Fisher, 2007) and successful completion of the programme is the only prerequisite to practice (Ma, Fouly and D'Antonio, 2011). The Egyptian Nursing Syndicate is a professional organisation which represents nurses on national, social and professional issues within the country and manages nurses' affairs. The syndicate also theoretically has a role in contributingto developing nursing education policy and enhancing programmes and curricula. While the syndicate generally has well-established standards and processes for initial registration, this has not been the case for determining continuing competence.

Bachelor degree nurses in Egypt are registered as a 'Licensed Professional Nurse' (international equivalent of first-level registered nurse (RN)), with Technical Diploma-level nurses registered as a 'Technical Licensed Nurse' (international equivalent being second-level enrolled nurse (EN) or licensed practical nurse (LPN)) (Baumann and Fisher, 2007). The defining factors differentiating first-level from second-level nurses not only relate to their scope of preparation, but also practice (Institute of Medicine, 2011), with first-level RNs accountable for all patient care, and nurses in the second-level category usually responsible for providing more basic nursing care under RN supervision (Jacob, McKenna and D'Amore, 2016). This division of labour is not unique to the Egyptian nursing workforce as it can be seen in several countries that still have two levels of practice (Blay and Smith, 2020). Nevertheless, there are wide variations internationally as to the educational requirements for professional nurse licensure and subsequent roles and responsibilities (Jacob, McKenna and D'Amore, 2016).

In an Egyptian context, Bachelor-prepared graduates take the most prestigious positions within nursing as promotional opportunities are often linked to academic preparation (Ma, Fouly and D'Antonio, 2011). Nurses who hold a Bachelor's degree are generally aligned to roles within administration and management, and oversee the supervision of TDNs, who are normally assigned positions at the bedside, responsible for delivering direct patient care (Brownie, et al., 2018). This has left Technical Diploma-prepared nurses suffering from low social image and professional esteem with limited promotional prospects if they fail to achieve adequate scores to access Bachelor-level education (Hofman, 2005; Ma, Fouly and D'Antonio, 2011).

In a recent general review of post-secondary general vocational-technical education in Egypt, Álvarez-Galván (2015) identified some key challenges which have led to technical education acquiring low status and lacking prestige. These challenges included a lack of quality assurance and governance systems within technical level educational institutions. A weak skill base exists in those students entering the system due to inadequate primary and secondary school education which has produced poor graduate outcomes. Insufficient employer engagement with curriculum design and limited use or recognition for workplace learning by Technical Institutes has also meant its graduates lack the necessary skills demanded by stakeholders (Álvarez-Galván, 2015). Moreover, Álvarez-Galván (2015) asserts that graduates encounter difficulties adding to their professional credentials due to limited career guidance on entering the workforce.

Despite the level of preparation, nurses, in general, have a very limited role in patient care compared with other countries and no defined ethical or professional standards for clinical practice for nursing exists (Fullerton and Sukkary-Stolba, 1995; WHO, 2012). There are often no defined written job descriptions for healthcare employees within hospitals nor supervision of their performance (Kamal Elden, Ibrahim Rizk and Wahby, 2016). These factors have led to role ambiguity and the consequent overlapping of duties between nurses and doctors (Abd El Hamid, El Mola and Mohamed, 2018). This has been exacerbated by the surplus of physicians, coupled with the chronic nursing shortage, which has led to physicians being assigned to healthcare roles and duties traditionally more associated with nursing (WHO, 2006; IOM, 2011). Medical dominance within the health professions in Egypt has therefore created obstacles for actualising nursing autonomy. This is coupled with authoritarian leadership styles of nurse managers, who often also fail to foster environments that are supportive of a nurse's sense of autonomy and

control over nursing practice within hospital settings (Mohamed, 2018). These factors have subsequently contributed to role conflict, dissatisfaction, and ineffective performance within nursing (Abd El Hamid, El Mola and Mohamed, 2018), as well as a deficit of nursing leaders both at local and national level within Egypt to advocate for the profession (Fullerton and Sukkary-Stolba, 1995).

### 1.4 CPD and career advancement for nurses in the context of Egypt

There is no robust post-registration career development framework or infrastructure to support the CPD needs of nurses in Egypt. Health facilities do not systematically offer possibilities for further professional training and specialisation for nurses, and career structures remain traditionally hierarchical and rigid, with a focus on linear rather than horizontal careers based in tertiary healthcare settings (IOM, 2011). The chronic nursing shortage in Egypt has been exacerbated by deficient educational and career prospects for healthcare workers who, as a result, pursue more attractive opportunities in other countries such as in the Gulf region (Farag, 2008; IOM, 2011). Poor societal image and working practices are also factors that induce migration or career change decisions among nurses in Egypt (Ali, 2017). National Academic Reference Standards (NARS) for Nursing Education in Egypt which were endorsed by the National Authority for Quality Assurance and Accreditation in Education (NAQAAE) in 2010 have identified basic nursing competencies and role dimensions which emphasises the individual nurse's responsibility for their CPD (NAQAAE, 2010). These standards refer to Bachelor degree programmes only and there is currently no such equivalent for Technical Diploma-level nursing education within the country.

The MOHP in its previous five-year strategy plan (1996-2010) initiated some incentives to inaugurate a continuing education system for nurses linked to professional re-licensing, focusing specifically on upskilling High School Diploma and Technical Diploma-level graduates to create a more seamless path to development (Baumann and Fisher, 2007). Moreover, the introduction of a new 'Technical' top-up degree was proposed for TDNs which is shorter in duration than the conventional Bachelor's degree (Egyptian Nursing Syndicate, 2014). Greater integration between HEIs and the MOHP was also advocated (ibid.). The Egyptian Nursing Syndicate (2014), also called for CPD to be linked to an accreditation body, and for regulation of standards for higher and professional education, continuing education programmes and professional standards of

practice. These plans were seen to try and tackle the problem of retention within nursing, as well as opening continued training and education channels for TDNs according to the requirements of the professional structure of nursing and health needs.

These strategies have partially been achieved to date with the introduction of Technical Degree programmes at selected public universities within the country which has allowed greater access to post-registration education for TDNs. The Egyptian Nursing Syndicate and MOHP have also introduced a re-licensure system whereby nurses renew their licence every five years (Egyptian Nursing Syndicate, 2014). However, CPD requirements for licence renewal are minimal with a focus on attendance at mandatory training in basic skills, which to date have not been stringently enforced. Nevertheless, there has been some increased collaboration between the MOHP and its HEIs working on upgrading the national Technical Diploma-level nursing curriculum to a competency-based model that better aligns with Egyptian health needs (Brownie, et al., 2018). These reforms aim to outline competency requirements and scope of practice for TDN graduates (ibid.).

### 1.5 The specific professional context for this study

The context for this research comprises a TIN situated in a governorate in the southeast of Egypt, and a cardiac specialist hospital located in a governorate in Upper Egypt. Each of these governorates is 50% urbanised. The Nursing Institute is situated 435 kilometres, and the hospital 867 kilometres, from the country's capital, Cairo.

The Nursing Institute and the hospital are non-profit, private organisations which are managed and financed by two separate flagship charities in Egypt. The Nursing Institute opened in 2010 and is one of the few non-profit privately-funded TINs in Egypt compared to other TINs in the country, which are state-financed by mainly the MOHP. The Institute falls under the remit of the MOHE and offers students a fully-funded scholarship to complete a two-and-a-half-year imported curriculum in collaboration with a North American nursing programme in which students are awarded a Technical Diploma in Nursing upon graduation. The imported academic programme offered at the Institute is most comparable to an Associate degree programme from the United States of America (USA) or Foundation degree in the UK. In comparison to other Technical

Diploma level programmes within the country, instructional methods are student-centred, and the curriculum is competency-based. The curriculum is delivered over five academic semesters, offering both theoretical and clinical learning, and the students complete a three-month internship programme in the last semester in one of the Institute's identified stakeholder hospitals. All students are Egyptian nationals and enrolled in the programme directly from high school, aged approximately 18 years. The Institute attracts students from all over Egypt. However, most students come from rural areas in the Nile Delta region of the country, from lower-social economic families. The student census at the Institute is made up of around 50% men and 50% women per cohort. Arabic is the first language of the students. Unlike most TINs (see Section 1.3), the students receive intensive English language support in the first academic semester and throughout their period of study as the Institute's curriculum is delivered fully in English. At the time of graduation, students achieve an estimated International English Language Testing System (IELTS) score of Band-6 (competent user) upon graduation. The TIN does not currently offer post-registration education for TDN graduates.

The cardiac specialist hospital, which opened in 2011, is the Nursing Institute's key stakeholder hospital. The hospital provides specialist and acute cardiac care services to underprivileged patients across Upper Egypt and surrounding areas. The hospital is a 100-bed facility which houses both adult and paediatric in-patient wards; critical care units; a coronary care unit; and specialist heart failure facilities. The hospital employs approximately 260 nurses, of whom around 19% are TDN graduates, of which around 60% of those are graduates from the host TIN at the time of the study. The Nursing Institute has a contractual agreement with the hospital. The majority of the Institute's TDN students complete their three-month internship programme at the hospital, and they are usually hired by the hospital immediately after graduation. Nurses are employed in several roles within the hospital, including clinical and supervisory positions, as well as clinical education positions and recently, a number of clinical specialist posts have been created. Most of the nursing employees are contracted to work a total of 19 x 12-hour shifts per month, on a rotational basis between days and nights, and all nurses work exclusively full-time hours. English is also the official working language of the stakeholder hospital. Like the majority of HEIs and healthcare organisations in Egypt, the Nursing Institute's Technical Diploma programme and the host hospital have not been accredited by a national or international quality assurance or accreditation agency.

In keeping with the interpretivist paradigm within which this Doctoral work is based, it is relevant for me, the researcher, to describe my role in the specific healthcare context. I am an RN from the UK who had a clinical background working within cardiac critical care, as well as teaching part-time on postgraduate nursing and healthcare courses for a local university, before taking up the position of Assistant Lecturer at the host TIN in Egypt in early 2011. My current role includes leading on the delivery of courses within the curriculum and providing students with appropriate academic support. I had been living and working in Egypt for a period of five years at the commencement of this study. As a result, I had attained colloquial and conversational Arabic language skills and a contextual understanding of educational and healthcare structures, as well as the social and cultural context of the country. My professional role consequently meant I was an 'insider' in many elements of this work. Matters related to insider research are discussed throughout this thesis (see Sections 3.6; 4.6.2) and reflected on in Chapter Six (see Section 6.4.3) which specifically addresses the advantages and challenges that can arise when the researcher has prior knowledge of the study site or population under study.

**1.6 Rationale for this research**

At the commencement of this study, the host TIN had graduated five cohorts of TDNs (n=55). Many of these graduates had subsequently recounted anecdotal frustrations during informal discussions with the nursing faculty about issues surrounding their professional development and careers. Previous research that I had conducted exploring the professional needs of newly graduated TDNs in a clinical setting in Egypt, also found issues related to post-registration education, training and CPD which were amongst the most identified needs. Although perceptions of professional development and career advancement have previously been researched within the international nursing literature, an Egyptian perspective and specifically from that of the view of Technical Diploma-level nurses has not been applied. The collective perspectives of nurses, nurse educators and healthcare managers on this topic have also not been gained from previous research. TNDs constitute an important part of the nursing workforce in Egypt and it is therefore critical they can fully actualise their professional development and career aspirations to contribute effectively to the country's healthcare system. Without a contextual understanding, it is difficult to provide a baseline for suggestions on how Technical Diploma-level nurses could be best supported to achieve optimum professional growth. In my own context as a nurse educator, this has been evident when trying to interpret graduates' concerns, the underlying causes, and importantly how I, as a nurse educator, and the host TIN should best respond. These factors

therefore focused my interest on exploring the opportunities and challenges that the TDNs faced and the influences on, and the relationship to, their motivations and aspirations towards their professional development and careers. Subsequent engagement with the literature led to the development of the research aim and objectives which are outlined in Sections 2.9.1 and 4.2 of this thesis.

My aim in developing this research focus was to help address these issues which I had encountered in my role in Technical Diploma-level nurse education in Egypt. The study therefore intended to influence the nursing faculty from the host TIN, as well as key stakeholders from the host hospital, by providing insight into how to best support TDNs' professional development and career advancement through to, and after graduation. Engagement in face-to-face dialogue with local selected stakeholders was an important instrument in communicating the study's findings. The study's pertinent findings and recommendations, and subsequent strategies related to dissemination are outlined in Chapter 7.

### 1.7 Overview of thesis structure

This thesis is composed of seven chapters. This first chapter has described the background and context of the study, as well as provide a rationale for this research.

Chapter Two offers a critical discussion of the literature relevant to the topic of this thesis and identifies what is already known, as well as the gaps within the existing literature which constitutes a justification for the research. This chapter consequently presents the conceptual framework of the study.

Chapter Three explores the theoretical issues pertaining to the methodology and methods which were employed in this study.

Chapter Four explains how the chosen research methodology and methods were employed throughout the course of the study and details how the subsequent research process was conducted.

Chapter Five presents the findings of this qualitative descriptive exploratory study.

Chapter Six provides a discussion and interpretation of the important findings raised in this study within the context of the broader literature. Implications for the practice of health professions

education (HPE) are also discussed. Additionally, a reflection on the methods used is also offered taking into consideration the strategies used to ensure the trustworthiness of this research.

Chapter Seven concludes with a summary of the main findings of this research. Moreover, recommendations for practice and policy, as well as further research are presented.

## 1.8 Chapter conclusion

This chapter has described the background and context in which this research took place, as well as providing a rationale for the study and an overview of the structure of this thesis. A critical analysis of the relevant literature of this research topic is presented in the following chapter along with the study's conceptual framework.

# Chapter Two: Literature Review

## 2.1 Introduction

A critical discussion of relevant literature is presented in this chapter. The aim of this chapter is to provide a critical summary of the relevant literature related to the study aim and objectives to provide justification for this research. A traditional narrative review of the literature (Mays, Pope and Popay, 2005) was undertaken. This approach was selected as it is exploratory in nature which fitted with the qualitative paradigm of the research. Moreover, its flexibility allowed for a breadth of literature coverage on the pertinent topics related to this research (Green, Johnson and Adams, 2006; Byrne, 2016). Literature searching was conducted periodically throughout the course of this research project which permitted evolving knowledge and concepts to be explored (Byrne, 2016).

## 2.2 Literature search strategy

Traditional narrative literature reviews have been criticised for being characteristically non-systematic. It is therefore important when conducting this type of review that the literature search strategy is clearly defined (Byrne, 2016). Haddaway, et al. (2015) advocate for the application of key aspects of systematic review guidance to narrative reviews to help ensure a rigorous approach. Haig and Dozier's (2003) guidance for literature searching within HPE was therefore adopted as a guiding framework. This framework provided an approach more specific to the discipline of HPE (Gordon and Gibbs, 2014) and subsequent context of this research in comparison to other guidance dedicated to either healthcare or education.

Key search terms were informed by the words and ideas that framed the research aim and objectives (Table 2.1). Alternative keywords, synonymous and variant terminology for the same concept were identified for each of the main keywords. Search terms were used both singly and in combination. Truncation (*) and Boolean operators 'AND' and 'OR' when appropriate were used to find articles that included all or any of the identified keywords. Initial searches generated a surplus of articles, and therefore keywords and the search strategy were adjusted as necessary to further refine the results (Haig and Dozier, 2003).

*Table 2.1: Key search terms*

| *Concept 1* | *Concept 2* | *Concept 3* | *Concept 4* | *Concept 5* | *Concept 6* |
|---|---|---|---|---|---|
| Nurse | Continuing professional development | Career advancement | Motivation* | Aspiration* | Barrier* |
| Health professions education | Continuing professional education | Career development | Academic motivation | Professional aspiration* | Deterrent* |
| Allied health profession* | CPD | Career* | Motive* | Ambition* | Facilitator* |
| | Professional development | Career growth | Self-determination | | Opportunities |
| | Continuing education | | Self-determination theory | | Influence* |

The rationale for the inclusion/exclusion criteria were based on the research aim and objectives of the study and are presented in Table 2.2. According to Haig and Dozier (2003, p.22), decisions regarding such criteria can be made on a conceptual basis in relation to the research topic or by considering three standard components: participants; educational aspects; and outcomes. This served as a useful guide when setting my criteria for this review. While the context of this study was within nursing education, preliminary searches indicated there were no papers that addressed all aspects of the research topic within the discipline of nursing. Consequently, the search criteria were expanded to include other disciplines within HPE, as well as within general education and psychology, as it was determined their relevance may add depth to the review's narrative. This also helped to gain a richer understanding of the concept of motivation. Any published peer reviewed quantitative and qualitative articles, as well as commentary papers that could be linked to the search terms were included in the inclusion criteria. This also allowed for the complexity of the issues related to this research topic to be considered. Grey literature was excluded from the search due to possible variations in quality standards that are associated with such types of evidence (Haig and Dozier, 2003).

The literature search was intentionally extended to 1990 because of the dearth of research relevant to the research topic from Egypt, North Africa and the Middle East. Therefore, papers from a Western perspective which captured international trends in nursing education in the 1990s

in relation to Diploma-level RNs and second-level ENs were provided, as they were thought to be mostcomparable to the study's TDN population. Highly cited seminal papers were also prevalent during this timeframe in relation to the concept of motivation. Seminal work before 1990 was also included for review if considered relevant. Although the present study was conducted in an Arab setting, it was unfeasible to include articles published in Arabic that would require translation, due to my low level of reading Arabic comprehension. However, as stated in Section 1.4, at university level in Egypt, HPE disciplines have adopted English as the language of instruction (Abdelaziz, et al., 2018). As a result, empirical research conducted within the country is usually published in English. Therefore, only articles published in English were included in the search.

*Table 2.2: Inclusion and exclusion literature search criteria*

| *Inclusion Criteria* | *Exclusion Criteria* |
|---|---|
| Articles written in English | Non-English language articles |
| Articles published between 1990 to 2018 | Articles published before 1990 |
| Empirical studies (qualitative and quantitative) whose main content was specific to registered / qualified nurses (or other healthcare professionals within other healthcare disciplines if relevant) and focus on aspects related to professional development and/or career advancement | Published grey literature / unpublished works |
| Systematic review/literature review articles | |
| Relevant supportive general educational / physiological literature | |
| Non-empirical, narrative style articles | |

The following electronic databases were searched: Cumulative Index to Nursing and Allied Health Literature (CINAHL); EMBASE; Medline; Education Resources Information Centre (ERIC); and PsycINFO. These databases were consulted because of their relevance to HPE to ensure a comprehensive search, whilst CINAHL was also included for its focus on nursing research (Haig and Dozier, 2003; Poirier and Behnen, 2014). The inclusion of EMBASE and Medline ensured coverage of both European and North American health professions literature, whereas ERIC and PsycINFO allowed for supportive general education and psychological content to be explored, both of which are significant to this research topic (Haig and Dozier, 2003).

Ancestry searching was conducted to search for articles not identified in the initial search (Haig and Dozier, 2003; Sharma, et al., 2015). Some manual searching of key journals in the field, such as Nurse Education Today, and Nurse Education in Practice was also undertaken, along with journals such as Medical Education and Medical Teacher. In order to ensure any pertinent literature related to the Egyptian context was uncovered, a search of the Egyptian Universities Libraries Consortium (EULC) (http://srv5.eulc.edu.eg/eulc_v5/libraries/start.aspx?ScopeID=1.&), which hosts scientific journals published by Egyptian universities was performed, along with a search of the Egyptian Nursing Journal (http://www.enj.eg.net/), a peer reviewed online journal with citations in the field of nursing education. Lastly, a web search was also carried out on Google (www.google.com) and Google Scholar (https://scholar.google.com.eg/) specifically to find any Egyptian or regional literature associated with the research topic.

Titles, abstracts and key words were examined for relevance to the search inquiry and ineligible publications were then excluded. Full-text version of articles were reviewed to make the final inclusion/exclusion decision (Sharma, et al., 2015). Selected articles were critically appraised using the Critical Appraisal Skills Programme (CASP) (2018) tools. Although there are many critical appraisal tools that could have been used as guides for critical appraisal, the CASP tools were chosen above others as they are succinct (Nadelson and Nadelson, 2014) and easily adaptable for use with different research methodologies (Singh, 2013) within the health professions literature.

The goal of this narrative review was to provide insight into aspects of CPD and career advancement of nurses, specifically in relation to the barriers and facilitators, and motivations and aspirations for development. The literature demonstrates a modest evidence base in relation to these concepts although most of the literature was limited to Western countries. No empirical research was identified from Egypt and only a small body of literature on motivation within the health-professions literature, with most research in this area focusing on medical, and to a lesser extent, dental education. Quantitative methodologies were predominant in this review and several systematic reviews of the literature were identified. Nevertheless, much of the quantitative literature relied on self-reported survey data, especially within the motivation literature, where questionnaires were based on predetermined constructs of self-determination motivation rather than participants' own perceptions. However, the weight of enquiry around this research topic

was mainly qualitative which was inherently retrospective and descriptive in nature, often with small cohorts, limited to one setting. The findings of this review therefore suggest the need for empirical evidence within the discipline of nursing to better understand these aspects of CPD and career advancement within an Egyptian educational healthcare context.

The literature identified through these searches will now be discussed critically; it is organised into five sections: overview of CPD and career structures for nurses; barriers to nurses' CPD and career advancement; organisational and social mechanisms that facilitate nurses' development; nurses' CPD motivation and career aspirations and support; before finishing with a consideration of motivational theory focusing on Self-determination Theory (SDT) of Human Motivation as described by Ryan and Deci (2000a).

## 2.3 CPD and career structures for nurses

### *2.3.1 Overview of CPD for nurses*

As introduced in Chapter One (Section 1.2), increased complexities in global healthcare settings mean it is imperative for nurses to pursue CPD and career progression. Issues such as changes in societal demographics, increased prevalence of chronic disease (Cashin, Theophilos and Green, 2017), technological innovations (Duffield, et al., 2009), and increasingly limited healthcare resources (Manley, et al., 2018), have highlighted the pressing need for CPD to ensure nurses can deliver safe and effective quality care. CPD is an integral part of nursing education and practice in developed countries such as the UK and is indeed often a professional responsibility (Lanlehin, 2018). Policies such as the Knowledge and Skills Framework Introduced within the NHS Agenda for Change reforms has facilitated CPD opportunities that are linked with performance-related pay and career progression (Drey, Gould and Allan, 2009). However, the literature highlights the differences in approach to CPD across countries (Manley, et al., 2018).

CPD is often 'conceptually vague' and poorly defined within the literature (Friedman and Phillips, 2004; Manley, et al., 2018), especially in relation to nursing (Gould, Drey and Berridge, 2007). However, there is a consistent theme that education should be a continuous process throughout an individual's career (Gallagher, 2007; Gould, Drey and Berridge, 2007). CPD and lifelong

learning are not only inherently linked (Gopee, 2001; Davis, Taylor and Reyes, 2014), but also a means of gaining career security, personal development and ensuring competence (Friedman and Phillips, 2004). Similar themes are found in the wider nursing (Gould, Drey and Berridge, 2007; Davis, Taylor and Reyes, 2014; Manley, et al., 2018) and medical (Schostak, et al., 2010) literature.

However, there is little consensus regarding what activities qualify as CPD with more emphasis often placed on 'formal' rather than 'informal' learning in both nursing and medicine (Lawton and Wimpenny, 2003; Schostak, et al., 2010). Despite this, Eraut (2001, 2004) advocates learning should be an ongoing, often informal process which is integrated into clinical practice. Critically, Eraut (2004) argues learning in the workplace is influenced by context and setting. Due to a lack of research, it is unclear whether such informal learning is culturally transferrable to a healthcare setting in a LMIC such as Egypt. Such contexts present distinct challenges for nurses where importance of learning in the clinical environment is not recognised nor supported by healthcare managers and organisations.

The literature has shown Dutch nurses view CPD as encompassing a wide range of formal, as well as informal learning activities where learning was often perceived as embedded into their daily clinical practice (Pool, Poell and Ten Cate, 2013; Pool, et al., 2015; Pool, et al., 2016). Age-related differences in perceptions of CPD among nurses and their managers at a university hospital in the Netherlands were studied using focus groups (Pool, Poell and Ten Cate, 2013; Pool, et al., 2015). Four focus groups were conducted: three focus groups consisting of 22 nurses in different age groups, and one group consisting of 10 nurse managers. Informal learning such as reading journals or learning from colleagues was considered to be important by many participants. Nurses in all groups believe CPD could either lead to career progression into management or educational roles 'away from the patient' or to more clinical roles 'around the patient'. Younger nurses (20-34 years) tended to have a broader focus in CPD compared with their older colleagues (35-49 and 50-65), who viewed CPD as a maintenance of professional knowledge and skills. Younger nurses were perceived by their older colleagues to be more ambitious to pursue career opportunities 'away from the bedside'. However, it was acknowledged by the authors that such observed age-related differences in perceptions of CPD might have reflected stereotype perceptions rather than reality.

In later work, Pool, et al. (2015) utilised semi-structured interviews using a biographical perspective to discover similarities and differences across age groups. The study involved 21 nurses working in direct care at general and university hospitals in the Netherlands. The youngest age group of nurses (20-34 years) was found to be more intensively engaged with professional development activities compared to their older counterparts. Younger nurses also saw CPD as more related to career development, focusing on building their knowledge and experience and were more motivated to undertake formal postgraduate education and make curriculum vitae (CV) and learning portfolios. Middle-aged nurses (35-49 years), however, were focused more on keeping work stimulating and maintaining a work-life balance due to changes in private life, such as having small children. Nevertheless, nurses of all age groups articulated professional development embedded in everyday work was a rich resource for learning. However, selection bias may have been introduced to the findings of this study through the use of intermediates to approach and recruit different types of nurses.

As a prolongation to this work, Pool, et al. (2016) re-analysed interview data on nurses' learning biographies from Pool, et al. (2015) using a literature-based framework on motives and learning activities for CPD. From a review of the literature, a total of four learning activities were identified (Appendix II: Framework for CPD Activities Based on the Literature). Pool, et al. (2016) found learning can be classified as either formal or informal, or implicit or incidental, spontaneous learning. Formal learning was defined by Pool, et al. (2016) as pre-planned CPD activities that were organised by others, taking place both in and outwith the workplace, in contrast to informal learning, which is initiated by the nurses themselves and mostly embedded in daily clinical practice.

These findings all highlight how valuable nurses consider the workplace as a learning resource and the need for a broader understanding of CPD outwith traditional learning experiences. Age- and career-related differences in perceptions of CPD should not be viewed as general (Gould, Drey and Berridge, 2007; Pool, Poell and Ten Cate 2013) but highly contextualized, which may impact their transferability to an Egyptian setting. Approaches to learning, constraints on professional autonomy and scope of practices, specific to nurses in Egypt may negatively impact their ability to partake in informal learning practices and the generation of knowledge from practice.

While the effectiveness of CPD in nursing has been studied previously, most studies focused on the outcomes of formal avenues of CPD. A systematic review conducted by Gijbels, et al. (2010) studied the impact on practice of post-registration nursing and midwifery education. Focus was given to formal academic programmes such as Masters or Doctoral-level degrees and thus, articles dealing with more informal CPD activities, such as self-directed study, were excluded. Searches were conducted on CINAHL, PubMed, ERIC, Academic Search Premier, Science Direct, Blackwell Synergy and Cochrane were limited to papers published in English between 1990 and 2007. Barr, et al.'s (1999) taxonomy of learner outcomes was adopted as a conceptual and analytical framework in which the studies were reviewed.

A total of 61 studies were identified from the UK (n=39), USA (n=8), Australia (n=8), Canada (n=2), New Zealand (n=2) and Ireland (n=2). Regarding their learning experience, students were generally found to hold positive views in terms of support received, course relevance and career opportunities. Such programmes encourage feelings of confidence, assertiveness, self-esteem and job-satisfaction. Students were also found to benefit from increased inter-personal skills as well as greater technical, cognitive and academic knowledge, all of which may promote learning in the workplace. However, there is limited evidence that such changes directly improved the health and well-being of patients.

A more recent systematic review conducted by Abu-Qamar, et al. (2020) investigating postgraduate nurse education and the implications for nurse and patient outcomes has confirmed Gijbels, et al's. (2010) findings in that postgraduate education improves knowledge and skills, as well as career opportunities and progression for nurses and improved job satisfaction. Nonetheless, the evidence from these reviews mainly relied on retrospective self-reports through questionnaires and interviews, often with small cohorts within one educational setting which may be subject to bias. The wide variety of settings and context, as well as nurses at a different level of experience and qualifications, also meant these reviews provide a broad rather than an in-depth evaluation of post-registration education. The findings, however, were consistent across diverse settings and contexts. Nevertheless, the findings reflected a Western context but it is unknown if these perceptions of formal avenues of CPD are culturally transferable to an Egyptian setting.

*2.3.2 Overview of career structures for nurses*

Traditional career advancement trajectories within nursing have been linear, with nurses progressing from staff nurse, to charge nurse, before moving out of direct patient care into management, educational or research positions (Sonmez and Yildirim, 2009; Philippou, 2015). However, in the last 20 years, advanced and specialist nursing practice has been a driving force for CPD and has helped make CPD an explicit part of the nursing role (Pelletier, Donoghue and Duffield, 2003; Drey, Gould and Allan, 2009). These changes have created more horizontal career advancement ladders allowing nurses to remain in clinical practice while progressing theircareers (Robinson, Murrells and Clinton, 2006; Duffield, et al., 2009). Rather than the traditional five stage progression of skill acquisition: novice, advanced beginner, competent, proficient, and expert (Benner, 1984), evidence from the UK (Hargreaves and Lane, 2001; Scholes, 2006; Jasper and Mooney, 2013), Canada (Bowen and Prentice, 2016) and Ireland (Kerr and Macaskill, 2020) suggests the modernisation of the nursing workforce and development of advanced nursing roles are changing the career trajectories of nurses.

Incentives and motivation for establishing advanced practice within nursing reflect the current global healthcare challenges (Schober, 2019). However, the definition, scope of practice and professional regulation of such roles are ill-defined in the international literature (Duffield, et al., 2009; Stasa, et al., 2014; Gardner, et al., 2016). However, there is evidence to suggest specialist and advanced nursing has a positive impact on quality of care, cost and access to healthcare services (Casey, et al., 2017). Yet several barriers have been reported, which have limited nurses' abilities to take on such advanced roles (Parker and Hill, 2017). These barriers included issues related to the educational preparation of the nursing workforce, role legitimacy, limitations of scope of practice, as well as professional promotion ladders, accreditation systems and performance evaluation systems within healthcare organisations. These barriers were more apparent in a Chinese context due to the lower education level of the workforce and career structures which favoured management roles.

Professional development plays an imperative role in allowing the nursing workforce to undertake roles with greater scope and complexity. The evidence demonstrating the need for more highly

educated nurses at the basic and advanced level in relation to better patient health outcomes has been recognised (Aiken, 2014). However, McPake, et al. (2015) argue that most studies indicating better patient outcomes for Bachelor degree-prepared nurses have taken place in the hospital setting, limiting the ability to generalise the findings to other healthcare contexts. The transition of nursing education into higher education institutions and the decision to move to a graduate workforce in some developed countries, such as the UK, has not been realised in all countries, including developed nations such as the USA and Australia, where inconsistency in education and practice preparation for nurses remains, presenting career progression challengesfor those who are not Bachelor degree-level prepared (Nardi and Diallo, 2014). Moreover, from the perspective of LMICs, Nardi and Diallo (2014) highlight that educational and economic challenges have been barriers that prevented the ability of the nursing workforce to keep up withinternational trends in professional development and career trajectories. To date most the empirical evidence originates from economically developed countries. Therefore, it would be of interest to explore such issues in Egypt where the healthcare culture and socio-political environment of healthcare are different.

### 2.4 Barriers to nurses' CPD and career advancement

The barriers to CPD of nurses working in hospital-based clinical roles has received little attention in the literature. However, Coventry, Maslin-Prothero and Smith (2015) concluded that opportunities to attend CPD during work time for such workers were often limited. Whittemore and Knafl's (2005) framework for an integrative review was used as a strategy to organise, analyse and synthesise the data abstracted. The review was conducted using CINAHL Plus fulltext, MEDLINE, ERIC, ProQuest Dissertations and Theses, Scopus and Google Scholar. Search parameters included peer-reviewed research articles from all countries published in English from the period of 2001 to 2015. From the 1616 citations found, 69 full text papers were retrieved and reviewed with a further 19 additional full text papers identified from reference list searching. Out of a total of 88 full text papers analysed, 11 international studies were retained and included in the final literature review. Data collected from each study focused on organisational factors which affect nurses' ability to be involved in or attend CPD opportunities in an acute care hospital environment. Three distinct themes were revealed from the reviewed literature: 'the opportunity to attend CPD in work time', 'CPD in personal time', and 'organisational culture and leadership'.

The review unveiled a number of factors which negatively impacted CPD opportunities for nurses in clinical settings. The factors ranged from inadequate nursing levels, demanding and inadequate workloads, especially in developing countries. Time shortages which arose from the above challenges, often meant nurses having to use personal time to pursue CPD (Coventry, Maslin-Prothero and Smith, 2015). Demanding work conditions have been reported to cause fatigue and demotivation, making nurses less likely to use personal time to undertake CPD. Further demands on time from family life as well as financial demands made using personal time to undertake CPD very challenging. Even though many consider it a professional responsibility, pursuing CPD during personal time has been reported to harbour feelings of dissatisfaction, resentment and frustration (Coventry, Maslin-Prothero and Smith, 2015).

Finally, supportive organisational leadership was reported to be key in encouraging CPD among nurses (Coventry, Maslin-Prothero and Smith, 2015). Lack of managerial support, through inflexible staff rostering, or failure to resolve workload issues has been reported as common barriers to pursuing CPD. Such lack of support may arise from managers feeling threatened by the career advancement of their staff. In contrast, positive and empowering managerial and leadership styles were identified as vital for nurses to make changes in practice as a result of CPD and improve patient care.

There are several limitations to this integrative review by Coventry, Maslin-Prothero and Smith (2015). Firstly, some of the studies included in the review had methodological and sample weaknesses which could have affected the studies' results, and consequently undermined the validity of the review. However, some articles which met the inclusion criteria were excluded as they contained data from healthcare professionals outwith an acute hospital environment or represented relevant grey literature. Consequently, some key information may have been missed which would have strengthened the findings of this review. Despite these weaknesses, which were acknowledged, however, this review yielded useful insights into the factors which affect CPD opportunities for nurses in a clinical environment.

Additional barriers related to the relevance, access and availability of CPD have been cited within the literature. Issues related to access and availability have been reported, particularly by nurses working in remote or rural settings (Edwards, Hui and Xin, 2001). The distance to education, travel issues and limited access to CPD were the major barriers to Canadian (Penz, et al., 2007) and Australian (Hegney, et al., 2010) nurses in rural areas, especially those with family commitments, time or financial constraints.

However, issues related to accessibility and availability are not confined to rural areas but are also apparent in urban settings within low income countries such as Tanzania (Tanaka, et al., 2015) and Malaysia (Chiu, 2005) where access to tertiary level and online nursing courses are scarce. Lack of accessibility, availability and flexibility of higher education meant many nurses, especially those with family commitments had to decline study. Language barriers for non-native English language speakers were also noted to limit access to further education (Chiu, 2005). Increased web-based, distance education provision (Penz, et al., 2007; Tanaka, et al., 2015) and shorter degree programmes (Tanaka, et al., 2015) have been advocated as solutions to allow nurses greater access to CPD in low-income countries (Nartker, et al., 2010).

Although barriers to the uptake of CPD appear consistent across the international nursing literature, there is a lack of empirical work focussing on how environmental and socio-economic factors affect the perceptions and career progression of nurses in clinical roles working in developing countries.

Limited access to further education and rigid bureaucratic CPD and healthcare structures were perceived as barriers to career development among 80 degree-level prepared nurses in Singapore (Cleary, et al., 2013). While a relatively small sample size, a clear trend, identifying cultural issues specific to this country, such as poor professional prestige and limited autonomy among nurses, emerged as hinderances to the fulfilment of their career goals.

The link between professional development and career advancement is particularly significant for those nurses with lower educational backgrounds where the attainment of a Bachelor's degree is often pivotal for promotion purposes. A study by Notzer, et al. (2004) found Bachelor degree

completion programmes were important to the career advancement of nurses in Israel who were notuniversity-level prepared. These findings are echoed in a more current study by MacDonald, et al. (2020) among a group of 19 diploma RNs returning to undergraduate study in Qatar which in recent years has seen the introduction of an organisational career ladder structure by most healthcare employers requiring Bachelor degree level qualifications. Yet it was salient that the primary reason most participants delayed educational advancement was lack of access to a Bachelor education provision in Qatar. Moreover, returning to education was viewed as challenging, requiring balancing the competing demands between their profession and personal lives (MacDonald, et al., 2020).

Career barriers confronting second-level ENs where career progression is often tied to RN transition programmes have also been described within the literature from countries such as Australia, where two levels of nursing registration have been retained. In a qualitative study involving interviews with nurse educators, Jacob, McKenna and D'Amore (2016) explored educator expectations of roles and career pathways of first-level RNs who had been prepared to degree level, and diploma prepared second-level ENs in Australia. Eight course coordinators from three university RN programmes, and five from HEIs delivering EN qualifying programmes were interviewed. ENs were perceived to have limited career advancement and post-registration study opportunities in relation to RNs. RNs were also considered to have more career options open to them within management and education, as well as specialty roles which were unattainable for ENs. Participants also expressed role confusion and uncertainty around scope of practice for ENs due to a perceived blurring of roles between ENs and RNs which was seen to either limit their practice or allow them to practise at levels for which they are unprepared. However, the study only gained the perceptions of 13 nursing course coordinators from one state in Australia. Moreover, the participants had limited understanding of the curricula and clinical context of other levels of nurses which may have limited their ability to reflect on the education and practice of these nurses.

These findings are consistent with recent studies from Australia which reported that ENs (McKenna, et al., 2019; Leon, Tredoux and Foster, 2019), nursing managers and clinical educators (Leon, Tredoux and Foster, 2019) perceived limited opportunities for CPD and career progression despite the introduction of formalised and sequential educational pathways. In a

qualitative study of ENs using 14 focus groups (n=95) and individual interviews (n=7), many participants perceived the only career pathway available to them was to convert to an RN management role rather than a clinical role which was often preferred (McKenna, et al., 2019). These perceived barriers to opportunities for professional development and career progression are salient as Leon, Tredoux and Foster (2019) concluded from an explanatory sequential mixed methods study, that such barriers led to feelings of ENs being undervalued which negatively influenced retention. Nevertheless, small response rates of the surveys for the EN (28.1%) and stakeholder (17.6%) cohorts meant the ability to develop statistically significant conclusions was limited. Moreover, data collected from five hospitals within one public health service in the country might not reflect other public or private organisations which employ ENs.

The EN participants in both studies mentioned were also mainly mature-aged graduates who may have had different perceptions to younger nurses in the early stages of their careers. Additionally, participants were working in an Australian healthcare setting where the scope, education and practice context of second-level nursing differs to Egypt. Perceptions of barriers to professional development and career advancement among second-level nurses, such as TDNs, is a concept that has not previously been researched from an Egyptian perspective. As structural support between academic and service providers was an important theme in overcoming these identified challenges, it would be of interest to also explore the perceptions of these stakeholders as well as TDNs themselves.

### 2.5 Organisational and social mechanisms that facilitate nurses' development

In addition to barriers, nurses' engagement is impacted by variables influenced by their workplace, managers and colleagues, and an individual's level of personal and domestic support. Studies within the nursing literature have highlighted this link between professional development and the workplace which will now be explored.

Nurses' perceptions of the clinical work environment and its influence on their professional development was investigated by Hart and Rotem in 1995. 596 paper-based Likert scale questionnaires were distributed to nurses working in five urban hospitals in Australia. A

conceptual framework, constructed from data from non-participant observations, structured interviews and a review of the literature, were used to produce the questionnaire. It was piloted before distribution and yielded a response rate of 87% (n=516). The sample consisted of RNs, most of whom were educated to Diploma-level with less than 7% of nurses prepared to degree-level. 65% of respondents were under 30 years of age. The questionnaire results were supportive of the conceptual framework which outlined six significant attributes within the clinical learning environment found to influence nurses' professional development (Table 2.3).

*Table 2.3: Hart and Rotem's (1995, p.6-7) conceptual framework: attributes within the clinical learning environment for registered nurses*

| |
|---|
| *Autonomy and Recognition* - the extent to which staff are valued, acknowledged and encouraged to take responsibility for their own practice. |
| *Job Satisfaction* - the extent to which nurses enjoy their work and intend to pursue a career in nursing. |
| *Role Clarity* - the extent to which staff understand and accept their role and responsibilities. |
| *Quality of Supervision* - the extent to which supervision and staff interaction facilitates or impedes improved practice. |
| *Peer Support*- the extent to which staff are friendly, caring and supportive toward one another. |
| *Opportunities for Learning* - the extent to which learning opportunities are restricted or unavailable. |

Organisational support for learning constitutes a construct which is difficult to separate from other environmental factors conducive to learning (Hart and Rotem, 1995). The findings suggested supportive and positive organisational structures which foster professional and personal growth subsequently allowed for good social support and appropriate levels of supervision and autonomy. Peer support also led to feelings of well-being and reduced stress levels among the RNs surveyed. Notable differences in levels of organisational support were highlighted both between and within hospitals which suggested some hospitals and wards were more encouraging in fostering learning and professional development than others.

Hart and Rotem (1995) consequently highlighted the need for a cooperative approach between education and management to develop effective strategies which facilitate professional development for nurses. An example strategy was to support nurses' professional autonomy and value their contribution to care, ensuring they have defined roles and responsibilities.

In addition, adequate levels of supervision by experienced nurses to develop a collegial work environment, supporting formal and informal learning opportunities, and fostering a collaborative approach to performance appraisals were deemed important. However, there are limitations to this research. Despite the high return rate, 25% of those returned were incomplete and this could have affected the validity of the results. The authors did not acknowledge this. Furthermore, as this study was conducted with RNs working in urban hospitals within an Australian context, the ability to generalise the findings to other nursing populations may be limited. As outlined in Chapter One, role ambiguity has created obstacles for actualising nursing autonomy within nursing in Egypt and consequently the conceptual framework by Hart and Rotem (1995) may not have a broad application within nursing practice in an Egyptian setting.

Similarly, a more recent study highlighted that aspects of the organisation in which a nurse works are important determinants in facilitating learning. Brekelmans, Poell and Van Wijk (2013) conducted a Delphi study with 38 nurse experts exploring the key factors influencing both formal and informal CPD activities of nurses in the Netherlands. Expert opinions were sought from nurses in senior positions, professional organisations and the nursing education sector. Two out of the six main influencing factors prioritised were aspects related to the organisation; 'opportunities for workplace learning' and 'the line manager as a role model'. Creating appropriate structural and cultural conditions for CPD were deemed critical, with nurse managers seen as having a central role in establishing the infrastructure necessary to facilitate nurses' optimum engagement in CPD and develop expertise. However, there are some methodological limitations of this study. No mention was made if a pilot of the first-round questionnaire was conducted, nor the response rates of subsequent rounds of the Delphi. A pilot of the first round of the Delphi study can increase the validity of its questions (Clibbens, Walters and Baird, 2012). In addition, the content analysis of the first two rounds of questionnaires results were conducted by the first author only. This may have led to opinionated accounts, leaving the findings open to researcher bias (Bowles, 1999). Moreover, no statement of how consensus was reached was documented. This suggests that what constituted consensus in the study was arbitrary or post hoc (Bowles, 1999; Wilkes, 2015). Lastly, the opinions of what influences the CPD participation of nurses were from a panel of expert nurses rather than the nurses working at the bedside in clinical practice.

However, empirical research from Australia has explored ward nurses' perceptions of CPD in clinical settings. Using a qualitative case study, Govranos and Newton (2014) conducted four

focus groups with 23 clinical ward-based nurses (RNs n=21, ENs n=3) working in one acute medical-surgical ward in a major teaching tertiary hospital. They explored nurses' values and perceptions towards professional development and the factors which drive learning. Six individual semi-structured interviews were then conducted with nurses, ranging from ENs to unit manager level, to further explore emergent themes. Senior staff, including clinical nurse educators, were viewed as an important influence on a nurse's ability and motivation to incorporate lifelong learning into their daily practice. The ability to act as a role model, encourage confidence among nurses, be approachable and supportive, were highlighted as pivotal attributes of clinical nurse educators that create a ward culture conducive to learning. It was suggested senior staff required training, as well as appropriately allocated managerial support to better facilitate the learning of others. This study highlights the importance of managers, clinical educators and senior colleagues in assisting the development of a learning culture and helping nurses to meet their professional development requirements. In addition to the general criticism about transferability of contextual research, the focus groups were also created using convenience sampling which meant participants' reasons for self-selecting may have potentially differed from those who did not (Robinson, 2014).

These studies have highlighted that the quality of management, leadership, senior staff and collegial support impact the learning opportunities of nurses. This body of literature has described perspectives from high-income countries rather than the context of LIMCs where challenges such as chronic nurse shortages, authoritarian leadership styles, and underinvestment in healthcare infrastructure are experienced. Consequently, further research exploring the perceived influences of nurses and key stakeholders in an Egyptian setting is required.

As well as organisational factors, social and domestic factors can act as catalysts for professional learning, in addition to personal motivation. In a qualitative study exploring nurses' perceptions of lifelong learning, Gopee (2002) undertook 27 semi-structured individual interviews and two focus groups with RNs of different grades in the UK. It was found that in addition to formal organisational mechanisms, various non-organisational and informal factors influenced participant stimulation in both formal and informal learning. This study concluded that professional learning was promoted and enriched through effective collegial relationships with healthcare professionals but importantly, also complemented by non-healthcare related

acquaintances such as friends, parents and spouses (Table 2.4). The benefits of these informal infrastructures and faciliatory social relations were often unacknowledged or even unrecognisedby employers which led to reduced CPD attainment for nurses. As a result, offering flexible learning methods and timing of courses to accommodate those with family responsibilities, protected and paid time for study, and assistance with course fees and childcare, were suggestedstrategies for healthcare organisations to facilitate participation in learning.

*Table 2.4: Human and social capital factors that impinge on lifelong learning (Adapted from Gopee, 2002, p.615)*

| ***Healthcare professional acquaintances*** | ***Non-healthcare related acquaintances*** |
|---|---|
| • Nursing colleagues | • Self-investment |
| • Clinical setting as a learning organisation | • Parents, family and friends support |
| • The role of academia | • Social attitudes |
| • Management approach | • Government approach |

Social and domestic support has an influence on a nurse's participation in formal learning. Burrow et al, (2016) conducted a qualitative review of literature focusing on motivations and experiences of health and social care professionals' in part-time higher education, and concluded that families were often a crucial source of support to facilitate formal mechanisms of CPD, in addition to organisational and managerial support. Databases relevant to health and social care were searched for articles that were qualitative in design to focus on student experiences, perceptions of and motivations to study. Mixed method papers were also included if they had identifiable qualitative data. Participants had to be qualified health or social care professionals who were undertaking accredited study in HEIs whilst working. Search parameters included peer-reviewed research articles published in English from 2000 to 2015. The searches produced 966 papers which were reduced to 13 articles after applying the inclusion and exclusion criteria and the removal of duplicates. Articles were reviewed independently by two of the authors using an appraisal tool developed by Elvish, et al. (2013), appropriate for assessing the methodological quality of qualitative studies. Studies were graded 0–3 against the eight criteria, after which the authors arrived at a consensus decision for each score. Although there were variations in methodological quality, no studies were excluded for the purposes of this review. Data in the identified papers were analysed using thematic analysis as described by Braun and Clarke (2006). In the sub-theme entitled 'sources of support', under the theme of 'experiences of study', two of the 13 identified articles (Stanley, 2003; Cooley, 2008), highlighted the effects of studying

on family and home life, especially for those with dependents, child care or domestic commitments, and the subsequent importance of supportive families. Stanley (2003), who conducted nine unstructured interviews with RNs, midwives, and health visitors of different grades, from both hospital and community settings in the UK, found family or partner support was imperative for participants to undertake a part-time post-registration nursing degree programme successfully. Similarly, Cooley (2008), undertook three focus groups with Irish RNs working as either a staff nurse (n=13), clinical nurse manager (n=4), or a clinical nurse specialist (n=1), who were studying on a post-registration Diploma or higher Diploma programme. Participants suggested their families were more supportive when they discussed their CPD motivations with them and cited support strategies provided by family members as being helping with household chores, childcare and offering emotional support, which in turn, enabled them to study. There are several significant limitations of this qualitative review of the literature. The 13 reviewed studies varied in methodological quality, with some achieving a low-quality scoring, including the paper by Cooley (2008). Moreover, the focus on peer-reviewed qualitative evidence in Burrow, et al.'s (2016) literature review meant relevant findings from quantitative studies and grey literature were excluded. Participants in Cooley's (2008) study were mature students, most of whom had dependants, and therefore might have emphasised the importance of domestic support differently in comparison to nurses in the early stages of their careers.

In conclusion, international literature has shown that nurses' friends and family are important instigators of professional development, along with managerial and collegial support. The clinical setting was viewed as a learning environment if the local organisational culture of the hospital was conducive. Contextual differences support the need for further research to confirm if such influences associated with assisting nurses with their development would also emerge in an Egyptian setting. Most studies also focused only on the perceptions of nurses and did not explore the perspectives of other key players such as healthcare managers, senior nurses and academic and clinical educators who have been deemed integral in helping nurses to meet their professional development requirements. As a result, further research which investigates a collective perspective is required.

### 2.6 Nurses' motivation for professional development

While learning and the intrinsic pursuit of learning are reported to be important drivers for engaging in professional development activities, the desire for career advancement and professional credibility were also found to be prominent motivators, especially among those nurses with lower educational levels than their Bachelor-prepared colleagues.

A comparative survey design of nurses, occupational therapists and physiotherapists in the UK found that the desire to increase professional knowledge was the prime motivator for seeking formal and informal methods of CPD, with the opportunity to enhance qualifications also cited as important (Ryan, 2003). Although the study had a high response rate of 60.6%, the information regarding the pre-registration preparation of respondents was incomplete which limited the interpretation of results. The questionnaire was not subject to a test-retest reliability during the pilot studies which raises questions about the reliability of the findings (Parahoo, 2014), which were also based on a self-reported measure of motivation.

Nevertheless, comparable findings have been reported in a Malaysian context. Chiu (2005) explored key motivators of Malaysian Diploma-prepared RNs to undertake a post-registration degree through an Australian university. Using a case study approach,12 in-depth semi-structured interviews were conducted, followed by a focus group with 10 of the 12 participants initially interviewed, to further explore emerging themes. Participants were found to be strongly motivated to enhance their qualifications due to the desire for personal and professional growth and credibility. The need to remain current and competent in professional practice was also cited as important. Undertaking a degree was also seen as imperative for career mobility, especially towards management. Although this study illuminates the motivations of nurses for higher education from the context of a non-western developing country, this study has limitations in that data was collected from the small sample who had the opportunity to undertake a transnational degree programme. Consequently, their experiences may not apply to other nurses within the country (and beyond) who have not had similar opportunities.

Focus group interviews with both RNs and ENs in a UK context have similarly reported that the desire to improve professional knowledge drove nurses to undertake formal and informal learning (Bahn, 2007a). Engagement in formal avenues of CPD was often prompted by perceived

educational deficits. Three focus groups were conducted with 25 nurses made up of RNs (n=18) and ENs (n=7), ranging from junior to senior positions, employed in both public and private clinical settings. Participants had recently completed, or were currently undertaking, continuing education. The focus groups were composed of a mix of either ENs (n=7) who were commencing, or RNs (n=10) who had recently completed, an EN to RN conversion Diploma programme, as well as traditional hospital-prepared RNs undertaking a Diploma (n=2) or degree-level top-up (N=6) qualification. ENs were found to consider higher education as important to validate their expertise and experience. Subsequent improvement in career mobility and opportunities were alsoconsidered strong motives to avoid a perceived loss of status in the workplace. Formal CPD sessions and informal learning were undertaken to attain personal growth and to maintain professional competence. Nonetheless, there are some limitations to this research. The heterogeneous nature of the focus groups in relation to nurses' positions and pre-registration preparation may have affected disclosure of individual participants' views and experiences (Baillie, 2019). An in-depth description of the data analysis process was also not provided by the author to decipher if it was sufficiently rigorous and how the categories were derived from the data. However, further work conducted by Bahn (2007b) has confirmed these findings.

Strikingly, Murphy, Cross and McGuire (2006) reported nurses in Ireland did not participate in formal avenues of CPD out of personal interest even though they were aware of the potential benefits. Instead they undertook CPD as a way of securing promotion. Data was collected from a cohort of practicing RNs participating in a management course at a higher education institution in Ireland via a postal questionnaire that contained both open and closed-ended questions. A total of 61 responses (62.9%) was yielded from the research population (n=97). The main motivators for participation were related to increasing knowledge and skill levels, and associated with increasing career satisfaction and gaining promotion. Interestingly, higher levels of professional respect from colleagues was ranked joint last of the options offered which contrasts to the findings of Chiu (2005) who found this to be an important motivator. This, however, could be explained by the greater social and professional esteem that nurses enjoy in Irish society compared to the Malaysian context. Moreover, degree-level education for nurses had only recently been introduced in Ireland meaning nurses had mostly qualified through hospital-based programmes. This may have led to the sentiment among respondents that their level of pre-registration preparation was being devalued and so undertaking CPD may not have been explicitly for personal or professional growth. Nevertheless, the educational credentials of respondents

were not specified by the authors. Moreover, the survey elicited a high response rate, possibly explained by the fact the researchers were lecturers on the management course which may have subsequently influenced participation and introduced bias to the findings. Such findings may be comparable to TDNs within an Egyptian context where Bachelor-prepared nurses hold higher prestige.

Joyce and Cowman (2007) found comparable results in their study investigating Irish nurses' motivations for participating in part-time post-registration education. Using a descriptive survey research design, the authors surveyed qualified nurses commencing either a part-time degree, higher Diploma or master's programme in several specialist areas of nursing practice at a HEI. The questionnaire asked respondents to rank 15 reasons for CPD participation in order of importance before allowing the expression of others in an open comment section. Data were analysed using Statistical Package for Social Sciences (SPSS), and additional comments from the open section of the questionnaire were coded and categorised under themes and integrated with the quantitative data. A total of 243 questionnaires were returned representing a response rate of 46.7%. While respondents spanned a wide range of clinical backgrounds, the majority were staff nurses (62.5%), qualified less than five years (38%) and undertaking a part-time degree (59%). 37 respondents completed the open comments section. Analysis showed that participation in such courses was mainly to obtain promotion to a higher grade/position (99%). Three broad themes of 'self-development', 'standards of care' and 'pressure to undertake a degree' were also generated from the qualitative data which somewhat supported the questionnaire's findings. The questionnaire items 'to enable me extend my clinical role' and 'to broaden my perspective on nursing' were endorsed by comments under the theme of 'self- development'. Moreover, the items 'to gain knowledge to enable me to contribute more effectively to discussions about patient/client treatment' and 'to improve my clinical judgement' were linked to the theme 'standards of care'. 12 of the comments in the open section spoke of the 'pressure to undertake a degree' which was not featured in the 15 standard items, highlighting that the questionnaire did not fully capture participants' motivations. Career pathways for nurses which promoted horizontal rather than purely vertical progression were still being realised in Ireland at the time of this study which may help to explain these findings. Despite motivations for personal development cited as salient, many respondents felt 'pressure' to acquire further qualifications which was often a pre-requisite for higher positions within management.

Although somewhat dated, this literature provides pertinent findings which may relate to the experiences of TDNs in Egypt. Overall, nurses were highly motivated to participate in CPD and opportunities to enhance personal and professional growth were important drivers. Underlying motives for engagement in professional development activities are often explained by the educational healthcare context. Opportunities to enhance professional credentials and career mobility were particularly salient drivers for nurses who were not degree-level prepared and who often pursued further education to gain credibility. Nevertheless, a large proportion of the literature focuses on nurses' motivations to engage in formal CPD activities, such as part-time university-based postgraduate programmes, which often involves a significant commitment in terms of money and time, in comparison to informal learning (Murphy, Cross and McGuire, 2006).Exploring motivations of nurses' engagement in informal CPD activities would therefore be of interest, as keeping up-to-date with knowledge and practice outwith a formal training or learning framework requires a degree of autonomous self-regulation (Ten Cate, Kusurkar and Williams, 2011). Moreover, the studies reviewed were largely based on retrospective reflections from mainly a Western context. Research examining second-level nurses, such as TDNs' motivations for their professional development in the context of an Egyptian setting is clearly lacking, which means that the specific underlying drivers of motivation for Egyptian TDNs are not well understood.

### 2.7 Nurses Career Aspirations and Career Support

Nurses need support to realise their career aspirations. To establish a viable career pathway and maintain career motivation, nurses, especially those in early career, require encouragement, role recognition and access to CPD opportunities (Coughlan and Patton, 2018). In a qualitative study involving 12 early career neonatal nurses and midwives in Ireland, most participants were motivated to achieve their career aspirations. Workplace, mentorship and encouragement were identified as valuable methods to make and pursue such goals (Coughlan and Patton, 2018). Participants were found to value clinical aspects of their role and aspired to careers in clinical settings rather than management. However, the economic downturn at the time meant the majority of participants felt such goals were unachievable in their current workplace. Consequently, many favoured emigration as a means to pursue career opportunities and jobs with higher salary. The authors advocate investment in regular contact with managers and greater educational opportunities to improve job satisfaction and retention (Coughlan and Patton, 2018). Nevertheless, it is unclear if such findings are applicable to LMICs where nurses' career

advancement trajectories may differ. Moreover, only females took part in the study which yielded no insights into gender influence on a nurses' career aspirations.

In contrast to the previous study, Spence Laschinger, et al. (2013) found that early career nurses who were Bachelor-prepared in Canada had stronger management career aspirations than older colleagues. Subsequent research which used a cross-sectional survey design supported these findings (Wong, Spence Laschinger and Cziraki, 2014). The career aspirations among 1241 nurses working in direct patient care across 9 provinces of Canada were studied. Age and education were significant predictors of career aspirations to management, with younger nurses and those who were Bachelor-prepared being more likely to aspire to such roles. Only 24% / 23% of staff nurses surveyed were either interested / very interested in pursuing management roles, with leaving the bedside being a significant predictor of interest. Incentives such as increased autonomy, the opportunity to take on new challenges and influence practice, were the strongest predictors of aspirations to management roles. However, these findings may be limitedby a low response rate.

The value of mentors was again highlighted in a narrative case study of the career expectations of early career Bachelor-prepared nurses in Canada (Price et al., 2018). Participants identified the need for mentorship and peer support to help with CPD and the achievement of career aspirations. Career decisions were also found to depend on personal and professional goals. Factors such as work-life balance and career progression were strongly coupled to career satisfaction and job retention. However, as noted previously no males took part in this study precluding the study of gender influence on findings, and the six narratives obtained may not have been sufficient to provide in-depth understanding of the topic under study (Parahoo, 2014). Notwithstanding, the link between the fulfilment of career expectations and career satisfaction and well-being in a Canadian context has also been identified in similar studies in the UK (Robinson, Murrels and Clinton, 2006) and Sweden (Hallin and Danielson, 2008). Similarly, the relationship between job satisfaction and retention in nursing has been noted previously in the nursing literature (Wang, et al., 2012; Price et al., 2018) where methods such as financial assistance with CPD to support career development has been advocated.

The career aspirations of second-level nurses have also been explored in the literature. A survey which explored the career aspirations of 356 LPNs in Japan found that younger LPNs were more ambitious and that some did not aspire to be RNs. While the negative image of the LPN was a source of career demotivation, this was counteracted by supportive working environments and recognition from managers. While this work studied only a Japanese context, the findings are mirrored by a similar study of ENs in Australia (McKenna et al., 2019), as well as a recent review of the literature of ENs from Australia, USA, Canada and Japan (Blay and Smith, 2020).

Donner and Wheeler (2001) advocate that the process of career planning and development should be an integral part of a nurse's professional development and that nurse educators play an important, supportive role. Career planning, where nurses set out career goals and opportunities to achieve them is distinct from career development where nurses set out a career vision and subsequently develop a personal development strategy towards its fulfilment (Donner and Wheeler, 2001). Such methods have been reported to improve nurses' professional satisfaction, motivation and quality of care (Sonmez and Yildirim, 2009). Donner and Wheeler (2001) determine there are five key stages to a nurse's career which starts with 'learning' during preparation education. Stage two occurs when a nurse explores employment options after graduation before the 'commitment' stage 2-5 years later, where career goals are evaluated, and a vision is formed. "Consolidation' occurs when nurses assume leadership and mentorship roles before 'withdrawal' at the end of a nurse's career.

The need for nurse managers to take an active role in career planning and development has been highlighted within the literature (Sonmez and Yildirim, 2009), especially for those in early stages of their career (Philippou, 2015) or remote settings (Hall, 2008). However, it has been reported that such support is often lacking. A descriptive study that surveyed 373 nurse managers in public and private hospitals in Turkey, found that career planning and development practices were found to be inadequate and not consistent in their delivery (Sonmez and Yildirim, 2009). The participation in formal COD programmes was found to be the most common strategy for career development used by nurses. Nevertheless, the study only included the opinions of nurse managers. However, more general insights were found in a multi-centered, cross-sectional survey of 871 employers and nurses in the UK (Philippou, 2015). The findings show that short-term career management responsibilities such as securing study-leave, were perceived to lie with

employers whereas long-term responsibilities regarding career planning were perceived to lie with individuals. Younger nurses were found to be more likely to ask for support in education and training. Philippou (2015) advocated that career management responsibilities should be shared to maximise benefits for both the nurse and the employer. Nonetheless, the validity and reliability of the survey tool used in this study had not been fully tested and this was acknowledged by the author. Further research is required to explore both employers' and employees' underlying motives for adopting different types of career management strategies and whether nurses have the desired attributes to take on more responsibility for building their careers.

In summary, nurses at early stages of their career have been shown to value career growth opportunities and support from their employers to achieve their career aspirations. Generational trends of how nurses value and navigate their career emerged (Boychuk-Duchscher and Cowin, 2004; Leiter, et al., 2010). Nurses of the Millennial generation, born between 1980 and 2000, have been found to value organisational work cultures that promote autonomy, moral practice, supportiveness and flexibility. Importantly they have been found to be more likely to leave jobs or even the profession if such values are not met, highlighting the link between support, satisfaction and retention (Stevanin, et al., 2018). Nevertheless, much of the career literature is from a Western perspective and therefore may not be transferable to societies such as Egypt who have different social-cultural and political-economic climates. Therefore, an understanding of the career aspirations and the influencing factors that facilitate their decision-making of second-level nurses in an Egyptian setting is required.

## 2.8 Theories of motivation

From the nursing literature reviewed, it is clear that nurses' motivation to develop and advance in their careers is impacted by several factors. It therefore was pertinent to consider theories of motivation in nursing and from the wider fields of general education and psychology.

### *2.8.1 Theories of motivation applied within HPE*

Cook and Artino (2016, p.997) define motivation as '*the process whereby goal-directed activities are initiated and sustained*'. Extrinsic motivation is defined to be 'driven by external control,

demands or requirements', whereas, intrinsic motivation arises '*out of interest or for inherent satisfaction*' (Ten Cate, Kusurkar and Williams, 2011, p.962). While defining the five basic human needs, Maslow (1943) proposed that low order extrinsic physiological needs were key for motivation towards intrinsic satisfaction, linked to higher order needs. While not referring to it specifically, this theory implied that fundamental needs must be met in order for an individual to have motivation for learning. However, this theory assumes the universal significance of these needs (Nishimura and Suzuki, 2016), which may fail to capture different competing drivers within society that could affect an individual's goals (Tay and Diener, 2011).

Since Maslow (1943), however, a variety of theories have emerged from different perspectives (Cook and Artino, 2016) which address the human motivation to learn within HPE. Examples include Achievement Goal Theory (AGT) (Dweck and Leggett, 1988), Social-cognitive Theory (SCT) (Bandura, 1986), and Self-determination Theory (SDT) (Ryan and Deci, 2000a). SCT contends that motivation to learn is influenced by a dynamic interaction between personal, behaviour and environmental factors (Bandura, 1986). Self-efficacy, where an individual believes their behaviour will lead to a desired outcome is identified as key for the initiation of a motivated action (Cook and Artino, 2016). Furthermore, self-regulatory mechanisms where individuals exert control over their behaviour is proposed to shape motivation. However, it is unclear if SCT is applicable across different cultural settings (Schunk and DiBenedetto, 2020).

AGT differentiates between two types of goals: mastery-focused and performance-focused (Dweck and Leggett, 1988). Mastery goals are undertaken for intrinsic reasons such as the desire to increase competence, whereas performance goals are pursued by extrinsic drivers such as to gain positive, or avoid negative perceptions of their skills from others (Pintrich, 2000). Individuals who undertake mastery goals tend to have a more flexible mindset than those who pursue performance goals who believe their abilities are unchangeable (Dweck and Leggett, 1988). While the influence of social context on the nature of goals is acknowledged, AGT has been criticised for not capturing the multidimensionality of motivation (Pintrich, 2000) and providing a 'simplistic generalization' of goal orientations (Harackiewicz, et al., 2002, p.643).

SDT recognises the importance of intrinsic motivation and identifies three basic psychological needs; autonomy, feelings of competency and relatedness, as being key for its support. Social and environmental conditions are proposed to be essential in facilitating or hindering optimum growth (Ryan and Deci, 2000a) and thus, SDT is appropriate for understanding contextual influences on motivation which became evident during the data analysis stage of this study. As discussed in Section 1.7, this study was initiated from anecdotal reports of the frustrations of TDN graduates relating to their CPD and career advancement. Issues raised by participants were found to be inherently dynamic and contextual. SDT represents '*both an expansive and expandable framework that provides a unified perspective of diverse phenomena*' (Ryan and Deci, 2020, p.7). SDT allowed for the collective analyses of this study's objectives (Section 2.8.1) and was key to my interpretation of the social and cultural impacts on the CPD and career advancement of TDN's in Egypt. Such robust and multidimensional analysis was not possible with the other aforementioned theories.

### *2.8.2 Self-determination Theory of Human Motivation*

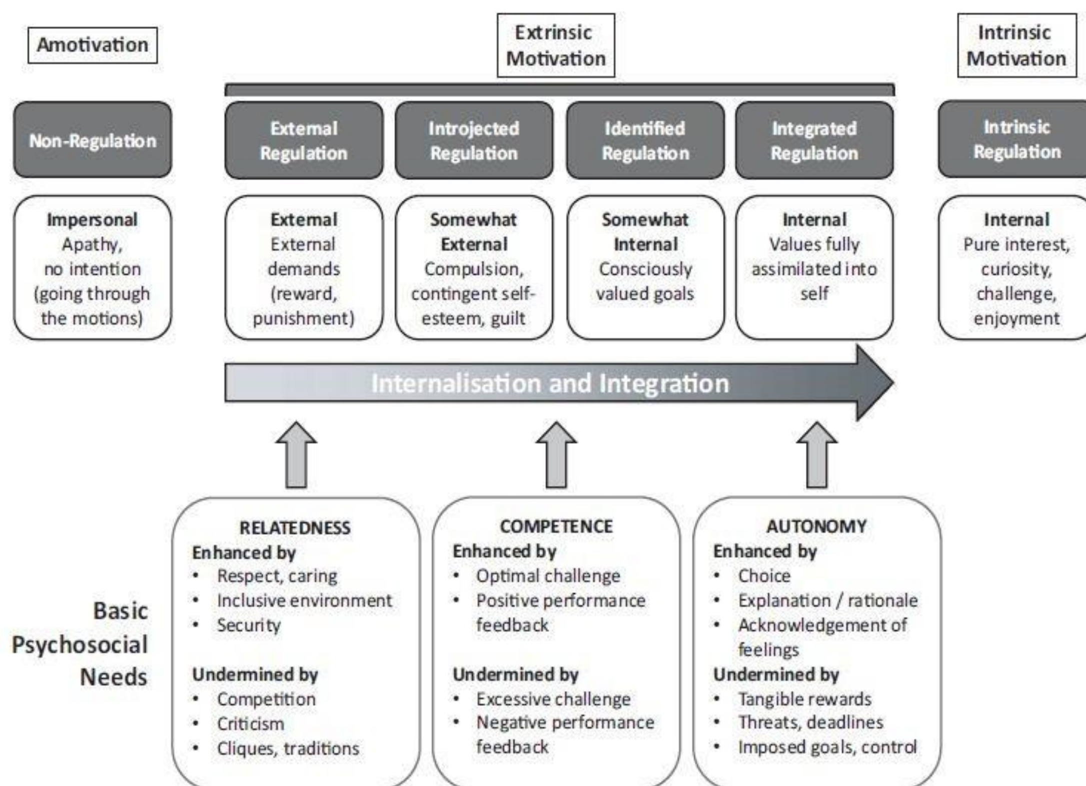
#### *2.8.2.1 Types of Motivation*

The basis of SDT assumes that there are three styles of motivation which vary on a spectrum of amotivation, through extrinsic motivation, where behaviour is driven by external demands suchas rewards or punishments, to intrinsic motivation where a natural tendency of engagement occurs through spontaneous interest or for inherent satisfaction (Ten Cate, Kusurkar and Williams, 2011) (Figure 2.1). Extrinsic motivation is further divided into four categories ranging from external regulation, where outside drivers such as the threat of punishment dominate, to integrated regulation, where external values become internalised and form inherent beliefs or values (Ten Cate, Kusurkar and Williams, 2011; Cook and Artino, 2016) (Figure 2.1). Such a process of internalisation and integration leads to extrinsically motivated behaviours becoming more self-determined (Ryan and Deci, 2000b) and thus, resembles intrinsic forms of motivation (Ryan and Deci, 2000a). Both forms of motivation are promoted through the satisfaction of basic psychological needs.

*2.8.2.2 Basic psychological needs*

SDT proposes that the satisfaction of three basic psychological needs: the need to feel autonomous, competent and related to the social environment, determine a person's ongoing psychological growth and development towards integrity and well-being (Ryan and Deci, 2000a) (Figure 2.1). The need for autonomy relates to making decisions through free will (Ten Cate, Kusurkar and Williams, 2011) while the need for competence concerns the desire to feel capable of performing a determined task (Ryan and Deci, 2000a). Relatedness is defined as the need for belongingness and acceptance with significant others in a group. (ibid.) If these basic needs are not satisfied, psychological well-being, optimum performance and level of intrinsic / integrated regulation are diminished (Ryan and Deci, 2000a).

*Figure 2.1: Ryan and Deci's (2000a) Self-determination theory (from Cook and Artino, 2016, p.1010)*




Deci and Ryan (2000) highlight that while these three psychological needs are universal, the means by which they may be satisfied may vary across cultures. Indeed, differences have been observed in Anglo-American children from an individualistic culture and Asian-American children

from a collectivist background enrolled in two schools in the USA (Lyengar and Lepper, 1999). Intrinsic motivation in the former group was promoted when given personal choice and diminished when decisions were made for them by authority figures or peers while the opposite was true for the Asian-American children. This study, although limited in its applicability to all cultures, highlighted the different values that distinct cultural groups place on personal autonomy. However, studies (Stewart, et al., 2000; Chirkov and Ryan 2001; Sheldon, et al., 2004; Vansteenkiste, et al., 2005) suggest that despite different cultural values, underlying motivation and well-being are basic and common psychological needs (Deci and Ryan, 2008). However, no studies have been carried out within North African or Middle Eastern culture, indicating that further research is required in other cultural settings.

*2.8.2.3 Basic psychological needs and social-contextual influences*

Section 2.5 highlights that a number of organisational and social mechanisms facilitate nurses' development. The influence of social-contextual factors has been addressed by motivational theory (Bandura, 1986; Dweck and Leggett, 1988) as well as other works which studied the links between social capital (Coleman, 1988) and environmental context (Knowles, 1990) on learning. SDT also argues environment can impact the basic needs which must be satisfied to promote intrinsic motivation or self-regulation (Deci and Ryan, 2008). SDT therefore provides robust theoretical grounds to analyse the effect of social-context factors on forms of motivation in an education environment, as well as others (Deci, et al., 1991; Deci and Ryan; 2008).

Significant others, such as managers or partners, are critical for the support of an individual's psychological needs (Deci and Ryan, 2008). Autonomy support, for example, includes '*taking their perspective, encouraging initiation, supporting a sense of choice and being responsive to their thoughts*' (Deci and Ryan, 2008, p.18). Managers who display such behaviour have been found to encourage greater engagement in their employees' work, reporting higher work performance and a greater job satisfaction as a result (Deci, et al., 2001). Similar findings occurred in a psychiatric hospital where autonomy-supportiveness improved the satisfaction of care-workers and their attitude towards patients (Lynch, Plant, and Ryan, 2005). However, no such studies have been conducted in Egypt where management and leadership styles are influenced by collectivist values (Elsaid and Elsaid, 2012).

Teachers who displayed need-supportive styles towards students helped create well-structured learning environments and promote autonomous self-regulation of behaviours. Conversely, teaching environments which are controlling, punishing, and neglecting, impede students' autonomous motivation (Deci and Ryan, 2000). Similar findings have been reported within the context of HPE (Williams, Saizow and Ryan, 1999; Kusurkar, et al., 2011; Ten Cate, Kusurkar and Williams, 2011; Orsini, et al., 2016; Orsini, Binnie and Tricio, 2018; Tjin A Tsoi, et al., 2018).

A systematic review of the HPE literature, conducted by Orsini, Evans and Jerez (2015), identified several strategies used by clinical teachers in their daily work to support students' self-determination (Table 2.5). Electronic searches were performed across relevant databases relating to HPE, general education and psychology with 16 articles meeting the inclusion criteria and included in the final review. Feelings of autonomy were enhanced when clinical teachers identified students' learning needs and ensured teaching content was interesting and relevant. Teaching methods which promoted active participation and gave students the freedom to develop their own learning path were also effective and also promoted a sense of responsibility. Positive and constructive feedback, structured supervision, and learning activities were all found to be important in promoting feelings of competence among students. Finally, relatedness was encouraged when clinical teachers displayed positive attitudes and created non-threatening, respectful and supportive learning environments. The exchange of ideas and opinions also promoted relatedness. However, articles in this review were predominantly from the UK and USA and related to undergraduate dental or medical students which could limit the generality of the findings.

*Table 2.5: Strategies for supporting intrinsic motivation and satisfying the three basic psychological needs (from Orsini, Evans and Jerez, 2015, p.7)*

| Supporting autonomy | Supporting competence | Supporting relatedness |
|---|---|---|
| Identify what students want | Provide optimal challenges | Respect students |
| Provide different learning approaches | Provide structured guidance | Give emotional support |
| Give value to uninteresting tasks | Value students work | Acknowledge students' expressions of negative effect |
| Promote active participation | Give positive and constructive feedback | |
| Give choice | Feedback | |
| Give learning responsibility | | |
| Provide freedom | | |
| Avoid external reward | | |

The role of significant others in supporting a student's basic psychological needs has also been explored within the literature. Social-contextual factors such as a student's home life have been found to influence their motivation towards educational activities. Autonomy-supportiveness from parents has been found to positively affect self-determined motivation in students and therefore enhance educational achievement (Deci, et al., 1991; Grolnick, 2009). Friends have also been found to play a significant role in predictors of academic motivation and self-esteem (Ryan,Stiller and Lynch, 1994). While the scope of this work was limited to the context of children in primary school or adolescents in high school in the USA, similar findings have been reported among university-level students in Canada (Ratelle, Simard and Guay, 2013). The latter study found supporting students' psychological needs for competence, autonomy, and relatedness and consequent feelings of subjective well-being, came from three important sources: parents, friends and romantic partners, when the relationship was perceived as highly autonomy-supportive.

However, no studies have explored factors that influence and support nurses' motivation working in a hospital setting in relation to participation in CPD and career development through the analytical lens of SDT. Moreover, social-cultural factors motivating Egyptian nurses to undertake CPD have not been recognised within the nursing literature.

*2.8.2.4 Motivation and education and healthcare outcomes*

In an educational context, SDT examines factors which enhance students' value and interest in learning, and promote confidence in their abilities (Deci, et al., 1991). Such outcomes are produced through intrinsic motivation and the internalising of values, which promote high quality learning and enhanced personal growth and development.

As engagement and participation in CPD requires a high level of self-directedness, the concept of motivation has gained greater recognition within the HPE literature (Tjin A Tsoi, et al., 2016). Research within HPE has proposed that intrinsic motivation is more effective at stimulating learning and positively influences study strategy, academic performance and well-being in students. This has been confirmed in a study involving 383 medical students at one university in the Netherlands (Kusurkar, et al., 2013). Using a 28-item scale based on SDT, the Academic Motivation Scale (AMS) questionnaire (Vallerand, et al., 1992), Kusurkar, et al. (2013), concluded that autonomous forms of motivation, such as integrated regulation (the most autonomous type of extrinsic motivation) and intrinsic motivation, positively affected academic performance through encouraging deep strategies towards study and higher study effort. A major limitation of the study, however, was a low response rate (26.6%). Tjin A Tsoi, et al. (2016) also used the AMS questionnaire in a study involving 432 registered pharmacists participating in structured CPD courses in the Netherlands, and found that autonomous forms of motivation were positively correlated with participation in CPD. Not all types of structured CPD activities, however, were included in the study.

SDT has also been applied in healthcare environments to help with outcomes such as weight-loss or smoking cessation (Deci and Ryan, 2012). SDT supports a patient-centered approach which encourages greater autonomy among patients in their motivation for change (Deci and Ryan, 2012). Moreover, promoting autonomous motivation among HPE students encourages similar concepts to be applied in their clinical care which may lead to more effective healthcare delivery (Williams, Saizow and Ryan, 1999; Orsini, Evans and Jerez, 2015; Orsini, Binnie and Wilson, 2016).

#### *2.8.2.5 Intrinsic and extrinsic aspirations*

SDT has been reported to be linked with career satisfaction in HPE contexts. In a qualitative study involving 26 postgraduate medical students undertaking a training residency programme in two hospitals in the USA, the positive perception of well-being was found to be correlated with perceptions of their daily work, career motivation and satisfaction. While self-reports from participants may have introduced a source of bias, the findings of this study have been supported in a systematic review which investigates determinants and outcomes of motivation in HPE. High levels of autonomous and controlled motivation among HPE students was associated with higher levels of stress, depression, anxiety, burnout, dropout rate and diminished career satisfaction (Orsini, Binnie and Wilson, 2016).

SDT has also sought to understand the connection between life aspirations and life satisfaction (Nishimura and Suzuki, 2016). Studies by Kasser and Ryan (1993; 1996) in the USA have distinguished between two types of life goals: intrinsic goals, which involve personal growth, emotional intimacy or community service; and extrinsic goals which focus on the attainment of self-worth through financial success, fame or social image. The pursuit of intrinsic goals is closely associated with well-being and the satisfaction of basic needs while people with strong extrinsic aspirations have more difficulty doing so (Kasser and Ryan, 1993; 1996). Similar findings have been duplicated in various countries (Schmuck, Kasser and Ryan, 2000; Kim, Kasser and Lee, 2003). However, the generality of these findings across cultures has been questioned (Ryan, et al., 1999). Deci and Ryan (2000) acknowledge goals and values that become integrated, and the opportunities for individuals to satisfy psychological needs, can differ greatly across cultures. However, they also argue that some cultural goals and values are themselves not integrateable because they are inherently incompatible with basic needs.

Research has shown that life aspirations in rich and poor countries, and individualistic and collectivistic cultures may differ (Brdar, Rijavec, and Miljković, 2009). In collectivist cultures, individuals tend to prioritise the extrinsic goals of in-group members, such as the needs of the family, rather than follow their own intrinsic preferences (Brdar, Rijavec, and Miljković, 2009). Furthermore, while the goals of college students were found to be consistent in wealthier and poorer cultures across 15 countries, including Egypt (Grouzet, et al., 2005), deviations appeared in relation to financial success aspirations, which were more aligned with health goals in poorer

cultures than in wealthier cultures. Such findings might reflect the fact that individuals in poorer nations may strive to make money to ensure basic survival and the basic welfare of significant others, such as family members, in comparison to richer nations where such goals are a means toacquire status and nonessential assets. A limitation of the study, acknowledged by the authors, is that the limited sample of college students is not representative of the general population, especially in poorer cultures. In more recent work, Martos and Kopp (2012) found that both intrinsic life goals, as well as extrinsic goals relating to financial success had a positive association with subjective well-being among a sample of Hungarian adults rather than just intrinsic goals alone. Nishimura and Suzuki (2016) conclude that in poorer countries, extrinsic aspirations might represent how people can achieve more important intrinsic aspirations in comparison to wealthier nations.

In summary, while several theories of human motivation are discussed, SDT distinguishes itself as being a robust and effective means to analyse the social-contextual factors which affect a nurse's aspirations and motivations for their career development. As discussed in the next section, SDT was used to complement the development of a conceptual framework in order to pursue the objectives of this study.

## 2.9 Conceptual Framework

According to Varpio, et al. (2019), a conceptual framework includes a description and summary of relevant literature and theory to systematise knowledge about related concepts and identify gaps in understanding of the phenomenon under study to provide research justification. Professional development and career advancement in nurses is multifaceted in nature and therefore the scope of study meant the development of a conceptual framework rather than a single theory or theoretical framework was appropriate. However, SDT (Ryan and Deci, 2000a) emerged as a complementary means to explore perceptions relating to what motivates professional development and career advancement, and therefore is linked with the framework.

It is clear nurses engage in a variety of learning activities and are generally motivated to participate in CPD and aspire to progress in their careers (Chapter 2). Furthermore, there is evidence of a link between engagement in CPD, perceived benefits and career opportunities. The key elements required for the professional development or career advancement of nurses have

also been identified in the literature, of which social and contextual factors clearly play an important role. The literature reviewed supports the view that the organisation has significant influence on a nurse's engagement in CPD and career progression. Other factors such as managers, senior colleagues, planning and development practices as well as domestic circumstances have all been highlighted to potentially influence learning and development.

From the psychological literature and subsequent exploration of motivational theory, SDT (Ryan and Deci, 2000a) describes how social contexts supportive of the basic psychological needs for autonomy, competence and relatedness maintain or enhance intrinsic motivation, and facilitate the internalisation and integration of extrinsic motivation resulting in behaviours that are more autonomous and self-determined. Supportive environments also promote or strengthen intrinsic aspirations or goals that continually provide satisfaction of the basic needs. From the psychological, general education and HPE literature, intrinsic motivation, autonomous regulation of extrinsic motivation, and intrinsic aspirations are associated with positive affective experiences such as increased active engagement in learning activities and better mental health and well-being. However, an understanding of the impacts practices and structures have on a nurse's satisfaction in relation to their professional development and careers, is absent in the literature.

Attention *has* been paid to general perceptions of professional development and career advancement within the international nursing literature. However, an Egyptian perspective, and specifically that of Technical Diploma-level nurses within the country has not been explored. Consequently, little is known of the motivations and aspirations, and the challenges, influencing factors and opportunities specific to TDN's decision making around their professional development and career growth in Egypt. This study therefore seeks to contextualise perceptions of Technical Diploma Nurse graduates themselves, as well as nurse educators and health care managers, within an Egyptian educational healthcare context. This is important as a nuanced understanding of the factors which impact TDNs working in a lower-middle-income setting such as Egypt and help them to develop professionally and advance in their careers is required.

The literature reviewed in this chapter supports the view that the theoretical concepts underpinning the study are those of the social and cultural context and its relationship to the motivations and aspirations of Technical Diploma Nurses' professional development and career advancement. How these concepts link to the satisfaction of the basic psychological needs of

autonomy, competence, and relatedness as described in SDT, informed the conceptual framework and was the main focus of the data analysis (Figure 2.2). These aforementioned concepts will be referred to when presenting (Chapter Five) and discussing (Chapter Six) the findings of this study.

### *2.9.1 Research aim and objectives*

The aim of this research therefore was to explore and describe the perceptions of the professional development and career advancement of Technical Diploma Nurse (TDN) graduates from a private non-profit Technical Institute of Nursing in Egypt and address the following research objectives:

1. Explore TDN graduates' perceptions of their professional development and career advancement;

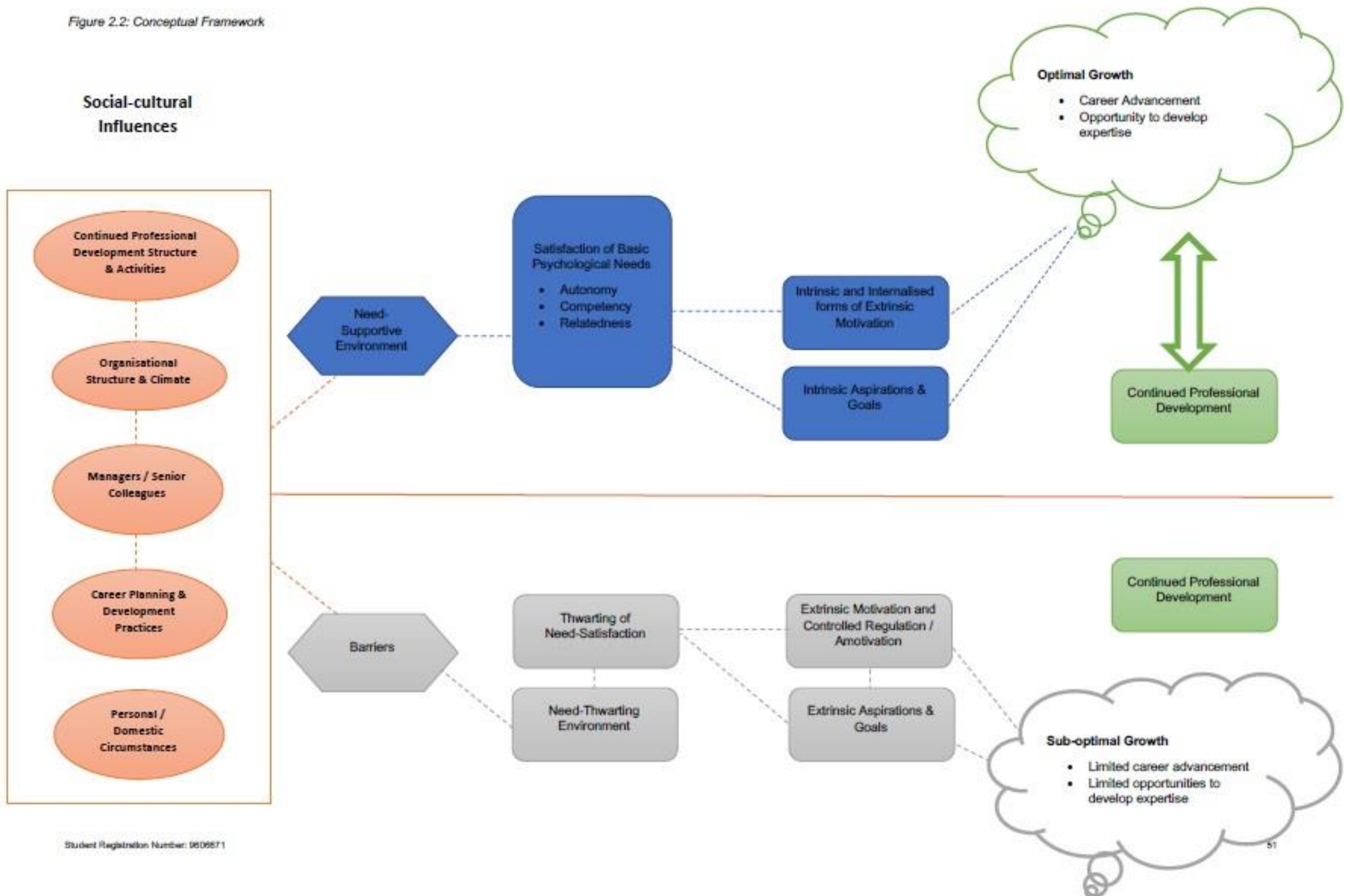
2. Explore TDN graduates' aspirations and motivations for their development;

3. Explore the challenges, influencing factors and opportunities that affect TDNs' professional development and career growth;

4. Explore senior academic nursing faculty and healthcare professionals' perceptions of TDN graduates' professional development and career advancement.

The following chapter will examine the literature pertaining to the methodology and methods utilised within this thesis.

*Figure 2.2: Conceptual Framework*



## Chapter Three: Methodology

### 3.1. Introduction

This chapter explores the theoretical issues pertaining to the methodology and methods which were employed in this study. A discussion of the philosophical stance taken in this research is presented and common qualitative methodologies are briefly described, before explaining why descriptive exploratory qualitative research was used. In addition, the specific methods for data collection and analysis are also justified in terms of the need to be sensitive to the cultural context in which the research was conducted. Strategies adopted to demonstrate rigour, and general ethical considerations are also outlined.

### 3.2 Philosophies and perspectives that underpin the research

At the beginning of the research process, it is critically important for the researcher to reflect on their own personal philosophy of social reality and how knowledge is constructed (Simmons, 1995). The choice of research questions or objectives and the rationale for the adoption of a particular research strategy, emphasising either quantitative or qualitative research, will in part be explained by the paradigmatic position of the researcher (Bunniss and Kelly, 2010). Weaver and Olson (2006, p.460) define research paradigms as '*patterns of beliefs and practices that regulate inquiry within a discipline by providing lenses, frames and processes through which investigation is accomplished'*. Each paradigm is distinguished by differing ontological, epistemological and methodological perspectives to both undertaking and conceptualising research and to their subsequent contribution to scientific knowledge (Weaver and Olson, 2006; Assalahi, 2015).

Within HPE research, numerous competing views of social sciences have been embraced (Bunniss and Kelly, 2010). Examples of such paradigms include positivism, post-positivism, interpretivism, and pragmatism (Weaver and Olson, 2006; Bunniss and Kelly, 2010; Creswell, 2014; Cohen, Manion and Morrison, 2018). Each paradigm holds a different conceptual view of science and interpretation of social reality (Cohen, Manion and Morrison, 2018). Weaver and Olson (2006) point out that no one paradigm should be viewed as superior to another.

Positivists consider natural science methods are appropriate for the study of social phenomena (Parahoo, 2014). A positivist stance hence lends itself to quantitative research strategies and is interested in universal laws to explain and predict patterns in social phenomena (Weaver and Olson, 2006; Parahoo, 2014). A deductive relationship between theory and data is adopted under this paradigm. The researcher draws on relevant theoretical ideas and what is already known about a phenomenon to generate hypotheses which can then be statistically tested (Bryman, 2016). Furthermore, from a positivist perspective, there is only one single reality or 'truth' which is independent of the actions and perceptions of both the researcher and research participants (Parahoo, 2014), and thus positivists adopt a social ontology rooted in objectivism (Bryman, 2016).

Quantitative research, however, rooted in a positivist paradigm may not always be helpful to address the *'why'*, '*how'* and '*what'* questions related to peoples' behaviours, attitudes, motives and interactions often posed by researchers within HPE (Hanson, Balmer and Giardino, 2011; Sullivan and Sargeant, 2011; Ramani and Mann, 2016). Consequently, over the decades there has been growing recognition of the value of qualitative approaches under an interpretivist paradigm within health education research and the contribution it can make to educational scholarship (Britten, 2005).

In contrast to a positivist paradigm, interpretivism rejects the idea that the scientific method can be used to study the social world (Bryman, 2016). Alternatively, it is believed that a different research process is required to study the subject matter of the social sciences, one which focuses on understanding social phenomena and giving it meaning rather than simply explaining it (Grove, Burns and Gray, 2013; Bryman, 2016). Therefore, interpretivists adopt qualitative methodologies and methods and focus on studying subjective experiences and perceptions (Parahoo, 2014). Under an interpretivist orthodoxy, theory is generated and reinforced inductively through understandings and interpretations of the social world (Cohen, Manion and Morrison, 2018). Interpretivists adopt a constructivist ontology as they conceive social reality or 'truth' to be actively and continually socially constructed and viewed from the perspective of each individual (Bryman, 2016). The interpretivist perspective gives the researcher a subjective role in the research process and the ability to acknowledge their own perspectives and their potential impact on uncovering the meanings of participants' experiences (Parahoo, 2014).

For the purposes of this research, I judged that interpretivism was appropriate to this research and adopted this paradigm. The study's aim and objectives meant it was critical to comprehensively explore and describe perceptions with TDN graduates themselves, as well as with senior academic nursing faculty and healthcare professionals. I believe that interpretivism would allow for the exploration of these multiple perspectives in-depth and provide crucial insights which numerical measurement would not offer. Moreover, an interpretivist paradigm and subsequent qualitative approach allowed me to not only to explain participants' perceptions, but importantly to *understand* them too, particularly in relation to the motivations and aspirations for professional development and career advancement of TDNs which was a focus of the study.

### 3.3 Methodology

Interpretivism aligns with a broad range of qualitative methodologies. Contemporary approaches, such as discourse analysis, narrative inquiry, case study and participatory action research, have gained recognition within HPE. Nevertheless, the three foundational methodologies discussed most frequently within qualitative research communities are phenomenology, grounded theory, and ethnography (Kahlke, 2014; Tavakol and Sandars, 2014). These frameworks share a collective goal of seeking to describe and understand human experience and behaviour from the perspective of the person who is living it. However, each methodology is derived from different disciplinary bases and has distinct approaches to the understanding of human experience, resulting in variations in how research questions are asked, as well as in sampling procedures, and data collection and analysis (Baker, Wuest and Stern, 1992; Merriam, 2009).

Phenomenology, which has its roots in both philosophy and psychology, is concerned with gaining insight into the inner 'essence' of the lived experience (Polit and Beck, 2006). Phenomenology attempts to search for truth and understanding through the lens of those being studied by exploring their subjective experiences and the meaning they attribute to them (Tavakol and Sandars, 2014). Researchers use grounded theory to generate theory in areas where there is little known or previously understood (Creswell and Poth, 2018). Grounded theory has its roots in sociology, specifically symbolic interactionism (Starks and Brown Trinidad, 2007). The aim of grounded theory is therefore to develop theories through describing and understanding the key social, psychological and structural processes which people experience within the social phenomenon under study (Polit and Beck, 2006). Lastly, ethnographic studies seek to

understand human behaviour within the cultural and social context in which it takes place (Creswell, 2012). An ethnographer aims to provide rich and holistic descriptions of the culture-sharing group under study and interpret the shared patterns of values, behaviours, beliefs and language the group adopts over time (Polit and Beck, 2006; Creswell and Poth, 2018). Ethnographers also attempt to reveal socioculturally tacit knowledge deeply embedded in cultural experiences and to make it explicit (Polit and Beck, 2006; Tavakol and Sandars, 2014).

Research questions or objectives often do not fit neatly within the traditional boundaries of a single established methodology (Caelli, Ray and Mill, 2003; Kahlke, 2014; Liu, 2016). Some research studies seek to explore the perspectives of participants involved in a particular process rather than investigate inner dimensions of various psychological phenomena, generate data to develop a theory, or explore cultural rules (Cooper and Endacott, 2007; Percy, Kostere and Kostere, 2015). Qualitative studies that do not naturally align with any specific category of qualitative research are often labelled as 'generic' (Caelli, Ray and Mill, 2003; Kahlke, 2014; Percy, Kostere and Kostere, 2015), 'basic' (Merriam and Tisdell, 2016), or 'descriptive exploratory' (Annells, 2007; Lim, 2011; Whitehead, 2013) qualitative research, or they can be simply referred to as 'interpretive' or 'qualitative' studies (Annells, 2007; Whitehead, 2013; Kahlke, 2014). Moreover, attempts have been made to classify generic approaches into genres of 'interpretive description' which Thorne, Kirkham and MacDonald-Emes (1997, p.169) describes as a 'non-categorical' alternative to inquiry, or 'qualitative description' which Sandelowski (2000, p.335) asserts should be seen as a 'categorical' and viable label for a qualitative research design.

Generic qualitative studies feature common principles of qualitative research (Caelli, Ray and Mill, 2003; Lim, 2011; Whitehead, 2013; Merriam and Tisdell, 2016). Caelli, Ray and Mill (2003, p.3) define generic qualitative studies as those which '*exhibit some or all of the characteristics of qualitative endeavour but rather than focusing the study through the lens of a known methodology they seek to do one of two things: either they combine several methodologies or approaches or claim no particular methodological viewpoint at all*'. Merriam and Tisdell (2016, p.15) describe the major characteristics of qualitative research as: '*the focus is on process, understanding and meaning; the researcher is the primary instrument of data collection and analysis; the process is inductive; and the product is richly descriptive*'. Accordingly, Merriam and Tisdell (2016) advocate the overall purpose of generic qualitative studies (as with all qualitative research) is to understand

how people make sense of their lives and their experiences. Consequently, these types of studies are interested in '*how people interpret their experiences, how they construct their worlds, and what meaning they attribute to their experiences*' (Merriam and Tisdell, 2016, p.24). Both Lim (2011) and Merriam and Tisdell (2016) maintain that generic qualitative research generally tends to reflect an interpretivist, constructivist framework. As a result, in generic qualitative studies, the research purpose statements highlight the goal of description and understanding, with sample selection, data collection and analysis also reflecting a similar interpretivist stance (Lim, 2011).

Generic qualitative approaches have been alleged to be 'atheoretical' (Neergaard, et al., 2009), and lacking a robust critical literature (Caelli, Ray and Mill, 2003) and rigour (Neergaard, et al., 2009). Nevertheless, these arguments have been highly contested. Both Sandelowski (2010) and Kahlke (2014) argue research is at no time devoid of theoretical or disciplinary underpinnings. According to Kahlke (2014, p.39), research is never designed on a 'blank slate', as it always draws from, and is built on, existing ideas and traditions. Further, a generic qualitative approach allows researchers the flexibility to utilise theoretical frameworks in their studies that make sense in the context of the research questions and design. Kahlke (2014) also asserts generic qualitative approaches allow researchers to read and think broadly about their work, offering the opportunity to draw on the strengths of existing methodologies, either by altering or developing new research designs.

Lim (2011) argues generic qualitative research is valuable for topics which have been rarely studied, for which few empirical studies or theories are available. In addition, generic qualitative research is also warranted when significant literature and theories about a topic already exist, as this gives the researcher the opportunity to explore the possibility of different concepts or understandings through an inductive approach (Lim, 2011). Similarly, Percy, Kostere and Kostere (2015) affirm generic qualitative studies are useful to describe a topic from the participants' perspective.

I believed a generic qualitative approach best aligned with the study's aims and objectives, as well as its interpretivist stance, and was therefore chosen as the most suitable methodology for this research. As mentioned in Section 2.9, the concept of the professional development and career advancement of nurses is multidimensional and hence a generic qualitative approach permitted flexibility to study this topic in-depth within an Egyptian context for which no empirical

evidence was available. The label of ‘descriptive exploratory’ (Annells, 2007; Lim, 2011; Whitehead, 2013) was used to characterise this qualitative research as it encompassed what I was seeking to achieve in this study, namely to comprehensively *explore* and *describe* the perspectives of the participants.

## 3.4 Methods

### *3.4.1 Data collection methods*

The methods used to collect and analyse data should be congruent with the ontological and epistemological assumptions of the approach taken and be able to answer the research questions or objectives (Burns, 2000). Qualitative research is characterised by adopting methods that are aimed at eliciting meaning (Morse and Richards, 2002). Generic qualitative research usually relies on a range of data collection methods, including interview, observation or document review (Lim, 2011). Moreover, the qualitative research methods for collecting data most commonly used within HPE research are focus groups and interviews (Tavakol and Sandars, 2014).

Focus groups can be defined as focused interviews which explore interactions between a group of participants to generate rich data (Mansell, et al., 2004; McLafferty, 2004). Dynamic group interaction and participation among members is the key to this method (Webb and Kevern, 2001; McLafferty, 2004). Through the group process, ideas can be explored and clarified (Webb and Kevern, 2001). For group dynamics to work well and ensure depth to discussions, there must be a perceived trust and openness between all group members and a willingness to share personal experiences (Mansell, et al., 2004). Hierarchical differences in focus group interviews may mean group members might not be comfortable to discuss issues openly (Mansell, et al., 2004). Furthermore, data generated may not represent the perspective of each participant. Instead, peer interaction may result in consensus rather than offering individual insights into the phenomena under study (Dreachslin, 1999; Stokes and Bergin, 2006).

The interview is a valuable method of gaining insight into individual participants’ perceptions (Ryan, Coughlan and Cronin, 2009; Tavakol and Sandars, 2014). Interviews can be catalogued on a continuum of either structured, unstructured or semi-structured (Burnard, 2005; Holloway and Wheeler, 2013). The degree to which the interview is structured depends on the research

questions or objectives and the philosophical orientation of the study (Rose, 1994; Ryan, Coughlan and Cronin, 2009; Ramani and Mann, 2016).

A structured interview is essentially a questionnaire administered by the researcher in person (Parahoo, 2014). The aim of a structured interview is to achieve standardisation and therefore is often deemed a quantitative method of data collection (Polit and Beck, 2006; Parahoo, 2014). In contrast to a structured approach, there are no predetermined questions in unstructured interviewing. It is equivalent to a 'guided conversation' where the researcher follows the direction of the participants' 'storytelling', loosely guided by a brief set of prompts to deal with a certain range of topics (DiCicco-Bloom and Crabtree, 2006; Doody and Noonan, 2013; Bryman, 2016). Although researchers have the ability to discuss issues deeply and generate rich data, unstructured interviews can be difficult to manage. The outcomes of the interview can be different for each participant making data analysis difficult (Doody and Noonan, 2013; Holloway and Wheeler, 2013; Cohen, Manion and Morrison, 2018). The effectiveness of this interview format also relies on the participants' ability to effectively engage in conversational storytelling (Hawamdeh and Raigangar, 2014).

A middle ground between structured and unstructured interviews are semi-structured interviews. Semi-structured interviews are the most widely used interview format and are often the primary or sole data source in a qualitative research study (DiCicco-Bloom and Crabtree, 2006; Whiting, 2008). Semi-structured interviews aim to explore in-depth experiences of participants and the meanings they ascribe to those experiences and are therefore often labelled 'in-depth semi-structured interviews' (Adams, 2010). The semi-structured interview consists of a set of predetermined open-ended questions, referred to as an interview guide or schedule (Whiting, 2008; Ryan, Coughlan and Cronin, 2009; Parahoo, 2014). Therefore, semi-structured interviews have a clear content and structure rather than a spontaneous exchange of opinions as found in an unstructured interview format. Nevertheless, this type of interview is flexible. Participants are asked all the questions from the interview schedule to ensure key topics are explored, but there is flexibility in the wording and sequence of those questions (Parahoo, 2014). The researcher also has the freedom to explore new concepts that emerge during the interview that have not been considered previously. Accordingly, additional questions may be asked by the researcher which spontaneously arise from the dialogue depending on the participant's replies (DiCicco-

Bloom and Crabtree, 2006; Doody and Noonan, 2013; Holloway and Wheeler, 2013; Bryman, 2016). The interviewer, however, maintains some control over the interview but remains largely non-directive as mainly, the interview is guided by the participant (Whiting, 2008; Adams, 2010; Parahoo, 2014).

### *3.4.2 Advantages and disadvantages of interviews*

One of the greatest advantages of interviewing is its flexibility, which allows the researcher to investigate people's views in greater depth and generate rich, detailed data about a certain topic or subject within a particular context (Kvale, 1996; Doody and Noonan, 2013; Bryman, 2016). There are, however, a few disadvantages to using interviewing as a data collection method. Interviews can be time-consuming, practically challenging, and those leading the interviews need to be trained in the technique to ensure rigour. Participants can also be subject to the 'interviewer effect', where they only reveal socially-desirable perceptions of events and opinions (Casey, 2006, p86). As a research method, the interview requires reflexivity on the part of the researcher to ensure the participant's voice is truly heard, as well as empathy and an awareness of the researcher's ethical responsibilities (Adams, 2010; Cohen, Manion and Morrison, 2018). Nonetheless, the interview remains a valuable research method and can be a positive experience for both researcher and participant (Adams, 2010). Interviews give the researcher the opportunity to observe as well as listen and can be rewarding for participants as they have an opportunity to tell their story (Doody and Noonan, 2013).

### *3.4.3 Cultural patterns of communication*

When selecting the appropriate interview style in qualitative research, it is important to consider the cultural patterns of communication which could influence expressions and behaviour of potential participants (Thomas, 2008; Hawamdeh and Raigangar, 2014; Al-amer, et al., 2018). Arab culture is highly collectivist and places value on hierarchical power structures within society, as well as social 'politeness' (Thomas, 2008; Hawamdeh and Raigangar, 2014). Conservative, religious and cultural practices also dictate interactions between members of the opposite sex (Hawamdeh and Raigangar, 2014). These factors could perhaps lead to decreased trust and non-disclosure of personal experiences between participants in focus groups within an Arab setting (Thomas, 2008). Moreover, a qualitative interview study found Arab participants were

unable to effectively develop their narratives when using an unstructured approach to interviewing (Hawamdeh and Raigangar, 2014). Semi-structured interviews, however, have been used successfully in an Arab setting (Hawamdeh and Raigangar, 2014; Al-amer, et al., 2018), as well as with participants for whom English is a second language (Barriball and While, 1994; Marshall and While, 1994).

### *3.4.4 Justification for in-depth semi-structured interviews*

The literature highlights the advantages of using complementary qualitative data collection methods within a study, such as semi-structured interviews and focus groups (Lambert and Loiselle, 2008; Morse, 2010). Nevertheless, in-depth semi-structured interviews were selected as the only method of data collection in this study for a number of reasons. Semi-structured interviews were well suited to the exploration of individual perceptions and allowed for the phenomenon under study to be explored in detail, eliciting rich and deep data which lent itself to the overall aim and objectives of this qualitative descriptive exploratory study and subsequent interpretivist framework. The flexibility of the semi-structured interview method permitted developing topics to be investigated and enabled in-depth probing but within the focus of the research. It was also deemed a culturally-sensitive method of data gathering and offered the opportunity for Phase 1 participants to speak openly about their experiences. Further, in Phase 2, the Egyptian culture of respect for those in positions of authority, dictated that I approached each participant individually, as to do otherwise, would have been construed as being disrespectful to their seniority. Participants experienced heavy workloads, which meant they may have been unable or unwilling to attend a focus group (Baillie, 2019). It was for these reasons; a focus group was not deemed appropriate for this study.

### *3.4.5 Developing a semi-structured interview guide*

To ensure effective interviews in qualitative research, it is critical to establish that an interview guide covers key constructs of importance in the literature and asks questions which deduce meaningful information related to the topic under study (Bryman, 2016). Reviewing the existing literature on the research topic is pertinent to ensure questions in the interview guide address research questions or objectives (ibid.). Kvale (1996) states that an interview question should have two dimensions: a thematic dimension that contributes to knowledge construction, and a

dynamic dimension that promotes a good interaction between the researcher and participant. A semi-structured interview guide typically entails a few broad, guiding questions, supported by sub-questions, which are either prompts or probes (Baumbusch, 2010). Prompts encourage the participant to expand upon a particular issue and re-engage in the research process if they lose their train of thought or re-focus on the subject matter if they get side-tracked. Similarly, probing questions can facilitate the researcher to draw out more information by asking the participant to elaborate on an issue. This allows the researcher to uncover deeper levels of meaning and seek clarity on the topic of interest (Ryan, Coughlan and Cronin, 2009).

It is important that questions are worded in a way that is comprehensible and relevant to those who are being interviewed (Bryman, 2016). As a result, questions should be open-ended, clear and sensitive (Doody and Noonan, 2013). Leading questions that would influence the response of the participants should be avoided (Creswell, 2012). Questions should also be organised in a logical sequence, although given the flexibility of a semi-structured interview, the ordering of questions may change, and the researcher may digress from the planned outline during the interview as required (DiCicco-Bloom and Crabtree, 2006). Bryman (2016) recommends the researcher to ask questions to collect general demographic information during the interview to help contextualise participants' responses. Finally, it is advised that the researcher become familiar with the interview guide beforehand to avoid referring to it too frequently during the process, as this could distract the participant or inhibit the natural flow of the interview (Bryman, 2016).

Discussing the interview guide with a co-researcher or academic supervisor, referred to as '*internal testing*' by Kallio, et al. (2016, p.2960), can be helpful to evaluate the relevance and meaning of interview questions. Bryman (2016) also stresses the value of conducting a pilot interview with a potential participant before commencement of data collection to identify novel issues and revise interview questions. Reflexivity during the process of establishing the interview guide is also deemed important to satisfy the researcher that questions really cover the range of issues required to be addressed (ibid.). Kallio, et al. (2016) argue these phases allow for the development of a rigorous semi-structured interview guide which enhances the trustworthiness of qualitative research. For the purposes of this research, the interview guide reflected the aim and objectives of the study and was developed from a review of the literature that focused on important

aspects surrounding the professional development and career growth of nurses (see Chapter Two). The provisional interview guide was revised by my academic supervisors for feedback on the content and clarity of questions before piloting with participants typical to those in the main research. The pilot interviews also served as another opportunity to critique the interview guide and for self-reflection (see Section 4.8.2).

*3.4.6 Interviews with participants who have English as a Second Language*

Language choice of interviews can be a critical factor when interviewing participants with other languages (Cortazzi, Pilcher and Jin, 2011). Interviewing in participants' first language is often thought to be advantageous, in that it leads to more open and expressive dialogue in which the researcher can elicit more accurate information (Cortazzi, Pilcher and Jin, 2011). Nevertheless, Cortazzi, Pilcher and Jin (2011) argue that some participants may prefer the option of being interviewed in their second, rather than their first language because their professional or topic knowledge may have been gained in the second language or they are professionals working in that language. Consequently, participants in this case may feel they are able to express their views better using their second rather than their first language.

The concept of 'face' within a culture is also a critical consideration in relation to language choice as this may mean a participant's need to preserve a positive social image may hold more weight than credibility or truth in cultures were social politeness is deemed important within society (Cortazzi, Pilcher and Jin, 2011). For example, within the context of Chinese culture, Cortazzi, Pilcher and Jin (2011) noted it is possible that interviews with Chinese participants conducted in English with a Westerner may lead to a frankness that would not be disclosed to a Chinese researcher using their native language. This is because participants can express themselves with more freedom to a non-Chinese interviewer and discuss issues that they may feel are too sensitive to divulge with a fellow Chinese person. As a result, it is essential researchers reflect on the influence of language choice at the end of an interview.

However, interviewing a participant who speaks in the context of another language and culture can threaten the accuracy of interpretation (Marshall and While, 1994). Marshall and While (1994) advocate that researchers need to implement strategies to ensure that participants, for whom

English is their second language, clearly understand the questions asked during the interview, as well as checking that the researcher's understanding is valid. Such strategies include probing, which can help to provide validation of the meaning of responses, although this should be subtle and non-threatening so as not to intimidate participants. During an interview, if a participant appears to misunderstand a question, Marshall and While (1994) suggest the researcher may replace certain words with more simple or appropriate terms to facilitate understanding, without changing the meaning of the question. It also recommended that the researcher avoids the use of examples to aid explanation or finish a participant's sentence if they are struggling for words, as this may lead responses and cause embarrassment. Alternatively, the researcher may use validating statements after each response to clarify meaning, although it is important not to appear to be rephrasing or correcting English as this may impede rapport (Marshall and While, 1994). It is also important the researcher pays attention to the participant's non-verbal behaviour to detect signs of non-comprehension, as well as the honesty of the responses (Hawamdeh and Raigangar, 2014).

*3.4.7 Justification for language choice of interviews*

I considered the possibilities of language options available (English and Arabic), as well as the implications of the language choice and its influence on the data received. For the purposes of this study, all data collection was conducted in English as all participants had studied and were working in that language. I had always conversed in English with the study population and felt confident that the English language competency of participants was adequate to conduct in-depth interviews and yield rich data. Therefore, it felt appropriate and logical to conduct the interviews in this language rather than consult interpreters and/or translators which would have impeded rapport and presented methodological challenges (Squires, 2009). Nevertheless, I was fluentin conversational Arabic which helped with rapport-building (Hawamdeh and Raigangar, 2014), and participants were instructed at the start of the interview that they could also use Arabic wordsor phrases when they felt necessary to convey meaning effectively (Cortazzi, Pilcher and Jin, 2011). The aforementioned strategies suggested by Marshall and While (1994) and Hawamdehand Raigangar (2014) were also considered during the interview process to ensure correct interpretation of questions and responses.

### *3.4.8 Analytic method*

The purpose of qualitative data analysis is to oragnise, provide structure to, and extract meaning from the data (Polit and Beck, 2006). Thematic analysis (TA) is a widely used analytic method within qualitative research and has been used across several disciplines (Boyatzis, 1998). In their seminal paper, Braun and Clarke (2006, p.79) describe TA as *'a method for identifying, analysing and reporting patterns (themes) within data'*. Braun and Clarke (2006) state a theme should capture something valuable about qualitative data in relation to the research questions or objectives and represents a level of 'patterned' meaning within the data set. These patterns are identified through a rigorous process of data familiarisation, open-coding, theme development and frequent revision. The outcome of a TA should be the creation of a rigorous narrative that addresses the research questions or objectives (Vaismoradi, Hannele and Bondas, 2013).

TA can incorporate either inductive, where coding and theme development is data-driven, or deductive strategies, where analysis is explicitly informed by pre-existing theories or theoretical frameworks. Themes can be identified at a semantic level, or at a latent level. The latent level enables the analytic process to move from description to interpretation, where there is an attempt to theorise the significance of identified patterns and their broader meanings and implications (Braun and Clarke, 2006). Braun and Clarke (2013) argue interpretation is also relevant to more descriptive studies, as they aim to both capture, as well as interpret experiences. Therefore, even in inductive and semantic forms of TA, where the analysis is descriptive and stays close to the content of the data, Braun and Clarke (2013) advocate the analysis should progress *beyond* the data to make sense of the patterns that are reported and address the '*so what?*' question. Braun and Clarke (2013) also suggest that in some studies, both semantic and latent approaches to TA may be combined. Regarding this approach to TA, the analysis is initially semantic and descriptive, and themes are reported in a straightforward way, and then moves to an interpretative approach where the researcher re-engages with existing scholarly literature, where more conceptual and theoretical issues related to the overall data analysis are explored and discussed (Braun and Clarke, 2013; Opperman, et al., 2014).

Braun and Clarke (2006) present a robust and systematic framework to performing a TA (Table 3.1). Although presented as six distinct phases, data analysis is a cyclical, rather than a linear process (Braun and Clarke, 2006). Another feature of data analysis in TA is the creation of a

thematic map which presents a visual presentation of distinctive themes and codes and their relationship (Braun and Wilkinson, 2003; Braun and Clarke, 2006; Vaismoradi, Hannele and Bondas, 2013). One of the main advantages of this version of TA as an analytic method is its flexibility (Braun and Clarke, 2006; 2014; Vaismoradi, Hannele and Bondas, 2013). Firstly, TA allows for a wide range of analytic options. Moreover, TA is not theoretically-bounded and therefore can be used across the epistemological and ontological spectrum, from realist to constructionist (also understood as 'interpretive') methods. As it is theoretically-independent, it can be underpinned by pre-existing theories or theoretical frameworks. Nevertheless, it is important that the theoretical position of the TA is made explicit (Braun and Clarke, 2006).

*Table 3.1: Phases of thematic analysis and description of the process (Braun and Clarke, 2006, p.87)*

| *1. Familiarising yourself with your data:* |
|---|
| Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas. |
| *2. Generating initial codes:* |
| Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code. |
| *3. Searching for themes:* |
| Collating codes into potential themes, gathering all data relevant to each potential theme. |
| *4. Reviewing themes:* |
| Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis. |
| *5. Defining and naming themes:* |
| Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme. |
| *6. Producing the report:* |
| The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis. |

#### *3.4.9 Justification for analytic method*

In generic qualitative research, data analysis is usually a highly inductive process with TA most commonly adopted as the analytic method to produce a rich description, identify recurrent patterns or themes across multiple individuals or cases, and contextualise and interpret findings (Lim, 2011; Percy, Kostere and Kostere, 2015). Braun and Clarke's (2006) approach to TA was therefore chosen as an analytic method as it was well-suited to the research aim and objectives posed in this study. This method was also consistent with the interpretivist epistemological and

constructivist ontological underpinnings of the research and had conceptual coherence with the chosen method of data collection – in-depth semi structured interviews. Its flexibility also allowed for conceptual framing of the findings to support higher levels of understanding and interpretation of the data.

Qualitative content analysis was considered as an analytic method for this research but was rejected for several reasons. In content analysis, themes are often based on the frequency of occurrence in the text and tend to focus on the meaning of data at a more surface level (Braun and Clarke, 2006). According to Vaismoradi, Hannele and Bondas (2013), this then risks removing meaning from its context and missing significant meanings in the text. In comparison, Braun and Clarke (2006) argue TA allows for a more detailed, and nuanced account of data which I was aiming for in this study. Furthermore, unlike content analysis, TA allowed me to consider both semantic and latent aspects of content during the data analysis process rather than viewing them as separate entities (Vaismoradi, Hannele and Bondas, 2013).

There are also a number of approaches to TA cited within the literature, such as the one described by Boyatzis (1998). Boyatzis' (1998) model fits more with what Braun and Clarke (2016, p.741) claim is a 'coding reliability' approach to TA, where a theme is '*captured*' or '*noticed*'. Braun and Clarke's (2006) 'organic' model of TA was chosen, as their conceptualisation of a theme, where themes are '*constructed*' rather than '*found*' (Braun and Clarke, 2016, p.742), helped to produce a more complex analysis which was more fitting with the exploratory and inherently subjective ethos of this qualitative research. Moreover, Braun and Clarke's (2006) criteria for TA (Table 3.1), along with their proposed checklist of good-practice (Appendix III: A 15-point Checklist of criteria for good Thematic Analysis) also brought clarity to the data analysis process, which guided and supported me in the process of conducting a rigorous and trustworthy TA.

**3.5 Rigour**

Establishing and maintaining rigour is acknowledged as a fundamental aspect of research (Mill and Ogilvie, 2003). The underlying philosophical perspectives of a study guide the criteria for rigour (Gray, 2017). Within a qualitative paradigm, sensitive to the ontological and epistemological underpinnings of an interpretivist worldview, Lincoln and Guba's (1985) concept of trustworthiness is one way researchers can ensure their constructed realities are robust and the research process is systematic (Sandelowski, 1986; Koch and Harrington, 1998; Noble and Smith, 2015). According to Lincoln and Guba (1985), trustworthiness involves demonstrating four

criteria: credibility; transferability; dependability; and confirmability (Table 3.2). Confirmability is established when the other three criteria are all achieved (Guba and Lincoln, 1989).

*Table 3.2: Trustworthiness criteria (Adapted from Lincoln and Guba, 1985)*

| ***Trustworthiness Criteria*** | ***Explanation**** | ***Examples of strategies to promote trustworthiness*** |
|---|---|---|
| **Credibility** | Confidence in the 'truth' of the findings. | • Prolonged engagement<br>• Persistent observation<br>• Triangulation<br>• Peer debriefing<br>• Member checking |
| **Transferability** | Showing the findings have applicability in other contexts. | • Thick description |
| **Dependability** | Showing that the findings are consistent and could be repeated. | • Audit trail |
| **Confirmability** | The extent to which the findings of a study are shaped by the respondents and not researcher bias, motivation, or interest. | • Audit trail<br>• Reflexivity |

**Explanation adapted from Pandey and Patnaik (2014. P.5746)*

Lincoln and Guba's (1985) concept of trustworthiness has been challenged in the literature for mirroring an interpretation of rigour parallel to a traditional positivist perspective (Sparkes, 2001). Rolfe (2006) has suggested a single set framework for assessing quality is ineffective for qualitative research, which encompasses contrasting epistemological stances, as well as multiple methodologies and methods. Therefore, each qualitative study should be assessed according to its individual merit (Rolfe, 2006). Nevertheless, Porter (2007) argued that such an 'aesthetic and rhetorical' approach to assessing quality of qualitative research as advocated by Rolfe (2006, p. 308) does not provide useful guidance for researchers and is not a viable alternative. When conducting studies that are outside of well-established qualitative theoretical traditions, Caelli, Ray and Mill (2003) affirm researchers should ensure their chosen approach to rigour is both knowledgeable and theoretically-informed and is philosophically and methodologically compatible with the study. After revision of the literature, I was confident that the criteria suggested by Lincoln and Guba (1985) were the most relevant for this qualitative descriptive exploratory study and were compatible with its interpretivist paradigm.

Reflexivity and maintaining an audit trail are important strategies in ensuring the robustness of a study, as researchers can make their rationale explicit for selected specific quality criteria and establish a transparent account of the research framework and the decision-making process (Koch, 1994; Tobin and Begley, 2004; Kahlke, 2014). According to Green and Thorogood (2004, p.194), reflexivity is '*the recognition that the researcher is part of the process of producing the data and their meanings, and a conscious reflection on that process*'. Maintaining a reflexive journal can be especially useful for researchers conducting qualitative research in Arab communities to enhance understanding of Arab culture in relation to the topic under study (Al-amer, et al., 2018). As advocated by Hand (2003), reflexivity was considered at every stage of this research project to make the whole research process transparent, providing a clear audit trail helping to generate credible findings. Green and Thorogood's (2004) dimensions of reflexive awareness: methodological openness; theoretical openness; awareness of the social setting of the research itself; and awareness of the wider social context, provided some good practice suggestions which helped me to structure the reflexive process in this study.

Reflexive notes were subsequently maintained during the planning phase, through to the data collection and analysis phases of the project and served as a log of my methodological decision-making. Given the interpretivist position adopted, maintaining reflexive notes also helped me to make explicit my personal values and assumptions and develop an awareness of, and reflect on, upon how these factors influenced the research. Lastly, meetings with my academic supervisors were also a useful platform to facilitate reflexive awareness and examine the decision-making process which promoted further ongoing self-critique and appraisal.

Lincoln and Guba (1985) recommend member checking as a useful technique for establishing credibility (see Table 3.2). However, member checking has been extensively debated within the literature and its benefits questioned, as it has been argued that ethical, practical and theoretical problems can arise with the return of data to participants (Sandelowski, 1993; Koch and Harrington, 1998; Morse, 2015). According to Varpio, et al. (2017), member checking involves the researcher presenting data transcripts or data interpretations to all or some participants for comment. Both Morse (2015) and Birt, et al. (2016) claim these methods of member checking are rooted in positivism and therefore do not fit with an interpretivist theoretical position. Furthermore, Morse (2015) argues it is questionable whether a participant would recognise their own experiences from a combined analysis of text when undertaking member checking, using

synthesised, analysed data. Consequently, the researcher should carefully consider the appropriateness of member checking for the context of the study (ibid.).

I decided not to ask participants in this study to review their interview transcripts to consider if they had been accurately recorded, or share initial or final data analyses to validate my interpretations of the data, as it was felt this was not coherent with the interpretivist stance of the study. Also, it was thought that asking participants who have participated in one interview to review analysis which covers all interviews would be of limited benefit. From a cultural stand point, I believed the returning of transcripts or data interpretations may have caused embarrassment (Carslon, 2010, p.112), which could have disrupted my relationship with participants, as some may have viewed sections of data as potentially sensitive or that their confidentiality was being compromised (Mercer, 2007).

### 3.6 Ethical considerations

The British Educational Research Association's (BERA, 2018) ethical guidance affirms educational researchers have a responsibility to multiple stakeholders, including participants. Ethical issues can arise at various stages of educational research (Cohen, Manion and Morrison, 2018), especially within qualitative research which attempts to study participants and interactions within their 'natural settings' (Sullivan and Sargeant, 2011). It is therefore imperative that the researcher thinks and acts ethically throughout each stage of the research process to ensure key ethical considerations are addressed and educational research is conducted in accordance with robust ethical standards (Bryman, 2016).

Guidelines for ethical behaviour are based on the principles of respect for autonomy, beneficence, non-maleficence, and justice, which are an invaluable frame of reference for a researcher when designing and conducting a research project (Beauchamp and Childress, 2001) and have been widely used as a framework for standards of ethical research conduct in HPE (Tavakol and Sandars, 2014). Nevertheless, both Tracy (2010) and Reid, et al. (2018) have highlighted that the emphasis on ethical thinking should extend beyond gaining formal ethical approval from an ethics committee. According to Tracy (2010), ethical thinking should not only be focused on 'procedural ethics' related to ethical approval processes, but also 'situational ethics' relating to the ethical issues that arise specific to the research context, 'relational ethics' associated with the

relationships between the researcher and participants, and lastly, 'exiting ethics' which encourages the researcher to reflect on the ethical issues that may be encountered beyond study completion.

The ethical principle of respect for autonomy implies that persons have the right to self-determination and self-governance (Downie and Calman, 1994). Ensuring voluntary informed consent is an important strategy that addresses the respect of people's autonomy in a research study (Hammersley and Traianou, 2012). Moreover, consistent with Tracy's perspective (2010), informed consent should be an ongoing dynamic process rather than a one-off step in the research process. Therefore, participants should not be subject to any sense of coercion or deception when deciding to partake in research (Scottish Educational Research Association (SERA), 2005).

The concept of beneficence refers to the researcher's duty to maximise benefits to participants and diminish harm when conducting research (Polit and Beck, 2006). Therefore, the researcher should ensure the aim of a research project is intended to 'do good' for research participants or for the wider society (Polit and Beck, 2006; Newell and Burnard, 2011). The principle of non-maleficence is closely related to the concept of beneficence, meaning 'do no harm'. Harm can be classified as either physical, emotional, social or financial (Polit and Beck, 2006). The researcher consequently has a responsibly to protect research participants from the risk of unnecessary detriment, discomfort or exploitation (SERA, 2005).

The ethical principle of justice entails there should be fair and equitable distribution of the benefits and burdens of research and encompasses the right to fair treatment (Polit and Beck, 2006). Participants should be fairly treated at all stages of the research process and preferential or discriminatory treatment avoided (Hammersley and Traianou, 2012). As a result, people have the right to decline to participate in research as well as the right to withdraw at any stage of the research process without the risk of detriment (BERA, 2018). The concept of justice also applies to issues of privacy. Privacy is invariably linked to protecting the confidentiality and anonymity of research settings and participants (Bryman, 2016). Vigorous procedures should therefore be in place to ensure privacy is upheld regarding personal information about participants, the recording

of information and the storage of data during the research process (Bryman, 2016). Recent legislation on data protection, namely the General Data Protection Regulation (GDPR), has also strengthened laws on data privacy (European Union, 2016).

Cultural competency is defined as '*developing sensitivity to the individuality of different cultural groups*' which is expressed in behaviour, attitudes and the interpretation of life events (Rashad, Phipps and Haith-Cooper, 2004, p.397). Cultural competency is accordingly required by the researcher to ensure sensitivity to cultural understanding and religious beliefs in the application of ethical guidelines (Rashad, Phipps and Haith-Cooper, 2004). Ethical considerations should also be considered when interviewing those with English as a second language to facilitate the authentic voices of participants (Marshall and Batten, 2004; Koulouriotis, 2011).

Finally, researchers should be mindful of the potential ethical challenges that may occur when conducting research amongst those with whom a pre-existing relationship is shared as possible dilemmas surrounding dual roles, potential power differentials, recruitment, trust, self-disclosure, informant bias and confidentiality can arise. In recent years, there has been an increase in the number of researchers engaging in research within their own institutions, known as 'insider research' (Greene, 2014). Insider research is defined as that which is conducted within an organisation, social group or culture of which the researcher is a member (Sikes and Potts, 2008). This contrasts with outsider research were the researcher may not have prior knowledge of the community or its members under study (Greene, 2014). Mikecz (2012, p.485) also talks of an 'informed outsider', which he describes as a neutral outsider with an inside view. However, it is suggested positionality is not static, meaning researchers do not have a single 'insider' or 'outsider' status, as researchers move continuously back and forth across a continuum as situations dictate (Mercer, 2007; Mikecz, 2012; Greene, 2014; Tuffour, 2018). Mikecz (2012) states that 'outsiders' may be perceived as less threatening and consequently more neutral and impartial than 'insiders', and therefore may be more willing to share potentially sensitive information during interviews. Insider researchers enjoy apparent advantages such as easier access, greater interaction and rapport with participants, and a more authentic understanding of the research context with which to interpret the data they collect. While insider research has been accused of being inherently biased, subject to both researcher and informant bias (Mercer, 2007; Greene, 2014), the extent to which different degrees of insiderness affect research processes

and findings has been challenged (Mercer, 2007; Tuffour, 2018). Nonetheless, it is essential that the researcher shows a commitment to rigor, especially through the use of reflexivity, to envision potential challenges that could arise so that strategies can be adopted to address them during the research process (Mercer, 2007; Greene, 2014; Tuffour, 2018). Prioritising participants' confidentiality and privacy throughout the research process (and beyond) is even more pertinent when conducting insider research (Mercer, 2007) or within small communities (Turcotte-Tremblay and McSween-Cadieux, 2018). Researchers must therefore develop and adopt strategies that protect the long-term confidentiality and anonymity of participants while disseminating findings of research (Turcotte-Tremblay and McSween-Cadieux, 2018). I had a degree of insiderness in many aspects of this work. My positionality within this study, as well as the potential ethical issues that were identified and how these were subsequently mitigated are discussed in Section 6.4.3.

### 3.7 Chapter conclusion

This chapter has discussed the main theoretical issues around the methodology and methods employed to best address the aim and objectives of this research. From a critique of the literature, a number of conclusions have been drawn which explain the choice of methods made for this study. This study is firmly interpretive in its orientation. Underpinning the whole research was an attempt to gain an in-depth understanding of the professional development and career advancement of TDN graduates in Egypt from the participants' perspective. Therefore, the approach chosen for this study was a qualitative descriptive exploratory one with the most suitable methods having been shown to be in-depth semi-structured interviews and Braun and Clarke's (2006) approach to TA. It is on the basis of this approach, a more detailed explanation of the research design which was developed and how the study was conducted will be made in the next chapter.

# Chapter Four: Study Design

## 4.1 Introduction

This chapter describes how the chosen research methodology and methods were employed throughout the course of the study and details how the subsequent research process was conducted.

## 4.2 Research aim and objectives

The aim of this research was to explore and describe the perceptions of the professional development and career advancement of Technical Diploma Nurse (TDN) graduates from a private non-profit Technical Institute of Nursing (TIN) in Egypt and address the following research objectives:

1. Explore TDN graduates' perceptions of their professional development and career advancement;

2. Explore TDN graduates' aspirations and motivations for their development;

3. Explore the challenges, influencing factors and opportunities that affect TDNs' professional development and career growth;

4. Explore senior academic nursing faculty and healthcare professionals' perceptions of TDN graduates' professional development and career advancement.

## 4.3 Overall study design

Bryman (2016, p.695) defines research design as "*a framework or structure within which the collection and analysis of data takes place*". The main intention of the study was to explore and describe the professional development and career advancement of TDN graduates in Egypt from the perspective of TDN graduates themselves, as well as with nurse educators and healthcare managers within the country. Consequently, as described in Chapter Three, a qualitative descriptive exploratory research methodology grounded in an interpretative worldview was

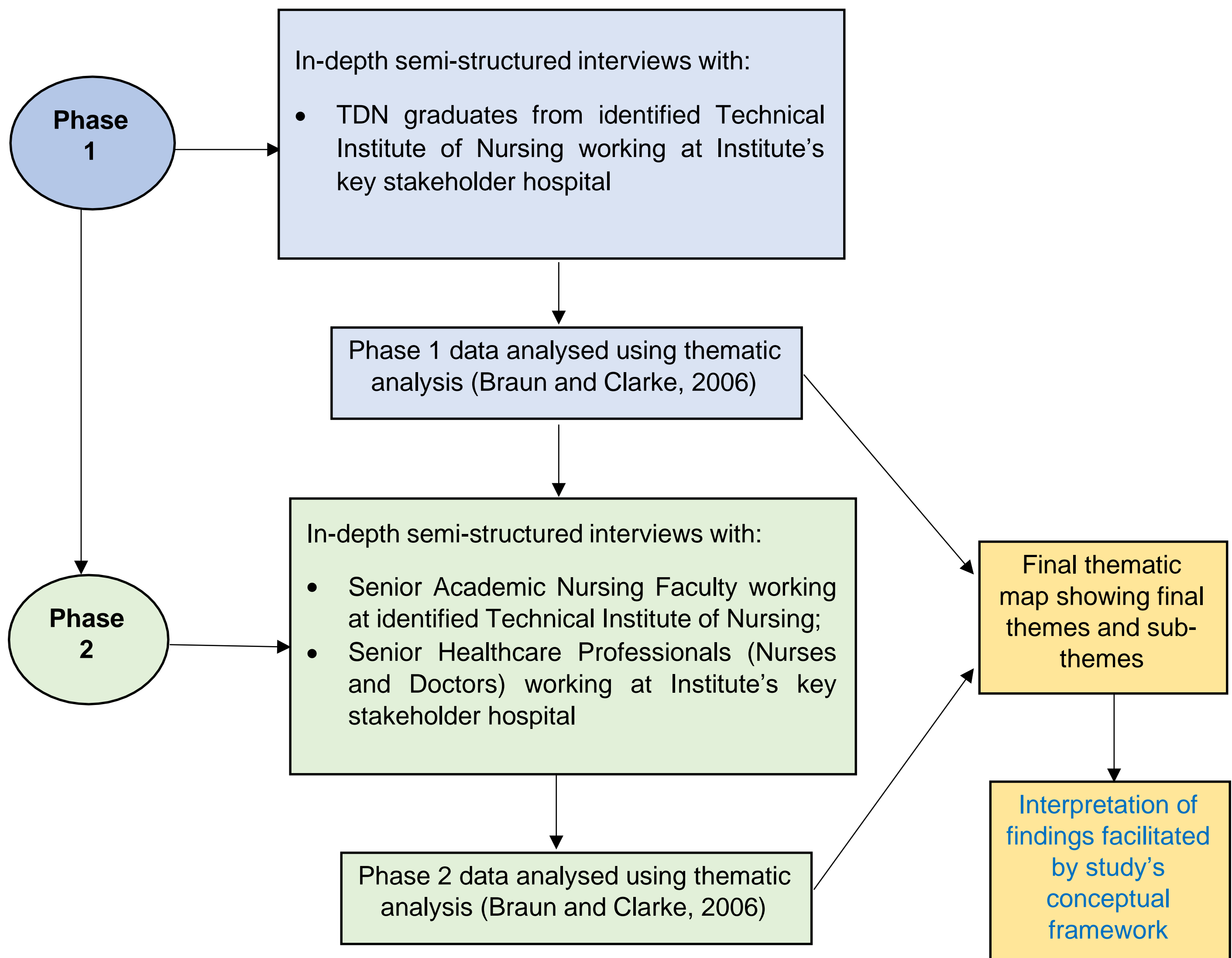
deemed most suitable for the purposes of this study (see Section 3.2; 3.3). Data were collected using in-depth semi-structured interviews (Section 3.4.4) and a thematic approach to data analysis informed by Braun and Clarke (2006) was adopted as an analytical framework (Section 3.4.9).

Qualitative studies may also include a supplemental qualitative component which may be paced either concurrently or sequentially (Morse, 2010). Morse (2010) asserts the addition of a supplementary component to a study design can enable the research aim and objectives to be met more comprehensively as it offers an opportunity to obtain other perspectives or answer a sub-question that cannot be answered within the core component. Designs using a sequential supplementary qualitative component also allows the researcher to further explore issues that have arisen from the core research (Morse, 2010). This study was comprised of two phases (see Figure 4.1) in which data collection and analysis took place sequentially rather than concurrently for several reasons. Data from two perspectives were required to meet the research objectives of this study, primarily the perspectives of TDN graduates themselves, but also those of nurse educators and healthcare managers. Phase 1 sought to gain perceptions from TDN graduates from the non-profit private TNI in Egypt, who were working at the TIN's key stakeholder hospital. Phase 1 consequently aimed to achieve an understanding of the issues addressed in the first, second and third research objective. Phase 2 of the study pursued the perceptions of senior academic nursing faculty members from the identified TIN, as well as senior healthcare professionals from the host TIN's key stakeholder hospital, regarding the professional development and career advancement of TDN graduates. Managers and education providers' perceptions were sought as they have a key role to play in fostering both the professional development and career growth of nurses (see Chapter Two). Moreover, these individuals may perceive differences in CPD and career advancement relative to the views of nurses and may influence nurses' perceptions. Phase 2 was therefore designed to address research objectives two, three and four.

Through sequential data collection and analysis, the initial findings from the Phase 1 analysis formed the development of Phase 2 interview questions. Phase 2 data subsequently sought to build directly on initial findings to provide an enhanced understanding of the issues raised in Phase 1, as well as capture different insights on the phenomenon under study. For example, a

key developing theme from Phase 1 data analysis suggested both personal and professional sources of support were important to TDN graduates for their professional development and career advancement. Therefore, a Phase 2 interview question related to this issue was '*What do you think are the key sources of support that facilitate TDN graduates' professional development and career advancement?*' and included prompts relating to different aspects of support based on arising sub-themes. This allowed for further exploration of this initial finding, leading to a richer and deeper analysis to construct the final theme and related sub-themes (see Chapter Five). In comparison, concurrent designs often aim to merge phases of research to directly compare the outcomes of data analysis (Creswell, 2014) which was not the intention of this study.

*Figure 4.1: Study Design*



Data collection for Phase 1 was conducted over a period of four months from December 2016 to March 2017. Data for Phase 2 were collected over a two-month period from September to October 2017. The interpretation of the findings was facilitated by the study's conceptual framework rooted in the SDT of Human Motivation (Ryan and Deci, 2000a) (see Section 2.9).

### 4.4 The study sites

The research site is the overall location where a study is conducted (Polit and Beck, 2006). The study was carried out within a private non-profit TIN located in a governorate situated in the southeast of Egypt, and a cardiac specialist hospital located in a governorate in Upper Egypt (see Section 1.5). As stated in Section 1.5, the TIN prepares nurses to Technical Diploma-level and has a contractual agreement with the hospital. Consequently, the majority of the TIN's graduates are hired by the hospital immediately after graduation. The overall context in which the research took place is detailed in Chapter One.

The host TIN is my place of work (see Section 1.5). As highlighted in Sections 3.6, this can present some methodological and ethical challenges. Consequently, strategies to establish trustworthiness as described by Lincoln and Guba (1985) were rigorously applied to mitigate potential issues (see Sections 3.5 and 6.4.2).

### 4.5 Access procedures

Access can be defined as the appropriate ethical, academic and organisational procedures used to gain entry to a given community for the purposes of undertaking research (Jensen, 2008) and should be considered early in the research process (Woods and Roberts, 2003). Permission to access participants for the study was granted from the two study sites prior to gaining ethics approval. Meetings were conducted with key organisational gatekeepers from both sites to facilitate access (Woods and Roberts, 2003; Høyland, Hollund and Olsen, 2015). Transparency regarding the scope, aims and findings of the research can help build mutual trust between gatekeepers and the researcher and avoid negative influences on the research activity (Opollo, et al., 2014; Høyland, Hollund and Olsen, 2015). A face-to-face meeting was therefore held with the Dean of the TIN to discuss the aim and objectives of the research in April 2016. Access was consequently granted by the Dean and the Chair of the Board of Directors of the TIN in May 2016

(Appendix IV: Access Approval Letter from Technical Institute of Nursing). Telephone meetings were then held with a member of the hospital's Executive Board and the Director of Nursing in June 2016 to discuss the study. Official permission from the hospital was subsequently secured in August 2016 (Appendix V: Access Approval Letter from hospital).

## 4.6 Ethical and management approval

### *4.6.1 Ethical approval process*

Ethical approval for the study was granted from the research ethics committee (REC) of the participating hospital in October 2016 (Appendix VI: Ethical Approval Letter from Hospital REC). The hospital does not have a Research and Development (R&D) department.

The host TIN does not have a REC or an R&D department. The research protocol was submitted to the Dean and the Chair of the Board of Directors of the TIN for review and a letter of approval to conduct the study was obtained, subject to ethical approval from the participating hospital (Appendix IV: Access Approval Letter from Technical Institute of Nursing). The ethical approval letter from the hospital's REC was later submitted to the TIN's Board of Directors before the commencement of data collection, at the Institute's request.

An application for ethical approval was submitted to the College of Medical, Veterinary and Life Sciences (MVLS) REC at the University of Glasgow in November 2016. After review, the MVLS REC were satisfied that ethical approval had been secured from the host hospital and advised that the study could proceed under the approvals already in place. Further formal approval from the University of Glasgow MVLS REC was therefore not required (Appendix VII: Email from Academic Supervisor regarding outcome of MVLS REC). Although it was not necessary to submit a revised application to the MVLS REC, suggestions received from peer reviewers regarding the wording and flow of items in participant recruitment and consent documents were addressed before commencement of the study (Appendix VIII: Response to MVLS REC Collated Comments).

### 4.6.2 Potential ethical issues

Potential ethical issues were identified during the planning stages of this study. Firstly, as acknowledged in Section 3.6 and 4.4, I was as an insider researcher in many aspects of this work as I was likely to be known to the TDN graduates. I had a pre-existing professional relationship with the academic nursing faculty from the TIN and was also likely to be known to some of the healthcare professionals from the stakeholder hospital. Nevertheless, I did not hold a position of authority or responsibility over any of the potential participants in either of the institutions. Secondly, it was recognised that as the research was being conducted in Egypt, participants could be affected by different belief systems to those of Western culture, which would also merit ethical consideration. Attention was therefore paid to respecting the sociocultural norms and values of Egyptians and was considered during both the design and implementation of the study which served to ensure the study was conducted in a culturally-and-ethically-sensitive manner.

All aspects of recruitment need to mitigate the perception of coercion, especially when recruiting participants with whom the researcher has a pre-existing relationship (McConnell-Henry, et al., 2009; McDermid, et al., 2014). Consequently, measures were put in place to ensure potential participants did not feel any sense of coercion during recruitment procedures. I strove to guarantee ongoing voluntary informed consent throughout the research process. Invitation documents were sent via a third party by email and potential participants were fully informed of the research aims and objectives and had the opportunity to ask questions prior to deciding whether to take part. It was stressed that a decision to participate was entirely voluntary and that their participation or non-participation would in no way affect their relationship with the TIN or stakeholder hospital. Informed written consent was obtained in advance of commencing the interviews and participants were advised they had the right to decline to answer any questions and to withdraw from the study at any time. Care was taken to make sure a trusting rapport was created between myself and the participants and a two-way reciprocal research relationship was upheld.

Assurances were given to participants that all information would be treated confidentially and their responses and the institutions in which they worked would be anonymised and kept securely. Data stored on a computer was password-protected and hard copies of data were kept in a cabinet secured with a lock to which only I had access. To honour the commitments made to

confidentiality and anonymity, as well as ensure non-traceability, participants were given identification numbers to safeguard their identities and only I had access to the key linking participants to identifiers (see Section 4.10.1).

## 4.7 Population, sample and recruitment

### *4.7.1 Phase 1 population, sample and recruitment*

The following criteria for inclusion in the study were stipulated for Phase 1:

- TDNs who had graduated from the identified non-profit private TIN in Egypt between the years 2013 and 2016;
- Employed at the TIN's key stakeholder hospital;
- Able to speak English fluently without the support of an interpreter;
- Provide voluntary informed written consent at the time of the interview.

The exclusion of TDN graduates working at the stakeholder hospital from other private or public Ministry of Health or Ministry of Higher Education TINs was explained by the variations in standards of educational provision and English language competency that exists between HEIs in Egypt (see Sections 1.3 and 1.5).

The target population of a study is the population which meets the inclusion criteria determined for the study (Parahoo, 2014). A sample refers to those participants chosen for a research study within the target population (Tavakol and Sandars, 2014). The target population was estimated to be in the region of 30 TDN graduates, comprised of nurses who were in the early stages of their careers having graduated four years or less at the commencement of Phase 1 data collection. As the total population (n=30) met the stipulated inclusion criteria, an invitation was extended to all the population to capture a diversity of experiences, ranging from those graduated less than one year, to those who were more established in practice. A convenience sample is one that is available and accessible to the researcher where participants are part of a target population and show willingness to participate (Parahoo, 2014; Robinson, 2014). Participants were selected based on those who volunteered and who were available during the days on which

I visited the hospital, therefore convenience sampling was utilised. No incentives were offered to participants to take part. Convenience sampling has many advantages, as it is generally easy to use and is less time-intensive than other sampling techniques. Robinson (2014) asserts convenience sampling is justifiable in qualitative research when there is a clear link between the sample and the target population. This occurs when the target population is defined as ‘demographically and geographically local’, meaning study findings are contextualised to that local level rather than ‘attempting decontextualized abstract claims’ (Robinson, 2014, p.32) which was the case in Phase 1. Self-selection bias may occur as individuals who consent to participate in interviews may be different from those who do not, in ways that are not related to the sampling criteria (Robinson, 2014). I was aware of the risk of bias and the possible impact on the study findings was considered (see Section 6.4.3).

A member of the administration team from the host TIN’s Office of Academic Student Services acted as an intermediary for recruitment purposes. TDN graduates were identified from the alumni database of the host TIN. A letter of invitation (Appendix IX: Phase 1 Participant Invitation Letter) along with an information sheet (Appendix X: Phase 1 Participant Information Sheet) were sent to potential participants via email by a member of the administration team. The information sheet indicated the purpose of the study and included details of what would be expected from participants if they decided to take part, including the format and estimated duration of the interview. Interested participants were invited to return an opt-in form (Appendix XI: Opt-in Form) by email or telephone to receive additional information about the study. If an email or telephone call was received, I then contacted the participant directly and a date and time for the interview were arranged. Four participants were initially recruited, all of whom requested to be interviewed at the hospital site. A reminder email was sent before each of my two visits to the hospital, detailing the dates and duration of the visit, the venue for interview, along with my contact details. Oral communication is more important than written to some cultural communities which means it is essential that the researcher does not rely solely on providing written information (Kim, 2011; Ismail, et al., 2014). Therefore, it can be helpful in recruiting participants to provide a personal introduction to the researcher, where the researcher explains the purpose of the study, and those who are interested in taking part have an opportunity to ask questions and discuss their concerns (Shaha, Wenzel and Hill, 2011; Ismail, et al., 2014; McDermid, et al., 2014). In the Egyptian context, where oral communication is deemed important, it was also specified in the email that I would be available each day during the visit to meet with anyone who wished to discuss the study

in person. I was available in the interview venue during the time of the evening shift handover to be accessible to those who were finishing or starting their shift. This elicited a further six participants. Others (n=7) were recruited through word-of-mouth from other participants.

Ismail, et al. (2014) assert that information provided to participants should also be clear and concise, and culturally and linguistically appropriate. Therefore, all documents provided to potential participants were written in plain English and an Arabic version of the consent form was also provided for participants at the request of the hospital's REC (Appendix XII: Phase 1 Consent Form (English and Arabic version)). A copy of the consent form was retained by both the participant and me.

*4.7.2 Phase 2: Population, sample and recruitment*

Phase 2 participants were selected according to the following inclusion criteria:

- Senior academic nursing faculty employed at the identified non-profit private TIN in Egypt;
- Senior healthcare professionals employed at the TIN's key stakeholder hospital;
- Able to speak English fluently without the support of an interpreter;
- Voluntary informed written consent was given at the time of the interview.

Stratification sampling ensures a range of different groups in a population are incorporated in a sample (Braun and Clarke, 2013). In a stratified sample, the researcher selects sub-groups based on an identified category to be purposely included in the final sample. The sample is divided or 'stratified' according to the selected sub-groups and a sample is drawn from each (Robinson, 2014). In qualitative research, stratified sampling is a specific strategy for implementing the broader goal of purposive sampling, where the researcher deliberately chooses who to include in the study on the basis of those selected who can provide 'information rich' data on the issues being researched (Patton, 1990; Parahoo, 2014). For Phase 2 of the study, a stratified, purposive sampling approach was used to select senior academic nursing faculty members from the identified TIN and senior healthcare professionals from the host TIN's key stakeholder hospital. These participants were deemed to be key informants (n=18). Participants were selected according to their position and if duties relating to facilitating the professional and career development of TDN graduates was relevant to their role. One of the advantages of using

stratified sampling in qualitative research is that it ensures a diversity of groups in the target population is incorporated into the sample (Braun and Clarke, 2013). This sampling strategy, therefore, helped to ensure the sample was representative of all stakeholders who influence TDN graduates' development, and that a diverse and more in-depth understanding of the emergent themes from Phase 1 from all perspectives was achieved.

Five categories were identified consisting of: senior academic nursing faculty members (n=5) from the identified TIN; as well as senior healthcare professionals, including a senior nurse manager (n=1), nurse supervisors (n=7), clinical nurse educators (n=2), and senior doctors (n=3) from the TIN's key stakeholder hospital. Senior academic nursing faculty members held either Assistant Lecturer or Lecturer positions within the TIN. Assistant Lecturers have been prepared to MSc level, while Lecturers hold a PhD. Their roles encompass either assistant course leader or course leader responsibilities. Consequently, they provide academic leadership to ensure effective delivery of courses and contribute to course design and development. Key responsibilities also include overseeing the provision of academic support for students. The senior nurse manager refers to the Director of Nursing who is responsible for organisational policy development related to the CPD and career advancement of nurses. Nurse supervisors are equivalent to ward or department managers. They are mid-level managers, at the level between Senior Charge Nurses and Deputy Director of Nursing. They are responsible for the operational running of the department, and they also have a supervisory aspect to their role, both in supporting junior members of their team and overseeing staff appraisals. Clinical nurse educators design and deliver in-house training courses within the hospital and have a role in the provision of orientation and supervision of new employees, including newly-graduated nurses. Senior doctors who had a sizeable role in policy development related to developing the nursing workforce within the hospital were also recruited.

Contact details of senior academic nursing faculty members were acquired from the TIN's email database. Senior healthcare professionals were selected in consultation with a member of the hospital's Executive Board and contact details were obtained from the hospital's Communication Officer. As in Phase 1, initial email correspondence was sent via a third party, by a member of the administration team from the host TIN's Office of Academic Student Services. An invitation letter (Appendix XIII: Phase 2 Participant Invitation Letter) and an information sheet (Appendix XIV: Phase 2 Participant Information Sheet) were emailed to all 18 potential participants. Those

who expressed an interest in participating were instructed to complete and return the opt-in form (Appendix XI: Opt-in Form) attached to the invitation email or to telephone and express their interest verbally. This elicited three participants.

The effective recruitment of participants is crucial to the success of a study and the initial approach made to potential subjects usually strongly affects their decision to participate in a study or not (Grove, Burns and Gray, 2013). The stratified nature of sampling in Phase 2 meant potential participants included senior academic nursing faculty from my place of work, as well as senior healthcare professionals of varying positions based at the host hospital, some of which were senior managers. I was aware that societal norms in Egypt dictated senior management positions, especially doctors, enjoy high status and occupational prestige. As a result, I anticipated some challenges in gaining access to potential participants from this specific sub-group. During the planning stages of this research, I found it useful to explore some existing literature on 'elites' (Harvey, 2011; Mikecz, 2012; Liu, 2018). Harvey (2011) defines elites broadly as those individuals who occupy senior management level positions within organisations. Understanding such types of participants' norms of behaviour and etiquette is therefore vital to facilitate access, gain trust and create rapport (Mikecz, 2012; Liu 2018). Accordingly, my familiarity with Egyptian culture proved invaluable when approaching potential participants from this 'elite' category.

From discussions with other researchers in Egypt, I realised that sending a written request to participate would be viewed as potentially insulting and disrespectful without an initial personal invitation, especially with anyone whom they viewed as an 'outsider'. The social side of professional life in Egypt is also very important. As a result, Egyptians prefer to cooperate with those they know and respect. Unlike the senior nurse faculty members who were my colleagues, I was known to only some of the Phase 2 participants and these professional relationships were not established. Cultural nuances therefore dictated that the research project was firstly introduced verbally to senior authority figures from the host hospital before invitation emails were disseminated to facilitate engagement in the study. Individual informal meetings were subsequently held with senior managers to discuss the study's aim and objectives during my second visit to the host hospital during the Phase 1 data collection. This ensured the recruitment strategy for this sub-group was culturally-sensitive and provided the opportunity to build personal and professional rapport. This led to a further two participants being recruited. As in Phase 1, all Phase 2 participants were asked to sign a consent form (Appendix XV: Phase 2 Consent Form

(English and Arabic version)) to ensure written informed consent before the interview commenced.

## 4.8 Data collection tools

### *4.8.1. Phase 1 interview guide*

The interview guide for Phase 1 was developed using methodological guidance outlined in Section 3.4.5 to contribute to the trustworthiness of the research (Appendix XVI: Phase 1 Interview Guide). The interview guide consisted of broad open-ended questions. Questions focused on participants' views of their professional development and career advancement, including their motivations and aspirations for their development and the challenges, influencing factors and opportunities which were perceived to affect this. The open-ended nature of the questions aimed to encourage participants to openly convey their views and experiences (Doody and Noonan, 2013). In addition, it allowed new concepts to emerge and to be explored during the interview. At the beginning of each interview, general information, such as age, date of graduation, number of years employed, and current position and department within the hospital, was collected.

### *4.8.2 Phase 1 pilot interview*

Pilot testing can also improve the quality of data collection and contributes to the trustworthiness of a study (Chenail, 2011; Kallio, et al., 2016). Therefore, it has a valued place within qualitative research (Morrison, et al., 2016). The interview guide was piloted in December 2016 with a newly-hired Clinical Instructor from the host TIN who most contextually represented the target population and who was independent from the main study. A second pilot interview was conducted with a TDN graduate from the target population who met the inclusion criteria.

As discussed in Section 3.4.5, conducting a pilot interview provides the opportunity for a semi-structured interview guide to be tested through which informed changes and adjustments to the interview questions can be made. Moreover, it provides the researcher with a valuable opportunity to test, develop and reflect upon their interview technique (Barriball and While, 1994; Chenail, 2011; Kallio, et al., 2016). The pilot interviews thus had several intentions. Firstly, they

presented an opportunity to pilot the interview guide to ensure questions were worded and ordered appropriately. Moreover, they offered me the chance to refine my interviewing skills in preparation for data collection. The pilots also served to ensure the approach to interviewing was culturally-appropriate and that language used during the interview was both comprehensible and relevant to participants who have English as a second language. Lastly, the pilot interviews were undertaken under the observation of two of my academic supervisors. A debriefing session was subsequently held immediately after each interview to allow for feedback and critique. I was aware that the presence of my academic supervisors could potentially have limited the ability of the participants in the Phase 1 pilot interviews to express their opinions. Accordingly, I tried to minimise any possible impact of their presence (Appendix XVII: Extracts from Reflexive Notes of Phase 1 Pilot Interviews). Doody and Noonan (2013) recommend the researcher to critically appraise the audio-recordings of their interviews to develop and monitor their interview technique in the early phases of the study. I therefore also listened to the audio-recording of the pilot interview to assist with further reflection in relation to my interview technique before conducting the next pilot interview. Minor amendments were made to the wording and ordering of questions in the interview guide as a result of the pilot interviews.

A checklist detailing the practical and technical aspects of preparation can be beneficial for researchers as preparation and planning can affect the quality of data obtained (Rose, 1994; Mack, et al., 2005; Whiting, 2008). An interview checklist was therefore developed and piloted based on guidance from the literature (Mack, et al., 2005). The interview checklist detailed the overview of procedures for the interview and served as a guide for me to ensure all steps were conducted effectively (Appendix XVIII: Interview Checklist). Extracts from my reflections on my pilot interviews for Phase 1 can be found in Appendix XVII: Extracts from Reflexive Notes of Phase 1 Pilot Interviews, illustrate some methodological and practical issues which arose and the subsequent considerations for the research plan for the larger study. Morrison, et al. (2016) advocate that pilot data can be incorporated with core research data for analysis if the pilot was conducted well and if only minor adjustments are made to data collection procedures between the pilot and main study. Therefore, on completion of the interviews in Phase 1, the second pilot interview data were collapsed into the main study. All pilot interviews were held at the host TIN.

### *4.8.3 Phase 2 interview guide*

Phase 1 findings helped to determine the most pertinent questions to be further explored during the Phase 2 interviews. The interview guide for Phase 2 of the study was consequently developed based on the key developing themes from the analysis of Phase 1 interview responses (Appendix XIX: Phase 2 Interview Guide). The guide was comprised of a set of broad, open-ended questions which focused on three key topics: TDN graduates' mechanisms for learning and development; key sources of support for TDNs; and TDN graduates' career goals and aspirations, and mechanisms for career progression. Questions were also included to stimulate discussion around perceptions of the main challenges and influences that shape the professional development and career advancement of TDN graduates, as well as how they could be best supported overall. Prompts were formulated for questions based on developing sub-themes from Phase 1 analysis and reflected the aim and objectives of the study. As in Phase 1, the interview guide for Phase 2 was firstly revised by my academic supervisors before piloting with a participant typical of the potential study participants.

### *4.8.4 Phase 2 pilot interview*

For Phase 2 of the study, the interview guide was pretested with a senior faculty member in early September 2017. The faculty member was a Course Leader for some of the general education courses implemented as part of the nursing programme at the host TIN. A debriefing session was later held with my supervisors via Skype. No amendments were made to the interview guide as a result of the pilot interview.

## 4.9 Data collection process

### *4.9.1 Phase 1 data collection*

A total of 18 in-depth semi-structured interviews were conducted for Phase 1 (17 participants and one pilot interview). Interviews ranged in duration from 44 minutes to 1 hour 36 minutes, with an average duration of 1 hour 10 minutes. All interviews were held in a seminar room in the administration department of the hospital during two separate week-long visits to the hospital in early February 2016 (n=8) and mid-March 2016 (n=9), apart from one interview (see Section 4.8.2). Interview procedures were conducted as per the steps specified in the interview checklist (Appendix XVIII: Interview Checklist).

Building trust and rapport with participants is essential for conducting successful interviews and generating high quality data (Brown and Danaher, 2017), especially within an Arab setting (Hawamdeh and Raigangar, 2014; Al-amer, et al., 2018). I tried to position myself as an 'insider' as much as possible during my contact with Phase 1 participants by implementing strategies that would dispel any power imbalances and assist in fostering trust and building rapport. For example, I tried to present myself as a researcher rather than as a lecturer (Mercer, 2007; McConnell-Henry, et al., 2009) and also dressed informally for those interviews (Dearnley, 2005). Additionally, interview rooms were arranged to promote comfort and privacy so that participants could express themselves freely (Doody and Noonan, 2013). Refreshments were also offered to participants on arrival as a sign of a hospitable welcome which is notable in Egyptian culture. Moreover, when interviewing in an Arab setting, it is important for participants know the researcher on a personal level rather than just professionally (Hawamdeh and Raigangar, 2014). I subsequently took time to engage in friendly 'chit-chat', often using colloquial Egyptian Arabic, with participants before commencing the interviews to create a relaxed atmosphere. These casual conversations were therefore imperative to establish myself as an in-group member.

Interviews were scheduled according to participants' availability due to heavy work burdens (Woith, et al., 2014). Most participants requested to be interviewed while at work during quiet periods of their shift. Therefore, some interviews were conducted *ad hoc* rather than at pre-planned times. Participants were also asked about their time limitations before commencing to make certain all questions in the interview guide could be covered within the available timeframe.

Before each interview, it was stressed that there were no 'right' or 'wrong' answers and it was the participant's opinion which was important. To elicit detailed information during each interview, prompts and probing questions were used such as, '*Can you tell me more about that?*' or '*How did you feel about that?*' to elaborate important contextual details embedded in each participant's narrative. Where appropriate, follow-up questions such as, '*What do you mean by that?*' or '*Can you develop that please?*' were used to further encourage dialogue. I used strategies suggested by Marshall and While (1994) (see Section 3.6.4), such as the use of probing and follow-up questions to help clarify meaning and validate participants' responses. This was conducted subtly to appear non-threatening. Moreover, I also tried to refrain from using contextual

examples to facilitate understanding (Hawamdeh and Raigangar, 2014), or asking leading questions to avoid influencing participants' responses which helped me to adopt a neutral approach (Kvale, 1996; Adams, 2010). Overall, I strove to establish an informal conversational style approach to interviewing. As I gained confidence, the interview guide served more as a checklist to ensure all topics were covered rather than a rigid set of questions.

Participants were given the opportunity to pause the interview if required. In addition, participants were given the chance to add any further points or elaborate on issues previously discussed before the interview ended, to ensure all issues deemed important to their perceptions of their professional development and career growth were expressed. At the end of the interview, time was also given to debrief when sensitive topics were raised, for example, regarding the impact of family and marriage on CPD and career development. Furthermore, verbal guidance on issues discussed during the interview was provided by me when requested. All interviews were digitally audio-recorded on obtaining consent.

Reflexive notes were kept during data collection and were written immediately after each interview and later expanded. In these notes, I documented important aspects of participants' responses, observations of body language, mood and behaviour (Hawamdeh and Raigangar, 2014), as well as initial thoughts and ideas for data analysis (Tong, Sainsbury and Craig, 2007). Adequate breaks between interviews, along with debriefing sessions with academic supervisors, where appropriate, can allow for reflection on the researcher's interview skills and facilitate the resolution of issues (Kvale, 1996; McConnell-Henry, et al., 2009). Therefore, no more than two interviews were conducted in a day to allow me the opportunity to reflect on each interview session before commencing with the next. Additionally, six out of the eight interviews conducted during the first visit to the hospital were transcribed by me before the second visit to the hospital in March 2016. This allowed me to study the transcripts and evaluate participants' responses and reflect on and refine the interview technique before the next round of interviews.

#### *4.9.2 Phase 2 data collection*

Five in-depth semi-structured interviews were conducted for Phase 2 of the study. As in Phase 1, the same interview procedures were utilised (Appendix XVIII: Interview Checklist). For senior academic nursing faculty members (n=2), one interview was conducted in the host TIN's meeting

room, while another was held in a faculty office. All the interviews involving senior healthcare professionals (n=3) were held in the office of the Director of Nursing in the host hospital during a visit in mid-September 2017. Interviews lasted between 30 minutes and 1 hour, with an average duration of 45 minutes.

Due to the stratified nature of phase 2 participants, it was important for me to gauge the tone of each interview and adjust my interviewing style appropriately (Harvey, 2011, p.439). I did this by observing and assessing the visual and verbal cues of participants early on in each interview and responded accordingly to help to make participants feel comfortable and build rapport. I envisioned a potential status imbalance between participants who held 'elite' senior management positions, and myself as the researcher, which could possibly negatively influence my ability to build trust and rapport. Given that appearances are very important to Egyptians, I was therefore conscious to dress in formal and conservative clothes and address participants by their appropriate titles to help to present myself professionally, decrease any potential power imbalance and improve the quality of their responses (Mikecz, 2012; Liu, 2018). Lastly, as in Phase 1, flexibility was important to fit with participants' busy work schedules.

### *4.9.3 Data Saturation*

The sample size of a qualitative study is typically small (Morse 2000; Tavakol and Sandars, 2014). The concept of data saturation as referred to by Saunders, et al. (2018) aligned with the interpretivist nature of this qualitative descriptive exploratory study and therefore served as a guide to enable decisions regarding sampling. Saunders, et al. (2018, p.1896) defines saturation as a '*matter of identifying redundancy in the data, with no necessary reference to the theory linked to these data; saturation appears to be distinct from formal data analysis*'. Therefore, the researcher identifies the degree to which new data repeat what was expressed in previous data, indicating the time to stop data collection and proceed to formal data analysis (Saunders, et al, 2018). Determining saturation should be an ongoing, incremental process (Saunders, et al, 2018). Ongoing analysis of my reflexive notes taken throughout the data collection process therefore served as a useful tool to aid decision-making as to when to stop with data collection and progress to data analysis, along with critical discussions with my academic supervision team (Braun and Clarke, 2016; Malterud, Siersma, and Guassora, 2016).

## 4.10 Data analysis process

### *4.10.1 Phase 1 data analysis*

Data analysis for Phase 1 was undertaken over a period of five months, from April to August 2017. Analysis was carried out using an inductive interpretative approach, informed by Braun and Clarke's (2006) six stages of TA (see Section 3.4.8, Table 3.1). As advocated by Braun and Clarke (2006), data analysis was a cyclical process. Data was analysed manually using a traditional paper-based approach in conjunction with Microsoft Word (v2013) (Hahn, 2008) and Microsoft Excel (v2013) (Bree and Gallagher, 2016) to support organisation and storage of data. Qualitative data analysis software packages, such as NVivo 11 for Windows, were initially considered to support data management. Although such analysis tools have recognised advantages in facilitating the data analysis process (Burnard, et al., 2008), manual techniques were used as it helped me to visualise and contextualise the data more easily (McLafferty and Farley, 2006).

All the interview tapes were transcribed verbatim into electronic format via Microsoft Word (v2013) by me. This enhanced familiarity with, and allowed me to become immersed in the data (Braun and Clarke, 2006). This also avoided potential misinterpretation during transcription which may have occurred if the data was transcribed by an audio-typist unfamiliar with the accents of participants who have English as a second language (Marshall and While, 1994). Names and locations were removed, and participants were referred to by their codes, for example, '*P5*' (participant #5), and me as '*F*' throughout the transcripts. As suggested by Braun and Clarke (2006, p.88), to ensure a '*rigorous and thorough orthographic*' transcription, every transcript was examined for accuracy by checking it against the original interview audio-recording before coding began. All the interview transcripts were then re-read carefully numerous times to gain an overall sense of the data, and simultaneously, notes were made on possible codes, patterns, and areas of interest or significance that were identified (Braun and Clarke, 2006). The reflexive notes written during data collection were also reviewed at this stage (Marshall and While, 1994; Ranney,et al., 2015). Analytic notes on concepts and patterns developing from the data were also documented throughout the analysis process.

Initial codes were developed from these analytic notes to produce an inductive bottom-up coding system and coding was systematically undertaken on the entire data set. Throughout the analysis

process, codes were continually revised, and new codes generated. In some cases, more than one code was applied to a text segment. This is justified by Braun and Clarke (2006) who highlight that no data set is without contradiction and the overall conceptualisation of the data patterns and relationships between them is not always smooth. Coding was undertaken on Microsoft Word (v2013) using the 'New Comment' feature. After all the transcripts were coded, each code and assigned meaningful unit of text from individual transcripts were extracted to create a table on a new Microsoft Word (v2013) document using a modified version of the Microsoft Word (v2013) 'Macro' feature. The table included columns detailing the participant's identification number, page number, the text segment, the assigned code, and the date the code was created. This information was useful to trace the origins of the code and text segment in the refinement process in the later stages of analysis. An example of this process from one Phase 1 interview transcript can be found in Appendix XX: Extracted Codes from a Phase 1 Interview Transcript. The tables created from each transcript were then copied and pasted onto a Microsoft Excel (v2013) worksheet to create one large table. Codes with assigned text sections were then collated into alphabetical order using the 'Sort and Filter' feature. This table was then printed as a hard copy and each code and text section were cut out individually to allow me to manually categorise the codes into groups, as well as search for duplications, or overlapping and similar codes. This allowed for reduction of the initial coding to produce a refined list of broader codes (Burnard, et al., 2008). After this, I referred to the Microsoft Excel (v2013) worksheet and a colour was assigned to each initial code and corresponding text section, according to the broader code it was allocated (Bree and Gallagher, 2016). The 'Sort and Filter' feature was then applied again to produce groups of codes of the same colour for every broader code. Each coloured group was then copied and pasted onto separate Microsoft Excel (v2013) worksheets and a brief description was written for each broader code to clearly define its meaning (Bree and Gallagher, 2016). Appendix XXI: Example of Reduction of Initial Codes, illuminates how initial codes were collapsed into the broader code of 'Geography' in Phase 1 data analysis. Regarding some units of text which were allocated to more than one initial code, the code and related text were duplicated, colour coded and placed in the worksheets belonging to the relevant broader categories (ibid.).

The broader codes along with their related brief descriptions were printed as a hard copy and cut out and arranged into potential 'candidate' themes and sub-themes on a poster board which helped me to understand and clarify the patterns and relationships among the data (Braun and Clarke, 2006). From this, an initial thematic map was developed (Braun and Wilkinson, 2003;

Braun and Clarke, 2006). Assigned coded text extracts were re-read, then checked against their allocated themes and sub-themes to ensure there was a comprehensible pattern. The entire data set was then re-read numerous times at this stage to ensure the themes overall were a truthful reflection of the meanings apparent in the complete data set (Braun and Clarke, 2006). Broader codes and thematic categories were further revised and collapsed, and collated text sections were rearranged accordingly to produce a more developed candidate thematic map (Braun and Wilkinson, 2003; Braun and Clarke, 2006).

#### *4.10.2 Phase 2 data analysis*

Phase 2 data analysis was conducted over a period of three months from November 2017 to January 2018. The thematic framework developed in Phase 1 was applied systematically to code all data collected during Phase 2 data analysis and revised to incorporate newly-generated codes as appropriate. Through a process of refinement, a final thematic map was then produced, showing the final themes and sub-themes (Braun and Wilkinson, 2003; Braun and Clarke, 2006). Themes and sub-themes were clearly defined, in that they were named and a short narrative detailing the essence of each theme was then written (Braun and Clarke, 2006).

Once a clear sense of the final thematic map was gained, I moved from a descriptive semantic form of analysis and progressed to a more interpretative approach to investigate the broader meanings and implications of the themes through engaging with the existing literature (Frith and Gleeson, 2004; Braun and Clarke, 2006; Bree and Gallagher, 2016). Vivid and illustrative exemplar quotes, which reflected the themes and related the analysis back to the research objectives and literature, were then selected (Braun and Clarke, 2006).

To ensure transparency of the interpretation of the data, I shared analytic documents with academic supervisors which were regularly discussed at supervision meetings throughout the data analysis process. For example, analytic notes were used to report back developing ideas and themes (Bryman, 2016) (see Section 3.5).

### 4.11 Chapter conclusion

This chapter has outlined the specific approach used in this qualitative descriptive exploratory study. The following chapter will present an account of the findings of the analysis.

## Chapter Five: Findings

### 5.1 Introduction

This chapter presents the findings of this qualitative descriptive exploratory study. The findings are organised and presented to address the research aim and objectives. In keeping with a qualitative paradigm and the analytical method of thematic analysis (TA), exemplar quotes are presented to illustrate themes and produce an analytical narrative of the data (Braun and Clarke, 2006). Some exploration of the findings in relation to the study's conceptual framework, embedded in the lens of SDT of Human Motivation (Ryan and Deci, 2000a), is presented in the narrative of this chapter, with further interpretation and discussion of the study's pertinent findings presented in Chapter Six. Participant interview numbers are used when presenting data extracts to protect confidentiality and anonymity (see Section 4.6.2). Moreover, all participants are referred to as female, unless specified, to further ensure anonymity.

### 5.2 Characteristics of participants

In Phase 1, a total of 18 out of 30 (60%) of the total population of TDN graduates who were invited to participate in Phase 1 of the study, were recruited and interviewed. Seventeen participants were interviewed and one pilot interview who met the inclusion criteria for the study was also included for analysis (n=18) (see Section 4.9.1). Out of the 30 participants invited in Phase 1, 11 did not reply to the invitation. One participant responded to the invitation, but an interview could not be arranged. No participants withdrew from Phase 1 of the study.

For Phase 2, a total of 18 participants were invited to participate (see Section 4.9.2). This resulted in a sample of five participants (28%). All participants who expressed interest in Phase 2 of the study were interviewed. As in Phase 1, no Phase 2 participants withdrew from the study.

In Phase 1, novel data regarding TDN graduates' perceptions of their professional development and career advancement stopped arising after 15 interviews, plus one pilot interview. However, another two interviews were conducted after this to ensure no new concepts were expressed. Only a total of five people accepted the invitation for interview in Phase 2. The number of potential Phase 2 participants numbered significantly fewer than those from Phase 1. These participants

were more difficult to recruit, given the bureaucratic and social barriers which arose due to their position as discussed in Section 4.7.2. Moreover, time was also an important factor for all Phase 2 participants which may also have influenced decisions to participate in the research. This may explain the difference in numbers with regard to recruitment between Phase 1 and Phase 2. However, I became aware that participants in Phase 2 were re-iterating what I had already found in Phase 1, and whilst this was useful to facilitate understanding, no new data evolved duringthe fifth interview.

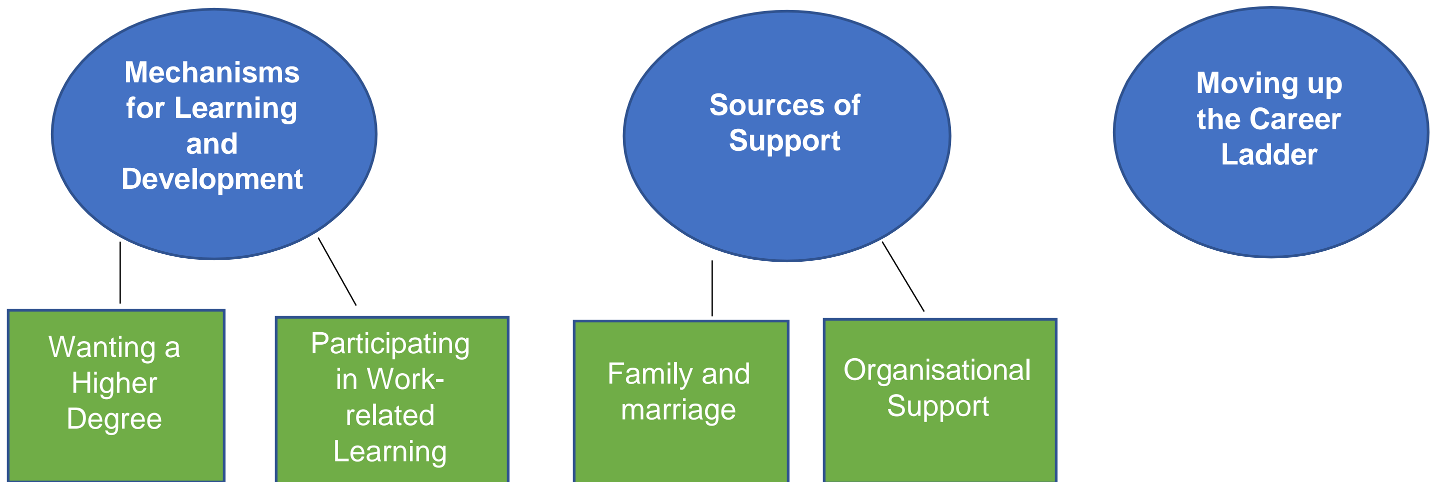
Appendix XXII shows the broad characteristics of the Phase 1 participants in terms of age, gender, graduation date, job position, specialty and whether they were enrolled to study for a higher degree at the time of interview. For Phase 2, two senior academic nursing faculty and three senior healthcare professionals were interviewed (see Appendix XXII: Participant Characteristics). The explicit job categories of Phase 2 participants have not been specified to protect the anonymity of participants.

### 5.3 Presentation of overall findings

Three main themes were constructed from the data: 1) mechanisms for learning and development; 2) sources of support; and 3) moving up the career ladder. Within the themes 'mechanisms for learning and development' and 'sources of support', sub-themes were also identified. The themes and sub-themes are depicted in Figure 5.1. The final thematic map is presented in Appendix XXIII which details how the final three themes were derived from sub-themes and broader codes. Descriptions of the final themes and sub-themes are found in Appendix XXIV. Issues which were found to be important to TDNs in Phase 1 were also highlighted by Phase 2 participants and provided further insight and a deeper understanding of the findings. However, differences in educational preparation between Phase 1 and Phase 2 participants, and the nature of TDNs' clinical role, versus the educational and administrative positions of the stakeholders, meant that the amount to which some topics were described by the two cohorts differed. This especially relates to perceptions of barriers to engage in formal and informal leaning, and aspects of feedback and support for development. These differences and

their impact on the findings of this research are further discussed in Chapter Six (see Section 6.2.4).

*Figure 5.1: Themes and sub-themes*




The various themes and sub-themes will be discussed in more detail below.

### 5.4 Mechanisms for learning and development

The first theme arising from the TA was 'mechanisms for learning and development', and the findings related to this are discussed below.

#### *5.4.1 Wanting a higher degree*

A sub-theme of the theme 'mechanisms for learning and development' was 'wanting a higher degree'. It was clear from the interviews that the TDN graduates placed a high value on higher education. A total of six (33%) graduates were enrolled in formal academic study (Appendix XXII: Participant Characteristics). For those Phase 1 participants who were not enrolled in a higher degree at the time of interview, all verbalised they aspired to join a degree course in the future:

> *P10: 'I want to do the Bachelor degree.'*

Some Phase 1 participants were highly motivated to continue their academic studies beyond a Bachelor's degree, and study to Masters or doctoral level:

*P14: 'I need the Doctoral degree, but I need to do my [Bachelor's] degree first, not depend on the [Technical Diploma] Institute. It's like stairs, I will take it one by one, one by one … When I finish my [Bachelor's] degree, so I will take my Masters degree and then the Doctoral degree after that.'*

*5.4.1.1 Competing in the certificate system*

Motivations to engage in formal academic study, however, stemmed from what was described as a system of 'certificates' in Egypt; for example, gaining a higher degree such as a Bachelor's degree, where career progression is centred upon academic credentials. This was clearly having a negative influence on Phase 1 participants' sense of fulfilment of their psychological needs which is key to intrinsic motivation:

*P15: 'I know that I'm qualified but here in the country you have to be certified, it's more important'.*

Within the stakeholder hospital where the Phase 1 participants were working, promotional opportunities were based on a performance appraisal system. However, this is not the norm in Egypt, as other hospitals, both in the private and government sector, rely solely on academic certificates rather than other promotional criteria, such as clinical competency. One Phase 1 participant described how she had been motivated to do a degree because of distinctions made between nurses in healthcare organisations in Egypt according to their level of preparation which was clearly thwarting her sense of relatedness:

*P14: 'I want to do the degree for development, to move from one level to another level, from the [Technical Diploma] Institute to a Bachelor degree … In Egypt, they make a difference between the person who have a degree and the nurse who have a Diploma. This is the only hospital in Egypt who [are] hiring and make me in a higher level, but in other areas [hospitals], if we have two nurses … one have [Technical Diploma] Institute and the other just graduate[d] from the university and she didn't have good knowledge and skills, she will take the one who graduated from the university.'*

Another Phase 1 participant also discussed the discrepancies in salary between TDNs and university-prepared nurses:

*P9: 'Also from the salary point of view … in the centre [hospital], they don't differentiate between the Bachelor and the Institute [of Nursing] but in another hospital, if you have the Technical Diploma you will take a less salary than the Bachelor degree even if you are more experienced than them!'*

A Phase 2 participant also explored this issue:

*P19: 'It's the Egypt culture … if you are going to the Ministry of Health [hospital] and you are highly graduated this will affect you, and this will give you a higher position … if you are graduated from the faculty of nursing [university], rather than a Technical Diploma … they are not looking for the quality, they are looking for the certificates!'*

Without a higher degree, Phase 1 participants expressed their career development would be limited. This was evidently frustrating their need for autonomy. One Phase 1 participant explained that she wanted to gain a higher degree to secure promotional opportunities if she decided to leave the stakeholder hospital in the future:

*P15: 'I would like to live anywhere … get the best contracts … If I want to leave here [the hospital] for any reason, it will not limit my choices, there will be many choices for me … so I can pick up the best one rather than something [that] is obligatory … no, I can take my time to think and tell them my terms … it will be powerful.'*

A Phase 2 participant similarly described how the promotional structures in Egypt extrinsically motivated TDN graduates to obtain a higher degree:

*P21: 'They look for a higher degree because of a sense of insecurity, we are a country of certificates! You deal with certificates … "My name is [participant's name] and I have a Master's degree in Hospital Administration, or my name is [participant's name] and I am a Technical Nurse." This nurse may be the best nurse I have ever seen, but outside [the hospital] she may not find job … a good job! We are a country of certificates … "What's your name and what [do] you*

> *have?" … so, it's about security, I should have a higher degree so I can work in any place … just [a] certificate to have in my CV [Curriculum Vitae].'*

Some of the Phase 1 participants described how this culture of 'certificates' had often left them feeling undervalued and 'stigmatised' as a TDN, which again was hindering their sense of relatedness:

> *P4: 'The problem that it's a stigma here in Egypt. They just classify you or put you in your category according to your degree regardless … they are not looking inside you, assessing your knowledge or level. When they know that you are a graduate from an [Technical Diploma] Institute they say, "Oh she's not qualified to do this job", because I sent my CV to several institutions, but in the end, I got an answer no because they are looking for a higher degree regardless all of your achievement.'*

Consequently, many Phase 1 participants stated they wanted a degree to affirm their abilities and be on the 'same level' as their colleagues:

> *P15: 'It will give me a better chance if any promotions are available, it will give me a higher chance … If I'm [from a Technical] Institute and someone else is [has a] Bachelor degree … you know that you are better than her, but in the eyes of the certification she is better, she has a Bachelor degree … so in terms to be in the same level or to be in the same degree, so you have to have a Bachelor degree.'*

#### *5.4.1.2 Perceived deficiencies in Bachelors' provision*

Although holding a degree was pivotal to career advancement, it was suggested that completion of a Bachelor degree programme would have little impact on professional development due to the perceived poor standards of education in Egypt. This was a great source of frustration for both Phase 1 and 2 participants and was negatively impacting on the graduates' satisfaction of the basic need for competence. One Phase 1 participant who was enrolled in a Bachelor degree described her experiences of teaching and learning on this programme:

*P8: 'The university don't give me extra knowledge, they just come in and put on the PowerPoint, that's it … you understand or not, they are not caring … and in the lab there are a lot … 50 students in one bed, you don't see the [simulation] doll, how they do the procedure … In the clinical they come in the morning, take the absenteeism and then say this sheet must be completed by the end of the day and you don't see their faces at all.'*

A Phase 2 participant explained why TDNs are still motivated to obtain a Bachelor degree despite these perceived issues:

*P19: 'I don't think there are much benefits to join the [local university Degree program], but again that is not the concept of Egypt … .when they people hear you are a Diploma nurse they say huh ok, she imagine that you don't have any information, that you didn't learn in a good way … you didn't learn in a good place, you will know nothing and I am better than you.'*

Some Phase 1 participants noted that they were going to do a Bachelor degree to 'have a piece of paper' and many felt that the current system in Egypt left TDNs no choice but to complete a degree if they wanted to progress in their careers. This was a clear example of how career structures for TDNs within the country were pushing the graduates to strive for purely extrinsic rewards:

*P4: 'Actually, I'm sure that they are not going to add for me anything from the perspective of knowledge or skills … they are just going to give me a piece of paper that prove I got this because the level of education, in Egypt as you know is, especially in the nursing field, is not good.'*

One of the Phase 2 participants expressed the same sentiments:

*P19: 'They feel that if they get the [Bachelor] certificate they will be released … it is not the highest, there is still the Masters or the Doctoral, but she will feel at least she has the [Bachelor] degree … instead of saying she is from the high school or the Institute … it is something wrong as a culture, and that affects them. When they are affected, they start to think I have to have that certificate … you will gain*

> *nothing, you will gain nothing from the study truly … but you have to have it, she have to have it.'*

Some Phase 1 participants expressed their frustrations that a higher degree would not contribute to their professional development. This was thwarting their aspirations to grow in competence:

> *P16: 'I was just asking her [a colleague who was undertaking a Bachelor degree] about the lectures and clinical practice and she said, you are just dreaming … so I said to her, I will not study? So why I have to do it? You know, it's just a way to get a certificate, and I don't like it, I want to study!'*

*5.4.1.3 Accessing higher education*

Accessing tertiary education presented a challenge for most Phase 1 participants. The educational infrastructure was poor outside the capital, Cairo, and there was a lack of educational opportunities available to the TDN graduates, as the hospital was located in Upper Egypt. Limited access to professional development failed to address the graduates' needs for autonomy and competence:

> *P12: 'The problem here [in the local area], it's so closed … you cannot make anything, just working … but in Cairo it's open, you can take a Diploma of Infection Control, Diploma of Hospital Administration, Diploma of Quality … a lot of branches … You can do it [a degree] inside your field.'*

A Phase 2 participant also discussed the issues of access to education:

> *P22: 'You know most of continuing education [is] in Cairo … so access to go through that, it is really an issue.'*

Tertiary education is also not tailored to adult learners. Degree programmes are inflexible and delivered via traditional face-to-face methods. Part-time or distance options to study are also not widely available. This was discussed by one Phase 2 participant:

*P19: 'For continuous education in Egypt there is a lot of challenges, especially in nursing. It is not well structured yet … no online courses, no programmes for development … you can find it outside Egypt … there is a lot online, exam, credit hours, but there are no such things in Egypt.'*

Phase 1 participants often described being faced with the dilemma of having to decide whether to stay at the hospital or resign from their position and pursue a Bachelor degree in Cairo:

*P16: 'I don't want to leave here [the hospital], I can't live in Cairo … I don't like this, but I have to find a way … I will not be willing to do it but if I don't have a choice, so I will.'*

Some Phase 1 participants also spoke about the difficulties of living in Cairo:

*P14: 'The way in Cairo not easy, housing, driving … and also the financial issues … it's a big issue in Cairo.'*

Having to go to Cairo to complete their studies also presented issues for the female TDN graduates as described by one Phase 1 participant:

*P16: 'It's a very crowded country [city], it's a big country and I can't, you know … I can't walk alone, I can't, I can't know the places … transport ... for me it's difficult, and I don't like to be alone … being alone is scaring me.'*

Opportunities for study leave or funding were also not widely available. These issues were not described to the same extent by Phase 2 participants in comparison to those TDNs interviewed in Phase 1. Private universities were the preferred option to government universities as they were deemed to provide a better standard of education. Nevertheless, private university fees were expensive which was frequently cited by Phase 1 participants as a challenge in continuing their education. Moreover, the cost of living in Cairo was also expensive. Monetary concerns associated with professional development limited choices and therefore unsupportive of the basic need for autonomy:

*P17: 'The first thing would be about money … if I have enough money to join the university, to attend lectures, to have enough money in my pocket … it will be effective. If I don't have enough money it will be a big challenge.'*

The economic crisis in the country also presented further challenges for Phase 1 participants to cover costs:

*P15: 'In Egypt, financial … financial influences everything because about the [USA] dollar issue, so the economical status of the country … everything now is like double or triple, so it will be difficult for the preparation [the Bachelor degree] because you are paying triple the money you were paying before.'*

Consequently, Phase 1 participants also stated that they would have to continue to work full-time hours while studying to pay university fees and meet living costs:

*P2: 'It's all about the financial issues, like I'm paying for the education, I'm paying for transportation, I'm paying for everything … so if I'm not working I cannot pay, I cannot pay for everything.'*

This is difficult as nurses in Egypt have long contracted working hours making it challenging for the Phase 1 participants to work and study at the same time. However, these issues were not emphasised to the same extent by Phase 2 participants. Heavy workloads subsequently reduced the TDNs' sense of autonomy, making it harder to achieve feelings of competence:

*P15: 'The Bachelor will be difficult because you have to be regularly in the college, so it will be difficult to do it beside my work.'*

Phase 1 participants spoke of their anxieties of feeling overloaded, trying to work and complete their Bachelor degree, as well as the effect it may have on their work and academic performance:

*P3: 'Work and study at the same time … In Cairo, it will be working beside the study, but it will be so difficult and maybe I make a mistake for the patient cause I didn't sleep well … it will be risky.'*

Moreover, Phase 1 participants discussed the problems they faced trying to balance their studies and fulfil their personal commitments:

> *P5: 'The challenges now are seeing my family, cause I have one day off the first semester, so one day I return to my family and I return back the two days, without working … if I work next semester, no days for my family, and it's not easy for me, it's difficult because my dad … need to take care of him.'*

### *5.4.2 Alternative study options*

A recent collaboration between the stakeholder hospital and a new local university Technical Degree programme in Upper Egypt was seen as a solution to some of these issues. For example, it meant nurses working at the hospital could study locally. Moreover, the Technical degree programme was shorter in duration in comparison to a Bachelor degree; only three years in comparison to four or five years in some cases. This development, to an extent, increased access to post-registration education and contributed to the satisfaction of basic psychological needs for some TDNs. Some advantages of this Technical degree over a traditional Bachelor degree programme were discussed by a Phase 1 participant:

> *P11: 'I think the difference is in the duration of learning … in the Technical degree, we can take it in a small time, but the degree, it's four years … and financial … For the degree every year I think it's around 15 thousand [Egyptian pounds] but in the Technical degree, it takes about nine [thousand Egyptian pounds], it's about half of the difference between the Bachelor and Technical degree.'*

Nevertheless, these sentiments were not voiced by all Phase 1 participants as some expressed uncertainty if this new bridging Technical degree would secure the career development opportunities or have the same status as the Bachelor degree programme:

> *P15: 'It's the first time to implement the Technical [degree] education here, so it's a new experience, so I don't know if its gonna proceed and it will be successful because it's the first time to implement here in Egypt … it's a new degree, so lots of challenges and worries about it, if it's gonna be successful or if they are going to stop it … if they will cut it at any time or no … or they will continue and it will be a*

*good experience … the certification … will I be able to continue my Masters after it? So lots of those questions.'*

With limited access to quality Bachelor degree programmes within Egypt, in order to meet their aspirations for competence, autonomy and relatedness, many of the Phase 1 participants sought access to online international courses as an alternative to facilitate career progression and gain credibility:

> *P7: 'I feel like I need to have a Bachelor degree from outside Egypt, to add to me … they [the international Bachelor degree] will add … they will not take from my knowledge.'*

For example, some Phase 1 participants indicated they were looking to complete the National Council Licensure Examination for Registered Nurses (NCLEX-RN) certification in the future. The NCLEX-RN is the nationwide examination for the licensing of nurses in North America, in which if successful, the individual will gain a nursing licence which permits them to practice nursing as an RN in the USA:

> *P4: 'Studying for [the NCLEX] RN is hard to get, so I think all this knowledge to get the RN will solid my knowledge and of course being in contact with international institutions and sharing experience with foreign nurses, this will promote me, promote my level of education or promote my level of the knowledge.'*

*5.4.2.1 Wanting to travel abroad*

Motivations to do such courses also stemmed from an underlying desire to emigrate. Lack of opportunities for professional or personal development and career advancement, as well as the economic and political crisis within the country, were influencing factors in the Phase 1 participants' aspirations to travel abroad. These motivations, although clearly driven by extrinsic factors, stemmed from underlying aspirations to fulfil more intrinsic goals:

> *P15: 'There you will feel, you know, everything is prepared, just you can do your best … but here you are trying to prepare to do your least not your best [laughing] So everything there, they are backing you up, they are motivating you … just you*

*have to do your work and do it good … so that's a great thing. Also new culture, try new culture, new experience … it will be great … There you will have a great support … they will always back you up … also you can continue learning…also financially it's good … the economical status you will feel like a human being there, I will regain my humanity again.'*

A Phase 2 participant discussed the issue of emigration, highlighting the extrinsic drivers motivating TDNs to leave the country:

> *P22: 'The motivation is money … most of their motivation, most of them … the motivation is money … and for having the opportunity to working in a good reputation hospital … and so they travel outside Egypt. So, for that reason they want to just get the [Bachelor] degree so they can travel abroad and work in any specialty.'*

Another Phase 2 participant, however, described how opportunities outside of Egypt would allow TDNs to achieve more intrinsic aspirations associated with their development:

> *P19: 'Travelling abroad is important in many aspects, new experience, new people and how they deal with each other … the culture of the nursing role and how they are treated, how they are important, how they develop themselves. They will see this abroad, not in Egypt … if we had it in Egypt we can limit travelling abroad.'*

*5.4.2.2 English language proficiency*

English language competency was associated with feelings of competence and building a sense of autonomy. It was cited as important to overall development and achieving the goal of emigration by Phase 1 participants:

> *P13: 'It's important for everything! All the work in English, all the research in English, everything! Even communication, participation in presentations, attending conferences … to do anything like that you need the language. In my career, if I'm preparing for Master degree, I need English. If I'm going to work in another*

*country, even an Arabic country, I need English. Internationally now it's the language for all people … that will help me a lot, I'm looking for that.'*

Knowing English was also noted as critical for progression by a Phase 2 participant:

*P20: 'What I think that is important to develop themselves [TDNs], one of the most priority is English language … it's one of the main points.'*

### *5.4.3 Participating in work-related learning*

Another sub-theme from the first theme was 'participating in work-related learning'. Findings related to this sub-theme are discussed below.

#### *5.4.3.1 Clinical practice prompting self-study*

Despite the weight placed on formal CPD strategies, informal learning was emphasised as playing an important role in Phase 1 participants' professional development. Although CPD requirements for licence renewal are minimal in Egypt, Phase 1 participants clearly had a degree of integrated and intrinsic motivation concerning their learning and felt a personal responsibility to develop themselves. Phase 1 participants identified a variety of informal learning activities that were motivated by several factors. Most Phase 1 participants identified the importance of self-study to develop their knowledge and skills, and stated they were motivated to conduct self-study when they encountered new things in daily clinical practice:

*P5: 'I am searching about anything, even if it's small words I heard in the rounds, doctor talking about it, I searched it … and I know why they talking about this part, why they are interesting in this part … I go and search.'*

One Phase 2 participant also highlighted the importance of learning from every day clinical practice:

*P21: 'Clinical practice can help them [Phase 1 participants] learn day by day … it's like a block you are building on each other … this is what I think about day to day learning from work.'*

*5.4.3.2 Evidence-based practice*

Phase 1 participants also felt an intrinsic responsibility to keep up-to-date and had a desire to apply evidence-based practice, which motivated them to study:

> *P8: 'I start to think … I extubate the patient many times, but I don't know what is the ideal … what is evidence-based … for example, suction … I suction the patient many times … but what is the ideal? For eye care, what is the ideal? So, it helped me a lot also.'*

The importance of keeping up-to-date with clinical practice was also echoed by a Phase 2 participant:

> *P18: 'I think it's really, really important to update … we should be looking to update ourselves … to be in the top, in international standards.'*

Knowledge gained from self-study also gave Phase 1 participants self-confidence in that they could provide their colleagues with a rationale for their practice. This was fostering feelings of competence:

> *P9: 'To be honest when I read something it's new, I feel satisfied first, and second, we try to use this new information to apply it afterwards. So, when you talk to the doctor about the patient and diagnosis and you don't know the diagnosis you will not have the power to talk.'*

*5.4.3.3 Methods of learning*

It was clear that TDNs sought learning from their everyday clinical practice. Phase 1 participants did not have access to academic libraries or books. However, online resources, such as electronic databases available within the hospital or trusted internet sites, were cited as important and the main method for graduates to conduct self-study and to provide opportunities to engage autonomously in managing their learning:

*Pilot 2: 'Reading, doing a research from the websites. Know about every diagnosis or everything we have we searched about it in the internet and read more about it.'*

Support from peers and a strong sense of teamwork were also important factors which increased relatedness, and in turn, feelings of competence among the TDNs interviewed. Many Phase 1 participants also articulated that they learned from supervising junior colleagues. This prompted them to learn when they were questioned about their practice:

*P13: 'The nurse they need to be teacher … also if they [junior colleagues] ask you questions and you don't know, you will gain a new knowledge and new information about something … maybe you do research with them. I'm not the person who say I know everything. Sometimes I receive questions from trainees [junior colleagues] and I search with them to find the answer or ask someone else. I'm not the one who knows everything or says something I don't know … It's good because we are working two minds on the case.'*

Sharing knowledge with colleagues through informal and formal discussions was also perceived as an important way to develop their practice:

*P16: 'Sometimes we are sitting together and I just explain a new thing for them [colleagues] … we are just sharing our knowledge.'*

Formal presentations within the hospital were deemed useful and provided the nursing team an opportunity to discuss and share knowledge:

*P17: 'There is lectures in the morning and in the evening before start of the shift and at the end of the shift. So, it help me, for example, the Supervisor nurse came*

*with a list of diseases, like heart failure, coronary artery disease, pneumothorax, haemothorax, something like that … and she ask everyone to choose one. So in the morning I attend and in the evening … and I need to read to discuss. Without reading the person who is giving the lecture, she is not experienced and he does not know everything, so it helped me cause I need to read more ... and make a discussion. So, it help me, it's very powerful to do this … so it helped me a lot.'*

Clinical rotations or taking on new roles were also identified by some Phase 1 participants as helping with their development. These opportunities fostered feelings of autonomy and competence and in turn, increased motivation for learning. One Phase 1 participant described how working in a new department was a break from the routine and an opportunity to gain new knowledge and skills:

*P13: 'I feel like I am giving more here than what I was giving in the ICU [Intensive Care Unit] because I like to have, be teacher and I like to be friendly with the patients and talk with them … my duty in this department is different because the nursing role, it's the same nursing role but in ICU I focus more on the skills I have learned and I practice it day after day … so I felt like it's a routine. Every day I have a critical case until she become ok and then I transfer her to the ward…so no new skills … but every day in this new department I met new patients with the heart failure and also VAD [ventricular assist device which is a mechanical circulatory support device used in people who have heart failure] patients is a new system in our country and it's not found, so I'm interested to work with it, and know everything about it … the position has new duties, it's better.'*

Formal learning activities within the hospital were also seen as helpful. However, some Phase 1 participants stated such activities did not always meet their needs:

*P12: 'They are not manage the educational programme by a good way … they have to make a programme for education like … we need now to focus in the practice … so we will learn the nurses how to make good suctioning, how to*

*measure CVP [central venous pressure], how to remove chest tube … they need to put a programme, but they didn't put a programme … they give presentation haphazard … now we will talk about stroke, now we will talk about the appendicitis … they are not focusing on what the nurses need!'*

Although a varied range of informal, as well as organised learning activities within the workplace were highlighted, barriers to learning were also highlighted by Phase 1 participants.

*5.4.3.4 Barriers to learning*

Lack of time was frequently cited as a challenge to learning by nearly all the Phase 1 participants, although to a lesser extent in Phase 2. Staff shortages coupled with long working hours affected their ability to conduct self-directed learning activities or attend organised formal CPD activities within the hospital. This hindered autonomous self-regulation for learning and TDNs' ability to build competence:

*P15: 'It's like an obstacle for your learning, for your studying, 12 hours a shift is a horrible thing … it's too much…you have less time to study … you only study on your off duty day … and on that day you have lots of things to do, to prepare for things for the next week … and you have to study, you have to prepare, to cook … it's a lot to do in one day … Time, finding time to study … you have the intention but you're not able to perform that, you wanna do but you can't find the appropriate time to do it.'*

To conclude, TDNs sought learning and professional development for the certification perceived as essential for promotion and employment; but they also intrinsically sought learning for its own sake, and ultimately for the benefit of their patients. Although engagement in formal academic postgraduate education was viewed as imperative for career advancement, issues related to the relevance, as well as the accessibility, affordability and availability of such courses were described. These factors were ultimately extrinsic drivers for TDNs.

## 5.5 Sources of support

The second theme arising from the TA was 'sources of support'. The relevant findings are discussed below, organised into the subthemes of 'family and marriage' and 'organisational support'.

### *5.5.1 Family and marriage*

In a culture where the family is a central component, having a supportive family was perceived as very important by all Phase 1 and Phase 2 participants for TDNs to continue to develop and progress in their careers. Consequently, families influenced the graduates' decisions regarding their career and professional development. Positive relationships with family were instrumental in supporting feelings of relatedness among TDNs. Moreover, those families that were more autonomy-supportive were seen to facilitate TNDs' development in relation to those who were more controlling.

Many Phase 1 participants lived a considerable distance from their families. Living in the family home until marriage, and sometimes after marriage too, is the cultural norm in Egypt. Therefore, having their parents' or, in the absence of a parent, an elder sibling's approval to live away from the family and continue working at the hospital was seen as essential:

> *P1: 'They supported me to continue the work here [the hospital], take a flat here and emm focus to live here in [the local area of the hospital] because is very important … is a very interesting place.'*

#### *5.5.1.1 Expectations and responsibilities*

One Phase 2 participant also highlighted the challenges that female graduates may face to be away from the family home:

> *P19: 'Working here [the hospital] can be especially difficult for the females because in Egypt it is a big issue for a young girl [of] 22 or 23 years old to leave her family*

*1000 km away and live alone … it is very difficult in Egypt, very difficult for the parents to agree!'*

Having permission to go to Cairo and continue with their studies was also crucial for Phase 1 participants. This was seen as key for female graduates:

*Pilot 2: 'My mother always encourage me to go to the university, they ask me to go … she doesn't have any bad feelings about going to Cairo at all, she more happy for me to go to Cairo to live with my friends.'*

Being away from their families often created tensions between the Phase 1 participants' desire to develop and progress in their careers and being compliant with their family's wishes or fulfilling family commitments. It was clear that these tensions often negatively affected TDNs' sense of well-being and undermined their ability to make self-determined decisions in relation to their careers:

*P3: 'I am the only boy, so they are, every vacation, they are stressed and nervous, "We need you here" … It makes me stressed also and I feel they need me now, you know I like [the local area of the hospital] more than Cairo, it's so difficult to me … I cannot imagine my life there, my career life.'*

One Phase 1 participant talked about his obligations to care for ageing parents:

*P15: 'Because I'm the only son for my father and mother … I only have one sister and she is married so they are living alone, and here in Egypt it is common that you live with your family in the same house, you know like that you are in the third floor and they are in the second … you live together in the same building. So, it's difficult for them that I am travelling all the time and they are becoming elderly and*

*they don't have anyone but me, it's so difficult … if my mum or dad get sick or tired I have to be beside them.'*

For a lot of the Phase 1 participants, one of their parents wasn't alive, meaning they were often supporting their family financially:

*P9: 'Now I responsible for the home, you know my father is dead, since I was ten … I have my brother in the third year of secondary school so I'm the one who care for them … so I need to think about money.'*

One of the Phase 2 participants explored how families heavily influenced the Phase 1 participants' career decisions. It was perceived that some families did not place value on continuing development and that the families saw nursing as a job rather than a career:

*P20: 'Some of them [Phase 1 participants] are refusing to sign [a work contract] before they consult their families, so it's one of the main influences … The families in Egypt believe that their son or their daughter should be hired after graduation and that's it! Just for the job biss [Arabic word meaning 'nothing else' in English].'*

##### *5.5.1.2 Marriage and children*

Strong societal expectations for marriage and starting a family in Egypt also influenced Phase 1 participants' decisions. Almost three-quarters of Phase 1 participants discussed the issue of marriage. Some Phase 1 participants spoke about societal pressures to get married before a certain age:

*P7: 'If I cannot find the husband, it will be hard after two years … our culture here in Egypt … the age'*

These societal perceptions were strong extrinsic drivers for TDNs. This issue was also discussed by Phase 2 participants:

> *P21: 'Because in Egypt those youth who are just graduated, they should marry, so they got a kind of commitment and because of this some of them stop this process of ongoing … to grow up their professional development … its opportunities … we are not that much a rich country, so those nurses need to struggle to have their own satisfactory level of living. Like basic things, like a home, spend money over their families and so on, and this might make them think not to continue their education.'*

Phase 1 participants discussed anxieties related to family pressure to marry. One Phase 1 participant verbalised his struggle with his family over their desire for him to marry and his conflicting plans for development which was notably thwarting his basic psychological needs and affecting his sense of well-being:

> *P13: 'It's not my plan now, but my family are stressing me now to go through the marriage … you have to choose and I refused that because it's not my plan. I want to continue my education first … my family, they are wishing for me the best but in another way [laughing]. They don't like this plan, they are from Upper Egypt, and you know I'm the youngest man … and my dad has died and my mum says I have seen all the children of your brothers except you, I will not see you in a family before I die … really that is affecting me, but I have taken a decision and I have to stand beside it … it's worrying me more than other challenges I mentioned … because I'm afraid I listen to my family. They are looking for me to agree for the decision of marriage, but I will not … It will affect on my life, about my plan, it will be stopped here to look for the marriage and children, and the family living … Not now! Not now!'*

Having an autonomy-supportive spouse was therefore seen as imperative. Social expectations for women to fulfil traditional duties after marriage, such as bringing up children and household

responsibilities, were often perceived as affecting their progression and development. Some female Phase 1 participants voiced the need to marry someone who would be supportive of their careers and allow them to continue to work and study. One female Phase 1 participant described the anxieties she had about marriage and how she tried to ensure she could continue her development:

> *P12: 'Maybe he change after marriage and after I be pregnant … maybe he will change his mind and say stay in home! In just this situation, I participated my family and his family to know that I will continue and there is no way I will leave my work. I spoke to him in the first to make sure he will not change his mind, I talked to my family, and after that his family to make sure that he will not say no.'*

One female Phase 1 participant also spoke of the importance of pursuing a Bachelor degree before she committed to marriage and children:

> *P5: 'I continue with my studies just now, and before I have a responsibility about marriage or having children or something like that … now I'm free so I want to continue to take it now because if I postpone it I won't take it [the Bachelor degree],I will be busy and I will have responsibility.'*

However, male Phase 1 participants also discussed the importance of having a supportive spouse:

> *P8: 'If you don't have a good partner who not support you, they will obstruct your plan … If you have a good support, you will do well in your life and support you in your career.'*

Friends were also seen as a good source of support for Phase 1 participants. Friends provided emotional support, and a way to relax and someone to reflect with informally:

*P7: 'My friends, they support me a lot. When I called them with the first shift as Charge Nurse, I called my friend and started to cry to her, "What I can do? Help me!" She encourage me a lot ... she said to me no you can do it … she helped me a lot, she helped me more than a lot.'*

*5.5.2 Organisational support*

*5.5.2.1 Supportive colleagues*

Working in a supportive organisation was perceived as critical by all Phase 1 and Phase 2 participants. Organisational factors, such as the leadership and management styles of senior colleagues and collegial support, created an autonomy-supportive learning environment in which Phase 1 participants could develop and advance their careers. Senior colleagues were perceived as a valuable source of support and contributed to feelings of well-being:

*P9: 'They [senior colleagues] are positive … they re-enforce, "'Keep going", something like that.'*

Senior nurses were seen to offer encouragement and facilitate opportunities for professional development and career advancement. This created feelings of relatedness and a subsequent sense of competence and autonomy in TDNs, increasing their autonomous self-regulation and interest in their development. Examples included one Phase 1 participant who spoke of how senior nurses were an important resource and motivated her to achieve her career goals:

*P13: 'There are many people, they are older than me and they had a good experience … I received from them the advice and I asked them about many things I want to do … They are really support me about my decision. Even though I didn't achieve what I want to achieve, but they are saying I have to achieve. So, they are advising me to go through and really I respect their opinion and advice … they are respecting and supporting you.'*

Another Phase 1 participant spoke of senior colleagues offering informal coaching and mentoring in clinical practice:

> *P17: 'Asking them [senior colleagues] about the new skills if I didn't know anything about it … they help me to know about it in the situation itself. Because for example, in the emergency situation, doctor give the order and we need to do it right away, so I need to think about how I can save this patient's life. So, the first one I think about to help me is the Charge Nurse, to help the patient and on the other side, help me.'*

Another Phase 1 participant also described how senior colleagues helped her to secure time to attend her university course:

> *P16: 'They help me to study … if I call the Charge Nurse to say please give me the day off I have exam or I can exchange this day with another of my colleague, she say ok no problem, if I available I will give it to you. It give me comfort, it will not put me under stress and at the same time at the end of the month I have good money to pay anything what I need to continue my education … it give me comfort.'*

Working in a supportive collegial team also helped to motivate Phase 1 participants to develop and achieve their career goals:

> *P15: 'Here there is something good about the hospital team, they are all supporting … they are all trying to make you do your best, try to put you in the right position… Yes, they do, if they believe in you, if you have the abilities … so they support and motivate you to do your best.'*

Nevertheless, not all Phase 1 participants had positive collegial experiences, which had a negative impact on satisfaction of their basic needs and their subsequent development:

*P11: 'Some Charges make me irritable, make the work in stress area, make us very irritable, not flexible, tried from nothing, they put us in the stress. Like when the Charge come and give me feedback or comment for a small thing but not by an effective way … they are shouting and say it by an unprofessional way, in front of the patient and relative. It makes me stressed and depressed and feel like I didn't want to work with my patient. Why do they deal with me this way? And it reduces my self-confidence.'*

#### *5.5.2.2 Hospital support*

As well as support from colleagues, all Phase 1 participants articulated the importance of working in a hospital which offered opportunities for career advancement and professional development. Aspects of the organisational structure and environment helped to facilitate a sense of autonomy, relatedness and competence among TNDs. This helped to foster internalised and intrinsic forms of motivation:

*P14: 'The hospital give us the power to complete our development, skills and knowledge, and also to work seriously with the patient, auditing every time for us … also the Supervisor, to work hard to improve our work. Also from myself, to know the plan, to go from the lowest step to the highest step, also gives us the skills and experience … Support from the salary from [the hospital], it's a good salary for nurses, it's one of the motivations in [the hospital] … all of this it's powerful.'*

Hospital incentives, particularly incentives such as salary, were noted as important due to the economic crisis and reduce threats to their autonomy:

*P9: 'The hospital provide you with all the things that you need to develop, good salary, good home living and transportation … so this is good for me to work here.'*

Working in a well-resourced hospital which implemented professional standards of practice was also seen as significant. This helped to satisfy TDN's basic psychological needs, supporting tendencies toward intrinsic motivation and the integration of extrinsically motivated behaviours. Phase 1 participants aspired to deliver a high quality of care to patients, contribute to developing the organisation in which they worked, and to be able to apply the nursing role to implement what they had learned. Phase 1 participants talked of having a sense of satisfaction in being able to deliver quality care:

> *P4: 'Dealing with patients, this is the most satisfied for me because the satisfaction of the patient influence on us. If the patient is satisfied, we will be satisfied. This give us a power to work and give the patient more and more.'*

This was also reiterated by Phase 2 participants:

> *P20: 'They [TNDs from the host TIN] have the concept of being a good nurse, they know what is the meaning of nursing, and why they are here, why they are coming to here. They are serving the patients, they are going to improve the quality of nursing care and they are here to help, not only to work and to get a salary and just left the hospital … they are here and looking for to developing themselves also.'*

#### *5.5.2.3 Organisational factors*

Organisational factors influenced their decisions regarding which hospitals Phase 1 participants selected to work in. MOHP hospitals which were in low resource settings were deemed to limit opportunities for development:

> *P14: 'In Egypt all the challenges for nurses are in the governmental [MOHP] hospital, all challenges … because there is no education in the government hospital, no care and no doctors all around the hospital. They depend only on*

*nurses or doctors [in] training. This affects the quality of care in hospitals, the care is not as good as here, and no financial support … not like here.'*

Government hospitals were therefore deemed to be thwarting environments which limited TDNs' opportunities to achieve optimal professional growth. This issue was also explored by Phase 2 participants:

> *P20: 'No one in a government hospital will not tell you that you are not moving up, that you are not developing yourself, that your evaluation is bad. There is no evaluation there, there is no one looking for your degree or your evaluation or your skills, there is no one who will look after that! Here we are looking after the knowledge, the skills and the attitude … we are keeping up this every day. In a governmental hospital, there is no system!'*

One Phase 2 participant also highlighted that some nurses may wish to work in government hospitals for job security due to the economic situation of the country:

> *P18: 'Because the Egyptian culture about governmental hospital, you just go there, there is no development, no one asks you about what you are going to do, what are you doing, why you doing that? Because the culture of Egypt now is different than before, it's poor and all of them they needed money and a secure job. Because they know they are here, under the stress of you have to develop yourself. This is a problem. They are worried about developing themselves, they are worried about evaluation and they are worried about appraisal and having to talk to them … they are under stress of that. Some of them they don't want to be in that, they want to be in a peace place where nobody asks you about anything.'*

The lack of quality hospitals in Egypt limited opportunities in that if Phase 1 participants left the stakeholder hospital it would be difficult to find an organisation with similar standards. This was threatening perceptions of autonomy:

*P15: ‘You will not find hospitals that are in the same level because it differs from a place to another. It’s too hard to find a place with the same quality and level like here [the stakeholder hospital] … it’s so difficult, It’s so difficult, it’s a terrible situation.’*

As a result, one Phase 2 participant expressed that in the absence of an organisation that had incentives for development or support structures in place, nurses had to be intrinsically motivated to develop themselves:

*P19: ‘You have to depend on yourself, rarely to find a hospital that cares, so you have to depend on yourself.’*

Phase 1 participants also viewed the support received from their TIN as valuable. Phase 1 participants often spoke about being formally supported by the TIN to develop during their internship period, which is the last academic semester of the Technical Diploma programme and lasts for a period of three months. However, after this period was complete, they felt they had to rely on themselves to study and advance in their careers.

*P4: ‘What we have in the first three months which is the internship we are closely followed by the [Nursing Institute], but after that, after the final graduation and we are joining the [hospital] hallas [Arabic word meaning ‘finished’ in English], we are just part now of whatever institution we are working in and we are just visiting the [Nursing Institute] or the [Nursing Institute], they visit us. So there is no clear communication between us … I think the support should be started immediately or even before your graduation, the last year. I think we need to get the advice from [the Nursing Institute] and we could develop our career, errr what are the choices we should have? How can I get my RN? And what are the chances that we have? And I think [the Nursing Institute] could help us in the idea of getting the Bachelor degree.’*

Phase 1 participants also suggested that their pre-registration education had prepared them to be lifelong learners which had consequently facilitated their development after graduation. This may suggest the host TIN supported internalisation of the value for learning among its students:

> *P11: 'The [Nursing] Institute support me from the way of education and the way of learning, the way of searching from the different knowledge, it make us different and supported.'*

Having a good level of nursing education preparation was emphasised as particularly important by Phase 2 participants who viewed the current national TDN curricula as typically representing extrinsic stimuli for learning:

> *P20: 'Some of them [TDNs not graduated from the host Institute of Nursing] are very stuck at a point because they didn't have the right teacher, they didn't have the right curriculum. They know nothing actually because they learn nothing because the relationship between the Instructor and the student is only that she is passing the exam. She just attend the lectures and that's it. What she is doing, how she is acting, they didn't follow up. For my training in the hospitals, I went for the hospitals, I signed for the attendance, I go in from a door and I go out from the other door! The organisations in Egypt, they are not in a good required standard, they must change! The curriculums are not changed for years and years! There is not attractive way of teaching … the teachers don't have the requirement to do the job!'*

In summary, organisational factors were key to supporting TDNs' participation in both formal and informal methods of CPD. Social support from senior colleagues and peers, as well as domestic support were also influential in stimulating learning and advancing careers of TDNs.

### 5.6 Moving up the career ladder

The final theme arising from the TA was 'moving up the career ladder', and the findings related to this will now be discussed.

*5.6.1 Promotion and authority*

All Phase 1 participants were ambitious to secure higher positions in their future careers. These career aspirations were often driven by extrinsic rewards. Some Phase 1 participants had secured promotional opportunities since graduation (Appendix XXII: Participant Characteristics). Most graduates aspired towards vertical promotion, such as to Charge Nurse or Nurse Supervisor posts:

> *P1: 'I was promoted to Charge Nurse … now I want to be promoted as a Supervisor.'*

Promotion was also seen generally as moving away from the bedside:

> *P12: 'I love to be a bedside nurse, but anyone need to improve themselves.'*

A few Phase 1 participants articulated their motivation for such positions was the perception that you only had authority or the power to change practice or contribute to organisational development if you held a senior post:

> *P9: 'Maybe when I am a Staff or Charge, I didn't have the authority to do something, the Supervisor have the authority … so then we can develop something new.'*

The concept of authority was discussed by a Phase 2 participant:

> *P21: 'Because having a high position is our vision of power among Egyptians, like how we visualise power. "I want to be supervisor, I want to give the order." They think that to be a Supervisor it will lay down responsibility by delegation, and when they are in the position they will discover they were wrong because it is not easy*

*to be a Supervisor … They thought that this good position come with money, come with the power, position and status and not do a lot of work or official work and not have contact with the patient, like the boss don't do any work. I refuse that.'*

Other Phase 1 participants perceived obtaining a higher position as a way to improve their CV, thereby enhancing their employability and to increase opportunities, for example, to travel abroad:

*P15: 'When I leave [the hospital] I can say that I was a Supervisor nurse. It has a good reputation here in Egypt, it has a good reputation … so I can be a head nurse or director in any other hospital … so that will make a good CV and also I'm trying to reach my requirements for travelling abroad … so it will be good for me, like a recommendation letter as a Supervisor.'*

Many Phase 1 participants also spoke of achieving career satisfaction from a position of responsibility, as well as benefits such as salary raises, demonstrating that these extrinsic aspirations were often seen as a pathway to fulfilling more intrinsic goals:

*P7: 'Being responsible, the responsibility itself, make me satisfied to have the opportunity to be responsible for 14 cases, 14 Staff Nurses … the ICU itself, the ICU machines. Whatever in the units, we are responsible for … so you feel like you grown up, and your mind also, you're thinking … and the salary also.'*

One Phase 1 participant described how she wanted to be a competent Charge Nurse rather than just having a position:

*P12: 'It is not difficult to be Charge Nurse, anyone can be Charge Nurse in Egypt, but I need to be a real Charge Nurse. There are Charge Nurses, but they don't have knowledge, they don't have good communication, they don't have assertiveness, they cannot do that. But I need to be a real Charge Nurse, that I*

*need to have a good knowledge, good practice … I can communicate very well, I can manage … I hope so.'*

### *5.6.2 Alternative career paths*

Furthermore, many Phase 1 participants also showed interest in pursuing a career in academic nurse education. A few of the female Phase 1 participants spoke of their motivations for this career path which were mainly driven by extrinsic factors, such as the opportunity for reduced working hours, as there were limited options for part-time contracts in Egypt. This meant they would be better able to balance work with the demands of their personal lives:

*P5: 'If I am married and I have responsibility, heavy responsibility, I will be in the faculty as an Instructor to decrease the hour of work. It develop myself and also I will not have a lot, errrr a shift 12 hour or eight hour. It will be six hour or something like that … and I can have a responsibility in the future so it will help me to work with my house, to take care of my house and study at the same time. Yes, and I can take care of my personal life and take care of my work also.'*

Horizontal career pathways were emerging within the stakeholder hospital. One Phase 1 participant stated that she had an advanced clinical role. Nevertheless, there were no formal support mechanisms within the hospital or in Egypt for nurses to develop themselves in these specialist roles:

*P4: 'In the previous year actually I don't have any support. Me and my colleague we are depending on our self in the nursing field regarding the heart failure. I'm looking through the websites is there is anything that I must study, or I should have an exam to be a certified heart failure nurse.'*

Some Phase 1 participants also discussed their desire to specialise in their practice but that there were few opportunities to do so within Egypt which was thwarting perceptions of autonomy:

*P16: 'I would like to be a specialist nurse or something. I like health teaching, especially in paediatric generally. I like this. I don't know if there is a special certificate for this or not … because I didn't hear about this in Egypt.'*

### *5.6.3 Performance appraisal*

The performance appraisal system within the hospital was generally perceived to aid development and career advancement. Positive and constructive feedback helped to foster a sense of competence, as well as relatedness amongst TNDs, and enhanced enthusiasm and motivation for learning. This was the opposite, however, if feedback from evaluators was perceived to be threatening or implausible. Most Phase 1 participants acknowledged feedback they received during evaluation sessions helped them to develop self-awareness in relation to their areas of growth and improve their performance:

*P15: 'For sure, it [the evaluation] help you when they are telling you your weak point or what are the points that you need to work on. It will develop you so it will put a plan for yourself and what I'm expecting after that … the outcome of my plan, how it will be and what are any other backup plans. So you want to plan for that so you can solve your problems and your issues if you have issues, communication, education or skills, leadership abilities, so you can work on them.'*

Nevertheless, one Phase 1 participant described how performance evaluations were a source of stress:

*P8: 'I have some challenges in the work to prove to myself and prove to others that I am a good one … it is stress for me. They change the Supervisor, so I only work with the new one only one or two shifts when she was a Charge, so she don't know about me, like "I don't know about you, you are not good", like this. I try to prove to her I'm ok … it will be better for my evaluation, so the evaluations are very stressful for me.'*

Not all Phase 1 participants were satisfied with the appraisal process. Some Phase 1 participants articulated that the feedback they received from their evaluator was not always timely or constructive which had a negative impact:

> *P12: 'The Charge Nurse will say you had a bad knowledge, you have a bad practice, you have a bad communication … bad, bad, bad … what happened? "In this time, you made this, in this time you made like that" When I make a mistake, the Charge Nurse should have a conversation with me about the mistake, what needs improvement to improve this mistake and that it doesn't happen again … I need that, to know! It can't be a surprise that I made this and this and this.'*

Moreover, a few Phase 1 participants mentioned their perception of their performance did not always align with the evaluator's. Not all feedback therefore was considered credible:

> *P13: 'Really, honestly I didn't trust her evaluation. Some of it based on other talks with other nurses, not based on what she observed … she didn't give me the good degree or grade in the communication part … and then after a little period she came to me and say, you are a good communicator … she was wrong.'*

One Phase 1 participant questioned the credibility of the appraisal criteria:

> *P7: 'She was using an evaluation criterion very bad … if I was to evaluate the evaluation criteria itself I will give it zero! A big zero! The tool itself has no meaning.'*

Negative perceptions of the appraisal process were not voiced by Phase 2 participants. Instead, they discussed how they thought the hospital's appraisal system helped to motivate staff to

develop to secure promotion opportunities. This clearly helped TDNs become more self-determined:

> *P20: 'You know the evaluation and contents are very linked to each other, when I know that this is the competency that I have to achieve, and there is no one telling me that you have to be here and this is what you have to achieve it, to get it. I will not be very initiative to achieve it. But when I saw that there is a reason to do it, like you will be paid better or you will be in the highest position, you will be noticed as a good one, there is benefits, then I will do it, I will do it, I will try to achieve it. If the person learned this way, to put the learning as a continuing issue in her life, she will not be stopped, she will develop … because she knows we are looking for her to be developed … to secure her job … so she must do it.'*

*5.6.4 Career development and advancement*

Phase 1 participants identified a number of strategies they used to develop their careers and obtain better opportunities for advancement which helped to foster feelings of competence. Improving their professional knowledge and clinical skill proficiency was perceived as essential. A Phase 2 participant expressed her opinion about why Phase 1 participants viewed this as important, implying that these strategies were extrinsically driven:

> *P22: 'They think confidence comes from being great at psychomotor [skills] … and they are very proud if they are the best one who can insert a cannula in an infant and everyone says, "Oh that's great!" They look for this way of actualisation, through psychomotor … For me it's more about, from my perspective, is attitude, it's a big one, and communication, all meaning of communication. I know they are great in psychomotor because they learn from experience and they are looking to know all the procedures because they feel this is the competence … They thought that to be a good nurse you have to be great in psychomotor and nothing else! And have a good knowledge of medical background, pathophysiology … this is what they think it is to be a good nurse.'*

Nonetheless, having good communication skills was also viewed as important for career advancement by both Phase 1 and Phase 2 participants. One Phase 1 participant discussed how she perceived her communication skills had affected her chances for promotion:

> *P8: 'I'm not a communicator, I know that, and this give the impression to the people that I am not skilful or knowledgeable. But if they ask me they saw that I have knowledge and skills and they told me your communication make all of these things to get down, and some people I saw them, they are a good communicator … so I think communication is the missing part for developing me.'*

Communication skills were particularly emphasised by Phase 2 participants as important. This helped to foster feelings of relatedness among the healthcare team:

> *P20: 'The communication is really important, really, really important. We lost some of nurses because of communication. They were really, really good in practice and skills and in knowledge they were amazing, but their communication with their colleagues, seniors and with the patients, it was not good. So we didn't accept that … being a good communication is one of the most important things, not only just being good in knowledge and skills, no.'*

Leadership, management skills and experience were also mentioned, as well as the importance of having self-confidence and self-esteem. This seemed important for TDNs to facilitate feelings of competence which was perceived to impact on career development and their ability to achieve their career goals:

> *P14: 'Self-confidence and self-esteem is the way to develop … if you don't have self-confidence and self-esteem it will affect your job and you won't progress.'*

Being self-determined to continue developing was also seen as significant. A Phase 1 participant discussed how she tried to stay intrinsically motivated to develop despite all the challenges she faced:

> *P13: 'I try not let the frustrating factors affect me … Solve all the problems, even if its economical … if this year I will not be able to finish it because of money, so I have to save money first and then I will achieve it … maybe it will affect the time also, but I will try to do it.'*

*5.6.5 Career planning and development guidance*

Despite some Phase 1 participants having made some career development plans, many were unsure about aspects of their career options, for example, how to carry these plans out or what education and training was required. Although most had a career vision, they did not receive any formal support to develop that vision. However, these perceptions were not specifically voiced by Phase 2 participants. This perceived lack of structured guidance was hindering perceptions of competence amongst TDNs. Most Phase 1 participants stated they relied on friends or colleagues for guidance through word of mouth. Social media was also a platform to discover educational opportunities. This suggests they had limited access to formal career advice to discuss their options to continue their education and careers:

> *P16: 'I just need if I asked someone, for clear information about this … I really need a clear information, because I will put my plan on it … so for me this is support … if I got clear information about the steps [on how to join a Bachelor degree programme] this will be a support, and then I will proceed on this step.'*

*5.6.6 Status*

The status of nursing within Egyptian society was perceived as a challenge for nurses to progress in their careers. This thwarted feelings of relatedness, as well as competence and autonomy, which negatively affected TDNs' motivation in relation to their careers. Feeling valued, having respect and receiving recognition for the nursing role within the workplace was important for the Phase 1 participants' development:

*P15: 'If you feel you don't have a role or not influencing or you're not important in what you're doing, of course it's disappointing. But when you feel like, no you have a role, you are doing a big thing here, you are a part of the place, we cannot work without him … When you're absent it makes a difference, so that makes you empowered, that makes you feeling happy, as well as trying to do your best and more, more working and more motivation … So you can do the best and be the best that you can … When you feel like neglected, or someone is not recognising your effort, of course that frustrates me … when I feel like I am no longer important, so that makes everyone frustrated.'*

Phase 1 participants talked about the poor image of nursing in Egypt and how they wished to improve the perception of the career:

*P7: 'In the future I need to do something to change the culture about the nursing career … I need the people to love the nursing career … not to go away from the nursing career, and I feel like it's a stigma here in Egypt, a big stigma here in Egypt … I need to say no and all the people to say no, it's not a stigma … your working like a doctor and more … Why the doctor take his right and the nurses didn't even take their rights to be a person? Why are you looking to the nurses as they are nothing?'*

One Phase 1 participant also expressed how she was afraid she may want to leave the career in the future due to the challenges she has faced:

*P16: 'I feel afraid that I lost interest in this … I'm just afraid of this.'*

Phase 2 participants also discussed the fact that nurses in Egypt were often perceived as doctors' assistants, rather than as healthcare professionals in their own right:

*P21: 'He [the doctor] perceive her [the nurse] like a home maid, something, rather than a professional woman or man working … and they perceive her like, I must give the order and you must obey. So it's really [a] dilemma for the nurses to work within the health team, and prove themselves.'*

To summarise, Phase 1 participants were ambitious to secure higher positions in their future careers and mostly aspired towards vertical promotion. These career aspirations were mostly driven by extrinsic rewards. Career development was generally seen to confer position and authority. Moreover, aspects of the performance appraisal system within the host hospital were, overall, portrayed to facilitate development. The attainment of professional skills and attributes were also emphasised as important for promotion. Lastly, the status of the nursing profession within Egypt was viewed as having a negative effect on TDNs' development.

### 5.7 Chapter conclusion

This chapter presented the findings from the in depth-semi structured interviews undertaken as part of this qualitative descriptive exploratory study. A full interpretation of the overall findings from this study is presented in Chapter Six, facilitated by the study's conceptual framework which was guided by the SDT of Human Motivation (Ryan and Deci, 2000a) (see Section 2.9).

# Chapter Six: Discussion

## 6.1 Introduction

This chapter discusses the findings and presents an overview of the important issues raised in this work. The interpretation of these findings, and how this research relates to the broader theory and literature was supported by the study's conceptual framework. Implications for practice on HPE are also addressed in this chapter. Additionally, the steps taken to ensure rigour are reviewed and the limitations of the study are discussed. The chapter finishes with a reflexive discussion of my potential influence on the research process.

## 6.2 Review of key findings

The findings of the study successfully addressed the original research aim and objectives, and highlighted stakeholder perceptions of the professional development and career advancement of TDN graduates within the Egyptian educational healthcare context. The conceptual framework presented in Chapter Two (Section 2.9 and Figure 2.2) outlined several key social and cultural influences and their relationship to the motivations and aspirations of TDNs' professional development and career advancement. The framework highlighted the multifactorial aspects of this study and recognised that there was not one perspective that would fully describe its scope. Nevertheless, as data analysis progressed, it became clear that SDT of Human Motivation (Ryan and Deci, 2000a) offered an explanation for aspects of the findings. The study's key findings will now be discussed in relation to each research objective (see Sections 2.9.1 and 4.2), drawing together the study's themes and sub-themes presented in Chapter Five (Figure 5.1).

### *6.2.1 Key findings relating to research objective 1*

The first objective was to explore TDN graduates' general perceptions of their professional development and career advancement. TDN graduates in this study participated in a broad and varied range of formal and informal learning activities, illustrated by the overarching theme 'Mechanisms for Learning and Development'. Formal learning activities were predominantly associated with pre-planned learning taking place outside the workplace, such as post-registration education. Informal learning was described by participants as self-directed and incidental,

prompted through participation in everyday clinical practice, highlighted by the sub-theme 'Participating in Work-related Learning'. This finding mirrored that of previous studies (Pool, Poell and Ten Cate, 2013; Pool, et al., 2015; Pool, et al., 2016). Nonetheless, this did not have a broad application to other healthcare settings within the country. Despite the emphasis placed on informal workplace learning by participants, outside the context of the host hospital, such methods of learning were given little recognition by healthcare organisations. Therefore, similar to other studies from the UK and the Netherlands (Pool, Poell and Ten Cate, 2013; Pool, et al., 2015), my findings therefore suggested participants had a wider-ranging perspective of what encompasses CPD and contributes to professional development than the current structures within Egypt.

Although highly valued, participation in formal postgraduate education in Egypt was not perceived to be especially relevant to the development of professional competencies of TDNs, described in the sub-theme 'Wanting a Higher Degree'. This was a striking finding which contrasts with conclusions from the international literature regarding the influence of post-registration education on nurses. The TDNs in this study did not have the rewards cited in previous studies wherenurses and managers reported improvement in knowledge and skills, and the attainment of personal and professional growth for nurses following education (Gijbels, et al., 2010; Abu- Qamar, et al., 2020). Ineffective regulatory and governance systems within the education sector, and limited collaboration between healthcare service providers and HEIs responsible for nursingeducation in Egypt help to explain these findings (Hofman, 2005; Ma, Fouly and D'Antonio, 2011).

Career advancement for TDNs was seen by participants as limited in contrast to their Bachelor-prepared colleagues, who were perceived to have greater career mobility. Healthcare organisations' policies and procedures outwith the host hospital hampered TDNs' opportunities to progress up the career ladder, and to develop skills and abilities, as well as their ability to move between different healthcare settings. Moreover, career progression generally occurred because of undertaking further education. Consequently, completion of a Bachelor degree was seen as imperative for the career advancement of TDNs in Egypt. Comparable findings are echoed in previous research regarding expectations of roles, employability and career pathways of ENs in Australia (Jacob, McKenna and D'Amore, 2016; Leon, Tredoux and Foster, 2019; McKenna, et al., 2019). These studies found enrolling in a nursing degree were chiefly aspirational for ENs to escape negative perceptions of the EN role, and for achieving their goals of working with higher

and increased responsibility, developing their career, and experiencing more job satisfaction. The TDNs interviewed in this study were predominantly from rural areas and low socio-economic backgrounds. SDT highlights the importance of satisfying the three fundamental psychological needs of autonomy, competence and relatedness to achieve optimal functioning and higher levels of well-being and personal growth (Ryan and Deci, 2000a). If these three basic psychological needs are not satisfied, the level of intrinsic motivation diminishes (ibid). The poor economic conditions within the country caused feelings of deprivation and insecurity, and poor perceptions of the TDN role impeded the basic psychological needs for autonomy and relatedness. Attaining academic credentials and higher positions were therefore perceived as an important means of acquiring socio-cultural and economic capital. This explains why Phase 1 participants were strongly extrinsically motivated to attain a higher degree, even when it was perceived as having limited value for their professional development.

### *6.2.2 Key findings relating to research objective 2*

This objective addressed TDN graduates' aspirations and motivations for their development. TDNs had distinct motivations for engagement with different methods of CPD. Motivations for participation and engagement in informal CPD activities were driven by intrinsic factors, such as personal interest or increased personal satisfaction, development of professional knowledge and skills, and the opportunity to deliver evidence-based quality care to patients. These findings are mirrored within the literature (Bahn, 2007a; Pool, et al., 2016). However, it was significant that post-registration education, a formal mechanism of CPD, was pursed for extrinsic rewards only, with predominant drivers attributed to opportunities for increased career advancement and professional status. This contrasts with other studies which suggest both intrinsic and extrinsic factors motivate nurses' participation in and engagement with postgraduate education (Ryan, 2003; Bahn, 2007a; Pool, et al., 2016). Nevertheless, previous research also indicates that extrinsic factors are more significant for nurses who are not Bachelor-prepared (Chiu, 2005; Bahn, 2007a; Murphy, Cross and McGuire, 2006), which is consistent with my findings. The perceived deficiencies in Bachelors' provision and the certificate-based promotional structure within Egypt, go some way towards explaining these findings (IOM, 2011; WHO, 2012). It is unsurprising, therefore, that TDNs felt strongly compelled to enhance their professional credentials through further academic study, even when it was perceived to have limited other benefits. Moreover, the population of TDNs in this study comprised of those in the early stages of their careers with a mean age of 23 years (see Appendix XXII: Participant Characteristics). Literature relating to age-

related differences among CPD in nurses asserts that younger nurses are more likely to pursue CPD options and have a focus on building their careers in relation to their older colleagues (Pool, Poell and Ten Cate, 2013; Pool, et al., 2015).

Another notable finding was that all TDNs interviewed in this study mainly aspired to higher positions in their future careers, as described in the theme 'Moving up the Career Ladder'. Promotion was seen as moving away from the bedside into management or positions within academia. Younger nurses in their early careers have been cited as being highly ambitious with regards to their careers (Pool, Poell and Ten Cate, 2013; Coughlan and Patton, 2018) and seek out opportunities to leave direct patient care (Pool, Poell and Ten Cate, 2013). Moreover, younger nurses have been found to be more interested in pursuing management roles (Spence Laschinger, et al., 2013; Wong, Spence Laschinger and Cziraki 2014). However, this finding conflicts with research on early career Bachelor-level nurses in Ireland who aspired to specialist clinical roles rather than positions within management (Coughlan and Patton, 2018), as well as from literature exploring the career aspirations of ENs (Ikeda, Inoue and Kamibeppu, 2008; McKenna, et al. 2019). Career structures, the status of the profession, and cultural values may explain the career aspirations of nurses in different countries. Thus, the poor status of nursing in Egypt, especially that of Technical Diploma-prepared nurses (Álvarez-Galván, 2015), the image of the bedside nurse, poor working conditions and long working hours within clinical settings (Hofman, 2005; IOM, 2011; WHO, 2012), elucidates why TDNs in this study aspired towards vertical promotion. Moreover, vertical career ladders for advancing in non-clinical areas such as management and education, and limited opportunities for horizontal movement or specialisation for advancing in clinical roles (IOM, 2011), also explains why they aspired to move out of clinical practice. Previous studies from economically-developed countries have shown that being overly reward-orientated towards extrinsic aspirations, such as goals related to achieving monetary wealth or social status, can decrease an individual's level of satisfaction in relation to basic psychological needs and subsequent feelings of enhanced well-being, in comparison to the pursuit and attainment of intrinsic aspirations (Kasser and Ryan, 1993; 1996). In contrast, my study suggests rewards such as better salaries, reduced working hours, and increased institutional recognition and authority, helped enable TDNs to experience greater autonomy, job satisfaction and feelings of well-being. As confirmed by Martos and Kopp (2012), these extrinsic goals also represented the means by which they could ultimately achieve more important intrinsic

aspirations, such as the ability to affect changes in healthcare, and the opportunity to continue learning and developing in their careers.

Another exemplar of this is in relation to emigration. Most TDNs discussed their desire to move abroad in the sub-theme of 'Wanting a Higher Degree'. Emigration among health-care professionals is a well-known phenomenon in Egypt and is explained by the circumstances that surround the Egyptian context of healthcare and education, and the economic crisis in the country (Farag, 2008; IOM, 2011). Nurses in the early stages of their careers have expressed a need to make career decisions that support their ideals of practice and career progression (Price, et al., 2018). Moreover, when professional aspirations are not met, it can impact on job and career satisfaction and retention of nurses (Robinson, Murrells and Clinton, 2006; Hallin and Danielson, 2008; Wang, et al., 2012). Previous research has also found when nurses are presented with limited prospects for development, they seek possibilities outwith their country of origin (Coughlan and Patton, 2018). Although these motivations were driven by extrinsic factors, such as monetary incentives, my findings imply that TDNs' career decisions to emigrate were also influenced by complex issues that go beyond economic benefits, such as the opportunity to implement quality nursing care and for increased prospects for development, as well as a chance for a better quality of life. These motivations, although clearly driven by extrinsic factors, again stemmed from underlying aspirations to fulfil more intrinsic goals. Existing studies within the SDT literature have also shown people prioritise extrinsic over intrinsic aspirations in situations of economic and interpersonal threat, and that financial satisfaction is a stronger predictor of life satisfaction and subjective well-being in poor countries in comparison to wealthier ones (Grouzet, et al., 2005; Martos and Kopp, 2012; Nishimura and Suzuki, 2016).

#### *6.2.3 Key findings related to research objective 3*

This objective asked about the challenges, influencing factors and opportunities that affect TDNs' professional development and career growth. Overall, structural inadequacies of the educational and healthcare system in Egypt posed significant challenges and limited TDNs' opportunities for development. Issues such as heavy workloads, financial constraints, as well as the accessibility, availability and relevance of tertiary education provision in the country were voiced by participants. The centralisation of Egypt's educational infrastructure being confined to the capital, Cairo, and inflexible and traditional approaches to learning (Abdelaziz, et al., 2018), as well as the general

lack of quality hospitals with policies that facilitate CPD and career advancement for TDNs, go some way to explain some of these findings (WHO, 2006; 2012; IOM, 2011). Nevertheless, these challenges are similar to those noted within the international nursing literature (Chiu, 2005; Penz, et al., 2007; Hegney, et al., 2010; Cleary, et al., 2013; Coventry, Maslin-Prothero and Smith, 2015; MacDonald, et al., 2020). Broader social and cultural attitudes, such as the low prestige of nursing, and to some extent gender issues, were also noted as affecting TDNs' development, a finding which also resonates with studies from other non-western countries, including Malaysia and Singapore (Chiu, 2005; Cleary, et al., 2013). Social and cultural factors impact on an individual's satisfaction of needs and subsequent motivation (Ryan and Deci, 2000a), as well as their pursuit and attainment of goals (Deci and Ryan, 2000). These challenges described by participants were subsequently thwarting innate psychological needs and help explain why controlled extrinsic motivation and aspirations tended to be prioritised by TDNs in this study.

Nevertheless, the theme of 'Sources of Support' offered examples of social-contextual influences which allowed for opportunities for need satisfaction. Healthcare organisations were perceived to play an important role in assisting with TDNs' development. As illustrated in the sub-theme 'Organisational Support', this support was comprised of many constructs. Managers, senior colleagues and peers were identified as important. These findings echo those from the international nursing literature (Hart and Rotem, 1995; Ikeda, Inoue and Kamibeppu, 2008; Brekelmans, Poell and Van Wijk, 2013; Govranos and Newton, 2014; Coughlan and Patton, 2018). Autonomy-supportive behaviours displayed by colleagues, along with other identified strategies within the workplace, helped to fulfil TDNs' basic needs, which in turn controlled external motivators. Examples of such strategies included the appraisal and promotional system which focused on performance rather than academic certificates, opportunities for horizontal career growth and clinical rotations, organised learning activities within the hospital, collaboration with a local HEI, access to the internet and electronic databases, as well as incentives for clinical nurses, such as a good salary. The importance of creating learning environments which facilitate intrinsic motivation and internalisation of autonomous self-regulation has been highlighted within SDT (Orsini, Evans and Jerez, 2015). It was also notable that the TDNs interviewed in this study voiced a strong sense of personal responsibility to engage in self-learning. This helps to explain why Phase 1 participants, outside of formal methods of learning, autonomously acquired a habit of spending time and effort in keeping up-to-date and on the whole, perceived the host hospital as an organisation in which TDNs could develop professionally and grow within their careers.

The influence of family, as well as marriage and children, on decision-making regarding CPD and careers was described by nearly all participants, highlighted in the sub-theme 'Family and Marriage'. Social and domestic factors have been found to be important catalysts for professional learning for nurses (Burrow, et al., 2016). Nevertheless, this has not emerged as powerfully in other published research regarding younger nurses in the early stages of their careers as the TDNs interviewed in this study. This can perhaps in some part be explained by the circumstances that surround the traditional collectivistic nature of the Arabic culture (Elsaid and Elsaid, 2012), where there are societal pressures for marriage and the responsibility to care for extended family dependents lies with the family itself rather than society (Okasha, Elkholy and El-Ghamry, 2012). As a result, TDNs encountered domestic obligations earlier in their careers, hence why the issue of domestic support was perceived to have a significant bearing on development. Notably, the subject of domestic commitments was expressed almost equally by both male and female participants interviewed in Phase 1, which contrasts to the literature wheresuch topics have been mostly noted among women (Chiu, 2005). From the perspective of SDT, close personal relationships provide satisfaction of the need for relatedness, and to some extentautonomy and competence (Ryan and Deci, 2000a), and consequently, individuals are pushed towards extrinsic goals when they perceive their need satisfaction to be thwarted (ibid). Extrinsicgoals, such as honouring the wishes of the family elders, can be particularly strong in collectivistsocieties and subsequently, more important (Brdar, Rijavec, and Miljković, 2009) and group autonomy, instead of personal autonomy, is often favoured (Lyengar and Lepper, 1999). As a result, individuals can subordinate their personal intrinsic goals to collective extrinsic ones and may forgo their well-being in favour of the overall group well-being (ibid.). It was evident that if families or spouses did not display autonomy-supportive behaviours towards TDNs' CPD and career goals, then it was difficult for them to make self-determined decisions and fulfil their intrinsic aspirations in relation to their careers. This finding echoes previous research within the SDT literature, which has found that satisfaction of psychological needs and consequent feelings of subjective well-being, were often reliant on parents and romantic partners when the relationshipswere viewed as highly autonomy-supportive (Deci, et al., 1991; Grolnick, 2009; Ratelle, Simard and Guay, 2013).

### *6.2.4 Key findings relating to research objective 4*

The last objective related to senior academic nursing faculty members and healthcare professionals' perceptions of TDN graduates' professional development and career advancement. Issues which were found to be important to TDNs in Phase 1 were also emphasised by Phase 2 participants. Hence, conceptualisation of themes and the categories within them remained fairly constant during data analysis. This could be because the issues highlighted in this study are well known (at an anecdotal level) within the Egyptian context. Nonetheless, although overall similar experiences of the professional development and career advancement of the TDN graduates were identified within the two data sets, the extent to which some issues were described by Phase 2 participants differed.

These differences were particularly evident when participants were describing the perceived challenges of TNDs' development. Insufficient time was mentioned as a significant barrier to learning and development by nearly all Phase 1 participants. Staff shortages combined with long-contractual hours affected their ability to engage in self-directed learning or in-house organised CPD activities within the hospital. Moreover, the lack of study leave and funding provision, together with rigid scheduling of university courses, meant inevitably, TDNs continued working full-time while studying for a Bachelor degree. These issues were not cited to the same extent in Phase 2. By merit of their positions within education and management, Phase 2 participants worked considerably fewer hours than their clinical colleagues which may explain why they did not perceive this issue as being a substantial challenge in comparison to the TDNs interviewed in this study. Moreover, a recent collaboration between the host hospital and a new local university Technical Degree programme in Upper Egypt was possibly seen by Phase 2 participants as a solution to some of these issues.

Notable differences in perceptions between the two groups of participants were also described in the theme 'Moving up the Career Ladder'. The majority of Phase 1 participants stressed the importance of working in a supportive collegial team and receiving timely and constructive feedback from senior colleagues. From an SDT standpoint, receiving feedback is an essential component of experiential learning in the clinical area (Ten Cate, Kusurkar and Williams, 2011) and is an important strategy to support the psychological need for competence (Orsini, Evans and Jerez, 2015). Some Phase 1 participants also discussed their negative experiences of the

hospital appraisal process. Notably, these topics were not elaborated upon by participants in Phase 2. Nevertheless, Phase 2 participants did stress the importance of good communication skills as influential for career advancement. This finding, however, may imply that some healthcare managers might not be self-aware of their appraisal practices or that criteria for effective performance for TDNs are not well-advertised. Previous work by Orsini, et al. (2016) has also found clinical educators unfamiliar with SDT principles may unintentionally exert controlling, pressurising and coercive behaviours, which might have been the case here. This finding could therefore suggest healthcare managers require further training in conducting effective performance appraisals, especially around the concept of feedback, although this is an area that merits further research.

Participants in Phase 1 also noted they did not receive formal support regarding their professional development options or career planning. These issues were not mentioned by Phase 2 participants. According to Donner and Wheeler (2001), career planning and development is an integral part of developing as a professional in which both schools of nursing and employers play an important role. Moreover, Philippou (2015) advocates younger employees are significantly more likely to indicate they would like responsibility for career and future development planning to be shared between the employee and employer, rather than solely the responsibility of the employee. Consistent with the literature, the most common technique utilised for career development in this study was formal, structured education programmes (Jacob, McKenna and D'Amore, 2016; McKenna, et al., 2019; Leon, Tredoux and Foster, 2019). Nevertheless, informally, senior colleagues within the hospital also played an important role through coaching and mentoring, and encouraging and facilitating continued education (Sonmez and Yildirim, 2009; Price, et al. 2018). These findings suggest a possible lack of awareness among Phase 2 participants of factors that affect career advancement, and a need for career planning and developing practices within the hospital to be more formalised and structured. Furthermore, the findings indicate both nurse educators and healthcare managers may require further training to support career development and management activities, both during preparation for practice and in subsequent postgraduate educational programmes, as well as within the workplace. These findings have also been found by Coughlan and Patton (2018).

The importance of having a good level of nursing education preparation to support the development of TDN graduates was mentioned both by Phase 1 and 2 participants. Nevertheless, this was emphasised much more in Phase 2 and was consistently viewed as the best way to support TDNs to develop professionally and advance their careers. This can perhaps be explained by the imported curriculum implemented at the host Technical Institute of Nursing (see Section 1.5). Traditional curricula and learning environments perceived as controlling are known to impede students' autonomous motivation, compared with those that are autonomy-supportive (Orsini, Evans and Jerez, 2015). As a result, it may have been perceived by Phase 2 participants that the nurses interviewed in Phase 1 had been exposed more to lifelong learning practices in comparison to other TDNs from government-run institutions in which the nursing curricula have a more traditional approach to teaching and learning. However, there is no evidence to support this.

### 6.3 Implications for the practice of HPE

Overall, this study's key findings helped to explain the phenomena described around extrinsic and intrinsic tendencies of TDNs' motivation towards their professional development, as well as their career aspirations. Moreover, it has identified the socio-cultural characteristics that were significant to stimulate and facilitate autonomous self-regulation and feelings of competence, autonomy and relatedness among TDNs within the Egyptian educational healthcare context. Although the findings show there were contextual determinants of CPD motivation and career aspirations for TDNs, overall, the spectrum of motivation according to SDT and the facilitation of intrinsic motivation, social development and well-being as hypothesised by Ryan and Deci (2000a) also holds true in non-western cultures. This has been also confirmed by other studies within the literature (Stewart, et al., 2000; Chirkov and Ryan 2001; Sheldon, et al., 2004; Vansteenkiste, et al., 2005). Nevertheless, the findings differ from the existing literature from economically developed countries, in that TDNs' extrinsic drivers were often a way to achieve more intrinsic desires.

These findings therefore have several important implications for the practice of HPE within the Egyptian context. STD implies fulfilment of an individual's basic psychological needs is required to develop autonomous regulation of behaviour and become intrinsically-motivated towards learning (Ten Cate, Kusurkar and Williams, 2011). Low indices of motivation are subsequently

associated with restricted growth in achievement (Ryan and Deci, 2000a). Previous SDT studies within the health professions context have shown intrinsic motivation and autonomous self-regulation have a positive influence on learning, study behaviour and overall academic performance (Kusurkar, et al., 2013; Tjin A Tsoi, et al., 2016). Moreover, autonomously-motivated health professions students have demonstrated greater career satisfaction and feelings of well-being, leading to lowering of stress and burnout possibilities (Ratanawongsa, Wright and Carrese, 2008). Autonomy-supportive learning environments can also stimulate interest and curiosity within healthcare professionals to facilitate changes within practice, leading to more effective healthcare delivery and patient outcomes (Williams, Saizow and Ryan, 1999). Such environments may also help healthcare practitioners to foster a more autonomy-supportive style to motivate their patients. This, in turn, has been shown to lead to increased autonomous self-regulation among patients themselves, guiding them to positive health behaviour changes (Orsini, Evans and Jerez, 2015; Orsini, Binnie and Wilson, 2016).

The findings of this study reveal a mixed picture, with some social-cultural factors clearly more supportive of intrinsically motivated behaviour than others. Therefore, there are clearly still threats to the intrinsic component of TDNs' motivation and it is evident that more could be done to ensure autonomy-supportive conditions which provide more opportunities to develop professionally and advance in their careers. Outwith the host hospital, the culture of nursing HEIs and healthcare organisations in Egypt appear to shift TDNs away from intrinsic goals towards extrinsic rewards, focusing on income, promotion and prestige. A learner's self-direction and independence is also one of the major characteristics of lifelong learning, of which informal learning is an important component (Davis, Taylor and Reyes, 2014). My findings, however, illuminate a concept of CPD within Egypt which confines CPD to formal, intentionally-planned learning within an educational setting and neglects informal learning activities embedded in daily clinical practice. Consequently, existing structures focus on attainment of short-term goals, and do not promote lifelong learning or encourage TDNs to take responsibility for their learning. It is important educational and healthcare structures take account of the personal and professional needs and aspirations of TDNs to avoid creating a frustrated and de-motivated workforce (Wang, et al., 2012). According to Donner and Wheeler's (2001) career model, between 2-and-5-years following graduation, nurses shift their job focus towards career and long-term commitment, followed by the consolidation period where they become comfortable with their chosen career path, assume mentor or leadership roles and display a commitment to ongoing learning, concentrating on

contributing to healthcare and society. TDNs in this study were unable to fully actualise their professional development and career aspirations. Although TDNs were not particularly regretful of their career choice, previous studies among second-level nurses have shown feelings of being undervalued negatively influence retention (Leon, Tredoux and Foster, 2019). Failure to attract, retain and develop competent frontline TDNs at the bedside exacerbates nursing shortages and the already poor standards of patient care within the health sector in Egypt (WHO, 2012). Subsequent recommendations for practice and policy are outlined in Chapter Seven (see Section 7.3.1).

## 6.4 Reflection on the research process

### *6.4.1 Reflection on steps taken to ensure rigour*

Throughout this study, steps were taken to ensure a rigorous and reflexive approach to the research process. Techniques outlined by Lincoln and Guba (1985) for establishing trustworthiness of qualitative data (see Section 3.5) were applied to this study.

Throughout the study, I maintained reflexive notes (see Sections 3.5). This practice prompted thoughtful self-awareness of how I both influenced, and was influenced by, the research. Moreover, it assisted me to identify preconceptions, question assumptions and helped ensure continuous self-appraisal and critique. Adopting a reflexive approach also offered enhanced insights into developing themes and facilitated a deeper understanding of the topic under study.

All records resulting from the research, including reflexive notes and those which illustrated data collection and analysis processes, were kept, forming an auditable record of the research process. Such documents were regularly presented in academic supervision meetings for scrutiny of the decision trail (see Section 4.10.2). This practice subsequently produced a rich description of the research process and provided a transparent and detailed account of research methods, methodological decisions, and interpretations of data.

*6.4.2 Study limitations*

There are limitations to this study. Phase 1 focused on graduates from a single TIN employed at one hospital in Egypt. Additionally, the recruitment of senior academic nursing faculty and healthcare professionals interviewed in Phase 2 was limited to the identified TIN and stakeholder hospital. As described in Section 1.5, both institutions are privately-funded, non-profit organisations overseen by Egyptian charities. Therefore, the perceptions of those who had graduated from, or were employed in, settings such as government-run MOHP establishments (see Sections 1.3 and 1.4) were not captured in this study. Moreover, only Egyptian English-speaking participants were eligible to take part in the study and so the views of those who could not speak English were not represented. In addition, participants were selected based on those who were available during the days on which I visited the hospital. Consequently, this meant the views and perceptions of those who were not available during the time of the visits were missed. Moreover, individuals who consented to participate in interviews may have had different reasons for doing so compared to those who did not provide consent. Another limitation of this study was the fact that the hospital is located in a mainly rural area in Upper Egypt. Consequently, some of the issues raised in this study, such as those related to accessing higher education (see Section 5.4.1.3), may not be representative of an urban population. Together, these factors may have limited the diversity of perspectives explored and limit the transferability of the findings.

60% of the total population of TDN graduates were recruited for Phase 1 of the study with an equal number of male and female participants represented (see Appendix XXII: Participant Characteristics). Moreover, the socio-demographic characteristics of the target population for Phase 1 were like those of TDN graduates from other TINs within the country. Therefore, I considered the sample who volunteered in Phase 1 were representative of all elements of the target population. The use of a stratified sampling method in Phase 2 also enabled recruitment from a variety of disciplines (see Sections 4.7.2). Collectively, this added to the richness of perceptions and experiences that were attained.

It is also acknowledged that only one data collection method was utilised in this study which could be viewed as a limitation. Nevertheless, as mentioned in Section 3.4.4, in-depth semi-structured interviews corresponded with the study's aims and epistemological assumptions and were viewed

as the most culturally-sensitive method to establish rapport, generate insightful responses, and provide a rich understanding of perceptions within an Arab setting.

Lastly, an additional limitation relates to language choice of the in-depth semi-structured interviews. The interviews were conducted in English with participants for whom English is a second language (see Section 3.4.7). This may have impacted on participants' performance in the interview setting as discussions may have been inhibited by language competency. Moreover, the level of understanding and accuracy of interpretation during interview exchanges could also have been affected (Marshall and While, 1994). A number of strategies were therefore employed to ensure participants' understanding of what was being asked and the subsequent validation of the meaning of the responses during the interview process (see Sections 3.4.7; 4.9.1). For the vast majority of interviews, however, language did not appear to be a barrier as evidenced by the in-depth insights gained on the phenomenon under study.

As with all qualitative work, priority is given to obtaining a rich description of the phenomenon under study (see Section 3.3). Some of these findings might not be reflective of other institutions within Egypt who operate different practices in relation to CPD and career structures for TDNs. Views could have been sought from stakeholders from additional TINs, and healthcare organisations from different service providers, such as the MOHP, as well as from other governorates in Egypt. This might have offered an opportunity to explore a wider range of experiences and show some of the hidden aspects that were not explored in this study. However, this was not feasible within the timescale of this research. Furthermore, the lack of openness and transparency among institutions, especially within government organisations in Egypt, meant I was constrained to accessing only the host institutions identified in this study (see Appendix I: The Social, Economic and Demographic Context of Egypt). Moreover, the central characteristics of the phenomenon identified across the Phase 1 and Phase 2 interviews suggest the issues raised in this study are indeed important to the professional development and career advancement of TDNs in Egypt.

This study demonstrates a robust approach to qualitative research, considering trustworthiness through maintaining reflexivity, with an audit trail to ensure transparency in the research process (see Section 6.4.1). Moreover, the key findings and implications of this research may be relevant

to nursing, and indeed other health professions within the context of LMIC settings, and also for those countries which have two levels of entry for registered nurses.

*6.4.3 Reflection on my influence on the research*

It is acknowledged that I had a degree of insiderness in many aspects of this work. Nevertheless, at times during the study, I also felt I was an 'outsider'. As discussed in Section 3.6, the literature describes an 'insider–outsider continuum' (Mikecz, 2012, p.490), where positionality is not static and researchers can hold more than one positionality at any given time rather than as an 'either/or dichotomy' (Greene, 2014, p.2). This can pose some methodological and ethical challenges for the researcher. Nonetheless, it can also present significant benefits in qualitative studies (Mercer, 2007; Greene, 2014). My contextual knowledge allowed me to make methodological decisions that were culturally-sensitive. Moreover, being already known to the host organisations and having a degree of pre-existing familiarity and rapport with some of the study population was critical for achieving access approval and facilitating engagement in the research. These benefits produced a more truthful, and authentic understanding of the topic under study.

Nonetheless, my role in relation to participants in this study was influenced by several factors. Firstly, there were variables between me and the participants in terms of age, educational level, ethnicity, religion and culture. Secondly, as mentioned in Section 4.6.2, I was also known to many of the participants. These factors could have influenced participants' decision to take part in the research and how they responded to interview questions.

To counteract these potential issues, a culturally-sensitive approach to recruitment and interviewing was adopted to help facilitate trust, establish a good rapport, and create an equal power dynamic between myself and participants (see Sections 4.7; 4.9.1; 4.9.2). Participating in friendly, casual conversation before the interviews, conversing in colloquial Arabic when appropriate, and adapting my style of dress for the Phase 1 and 2 interviews, were simple, yet helpful strategies to help me 'blend in' (Mikecz, 2012) and dispel the risk of possible power discrepancies during data collection (Hawamdeh and Raigangar, 2014). Moreover, as advised by Mercer (2007), presenting oneself as a researcher rather than as a nurse educator to participants was also useful to further minimise any would-be power differentials. Reassurances

of confidentiality and anonymity were also given during the interview encounter and I was careful to maintain neutrality by refraining from asking leading questions or appearing to challenge or oppose participants' opinions during the interview process. Reflexive notes taken immediately after each interview regarding non-verbal body language and behaviour also served as a useful tool to reflect on the perceived honesty of participants' responses (Hawamdeh and Raigangar, 2014).

Differences in age and educational level between myself and participants were more apparent in Phase 1. I am a British expatriate and I was in my late thirties at the time of conducting the research. This contrasted with Phase 1 participants, who were Egyptian nationals mainly in their early twenties. I knew from experience of Egyptian culture that members of the younger generation are expected to show signs of respect and not to challenge their seniors. Also, social class is very apparent in Egypt and influences a person's access to power and position. I was known to Phase 1 participants as a nurse educator from the identified TIN. As a result, the TDN graduates may have perceived me as being in a position of authority and could have adjusted their replies to comply with what they thought I wanted to hear. This has been noted of Arab participants in previous qualitative interview studies (Hawamdeh and Raigangar, 2014). While it is arguable that these factors made me an 'outsider', I believe my prior knowledge of this group of participants and Egyptian culture simultaneously made me an 'insider'. I was conscious of how aspects of my outsider status impacted on the interviews and this was subject to ongoing self-critique during Phase 1 data collection process. An extract from my reflexive notes after a Phase 1 interview and the discussion that follows, illustrates my reflections and how at times, the boundaries between my insider/outsider status were often as Greene (2014, p.2) refers to as 'blurred'.

> *'She was an active participant in the interview, and we had good rapport. However, she (like other participants interviewed earlier) discussed at length her aspirations to continue her studies to Doctoral level and gain a prominent position in a hospital. It got me thinking: did the participants speak truthfully and honestly, or did the fact that I was a nurse educator from the Institute affect their responses? Are they worried about 'losing face' and therefore expressing inflated aspirations?'*

This is an issue I had first recognised and reflected on in the second pilot interview for this phase of the study (Appendix: XVII). As interviewing progressed in Phase 1, it became clear that aspiring to a higher degree and position was becoming a developing theme. My contextual knowledge helped me to reflect upon and interpret these findings. Rather than 'losing face', it became clear the poor societal image of the bedside nurse, and unclear CPD and career pathways for TDNs were extrinsically motivating participants to assume high positions that may be associated with greater esteem.

My insider status was also critical to establishing trust and rapport and obtaining personal views during the interview process. One illuminative example of this relates to the frank discussions that arose during many Phase 1 interviews about participants' anxieties of the impact of family and marriage on their CPD and career development (see Section 5.5.1). The collective nature of Egyptian society means loyalty to the family unit and strong societal expectations for marriage are often placed above individual desires (See Appendix XXII: Participant Characteristics). Such culturally-sensitive issues might not have otherwise been disclosed if I had been Egyptian or unfamiliar to the participants.

I also had a professional relationship with the senior academic nursing faculty and was known to some of the healthcare professionals at the host hospital. Although I did not hold a hierarchical position above any of Phase 2 participants, some may have been reluctant to disclose information which was perceived to be damaging to individuals or the host organisations involved in the study. Senior healthcare professionals might also have felt their practice and policy related to CPD and career structures of TDN employees within the host hospital was under scrutiny. These factors may have made Phase 2 participants hesitant to disclose their true feelings for fear of losing face or credibility.

I considered myself an 'informed outsider' (Mikecz, 2012) when interviewing senior managers, which was valuable. My position as a foreign researcher from a UK university gave me credibility and put me on the same 'level' as this group of participants, and allowed me to foster individual rapport and ask blunt questions which I might have been hesitant to do if interviewing a senior positioned above me from my own institution. Yet, at the same time, my 'inside view' of the

Egyptian context allowed me to understand and interpret the obtained information. The advantages of foreign researchers interviewing elites has been discussed previously (Mikecz, 2012).

Overall, it was evident that the aforementioned issues did not seem to hinder participants' willingness to speak openly and candidly and the interviews appeared to represent a welcome opportunity to discuss their experiences and express their views. It was apparent in Phase 1 that participants, because they had already graduated from the TIN, viewed me as more of a supportive mentor rather than a traditional authority figure. Also, the pre-established collegial working relationships that I had with the senior academic nursing faculty in Phase 2 helped to satisfy me that their responses were representative of their opinions. Additionally, my positionality with senior healthcare professionals from the host hospital meant that the interview was perceived as an opportunity to have an informed discussion as evidenced by the in-depth responses to my questions.

### 6.5 Chapter conclusion

This chapter has discussed the key findings of this research. It has also offered an interpretation of the findings facilitated by the study's conceptual framework which was rooted in SDT of Human Motivation (Ryan and Deci, 2000a). The implications for the practice of HPE were also presented. A reflection on the research process was also offered regarding the steps taken to ensure rigour, the study's limitations, as well as my influence on the research process. The next chapter provides a brief overview of the main conclusions and recommendations related to this work.

## Chapter Seven: Conclusions and Recommendations

### 7.1 Introduction

In this final chapter, the main findings of this qualitative descriptive exploratory study are summarised. Recommendations for practice, policy, and further research concerning TDN education are also presented.

### 7.2 Summary of main findings

The findings of this research contextualise the study of professional development and career advancement among TDNs within an Egyptian setting. It does so by describing and exploring perceptions from TDN graduates themselves, and from the standpoint of nurse educators and healthcare managers within the country. The study's conceptual framework, guided by Ryan and Deci's (2000a) SDT of Human Motivation, illustrates extrinsic and intrinsic tendencies of the graduates' aspirations and motivations, and the sociocultural factors which influenced their decision-making around their professional development and careers. Overall, the findings showed TDNs often faced significant challenges which limited opportunities for professional growth. These challenges thwarted the satisfaction of innate psychological needs and shifted the graduates towards extrinsic rewards. Nevertheless, often these extrinsic drivers represented how TDNs could ultimately achieve more important intrinsic goals. The findings of this research build upon the existing international body of literature, adding new perspectives from an Egyptian context. The main findings from this research are listed below:

- TDN graduates participated in a broad and varied range of formal and informal learning activities to develop expertise. However, participation in postgraduate studies within Egypt was not perceived to be associated with the development of professional competencies.

- Emphasis was placed on informal learning within the workplace environment. However, outside of the context of the host hospital, such methods of learning were given little recognition by healthcare organisations in Egypt.

- Perceived healthcare organisations' policies and procedures outwith the host hospital hampered TDNs' opportunities to progress up the career ladder, develop skills and abilities, and move between different healthcare settings.

- Postgraduate education was pursued for extrinsic rewards only, with predominant drivers attributed to opportunities for increased career advancement and professional status, in comparison to engagement in informal CPD activities, which were motivated by intrinsic factors.

- TDNs mainly aspired to higher positions in their future careers. Promotion was seen as moving away from the bedside into management or positions within academia.

- When presented with limited prospects for development, TDNs sought possibilities outside of Egypt to fulfil their professional development and career aspirations.

- The structural and system inadequacies of the educational and healthcare system in Egypt posed significant challenges for TDNs, which limited opportunities for development.

- Social and cultural attitudes, such as the low prestige of nursing and of TDNs, were noted to affect development.

- Organisational factors were key to facilitating both formal and informal methods of CPD, as well as career advancement for TDNs. Moreover, social support from senior colleagues and peers, as well as domestic support were influential in stimulating learning and career development.

- The influence of family, as well as marriage and children, played a significant role in the decision-making regarding TDNs' CPD and careers.

- TDNs received limited formal support regarding their professional development options or career planning.

## 7.3 Recommendations

### *7.3.1 Recommendations for practice and policy*

Based on the findings from this study, there are some recommendations for practice and policy that may be considered by nurse educators and healthcare managers from the host institutions. This study suggests that the principles of SDT could be a valuable foundation for informing strategies to best support TDNs to develop professionally and advance in their careers. Consequently, practice and policy recommendations within the host TIN and stakeholder hospital should focus on creating conditions which enhance TDNs' satisfaction of basic psychological needs and subsequent forms of autonomous motivation, which in turn, will allow them to become more self-determined and support optimal functioning.

There is scope for the host stakeholder hospital to strengthen policies which value, support and empower clinical nurses at the bedside so that they can contribute positively to improvement initiatives in the delivery of care and services that ultimately meet patients' needs. Incentives such as manageable working hours, better working conditions and salaries would help to improve the attractiveness of clinical positions at the bedside, along with a review of job descriptions which allows TDNs to take more responsibility for managing their own work. Furthermore, career structures for nurses need to be re-reviewed within the host hospital to allow for more promotional ladders within clinical practice. Promotion should be linked to performance review based on clinical competence and experience, provide opportunities for horizontal rather than purely vertical career mobility, and offer more possibilities for specialisation.

The host TIN does not currently offer post-registration provision for TDN graduates. The development of tailored post-registration courses through stronger collaboration between the host institutions would increase opportunities for TDNs to engage in formal mechanisms of CPD which are more aligned with the needs of the host hospital, the requirements of the nursing profession, and importantly, the needs of TDNs themselves. Post-registration curricula developed by the TIN should be flexible and student-centred, with teaching and learning strategies to meet the needs of adult learners. Technology could be utilised to deliver such courses online and allow for options of part-time distance and/or work-based learning which will also help ensure better accessibility.

The host hospital should also provide greater levels of support for TDNs to engage in formal CPD activities through offering financial support and study leave provision. CPD provision in the host hospital should also go further to recognise the value of informal learning in the clinical environment.

Both senior healthcare professionals and nurse educators from the host institutions should be offered the appropriate training and support to acquire the knowledge and skills necessary to satisfy the psychological needs of competence, relatedness, and autonomy of junior TDN colleagues and students; and to adopt instructional strategies to foster an autonomy-supportive environment. Special focus should be given to aspects related to the feedback process, performance appraisals, personal development plans, as well as structured mentoring and coaching from an SDT perspective. Career support and guidance strategies could become more formalised and built into both the Technical Diploma curriculum of the host TIN and within the host stakeholder hospital. This will help to ensure TDNs are adequately prepared to assume greater responsibility for their career management and make informed choices regarding their continuing education and careers.

Lastly, domestic support from parents and spouses are not variables which can be manipulated by nurse educators or healthcare managers. Nevertheless, the introduction of family-friendly policies such as options for part-time contracts, flexible working hours and creating more opportunities for work and study closer to home by the host stakeholder hospital may help to integrate gender and cultural issues into the framework of the recruitment and retention process.

### *7.3.2 Recommendations for further research*

This study has highlighted some areas for future research. If feasible, further work with a larger research sample would be of benefit to explore perceptions of TDNs' professional development and career advancement across a range of healthcare and educational institutions in Egypt to expand the findings of this study. It would be of interest to explore the extent to which SDT principles are currently applied within the host TIN's academic curriculum and its subsequent impact on promoting intrinsic motivation and internalisation of autonomous self-regulation among Technical Diploma Nursing students. Moreover, additional work should perhaps be directed at

examining the needs and competency of nurse educators and senior healthcare professions from the host institutions in promoting self-determination within the academic and clinical environment. A wider range of research methodologies could be employed to explore these suggested areas. Quantitative data collection methods could be also utilised to triangulate the findings of this qualitative work which would add further insights into the concept of TDNs' motivations for their professional development and career aspirations from the perspective of SDT.

### *7.3.3 Next steps and dissemination of work*

A summary of the key findings of this research was sent individually, *via* email, to those participants who requested it during the consent process. I adopted certain strategies when disseminating the findings of this research locally to stakeholders from the host institutions to ensure the long-term confidentiality of participants (Mercer, 2007). In keeping with the cultural preference for oral communication, I chose to engage in individual face-to-face dialogue with selected stakeholders to discuss the key findings and recommendations of the study in a more general manner rather than sharing written information. Moreover, I waited for up to one year after the completion of the research before approaching stakeholders in the knowledge that several of the participants had left their position at their respective institution (Turcotte-Tremblay and McSween-Cadieux, 2018).

Many of the challenges highlighted by participants in this research related to current educational and healthcare structures within the country. Therefore, a synopsis of this work's general findings and recommendations will be sent to the Supreme Council of Deans of Faculties of Nursing in the MOHE, who are responsible for monitoring and reviewing all Bachelor-level nursing curricula, and the head of the Egyptian Nursing Syndicate to ensure findings are disseminated to key audiences within the academic community, as well as health and education, at a national level. The research context will be described in a way as to protect the collective confidentiality and anonymity of participants and host institutions.

To disseminate the findings at an international level, I am currently pursuing publication in a peer-reviewed health professions education journal and plan to present key findings at a conference

in the healthcare professions across the continuum of undergraduate, postgraduate and continuing education.

To build on the findings of this research, work is currently being undertaken within the host TIN to strengthen career support and guidance offered to TDNs during their period of study through to and after graduation. Additionally, training workshops in mentoring and coaching strategies from an SDT perspective are in the process of being developed and will be offered to nurse educators at the host TIN, as well as clinical educators and senior nurses from the host stakeholder hospital. Discussions are planned with stakeholders from the host institutions to help to inform course development opportunities and better plan and deliver post-registration education that meets the needs of TDN graduates within their work context.

### 7.4 Thesis conclusion

In conclusion, this study has provided an opportunity to explore and describe the perceptions of the professional development and career advancement of TDN graduates from a private non-profit TIN employed at one hospital in Egypt. The conceptual framework of this study, which encompassed aspects of SDT, helped to draw together findings from perceptions of TDNs, nurse educators and healthcare managers within the country and provided a more nuanced understanding of the social and cultural factors which influenced the graduates' motivations and aspirations for development. TNDs constitute a significant part of the nursing workforce in Egypt and it is therefore important they can fully actualise their professional development and career aspirations to contribute effectively to the country's healthcare system. Although perspectives were gathered from only two institutions, the study's key findings and implications could provide a baseline for suggestions on how Technical Diploma-level nurses could be best supported to achieve optimal growth within an Egyptian context.

**List of References**

Abdelaziz, A., Kassab, S.E., Abdelnasser, A. and Hosny, S., 2018. Medical education in Egypt: historical background, current status, and challenges. *Health Professions Education*, [e-journal] 4 (4), pp.236 – 244. doi.org/10.1016/j.hpe.2017.12.007.

Abd El Hamid, A., El Mola, M. and Mohamed, S., 2018. Staff nurses expected role versus actual role at South Valley University. *Egyptian Nursing Journal*, [e-journal] 15 (1), pp.62 – 70. doi: 10.4103/ENJ.ENJ_30_17.

Abu-Qamar, M., Z, Vafeas, C., Ewens, B., Ghosh, M. and Sundin, D., 2020. Postgraduate nurse education and the implications for nurse and patient outcomes: A systematic review. *Nurse Education Today*, [e-journal] 92. doi.org/10.1016/j.nedt.2020.104489.

Adams, E., 2010. The joys and challenges of semi-structured interviewing. *Community Practitioner*, [e-journal] 83 (7), pp.18 – 21. Available at: <http://search.ebscohost.com.ezproxy.lib.gla.ac.uk/login.aspx?direct=true&db=cin20&AN=105038576&site=ehost-live> [Accessed 15 March 2016].

Aiken, L. H., 2014. Baccalaureate nurses and hospital outcomes more evidence. *Medical Care*, [e-journal] 52 (10), pp. 861 – 863. doi: 10.1097/MLR.0000000000000222.

Al-amer, R. M., Ramjan, L., Glew, P., Darwish, T. T., Randall, S. and Salamonson, Y., 2018. A reflection on the challenges in interviewing Arab participants. *Nurse Researcher*, [e-journal] 26 (1), pp. 19 – 22. doi: 10.7748/nr.2018.e1559.

Ali, H. I., 2017. Societal factors that induce career change decision among nurses working at different Sohag city hospitals. *Egyptian Nursing Journal*, [e-journal] 14 (2), pp. 130 – 140. Available at: <http://www.enj.eg.net/text.asp?2017/14/2/130/223094> [17 April 2018].

Álvarez-Galván, J., 2015. *A Skills beyond school review of Egypt*. [pdf] OECD Reviews of Vocational Education and Training, OECD Publishing. Available at: <http://dx.doi.org/10.1787/9789264209626-en> [Accessed 26 June 2016].

Ameliabd.com, 2018. Upper Egypt Map. [image online] Available at: <http://ameliabusinessdirectory.com/world/upper-egypt-map/attachment/upper-egypt-map-from-i-4> [Accessed 25 March 2019].

Annells, M., 2007. Guest editorial: What's common with qualitative nursing research these days? *Journal of Clinical Nursing*, [e-journal] 16, pp.223 - 224. doi:10.1111/j.1365-2702.2006.01666.x.

Assalahi, H., 2015. The philosophical foundations of educational research: a beginner's guide. *American Journal of Educational Research*, [e-journal] 3 (3), pp. 312 - 317. doi: 10.12691/education-3-3-10.

Bahn, D., 2007a. Reasons for post registration learning: impact of the learning experience. *Nurse Education Today*, [e-journal] 27 (7), pp. 715 – 722. doi.org/10.1016/j.nedt.2006.10.005.

Bahn, D., 2007b. Orientation of nurses towards formal and informal learning: motives and perceptions. *Nurse Education Today*, [e-journal] 27 (7), pp.723 – 730. doi.org/10.1016/j.nedt.2006.10.006.

Baillie, L., 2019. Exchanging focus groups for individual interviews when collecting qualitative data. *Nurse Researcher*, [e-journal], [published online ahead of print 11 April]. doi:10.7748/nr.2019.e1633.

Baker, C., Wuest, J. and Stern, P. N., 1992. Method slurring: the grounded theory/phenomenology example. *Journal of Advanced Nursing*, [e-journal] 17 (11), pp.1355 - 1360. doi:10.1111/j.1365-2648.1992.tb01859.x.

Bandura, A., 1986. *Social Foundations of Thought and Action: A Social Cognitive Theory*. Englewood Cliffs, New Jersey: Prentice Hall.

Barr, H., Freeth, D., Hammick, M., Koppel, I., Reeves, S., 1999. *Evaluating Interprofessional Education: A United Kingdom Review for Health and Social Care*. [pdf] London: British Educational Research Association/Centre for the Advancement of Interprofessional Education. Available at: <https://www.caipe.org/resources/publications/barr-h-freethd-hammick-m-koppel-i-reeves-s-2000-evaluations-of-interprofessional-education> [Accessed 26 May 2020].

Barriball, K. L. and While, A., 1994. Collecting data using a semi-structured interview: a discussion paper. *Journal of Advanced Nursing*, [e-journal] 19 (2), pp.328 – 335. doi: 10.1111/j.1365-2648.1994.tb01088.x.

Baumann, A. and Fisher, A., 2007. *Capacity building in higher education: situational analysis of nursing Aswan, Egypt*. [consultation report] Aswan: Om Habibeh Foundation. Unpublished.

Baumbusch, J., 2010. Semi-structured interviewing in practice-close research. *Journal for Specialists in Pediatric Nursing*. [e-journal] 15 (3), pp.255 – 258. doi: 10.1111/j.1744-6155.2010.00243.x.

Beauchamp, T. and Childress, J., 2001. *Principles of biomedical ethics*. Oxford: Oxford University Press.

Benner, P., 1984. *From novice to expert*. Menlo Park, California: Addison-Wesley.

Birt, L., Scott, S., Cavers, D., Campbell, D., and Walter, F., 2016. Member Checking: A Tool to Enhance Trustworthiness or Merely a Nod to Validation? *Qualitative Health Research*. [e-journal] 26 (13), pp. 1802 – 1811. doi: 10.1177/1049732316654870.

Blay, N. and Smith, L., 2020. An integrative review of Enrolled Nurse recruitment and retention. *Collegian*. [e-journal] 27 (1), pp. 89 – 94. doi.org/10.1016/j.colegn.2019.06.005.

Bowen, K. and Prentice, D., 2016. Are Benner's expert nurses near extinction? *Nursing Philosophy*, [e-journal] 17 (2), pp. 144 - 148. doi:10.1111/nup.12114.

Bowles, N., 1999. The Delphi technique. *Nursing Standard*, [e-journal] 13 (45), pp.32 - 36. doi: 10.7748/ns1999.07.13.45.32.c2650.

Boyatzis, R. E., 1998. *Transforming qualitative information: thematic analysis and code development*. Thousand Oaks, California: Sage Publications.

Boychuk-Duchscher, J., Cowin, L., 2004. Multigenerational nurses in the workplace. *The Journal of Nursing Administration*, [e-journal], 34 (11), pp.493 – 501. DOI:10.1097/00005110-200411000-00005.

Braun, V. and Clarke, V., 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology*, [e-journal] 3 (2), pp.77 – 101. doi: 10.1191/1478088706qp063oa.

Braun, V. and Clarke, V., 2013. *Successful qualitative research: A practical guide for beginners*. London: Sage publications.

Braun, V. and Clarke, V., 2014. What can thematic analysis offer health and wellbeing researchers? *International Journal of Qualitative Studies on Health and Well-being*, [e-journal] 9 (1), p. 26152. doi: 10.3402/qhw.v9.26152.

Braun, V. and Clarke, V., 2016. (Mis)conceptualising themes, thematic analysis, and other problems with Fugard and Potts' (2015) sample-size tool for thematic analysis. *International Journal of Social Research Methodology*, [e-journal] 19 (6), pp.739 – 743. doi: 10.1080/13645579.2016.1195588.

Braun, V. and Wilkinson, S., 2003. Liability or asset? Women talk about the vagina. *Psychology of Women Section Review*, 5 (2), pp.28 - 42.

Brdar, I., Rijavec, M., and Miljković, D., 2009. Life goals and well-being: are extrinsic aspirations always detrimental to well-being? *Psychological Topics*, [e-journal] 18 (2), pp.317 - 334. Available at: <https://hrcak.srce.hr/48216> [Accessed 7 January 2019].

Bree, R. and Gallagher, G., 2016. Using Microsoft Excel to code and thematically analyse qualitative data: a simple, cost-effective approach. *All Ireland Journal of Teaching and Learning in Higher Education (AISHE-J)*, [e-journal] 8 (2), pp.2811 - 28114. Available at: <http://ojs.aishe.org/index.php/aishe-j/article/view/281/467> [Accessed 2 April 2017].

Brekelmans, G., Poell, R. F. and Van Wijk, K., 2013. Factors influencing continuing professional development: a Delphi study among nursing experts. *European Journal of Training and Development*, [e-journal] 37 (3), pp.313 – 325. doi.org/10.1108/03090591311312769.

British Educational Research Association (BERA), 2018. *Ethical Guidelines for Educational Research*. 4th ed. [pdf] London: BERA. Available at: < https://www.bera.ac.uk/wp-content/uploads/2018/06/BERA-Ethical-Guidelines-for-Educational-Research_4thEdn_2018.pdf?noredirect=1> [Accessed 2 December 2019].

Britten, N., 2005. Making sense of qualitative research: a new series. *Medical Education*, [e-journal] 39, p5 - 6. doi:10.1111/j.1365-2929.2004.02024.x.

Brown, A. and Danaher, P. A., 2017. CHE Principles: facilitating authentic and dialogical semi-structured interviews in educational research. *International Journal of Research and Method in Education*, [e-journal] 42 (1), pp.76 – 90. doi: 10.1080/1743727X.2017.1379987.

Brownie, S., Docherty, C., Al-Yateem, N., Gadallah, M. and Rossiter, R., 2018. Developing a national competency-based curriculum for Technical nurses in Egypt. *Eastern Mediterranean Health Journal*, [e-journal] 24 (9), pp.922 – 932. doi: org/10.26719/2018.24.9.922.

Bryman, A., 2016. *Social Research Methods*. 5th ed. Oxford: Oxford University Press.

Bunniss, S. and Kelly, D. R., 2010. Research paradigms in medical education research. *Medical Education*, [e-journal] 44, pp.358 - 366. doi:10.1111/j.1365-2923.2009.03611.x.

Burnard, P., 2005. Interviewing. *Nurse Researcher*, [e-journal] 13 (1), p4 - 6. doi:10.7748/nr2005.07.13.1.4.c5995.

Burnard, P., Gill, P., Stewart, K., Treasure, E. and Chadwick, B., 2008. Analysing and presenting qualitative data. *British Dental Journal*, [e-journal] 204 (8), pp.429 – 432. doi.org/10.1038/sj.bdj.2008.292.

Burns, R. B., 2000. *Introduction to research methods*. 4th ed. Thousand Oaks, California: Sage Publications.

Burrow, S., Mairs, H., Pusey, H., Bradshaw, T. and Keady, J., 2016. Continuing professional education: motivations and experiences of health and social care professional's part-time study in higher education. A qualitative literature review. *International Journal of Nursing Studies*, [e-journal] 63, pp.139 – 145. doi:10.1016/j.ijnurstu.2016.08.011.

Byrne, J., 2016. Improving the peer review of narrative literature reviews. *Research Integrity and Peer Review*, [e-journal] 1 (12), p.1 – 4. DOI 10.1186/s41073-016-0019-2.

Caelli, K., Ray, L. and Mill, J., 2003. 'Clear as mud: toward greater clarity in generic qualitative research. *International Journal of Qualitative Methods*, [e-journal] 2 (2) pp.1 – 13. doi: 10.1177/160940690300200201.

Carlson, J. A., 2010. Avoiding traps in member checking. *The Qualitative Report*, [e-journal] 15 (5), pp.1102 – 1113. Available at: <https://nsuworks.nova.edu/tqr/vol15/iss5/4> [Accessed 23 November 2017].

Casey, D., 2006. Choosing an appropriate method of data collection. *Nurse Researcher*, [e-journal] 13 (3), pp.75 – 92. doi: 10.7748/nr2006.04.13.3.75.c5980.

Casey, M., O'Connor, L., Cashin, A., Smith, R., O'Brien, D., Nicholson, E., O'Leary, D., Fealy, G., McNamara, G., Glasgow, M. E., Stokes, D. and Egan, C., 2017. An overview of the outcomes and impact of specialist and advanced nursing and midwifery practice, on quality of care, cost and access to services: A narrative review. *Nurse Education Today*, [e-journal] 56, pp.35 – 40. doi.org/10.1016/j.nedt.2017.06.004.

Cashin, A., Theophilos, T. and Green., R., 2017. The internationally present perpetual policy themes inhibiting development of the nurse practitioner role in the primary care context: An Australian—USA comparison. *Collegian*, [e-journal] 24 (3), pp.303 – 312. doi.org/10.1016/j.colegn.2016.05.001.

Chenail, R. J., 2011. Interviewing the investigator: strategies for addressing instrumentation and researcher bias concerns in qualitative research. *The Qualitative Report*, [e-journal] 16 (1), pp.255 - 262. Available at: <https://nsuworks.nova.edu/tqr/vol16/iss1/16> [Accessed 11 February 2016].

Chirkov, V. I. and Ryan, R. M., 2001. Parent and teacher autonomy support in Russian and US adolescents: Common effects on well-being and academic motivation. *Journal of Cross-Cultural Psychology*, [e-journal] 32 (5), pp.618 – 635. doi: 10.1177/0022022101032005006.

Chiu, L. H., 2005. Motivation for nurses undertaking a post-registration qualification in Malaysia. *International Nursing Review*, [e-journal] 52 (1), pp.46 – 51. doi.org/10.1111/j.1466-7657.2004.00415.x.

Clibbens, N., Walters, S. and Baird, W., 2012. Delphi research: issues raised by a Pilot study. *Nurse Researcher*, [e-journal] 19 (2), pp.37 - 43. doi: 10.7748/nr2012.01.19.2.37.c8907.

Cleary, M., Horsfall, J., Muthulakshmi, P., Happell, B. and Hunt, G.E., 2013. Career development: graduate nurse views. *Journal of Clinical Nursing*, [e-journal] 22, pp.2605 – 2613. doi.org/10.1111/jocn.12080.

Cohen, L., Manion, L. and Morrison, K., 2018. *Research methods in education*. 8th ed. London: Routledge.

Coleman, J. S., 1988. Social capital in the creation of human capital. *American Journal of Sociology*, [online] 94, pp.S95 - S120. Available at: <http://www.jstor.org/stable/2780243> [Accessed 2 September 2018].

Cook, D. A. and Artino, A. R., 2016. Motivation to learn: an overview of contemporary theories. *Medical Education*, [e-journal] 50 (10), pp.997 – 1014. doi.org/10.1111/medu.13074.

Cooley, M., 2008. Nurses' motivations for studying third level post-registration nursing programmes and the effects of studying on their personal and work lives. *Nurse Education Today*, [e-journal] 28, pp.588 – 594. doi.org/10.1016/j.nedt.2007.11.002.

Cooper, S. and Endacott, R., 2007. Generic qualitative research: a design for qualitative research in emergency care? *Emergency Medicine Journal*, [e-journal] 24 (12), pp.816 – 819. doi:10.1136/emj.2007.050641.

Cortazzi, M., Pilcher, N., and Jin, L., 2011. Language choices and 'blind shadows': investigating interviews with Chinese participants. *Qualitative Research*, [e-journal] 11 (5), pp.505 – 535. doi.org/10.1177/1468794111413225.

Coughlan, L. M. and Patton, D., 2018. A qualitative descriptive exploration of the educational and career plans of early career neonatal nurses and midwives: An Irish perspective. *Nurse Education in Practice*, [e-journal] 28, pp.182 – 188. doi.org/10.1016/j.nepr.2017.10.026.

Coventry, T. H., Maslin-Prothero, S. E. and Smith, G., 2015. Organisational impact of nurse supply and workload on nurses continuing professional development opportunities: an integrativereview. *Journal of Advanced Nursing*, [e-journal] 71 (12), pp.2715 – 2727. doi: 10.1111/jan.12724.

Creswell, J., 2012. *Educational research: planning, conducting and evaluating qualitative and qualitative research*. 4th ed. Boston: Pearson.

Creswell, J. W., 2014. *Research design: qualitative, quantitative, and mixed methods approaches*. 4th ed. Thousand Oaks, California: Sage Publications.

Creswell, J. W. and Poth, C. N., 2018. *Qualitative inquiry and research design: choosing among five approaches*. 4th ed. Thousand Oaks, California: Sage Publications.

Critical Appraisal Skills Programme (CASP), 2018. *CASP checklists*. [online] Available at: <https://casp-uk.net/casp-tools-checklists/> [Accessed 8 January 2018].

Davis, L., Taylor, H. and Reyes, H., 2014. Lifelong learning in nursing: a Delphi study. *Nurse Education Today*, [e-journal] 34 (3), pp.441 – 445. doi.org/10.1016/j.nedt.2013.04.014.

Dearnley, C., 2005. A reflection on the use of semi-structured interviews. *Nurse Researcher*, [e-journal] 13 (1), pp.19 – 28. doi: 10.7748/nr2005.07.13.1.19.c5997.

Deci, E. L. and Ryan, R. M., 2000. The “what” and “why” of goal pursuits: human needs and the self-determination of behaviour. *Psychological Inquiry*, [e-journal] 11, pp.227 - 268. doi: 10.1207/S15327965PLI1104_01.

Deci, E. L. and Ryan, R. M., 2008. Facilitating optimal motivation and psychological well-being across life's domains. *Canadian Psychology*, [e-journal] 49 (1), pp.14 - 23. doi.org/10.1037/0708-5591.49.1.14.

Deci, E. L. and Ryan, R. M., 2012. Self-determination theory in health care and its relations to motivational interviewing: A few comments. *The International Journal of Behavioral Nutrition and Physical Activity*, [e-journal] 9 (24). doi: 10.1186/1479-5868-9-24.

Deci, E. L., Ryan, R. M., Gagne´, M., Leone, D. R., Usunov, J. and Kornazheva, B. P., 2001. Need satisfaction, motivation, and well-being in the work organizations of a former Eastern Bloc country. *Personality and Social Psychology Bulletin*, [e-journal] 27 (8), pp.930 – 942. doi.org/10.1177/0146167201278002.

Deci, E. L., Vallerand, R. J., Pelletier, L. G. and Ryan, R. M., 1991. Motivation and education: the self-determination perspective. *Educational Psychologist*, [e-journal] 26 (3-4), pp.325 - 346. doi: 10.1080/00461520.1991.9653137.

Department of Health (2006) *Modernising nursing careers: setting the direction*. [pdf] London: Department of Health. Available at: <https://webarchive.nationalarchives.gov.uk/20071104154823/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4138756> [Accessed 7 July 2016].

DiCicco-Bloom, B. and Crabtree, B. F., 2006. The qualitative research interview. *Medical Education*, [e-journal] 40 (4), pp.314 – 321. doi:10.1111/j.1365-2929.2006.02418.x.

Doody, O. and Noonan, M., 2013. Preparing and conducting interviews to collect data. *Nurse Researcher*, [e-journal] 20 (5), pp.28 – 32. doi: 10.7748/nr2013.05.20.5.28.e327.

Donner, G. J. and Wheeler, M. M., 2001. Career planning and development for nurses: the time has come. *International Nursing Review*, [e-journal] 48, pp.79 - 85. doi.org/10.1046/j.1466-7657.2001.00028.x.

Downie, R. S. and Calman, K. C., 1994. *Healthy respect: ethics in health care*. 2nd ed. Oxford: Oxford Medical Publication.

Drey, N., Gould, D. and Allan, T., 2009. The relationship between continuing professional education and commitment to nursing. *Nurse Education Today*, [e-journal] 29 (7), pp.740 -745. doi: 10.1016/j.nedt.2009.03.008.

Dreachslin, J. L., 1999. Focus groups as a quality improvement technique: a case example from health administration education. *Quality Assurance in Education*, [e-journal] 7 (4), pp.224 – 233. doi.org/10.1108/09684889910297730.

Duffield, C., Gardner, G., Chang, A,. M. and Catling-Paull, C., 2009. Advanced nursing practice: a global perspective. *Collegian*, [e-journal] 16 (2), pp.55 - 62. doi:10.1016/j.colegn.2009.02.001.

Dweck, C.S. and Leggett, E. L., 1988. A social-cognitive approach to motivation and personality. *Psychological Review*, [e-journal] 95, pp.256 – 273. doi.org/10.1037/0033-295X.95.2.256.

Edwards, N., Hui, Z. D. and Xin, S. L., 2001. Continuing education for nurses in Tianjin Municipality, the People's Republic of China. *The Journal of Continuing Education in Nursing*, [e-journal] 32 (1), pp.31 – 37. doi.org/10.3928/0022-0124-20010101-10.

Elsaid, E. and Elsaid, A. M., 2012. Culture and leadership: comparing Egypt to the GLOBE Study of 62 societies. *Business and Management Research*, [e-journal] 1 (2), pp1 – 12. doi:10.5430/bmr.v1n2p1.

El-Salam, G., Ibrahim, M., Mohsen, M., and Hassanein, S., 2008. Relationship between Organisational Climate and Empowerment of Nurses in Menoufiya Hospitals, Egypt. *Eastern Mediterranean Health Journal*, [e-journal] 14 (5), pp.1173 – 1184. Available at: <http://www.emro.who.int/emhj-volume-14-2008/volume-14-issue-5/relationship-between-organisational-climate-and-empowerment-of-nurses-in-menoufiya-hospitals-egypt.html> [Accessed 14 February 2015]

Elvish, R., Lever, S., Johnstone, J., Cawley, R. and Keady, J., 2013. Psychological interventions for carers of people with dementia: A systematic review of quantitative and qualitative evidence. *Counselling and Psychotherapy Research*, [e-journal] 13 (2), pp.106 - 125, DOI: 10.1080/14733145.2012.739632.

Eraut, M., 2001. Do continuing professional development models promote one-dimensional learning? *Medical Education*, [e-journal] 35 (1), pp.8 – 11. doi:10.1111/j.1365-2923.2001.00851.x.

Eraut, M., 2004. Informal learning in the workplace. *Studies in Continuing Education*, [e-journal] 26 (2), pp.247 – 273. doi: 10.1080/158037042000225245.

Egyptian Nursing Syndicate, 2014. Egyptian Nursing Syndicate nursing plan 2015 – 2018. Cairo: Egyptian Nursing Syndicate. Unpublished.

Farag, M., 2008. *Economic Analysis of the Nurse Shortage in Egypt*. [online] Dubai: Harvard Kennedy School Belfer Center Programs. Available at: <https://www.belfercenter.org/publication/economic-analysis-nurse-shortage-egypt> [Accessed 2 December 2016].

Friedman, A. and Phillips, M., 2004. Continuing professional development: developing a vision. *Journal of Education and Work*, [e-journal] 17 (3), pp.361 – 376. doi: 10.1080/1363908042000267432.

Frith, H. and Gleeson, K., 2004. Clothing and embodiment: men managing body image and appearance. *Psychology of Men and Masculinity*, [e-journal] 5 (1), pp.40 - 48. doi.org/10.1037/1524-9220.5.1.40.

Fullerton, J. and Sukkary-Stolba, S., 1995. Advancing the Status of Nursing in Egypt: The Project to Promote the Development of the High Institutes of Nursing. *International Journal of Nursing Studies*, [e-journal] 32 (5), pp.518 – 524. doi.org/10.1016/0020-7489(95)00038-Y.

Gallagher, L., 2007. Continuing education in nursing: a concept analysis. *Nurse Education Today*, [e-journal] 27 (5), pp.466 – 473. doi.org/10.1016/j.nedt.2006.08.007.

Gardner, G., Duffield, C., Doubrovsky, A. and Adams, A., 2016. Identifying advanced practice: A national survey of a nursing workforce. *International Journal of Nursing Studies*, [e-journal] 55, pp. 60 – 70. DOI: 10.1016/j.ijnurstu.2015.12.001.

Gericke, C. A., 2005. Comparison of health care financing in Egypt and Cuba: lessons for health reform in Egypt. *Eastern Mediterranean Health Journal*, [e-journal] 11 (5/6) pp.1073 – 1086. Available at: <http://applications.emro.who.int/emhj/1105_6/11_5-6_2005_1073_1086.pdf> [Accessed 16 December 2016].

Gijbels, H., O'Connell, R., Dalton-O'Conner, C. and O'Donovan, M., 2010. A systematic review evaluating the impact of post-registration nursing and midwifery education on practice. *Nurse Education in Practice*, [e-journal] 10 (2), pp.64 – 69. doi: 10.1016/j.nepr.2009.03.011.

Gopee, N., 2001. Lifelong learning in nursing: perceptions and realities. *Nurse Education Today*, [e-journal] 21 (8), pp.607 – 615. doi.org/10.1054/nedt.2001.0670.

Gopee, N., 2002. Human and social capital as facilitators of lifelong learning in nursing. *Nurse Education Today*, [e-journal] 22 (8), pp.608 – 616. doi.org/10.1016/S0260-6917(02)00139-9.

Gordon, M., and Gibbs, T., 2014. STORIES statement: Publication standards for healthcare education evidence synthesis. *BMC Medicine*, [e-journal] 12 (143), pp.1 – 9. doi.org/10.1186/s12916-014-0143-0.

Gould, D., Drey, N. and Berridge, E., 2007. Nurses' experiences of continuing professional development. *Nurse Education Today*, [e-journal] 27 (6), pp.602 – 609. doi.org/10.1016/j.nedt.2006.08.021.

Govranos, M. and Newton, J. M., 2014. Exploring ward nurses' perceptions of continuing education in clinical settings. *Nurse Education Today*, [e-journal] 34 (4), pp.655 – 660. doi: 10.1016/j.nedt.2013.07.003.

Gray, J., 2017. Introduction to qualitative research. In: J. Gray, S. Grove, and S. Sutherland, eds. 2017. *Burns and Grove's The practice of nursing research: appraisal, synthesis, and generation of evidence*. 8th ed. St. Louis, Missouri: Elsevier. pp.62 – 75.

Greene, M. J., 2014. On the inside looking in: methodological insights and challenges in conducting qualitative insider research. *The Qualitative Report*, [e-journal] 19 (29), pp.1 - 13. Available at: <https://nsuworks.nova.edu/tqr/vol19/iss29/3> [Accessed 23 November 2016].

Green, J. and Thorogood, N., 2004. *Qualitative Methods for Health Research*. London: Sage Publications.

Green, B., Johnson, C. and Adams, A., 2006. Writing narrative literature reviews for peer-reviewed journals: secrets of the trade. *Journal of Chiropractic Medicine*, [e-journal] 5 (3), pp.101 – 117. doi.org/10.1016/S0899-3467(07)60142-6.

Grolnick, W. S., 2009. The role of parents in facilitating autonomous self-regulation for education. *Theory and Research in Education*, [e-journal] 7 (2), pp.164 – 173. doi.org/10.1177/1477878509104321.

Grouzet, F. M. E., Kasser, T., Ahuvia, A., Doles, J. M. F., Kim, Y., Lau, S. and Sheldon, K. M., Ryan, R. M., Saundars, S., Schmuck, P., Sheldon, K. M., 2005. The structure of goal contents across 15 cultures. *Journal of Personality and Social Psychology*, [e-journal] 89 (5), pp.800 – 816. doi: 10.1037/0022-3514.89.5.800.

Grove, S. K., Burns, N. and Gray, J., 2013. *The practice of nursing research: appraisal, synthesis, and generation of evidence*. 7th ed. Missouri: Elsevier Saunders.

Guba, E. G., and Lincoln, Y., 1989. *Fourth generation evaluation*. Newbury Park, California: Sage Publications.

Haddaway, N., Woodcock, P., Macura, B. and Collins, A., 2015. Making literature reviews more reliable through application of lessons from systematic reviews. *Conservation Biology*, [e-journal] 29 (6), pp.1596 - 1605. doi:10.1111/cobi.12541.

Hahn, C., 2008. *Doing qualitative research using your computer: a practical guide*. Thousand Oaks, California: Sage Publications.

Haig, A., and Dozier, M., 2003. BEME Guide no. 3: systematic searching for evidence in medical education-Part 2: constructing searches. *Medical Teacher*, [e-journal] 25 (4), pp.463 – 84. doi: 10.1080/01421590310001608667.

Hall, L. M., 2008. Career planning and development needs of rural and remote nurses. *Journal of Research in Nursing*, [e-journal] 13 (3), pp.207 – 217. doi.org/10.1177/1744987107083544.

Hallin, K. and Danielson, E., 2008. Registered Nurses' perceptions of their work and professional development. *Journal of Advanced Nursing*, [e-journal] 61, pp.62 - 70. doi:10.1111/j.1365-2648.2007.04466.x.

Hammersley, M. and Traianou, A., 2012. Ethics and Educational Research. [pdf] British Educational Research Association. Available at <https://www.bera.ac.uk/wp-content/uploads/2014/03/Ethics-and-Educational-Research.pdf?noredirect=1> [Accessed 5 September 2016]

Hand, H., 2003. The mentor's tale: a reflexive account of semi-structured interviews. *Nurse Researcher*, [e-journal] 10 (3), pp.15 - 27. doi:10.7748/nr2003.04.10.3.15.c5893.

Hanson, J. L., Balmer, D. F., Giardino, A. P., 2011. Qualitative research methods for medical educators. *Academic Pediatrics*, [e-journal] 11 (5), pp.375 – 386. doi: 10.1016/j.acap.2011.05.001.

Hargreaves, J. and Lane, D., 2001. Delya's story: from expert to novice, a critique of Benner's concept of context in the development of expert nursing practice. *International Journal of Nursing Studies*, [e-journal] 38 (4), pp.389 - 394. doi:10.1016/s0020-7489(00)00091-2.

Hart, G. and Rotem, A., 1995. The clinical learning environment: nurses perceptions of professional development in clinical settings. *Nurse Education Today*, [e-journal] 15 (1), pp.3 - 10. doi.org/10.1016/S0260-6917(95)80071-9.

Harvey, W. S., 2011. Strategies for conducting elite interviews. *Qualitative Research*, [e-journal] 11 (4), pp.431 – 441. doi: 10.1177/1468794111404329.

Hawamdeh, S. and Raigangar, V., 2014. Qualitative interviewing: methodological challenges in Arab settings. *Nurse Researcher*, [e-journal] 21 (3), pp.27 – 31. doi: 10.7748/nr2014.01.21.3.27.e357.

Hegarty, J., Walsh, E., Condon, C. and Sweeny, J., 2009. The Undergraduate Education of Nurses: Looking to the Future. *International Journal of Nursing Education Scholarship*, [e-journal] 6 (1), pp.1 – 11. doi:10.2202/1548-923X.1684.

Harackiewicz, J. M., Barron, K. E., Pintrich, P. R., Elliot, A. J. and Thrash, T. M., 2002. Revision of achievement goal theory: Necessary and illuminating. *Journal of Educational Psychology*, [e-journal] 94 (3), pp.638 – 645. doi.org/10.1037/0022-0663.94.3.638.

Hegney, D., Tuckett, A., Parker, D. and Robert, E., 2010. Access to and support for continuing professional education amongst Queensland nurses: 2004 and 2007. *Nurse Education Today*, [e-journal] 30 (2), pp.142 – 149. doi:10.1016/j.nedt.2009.06.015.

Hofman, K., 2005. *Situation analysis of nursing and strategies for improvement of nursing in Egypt/Aswan Governorate*. [consultation report] Aswan. Unpublished.

Holloway, I. and Wheeler, S., 2013. *Qualitative Research in Nursing and Healthcare*. 3rd ed. Oxford: John Wiley and Sons.

Høyland, S., Hollund, J. G. and Olsen, O. E., 2015. Gaining access to a research site and participants in medical and nursing research: a synthesis of accounts. *Medical Education*, [e-journal] 49 (2), pp.224 – 232. doi: 10.1111/medu.12622.

Ikeda, M., Inoue, K. and Kamibeppu, K., 2008. Goals and potential career advancement of licensed practical nurses in Japan. *Journal of Nursing Management*, [e-journal] 16 (7), pp. 821 - 828. doi:10.1111/j.1365-2834.2008.00855.x.

International Council of Nurses, 2017. *Definition and Characteristics of the Role. Nurse Practitioner and Advanced Practice Roles*. [Online] Available at: <https://international.aanp.org/Practice/APNRoles> [Accessed: 14 February 2020].

International Organisation for Migration (IOM), 2011. *National profile of migration of health professionals – Egypt*. [pdf] Brussels: International Organisation for Migration. Available at:

<http://philipus.de/mohprof.eu/LIVE/DATA/National_profiles/national_profile_Egypt.pdf> [Accessed 9 September 2016].

Institute of Medicine, 2011. *The future of nursing: Leading change, advancing health*. [pdf] Washington, DC: The National Academies Press. Available at: <https://doi.org/10.17226/12956> [Accessed 23 June 2020].

Ismail, M. M., Gerrish, K., Naisby, A., Salway, S. and Chowbey, P., 2014. Engaging minorities in researching sensitive health topics by using a participatory approach. *Nurse Researcher*, [e-journal] 22 (2), pp. 44 – 48. doi:10.7748/nr.22.2.44.e1268.

Lyengar, S. S. and Lepper, M. R., 1999. Rethinking the value of choice: A cultural perspective on intrinsic motivation. *Journal of Personality and Social Psychology*, [e-journal] 76 (3), pp.349 - 366. doi.org/10.1037/0022-3514.76.3.349.

Jacob, E. R., McKenna, L. and D'Amore, A., 2016. Educators' expectations of roles, employability and career pathways of registered and enrolled nurses in Australia. *Nurse Education in Practice*, [e-journal] 16 (1), pp.170 – 175. doi: 10.1016/j.nepr.2015.05.011.

Jasper, M. and Mooney, G., 2013. The Context of Professional Development. In: M. Jasper, M. Rosser, G. Mooney, eds. 2013. *Professional Development, Reflection and Decision-Making in Nursing and Health Care*. 2nd ed. Oxford: John Wiley and Sons, Ltd. Ch.1.

Jensen, D., 2008. Access. In: L. M. Given, ed. 2008. *The Sage encyclopaedia of qualitative research methods*. Thousand Oaks, California: Sage Publications.  pp.2 – 3.

Joyce, P. and Cowman, S., 2007. Continuing professional development: investment or expectation? *Journal of Nursing Management*, [e-journal] 15 (6), pp.626 – 633. doi: 10.1111/j.1365-2834.2007.00683.x.

Kahlke, R. M., 2014. Generic qualitative approaches: pitfalls and benefits of methodological mixology. *International Journal of Qualitative Methods*, [e-journal] pp.37 – 52. doi: 10.1177/160940691401300119.

Kallio, H., Pietilä, A. M., Johnson, M. and Kangasniemi, M., 2016. Systematic methodological review: developing a framework for a qualitative semi-structured interview guide. *Journal of Advanced Nursing*, [e-journal] 72 (12), pp.2954 – 2965. doi: 10.1111/jan.13031.

Kandiel, H. M. H. and Gharib, S., 2017. Economic analysis of the latent factors related to the nursing shortage. *Asian Social Science*, [e-journal] 13 (3), pp.89 – 101. doi:10.5539/ass.v13n3p89.

Kamal Elden, N. M., Ibrahim Rizk, H. I. and Wahby, G., 2016. Improving health system in Egypt: perspectives of physicians. *The Egyptian Journal of Community Medicine*, [e-journal] 34 (1), pp.45 - 58. doi: 10.21608/ejcm.2016.646.

Kassem, T., 2014. Poor governance in Egypt, an obstacle to economic development. *IOSR (international organisation of scientific research) Journal of Humanities and Social Science*, [e-journal] 19 (7), pp.1 – 14. doi: 10.9790/0837-19720114.

Kasser, T. and Ryan, R. M., 1993. A dark side of the American dream: correlates of financial success as a central life aspiration. *Journal of Personality and Social Psychology*, [e-journal] 65 (2), pp.410 -422. doi.org/10.1037/0022-3514.65.2.410.

Kasser, T. and Ryan, R. M., 1996. Further examining the American dream: differential correlates of intrinsic and extrinsic goals. *Personality and Social Psychology Bulletin*, [e-journal] 22 (3), pp.280 - 287. doi.org/10.1177/0146167296223006.

Kerr, L. and Macaskill, A., 2020. The journey from nurse to advanced nurse practitioner: applying concepts of role transitioning. *British Journal of Nursing*, [e-journal] 29 (10), pp.561 – 565. doi.org/10.12968/bjon.2020.29.10.561.

Kim, Y., 2011. The Pilot study in qualitative inquiry. *Qualitative Social Work*, [e-journal] 10 (2), pp.190 – 206. doi: 10.1177/1473325010362001.

Kim, Y., Kasser, T. and Lee, H., 2003. Self-concept, aspirations, and well-being in South Korea and the United States. *The Journal of Social Psychology*, [e-journal] 143 (3), pp.277 - 290. doi.org/10.1080/00224540309598445.

King, R., Tod, A. and Sanders, T., 2017. Development and regulation of advanced nurse practitioners in the UK and internationally. *Nursing Standard*, [e-journal] 32 (14), pp.43 - 50. doi: 10.7748/ns.2017.e10858.

Koch, T., 1994. Establishing rigour in qualitative research: the decision trail. *Journal of Advanced Nursing*, [e-journal] 19 (5), pp.976 – 986. doi:10.1111/j.1365-2648.1994.tb01177.x.

Koch, T. and Harrington, A., 1998. Reconceptualising rigour: the case for reflexivity. *Journal of Advanced Nursing*, [e-journal] 28 (4), pp.882 - 890. doi.org/10.1046/j.1365-2648.1998.00725.x.

Koulouriotis, J., 2011. Ethical considerations in conducting research with non-native speakers of English. *TESL Canada Journal*, [e-journal] 28 (5), pp. 1 - 15. doi: 10.18806/tesl.v28i0.1078.

Knowles, M., 1990. *The adult learner: a neglected species*. 4th ed. London: Gulf Publishing.

Kusurkar, R. A., Ten Cate, T. J., Van Asperen, M. and Croiset, G., 2011. Motivation as an independent and a dependent variable in medical education: a review of the literature. *Medical Teacher*, [e-journal] 33 (5), pp.242 - 262. doi: 10.3109/0142159X.2011.558539.

Kusurkar, R. A., Ten Cate, T. J., Vos, C. M. P., Westers, P. and Croiset, G., 2013. How motivation affects academic performance: a structural equation modelling analysis. *Advances in Health Sciences Education*, [e-journal] 18 (1), pp.57 – 69. doi.org/10.1007/s10459-012-9354-3.

Kvale, S., 1996. *Interviews: an introduction to qualitative research interviewing*. London: Sage Publications.

Lambert, S. D. and Loiselle, C. G., 2008. Combining individual interviews and focus groups to enhance data richness. *Journal of Advanced Nursing*, [e-journal] 62 (2), pp.228 – 237 doi: 10.1111/j.1365-2648.2007.04559.x.

Lanlehin, R. M., 2018. Self-tracking, governmentality, and Nursing and Midwifery Council's (2016) revalidation policy. *Nurse Education Today*, [e-journal] 64, pp.125 – 129. doi.org/10.1016/j.nedt.2018.01.033.

Lawton, S. and Wimpenny, P., 2003. Continuing professional development: a review. *Nursing Standard*, [e-journal] 17 (24), pp.41 - 4. doi: 10.7748/ns2003.02.17.24.41.c3351.

Leiter. M. P., Price, S. L., Spence-Laschinger, H. K., 2010. Generational differences in distress, attitudes and incivility among nurses. *Journal of Nursing Management*, [e-journal] 18 (8), pp.970 - 980. doi:10.1111/j.1365-2834.2010.01168.x.

Leon, R., Tredoux, J. and Foster, S., 2019. Valuing Enrolled Nurses – A study to better understand the investment education and training have on the retention of Enrolled Nurses. *Collegian*, [e-journal] 26 (1), pp.158 – 164. doi.org/10.1016/j.colegn.2018.07.001.

Lim, J. H., 2011. Qualitative methods in adult development and learning: theoretical traditions, current practices, and emerging horizons. In: C. Hoare, ed. 2011. *The Oxford handbook of reciprocal adult development and learning*. 2nd ed. New York: Oxford University Press. pp. 39 – 60.

Lincoln, Y. and Guba, E., 1985. *Naturalistic Inquiry*. Newbury Park: Sage Publications.

Liu, L., 2016. Using generic inductive approach in qualitative educational research: a case study analysis. *Journal of Education and Learning*, [e-journal] 5 (2), pp.129 – 135. doi:10.5539/jel.v5n2p129.

Liu, X., 2018. Interviewing Elites: Methodological Issues Confronting a Novice. *International Journal of Qualitative Methods*, [e-journal] 17, p.1 – 9. doi: 10.1177/1609406918770323.

Lynch, M. F. Jr., Plant, R. W. and Ryan, R. M., 2005. Psychological needs and threat to safety: implications for staff and patients in a psychiatric hospital for youth. *Professional Psychology: Research and Practice*, [e-journal] 36 (4), pp.415 – 425. doi.org/10.1037/0735-7028.36.4.415.

Ma, C., Fouly, H., Li, J. and D'Antonio, P., 2011. The education of nurses in China and Egypt. *Nursing Outlook*, [e-journal] 60 (3), pp.127 – 133. doi: 10.1016/j.outlook.2011.08.002.

Mack, N., Woodsong, C., MacQueen, K., Guest, G. and Namely, E., 2005. *Qualitative Research Methods: A Data Collector's Field Guide*. [e-book] North Carolina: Family Health International. Available at:

<https://www.fhi360.org/sites/default/files/media/documents/Qualitative%20Research%20Methods%20-%20A%20Data%20Collector's%20Field%20Guide.pdf> [Accessed 9 January 2016].

Malterud, K., Siersma, V. D. and Guassora, A. D., 2016. Sample size in qualitative interview studies: guided by information power. *Qualitative Health Research*, [e-journal] 26 (13), pp.1753 – 1760. doi: 10.1177/1049732315617444.

Manley, K., Martin, A., Jackson, C. and Wright, T., 2018. A realist synthesis of effective continuing professional development (CPD): A case study of healthcare practitioners' CPD. *Nurse Education Today*, [e-journal] 69, pp.134 – 141. doi.org/10.1016/j.nedt.2018.07.010.

Mansell, I., Bennett, G., Northway., R., Mead, D. and Moseley, L., 2004. The learning curve: the advantages and disadvantages in the use of focus groups as a method of data collection. *Nurse Researcher*, [e-journal] 11 (4), pp.79 – 88. doi: 10.7748/nr2004.07.11.4.79.c6217.

Marshall, S. L. and While, A. E., 1994. Interviewing respondents who have English as a second language: challenges encountered and suggestions for other researchers. *Journal of Advanced Nursing*, [e-journal] 19 (3), pp.566 – 571. doi: 10.1111/j.1365-2648.1994.tb01122.x.

Marshall, A. and Batten, S., 2004. Researching across cultures: issues of ethics and power. Forum: *Qualitative Social Research*, [e-journal] 5 (3). doi.org/10.17169/fqs-5.3.572.

Martos, T. and Kopp, M. S., 2012. Life goals and well-being: does financial status matter? Evidence from a representative Hungarian sample. *Social Indicators Research*, [e-journal] 105 (3), pp.561 - 568. doi.org/10.1007/s11205-011-9788-7.

Maslow, A. H., 1943. A theory of human motivation. *Psychological Review*, [e-journal] 50 (4), pp.370 – 396. doi.org/10.1037/h0054346.

Mays, N., Pope, C. and Popay, J., 2005. Systematically reviewing qualitative and quantitative evidence to inform management and policy-making in the health field. *Journal of Health Services Research and Policy*, [e-journal] 10 (1), pp.6 – 20. doi.org/10.1258/1355819054308576.

MacDonald, C., Benjamin, K., Wolsey, C. and Topping, A., 2020. The experiences of diploma registered nurses returning to undergraduate study in Qatar: A descriptive qualitative study. *Nurse Education Today*, [e-journal] 91. doi.org/10.1016/j.nedt.2020.104456.

McConnell-Henry, T., James, A., Chapman, Y. and Francis, K., 2009. Researching with people you know: issues in interviewing. *Contemporary Nurse: A Journal for the Australian Nursing Profession*, [e-journal] 34 (1), pp.2 – 9. doi: 10.5172/conu.2009.34.1.002.

McDermid, F., Peters, K., Jackson, D. and Daly, J., 2014. Conducting qualitative research in the context of pre-existing peer and collegial relationships. *Nurse Researcher*, [e-journal] 21 (5), pp.28 – 33. doi: 10.7748/nr.21.5.28.e1232.

McKenna, L., Wood, P., Williams, A., O'Connor, M., Moss, C., Griffiths, D., Della, P., Endacott, R. and Cross, W., 2019. Scope of practice and workforce issues confronting Australian Enrolled Nurses: A qualitative analysis. *Collegian*, [e-journal] 26 (1), pp.80 – 85. doi.org/10.1016/j.colegn.2018.04.001.

McLafferty, I., 2004. Focus group interviews as a data collecting strategy. *Journal of Advanced Nursing*, [e-journal] 48 (2), pp.187 – 194. doi: 10.1111/j.1365-2648.2004.03186.x.

McLafferty, E. and Farley, A. H., 2006. Analysing qualitative research data using computer software. *Nursing Times*, [e-journal] 102 (24), pp.34 – 36. Available at: <https://www.nursingtimes.net/analysing-qualitative-research-data-using-computer-software/203184.article> [Accessed 7 April 2017].

McPake, B., Squires, A. P., Mahat, A. and Araujo, E.C., 2015. *The economics of health professional education and careers: insights from a literature review*. [pdf] Washington (DC): World Bank. Available at: <http://documents.worldbank.org/curated/en/570681468190783192/The-economics-of-health-professional-education-and-careers-insights-from-a-literature-review> [Accessed 23 June 2020]

Mercer, J., 2007. The challenges of insider research in educational institutions: wielding a double-edged sword and resolving delicate dilemmas. *Oxford Review of Education*, [e-journal] 33 (1), pp.1 - 17, doi: 10.1080/03054980601094651.

Merriam, S. B., 2009. *Qualitative research: a guide to design and implementation*. San Francisco, California: Jossey-Bass.

Merriam, S. B., and Tisdell, E. J., 2016. *Qualitative research: a guide to design and implementation*. 4th ed. San Francisco, California: Jossey-Bass.

Mill, J. E., Ogilvie, L. D., 2003. Establishing methodological rigour in international qualitative nursing research: a case study from Ghana. *Journal of Advanced Nursing*, [e-journal] 41 (1), pp.80 – 87. doi:10.1046/j.1365-2648.2003.02509.x.

Mikecz, R., 2012. Interviewing Elites: Addressing Methodological Issues. *Qualitative Inquiry*, [e-journal] 18 (6), pp. 482–493. doi: 10.1177/1077800412442818.

Ministry of Health and Population, 2015. *Demographic and Health Survey 2014: Egypt*. [pdf] Cairo, Ministry of Health and Population. Available at: <https://egypt.unfpa.org/sites/default/files/pub-pdf/0e0409a0-7af6-46d5-a346-7a7d9aeb12c6.pdf> [Accessed 10 May 2017].

Ministry of Planning, Monitoring and Administrative Reform, 2016. *Sustainable Development Strategy: Egypt's Vision 2030*. [pdf] Cairo: Ministry of Planning, Monitoring and Administrative Reform. Available at: <http://sdsegypt2030.com/wp-content/uploads/2016/10/1.-Introduction.pdf> [Accessed 8 August 2017].

Mohamed, N., 2018. Relationship between leadership styles and clinical decision-making autonomy among critical care nurses. *Egyptian Nursing Journal*, [e-journal] 15 (2), pp.201 – 111. doi: 10.4103/ENJ.ENJ_4_1.

Mohamed, H. and El-Nemer. A., 2013. The experience of newly enrolled Egyptian male nursing students into maternity nursing curriculum. *Life Science Journal*, [e-journal] 10 (1), pp.2810 – 2815. doi:10.7537/marslsj100113.338.

Morrison, J., Clement, T., Nestel, D. and Brown, J., 2016. "Underdiscussed, underused and underreported": Pilot work in team-based qualitative research. *Qualitative Research Journal*, [e-journal] 16 (4), pp.314 – 330. doi.org/10.1108/QRJ-07-2015-0053.

Morse, J. M., 2000. Determining sample size. *Qualitative Health Research*, [e-journal] 10 (1), pp.3 – 5. doi: 10.1177/104973200129118183.

Morse, J. M., 2010. Simultaneous and Sequential Qualitative Mixed Method Designs. *Qualitative Inquiry*, [e-journal] 16 (6), pp. 483 – 491. doi: 10.1177/1077800410364741.

Morse, J. M., 2015. Critical analysis of strategies for determining rigor in qualitative inquiry. *Qualitative Health Research*, [e-journal] 25 (9), pp. 1212 – 1222. doi:10.1177/1049732315588501.

Morse, J. M. and Richards, L., 2002. *Readme first for a user's guide to qualitative methods*. London: Sage Publications.

Murphy, C., Cross, C., McGuire, D., 2006. The motivation of nurses to participate in continuing professional education in Ireland. *Journal of European Industrial Training*, [e-journal] 30 (5), pp.365 – 384. doi.org/10.1108/03090590610677926.

Nadelson, S. and Nadelson, L., 2014. Evidence-based practice article reviews using CASP Tools: A method for teaching EBP. *Worldviews on Evidence-Based Nursing*, [e-journal] 11 (5), pp.344 - 6. doi: 10.1111/wvn.12059.

Nardi, D., A. and Diallo, R., 2014. Global trends and issues in APN practice: Engage in the change. *Journal of Professional Nursing*, [e-journal] 30 (3), pp. 228 – 232. doi.org/10.1016/j.profnurs.2013.09.010.

Nartker, A. J., Stevens, L., Shumays, A., Kalowela, M., Kisimbo, D. and Potter K., 2010. Increasing health worker capacity through distance learning: a comprehensive review of programmes in Tanzania. *Human Resources for Health*, [e-journal] 8 (30). doi.org/10.1186/1478-4491-8-30.

National Authority for Quality Assurance and Accreditation in Education (NAQAAE), 2010. *National Academic Reference Standards (NARS) Nursing Education*. [pdf] NAQAAE. Available at: <http://naqaae.eg/wp-content/uploads/2014/10/nursing.pdf> [Accessed 22 February 2016].

Neergaard, M. A., Olesen, F., Andersen, R. S. and Sondergaard, J., 2009. Qualitative description – the poor cousin of health research? *BMC Medical Research Methodology*, [e-journal] 9 (1), pp.52 – 56. doi:10.1186/1471-2288-9-52.

Newell, R. and Burnard, P., 2011. *Research for Evidence-Based Practice in Health Care*. 2nd ed. Oxford: Wiley-Blackwell.

NHS Education for Scotland (NES), 2015. *Perceptions of the benefits and potential impact of the Early Clinical Career Fellowships (ECCF).* [pdf] Edinburgh: NES. Available at: <https://www.nes.scot.nhs.uk/media/3575431/eccf_evaluation_report__final_21_5_15_n7v65v.pdf> [Accessed 7 February 2020].

NHS Education for Scotland (NES), 2017. *Post-registration career development framework for nurses, midwives and allied health professionals*. [pdf] Edinburgh: NES. Available at: <http://www.careerframework.nes.scot.nhs.uk/media/32227/nesd0057_postregistrationcareerframework_f.pdf> [Accessed 7 February 2020].

Nishimura, T. and Suzuki, S., 2016. Aspirations and life satisfaction in Japan: The big five personality makes clear. *Personality and Individual Differences*, [e-journal] 97, pp.300 – 305. doi.org/10.1016/j.paid.2016.02.070.

Noble, H. and Smith, J., 2015. Issues of validity and reliability in qualitative research. *Evidence-Based Nursing*, [e-journal] 18 (2), pp.34 - 35. doi: 10.1136/eb-2015-102054.

Notzer, N., Ribak, J., Abramovitz, R., Ben-Yair, R. and Yaakobson, O., 2004. The impact of bachelor degree completion programs on career development of nurses in Israel. *International Journal of Nursing Studies*, [e-journal] 41 (7), pp.713 – 719. doi.org/10.1016/j.ijnurstu.2004.02.006.

Okasha, T., Elkholy, H. and El-Ghamry, R., 2012. Overview of the family structure in Egypt and its relation to Psychiatry, *International Review of Psychiatry*, [e-journal] 24 (2), pp.162 – 165. doi: 10.3109/09540261.2012.658030.

Opollo, J. G., Opollo, D. A., Gray, J. and Spies, L., 2014. Conducting international nursing research: challenges and opportunities. *Nurse Researcher*, [e-journal] 22 (2), pp.29 – 33. doi: 10.7748/nr.22.2.29.e1279.

Opperman, E., Braun, V., Clarke, V. and Rogers, C., 2014. It feels so good it almost hurts: young adults experiences of orgasm and sexual pleasure. *Journal of Sex Research*, [e-journal] 51 (5), pp.503 - 515. doi.org/10.1080/00224499.2012.753982.

Orsini, C., Binnie, V. and Wilson, S. L., 2016. Determinants and outcomes of motivation in health professions education: a systematic review based on self-determination theory. *Journal of Educational Evaluation for Health Professions*, [e-journal] 13 (19), pp.1 - 14. doi.org/10.3352/jeehp.2016.13.19.

Orsini, C. A., Binnie, V. I. and Tricio, J. A., 2018. Motivational profiles and their relationships with basic psychological needs, academic performance, study strategies, self-esteem, and vitality in dental students in Chile. *Journal of educational evaluation for health professions*, [e-journal] 15 (11). doi:10.3352/jeehp.2018.15.11.

Orsini, C., Evans, P., Binnie, V., Ledezma, P. and Fuentes, F., 2016. Encouraging intrinsic motivation in the clinical setting: teachers' perspectives from the self-determination theory. *European Journal of Dental Education*, [e-journal] 20 (2), pp.102 - 111. doi:10.1111/eje.12147.

Orsini, C., Evans, P. and Jerez, O., 2015. How to encourage intrinsic motivation in the clinical teaching environment?: a systematic review from the self-determination theory. *Journal of Educational Evaluation for Health Professions*, [e-journal] 12 (8). doi.org/10.3352/jeehp.2015.12.8.

Pandey, S. C. and Patnaik, S., 2014. Establishing reliability and validity in qualitative inquiry: A critical examination. *Jharkhand journal of development and management studies*, [online] 12 (1),

pp.5743 – 5753. Available at: <https://www.researchgate.net/profile/Satyendra_Pandey2/publication/266676584_ESTABLISHING_RELIABILITY_AND_VALIDITY_IN_QUALITATIVE_INQUIRY_A_CRITICAL_EXAMINATION/links/543779b40cf2dc341db4d7fb/ESTABLISHING-RELIABILITY-AND-VALIDITY-IN-QUALITATIVE-INQUIRY-A-CRITICAL-EXAMINATION.pdf> [Accessed 7 February 2018].

Parahoo, K., 2014. *Nursing research: principles, processes and issues*. 3rd ed. London: Palgrave.

Parker, J. M. and Hill, M. N., 2017. A review of advanced practice nursing in the United States, Canada, Australia and Hong Kong Special Administrative Region (SAR), China. *International Journal of Nursing Sciences*, [e-journal] 4 (2), pp.196 – 204. doi.org/10.1016/j.ijnss.2017.01.002.

Patton, M. Q., 1990. *Qualitative evaluation and research methods*. 2nd ed. Thousand Oaks, California: Sage Publications.

Pelletier, D., Donoghue, J. and Duffield, C., 2003. Australian nurses' perception of the impact of their postgraduate studies on their patient care activities. *Nurse Education Today*, [e-journal] 23 (6), pp.434 – 442. doi.org/10.1016/S0260-6917(03)00069-8.

Penz, K., D'Arcy, C., Stewart, N., Kosteniuk, J., Morgan, D. and Smith, B., 2007. Barriers to participation in continuing education activities among rural and remote nurses. *Journal of Continuing Education in Nursing*, [e-journal] 38 (2), pp.58 – 68. doi.org/10.3928/00220124-20070301-03.

Percy, W. H., Kostere, K. and Kostere, S., 2015. Generic qualitative research in psychology. *The Qualitative Report*, [e-journal] 20 (2), pp.76 - 85. Available at: <http://nsuworks.nova.edu/tqr/vol20/iss2/7> [Accessed 10 May 2016].

Philippou, J., 2015. Employers' and employees' views on responsibilities for career management in nursing: a cross-sectional survey. *Journal of Advanced Nursing*, [e-journal] 71 (1), pp.78 – 89. doi: 10.1111/jan.12473.

Pintrich, P. R., 2000. An Achievement Goal Theory perspective on issues in motivation terminology, theory, and research. *Contemporary Educational Psychology*, [e-journal] 25 (1), pp.92 – 104. doi.org/10.1006/ceps.1999.1017.

Poirier, T. and Behnen, E., 2014. Where and how to search for evidence in the education literature: the WHEEL. *American Journal of Pharmaceutical Education*, [e-journal] 78 (4), p.70. doi: 10.5688/ajpe78470.

Polit, D. F. and Beck, C. T., 2006. *Essentials of nursing research: methods, appraisal, and utilization*. 6th ed. Philadelphia: Lippincott, Williams and Wilkins.

Pool, I., Poell, R. and Ten Cate, O., 2013. Nurses and managers' perceptions of continuing professional development for older and younger nurses: A focus group study. *International Journal of Nursing Studies*, [e-journal] 50 (1), pp.34 – 43. doi: 10.1016/j.ijnurstu.2012.08.009.

Pool, I., Poell, R., Berings, M. and Ten Cate, O., 2015. Strategies for continuing professional development among younger, middle-aged, and older nurses: a biographical approach. *International Journal of Nursing Studies*, [e-journal] 52 (5), pp.939 – 950. doi: 10.1016/j.ijnurstu.2015.02.004.

Pool, I., Poell, R., Berings, M. and Ten Cate, O., 2016. Motives and activities for continuing professional development: an exploration of their relationships by integrating literature and interview data. *Nurse Education Today*, [e-journal] 38, pp.22 – 28. doi: 10.1016/j.nedt.2016.01.004.

Porter, S., 2007. Validity, trustworthiness and rigour: reasserting realism in qualitative research. *Journal of Advanced Nursing*, [e-journal] 60 (1) pp.79 - 86. doi: 10.1111/j.1365-2648.2007.04360.x.

Price, S. L., McGillis Hall, L., Murphy, G. T. and Pierce, B., 2018. Evolving career choice narratives of new graduate nurses. *Nurse Education in Practice*, [e-journal] 28, pp.86 – 91. doi: 10.1016/j.nepr.2017.10.007.

Ranney, M. L., Meisel, Z. F., Choo, E. K., Garro, A. C., Sasson, C. and Morrow Guthrie, K., 2015. Interview-based qualitative research in emergency care part II: data collection, analysis and results reporting. *Academic Emergency Medicine*, [e-journal] 22 (9), pp1103 – 1112. doi.org/10.1111/acem.12735.

Ramani, S. and Mann, K., 2016. Introducing medical educators to qualitative study design: twelve tips from inception to completion, *Medical Teacher*, [e-journal] 38 (5), pp.456 – 463. doi: 10.3109/0142159X.2015.1035244.

Rashdan, T., 2007. *Implications for Advancement of Egyptian Nursing: Input equals Output*. In: Fulbright Academy Workshop. Doha, Qatar, 23 - 25 March 2007. Doha: Fulbright Academy.

Rashad, A. M., Phipps, F. M. and Haith-Cooper, M., 2004. Obtaining Informed Consent in an Egyptian Research Study. *Nursing Ethics*, [e-journal] 11 (4), pp.394 – 399. doi: 10.1191/0969733004ne711oa.

Ratanawongsa, N., Wright, S. M., Carrese, J. A. 2008, Well-being in residency: effects on relationships with patients' interactions with colleagues performance and motivation. *Patient Education and Counselling*, [e-journal] 2 (2), pp.194 – 200. doi: 10.1016/j.pec.2008.04.010.

Ratelle, C. F., Simard, K. and Guay, F., 2013. University students' subjective well-being: the role of autonomy support from parents, friends, and the romantic partner. *Journal of Happiness Studies*, [e-journal] 14 (3), pp.893 - 910. doi: http://dx.doi.org/10.1007/s10902-012-9360-4.

Regulation (European Union) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC (General Data Protection Regulation). [pdf] Available at: <https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32016R0679&from=EN> [Accessed August 2018].

Reid, A. M., Brown, J. M., Smith, J. M., Cope, A. C. and Jamieson, S., (2018). *Perspectives on Medical Education*, [e-journal] 7 (2), pp.69 – 75. doi.org/10.1007/s40037-018-0412-2.

Robinson, S., Murrells, T. and Clinton, M., 2006. Highly qualified and highly ambitious: implications for workforce retention of realising the career expectations of graduate nurses in England. *Human Resource Management Journal*, [e-journal] 16 (3), pp.287 - 312. doi:10.1111/j.1748-8583.2006.00015.x.

Robinson, O. C., 2014. Sampling in interview-based qualitative research: a theoretical and practical guide. *Qualitative Research in Psychology*, [e-journal] 11 (1), pp.25 – 41. doi: 10.1080/14780887.2013.801543.

Rolfe, G., 2006. Validity, trustworthiness and rigour: quality and the idea of qualitative research. *Journal of Advanced Nursing*, [e-journal] 53 (3), pp.304 – 310. doi: 10.1111/j.1365-2648.2006.03727.x.

Rose, K., 1994. Unstructured and semi-structured interviewing. *Nurse Researcher*, [e-journal] 1 (3), pp.23 – 32. doi: 10.7748/nr.1.3.23.s4.

Ryan, J., 2003. Continuous professional development along the continuum of lifelong learning. *Nurse Education Today*, [e-journal] 23 (7), pp.498 – 508. doi.org/10.1016/S0260-6917(03)00074-1.

Ryan, F., Coughlan, M. and Cronin, P., 2009. Interviewing in qualitative research: the one-to-one interview. *International Journal of Therapy and Rehabilitation*, [e-journal] 16 (6), pp.309 – 314. doi.org/10.12968/ijtr.2009.16.6.42433.

Ryan, R. M., Chirkov, V. I., Little, T. D., Sheldon, K. M., Timoshina, E. and Deci, E. L., 1999. The American dream in Russia: extrinsic aspirations and well-being in two cultures. *Personality and Social Psychology Bulletin*, [e-journal] 25 (12), pp.1509 – 1524. doi.org/10.1177/01461672992510007.

Ryan, R. M. and Deci, E. L., 2000a. Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American psychologist*, [e-journal] 55 (1), p.68 – 78. doi.org/10.1037/0003-066X.55.1.68.

Ryan, R. M. and Deci, E. L., 2000b. Intrinsic and extrinsic motivations: classic definitions and new directions. *Contemporary educational psychology*, [e-journal] 25 (1), pp.54–67. doi.org/10.1006/ceps.1999.1020.

Ryan, R. M. and Deci, E. L., 2020. Intrinsic and extrinsic motivation from a self-determination theory perspective: Definitions, theory, practices, and future directions. *Contemporary Educational Psychology*, [e-journal] 61. doi.org/10.1016/j.cedpsych.2020.101860.

Ryan, R. M., Stiller, J. D. and Lynch, J. H., 1994. Representations of relationships to teachers, parents, and friends as predictors of academic motivation and self-esteem. *The Journal of Early Adolescence*, [e-journal] 14 (2), pp.226 – 249. doi.org/10.1177/027243169401400207.

Sandelowski, M., 1986. The problem of rigor in qualitative research. *Advances in Nursing Science*, [e-journal] 8 (3), pp.27 – 37. doi.org/10.1097/00012272-198604000-00005.

Sandelowski, M., 1993. Rigor or rigor mortis: The problem of rigor in qualitative research revisited. *Advances in Nursing Science*, [e-journal] 16. (2), pp.1 – 8. doi.org/10.1097/00012272-199312000-00002.

Sandelowski, M., 2000. Whatever happened to qualitative description? *Research in Nursing and Health*, [e-journal] 23 (4), pp.334 – 340. doi.org/10.1002/1098-240X(200008)23:4<334::AID-NUR9>3.0.CO;2-G.

Sandelowski, M., 2010. What's in a name? Qualitative description revisited. *Research in Nursing and Health*, [e-journal] 33 (1), pp.77 – 84. doi:10.1002/nur.20362.

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., Burroughs, H. and Jinks, C., 2018. Saturation in qualitative research: exploring its conceptualization and operationalization. *Quality and Quantity*, [e-journal] 52 (4), pp 1893–1907. doi.org/10.1007/s11135-017-0574-8.

Schostak, J., Davis, M., Hanson, J., Schostak, J., Brown, T., Driscoll, P., Starke, I. and Jenkins, N., 2010. Effectiveness of continuing professional development project: a summary of findings. *Medical Teacher*, [e-journal] 32 (7), pp.586 – 592. doi: 10.3109/0142159X.2010.489129.

Schmuck, P., Kasser, T. and Ryan, R. M., 2000. Intrinsic and extrinsic goals: their structure and relationship to well-being in German and U.S. college students. *Social Indicators Research*, [e-journal] 50 (2), pp.225 - 241. doi.org/10.1023/A:1007084005278.

Scholes, J., 2006. *Developing expertise in critical care nursing*. Oxford: Blackwell Publishing.

Scottish Educational Research Association (SERA), 2005. *Ethical Guidelines for Educational Research*. 2nd ed. [pdf] SERA. Available at: <https://www.sera.ac.uk/wp-content/uploads/sites/13/2018/08/SERA-Ethical-GuidelinesWeb.pdf> [Accessed 16 February 2016].

Scottish Government, 2014. *Setting the direction for nursing and midwifery education in Scotland.* [pdf] Edinburgh: Scottish Government. Available at: <http://www.gov.scot/Publications/2014/02/4112> [Accessed 7 February 2020]

Scottish Government, 2017. *Nursing 2030 vision: promoting confident, competent and collaborative nursing for Scotland's future*. [pdf] Edinburgh: Scottish Government. Available at: <https://www.gov.scot/publications/nursing-2030-vision-9781788511001/> [Accessed 27 September 2017].

Schober, M., 2019. Development of advanced practice nursing (APN): the international context. *Enfermería Clínica*, [e-journal] 29 (2), pp.63 – 66. DOI: 10.1016/j.enfcle.2018.08.006.

Schunk, D. H. and DiBenedetto M. K., 2020. Motivation and social cognitive theory. *Contemporary Educational Psychology*, [e-journal] 61, doi.org/10.1016/j.cedpsych.2019.101832.

Shaha, M., Wenzel, J. and Hill, E. E., 2011. Planning and conducting focus group research with nurses. *Nurse Researcher*, [e-journal] 18 (2), pp.77 – 87. doi: 10.7748/nr2011.01.18.2.77.c8286.

Sharma, R., Gordon, M., Dharamsi, S., and Gibbs, T., 2015. Systematic reviews in medical education: A practical approach: AMEE Guide 94. *Medical Teacher*, [e-journal] 37 (2), pp.108 – 124. doi: 10.3109/0142159X.2014.970996.

Sheldon, K. M., Elliot, A. J., Ryan, R. M., Chirkov, V., Kim, Y., Wu, C., Demir, M. and Sun, Z., 2004. Self-concordance and subjective well-being in four cultures. *Journal of Cross-Cultural Psychology*, [e-journal] 35 (2), pp.209 – 223. doi.org/10.1177/0022022103262245.

Sikes, P. and Potts, A., 2008. *Researching education from the inside: Investigations from within*. London: Routledge.

Singh, J., 2013. Critical appraisal skills programme. *Journal of Pharmacology and Pharmacotherapeutics*, [online] 4 (1), pp.76 - 7. Available at: <http://www.jpharmacol.com/text.asp?2013/4/1/76/107697> [Accessed 4 May 2020].

Simmons, S., 1995. From paradigm to method in interpretive action research. *Journal of Advanced Nursing*, [e-journal] 21 (5), pp.837 - 844. doi:10.1046/j.1365-2648.1995.21050837.x.

Sonmez, B. and Yildirim, A., 2009. What are the career planning and development practices for nurses in hospitals? Is there a difference between private and public hospitals? *Journal of Clinical Nursing*, [e-journal] 18 (24), pp.3461 - 3471. doi:10.1111/j.1365-2702.2009.02906.x.

Sparkes, A., 2001. Myth 94: qualitative researchers will agree about validity. *Qualitative Health Research*, [e-journal] 11 (4), pp.538 – 552. doi.org/10.1177/104973230101100409.

Spence Laschinger, H. K., Wong, C. A., Macdonald-Rencz, S., Burkoski, V., Cummings, G., D'amour, D., Grinspun, D., Gurnham, M-E., Huckstep, S., Leiter, M., Perkin, K., Macphee, M., Matthews, S., O'brien-Pallas, L., Ritchie, J., Ruffolo, M., Vincent, L., Wilk, P., Almost, J. and Purdy, N., 2013. Part 1: The influence of personal and situational predictors on nurses' aspirations to management roles: preliminary findings of a national survey of Canadian nurses. *Journal of Nursing Management*, [e-journal] 21 (2), pp.217 – 230. doi: 10.1111/j.1365-2834.2012.01452.x.

Squires, A., 2009. Methodological challenges in cross-language qualitative research: a research review. *International Journal of Nursing Studies*, [e-journal] 46 (2), pp.277 - 87. doi: 10.1016/j.ijnurstu.2008.08.006.

Stanley, H., 2003. The journey to becoming a graduate nurse: a study of the lived experience of part-time post-registration students. *Nurse Education in Practice*, [e-journal] 3 (2), pp.62 – 71. doi.org/10.1016/S1471-5953(02)00055-0.

Starks, H. and Brown Trinidad, S., 2007. Choose your method: a comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research*, [e-journal] 17 (10), pp.1372 – 1380. doi: 10.1177/1049732307307031.

Stasa, H., Cashin, A., Buckley, T. and Donoghue, J., 2014. Advancing advanced practice — Clarifying the conceptual confusion. *Nurse Education Today*, [e-journal] 34 (3), pp. 356 – 361. doi.org/10.1016/j.nedt.2013.07.012.

Stevanin, S., Palese, A., Bressan, V., Vehviläinen-Julkunen, K., Kvist, T., 2018. Workplace-related generational characteristics of nurses: A mixed-method systematic review. *Journal of Advanced Nursing*, [e-journal] 74 (6), pp.1245 - 1263. doi:10.1111/jan.13538.

Stewart, S. M., Bond, M. H., Ho, L. M., Zaman, R. M., Dar, R. and Anwar, M., 2000. Perceptions of parents and adolescent outcomes in Pakistan. *British Journal of Developmental Psychology*, [e-journal] 18 (3), pp.335 - 352. doi:10.1348/026151000165733.

Stokes, D. and Bergin, R., 2006. Methodology or “methodolatry”? An evaluation of focus groups and depth interviews. *Qualitative Market Research: An International Journal*, [e-journal] 9 (1), pp.26 – 37. doi.org/10.1108/13522750610640530.

Sullivan, G. M. and Sargeant, J., 2011. Qualities of Qualitative Research: Part I. *Journal of Graduate Medical Education*, [e-journal] 3 (4), pp.449 - 452. doi.org/10.4300/JGME-D-11-00221.1.

Tanaka, N., Horiuchi, S., Shimpuku, Y. and Leshabari, S., 2015. Career development expectations and challenges of midwives in Urban Tanzania: a preliminary study. *BMC Nursing*, [e-journal] 14 (1), pp.1 – 6. doi: 10.1186/s12912-015-0081-y.

Tay, L. and Diener, E., 2011. Needs and subjective well-being around the world. *Journal of Personality and Social Psychology*, [e-journal] 101 (2), pp.354 – 365. doi.org/10.1037/a0023779.

Tavakol, M. and Sandars, J., 2014. Quantitative and qualitative methods in medical education research: AMEE Guide No 90: Part II. *Medical Teacher*, [e-journal] 36 (10) pp.838 – 848. doi: 10.3109/0142159X.2014.915297.

Ten Cate, T. J., Kusurkar, R. A. and Williams, G. C., 2011. How self-determination theory can assist our understanding of the teaching and learning processes in medical education: AMEE Guide No. 59. *Medical Teacher*, [e-journal] 33 (12), pp.961 – 973. doi: 10.3109/0142159X.2011.595435.

Thomas, A., 2008. Focus groups in qualitative research: culturally sensitive methodology for the Arabian Gulf? *International Journal of Research and Method in Education*, [e-journal] 31 (1), pp.77 – 88. doi: 10.1080/17437270801919941.

Thorne, S., Kirkham, S. R. and MacDonald-Emes, J., 1997. Interpretive description: a noncategorical qualitative alternative for developing nursing knowledge. *Research in Nursing and Health*, [e-journal] 20 (2), pp.169 - 177. doi:10.1002/(SICI)1098-240X(199704)20:2<169::AID-NUR9>3.0.CO;2-I.

Tjin A Tsoi, S. L. N. M., de Boer, A., Croiset, G., Koster, A. S. and Kusurkar, R. A., 2016. Factors influencing participation in continuing professional development: a focus on motivation among pharmacists. *Journal of Continuing Education in the Health Professions*, [e-journal] 36 (3), pp.144 – 150. doi: 10.1097/CEH.0000000000000081.

Tjin A Tsoi, S. L. N. M., de Boer, A., Croiset, G., Koster, A. S. and Van der Burgt, S., 2018. How basic psychological needs and motivation affect vitality and lifelong learning adaptability of pharmacists: a structural equation model. *Advances in Health Sciences Education*, [e-journal] 23 (3), pp.549 - 566. doi.org/10.1007/s10459-018-9812-7.

Tobin, G. A. and Begley, C. M., 2004. Methodological rigour within a qualitative framework. *Journal of Advanced Nursing*, [e-journal] 48 (4), pp.388 – 396. doi:10.1111/j.1365-2648.2004.03207.x.

Tong, A., Sainsbury, P. and Craig, J., 2007. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, [e-journal] 19 (6), pp.349 – 357. doi.org/10.1093/intqhc/mzm042.

Tracy, S. J., 2010. Qualitative quality: eight “big-tent” criteria for excellent qualitative research. *Qualitative Inquiry*, [e-journal] 16 (10), pp.837 – 851. doi: 10.1177/1077800410383121.

Tuffour, I., 2018. Reflections of a black African insider researcher. *Nurse Researcher*, [e-journal] 26 (1), pp.13 – 18. doi: 10.7748/nr.2018.e1570.

Turcotte-Tremblay, A. M. and McSween-Cadieux, E., 2018. A reflection on the challenge of protecting confidentiality of participants while disseminating research results locally. *BMC Medical Ethics*, [e-journal] 19 (Suppl 1) (45), p.5 - 9. doi.org/10.1186/s12910-018-0279-0.

United Nations International Children's Emergency Fund (UNICEF), 2017. *Children in Egypt 2016: a statistical digest*. [online] Available at: <https://www.unicef.org/egypt/sites/unicef.org.egypt/files/2018-05/eg_Children_In_Egypt_2016_en%283%29.pdf> [Accessed 18 March 2019].

United Nations Development Programme (UNDP), 2015. *Egypt's Progress towards Millennium Development Goals (MDGs)*. [online] Available at: <https://www.undp.org/content/dam/egypt/docs/Publications/Docs%20MDGs/Final%20MDG%20English%202015.pdf> [Accessed 10 January 2016].

United Nations Development Programme (UNDP), 2019. *About Egypt*. [online] Available at: <http://www.eg.undp.org/content/egypt/en/home/countryinfo/> [Accessed 1 March 2019].

Vaismoradi, M., Hannele, T., Bondas, T., 2013. Content analysis and thematic analysis: implications for conducting a qualitative descriptive study. *Nursing and Health Sciences*, [e-journal] 15 (3), pp.398 – 405. doi.org/10.1111/nhs.12048.

Vallerand, R. J., Pelletier, L. G., Blais, M. R., Brière, N. M., Senècal, C. and Vallières, E. F., 1992. The academic motivation scale: a measure of intrinsic, extrinsic and amotivation in education. *Educational and Psychological Measurement*, [e-journal] 52 (4), pp.1003 – 1017. doi.org/10.1177/0013164492052004025.

Vansteenkiste, M., Mingming, Z., Lens, W. and Soenens, B., 2005. Experiences of autonomy and control among Chinese learners: vitalizing or Immobilizing? *Journal of Educational Psychology*, [e-journal] 97 (3), pp.468 – 483. doi.org/10.1037/0022-0663.97.3.468.

Varpio, L., Ajjawi, R., Monrouxe, L.V., O'Brien, B.C. and Rees, C.E., 2017. Shedding the cobra effect: problematising thematic emergence, triangulation, saturation and member checking. *Medical Education*, [e-journal] 51 (1), pp.40 - 50. doi:10.1111/medu.13124.

Varpio, L., Paradis, E., Uijtdehaage, S. and Young, M., 2019. The Distinctions Between Theory, Theoretical Framework, and Conceptual Framework. *Academic Medicine*, [e-journal] Volume Publish Ahead of Print - Issue - doi: 10.1097/ACM.0000000000003075.

Wang, L., Tao., H., Ellenbecker, C. H. and Liu, X., 2012. Job satisfaction, occupational commitment and intent to stay among Chinese nurses: a cross-sectional questionnaire survey. *Journal of Advanced Nursing*, [e-journal] 68 (3), pp.539 - 549. doi:10.1111/j.1365-2648.2011.05755.x.

Weaver, K. and Olson, J. K., 2006. Understanding paradigms used for nursing research. *Journal of Advanced Nursing*, [e-journal] 53 (4), pp.459 - 469. doi:10.1111/j.1365-2648.2006.03740.x.

Webb, C. and Kevern. J., 2001. Focus groups as a research method: a critique of some aspects of their use in nursing research. *Journal of Advanced Nursing*, [e-journal] 33 (6), pp.798 – 805. doi: 10.1046/j.1365-2648.2001.01720.x.

Whitehead, D., 2013. Common qualitative methods. In: Z. Schneider, D. Whitehead, G. LoBiondo-Wood and J. Haber, eds. 2013. *Nursing and midwifery research: methods and appraisal for evidence-based practice*. 4th ed. Sydney: Elsevier - Mosby. pp.103 - 122.

Whiting, L. S., 2008. Semi-structured interviews: guidance for novice researchers. *Nursing Standard*, [e-journal] 22 (23), pp.35 – 40. doi: 10.7748/ns2008.02.22.23.35.c6420.

Whittemore, R. and Knafl, K., 2005. The integrative review: updated methodology. *Journal of Advanced Nursing*, [e-journal] 52 (5), pp.546 - 553. doi:10.1111/j.1365-2648.2005.03621.x.

Williams, G. C., Saizow, R. B. and Ryan, R. M., 1999. The importance of self-determination theory for medical education. *Academic Medicine*, [e-journal] 74 (9) pp.992 - 955. Available at: <https://journals.lww.com/academicmedicine/Abstract/1999/09000/The_importance_of_self_determination_theory_for.10.aspx#pdf-link> [Accessed 14 October 2018].

Wilkes, L., 2015. Using the Delphi technique in nursing research. *Nursing Standard*, [e-journal] 29 (39), pp.43 - 49. doi: 10.7748/ns.29.39.43.e8804.

Woith, W. M., Jenkins, S. H., Astroth, K. S. and Kennedy, J. A., 2014. Lessons learned from conducting qualitative research in a hospital. *Nurse Researcher*, [e-journal] 22 (2), pp.40 – 43. doi: 10.7748/nr.22.2.40.e1280.

Wong, C., Spence Laschinger, H. and Cziraki, K., 2014. The role of incentives in nurses' aspirations to management roles. *The Journal of Nursing Administration*, [e-journal] 44 (6) pp.362 – 367. doi: 10.1097/NNA.0000000000000082.

Woods, L. and Roberts, P., 2003. Requesting access for research purposes: issues and guidelines. *Nurse Researcher*, [e-journal] 10 (3), pp.38 – 47. doi: 10.7748/nr2003.04.10.3.38.c5895.

World Health Organisation, 2006. *Health System Profile Egypt*. [pdf] Reginal Office for Eastern Mediterranean, World Health Organisation. Available at: <http://apps.who.int/medicinedocs/documents/s17293e/s17293e.pdf> [Accessed 24 June 2016].

World Health Organisation, 2010. *Country Cooperation Strategy for WHO and Egypt 2010–2014*. [pdf] Cairo: World Health Organisation. Available at: < http://applications.emro.who.int/docs/CCS_Egypt_2010_EN_14481.pdf> [Accessed 9 September 2016].

World Health Organisation, 2012. *Egypt Nursing Profile*. [pdf] Cairo: World Health Organisation. Available at: <http://www.emro.who.int/images/stories/cah/fact_sheet/Nursing_Profile.pdf> [Accessed 27 September 2015].

World Health Organisation, 2016a. *Global strategic directions for strengthening nursing and midwifery 2016 – 2020*. [pdf] Geneva: World Health Organisation. Available at: <https://www.who.int/hrh/nursing_midwifery/global-strategic-midwifery2016-2020.pdf> [Accessed 7 February 2017].

World Health Organisation, 2016b. *Global strategy on human resources for health: Workforce 2030*. [pdf] Geneva: World Health Organisation. Available at: <https://www.who.int/hrh/resources/global_strategy_workforce2030_14_print.pdf?ua=1> [Accessed 7 February 2017].

World Health Organisation, 2016c. *Strengthening nursing and midwifery in the Eastern Mediterranean Region: a framework for action 2016 - 2025*. [pdf] Geneva: World Health Organisation. Available at: <http://applications.emro.who.int/dsaf/EMROPUB_2016_EN_18976.pdf> [Accessed 7 February 2017].

World Health Organisation, 2018. *WHO country cooperation strategy at a glance: Egypt*. [pdf] Cairo: World Health Organisation. Available at <http://www.who.int/iris/handle/10665/137164> [Accessed 20 June 2018].

World Health Organisation, 2019. *Eastern Mediterranean Region: framework for health information systems and core indicators for monitoring health situation and health system performance 2018*. [pdf] Cairo: World Health Organisation. Available at: <http://applications.emro.who.int/docs/EMROPUB_2018_EN_20620.pdf?ua=1> [Accessed 20 January 2020].

World Health Organisation, 2020a. *State of the world's nursing 2020: investing in education, jobs and leadership*. [pdf] Geneva: World Health Organization. Available at: <https://www.who.int/publications/i/item/9789240003279> [Accessed 23 April 2020].

World Health Organisation, 2020b. *State of the world's nursing 2020 - country profiles: Egypt*. [pdf] Geneva: World Health Organisation. Available at: <https://apps.who.int/nhwaportal/Sown/Files?name=EGY> [Accessed 23 April 2020].

# Appendices

## Appendix I: The Social, Economic and Demographic context of Egypt

### The social, economic and demographic context of Egypt

The Arab Republic of Egypt is situated in the north-eastern region of Africa (International Organisation for Migration (IOM), 2011). It is the most populous country in the Middle East and North Africa with an estimated population of over 90 million and a total of 40% of the population under the age of 20 years (United Nations Development Programme (UNDP), 2019). Around 60% of the people live in sparsely populated rural regions. The other 40% reside in urban areas inhabiting densely populated areas in the Nile Valley and Delta regions including the capital, Cairo, and other major cities such as Alexandria, which make up only 5% of the total surface area of the country (World Health Organisation (WHO), 2010; IOM, 2011).

Geographically, Egypt is made up of three main provinces and further divided into 27 administrative governorates: the northern region of the country which includes Lower Egypt and the Nile Delta; the southern region which includes Upper Egypt and the Nile Valley, and the Frontier region which is the eastern and western borders of the country (Ministry of Health and Population (MOHP), 2015) (See Figure below).

*Figure: Map of Egypt showing main provinces (Ameliabd.com, 2018)*

## Appendix I: The Social, Economic and Demographic context of Egypt

Egypt is classed as a lower-to-middle income (LMIC) country (WHO, 2010). Around 27.8% of the population live below the poverty level (UNDP, 2019) and vast disparities exist in the distribution of wealth, healthcare and education (Gerike, 2005; UNDP, 2015). Gender inequality is especially problematic in the rural areas of Upper Egypt (WHO, 2010), although women have started to enter the labour force in larger numbers (Elsaid and Elsaid, 2012). Whilst communicable diseases are on the decline, lifestyle-related illnesses such are cardiovascular disease are rapidly increasing (WHO, 2010).

Egypt has been going through a critically unstable period of social, economic and political transition since the Arab Spring in 2011 (UNDP, 2019). Unemployment is around 13.2% and is greater amongst the youth and three times higher on average for women (ibid.). Egypt was placed 99/140 in the 2018 World Economic Forum Global Competitiveness report for education and skills, as well as for health. There is a lack of openness and transparency among public and private institutions within Egypt with high levels of corruption (Kassem, 2014). In line with the United Nation's Sustainable Development Goals, the Egyptian Government has launched 'Egypt's Vision 2030', a sustainable development strategy which has identified education and economic reform as key areas for investment and development for the future (Ministry of Planning,Monitoring and Administrative Reform, 2016).

Egypt is a collectivist society which emphasises family and in-group goals, loyalty and cohesiveness above individual needs or desires (IOM, 2011; Elsaid and Elsaid, 2012). In Arabic culture, the extended family is the basic unit and the care of the sick, elderly and other dependents are family responsibilities (Okasha, Elkholy and El-Ghamry, 2012). The behaviour of family members especially that of women, is often under scrutiny and criticism, for either social or religious reasons. Egyptian men and women have distinct roles within society. Once women have children they are often pressured into leaving their jobs to look after the family (Elsaid and Elsaid, 2012). Failure to comply with societal expectations and norms leads to stigma, associatedwith withdrawal of social support from communities and loss of self-esteem (Okasha, Elkholy andEl-Ghamry, 2012). There is strong societal pressure for marriage and establishing a family, particularly in rural areas were child marriage continues to be problematic (United Nations International Children's Emergency Fund (United Nations International Children's Emergency Fund (UNICEF), 2017). Religion also plays a major role in people's daily lives, with majority of

the population being Muslim, and 10% identifying as Coptic Christians (Elsaid and Elsaid, 2012). Lastly, power, status and position are important societal norms reflecting an unequal sharing of power in the society (ibid.)

## Appendix II: Framework of CPD Activities Based on the Literature

*Framework of CPD activities based on the literature (Pool, et al., 2016, p.23)*

| *CPD Activities* | *Description* |
|---|---|
| Learning from organised learning activities:<br>Short courses and training, including clinical teaching sessions, annual training day on the ward/retaining; conferences and symposia; postgraduate education. | Formal learning activities at the ward, hospital, or outside the workplace setting. These includes conferences, postgraduate education, clinical teaching sessions, (online) courses, etc. |
| Learning from experience | Knowledge and skills gathered through experiences on the job. Learning happens as a by-product of working. |
| Learning from social interaction with colleagues | Learning with and from peers, students, and other healthcare professionals through exchange of knowledge, consultation, feedback, and observation. |
| Learning from consulting media | Self-directed learning through media including the Internet, books, journals, protocols, etc. |

## Appendix III: A 15-point checklist of criteria for good thematic analysis

*A 15-point checklist of criteria for good thematic analysis (Braun and Clarke, 2006, p.96)*

| Process | Number | Criteria |
|---|---|---|
| **Transcription** | 1 | The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'. |
| **Coding** | 2 | Each data item has been given equal attention in the coding process. |
| | 3 | Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive. |
| | 4 | All relevant extracts for all each theme have been collated. |
| | 5 | Themes have been checked against each other and back to the original data set. |
| | 6 | Themes are internally coherent, consistent, and distinctive. |
| **Analysis** | 7 | Data have been analysed – interpreted, made sense of – rather than just paraphrased or described. |
| | 8 | Analysis and data match each other – the extracts illustrate the analytic claims. |
| | 9 | Analysis tells a convincing and well-organised story about the data and topic. |
| | 10 | A good balance between analytic narrative and illustrative extracts is provided. |
| **Overall** | 11 | Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly. |
| **Written report** | 12 | The assumptions about, and specific approach to, TA are clearly explicated. |
| | 13 | There is a good fit between what you claim you do, and what you show you have done – i.e., described method and reported analysis are consistent. |
| | 14 | The language and concepts used in the report are consistent with the epistemological position of the analysis. |
| | 15 | The researcher is positioned as active in the research process; themes do not just 'emerge'. |

## Appendix IV: Access approval Letter from Technical Institute of Nursing

Date: 26 May 2016

h

e

a
Egypt

Dear L

**Re: Approval for Research Study *"The Professional Development and Career Advancement of Technical Diploma Nurse Graduates in Egypt"***

I am writing on behalf of the Chair of ( Board of Directors, Mr. H n, and myself, Dr b, Dean of the G l, in relation to our previous discussions regarding your proposed doctoral level research which you are undertaking as part of your studies at the University of Glasgow, UK. I am pleased to inform you that we have revised your proposal and you have been granted formal approval by the Board of Directors to conduct your study in the G l and have access to the graduates of the Technical Diploma in Nursing Programme and the faculty of the institute. Please note that as the GTNI does not have an ethics committee for research, as good practice we request that you also submit your approval letter from the Research Ethics Committee of A e to the G Board before commencing your study.

We wish you best of luck with your research and we are on hand to assist you as per required.

Best Wishes.

Yours sincerely

Dr H b, PhD
Dean, G l

Mr. H
Chair, G Board of Directors

G
H a, Egypt.
Tel.: (+20 1
E-mail: r g.com

المعهد الفني للتمريض بالجونة
الغردقة، البحر الأحمر، ج.م.ع.
تليفون: 0
البريد الإلكتروني: r g.com

## Appendix V: Access Approval Letter from Hospital

24th August 2016

Egypt

Dear

**Re: Access Approval for Research Study**

I am writing in relation to our previous discussions regarding your proposed study entitled: *"The professional development and career advancement of Technical Diploma nurse graduates in Egypt"*, which you are undertaking as part of your Doctoral studies at the University of Glasgow, UK. You have now been approved to access to your target population who are employees of ) and to conduct this study in our hospital. Please don't hesitate to contact me if you have further requests and good luck with your studies.

Yours sincerely

Nursing Director,

Mobile No.:

E-mail: .com

**Head Office**

, Egypt

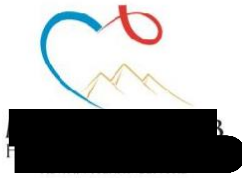
Tel: (202) 2 8 Fax: (202) 2 9

www. .org

, Egypt

Tel: (2097) 2 Fax: (2097)

## Appendix VI: Ethical Approval Letter from Hospital REC



**Research Ethics Committee (REC)**
**Decision Notification**

Cairo in 26-Oct-2016

Dear

With regards to your submitted protocol entitled:

**The professional development and career advancement of Technical Diploma nurse graduates in Egypt.**

We would like to inform you that the committee has decided to: **Approve** the protocol submitted after review..

## Important Notes:

As part of the REC requirements for continuing review of approved study, you are kindly responsible to submit periodic progress reports to the committee at intervals appropriate to the degree of subject risk involved but no less than once per year.

A final report is required to be submitted to the committee following study completion.

REC Vice Chairman

Prof

REC Chairman

Eng

Research Ethics Committee
FWA 00019142

## Appendix VII: Email from Academic Supervisor regarding outcome of MVLS REC

-----Original Message-----
From: l [mailto: @glasgow.ac.uk]
Sent: Friday, November 25, 2016 9:07 PM
To: < @ .com>
Cc: < @glasgow.ac.uk>; < @glasgow.ac.uk>
Subject: RE: Feedback

Dear

Please find attached the ethics committee comments. They have rejected the application and you can see that they state there is no requirement for us to resubmit the documents.

They have made various suggestions to the wording of some items and the flow of others. I strongly recommend that you make these changes before actually using this paperwork.

Have a good weekend,

Best wishes,

Dr l

School of Medicine, Dentistry and Nursing & Health Care, College of Medical, Veterinary and Life Sciences University of Glasgow

Glasgow

0141

## Appendix VIII: Response to MVLS REC Collated Comments

University of Glasgow | College of Medical, Veterinary & Life Sciences

**MVLS Ethics Committee Reviewers' Report on Application No. 200160034**

**Project title:** The professional development and career advancement of Technical Diploma nurse graduates in Egypt.

**Applicants:** [redacted]

Please find below the comments of the Reviewer who assessed your application. In order to facilitate the review process, we ask that, when you submit your revised application, you return this Review Form stating how you have responded to each of the reviewers' comments. Please also ensure that you highlight clearly in any revised documents (**preferably using a different font colour**) where changes have been made. Failure to comply with these instructions may result in your revised application being returned to you.

Thank you for your valued feedback. I have written my response to these comments/suggestions in blue.

**Reviewer 1:**

This postgraduate student study aims to examine the career development of technical diploma grade nurses in Egypt using a qualitative methodology. Interviews will be conducted on the perceptions of and motivations for career progression and the obstacles faced; phase 1 will involve nurses themselves; phase 2, senior nursing and medical staff.

The proposed methodology appears appropriate to answer the research questions.

Although being conducted overseas, the study is not of a clinical nature. There is, therefore, no restriction from an Insurance perspective and there is no need to refer it to the Research Governance Office.

The research team is suitably qualified.

Section 2: is there a minimum number required for phase one, given that not all 29 may want to take part? Written informed consent should also be one of the inclusion criteria.

After consulting the literature relating to the topic under study, discussions with the my academic supervisors and guidance from the literature on determining a satisfactory number

of participants in qualitative studies, it was judged a minimum of 16 interviews would be adequate for Phase 1, and a minimum of five to six interviews for Phase 2, to capture varied perceptions, support a deep understanding of the data and consequently answer the research aim and secondary objectives posed. Nevertheless, I plan to interview until all no new concepts are expressed. This will be continuously evaluated during the research process in a critically reflective way.

Written informed consent has been added as an inclusion criteria for Phase 1 and Phase 2 of the study. The following statement was added: "*Provide voluntary informed written consent at the time of the interview*."

Section 4: it would not usually be acceptable for researchers to have access to potential participants' identifiable information or to make initial contact without express permission first. However, the researcher describes the cultural norms expected in this location and the methodology has been approved by the local ethics committee and board of directors respectively at site.

For clarification, cultural nuances dictate that individual informal meetings will be held with those in senior positions in management at the host hospital to discuss the aim and objectives of the study before invitation emails are sent to facilitate engagement in the study. The rest of Phase 2 (and all of Phase 1) participants, will be contacted initially via invitation emails which will be sent by a third party.

Section 20: if no funding, how will travel expenses be reimbursed?

Travel expenses will not be reimbursed. Participants can request to be interviewed in an area of their choosing but it is envisioned that participants will wish to be interviewed in or near to their place of work.

Section no./title: Phase 1 Participant Information Sheet v1 08/10/2016

Please delete version number 1.4.1 in footer to avoid confusion

Footer deleted as requested.

Section 4. Why have I been chosen? Final sentence, please change to '…..have been invited to participate in the study', rather than '……have been asked……'

Changed as requested.

**MVLS Ethics Committee Reviewers' Report on Application No. 2001500**

Section 15: change the title of this section. At the point of reading the Information Sheet, they haven't agreed to take part yet.

Changed as requested. Section 15: "*Thank you for taking part in this study!*" title has been removed and changed to: "*What do I do if I am interested in participating in the study?*" (Now Section 14).

Section no./title: Phase 2 Participant Information Sheet v1 08/10/2016

Please delete version number 1.4.1 in footer to avoid confusion

Footer deleted as requested.

Section 4. Why have I been chosen? Final sentence, please change to '…..have been invited to participate in the study', rather than '……have been asked…..'

Changed as requested.

Section 5. Do I have to take part? Presumably, a decision not to take part won't affect relationship with AHC, as well as GTNI?

The following statement was added to this section to clarify this: "*A decision not to take part or withdraw from the study will not affect your relationship with the GTNI or AHC as an employee or as a stakeholder in any way*."

Section 15: change the title of this section. At the point of reading the Information Sheet, they haven't agreed to take part yet.

Changed as requested. Section 15: 'Thank you for taking part in this study!' title has been changed to "*What do I do if I am interested in participating in the study?*" (Now Section 14).

Section no./title: Phase 1 Consent Form v1 08/10/2016

Please delete version number 1.2 in the footer to avoid confusion

Footer deleted as requested.

If updating the corresponding Participant Information Sheet version number and date, remember to update item 1 in this document accordingly.

Done – updated version has been added.

Section no./title: CV of Principal Investigator

**MVLS Ethics Committee Reviewers' Report on Application No. 2001500**

The document submitted is blank; please submit the correct one.

A completed CV of the PI was submitted.

**Reviewer 2:**

This project involves interviews with Diploma nurse graduates and senior healthcare professionals and educators about career prospects. Approval has already been received from an ethics committee in Egypt.

CV

Please complete.

A completed CV of the PI was submitted.

Application Form

Q3. A pilot study is mentioned here for the interview questions. Who will take part in this? It also mentions 'member checking'. What does this mean?

A pilot interview will be held with a Clinical Instructor employed the host Technical Institute of Nursing who is most contextually representative of the target population and independent from the main study. A second pilot interview will be held with a Technical Diploma Nurse employed at the host hospital from the target population who meets Phase 1 inclusion criteria. For Phase 2, a faculty member employed at the host Technical Institute of Nursing most contextually representative of the target population and independent of the main study will be interviewed. Member checking is when the researcher returns data, either in the form of transcripts or data interpretations, to participants for comment.

Q4. My only real ethical concern about this study is the use of the data from HR and the Student Affairs Admin Office to identify participants. Although permission has been received from senior management at both institutions for the researchers to access this data, they [the researchers] should ensure that this is appropriate use of this data, i.e., have the staff/graduates given general permission for their data to be given out in circumstances such as this?

Yes, on conferring with the relevant organisations, general permission has been previously granted by staff and graduates.

Q5. Who will hold the 'key' to the participant identities?

**MVLS Ethics Committee Reviewers' Report on Application No. 2001500**

To honour the commitments made to confidentiality and anonymity, as well as ensure non-traceability, participants were given identification numbers to safeguard their identities and only I had access to the key linking participants to identifiers. As mentioned in the ethics application form, data will be stored on a computer was password-protected and hard copies of data will be kept in a cabinet secured with a lock to which only I have access.

Q15. Presumably the participants will also have access to their data e.g., the transcript.

Although initially considered, member checking was not considered appropriate for the context of the study. Participants will be sent a summary of the findings of the study after the study's completion.

Appendix 2

Is it the senior staff's 'perceptions' of aspirations etc. for Diploma graduates that are being asked about here, rather than their own development plans? Perhaps clarify this.

Yes, it is the perceptions of senior staff that are being sought regarding Technical Diploma Nurse graduates' aspirations etc., rather than their own perceptions of their development. This has been clarified in the Phase 2 interview guide.

Appendices 5 & 6

The numbers 1. and 2. should be in bold for consistency.

Done – number changed to bold.

Section 5 needs to be reworded. As the prospective participants are receiving the information sheet by email they can already have a copy. This appears again in section 15. Perhaps add the words 'or withdraw' to the sentence beginning 'A decision…'

Done – the sentence in Section 5 has been reworded to: "*A decision not to take part or withdraw from the study will not affect your relationship with the* [redacted] *or* [redacted] *as an employee or as a stakeholder in any way*." The wording has also been changed in Section 15 and retitled to "*What do I do if I am interested in participating in the study?*" (Now Section 14).

Sections 6 and 7 are quite repetitive. Could they be merged?

Done – Section 6 and 7 have been merged, condensed and retitled: "What will happen to me if I take part and what do I have to do?" (Now Section 6).

**MVLS Ethics Committee Reviewers' Report on Application No. 2001500**

To clarify section 10, perhaps answer the question asked in the title with the word 'Yes' or some other statement.

Done – the word 'yes' was added as the first word of this section to answer the question in the title. (Now Section 9).

13. If the other REC has provided a code, perhaps include here?

The local REC did not provide a code and therefore it was not added.

15. There's a mismatch between the title of this section and the first line. The participants haven't agreed to take part yet.

The wording has been changed in Section 15 and retitled to "*What do I do if I am interested in participating in the study?*" The opening sentence has now been changed to "*After you have read this information sheet and you are still interested in taking part……*" (Now Section 14).

Consent Form

Who else could take consent except for the researcher? This is not mentioned in the protocol.

Only the researcher will take consent due to the scope of the study.

Could you record somewhere on the consent form if the participant would like to receive the results of the study?

The following statement has been added to Phase 1 and Phase 2 consent forms: "*If you would like to receive a copy of the findings after the study's completion, please initial the box.*"

**Reviewer 3:**

Contacted the MVLS ethics group directly with concerns around the use of participants already known to the researcher.

**Lead Reviewer:**

All reviewers were concerned at the recruitment, using only students and staff with whom the interviewer has a direct relationship. In general this would be strongly discouraged as it risks potential coercion and may limit the validity of responses.

However, we are sympathetic to the differing cultural context and it is clear the applicant has reflected on this.

**MVLS Ethics Committee Reviewers' Report on Application No. 2001500**

We discussed this submission amongst the MVLS ethics leads. As the project already has ethical from the local site, who will be more familiar with the cultural nuances, we felt that further formal approval from University of Glasgow MVLS was not required. The study can proceed under the approvals already in place. I have attached the comments from the peer reviewers for your interest but we do not need to see a revised application.

It is acknowledged my professional role means that I am an 'insider' in many elements of this qualitative research within the discipline of health professions education. As an insider researcher, as stated in the ethics application, I will likely to be known to the Technical Diploma Nurse graduates and I also have a pre-existing professional relationship with academic nursing faculty from the host Institute. Moreover, I will likely to be known to some of the healthcare professionals from the stakeholder hospital. Nevertheless, I do not hold a position of authority or responsibility over any of the potential participants in either of these organisations. Aspects of the recruitment process, such as contacting those in Phase 2 who hold senior positions in management before written requests to participate are disseminated, is deemed necessary to respect cultural nuances and facilitate engagement in the study. Consequently, recruitment procedures have been constructed based on discussions with other researchers in Egypt and my knowledge of societal norms. Measures outlined in this ethics application have summarised the strategies put in place to ensure potential participants will not feel any sense of coercion during recruitment procedures and guarantee a process of ongoing voluntary informed consent. Reflexivity will be practiced throughout the research process to mitigate potential ethical challenges that may arise when conducting research amongst those with whom a pre-existing relationship is shared.

## Appendix IX: Phase 1 Participant Invitation Letter

University of Glasgow | College of Medical, Veterinary & Life Sciences

Egypt

**Phase 1: One-to-one interviews with Technical Diploma Nurse graduates**

**Participant Invitation Letter**

Dear Graduate,

I am leading a study to explore "The professional development and career advancement of Technical Diploma Nurse graduates in Egypt" from your perceptions. Your name and email address was sourced by a third party from the Alumni database who holds the graduate contact information list. You qualify for this study because you are a graduate of the Technical Diploma in Nursing programme at the and working as a nurse in the Institute's key stakeholder hospital, in Egypt, and your knowledge and experience is of value to this research.

This study is being conducted by myself as part of a Doctoral Degree on the Health-Professions' Education Doctorate Programme, which I am undertaking at the University of Glasgow in the United Kingdom.

If you are interested in learning more about this study and taking part, please look at the attached Participant Information Sheet in this email, then fill in the opt-in form also attached, and email it back to .com. You can also call on (+2) . You do not have to respond if you are not interested in this study. It is important to know that this letter is not to tell you to join this study. It is your decision and your participation is voluntary.

Thank you for your time and consideration and look forward to hearing from you.

Sincerely,

**Attachments:**

- Phase 1 Participant Information Sheet
- Opt-in form

## Appendix X: Phase 1 Participant Information Sheet

**Phase 1: One-to-one interviews with Technical Diploma Nurse graduates**
**Participant Information Sheet**

### 1. Study title

The professional development and career advancement of Technical Diploma Nurse graduates in Egypt.

### 2. Invitation paragraph

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and talk about it with others if you wish. Please contact the researcher if there is anything that is not clear or if you would like more information and she will happy to go through this information sheet with you, to help you decide if you would like to take part. The researcher will also be happy to answer any questions you may have. Take time to decide whether you wish to take part.

### 3. What is the purpose of the study?

The aim of this study is to explore and describe the perceptions of professional development and career advancement of Technical Diploma Nurse graduates in Egypt. The results of this study will inform discussions on continuing professional development (CPD) policies, the development of post-graduate CPD programmes and career advancement for Technical Diploma nurse graduates, as there has not been a lot of research done in this area before in Egypt. This study is part of a Doctoral level research project which is being done by the researcher and is part of a Health- Professions' Education Doctorate Programme, which is being undertaken at the University of Glasgow in the United Kingdom. This research project will be carried out from November 2016 to August 2018.

### 4. Why have I been chosen?

You have been invited to participate in this study as you have graduated from the Technical Diploma in Nursing Programme at [redacted] and you are working as a nurse in the Institute's key stakeholder hospital, [redacted] in Egypt, and your knowledge and experience is of value.

The researcher wishes to examine your views about your professional development and career advancement as a Technical Diploma Nurse graduate in Egypt. All of the

nurse graduates from the ████ who are working at ██████████████ have been invited to participate in the study.

**5. Do I have to take part?**

No, it is up to you to decide if you want to take part. If you do decide to take part, you will be asked to sign a consent form. You are still free to withdraw at any time and without giving a reason. During the interview you have the right to decline to answer any questions the researcher may ask and you have the right to stop the interview andleave if you wish. A decision not to take part or withdraw from the study will not affect your relationship with the █ as a graduate nurse in any way or ██████████████ as an employee.

**6. What will happen to me if I take part and what do I have to do?**

If you decide you wish to take part in the study, you will be asked to participate in a one-to-one interview in English with the researcher. The researcher will ask you to talkabout your views of your professional development and career advancement as a Technical Diploma Nurse graduate in Egypt. The interview may take from 45 minutes up to 1 hour and will be audio recorded with your permission. The interview can be conducted at a time and in an area of your choosing to make sure of your comfort and convenience. This may be either at the hospital in which you work, at the ████ or another area at your request.

**7. What are the possible disadvantages and risks of taking part?**

There are no disadvantages or risks to taking part in the study.

**8. What are the possible benefits of taking part?**

You will receive no direct benefit from taking part in this study. You will however, have the opportunity to be part of a research study. The information that is collected during this study will give the researcher a better understanding of how graduates from the GTNI perceive their professional development and career advancement. This will lead to recommendations for policy development, post-graduate CPD provision and a career framework for Technical Diploma Nurse graduates in Egypt, as well as, questions for further research.

**9. Will my taking part in this study be kept confidential?**

Yes, confidentiality will be strictly adhered to both throughout and after the study. All information which is collected about you, including the responses that you give, the audio recording and the transcript from your interview will be anonymised and kept in a secure place. You will be identified by an identification number, and any information

about you will have your name and personal details removed so that you cannot be recognised from it. Other people who you mention in the interview will also have their name changed so not to be identifiable. Only the researcher will have access to the information.

**10. What will happen to the results of the research study?**

The information from the interviews will be part of the researcher's doctoral research thesis which will be assessed in order for her to gain the doctoral degree. The results of the research may also be published in a relevant academic journal, presented at an academic conference and a copy of the findings will be made available to you by August 2018 if you ask the researcher. You, or the institution in which you work, will not be identified in any report/publication to make sure of confidentially and anonymity.

**11. Who is organising and funding the research?**

There is no organisation or company sponsoring or funding the research.

**12. Who has reviewed the study?**

The project has been reviewed by [redacted] Research Ethics Committee, Egypt, the University of Glasgow's College of Medical, Veterinary and Life Sciences Research Ethics Committee, UK and permission has been given to carry out the study by the [redacted], Egypt.

**13. Contact for further information**

The researcher [redacted] will be glad to answer your questions about this study at any time and can tell you about the results of the study once data collection is finished. You may contact her by email at [redacted].com or by telephone (+2) [redacted].

**14. What do I do if I am interested in participating in the study?**

After you have read this information sheet and you are still interested in taking part, fill in the opt-in form and email it to [redacted].com or call (+2) [redacted] and tell us of your interest verbally. Thank you very much for considering taking part in this research.

## Appendix XI: Opt-in Form

University of Glasgow | College of Medical, Veterinary & Life Sciences

[REDACTED], Egypt

**Opt-in Form**

**Title of Project:** The professional development and career advancement of Technical Diploma Nurse graduates in Egypt.

Please complete this form and email it to the following address: [REDACTED].com or you can call me on (+2) [REDACTED].

I am interested in learning more about this study and possibly taking part in theresearch being conducted by [REDACTED] in fulfilment of her Doctoral Degree as part of a Health-Professions' Education Doctorate Programme at the University of Glasgow in the United Kingdom. I understand I can withdraw at any time.

Please contact me using the following information:

Name:______________________________________________________________

Telephone(s):_________________________________________________________

Best time and day/s to call:_____________________________________________

Email:_____________________________________@_________________________

## Appendix XII: Phase 1 Consent Form (English and Arabic version)

### Phase 1: One-to-one interviews with Technical Diploma Nurse graduates

### Consent Form (English)

**Title of Project:** The professional development and career advancement of Technical Diploma Nurse graduates in Egypt.

**Name of Researchers:** [redacted] and [redacted]

**Please initial box**

I confirm that I have read and understand the participant information sheet dated 7th December 2016 (Version 2) for the above study and have had the opportunity to ask questions. ☐

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected. ☐

I agree to the interview being audio taped and transcribed. ☐

I agree to take part in the above study. ☐

______________________________

Name of participant Date Signature

Researcher Date Signature

(1 copy for subject; 1 copy for researcher)

If you would like to receive a copy of the findings after the study's completion, please initial the box. ☐

**Phase 1: One-to-one interviews with Technical Diploma Nurse graduates**

**Consent Form (Arabic)**

**Title of Project:** The professional development and career advancement of Technical Diploma Nurse graduates in Egypt.

**Name of Researchers:** ████████ and ████████

**يرجاء التوقيع بالمربع أدناه:**

أوقر بإننى قد قرأت وفهمت ورقة المعلومات الخاصة بالمشاركة بالبحث المذكور أعلاه والمؤرخة(إصدار) 7ديسمبر 2016 ، وكذلك إتاحة الفرصة لطرح الأسئلة. ☐

وأعلم جيدا أن مشاركتي تعتبر تطوعية ولى مطلق الحرية فى الانسحاب في أي وقت، دون إبداء أي سبب، ودون المساس بحقوقى القانونية. ☐

أوافق على إجراء جميع المقابلات وتسجليها صوتيا ونسخها . ☐

أوافق على المشاركة في الدراسة المذكورة أعلاه. ☐

| **اسم المشارك** | **التاريخ** | **التوقيع** |
| --- | --- | --- |
| ____________ | ____________ | ____________ |

| **إسم الباحث** | **التاريخ** | **التوقيع** |
| --- | --- | --- |
| ____________ | ____________ | ____________ |

**(1 نسخة عن الموضوع؛ 1 نسخة للباحث)**

إذا كنت ترغب في الحصول على نسخة من النتائج بعد الانتهاء من الدراسة، يرجى التوقيع بالمربع. ☐

## Appendix XIII: Phase 2 Participant Invitation Letter

University of Glasgow | College of Medical, Veterinary & Life Sciences

[redacted] Egypt

**Phase 2: One-to-one interviews with senior academic nursing faculty and health care professionals**

**Participant Invitation Letter**

Dear Colleague,

I am leading a study to explore “The professional development and career advancement of Technical Diploma Nurse graduates in Egypt” from your perceptions. You qualify for this study because you are a senior academic nursing faculty member working at [redacted] or a senior health care professional working at [redacted] in Egypt and your knowledge and experience is of value to this research.

This study is being conducted by myself as part of a Doctoral Degree on the Health-Professions’ Education Doctorate Programme, which I am undertaking at the University of Glasgow in the United Kingdom.

If you are interested in learning more about this study and taking part, please look at the attached Participant Information Sheet in this email, then fill in the opt-in form also attached, and email it back to [redacted].com. You can also call on (+2) [redacted]. You do not have to respond if you are not interested in this study. It is important to know that this letter is not to tell you to join this study. It is your decision and your participation is voluntary.

Thank you for your time and consideration and look forward to hearing from you.

Sincerely,

[redacted]

[redacted]

**Attachments:**

- Phase 2 Participant Information Sheet
- Opt-in form

**Appendix XIV: Phase 2 Participant Information Sheet**

**Phase 2: One-to-one interviews with senior academic nursing faculty and health care professionals**

**Participant Information Sheet**

**1. Study title**

The professional development and career advancement of Technical Diploma Nurse graduates in Egypt.

**2. Invitation paragraph**

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and talk about it with others if you wish. Please contact the researcher if there is anything that is not clear or if you would like more information and she will happy to go through this information sheet with you, to help you decide if you would like to take part. The researcher will also be happy to answer any questions you may have. Take time to decide whether you wish to take part.

**3. What is the purpose of the study?**

The aim of this study is to explore and describe the perceptions of the professional development and career advancement of Technical Diploma Nurse graduates in Egypt. The results of this study will inform discussions on continuing professional development (CPD) policies, the development of post-graduate CPD programmes, and career advancement for Technical Diploma nurse graduates, as there has not been a lot of research done in this area before in Egypt. This study is part of a Doctoral level research project which is being done by the researcher and is part of a Health- Professions' Education Doctorate Programme, which is being undertaken at the University of Glasgow in the United Kingdom. This research project will be carried out from November 2016 to August 2018.

**4. Why have I been chosen?**

You have been invited to participate in this study as you are either a senior member of the academic nursing faculty team at [redacted] or a senior nurse or doctor working at the [redacted]'s key stakeholder hospital, [redacted] [redacted] in Egypt and your knowledge and experience is of value.

## Appendix XIV: Phase 2 Participant Information Sheet

The researcher wishes to examine your perceptions of the professional development and career progression for Technical Diploma Nurse graduates in Egypt. All of the senior nursing faculty from the [redacted] have been invited to participate in the study, as well as, a selection of the senior nurses and doctors of . [redacted]

### 5. Do I have to take part?

No, it is up to you to decide if you want to take part. If you do decide to take part, you will be asked to sign a consent form. You are still free to withdraw at any time and without giving a reason. During the interview you have the right to decline to answer any questions the researcher may ask and you have the right to stop the interview andleave if you wish. A decision not to take part or withdraw from the study will not affect your relationship with the [redacted] or [redacted] as an employee or as a stakeholder in any way.

### 6. What will happen to me if I take part and what do I have to do?

If you decide you wish to take part in the study, you will be asked to take part in a one-to-one interview in English with the researcher. The researcher will ask you to talk about your views of the professional development and career progression of TechnicalDiploma Nurse graduates in Egypt. The interview may take from 45 minutes up to 1 hour and will be audio recorded with your permission. The interview can be conductedat a time and in an area of your choosing to make sure of your comfort and convenience. This may be either your place of work, namely the [redacted] or [redacted]or at another area at your request.

### 7. What are the possible disadvantages and risks of taking part?

There are no disadvantages or risks to taking part in the study.

### 8. What are the possible benefits of taking part?

You will receive no direct benefit from taking part in this study. You will however, have the opportunity to be part of a research study. The information that is collected during this study will give the researcher a better understanding of the perceptions of professional development and career advancement for Technical Diploma Nurse graduates in Egypt. This will lead to recommendations for policy development, post-graduate CPD delivery and a career framework for Technical Diploma Nurse graduates in Egypt, as well as, questions for further research.

**9. Will my taking part in this study be kept confidential?**

Yes, confidentiality will be strictly adhered to throughout and after the study. All information which is collected about you, including the responses that you give, the audio recording and the transcript from your interview will be anonymised and kept in a secure place. You will be identified by an identification number, and any information about you will have your name and personal details removed so that you cannot be recognised from it. Other people who you mention in the interview will also have their name changed so not to be identifiable. Only the researcher will have access to the information.

**10. What will happen to the results of the research study?**

The information from the interviews will be part of the researcher's doctoral research thesis which will be assessed in order for her to gain the doctoral degree. The results of the research may also be published in a relevant academic journal, presented at an academic conference and a copy of the findings will be made available to you by August 2018 if you ask the researcher. You, or the institution in which you work, will not be identified in any report/publication to make sure of confidentially and anonymity.

**11. Who is organising and funding the research?**

There is no organisation or company sponsoring or funding the research.

**12. Who has reviewed the study?**

The project has been reviewed by [redacted]'s Research Ethics Committee, Egypt, the University of Glasgow's College of Medical, Veterinary and Life Sciences Research Ethics Committee, UK and permission has been given to carry out the study by the [redacted], Egypt.

**13. Contact for further information**

The researcher [redacted] will be glad to answer your questions about this study at any time and can tell you about the results of the study once data collection is finished. You may contact her by email at [redacted].com or by telephone (+2) [redacted].

**14. What do I do if I am interested in participating in the study?**

After you have read this information sheet and you are still interested in taking part, fill in the opt-in form and email it to [redacted].com or call (+2) [redacted] and tell us of your interest verbally. Thank you very much for considering taking part in this research.

## Appendix XV: Phase 2 Consent Form (English and Arabic version)

University of Glasgow | College of Medical, Veterinary & Life Sciences

**Phase 2: One-to-one interviews with senior academic nursing faculty and health care professionals**

**Consent Form (English)**

**Title of Project:** The professional development and career advancement of Technical Diploma Nurse graduates in Egypt.

**Name of Researchers:** [redacted] and [redacted]

**Please initial box**

I confirm that I have read and understand the participant information sheet dated 7th December 2016 (Version 2) for the above study and have had the opportunity to ask questions. ☐

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected. ☐

I agree to the interview being audio taped and transcribed. ☐

I agree to take part in the above study. ☐

| Name of participant | Date | Signature |
|---|---|---|
| Researcher | Date | Signature |

(1 copy for subject; 1 copy for researcher)

If you would like to receive a copy of the findings after the study's completion, please initial the box. ☐

## Appendix XV: Phase 2 Consent Form (English and Arabic version)

**Phase 2: One-to-one interviews with senior academic nursing faculty and health care professionals**

**Consent Form (Arabic)**

**Title of Project:** The professional development and career advancement of Technical Diploma Nurse graduates in Egypt.

**Name of Researchers:** ████████████ and ██████

**يرجاء التوقيع بالمربع أدناه:**

أوقر بإننى قد قرأت وفهمت ورقة المعلومات الخاصة بالمشاركة بالبحث المذكور أعلاه والمؤرخة(إصدار) 7 ديسمبر 2016 ، وكذلك إتاحة الفرصة لطرح الأسئلة. ☐

وأعلم جيدا أن مشاركتي تعتبر تطوعية ولى مطلق الحرية فى الانسحاب في أي وقت، دون إبداء أي سبب، ودون المساس بحقوقى القانونية. ☐

أوافق على إجراء جميع المقابلات وتسجليها صوتيا ونسخها . ☐

أوافق على المشاركة في الدراسة المذكورة أعلاه. ☐

| اسم المشارك | التاريخ | التوقيع |
|---|---|---|
| ____________________ | __________ | ______________ |

| إسم الباحث | التاريخ | التوقيع |
|---|---|---|
| ____________________ | __________ | ______________ |

**(1 نسخة عن الموضوع؛ 1 نسخة للباحث)**

إذا كنت ترغب في الحصول على نسخة من النتائج بعد الانتهاء من الدراسة، يرجى التوقيع بالمربع. ☐

## Appendix XVI: Phase 1 Interview Guide

University of Glasgow | College of Medical, Veterinary & Life Sciences

| **Interview Guide Sheet<br>Phase 1: Technical Diploma Nurse Graduates** | | | |
|---|---|---|---|
| **Research Study Title:** The professional development and career advancement of Technical Diploma Nurse graduates in Egypt | | | |
| **Archival Number:** | | **Interviewer:** | |
| **Location of interview:** | Nursing Institute | Stakeholder hospital | Other: *(Please specify)* |
| **Date of interview:** | | **Start time:** | **End time:** |
| **General Information:**<br>• Age<br>• Date of graduation<br>• Number of years employed<br>• Current position and department within the hospital | | | |
| | | | |
| **Topic: Perceptions of Career Advancement**<br>• Tell me about your current role you have within the hospital | | | |
| | | | |
| **Topic: Perceptions of Professional Development**<br>• Tell me about your experiences of further education or training activities (formal or informal)<br>• From the education you have undertaken, to what extent, if any, has this influenced your learning/career? | | | |
| | | | |
| **Topic: Aspirations and Motivations for Development**<br>• Can you tell me your main purpose for having done/not done further education and training since graduation?<br>• Can you describe any plans you have, if any, to do further education and/or training in the future?<br>• Tell me how you see your future with regards to your career.<br>• What do you think you will need to have/do to reach your career goal? | | | |
| | | | |

## Appendix XVI: Phase 1 Interview Guide

**Topic: Challenges, Influencing Factors and Opportunities**

- Can you describe the factors that have influenced your educational and career plans since graduation? What factors may influence your plans in the future?
- Can you describe any challenges you have had or think you will face in the future to implement your career plans?
- Can you tell me about any support or guidance you have had to help you with your development? Can you tell me how it helped you?
- Can you tell me how you feel you could be best supported to help you with your continued development and career growth?

**Additional Notes:**

## Appendix XVII: Extracts from Reflexive Notes from Phase 1 Pilot Interviews

**Pilot Interview 1:**

*This interview was observed by my two academic supervisors as it was the first pilot interview. We discussed before the interview the potential impact on their presence with regards to how the participant might respond. We arranged the seating accordingly in the interview room – my supervisors would sit at the back of the room out of eyesight of the both myself and the participant as to not offer a distraction. I felt really nervous before the interview – will I remember what questions I should ask? Would there be a language barrier? The participant was a colleague – she was a newly hired Clinical Instructor at the host Technical Institute of Nursing who had recently graduated from a Bachelor top-up degree programme. However, she had previously graduated as a Technical Diploma Nurse and worked for a few years by the bedside. The interview room was quiet, however there was an interruption during the interview despite there being a sign on the door.*

*I discussed with the participant before entering that my two academic supervisors would be observing me, and I asked for oral consent for them to attend. She agreed and did not seem to be overly phased by their presence and she seemed excited that someone was interested in learning about her experience. We agreed that I should introduce them to the participant – I didn't use the title of 'Doctor' when I introduced them to dispel any power imbalances and reiterated that they were there to observe me and my interview skills rather than herself.*

*The participant spoke freely and openly without much prompting. I didn't feel English language was a problem and the participant seemed relaxed. However, I felt at times my mind went blank during the interview! I couldn't remember what questions I should ask and felt like I kept looking at my interview guide. I often asked irrelevant questions and spent too much time on aspects of work history rather than what I should actually be asking, and missed some important points that I should have probed, such as her motivations for development. I was focused too much on understanding her work history and what interested me rather than what was important to ask! Nevertheless, eye contact was good and there seemed a good rapport between us.*

*The following issues seemed to be important:*

- *Time and feeling overloaded*

## Appendix XVII: Extracts from Reflexive Notes from Phase 1 Pilot Interviews

- *Money*
- *Geography –Cairo*
- *Didn't want to be a 'doer' but a 'thinker'*

*Things to change for next interview: need to incorporate work history questions at the beginning of the interview rather than later to gather details of work history and avoid spending too much time on this during the interview process. The interview guide had initially begun with general questions regarding their current role within the hospital. Also, it would be of benefit to add in the words 'formal or informal' to the interview guide as a prompt when asking about experiences of further education or training activities, as it was implied by the participant that I was asking about formal continuing professional development activities only. Therefore, this point needed to be clarified to the participant.*

**Pilot Interview 2:**

*This interview was again observed by my two academic supervisors. The participant this time was a graduate from the Technical Diploma program from the Institute in which I worked. She was employed at the host hospital. The interview was interrupted again, this time by the housekeeping staff. I had put the sign on the door in English 'Please do not disturb interview in progress'. However, it occurred to me that I should also have the sign displayed in Arabic also toavoid future interruptions! The room was quite otherwise.*

*I felt less nervous this time and bit more confident. The participant seemed really keen to be interviewed and again spoke openly freely. I didn't feel there was a language barrier. We had a good rapport. On review of the interview audio-recording it was apparent that nearer the end of the interview I seemed to ask two questions at the same time! I need to be careful of this for the next interview. I asked work history questions at the beginning of the interview which allowed me to quickly address the issue without elaborating too much and taking away the focus of the interview which proved to be a simpler and natural interview opener. Rewording the question related to experiences of further education to include 'formal and informal' activities as an additional prompt helped to clarify any ambiguity regarding this question for the participant.*

## Appendix XVII: Extracts from Reflexive Notes from Phase 1 Pilot Interviews

*Again the participant seemed excited that I was interested to hear her story. However, later after listing again to the audio-recording of this pilot interview to assist with further reflection, it occurred to me that she focused a great deal on her motivations to gain a higher degree and her aspirations of promotion. I began to think - could this may have been as a result of my position as a nurse educator and/or the presence of my academic supervisors? Was she trying to impress me (or them) and tell me what she thought I (or we) wanted to hear, rather than the 'truth'? Or is it the fact that issues related to the need for further academic study and progress to a high position in her career were indeed important for this participant?*

*Issues raised:*

- *Financial challenges and work overload*
- *The evaluation / appraisal was a source for frustration*
- *Online learning*
- *Knowledge and skills and education important aspects of promotion*
- *Getting a Bachelor degree is important for career development*
- *Promotion was a source of motivation*
- *Self-learning was important*
- *Informal support mechanisms and career planning advice from institute and from colleagues*
- *Family support also seemed to be an important source of support*

*Being a nurse educator from the host Technical Institute of Nursing, I am aware that this could raise a potential power imbalance in the relationship between myself and Phase 1 participants which may limit their contributions to the interview. The issue of 'power' is also a consideration for an Arab context were status and position are important cultural norms (Hawamdeh and Raigangar, 2014). The presence of my academic supervisors for the pilot interviews may have amplified this. However, the literature also suggests that familiarity can enable a more open dialogue (McConnell-Henry, et al., 2009) and highlights the importance of establishing a good level of trust and rapport (DiCicoo-Bloom and Crabtree, 2006; Brown and Danaher, 2017). I felt that the participant and I had a good level of rapport during the interview and she didn't seem to*

*be inhibited by the presence of my supervisors. Moreover, rapport and trust seemed to be facilitated by familiarity in this interview. However, I discussed my feelings further with my academic supervisors during a subsequent Skype meeting before commencement Phase 1 data collection for the main study and we stressed on the importance of continually monitoring my relationships with participants and the impact these had on my research in my reflexive notes, as well as being conscious of implementing strategies to facilitate trust and rapport during data collection.*

*Note all participants have been addressed as female to ensure anonymity.*

## Appendix XVIII: Interview Checklist

**Interview Checklist**

**Overview of Procedures – Researcher's Guide**

**Research Study Title:** The professional development and career advancement of Technical Diploma Nurse graduates in Egypt

**Preparation for the interview:**

- Study the interview guide and informed consent form
- Make arrangements for
  - Private setting for interview site
  - Transportation of participant to interview site (if applicable)
  - Refreshments for participants (i.e. bottles of water and cups)

**Preparation on the day of the interview:**

- Assign archival number for the interview
- Prepare the following supplies required for the interview:
  - Interview packet containing the following:
    - 1 large envelope (archival envelope)
    - Archival information sheet with archival number
    - 1 copy of interview guide
    - 2 informed consent forms
- Label all data documentation materials, including archival envelope with identical archival number
- Organise interview room appropriately to ensure comfort and rapport
- Place "do not disturb" sign on door of interview room to minimise interruptions
- Prepare the following equipment required for the interview:
  - 1 audio recorder and back-up recorder – carry out audio test
  - Spare batteries for audio recorder
  - Field notebook and pens

**Conducting the interview:**

- Greet the participant in a friendly manner to begin establishing rapport
- Ask participant about any time constraints they have
- Briefly describe the steps of the interview process (informed consent, question and answer, their questions, clarify roles)
- Obtain written informed consent and emphasise the voluntary nature of interview – participant and researcher sign research form (one copy for participant, one for the researcher)
- Ensure mobile phones are turned off and out of view
- Turn on the audio recorder and back-up recorder and verify that it is working

## Appendix XVIII: Interview Checklist

- Verify informed consent orally with the audio recorder on
- Conduct the interview according to the interview guide (address all topics listed in interview guide)
- End the question-asking phase of the interview
- Give the participant the opportunity to ask questions / clarify points
- Reconfirm the participant's consent while the audio recorder is still on
- Turn of the audio recorder and back-up recorder and thank the participant, allow time for debrief if appropriate
- Take reflexive notes on key words and phrases, body language, moods or attitudes, the general environment/observations, and other relevant information on interview guide

**After the interview:**

- Check audio recording to see if the interview was recorded – if interview not recorded expand detailed notes immediately
- Expand reflexive notes immediately if possible (if not within 24 hours)
- Ensure all data documentation materials are labeled with the archival number
- Assemble all labelled data documentation materials into archival envelope:
    - Completed archival information sheet
    - Signed informed consent form (signed by the participant and researcher)
    - Interview guide with notes
    - Reflexive notes
- Return archival envelope to identified secured cabinet as per data management protocol
- Upload copy of audio recording of interview into computer file on identified secure password-protected computer as per data management protocol. Label file appropriately.
- Conduct preliminary analysis of interview data:
    - Identify questions for follow-up, issues to pursue, new information etc.
- Adjust interview guide and/or interview technique accordingly in preparation for next interview

*Adapted from Mack, et al. (2005, pp.48 – 49)*

## Appendix XIX: Phase 2 Interview Guide

<table>
<tr><th colspan="4">Interview Guide Sheet<br>Phase 2: Senior Academic Nursing Faculty and Health Care Professionals</th></tr>
<tr><td colspan="4">Research Study Title: The professional development and career advancement of Technical Diploma nurse graduates in Egypt</td></tr>
<tr><td>Archival Number:</td><td></td><td>Interviewer:</td><td></td></tr>
<tr><td>Location of interview:</td><td>Nursing Institute</td><td>Stakeholder hospital</td><td>Other: (Please specify)</td></tr>
<tr><td>Date of interview:</td><td></td><td>Start time:</td><td>End time:</td></tr>
<tr><td colspan="4">General Information:<br>• What is your position in the hospital/Nursing Institute?<br>• Please indicate how long in total you have worked at the hospital/Nursing Institute</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="4">Topic: Theme - Mechanisms for Learning and Development<br>• What do you think are the main mechanisms that Technical Diploma Nurse graduates use to develop professionally and progress their careers?<br>- Prompts: Aspiration, motivation and opportunities for development; ‘wanting a higher degree’; ‘wanting to travel abroad’; ‘participating in work related learning’.</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="4">Topic: Theme - Sources of Support<br>• What do you think are the key sources of support that facilitate Technical Diploma Nurse graduates’ professional development and career advancement?<br>- Prompts: ‘family members and friends’; ‘work colleagues’; ‘organisational support’</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="4">Topic: Theme - Moving up the Career Ladder<br>• What career goals to Technical Diploma Nurse graduates aspire to and why? How can they affectively move up the career ladder?<br>- Prompts: Aspirations, motivations and opportunities for development; ‘wanting a good position’; ‘professional skills’</td></tr>
</table>

## Appendix XIX: Phase 2 Interview Guide

| |
|---|
| |
| **Topic:**<br>• What are the key challenges and influences that affect the professional development and career advancement of Technical Diploma Nurse graduates?<br>• Overall, how should Technical Diploma Nurse graduates be best supported to develop professionally and advance their careers? |
| |
| **Additional Notes:** |
| |

## Appendix XX: Extracted Codes from a Phase 1 Interview Transcript

Comments extracted from: Document1
Created by: XXXXXX
Creation date: June 18, 2017

| Participant ID # | Page | Text Segment | Assigned Initial Code | Date |
|---|---|---|---|---|
| P13 | 1 | Nowadays I'm newly joined to the research department…..as a heart failure specialist nurse….I am joining for two or three months and I will have the opportunity to choose if I want to continue in the research department or I will return back to my unit, which is adult ICU…. | Rotations | 11-May-2017 |
| P13 | 2 | I think so….good [laughing], I like it…..I feel like I am giving more than what I was giving in the ICU….because I like to have, be teacher and I like to be friendly with the patients and talk with them and doing like….my duty in the research department is different because the nursing role…the same nursing role but in ICU I focus more on the skills I have learned and I practice it day after day…..so I felt like it's a routine….every day I have a critical case until he become ok and then I transfer him to the ward…so no new….but errr every day in the research department I met new patients with the heart failure and also VAD patients is a new system in our country and its not found, so I'm interested to work with, and know everything about it, and also looking for how we can choose the patients and how we apply if err if the patient is a candidate for this device or not…..And the position has new duties but its ok…..its better…… | Rotations | 11-May-2017 |
| P13 | 2 | my duty in the research department is different because the nursing role…the same nursing role but in ICU I focus more on the skills I have learned and I practice it day after day…..so I felt like it's a routine….every day I have a critical case until he become ok and then I transfer him to the ward…so no new….but errr every day in the research department I met new patients with the heart failure and also VAD patients is a new system in our country and its not found, so I'm interested to work with, and know everything about it, and also looking for how we can choose the patients and how we apply if err if the patient is a candidate for this device or not…..And the position has new duties but its ok…..its better…… | A break from routine | 11-May-2017 |
| P13 | 3 | Yes……it was also my choice. I have written in my recommendation about the unit I want to work in and I chose adult ICU….because I found the unit itself can give me more skills to learn….and I thought at the beginning of the participation in [the hospital] during the internship period, I have lack of skills and I wanted to improve it….and I found sometimes in the unit we have pediatric patients, sometimes we have post catheterization patients, we have the adult patients also post operatively…..so I liked to gain more……. | Chose unit because of opportunities for learning | 11-May-2017 |

Comments extracted from: Document1
Created by: XXXXXX
Creation date: June 18, 2017

| Participant ID # | Page | Text Segment | Assigned Initial Code | Date |
|---|---|---|---|---|
| P13 | 3 | after the six months or eight months, the Supervisor of the team of nursing in the research department offered for me to join them…..and I agreed….but after I took some time to think about it….. | Rotations | 11-May-2017 |
| P13 | 3 | Not like that but they said, I have observed you many times, you are working with patients, even the VAD patients in adult ICU and your way of communication and some human factors also, I think it will be better if you join with us….. | Non-technical skills | 11-May-2017 |
| P13 | 3 | Not like that but they said, I have observed you many times, you are working with patients, even the VAD patients in adult ICU and your way of communication and some human factors also, I think it will be better if you join with us…..she said that she has a choice of some nurses or some names but I'm offering that and your one of them…..I asking if you decline or don't want I will see to find another one….So its not about myself only. | Communication skills | 11-May-2017 |
| P13 | 3 | First I have some time to think about it….and I answered, its ok for me…Its like formally by the nursing director in the hospital and the Supervisor of my unit…..and then the Supervisor of my unit asked me for a meeting and asked me really if I want to join the team or not….and I said it will be a good experience, if I continue with them or not I will have gained a new experience……I will not loose anything…..even if it will delay me in my unit and my improvement in the unit because it's a time, like two months or three months it will affect on my work, like I left the unit and I returned back, things change and I will be focused on another thing……so it will affect….but I found the advantages will be more…… | Learning from rotations | 11-May-2017 |
| P13 | 4 | To be specialist…..because when I was working in ICU I'm not specialist……I'm a nurse and I can work in inpatients, also in any other area……Also like human factors was less than expected in ICU because as I said, critical patients all the time, so I felt I'm not communicating well with the patients, even I'm doing well in my communication with patients who are conscious or not…but if you have teaching sessions like in the research department, consent that you participant in to sign with patients, also to communicate with patients out of the hospital, to arrange and admission or some patients ask you because they are sick and want to come to the centre and you can bring them to come or you can contact them by phone…….The duty is different and I like to learn about it……. | Specialist practice | 22-May-2017 |

Comments extracted from: Document1
Created by: XXXXXX
Creation date: June 18, 2017

| Participant ID # | Page | Text Segment | Assigned Initial Code | Date |
|---|---|---|---|---|
| P13 | 4 | To be specialist…..because when I was working in ICU I'm not specialist……I'm a nurse and I can work in inpatients, also in any other area……Also like human factors was less than expected in ICU because as I said, critical patients all the time, so I felt I'm not communicating well with the patients, even I'm doing well in my communication with patients who are conscious or not…but if you have teaching sessions like in the research department, consent that you participant in to sign with patients, also to communicate with patients out of the hospital, to arrange and admission or some patients ask you because they are sick and want to come to the centre and you can bring them to come or you can contact them by phone…….The duty is different and I like to learn about it……. | Learning from new duties | 22-May-2017 |
| P13 | 4 | Not only me……I'm not saying I'm the best in ICU….its not about that….they were observing people and I'm one of them…. | Observation of practice | 22-May-2017 |
| P13 | 4 | Like communication by all branches…..with the staff, other workers in the hospital, other departments, also with patients….even VAD patients after they are able to talk and walk….my communication with them was good and also my health teaching way….it was the stress point that my Supervisor talk with me about….. | Communication skills | 11-May-2017 |
| P13 | 4 | Like communication by all branches…..with the staff, other workers in the hospital, other departments, also with patients….even VAD patients after they are able to talk and walk….my communication with them was good and also my health teaching way….it was the stress point that my Supervisor talk with me about….. | Observation of practice | 22-May-2017 |
| P13 | 5 | not only about you but the hospital overall works good to be professional for the patients | Quality hospital | 22-May-2017 |
| P13 | 5 | Many things….really about the patients, the patients here are not just from one layer of society…..they are poor patients and rich patients….it doesn't matter I deal with any kind of patients and its ok to find that they thank you and they are happy to work with you……and you found improvement….not only about you but the hospital overall works good to be professional for the patients….we have a good rate of health maintenance and recovery…..that's one of the most issues that feel me good…..I remember once I was working with a patient…a post-operative patient and I worked with her from shift seven to seven….pm but she was intubated and sedated…..and I didn't leave the patient even after my shift has gone two hours, to extubate the patient before I leave…..It is something I found myself in, I did something well with the patient…the case was complicated but errr the patient had good improvement within 12 hours. | Improving patient outcomes | 11-May-2017 |

Comments extracted from: Document1
Created by: XXXXXX
Creation date: June 18, 2017

| Participant ID # | Page | Text Segment | Assigned Initial Code | Date |
|---|---|---|---|---|
| P13 | 5 | Something also…..the level I work in….we have seen many hospitals…and I think this is one of the most…I wanna say standard…is this hospital……and besides that, the hospital is a non-profit organization so it is also a good title to work under….. Also the duty for all is not just to finish the shift, but really be professional for the patients and do well with the patients…..also they are working under evidence based practice, if I have a resource I give it to the Supervisor or the Charge Nurse in the unit, they study it…..if it will be applicable in the unit…..it doesn't matter if they have learned about it before…..by what is right now…updated knowledge all the time…..knowledge…new knowledge I get…I can't say all the knowledge I get in the institute I use it now….of course I use it now but its not enough! Over the time I need more and more and more….even nowadays I'm studying good…… | Working in a quality hospital | 11-May-2017 |
| P13 | 5 | also they are working under evidence based practice, if I have a resource I give it to the Supervisor or the Charge Nurse in the unit, they study it…..if it will be applicable in the unit…..it doesn't matter if they have learned about it before…..by what is right now…updated knowledge all the time…..knowledge…new knowledge I get…I can't say all the knowledge I get in the institute I use it now….of course I use it now but its not enough! Over the time I need more and more and more….even nowadays I'm studying good…… | Evidence based practice | 11-May-2017 |
| P13 | 5 | Of course research, studying | Self-study | 11-May-2017 |
| P13 | 5 | …..asking…. | Asking questions | 11-May-2017 |
| P13 | 6 | Emmm Charge, Supervisor…..even I ask the nursing director if anything not clear among all of us or there is a conflict……it doesn't matter….but they are cooperative in that…….They are asking you to do research and come and discuss…..it is not a problem….. | Asking questions | 11-May-2017 |
| P13 | 6 | Emmm something you don't know like a new type of surgery or I'm expecting to receive a patient post operatively, this surgery I didn't hear about it before…..so I have to read about it ….even I ask about a good source to read on……or I do it by myself….on a trusted website….. | Self-study | 11-May-2017 |
| P13 | 6 | so I have to read about it ….even I ask about a good source to read on……or I do it by myself….on a trusted website….. | Online resources | 11-May-2017 |

Comments extracted from: Document1
Created by: XXXXXX
Creation date: June 18, 2017

| Participant ID # | Page | Text Segment | Assigned Initial Code | Date |
|---|---|---|---|---|
| P13 | 6 | Yes, I'm using it all the time…… | Online resources | 11-May-2017 |
| P13 | 6 | Yes, somethings within the work itself……I can't say the organization at all, but there is individual persons…..about the characteristics about the person itself…..so its not about the organization…….maybe if this person is a position or not…..is not the orgnaisaiton, because the mistake of the one is not the mistake of the organisaiton….. | Frustrated by colleagues | 22-May-2017 |
| P13 | 7 | Ok, I'm doing well…I agree if I'm not ok…..I agree of my grade of evaluation and I accept that and I'm assigned it and I have no complaints to ask about or not…I'm trying to make myself do well next time and what I have failed in I want to achieve | Evaluations | 11-May-2017 |
| P13 | 7 | Honestly its about those above me…its not only about me but I have heard and I found many situations I have met about someone who prefer one out of work, so all of the time during the work prefer him over the others…..and its obviously talked about….like that…..its not affecting on me, but its frustrating…..Ok, I'm doing well…I agree if I'm not ok…..I agree of my grade of evaluation and I accept that and I'm assigned it and I have no complaints to ask about or not…I'm trying to make myself do well next time and what I have failed in I want to achieve…….but this frustrates you…..not jealous…… | Taking preference over others | 11-May-2017 |
| P13 | 7 | Not all of them….. I don't say all the persons in my unit…but a little…… | Opportunities given be preference rather than performance | 11-May-2017 |
| P13 | 7 | Sometimes when a group of new trainees come and mistakes done……Of course there are mistakes…but it frustrates you….. | New trainees | 11-May-2017 |
| P13 | 8 | Like, I have a new trainee nurse and the unit ask him to work with a complicated case, a critical case and he also all the time is asking, so I'm working with him…..its frustrating….why is he now covered by a senior or a monitor at all times…..they are not safe for the patient….its based on what I have worked with in ICU…..and also its not all the time….Also they have their point of view, maybe monitoring is out of their point of view….sometimes I put myself in their place, also I found the unit is not prepared to be complete today and then the night shift, and there is two critical cases come from the ward and another pediatric is to come, so they don't have enough staff in this shift…its not all the time but I bothers me….. | Staff shortages | 11-May-2017 |

Comments extracted from: Document1
Created by: XXXXXX
Creation date: June 18, 2017

| Participant ID # | Page | Text Segment | Assigned Initial Code | Date |
|---|---|---|---|---|
| P13 | 8 | Like, I have a new trainee nurse and the unit ask him to work with a complicated case, a critical case and he also all the time is asking, so I'm working with him…..its frustrating….why is he now covered by a senior or a monitor at all times…..they are not safe for the patient….its based on what I have worked with in ICU…..and also its not all the time….Also they have their point of view, maybe monitoring is out of their point of view….sometimes I put myself in their place, also I found the unit is not prepared to be complete today and then the night shift, and there is two critical cases come from the ward and another pediatric is to come, so they don't have enough staff in this shift…its not all the time but I bothers me….. | Lack of supervision for trainee nurses | 11-May-2017 |
| P13 | 8 | I have….they observe me during the work with my case and I explain for them to be monitor….like when I came here for the first time I was working with my preceptor but its according to my institute….really its really beneficial and it was a good period the three months…..it helped us a lot…. | Internship beneficial | 11-May-2017 |
| P13 | 8 | I have….they observe me during the work with my case and I explain for them to be monitor….like when I came here for the first time I was working with my preceptor but its according to my institute….really its really beneficial and it was a good period the three months…..it helped us a lot…..but they come and their faculty doesn't observe or doesn't ask…..so all of them on the Charge Nurse and the Supervisor of the unit…they are responsible for them….so today they work with someone but maybe tomorrow they work alone with a case…..it is not their fault…… | Lack of supervision for trainee nurses | 11-May-2017 |
| P13 | 8 | Of course….in teaching….the nurse they need to be teacher…..also if they ask you questions and you don't know, you will gain a new knowledge…..and new information about something….maybe you do research with them…..I'm not the person who say I know everything……Sometimes I receive questions from trainees and I search with them to find the answer or ask someone else…I'm not the one who knows everything or says something I don't know…..Its good because we are working two minds on the case….and beneficial to sharing knowledge….. | Supervising others | 11-May-2017 |
| P13 | 8 | Of course….in teaching….the nurse they need to be teacher…..also if they ask you questions and you don't know, you will gain a new knowledge…..and new information about something….maybe you do research with them…..I'm not the person who say I know everything……Sometimes I receive questions from trainees and I search with them to find the answer or ask someone else…I'm not the one who knows everything or | Sharing knowledge | 11-May-2017 |

Comments extracted from: Document1
Created by: XXXXXX
Creation date: June 18, 2017

| Participant ID # | Page | Text Segment | Assigned Initial Code | Date |
|---|---|---|---|---|
| | | says something I don't know…..Its good because we are working two minds on the case….and beneficial to sharing knowledge….. | | |
| P13 | 9 | Yes….errr its about the Supervisor of the unit…it was firstly at the end of the year….a meeting and an appraisal based on one especially for the unit…..and clarifies if I deserve which Grade…A or B or C….A of course for those applicable for those who can be acting as a Charge…..and B who has an administrative role next to a critical case and C, those who can take a critical case but without the administrative role….Of course after six months I was Grade C…..It was like…I wanna to be B and A…but it takes time…its ok……its like a lesson….I learn from it and I do well to achieve better…..Its not about I'm not well, I will leave the place….no…..its not like that….Of course it affects me to work better….. | Evaluations | 11-May-2017 |
| P13 | 9 | Some points….you know the self-awareness? I have of course issues and I told the Supervisor, because before evaluating me I told him I'm focusing or stressing on bla bla bla because I feel I'm not doing well and I'm doing action plan…..as we learned in the institute…..and it made him happy about to hear that….But also issues I didn't know about, he told me about so I tried to find it out and the reasons why and go over an action plan also…. | Developing self-awareness | 11-May-2017 |
| P13 | 9 | But also issues I didn't know about, he told me about so I tried to find it out and the reasons why and go over an action plan also…. | Developing an action plan | 22-May-2017 |
| P13 | 10 | Actually it was like errrr participating in administration in the unit…Like errr participating with the Charge in preparing for something, doing for another something……about knowledge, of course I was feeling that I'm doing well with my knowledge because I have the basics of course from the institute…..Also, I found the new trainee that come to the centre with me, I'm better than…its not based on what I'm dealing now but based on the institute, event they are bachelor degree and I am diploma…..but I found it is good so they are not like me so I'm ok…..but I found he said that you are almost 50% of knowledge you need to know……I was expecting 60 or 65 because also I don't have a long time….its not one year, two years or three years to learn in the centre, to learn the new diagnosis….because the centre is about cardiac only….not neuro, not GI….focusing on post operatively….mainly respiratory and cardiothoracic…..so I have a lot of information to know and a lot of knowledge I have to learn about…..but 50%? [laughing] So I asked him how did he know? | Feedback of performance during evaluations | 22-May-2017 |

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| P13 | 10 | Yes, I didn't expect…..he told me, if you have knowledge, show….show your knowledge….so come to me to share with me a research, come and ask me to go to a lecture to present for your colleagues…..I know you have a good knowledge…but show it……I have evidence for what you have and its 50%...... he said that and I believe him…..he is right….. | Feedback of performance during evaluations | 22-May-2017 |
| P13 | 10 | Not all! Really, honestly….some of it based on other talks…..not based on what he observed….. | Does not agree with feedback during evaluations | 12-May-2017 |
| P13 | 11 | Like, first of all, communication…….he didn't give me the good degree or grade in the communication part……and then after a little period he came to me and say, you are a good communicator….also during this period someone also, I will not give the name, but she was from Scotland I think, she came here from there and during her visits she focuses on something about human factors…..like communication, like health teaching…..She observed me for a while and I tried to talk and make and interview with her and I talked a lot with her and she asked the Supervisor to put me in the position of communication person in the unit…its not like a formal position but like the one who asks his colleagues and reminding them all the time to be in a good communication mode…..Of course he looked at me like it was a mistake to give you a low grade in communication……I'm not saying that about me….I feel it but about him…..he felt it after the evaluation time…..and it didn't bother me…..Of course he has many nurses, the unit is very crowded by nurses so….his duties are big, it is not a little role to work on…so he had to listen to others which is the Charges….not all the Charges because I have asked others to evaluate me on communication and I asked them about their opinion and I found one that told me you are not good with communication….it was something strange…..and now I have proof! Now I'm joining the most unit that needs good communicators…..It was one…..as I said I have a proof I didn't have my right, but others maybe he is right…..maybe I'm not aware about it so I accept….. | Does not agree with feedback during evaluations | 12-May-2017 |
| P13 | 11 | About the skills and the skills was like errr, you are doing well about your colleagues about the period you have spent in the unit and you gained a lot of skills but you are not the one who worked for one year or two years….three years or even seven years….So I accept that, because ok I'm working well, I'm handling the most critical cases but there are some procedures that I haven't met at all and that is put in the appraisal and I got zero….Even I have read about them, but I have got zero…..because I didn't have the | Evaluations | 12-May-2017 |

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| | | chance to work with this procedure itself…….It was ok for me….it was not a problem…by the time I will find the chance to work with these skills….Also, some of the skills we don't find in the ICU…..like family teaching…..I got zero….even though I'm doing well….but in ICU the visiting time is like 30 minutes or one hour…mostly about 45 minutes….and all the family come to see the patient so its 'how are you? Fine? Humdulliah' [Arabic word meaning 'thanks god' in English] and go on…..So you don't have time to explain, to support, to assess even…assess psychosocial, what the background of the patient…you have the patient only…..so for family I got zero…..I don't have the chance…So some points written in the appraisal, because the appraisal is generalized about all the nurses all over the centre…..even the critical areas have the most heavy one….so some parts I missed because I didn't have the chance to do…. | | |
| P13 | 12 | So as the institute tell me….organizing, doing an action plan…and also err a timely manner and achievement…assessing what the time and go over others to judge and like that….I did most…even with communication…..what was impressing me I go for the Charge and I say, I'm not well in which part of communication?..... With other coworkers even out with the unit…'no you are doing well, you are ok' so what can I do? | Making a plan for improvement | 12-May-2017 |
| P13 | 12 | Yes….but after what I said, the situation that happed after that time, I realized that I am ok…..not the maximum one or the best one but I'm ok…..I'm doing ok…..I'm doing well as I know….. | Conflicting opinions of performance | 12-May-2017 |
| P13 | 12 | by self-awareness…..so I'm hoping to improve that…because no one knows everything….. | Self-awareness | 12-May-2017 |
| P13 | 12 | Its only about the Technical Bachler degree…..I started to apply for that after the graduation by two or three months……and we've started it…it's the first year….its about two years the Technical Degree for critical care….so I didn't loose a lot of time after graduation…… | Applied for Technical Bachelor Degree | 11-May-2017 |
| P13 | 13 | Continuing education…… | Wants to continue education | 11-May-2017 |
| P13 | 13 | Of course improvement….not only by the improvement in the place…..I may gain a good position in the place…..but its not the end of the world…..I want to be better….. | Wants to improve | 11-May-2017 |

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| P13 | 13 | Not only position……about knowledge, about new skills, new ways of living even…..new places to go, new courses to know…..about registration……I want to take the course…. | International registration | 12-May-2017 |
| P13 | 13 | Nursing…..to be a Registered Nurse…. | International registration | 11-May-2017 |
| P13 | 13 | Yes, of course! Now I'm not preparing for it, but by this course I am in now, I'm preparing…….because after that I will go through the IETLS exam….I will find my way to prepare for the RN….. | International registration | 11-May-2017 |
| P13 | 14 | To be a nurse who can work all over the world……because now I'm the nurse who can work in Egypt but even can be a good position in Egypt? Till now no…..but after work here for a period of time, I will be……but will I be the one who work out? Maybe not…..with this certification or Grade, I will be ok to go…… | Certificates to travel abroad | 12-May-2017 |
| P13 | 14 | RN…….the Technical Degree is like a step….. | Technical Degree as first step | 12-May-2017 |
| P13 | 14 | [laughing] There is plan A and B but honestly I will not be at [the hospital]…but after finishing my duty here, my two years…..and also one or two years, it will be a good time to learn what I can learn here….but after that it will be routine…..even if I have a high position in the place……because I think, the high position here, they are thinking about leaving the place…..So why I'm thinking about the positon, I'm not thinking about leaving the place…..not leaving the place because I hate the place, of course not, I like it and as I said there are many things that prevent me from doing that…..its a good place….but what about after? | Leaving the hospital | 12-May-2017 |
| P13 | 14 | So why I'm thinking about the positon, I'm not thinking about leaving the place…..not leaving the place because I hate the place, of course not, I like it and as I said there are many things that prevent me from doing that…..its a good place….but what about after? | Quality hospital | 12-May-2017 |
| P13 | 14 | I want international learning and international practicing also…… | Want to be on international standards | 11-May-2017 |
| P13 | 15 | American and the UK are good….from the researches that we download and go over, they are doing well……they are doing well….even in Egypt, we are in a development | Traveling abroad | 11-May-2017 |

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| | | but not that much….because I wanna to reach a high level……Before I was not having this intension, even during my studying in the institute….. | | |
| P13 | 15 | When you are studying, just your focus I need to finish my course, I need to finish this year…..and I want to work….but when you work, you are looking for a new plan….. | Making a plan | 22-May-2017 |
| P13 | 16 | Not only America….its my specific plan now….initially I select it now….first I will achieve my degree and achieve my goal of reaching RN after that I can choose the hospital, maybe in an Arab country but it will be like out of Egypt……I think….because I think now I'm working in the most important place in Egypt….so if I leave this place, I will leave for a better place…… | Traveling abroad | 12-May-2017 |
| P13 | 16 | After the degree and certifications and the goals will be achieved, I think it will…..After the degree [the RN] there is no improvement in Egypt…so for continuous improvement I need to go and preparing for Master degree or….and I will have the certification that make me prepared for that…..now I admit I don't…….but maybe after that I will …. | Masters | 12-May-2017 |
| P13 | 17 | it's the first step….second step I will prepare for the RN….and it's a long plan I know……Maybe during that time if I could to get the Master Degree in Egypt…..I will see….if its not ok I will, if not after receiving the RN, I will prepare for that…… | Preparing for Masters | 12-May-2017 |
| P13 | 17 | it's the first step….second step I will prepare for the RN….and it's a long plan I know……Maybe during that time if I could to get the Master Degree in Egypt…..I will see….if its not ok I will, if not after receiving the RN, I will prepare for that…… | International Registration | 12-May-2017 |
| P13 | 17 | I'm lucking to graduate from my institute because our curriculum is not Egyptian…..and also I found that in reality, because I'm teaching the Bachelor degree graduate nurse in [the hospital]. | Supervising Bachelor degree | 11-May-2017 |
| P13 | 17 | Better learning….better level of education there, its better than Egypt of course…..I'm lucking to graduate from my institute because our curriculum is not Egyptian…..and also I found that in reality, because I'm teaching the Bachelor degree graduate nurse in [the hospital]. So I believe I can do it and achieve not only the Bachelor degree in Egypt, but I can achieve more…..why not? | Traveling abroad | 11-May-2017 |
| P13 | 17 | It's beside the work….. | University near to work | 11-May-2017 |

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| P13 | 17 | I need to work to know skills and experience and also to finish my two mandatory years for the institute. | Working and studying | 12-May-2017 |
| P13 | 17 | I need to work to know skills and experience and also to finish my two mandatory years for the institute. | Learning from daily practice | 12-May-2017 |
| P13 | 17 | Also during this time, I wanna have an improvement in theory and I also want to have a certification in nursing…..so I think its an appropriate one for this time…… | Certificates | 12-May-2017 |
| P13 | 18 | Yes, I asked about other universities in Egypt, good universities like [names a list of private universities in Cairo] but it was difficult, it was really difficult about the work, the place….its not applicable…..its difficult….I found I have to spend the two years first here and then go to apply….so I'm sitting for the two years doing nothing…so I can have a certification here….. | Difficult to study in Cairo | 11-May-2017 |
| P13 | 18 | even if its not about the certification or even if its not about the plan I put, but its about the actual plan….the place and time….its ok…..it helps a lot…..so no disadvantages | Place and time of study | 12-May-2017 |
| P13 | 18 | Its in critical care and I'm working in a place that needs that…..so I'm studying and applying…..all of the examples that we are using from the lecture from the centre itself…..from the unit I work in…so it help….even if its not about the certification or even if its not about the plan I put, but its about the actual plan….the place and time….its ok…..it helps a lot…..so no disadvantages….About the vacations I not looking forward to that! [laughing] | Working and studying | 11-May-2017 |
| P13 | 18 | So I'm spending all the time in [the local area] now….because I'm working and studying at the same time…..so I need to organize my roster on the study time…so no time to go for vacation…..maybe it will be two days or three days and its difficult to travel and come again….. | Working and studying | 11-May-2017 |
| P13 | 18 | So I'm spending all the time in [the local area] now….because I'm working and studying at the same time…..so I need to organize my roster on the study time…so no time to go for vacation…..maybe it will be two days or three days and its difficult to travel and come again….. | Lack of vacations | 11-May-2017 |
| P13 | 19 | Like ten to eleven hours…so its difficult….. | Long distance between hospital and home | 11-May-2017 |

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| P13 | 19 | Of course……I will not only be the Staff Nurse but I will be maybe the Charge Nurse….I will be something better….Not only the position but if I become the Charge for ten nurses, but now I'm working as a Nurse…..not only for me, also for patients, what I will feel I am doing something effective….not I'm sitting doing nothing……. | Education for better position | 11-May-2017 |
| P13 | 19 | Of course……I will not only be the Staff Nurse but I will be maybe the Charge Nurse….I will be something better….Not only the position but if I become the Charge for ten nurses, but now I'm working as a Nurse…..not only for me, also for patients, what I will feel I am doing something effective….not I'm sitting doing nothing……. | Position to improve patient care | 12-May-2017 |
| P13 | 19 | Errr really…many things, not just one……I may join educational programmes, I may find something else……but its about that…. | Education for better positions | 11-May-2017 |
| P13 | 20 | The work itself…….working in this hospital is effective and helpful….. | Learning from daily practice | 11-May-2017 |
| P13 | 20 | Of course to be updated…..to work on evidenced based all the time because the knowledge is not fixed… | Keeping up to date | 11-May-2017 |
| P13 | 20 | You will see….maybe I will achieve the RN or not….it depends….. | International registration | 11-May-2017 |
| P13 | 20 | Of course the experience, of course the degree…..I have to have of course the knowledge….and of course the courses….like IELTS and so on…like be prepared for their exams….. | English language | 11-May-2017 |
| P13 | 21 | Its ok but I'm not the one who will pass it now…..so I put a plan to work on these days beside the studying, even we have also English in the studying but its not better than the English in the institute….but I will prepare myself for the course…..I'm not that much bad in English, but I'm still bad [laughing] | English language | 11-May-2017 |
| P13 | 21 | For everything! All the work in English…..all the research in English…..everything! Even communication, participation in presentations, attending conferences….to do anything like that you need the language of course……Because the IELTS means international English language……..that will help me a lot…..I'm looking for that….. | English language | 11-May-2017 |
| P13 | 21 | Because the IELTS means international English language ......... that will help me a lot…..I'm looking for that….. | International certification in English | 11-May-2017 |

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| P13 | 21 | In my career…if I'm preparing for Master degree I need English…..If I'm going to work in another country, even an Arabic country or another country, I need English…..Internationally now it's the language for all people…. | English language | 11-May-2017 |
| P13 | 22 | I think the career is ok…..is good and has opening arms to through….If you need to work as a nurse and go over to be a specialist nurse, with a good degree or grade in nursing or of you need to focus more you can be a doctor of nursing…..so I think it's a good career…… | Good career | 12-May-2017 |
| P13 | 22 | How I discover? I can say the institute…..not only the institute but the institute give me the basics that help me all over my plan….I have learned research skills, I've learned English, I have learned all about nursing….even I've studied the basics and the diploma degree but I have taken subjects like ethics and professional issues…all of that are discussing about how to go through the career, how to know everything about the career…it was effective…..it was easy after the two or three years of the institute but not before….before I was doing very, very bad…..I know…[laughing] | Perceptions of good preparation | 11-May-2017 |
| P13 | 23 | So I asked people about….even my colleagues here, some nurses here who are in positions…..even I asked my brother….because he is working also as a nurse…..to also ask for me……and the final decision was here | Asking colleagues for advice | 12-May-2017 |
| P13 | 23 | Also I have done a search on the internet and looked for many times about the site for the university and the other university and I asked some questions, even on Facebook but the account of the university, even the faculty itself…..I look a lot but really the final and right decision was here…… | Searching on the internet for opportunities | 12-May-2017 |
| P13 | 23 | Its about military duty……I'm worried about it……[laughing] Its not about the experience, its about the time……After the degree I have to spend one year….. | Military duty | 11-May-2017 |
| P13 | 23 | I have to go…..unless if they said no! [laughing] | Military duty | 11-May-2017 |
| P13 | 24 | I don't say I do, I don't say I do…but I don't mostly because of the time….I'm not worried about the experience….I would like to have the experience but I don't want to waste one year……really…. | Military duty | 11-May-2017 |
| P13 | 24 | Yes……but during I'm preparing for RN, I have to go! | Military duty | 11-May-2017 |

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| P13 | 24 | I have chosen that I will continue my education, even in another faculty or here, I will not go to the military after the institute itself, I will go to do another degree…I decided that before…. | Military duty | 11-May-2017 |
| P13 | 24 | Everything…..everything I have learned, everything I have learned about…I need to be better….I don't have to stay…… | Wants to have continuous improvement | 12-May-2017 |
| P13 | 25 | If I'm thinking about marriage and go on….but its not my plan now…..its like many things…..like my family are stressing me now to go through the marriage…you have to choose and we will be supporting you and go on but I refused that because its not my plan….I want to continue education first….. | Marriage plans | 11-May-2017 |
| P13 | 25 | My dad has died…… | Parent died | 11-May-2017 |
| P13 | 25 | Its from a long time….I was in the second year in high school….. | Parent died | 11-May-2017 |
| P13 | 25 | Maybe……some….not all…..its a factor….. | Parent died | 11-May-2017 |
| P13 | 26 | I'm the youngest brother…I have three brothers older than me…..and they are all married and have children…..also I have three sisters….I'm the youngest of all…I'm the only one who's not married….[laughing] So they are looking for me to agree for the decision of marriage….but I will not….. | Marriage plans | 11-May-2017 |
| P13 | 26 | It will affect on my life….about my plan…..It will be stopped here and look for the marriage and children…..and the family living……not now!....Not now! Maybe after the five years that we are talking about [laughing] I will think about it……And in my age 23, 24….five years I will not be 50 years….28 or 29….it will be good…..even 30! | Marriage plans | 11-May-2017 |
| P13 | 26 | Of course….of course…….. | Marriage affecting development | 11-May-2017 |
| P13 | 26 | Yes, negative! | Marriage affecting development | 11-May-2017 |
| P13 | 27 | Family….according to our culture….now I don't have to go and travel to my city every month….but if I'm married I have too…..even maybe they will affect me to work there in my town and live the constant life…..but I don't like that…..I want to be better…..I want to be something……it's a hope….. | Affect of marriage on development | 11-May-2017 |

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| P13 | 27 | I tried….[laughing] | Family pressure for marriage | 11-May-2017 |
| P13 | 27 | The closed the conversation [laughing]….they are asking….. | Family pressure for marriage | 11-May-2017 |
| P13 | 27 | They don't care……even if its someone from here…… | Family pressure for marriage | 11-May-2017 |
| P13 | 27 | I'm not thinking about now…..really……I'm not……What I'm thinking about is what I'm going to do…… | Marriage plans | 11-May-2017 |
| P13 | 28 | They wont support…..no……they are also from Upper Egypt…..and you know I'm the youngest man….and my dad has died and my mum needs to die……[laughing] Like not needs to die, but she says I has seen all the children of your brothers except you…..I will not see you in a family before............really that is affecting me really but I have taken a decision and I have to stand beside it…… | Family pressure for marriage | 11-May-2017 |
| P13 | 28 | Really, not much….because they were expecting from me to be something better than a nurse…….because the persons within the family, I have like my mum….her nephew was like the same age and he was hating me because I'm better than him in studying in school and even during high school and he now is a doctor….but newly graduate…in Palestine… | Image of nursing | 12-May-2017 |
| P13 | 29 | but thank god and thank [the institute] that I have changed……because if I didn't it would be the last chance……I remember when I newly joined [the institute] my brother called me, if you want to join nursing institute there is one [in a governate] beside mine and its an Egyptian curriculum and you will pass it with an excellent degree but it wasn't my focus point then…..but my focus point was that I wanted to change….and the person who can to [the institute]….suddenly I wake up……so the institute has helped me a lot to change……I didn't do well…..not very well…..but is enough to be the person who graduated from [the institute]…… | Personal development | 12-May-2017 |
| P13 | 29 | Yes….and military……. | Military duty | 11-May-2017 |
| P13 | 29 | Maybe my ability for studying….but I think its improving…..its improving really…..now I work and even I go home and I study…..really I didn't expect that….[laughing]….but I'm doing that….. | Self-study | 12-May-2017 |

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| P13 | 29 | Around the books…PDF that I download from the internet | Online resources | 11-May-2017 |
| P13 | 29 | Around the books…PDF that I download from the internet….I save it and I read it later….. | Self-study | 11-May-2017 |
| P13 | 30 | I'm working….so its ok now…..now its ok, I'm working and I'm studying….. | Working and studying | 11-May-2017 |
| P13 | 30 | Beside the work?.....Now its ok .........I have time….I'm managing the time….I'm not wasting it….[laughing] | Managing time | 12-May-2017 |
| P13 | 30 | My intension….what I have learned about and what I want to know…..what my plan and I want to achieve it…..that's all my support…… | Self-motivation | 12-May-2017 |
| P13 | 30 | Even my family….they are wishing for me the best but in another way [laughing] They don't like this plan, but they support me if I need anything | Family pressure to marry | 12-May-2017 |
| P13 | 30 | Even my family….they are wishing for me the best but in another way [laughing] They don't like this plan, but they support me if I need anything…like I have backup….someone if I need something urgently or in an emergency situation…they are ready…..Also I have, I will not say very good economical situation, but its ok……I can pass it……. | Family support | 12-May-2017 |
| P13 | 31 | They centre here, they are supporting us for this continuing education for these years….but after that I don't know…… | Support from hospital | 11-May-2017 |
| P13 | 31 | It supported me before graduation… | Perceptions of good preparation | 12-May-2017 |
| P13 | 31 | but after graduation I think its not their duty…..they don't have to ask me every month….are you doing well during your life? No, its not about that….but I'm sure if I returned back to them to ask for help or support, they are ready I think……of course…… | Support from institute after graduation | 12-May-2017 |
| P13 | 31 | But now I can manage it…I don't need to ask for that now because what I learned in the institute, now I'm studying…..maybe the curriculum bigger a little bit but really, really, really what I'm studying in [the institute], I'm studying it now…… | Not learning anything new | 12-May-2017 |

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| P13 | 31 | The lecture today was like, things I have learned and I have done research about it….but I found it not matched with what I am studying in the new curriculum……so I'm asking about it, but the doctor [lecturer] may consider that as an objection……. | Conflicting information | 12-May-2017 |
| P13 | 32 | Like today….I wrote it as a note and I will research about it….during the lecture, the doctor say about….do you remember 'time is muscle' in ACS…is about 90 minutes? She said today that it is 120 minutes so I got shocked…how is that possible? I will read about it……maybe the new guidelines say about 120 minutes so I didn't say anything…..I didn't say they are wrong but there is a conflict….I will research about it…..and find out…..I studied it more than one year ago so maybe its changed…….. | Conflicting information | 12-May-2017 |
| P13 | 32 | even if its economical…if this year I will not be able to finish it because of money, so I have to save money first and then I will achieve it….so its not my worrying point…..maybe it will affect the time also | Financial constraints | 12-May-2017 |
| P13 | 32 | but its not worrying me more than other challenges I mentioned……because I'm afraid I listen to my family…… | Family pressure to marry | 11-May-2017 |
| P13 | 32 | Many things….not just one thing……errr keeping the intension first…..the decision I have chosen of course…..to be keen about it as I said…..and not let the frustrating factors affect me…..Solve all the problems….even if its economical…if this year I will not be able to finish it because of money, so I have to save money first and then I will achieve it….so its not my worrying point…..maybe it will affect the time also…..but its not worrying me more than other challenges I mentioned……because I'm afraid I listen to my family…… | Keeping the intension to learn | 12-May-2017 |
| P13 | 33 | Work…..because every day I'm working, I see situations and I would like to add…..to be developed more, to be improved more…..to be effective more….to be a good status more…..everything…… | Developing through daily practice | 12-May-2017 |
| P13 | 33 | Many…..there are many people….not from [the institute]…they are older than me and they had a good experience……I received from them the advice and I asked them about many things I want to do…..They are really support me about my decision….they love the nursing career…..Even the didn't achieve what I want to achieve but they are saying I have to achieve……So they are advising me to go through and really I respect their opinion of course and advice…..Its not one or two or three….its like more | Support from senior colleagues | 11-May-2017 |

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| | | than…..from different units in the centre…..my colleagues…you are respecting them and they are respecting you and supporting you…… | | |
| P13 | 34 | Also, the persons who are near to me like my oldest brother…..the stakeholder of the family [laughing], I have his support also……he likes that…he is a nurse…..Maybe he doesn't like that I am a nurse, but he didn't say it….he is supporting me all the time…..Even he was the one asking me during the beginning of the [institute] period to leave…..He was worried about the institute…like if I would pass or not….also it was not an Egyptian curriculum and approved by the Ministry…he is my bother and he worry about me…….because he didn't know about the institute and what they are doing….but my level now he is thanking me because if I listened to him before I would not have this intension, this career, even this motivation to go on……he feels like I'm a different nurse….Sometimes I was joking and I said let me work with you in the hospital you work in….he is not like a Charge Nurse…be he feel like I didn't study in Egypt…..I'm a different nurse….I said I want to work with you [his brother] but I was joking really…..he refused totally! [laughing] | Family support | 11-May-2017 |
| P13 | 34 | I need to be….yes of course……I'm not talking about my feelings or what I have, I'm looking at the external what affect me…..The word intension I think that affect like goals and planning, even confidence, even human factors….so if you have the intension to do something, you will do it…… | Having intention to develop | 12-May-2017 |
| P13 | 34 | Its difficult to decide……but I would never work in a governmental hospital…..unless all the plan will be changed……all the plan will be changed! | Government hospital | 12-May-2017 |
| P13 | 35 | Maybe I would think about but maybe it would be something to do but not working….maybe I ask for work in a governmental hospital but I will not work…..just apply and have a vacation……without salary….I'm with you but I will not work…..I have health insurance now so it doesn't matter…..Let me finish the mandatory two years first and think about it….but if I thought about it, sure I will not work…..maybe I will apply as you said for that, maybe I pay for that but I will not work….I think its difficult…I have visited many hospitals and I found all are the same…..poor quality….. | Government hospitals | 12-May-2017 |
| P13 | 35 | Of course….from the beginning I said this organization helped me because its like working on a standard I have learned….. | Quality hospital | 12-May-2017 |

Comments extracted from: Document1
Created by: XXXXXX
Creation date: June 18, 2017

| Participant ID # | Page | Text Segment | Assigned Initial Code | Date |
|---|---|---|---|---|
| P13 | 35 | Of course….from the beginning I said this organization helped me because its like working on a standard I have learned…..but imagine if I work in a governmental hospital now during this mandatory years? I will lose everything I have learned in the [institute] so I will not build up…..just after that I want to refresh what I have learned…..not destroy……of course…… | Government hospitals | 12-May-2017 |
| P13 | 35 | It will be better…..it said that….for development, for high status, for position…..helping…effective in society…..everything……maybe I will be an educator in Egypt…..I will be helpful for my country….. | Doing a Masters | 11-May-2017 |

## Appendix XXI: Example of Reduction of Initial Codes

| Assigned Broader Code: | Geography | | | |
|---|---|---|---|---|
| **Broader Code Description:** | **Highlights accessibility issues surrounding TDNs' ability to attain further higher education after graduation due to centralisation of Egypt's educational infrastructure to the capital Cairo. Moreover, it also describes the challenge of TDNs living away from their families to pursue opportunities to advance their careers.** | | | |
| **Participant ID #** | **Page** | **Text Segment** | **Assigned Initial Code** | **Date** |
| P6 | 24 | I feel I need some courses but here in [the local area] its not available……like hospital managing….we need to have a course like that and also English courses……we need to have some courses for motivation…….also not just for working but for our self……and for motivation. In Cairo everything is available and cheap about courses and everything but here in [the local area] we didn't consider the teaching and courses and things like that……. | Access to courses | 01-May-17 |
| P2 | 7 | I have got a good score in the institute so I have the errr government university I have applied my paper as good and its approved but its all about the work and the university…..the university in my town…. | Applied for university in home town | 25-May-17 |
| Pilot 2 | 31 | When I came to [the institute] she…she wasn't happy because I am away from her | Being separated from family | 01-May-17 |
| P5 | 33 | The disadvantages of staying here in [the hospital] is not to continue the education and you will stop in this….the only place you will stop is [the hospital]……because no other places ignoring about your certification…….but [the hospital] will evaluate you about your skills and practice and experience…..and knowledge but another place not accept that…….so I left [the hospital] at any time I will not working in another place….. | Can't continue education if stay at hospital | 16-Jun-17 |
| P16 | 24 | It's a very crowded country….its a big country and I can't, you know….I can't walk alone, I can't…..I can't know the places…..transport….for me its difficult….and I don't like to be alone…..being alone is scaring me….. | Challenges of living in Cairo | 12-May-17 |
| P4 | 10 | For a few years and after that I will come back to [the hospital] again | Coming back to hospital | 09-May-17 |
| P12 | 18 | They agreed because they agreed to let me go to the institute in [the red sea] and I am from upper Egypt….it is so difficult to leave my home and leave my city….to go outside my city……and they let me go….now they can let me go a second time…… | Cultural constraints for women living away from home | 07-May-17 |
| P12 | 17 | Yes, a big decision! Because since graduation I stay here in the centre….I learned here everything….knowledge, practice, I take my first money here……everything its here! And when I leave the centre I feel like, what I will do after that? It is a big decision, yes…… | Decision to leave the hospital | 07-May-17 |
| P12 | 27 | Yes….it was a very hard decision……. | Decision to leave the hospital | 07-May-17 |
| P5 | 33 | Very difficult….the most difficult decision I take in my life……but I will have a good position or grades here in [the hospital] and all of my colleagues get a positon here…..[name of colleague] get a Charge Nurse in ICU, [name of colleague] Charge Nurse in Adult ward….[name of colleague], Charge Nurse……why I not have a position here? And also I will be balanced between……it's the same for me…..if you continue there is advantage and disadvantage and also if you stay there is advantage and disadvantage…..I take time to choose which one is preferable for me……But I didn't not feel happy about me decision……I feel happy……. | Difficult decision to leave hospital | 16-Jun-17 |
| P13 | 18 | Yes, I asked about other universities in Egypt, good universities like [names a list of private universities in Cairo] but it was difficult, it was really difficult about the work, the place….its not applicable…..its difficult….I found I have to spend the two years first here and then go to apply….so I'm sitting for the two years doing nothing…so I can have a certification here….. | Difficult to study in Cairo | 11-May-17 |
| P5 | 32 | Yes it was very difficult……. | Difficulty decision to leave hospital | 16-Jun-17 |
| P15 | 8 | The challenge just in the money, it need a lot of money…..also the distance….between here and my city also….. | Distance between home and hospital | 30-Apr-17 |
| P14 | 17 | Also the distance between the Delta and here…. | Distance between home and hospital | 30-Apr-17 |
| P17 | 23 | I live in the Delta so its quite far away | Distance between home and hospital | 20-May-17 |
| P1 | 32 | Asuit…no down….Aswan is down and err upper Asuit and then upper Cairo and then Alexandria. | Distance between hospital and family home | 03-Jun-17 |
| P6 | 35 | Maybe…..according to the time……and according to the area around us, if we have a good chance in Cairo we will go…..its a long distance between our village and here in [the hospital] | Distance between hospital and home | 02-May-17 |
| P12 | 33 | and it should be near to me…… | Distance between hospital and home | 08-May-17 |
| P15 | 15 | It will be difficult to stay here [in the local area] 12 hours from my city forever…..I have to go for my family and also I don't know what will happen after marriage…I don't know if I can adapt or both of us with the traveling all the time…. | Distance between hospital and home | 30-Apr-17 |
| P14 | 8 | if I joined the university I will leave the hospital…so I didn't want to leave the hospital right now….. | Distance between hospital and universities | 30-Apr-17 |
| P14 | 3 | According to the place, I am from around the Delta…it takes 12 hours from there to [the hospital]….the distance away from my country…… | Distance from home to hospital | 20-May-17 |
| P1 | 31 | No I'm from Asuit | Distance from hospital and family home | 03-Jun-17 |
| P1 | 31 | Nine hours…. | Distance from hospital and family home | 03-Jun-17 |
| P8 | 18 | Yes……and also I don't like to live in Cairo because its too busy and very crowed…to go to work it will be two hours……traffic….these things came in my mind…..here is a very quiet city and I love it too much….I have friends here…so it helps….. | Does want to live in Cairo | 17-Jun-17 |
| P9 | 16 | its beside my work, I cannot leave my work and take my degree… | Doesn't have to leave work to do degree | 05-May-17 |
| P9 | 13 | For my work, I'm really satisfied…..out of work, the city itself is very beautiful…..there is no crowded…..I hate Cairo because it is very crowded…..and I cannot live in Cairo….so [this area] is like my village…… | Doesn't like Cairo | 05-May-17 |
| P9 | 22 | No because I hate working in Cairo…..in the first when we graduated, we had the choice of [a children's cancer hospital in Cairo] or here…….because Cairo is a very crowed city so I choose here……even Cairo have a lot of cardiac center….but the city itself…….not the nature of work…..although Cairo is nearest to me rather than here for my village….between Cairo and my village, three hours….here and my village, 18 hours! | Doesn't like Cairo | 05-May-17 |
| P2 | 8 | I found the chances here is much better….I have built up myself a little bit and I have made my name in the unit…I have a good position so….. | Doesn't want to leave good position | 25-May-17 |
| P1 | 40 | I said lata [Arabic meaning 'no' in English] [Laughing] | Doesn't want to return back home | 03-Jun-17 |
| P5 | 31 | Yes, but the money…….the money for food or transfer to home or traveling or something like that, it will be more……and housing….its four thousand for housing….. | Expenses of living in Cairo | 16-Jun-17 |
| P5 | 36 | In upper Egypt, ten hours by train far away from [the hospital] and three hours and a half far away Cairo….. | Family home far from Cairo | 16-Jun-17 |
| P11 | 14 | I feel worried…..because I will start from the zero…..I will start to search about new job in new hospital and I don't know how they deal with each other there and in my country I didn't know anything, just my home only….. | Feeling worried about returning back home | 03-May-17 |
| P9 | 19 | Maybe if I don't work in academic career, I have a good hospital better than here near to my home | Going back home | 17-Jun-17 |

| P8 | 19 | Everyone will go to his home when he become old….also the governmental hospital will support you with money after you retire…..if I work in an non-governmental hospital, it will not provide me with anything after retirement…….. | Going back home | 17-Jun-17 |
|---|---|---|---|---|
| P6 | 14 | I was thinking about Cairo….if we can go to Cairo and complete our studies in any college….But we will have a problem…..the salary will be deceased….we need to take a flat there…..our life will be changed a lot…. | Going to Cairo | 02-May-17 |
| P6 | 20 | There is many opportunities but we need to have the easiest one first…..Like two Technical years, it will be very helpful for us…….working and educational together will be very effective for us……but if we don't have this now, we will go inshallah [Arabic word meaning 'God willing' in English] to Cairo…..but after time…… | Going to Cairo to study | 23-May-17 |
| Pilot 2 | 24 | I want to finish my two years of err….after the institute, working in the hospital then I want to apply to university in Cairo… | Going to university in Cairo | 01-Jun-17 |
| P5 | 33 | Very difficult….the most difficult decision I take in my life……but I will have a good position or grades here in [the hospital] and all of my colleagues get a positon here…..[name of colleague] get a Charge Nurse in ICU, [name of colleague] Charge Nurse in Adult ward….[name of colleague], Charge Nurse……why I not have a position here? And also I will be balanced between……it's the same for me…..if you continue there is advantage and disadvantage and also if you stay there is advantage and disadvantage…..I take time to choose which one is preferable for me……But I didn't not feel happy about me decision……I feel happy……. | Have to leave hospital to study in Cairo | 16-Jun-17 |
| P4 | 15 | What makes me look for another place, especially in Cairo is cause in the previous year I was looking for any place I join a faculty and the same time I could have a work so this is what making me look in Cairo | Having to go to Cairo to continue education | 09-May-17 |
| P3 | 38 | Yes….and if I leave Aswan, I will leave [the hospital] so it will be very difficult | Having to leave the hospital | 24-May-17 |
| P16 | 24 | The main issue is my work here…I will leave or I will just go and come….. | Having to leave the hospital | 17-May-17 |
| P4 | 29 | Its limited yeah….because I don't think in any day I leave [the hospital] to any other institution except in the chance that I didn't get the chance to join [the local university] so I need to leave [the hospital]….but I think this is the best in Egypt…. | Having to leave the hospital to do degree | 10-May-17 |
| P10 | 15 | We can take a home next to the hospital……and also he is in the airport | Home next to work | 22-May-17 |
| P12 | 20 | If its near….. | Hospital near to home | 08-May-17 |
| P12 | 24 | Yes…..the problem here [in the local area]. Its so closed….you cannot make anything, just working….but in Cairo its open….you can take a Diploma of infection control, diploma of hospital administration…..diploma of quality….a lot of branches….You can do it inside your field…but in [the local area] its so closed…… | Lack of access to education | 07-May-17 |
| P10 | 15 | This hospital is like my place…..my home….I spend a year and two months and leave for one week only so it's a difficult decision but it should be…….one day I will leave…..its the right decision but it effect on me……I will leave the place that I learn, the first place for me that I see people in reality……working…… | Leaving the hospital | 04-May-17 |
| P13 | 14 | [laughing] There is plan A and B but honestly I will not be at [the hospital]…but after finishing my duty here, my two years…..and also one or two years, it will be a good time to learn what I can learn here….but after that it will be routine…..even if I have a high position in the place……because I think, the high position here, they are thinking about leaving the place…..So why I'm thinking about the positon, I'm not thinking about leaving the place…..not leaving the place because I hate the place, of course not, I like it and as I said there are many things that prevent me from doing that…..its a good place….but what about after? | Leaving the hospital | 12-May-17 |
| P4 | 17 | I'm waiting for the final answer from the faculty here……I hope so that their answer is going to be positive…..because I love to stay here in Aswan and work here in [the hospital]…..but this is the life in Egypt….. | Leaving the hospital to do degree | 09-May-17 |
| P14 | 17 | Also, the way in Cairo not easy…..housing, driving….and also the financial issues….its a big issue in Cairo…..we asked about all of this…… | Living in Cairo | 22-May-17 |
| P13 | 19 | Like ten to eleven hours…so its difficult….. | Long distance between hospital and home | 11-May-17 |
| P7 | 16 | This would effect on my work, from a long distance from here to there……to the [local] university….its along distance…..it will take from you an effort and time….. | Long distance between hospital and university | 05-May-17 |
| P4 | 18 | Because Cairo have lots of the opportunities especially in the faculty…..they have the [university] and the [university], so they have lots of the faculties that I could join. | More opportunities in Cairo to continue education | 09-May-17 |
| P12 | 21 | Yes, it will be a new city, it will be a new hospital, new system, new people! It will be a new experience…. | Moving to Cairo | 08-May-17 |
| P15 | 13 | I would go to Cairo…..to [states a university in Cairo] | Moving to Cairo | 17-May-17 |
| P16 | 11 | I don't want…..[laughing] I can't live in Cairo……I don't like this…..but I have to find a way….. | Moving to Cairo | 12-May-17 |
| P16 | 24 | I will not be willing to do but if I don't have a choice, so I will….. | Moving to Cairo | 17-May-17 |
| P16 | 25 | I just need to know a primary things for this…..after this, the secondary things I can find out…..maybe living with colleagues I know…..one from my family will move to live with me….. | Moving to Cairo | 17-May-17 |
| P17 | 15 | Because I depend on myself since I was in the Technical institute, so I depend on my salary now….I am not talking any money from my family….so if I transfer to Cairo it will make a very big effort for me….I need to go to the hospitals….I will not be permanent nurse here….the opportunity from here is very good….. | Moving to Cairo | 20-May-17 |
| P6 | 16 | Because it need clinical days so I have to be there…..I can't return back to [the hospital area] it's a long distance….. | Need to leave hospital to study in Cairo | 16-Jun-17 |
| P2 | 7 | Yeah, but I found it difficult to stay in the work…the bachelor degree there | Need to leave the hospital | 25-May-17 |
| P5 | 24 | Also, I have my friend, she studied at [a university in Cairo] management, will be with me. Also doctor want some people who live in Cairo, it will be near for me….. | New job in Cairo | 16-Jun-17 |
| P6 | 33 | We need take only a vacation…… | Not planning on going back home | 02-May-17 |
| P6 | 35 | Maybe…..according to the time……and according to the area around us, if we have a good chance in Cairo we will go…..its a long distance between our village and here in [the hospital] | Opportunities in Cairo | 02-May-17 |
| P16 | 10 | it is my Supervisor and then I…..so I should leave without….we have to put a plan for the unit before I leave……He told me that I will help you if you want to join this, I will help you…..but I know the responsibility….. | Planning to leave the hospital | 17-May-17 |
| P10 | 13 | There is a Bachelor here but I will not enter because I only have eight months then I will leave…..so I plan to have in my country after I working and have a good position in another hospital so I will join another Bachelor…. | Plans to leave the hospital | 04-May-17 |
| P14 | 18 | Also, I have the plan I will not complete all my life in [the hospital]…..it could be in my city in another hospital……in a governmental hospital…..could be…… | Plans to work in another hospital | 21-May-17 |
| P11 | 10 | After I finished here I will return back to my home and search about a hospital…we have a private cardiac hospital….I will ask about it and beside it I will continue my education… | Returning home | 04-May-17 |
| P11 | 16 | Yes…..I will start to search and asking to join a governmental hospital or private hospital……its according to the availability in our country….. | Searching for a hospital | 04-May-17 |
| P6 | 20 | We will go to and ask first before leaving here….we have many friends in Cairo……they can help us…..Also, we will go to the college and ask, what is available, what is the best for us…….Where we will work, where we will live…… | Searching for opportunities in Cairo | 02-May-17 |
| P9 | 24 | No….because I will stay in [the hospital]….. | Want to stay at hospital | 06-May-17 |
| P11 | 27 | I feel enough to be here….I feel I have learned knowledge, skills, being a part of this hospital…..I think its enough…..to being here…. | Wanting to go back home | 04-May-17 |
| P11 | 27 | [The local area], not in the hospital…… | Wanting to go back home | 22-May-17 |
| P5 | 40 | But if they want me anytime I will come……if is available for me work, I will come…..because also they help my dad a lot here……I never forget this point…… | Wants to return back to hospital | 16-Jun-17 |

| | | | | |
|---|---|---|---|---|
| P9 | 12 | Five years from now? Errr to have a position in my field……because I didn't plan to go from the centre….I need to complete my life in the centre….. | Wants to stay at the hospital | 05-May-17 |
| P10 | 14 | I want to work in [a hospital in Cairo] | Wants to work in Cairo | 04-May-17 |
| P5 | 42 | And I also did an interview in [a hospital in Cairo]….in CCU as a CCU Staff Nurse, they accept…..and also they told me that we want this nurse for ICU, not CCU. But I told them I can't work in ICU because it is general and adult and I'm working cardiac and paediatric…..and I can't change both of them…..I can change and working in adult in CCU but I can't change two. So after that no, I didn't went to [the hospital] because the time not available with my schedule……It need to be a morning….one week for orientation........ so I can't go morning shift. They told me its ok, you can come in the vacation……this vacation….but I return back here in [the hospital] because they need me and they called me before coming [the hospital] one day and I said sorry I will return to my work, he told me, when will you return back? I said to him in March, he told me he will call me…. | Working in new hospital in Cairo | 16-Jun-17 |
| P5 | 34 | Yes……..if the university here I would have a both of them….. | Would stay at hospital if it was near university | 16-Jun-17 |
| P7 | 30 | Like here with my friends…close friends…..I love the place…..there is a good memory here in [the hospital]….like if I'm in Cairo I will lose it…..or forget it….so my personality is if I'm in a place I loved it, I cannot be away from it easily…..like when we was at the institute and I was with my friends and all of us…..the last day in the institute was a hell with me…….I was crying……I cannot leave a place a loved yannie. But if I took a decision I will do it……and I will put everything under my feet….. | Does not want to leave the hospital | 03-May-17 |
| P7 | 12 | how to be away from here? More than one thought yannie…..to be away from here and start from the zero point….. | Having to leave the hospital | 03-May-17 |
| P7 | 12 | Yes, the position! I think its challenging me now…. | Having to leave the hospital | 23-May-17 |
| P5 | 12 | Yes….If there is a university here like [a private university in Cairo] I can….but to be away from the hospital after I have gone through steps that no one can catch it by easy way……these are thoughts that make my mind………saladta [Arabic word meaning 'salad' in English] | Having to leave the hospital for study | 03-May-17 |

## Appendix XXII: Participant Characteristics

*Overview of characteristics of Phase 1 participants:*

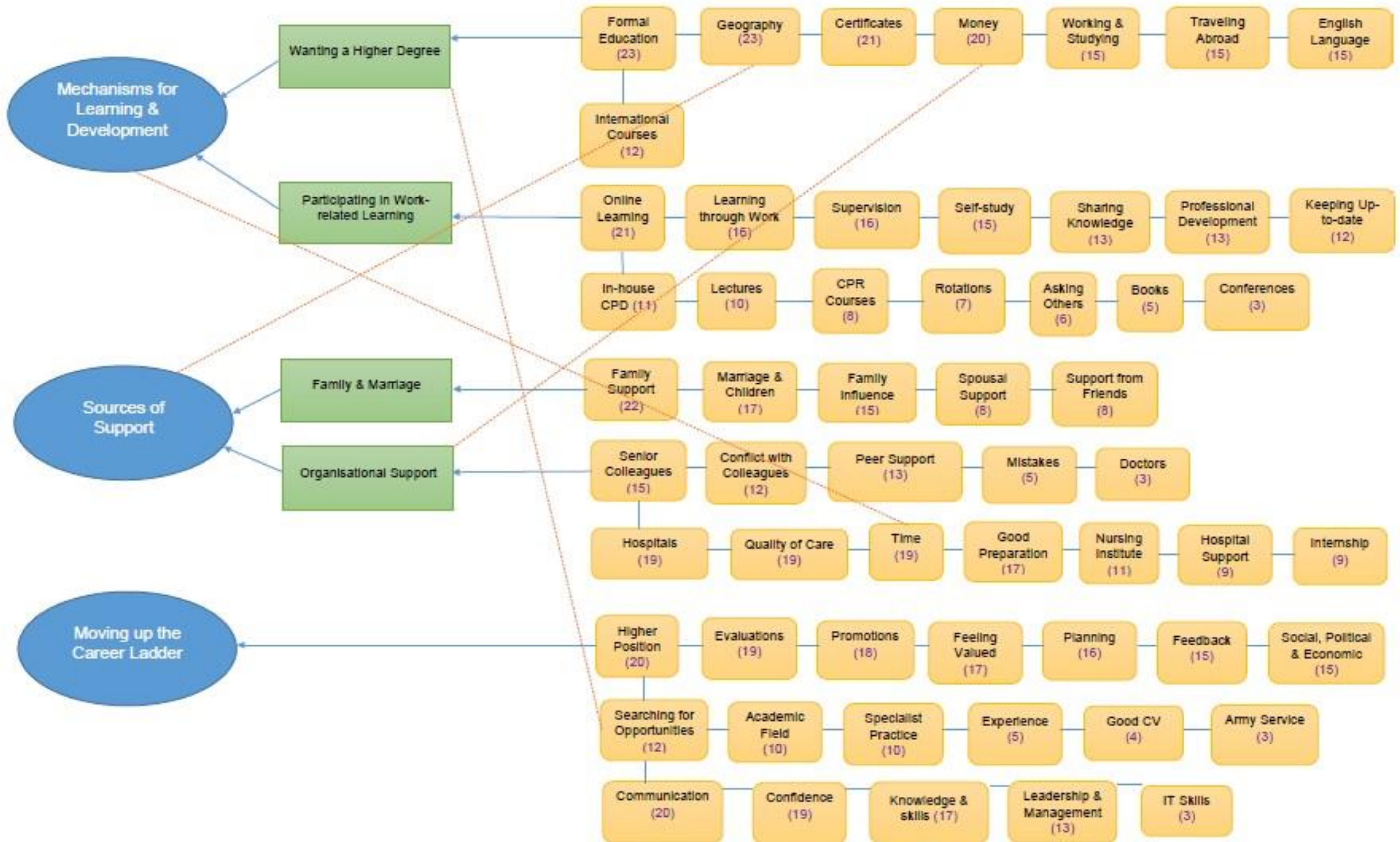
| **Age** | **Mean** |
|---|---|
| | 23 |
| **Gender** | **Total #** |
| Female | 9 |
| Male | 9 |
| **Graduation Date** | **Total #** |
| 2016 | 4 |
| 2015 | 5 |
| 2014 | 5 |
| 2013 | 4 |
| **Job Position** | **Total #** |
| Staff Nurse | 9 |
| Acting Charge Nurse | 5 |
| Charge Nurse | 2 |
| Specialist Nurse / Other | 2 |
| **Specialty** | **Total #** |
| Adult Intensive Care Unit (ICU) | 6 |
| Paediatric ICU | 3 |
| Adult Ward | 2 |
| Paediatric Ward | 2 |
| Coronary Care Unit | 3 |
| Heart Failure Unit | 2 |
| **Enrolled in Higher Degree** | **Total #** |
| Yes | 6 |
| No | 12 |

## Appendix XXII: Participant Characteristics

*Overview of characteristics of Phase 2 participants:*

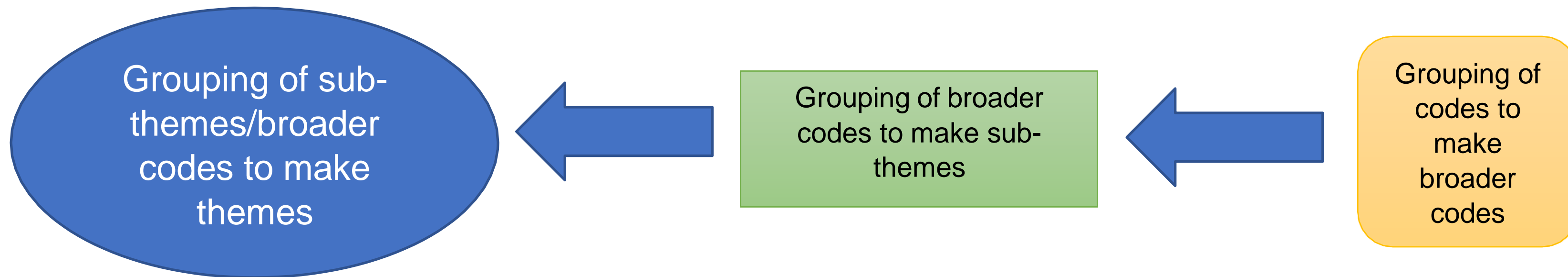
| Gender | Job Position | Place of Work | Date Appointed |
|---|---|---|---|
| Male | Senior healthcare professional (Nurse) | Stakeholder Hospital | 2015 |
| Male | Senior healthcare professional (Nurse) | Stakeholder Hospital | 2015 |
| Male | Senior healthcare professional (Doctor) | Stakeholder Hospital | 2015 |
| Female | Senior academic nursing faculty member | Technical Institute of Nursing | 2011 |
| Female | Senior academic nursing faculty member | Technical Institute of Nursing | 2011 |

**Appendix XXIII: Final Thematic Map**



## Appendix XXIII: Final Thematic Map

**Final Thematic Map Key:**




Frequency of code mentioned by participants: (#)

Broader Code linked with another theme/subtheme:

## Appendix XXIV: Themes and Sub-themes Descriptions

**Themes and Sub-themes Descriptions (February 2018)**

| *Theme* | *Description* |
|---|---|
| ***Mechanisms for Learning and Development*** | Focuses on the particular types of learning activities in which TDNs engage in to develop professionally and/or advance in their careers |
| *Sub-themes* | |
| *Wanting a Higher Degree* | Depicts the emphasis placed on participating in formal postgraduate education to gain academic credentials in order for TDNs to progress in their careers. Issues related to the relevance, as well as the accessibility, affordability and availability of such courses are described. Underlying motivations for postgraduate education, along with reasons for seeking prospects for development outside of Egypt, are also highlighted. |
| *Participating in Work-related Learning* | Highlights TDNs' participation and engagement in informal, as well as organised learning activities within the workplace. Motivations for participation in such CPD activities, and its subsequent effect on TDNs' professional development are described. Barriers to learning within the clinical environment, such as time constraints are also stressed. |

| *Theme* | *Description* |
|---|---|
| ***Sources of Support*** | Focuses on organisational factors which were key to supporting participation in both formal and informal methods of CPD. Social support from senior colleagues and peers, as well as domestic support, which were influential in stimulating learning and advancing careers of TDNs are also described. |
| *Sub-themes* | |
| *Family and Marriage* | Focuses on the private lives of TDNs, namely the importance of domestic support and the influence of family, as well as marriage and children, on decision-making regarding TDNs' CPD and careers. |

## Appendix XXIV: Themes and Sub-themes Descriptions

| | |
|---|---|
| *Organisational Support* | Highlights the role of healthcare organisations in facilitating TDNs' development and career progression. The importance of a good standard of pre-registration nursing education to support the development of TDNs after graduation was also described. |

| *Theme* | *Description* |
|---|---|
| ***Moving up the Career Ladder*** | Includes issues related to career and promotional structures for TDNs. Aspects of the performance appraisal system within the host hospital are portrayed, along with perceived professional skills and attributes required for promotion. Career aspirations of TDNs and underlying motivations for such positions are additionally described. The issue of formal career guidance is also highlighted. Moreover, the status of the nursing profession within Egypt and the subsequent effect on TDNs' development is also emphasised. |